Quick OMT for the Busy Outpatient Clinic

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Objectives

- Briefly Review specific OMT techniques
- Practice quick screening and diagnosis techniques of somatic dysfunction
- Discuss somatic dysfunctions commonly seen in outpatient primary care
- Practice OMT for somatic dysfunctions commonly seen in outpatient primary care
- Review Reimbursement codes for OMT

Counterstrain Recap

- Indirect Technique
- Monitor counterstrain point
- Place patient in position of ease (≤3/10 pain)
- Hold for 90 seconds or until tissue releases

Functional Recap

- Indirect Technique
- Balance & Hold localizes ease in all directions and adds respiratory effort until balance of tissue tension occurs
- Dynamic indirect approach adds compression in direction of ease and follows the inherent tissue motion until tissue tension is relieved

HVLA Recap

- High-velocity, low-amplitude
- Direct Technique
- Directed force (short thrust) is applied to a synovial joint at the end of its passive range of motion

Muscle Energy Recap

- Direct Technique
- Incorporates post-isometric relaxation

Still Technique Recap

- Indirect, then direct articulatory technique
- Shortens tissue and uses compression

MFR

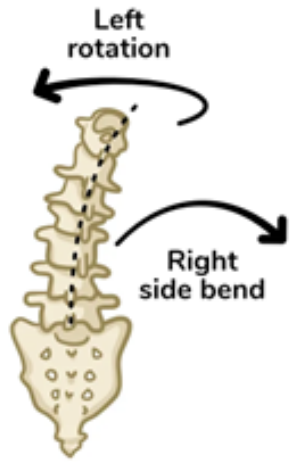
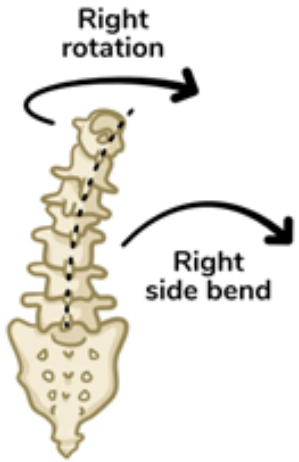
- Myofascial release
- Direct or Indirect
- Applies sustained manual pressure and stretching to the fascial tissue

TART

- **T** — Tissue texture abnormality (e.g., edema, fibrosis, muscle hypertonicity)
- **A** — Asymmetry of bony landmarks or soft tissue
- **R** — Restriction of motion (active and passive range of motion)
- **T** — Tenderness to palpation
- Find AGR

Evaluation of the Spine

- Screen
- Find AGR
- Fryette's laws
  - Type 1 dysfunction - group of dysfunction
  - Type 2 dysfunction – single segment

FRYETTE LAWS		
	PRINCIPLE I	PRINCIPLE II
MOTION	TYPE I Neutral	TYPE II Flexion & Extension
DIRECTION of ROTATION & SIDE-BENDING	Opposite direction	Same direction
EXAMPLE		

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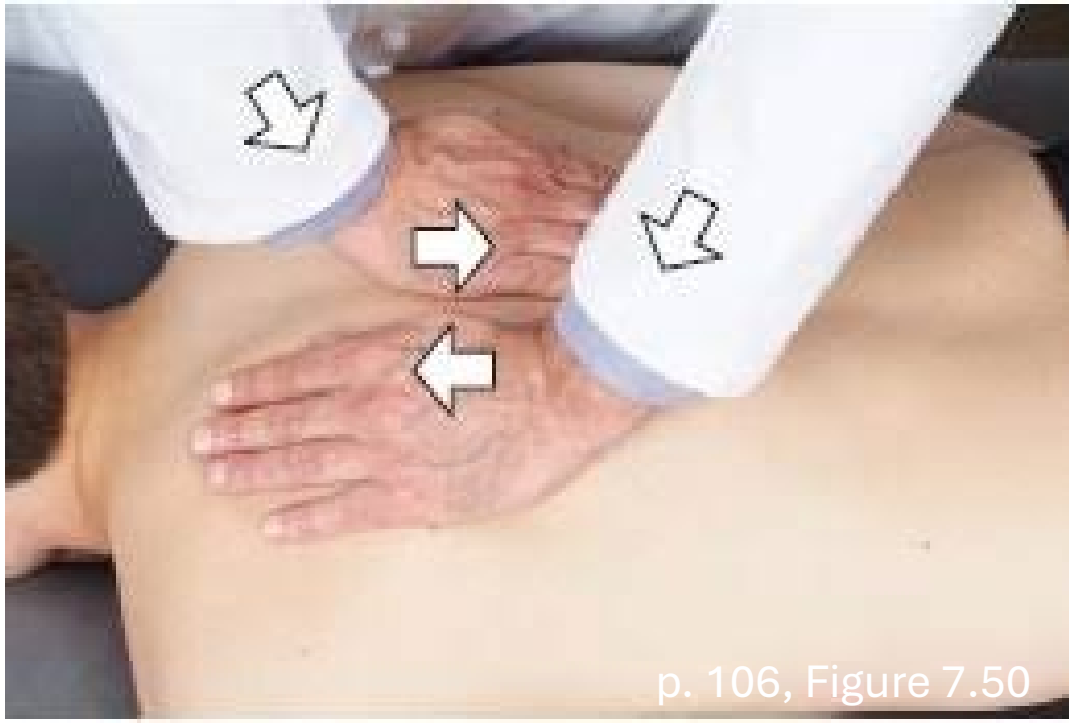
Unilateral



Bilateral

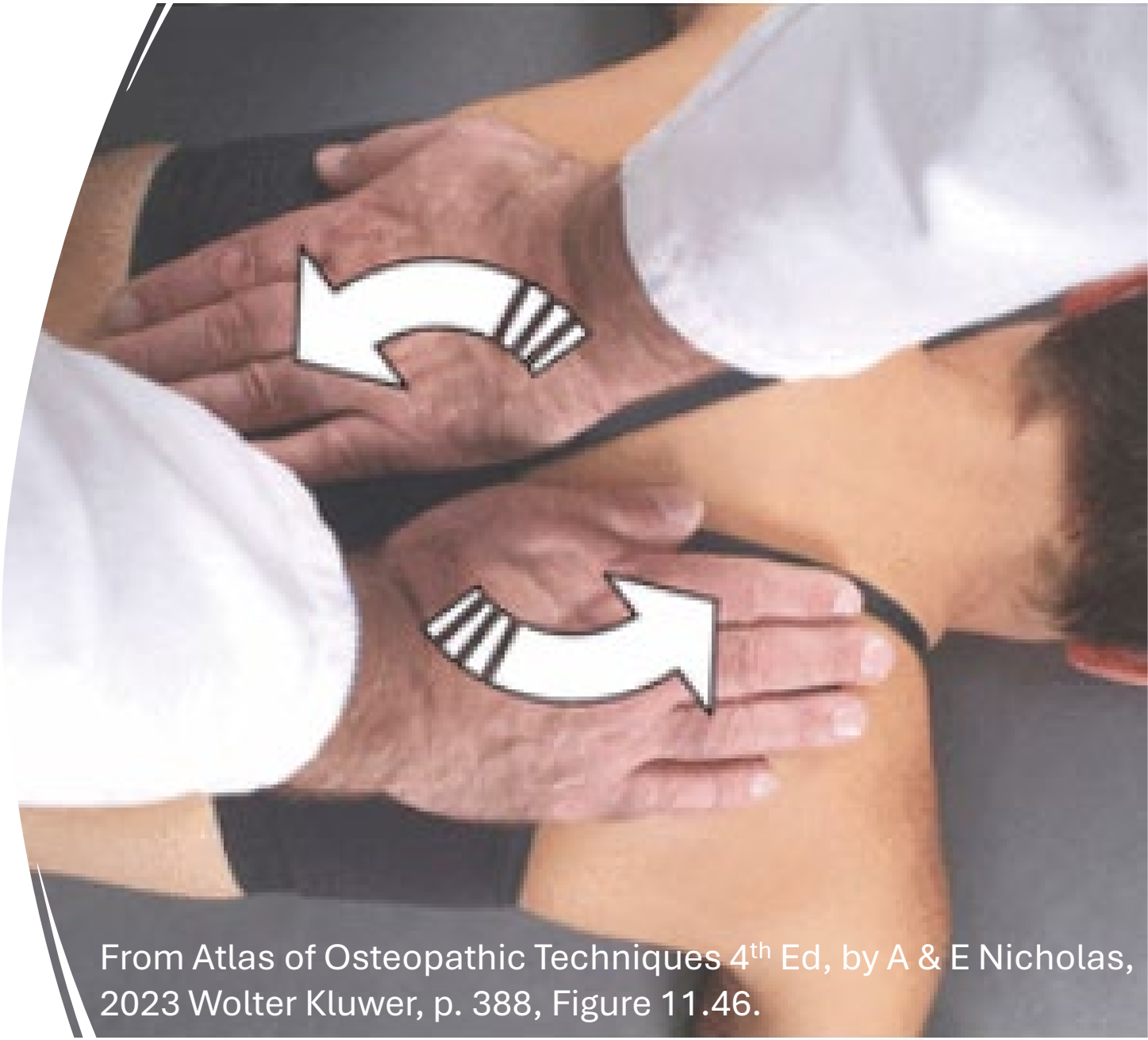
Thoracic Prone Pressure

Thoracic Spine Muscle Energy

- Direct technique
- Type 1 somatic dysfunction
  - Treat apex of curve
- Type 2 somatic dysfunction
  - Treat specific segment

HVLA Thoracic Spine: Texas Twist

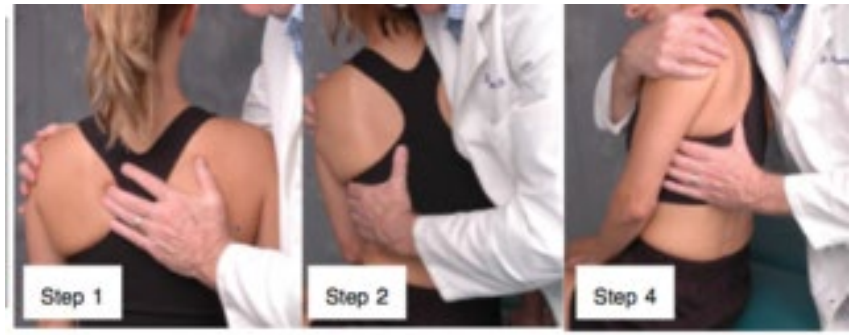
- Emphasis on side-bending and rotation
- Patient prone and physician stands on patient's side (opposite of rotation is usually more efficient)
- Physician places thenar eminence on posterior/shallow transverse process of dysfunctional vertebrae and other hand opposite
- Patient inhales and exhales and physician thrusts down/anteriorly during exhalation

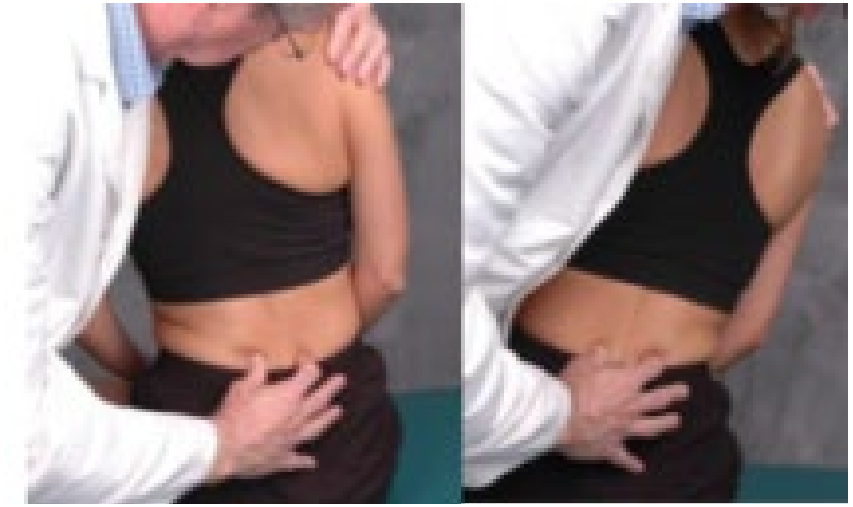


From Atlas of Osteopathic Techniques 4th Ed, by A & E Nicholas, 2023 Wolter Kluwer, p. 388, Figure 11.46.

Still Technique for Thoracic and Lumbar Spine

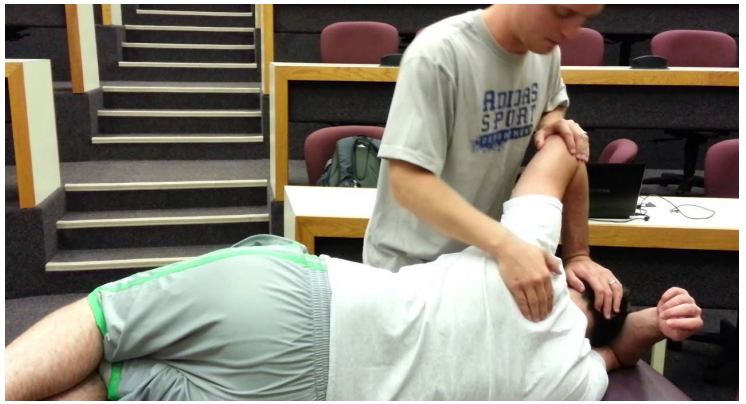
- Place patient in position of ease and add compression through spine
- Take patient to barrier until tissue releases
- Return patient to neutral

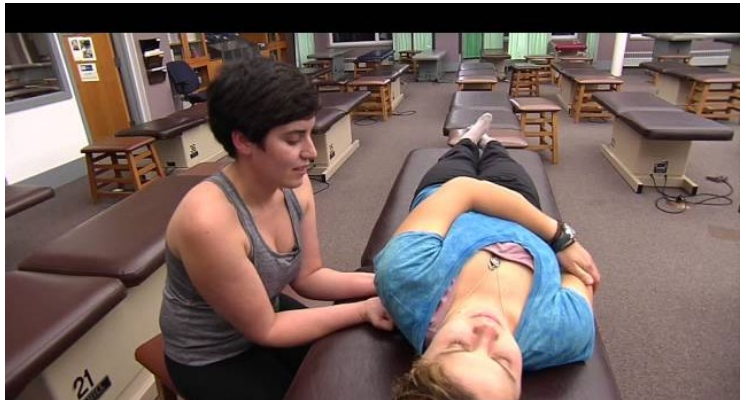


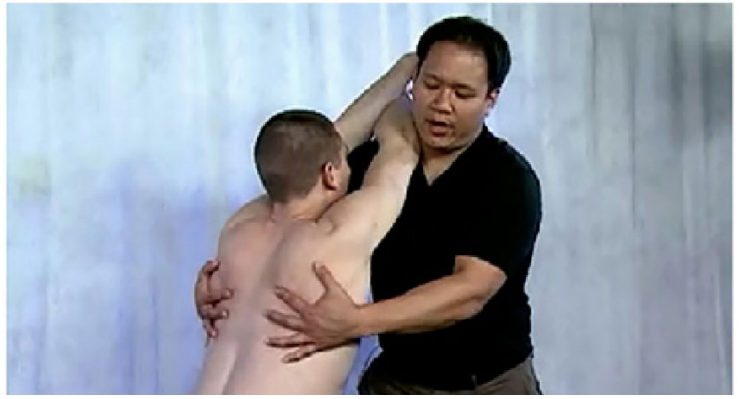


Rib Raising

- Lymphatic technique
- Indications
  - Lymphatic drainage
  - Improve respiratory excursion
  - Alleviate postoperative ileus
- Positions
  - Seated, supine, lateral recumbent
- Technique
  - Physician’s finger pads of both hands contact the paravertebral tissues over the costotransverse articulation
  - Pull tissue anterior and pull laterally or cephalad
  - Can do in an intermittent kneading technique or with sustained deep inhibitory pressure for 2 to 5 minutes



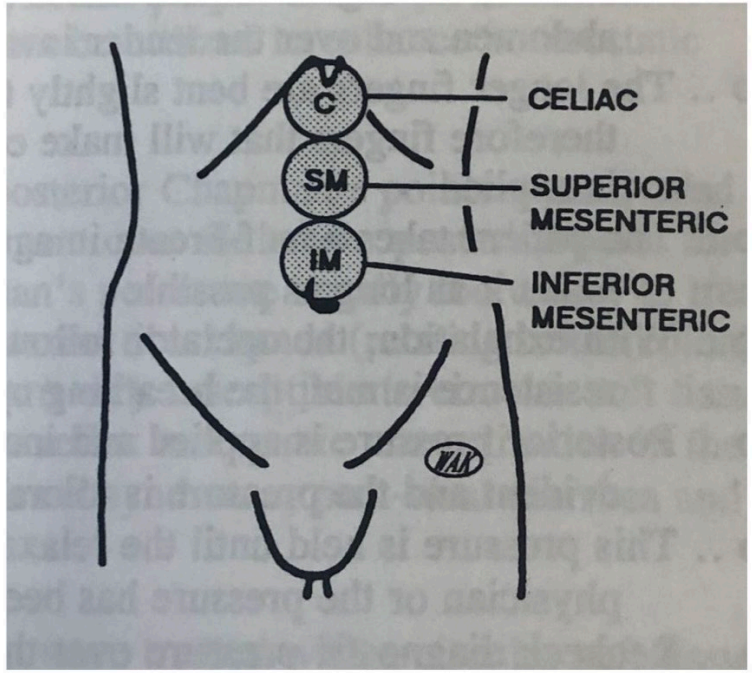




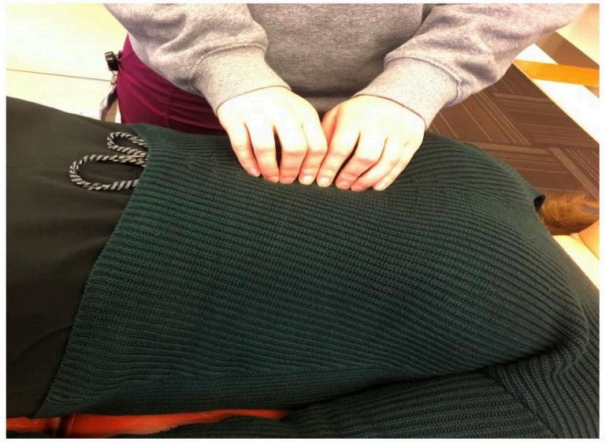
Common GI Concerns Coming Into Clinic

- Gastric Irritation (heartburn, cramps, nausea, etc.)
- Irritable Bowel Syndrome
- Diarrhea
- Constipation

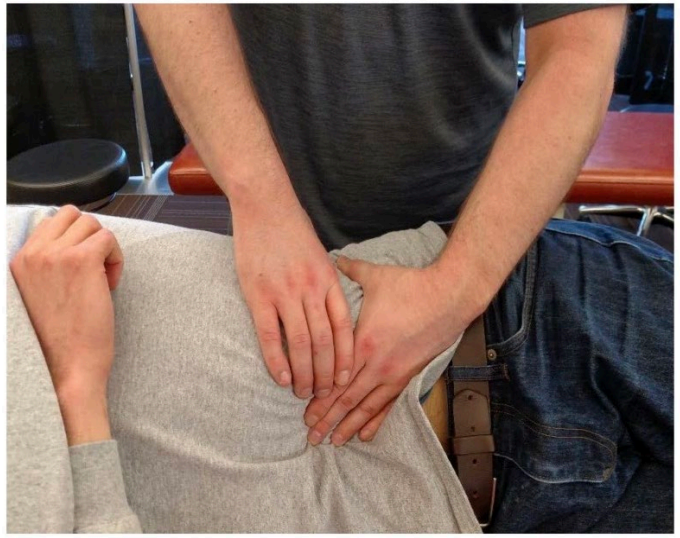
Abdominal Collateral Ganglia



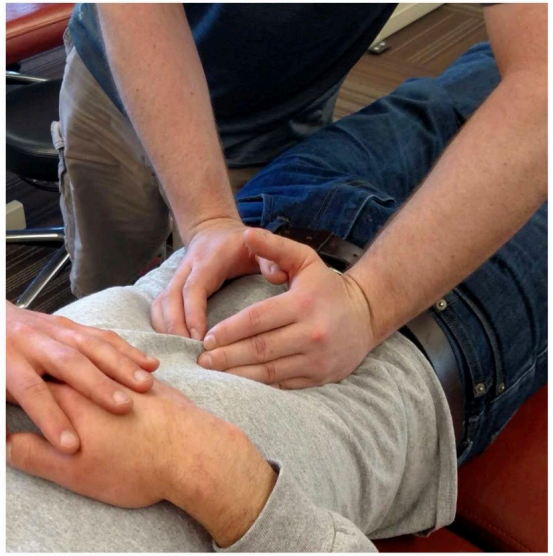
- Located in the midline of the abdomen along a "line" from the xiphoid to the umbilicus
- Celiac
  - Upper GI to Duodenum
- Superior Mesenteric
  - Small Intestine (below duodenum) to 1st half of the transverse colon
- Inferior Mesenteric
  - 2nd half of the transverse colon to the rectum and pelvic organs



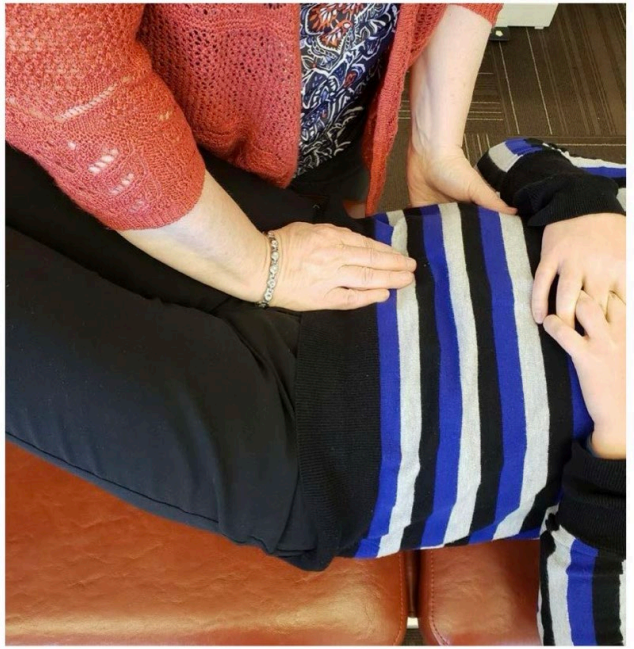
Intestinal Motility



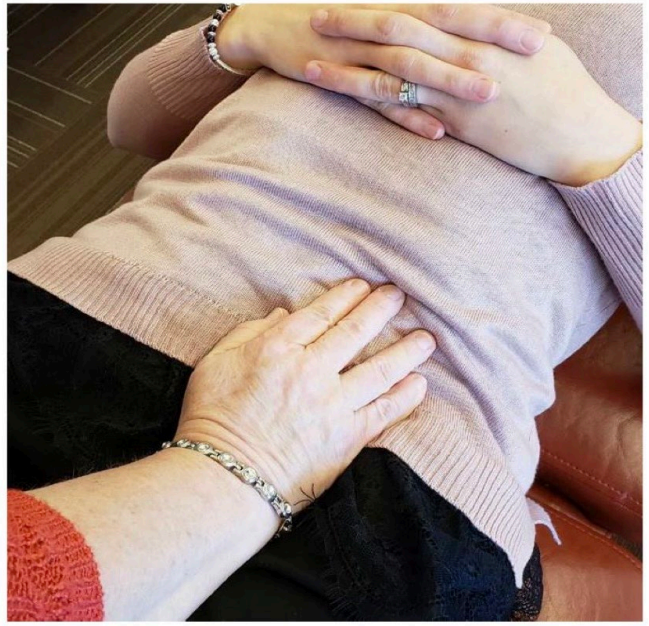
Still Stomach Technique



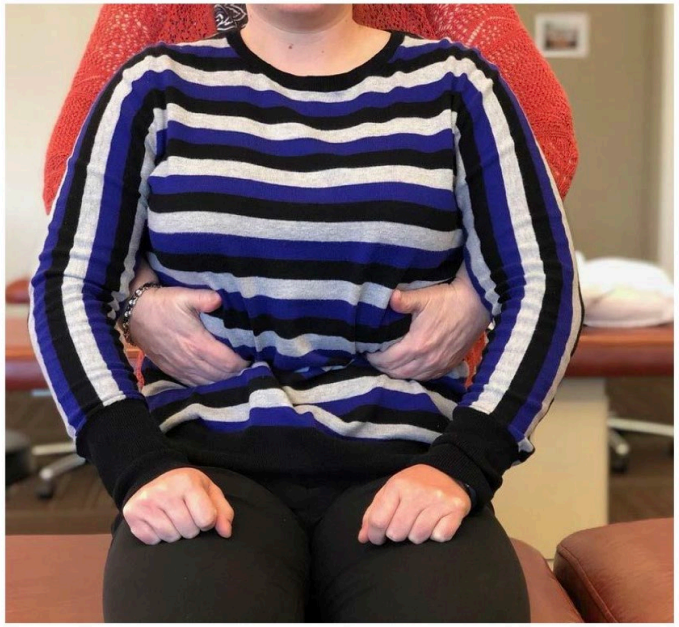
Small Intestine



Cecum Lift



Sigmoid Colon



Transverse Colon and Flexure

Colonic Stimulation

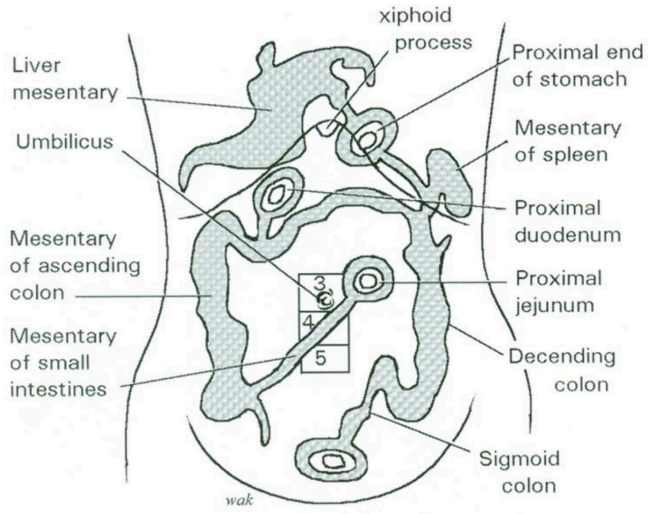
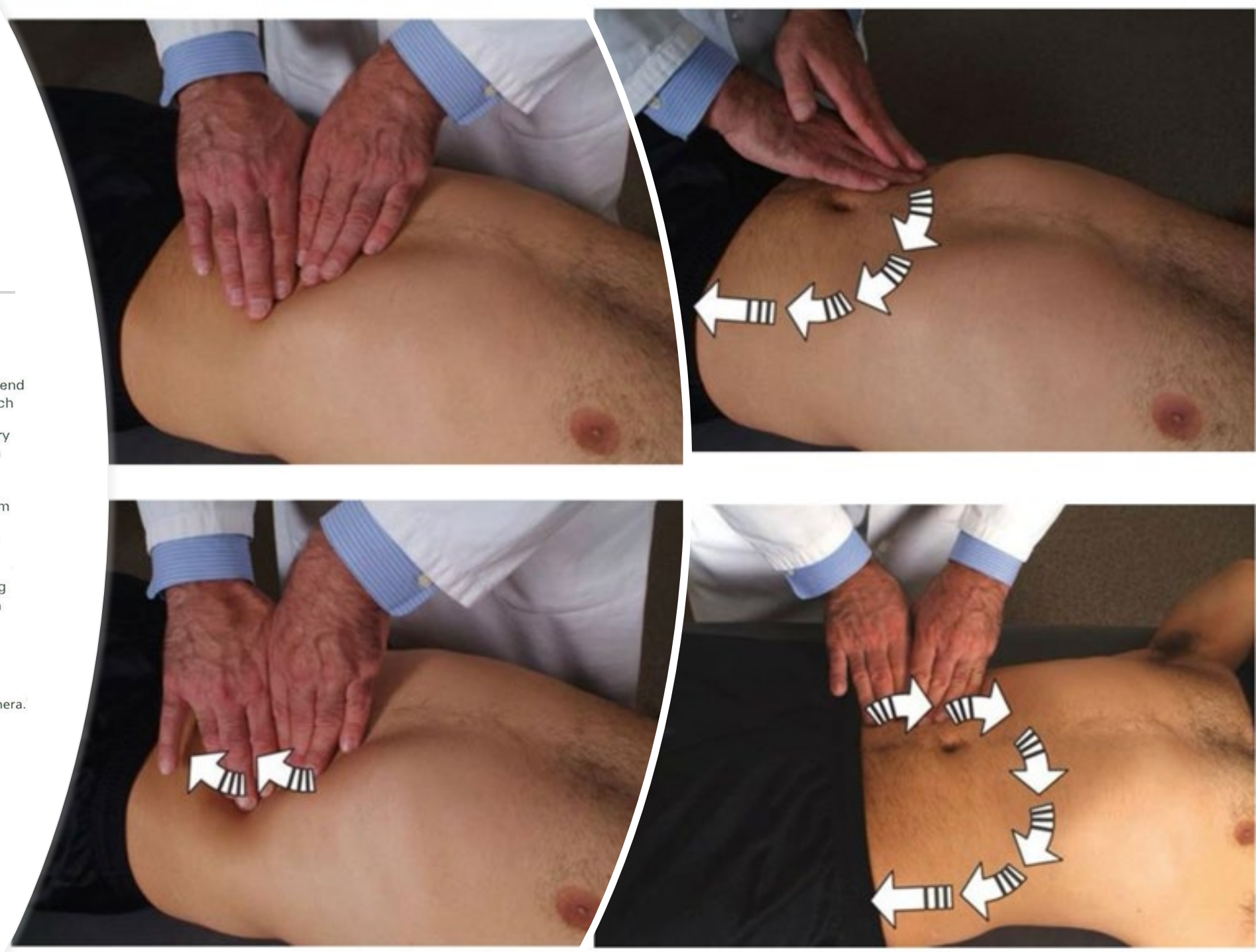


FIGURE 68.24. Mesenteric attachments. (Illustration by W. A. Kuchera.



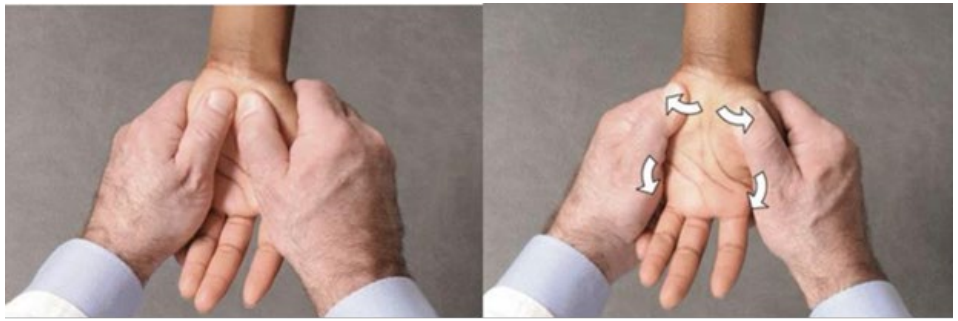
Mesenteric Lift

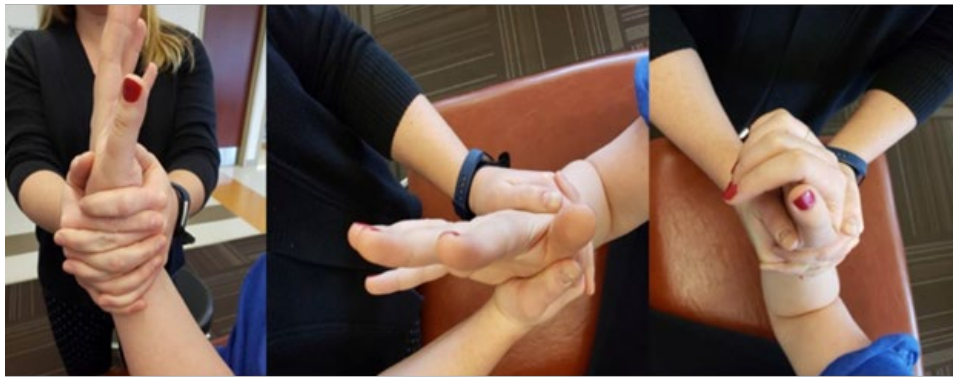
- Be sure to have the patient's supine with knees bent to soften abdominal wall
- Find the space between the small intestines and descending colon. Adjust angle of your hands as needed to forma diagonal line from the LUQ to the RLQ.
- Add pressure and ease fingers in slowly with exhalations
- Apply traction aiming toward the right shoulder and hold until release is felt.

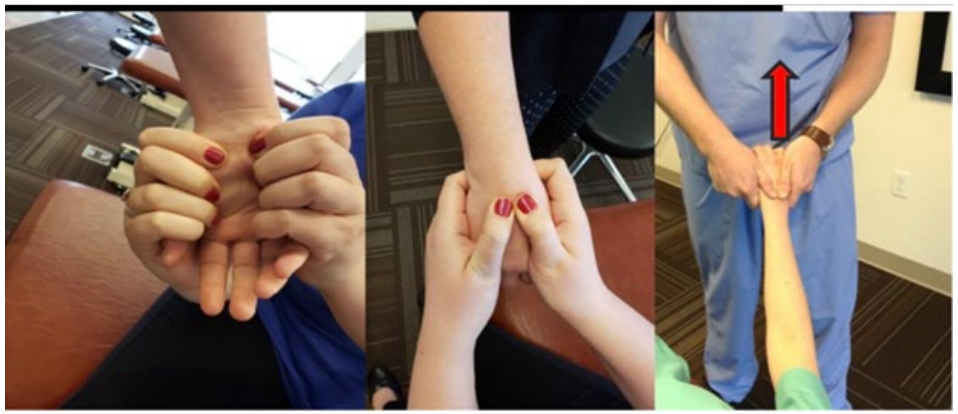
Common Upper Extremity Concerns

- Elbow pain
- Wrist pain
- Carpal Tunnel Syndrome
- Shoulder Pain

OMT for Carpal Tunnel Syndrome

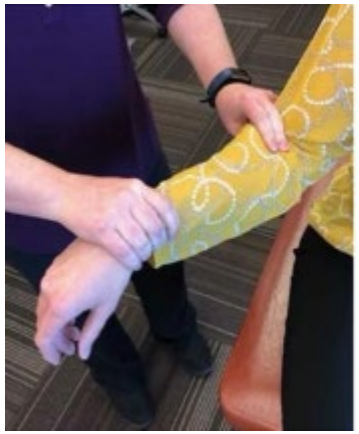


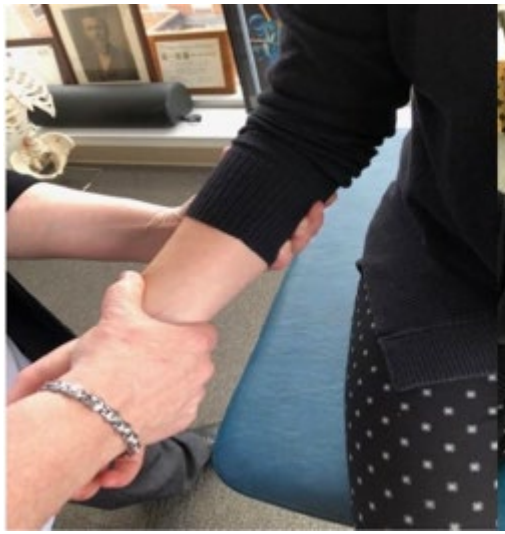




Radial Head Dysfunction

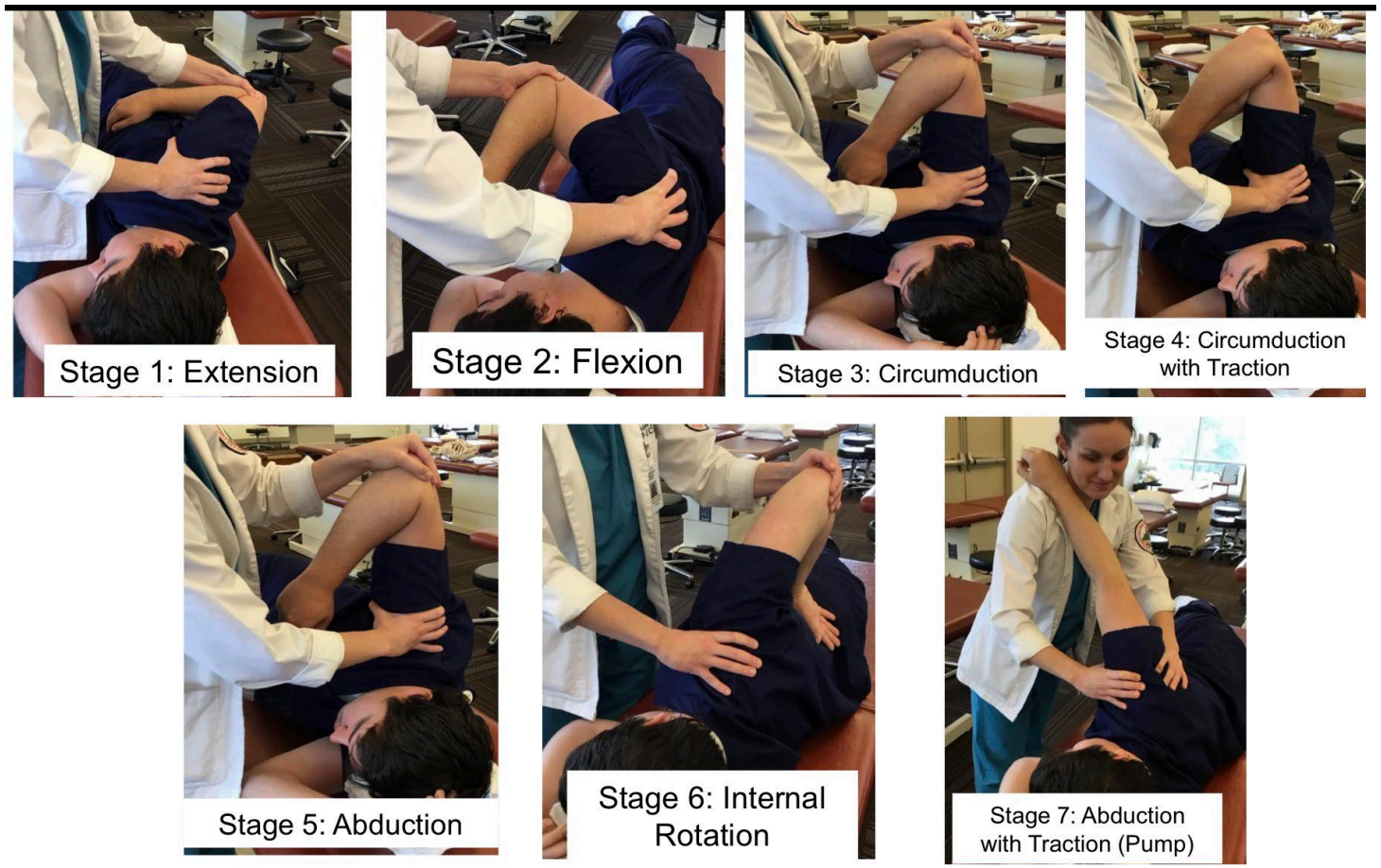
- Posterior Radial Head
  - Preference for forearm pronation
- Anterior Radial Head
  - Preference for forearm supination





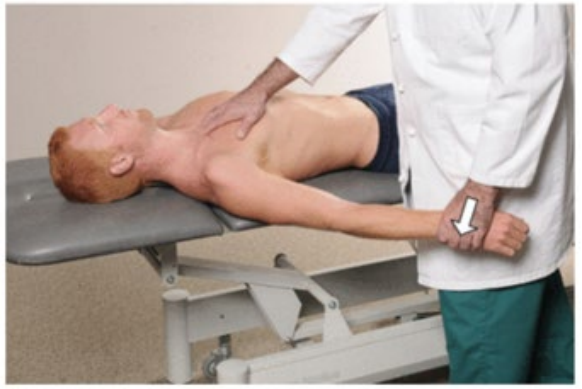
Shoulder ROM – The Seven Stages of Spencer

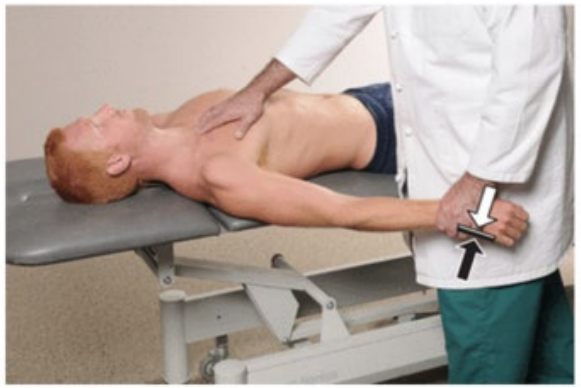
- Extension
- Flexion
- Circumduction
- Circumduction w/ Traction
- Abduction
- Internal Rotation
- Abduction w/ Traction (Pump)

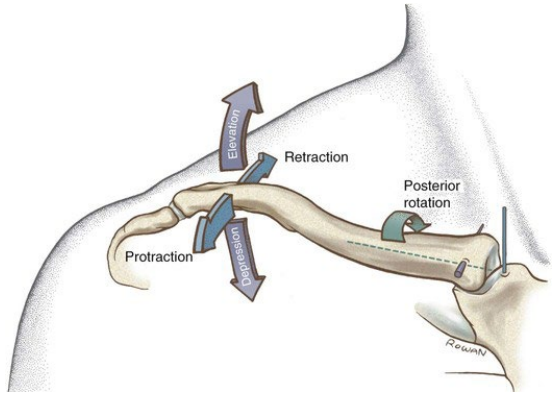


Clavicular Dysfunctions

- Acromioclavicular Dysfunction
- Sternoclavicular Dysfunction
  - Shoulder restriction with extension and internal rotation







Sinus Complaints

- Complaints will include increased sinus pressure, cough, congestion.
- Most common technique is sinus effleruage to help encourage lymphatic drainage.
- Before performing, always remember to release the thoracic inlet to allow lymph to drain completely.

Photo source: Osteopathic Clinic Skills

TMJ

- TMJ is a common complaint that can be treated with OMT.
- They’re multiple techniques that can be used including muscle energy, cranial, Galbreath, and masseter muscle release.

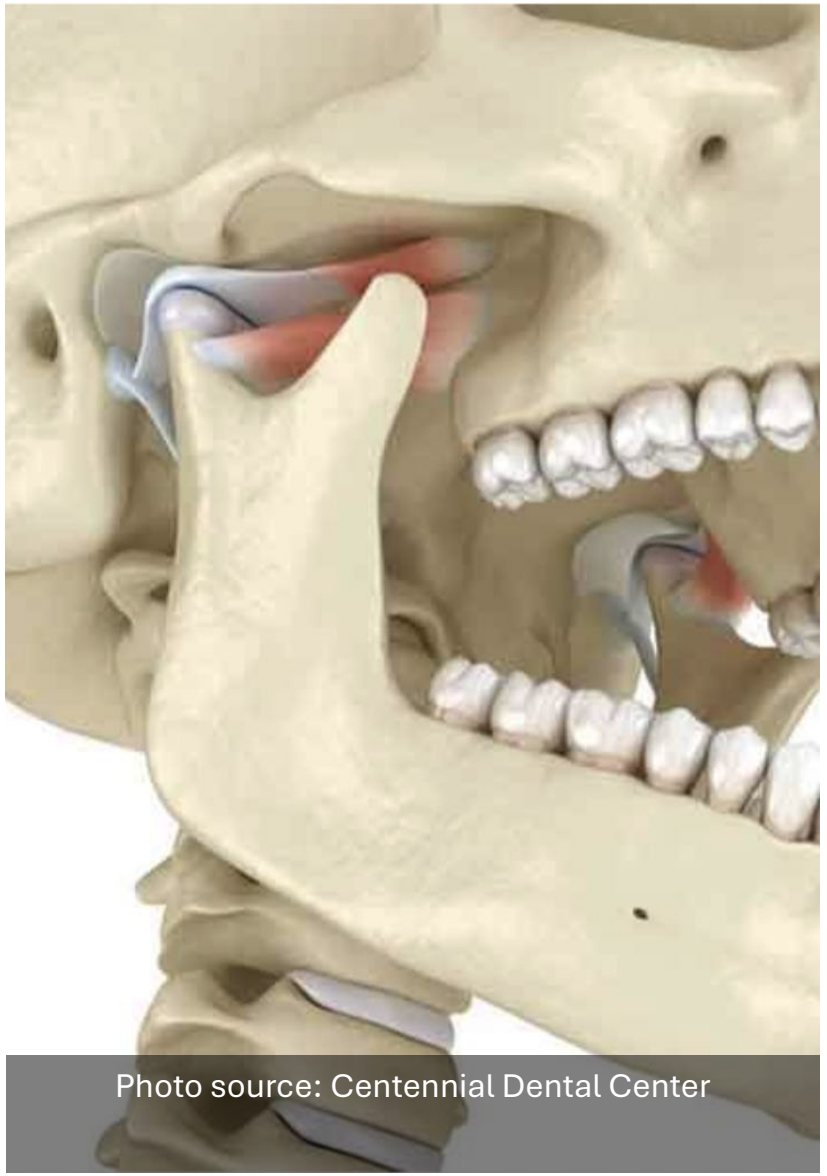


Photo source: Centennial Dental Center

Muscle Energy for TMJ

- Sit at the head of the table and instruct the patient to slowly open the mouth to observe exaggerated deviation to the side of the restriction;
- Slowly translate the mandible in the opposite direction of the deviation.
- With support from your hand opposite to the barrier, mobilize the lateral mandible into its barrier; instruct the patient to slowly push their mandible against your equal resistance for 3 to 5 seconds;
- The patient should relax and then push the mandible to a new side-bending restrictive barrier;
- Repeat this counteractive contraction and stretch 3 to 5 times or until the barrier is engaged;
- Reassess TMJ's motion to confirm the engagement.

MFR and BLT for TMJ

- **Direct MFR for the TMJ**
- With the patient in a supine position:
  - Sit at the head of the table and gently hold the mandible with 1 hand and the opposite mandible with your other hand;
  - Gently abduct the mandible, holding a firm and static force at the barrier until tissue release finishes;
  - Slowly rotate the mandible and move it into additional abduction, keeping the steady force at the barrier until tissue release finishes;
  - Gently adduct the mandible while keeping external rotation, applying steady force at the barrier until tissue release finishes;
  - Slowly restore the mandible to a resting position and reassess the TMJ in motion for checking engagement.

- **BLT for the TMJ**
- With the patient in a supine position:
  - Apply the vault hold to palpate the TMJ joint to assess asymmetry of motion;
  - Since this is indirect, softly exaggerate the membranous asymmetry;
  - Resume exaggerating membranous asymmetry and blockading return to neutral position until the TMJ stops at a static point;
  - Hold this position until the TMJ returns and then softly follow it back to the neutral position before relieving the pressure;
  - Reassess the TMJ and its membranes for the return of symmetry

Headaches/Migraines

- Tension headaches and migraines are common complaints in a primary care office. Many patients are unaware of osteopathic treatments to help.
- Quick and helpful techniques include suboccipital release, treating the cervical spine, and cranial.

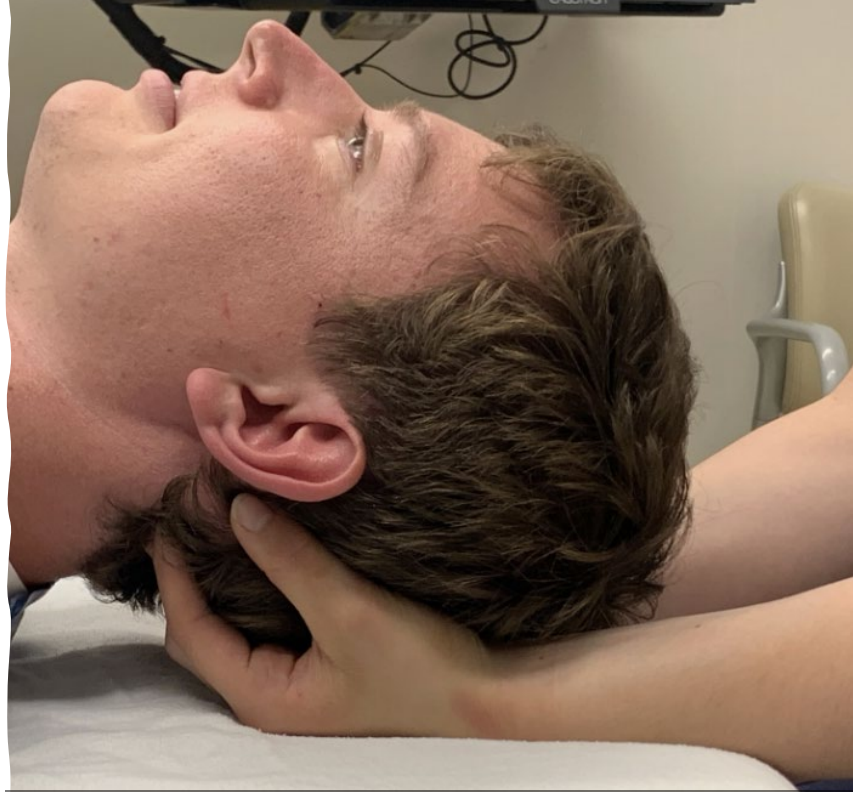
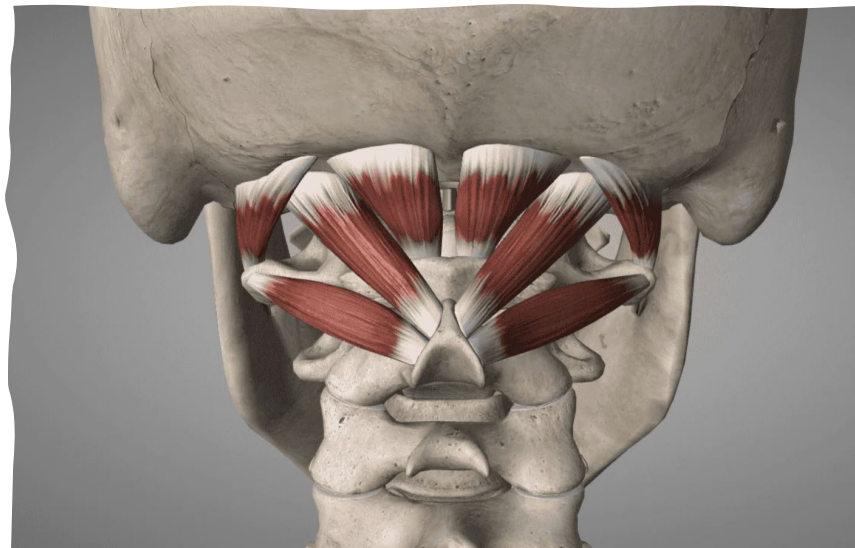


Photo source: Stat Pearls



Cervical Spine Techniques: Muscle Energy

- Find the asymmetrical cervical vertebrae by check translation.
- Remember that all cervical vertebrae will have Type 2 dysfunctions (will have rotation and sidebending in the same direction). Be sure to check for flextion/extension.
- First, dysfunction of a vertebra should be diagnosed (e.g., C4 flexed, rotated right, side bent right (C4 F Rr Sr)).
- While holding the patient's head with one hand, the articular pillars should be palpated with the other at the level of the dysfunctional vertebrae.
- The patient's head is then placed towards the barrier or in opposition to the diagnosis (ie, if the patient is C4 F Rr Sr, rotate the patient to the left, side bend to the left, and extend).
- The patient should attempt to move their head back into a neutral position and provide an isometric force for 3 to 5 seconds.
- The patient is repositioned further toward the barrier, and step 4 is repeated.
- Steps 4 and 5 are repeated 3 to 5 times, and the dysfunction is reevaluated

Cervical Spine Techniques: Counterstrain

- Find a tender point (TP).
- Assess the tenderness using a pain scale.
- Passively and gently place the patient in a position-of-comfort that results in the greatest reduction of tenderness at the TP. Approximate the position first, then fine-tune through small arcs of movement. Aim to achieve at least 70% tenderness reduction, with the goal of 100%.
- Maintain the position for 90 seconds while continuing to monitor the patient's TP.
- Passively return the patient to a neutral position.
- Re-test for tenderness at the TP

Cervical Spine Techniques: Still Technique

- Place the affected tissue in its position of ease.
- Introduce a force vector of less than 1 pound through the affected tissue. The force vector can be from another part of the body (long lever) or directly over the affected tissue (short lever).
- Move the affected tissue in a smooth path from its position of ease toward and through the position of its restriction.
- As the tissue moves through its restriction a “bump” and/or a click may be felt or heard. Neither is necessary for correction of the somatic dysfunction.
- Passively move the patient back to neutral and retest.

Cranial

- Cranial therapy can be beneficial in all dysfunctions/complaints described above.
- Vault hold is a quick and easy way to palpate any dysfunction in the cranial motion.
- Place hands on both sides of the cranium.
    - Index fingers: on the greater wing of the sphenoid over the pterion
    - Middle fingers: on the temporal bone, anterior to the ear
    - Ring fingers: on the temporal bone in the mastoid region, posterior to the ear
    - Little fingers: on the occiput
    - Thumbs: gently resting over the superior parietal aspect of the cranium
- Palpate the cranial motion through the respiratory cycle.
- One way to treat is to follow the direction of ease and allow the dysfunction to unwind similar to MFR.

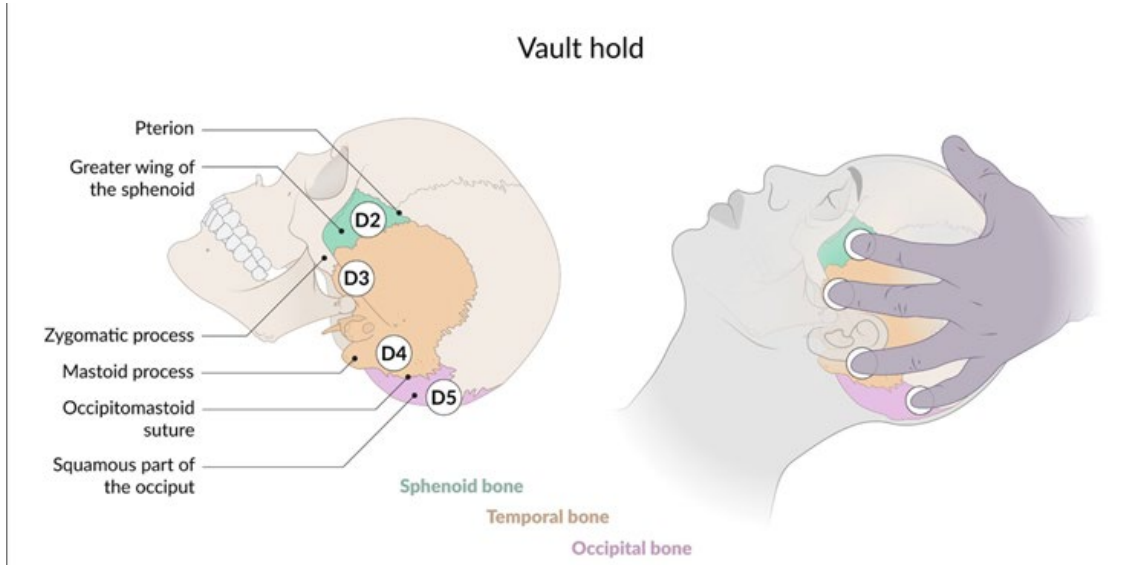


Photo source: Amboss

OMT Reimbursement

- E/M code
- Modifier 25
- OMT CPT code

Table 1. Comparative CMS Reimbursement Rates of OMT Procedures vs. Other Common Billing Codes (4)

CPT Code[a]	Description	Work RVU[b]	Price[c]
98925	Osteopath manj 1-2 regions	0.46	$32.18
98926	Osteopath manj 3-4 regions	0.71	$45.33
98927	Osteopath manj 5-6 regions	0.96	$59.18
98928	Osteopath manj 7-8 regions	1.21	$72.67
98929	Osteopath manj 9-10 regions	1.46	$86.17

In summary, OMT can be....

- Quick and efficient
- Highly versatile and adapted manage symptoms across a broad spectrum of medical conditions
  - Chronic
  - Acute
  - Localized
  - Systemic
- Reimbursed well

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Questions?