Facilitated Positional Release:
Efficient and Integrative OMT for Diagnosis and Treatment

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Program Director: NMM Plus 1 Residency CUSOM
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Conflict of Interest Statements

Dr. Smutny has no conflicts of interest!
Learning Objectives:

1. Remember (or learn) the Fundamentals of FPR
2. Identify common office and hospital reasons to use FPR
3. Analyze the utility of FPR in office and hospital practice
• QUOTATIONS:
  • “FPR is much like high speed CS”
  • “Many of my patients were getting older and I felt that HVLA should be avoided…my fingers began to talk to me and I found that I could get the results I wanted without HVLA”.
  • “As I discovered this reflex process it seemed to me to be more like rapid counter strain”
  • “Find it, fix it, and leave it alone”
NYCOM teachers, peers, undergraduate fellows and life long students
Stanley Schiowitz, D.O., F.A.A.O.

Eileen L. DiGiovanna, D.O., F.A.A.O.

Gary Ostrow, D.O

Robert G. Thorpe, D.O., F.A.A.O.

Mary Hitchcock, D.O., F.A.A.O.

Andrew “Jack” Tatom, D.O

Hugh Ettlinger D.O., F.A.A.O.

Dennis Dowling D.O., F.A.A.O.
Theory and practice generated by Stanley Schiowitz DO FAAO (1922-2011) with nearly 70 years of service to our profession

• Introduction

• Facilitated positional release was developed by Dr. Schiowitz. He first presented it to the profession in an article in the *Journal of the American Osteopathic Association*, “Facilitated Positional Release,” in 1990.

• This technique uses a modification of indirect myofascial release techniques, enhanced by placing the region in the *postural* neutral position and adding a facilitating force of compression or torsion. The advantage of this technique is its ease of application and speed of response. In addition, if the desired results do not occur immediately, it may be repeated or other methods of treatment can be added.
Publication History:

F.P.R.


Still Technique

Fundamentals of FPR

Can be considered a High Speed Counter Strain, a Modification of Myofascial release, the Second iteration of Still technique

1. Diagnose a somatic dysfunction and identify ALL the freedoms of motion
2. Place the joint in a neutral position (postural neutral)
3. Compress to the joint until an initial movement of the joint can be palpated
4. Move sequentially under compression into each of the freedoms, stacking them
5. If the joint or muscle group has not released up to this point, add a small joint ACCESSORY motion (“Jiggle”) to signal the vestibular system that “there are no restrictions here” (appx. 5 seconds with palpable changes) and continuously palpate for tissue texture changes. Restore slowly to neutral and re-assess.
   • Repeat if necessary one more times, RE-diagnose first, THEN RE-APPLY THE PRINCIPLES, 2-5.
   • Or use other techniques to reduce or eliminate the somatic dysfunction
Principles and Models of Thinking

- Joint motion
- Muscle spindle apparatus (CS)
- Golgi tendon apparatus (ME)
- The reflex circuit (and vestibular proprioceptive sense)
- The homunculus circuit (Posture, muscle tone, ligamentous tension, vestibular awareness and mapping to conscious and subconscious memory sectors in the cerebrum and cerebellum)
- The vestibular system and cerebellum as agents of reflex (Real Muscle Memory = practiced movement patterns)
- Tissue texture change as a response to the reflex (is a homeostatic mechanism in dynamic change)
Images from: Osteopathic approach to diagnosis and treatment, Schiowitz & DiGiovanna 3rd ed. pgs. 30-31

modify (reduce) motion

reduce

Philip E. Greenman; Principles of Manual medicine; Lippincott Williams and Wilkins; 3 rd ed; pg:53 – 65
Compression decreases the movement necessary to “stack” all Planes in freedoms. (Fryette’s rule III)
Respectful and Mindful Use of Our Hands Across the Osteopathic Disciplines

When alpha motor neurons contract the entire gamma complex responds in reciprocation. The sensory tracts all report all the time.
Respectful and Mindful Use of Our Hands Across the Osteopathic Disciplines

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## Primary Descending (Motor) Pathways

<table>
<thead>
<tr>
<th>Tract</th>
<th>Location of Upper Motor Neurons</th>
<th>Destination (termination)</th>
<th>Site of Decussation (crossover)</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORTICOSPINAL PATHWAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corticobulbar tracts</td>
<td>Primary motor cortex (cerebral hemispheres)</td>
<td>Lower motor neurons of cranial nerve nuclei in brainstem</td>
<td>Brainstem</td>
<td>Conscious motor control of skeletal muscles</td>
</tr>
<tr>
<td>Lateral corticospinal tract</td>
<td>As above</td>
<td>Lower motor neurons of anterior gray horns of the spinal cord</td>
<td>Pyramids of medulla oblongata</td>
<td>As above</td>
</tr>
<tr>
<td>Anterior corticospinal tract</td>
<td>As above</td>
<td>As above</td>
<td>Level of lower motor neuron</td>
<td>As above</td>
</tr>
<tr>
<td><strong>MEDIAL PATHWAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vestibulospinal tracts</td>
<td>Vestibular nuclei (at the border of pons and medulla oblongata)</td>
<td>As above</td>
<td>None (uncrossed)</td>
<td>Subconscious regulation of balance and muscle tone</td>
</tr>
<tr>
<td>Tectospinal tract</td>
<td>Tectum (mesencephalon: superior and inferior colliculi)</td>
<td>Lower motor neurons of anterior gray horns (cervical spine only)</td>
<td>Brain stem (mesencephalon)</td>
<td>Subconscious regulation of eye, head, neck, and upper limb position in response to visual and auditory stimuli</td>
</tr>
<tr>
<td>Reticulospinal tracts</td>
<td>Reticular formation (network of nuclei in brainstem)</td>
<td>Lower motor neurons of anterior gray horns of spinal cord</td>
<td>None (uncrossed)</td>
<td>Subconscious regulation of reflex activity</td>
</tr>
<tr>
<td><strong>LATERAL PATHWAYS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubrospinal tracts</td>
<td>Red nuclei of mesencephalon</td>
<td>As above</td>
<td>Brain stem (mesencephalon)</td>
<td>Subconscious regulation of upper limb muscle tone and movement</td>
</tr>
</tbody>
</table>
Respectful and Mindful Use of Our Hands Across the Osteopathic Disciplines

OMED 18 • Come together.

Somatosensory & Spinocerebellar

RIGHT SIDE OF BODY
- Thalamus (ventral posterior nucleus)
- Medial lemniscus
- Gracile nucleus
- Cuneate nucleus
- FIRST-ORDER NEURONS
- Posterior root ganglion
- Receptors for touch, pressure, vibration, and proprioception in the upper limbs, upper trunk, neck, and posterior head

LEFT SIDE OF BODY
- Primary somatosensory area of cerebral cortex
- THIRD-ORDER NEURONS
- Medulla
- SECOND-ORDER NEURONS
- POSTERIOR COLUMN:
  - Gracile fasciculus
  - Cuneate fasciculus
- Spinal nerve
- Lumbar spinal cord
- Receptors for touch, pressure, vibration, and proprioception in the lower limbs and lower trunk

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10 Major Tracts

Conscious sensation
Anterolateral system
Dorsal columns
Other ascending tracts
SUB-conscious sensation
Dorsal spinocerebellar tract
Cuneocerebellar tract
Ventral spinocerebellar tract
Indirect spinocerebellar tracts
Gaiting at the interneuron

Contemporary summary of the afferent (sensory) pool of the alpha motor neuron. Significant contributions include those from the spinal interneuron pool whose inputs include the same projections received from the corticospinal tract. This allows for cortical suppression or facilitation at segmental levels. FPR hits this reflex mechanism at multiple levels.

Identify common office and hospital reasons to use FPR

• What are your reasons? Diagnostic?
1. Speed
2. Gentle
3. Indirect
4. Few contraindications- patient refusal, necrotizing fasciitis, etc.
5. Many indications-viscerosomatic, lymphatic, biomechanical, 5 models
   1. Neurological
   2. Biomechanical
   3. Metabolic
   4. Respiratory-circulatory
   5. Psycho-social-behavioral
6. Outcomes- improved motion, drainage, normalized PS-S balance, L.O.S.
7. Safety- everyday motions create more force that FPR, side effects minimal to none
8. Easy to Supervise student’s and resident’s in hands on Tx
9. Billable (next slide for details)
Respectful and Mindful Use of Our Hands Across the Osteopathic Disciplines
OMED 18 • Come together.

Coding
• Office visit New pt. (99201-99205) Established pt. (99211-99215)
• Initial Hospital Care code (99221-99223)
• Subsequent Hospital Care code (99231-99233)
• Regions treated ICD-10 regions M99.xx codes
• Time spent in counseling on exercise, LfSt,
  • Ergonomics and nutrition
• Modifiers: 25 for combined E&M

<table>
<thead>
<tr>
<th>ICD-10 codes</th>
<th>Region of Somatic</th>
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<tr>
<td>M99.00</td>
<td>Head (includes occi</td>
</tr>
<tr>
<td>M99.01</td>
<td>Cervical</td>
</tr>
<tr>
<td>M99.02</td>
<td>Thoracic</td>
</tr>
<tr>
<td>M99.03</td>
<td>Lumbar</td>
</tr>
<tr>
<td>M99.04</td>
<td>Sacral/sacroiliac</td>
</tr>
<tr>
<td>M99.05</td>
<td>Hip/pelvic</td>
</tr>
<tr>
<td>M99.06</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>M99.07</td>
<td>Upper extremity</td>
</tr>
<tr>
<td>M99.08</td>
<td>Rib</td>
</tr>
<tr>
<td>M99.09</td>
<td>Abdomen</td>
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</table>

Procedure codes

<table>
<thead>
<tr>
<th>CPT 2009 Codes</th>
<th>Body Regions Treated With OMT, No.</th>
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</thead>
<tbody>
<tr>
<td>98925</td>
<td>1 or 2</td>
</tr>
<tr>
<td>98926</td>
<td>3 or 4</td>
</tr>
<tr>
<td>98927</td>
<td>5 or 6</td>
</tr>
<tr>
<td>98928</td>
<td>7 or 8</td>
</tr>
<tr>
<td>98929</td>
<td>9 or 10</td>
</tr>
</tbody>
</table>
Analyze the utility of FPR in office and hospital practice

• Outcomes
  1. Improves healing by:
     • Reducing energy drains on a weakened system
     • Promotes increased mobility therefore reduces the work of movement
     • Promotes clearing of toxins in tissue in the region
     • Reduces pain
     • Reduces medication usage
     • Improves responses to medication at lower doses
  2. Biomechanical advantages
  3. Viscerosomatic assessment (diagnostic) targeting of specific organs
  4. Lymphatic changes restoring circulatory balance
Demonstration and Practice of FPR Technique
• For each body region we will be treating:
  1. Scan, Screen, and Diagnose the body regions related to systemic diagnosis
  2. Check for Chapman’s points
  3. Confirm Diagnosis and discuss with Preceptor consider lymphatic, viscerosomatic, neurological and biomechanical effects of treatments
  4. Treat the Somatic Dysfunction Using FPR
  5. After completing FPR and rechecking the dysfunctions, re-check the Chapman’s points

• Be prepared to answer questions regarding how treatment to the relevant regions would produce a desired therapeutic effect on the Organ system(s) using information from the biomechanical effects, the viscerosomatic effects and/or the lymphatic effects.
FPR Treatment of the OA – C2-Supine Segmental

Isolate atlas lateral masses with upper C-spine in neutral “idling position”), Compress, “Stack” into freedoms, side bending, then rotation, then flex/ext – monitor for TART changes, 3-15 seconds, return to neutral, recheck
FPR Treatment of the Cervical Vertebral (Supine Segmental) C3-7 E SRRR

Isolate vertebral segment with upper C-spine in neutral “idling position”), Compress, “Stack” into freedoms, side bending, then rotation, then flex/ext – monitor for TART changes, 3-15 seconds, return to neutral, recheck
Contact the 1st rib posteriorly at the costo-transverse junction and anteriorly near the scalene tubercle.
FPR Treatment of the Elevated First Rib-Supine Segmental

Contact the 1st rib posteriorly at the costo-transverse junction and anteriorly near the scalene tubercle.
FPR Treatment of the thoracic vertebral 1-4 – T3 F SRRR (Seated Segmental)

{Consider T4 N RLSR}
FPR Treatment of the thoracic vertebral 5-12 – T6 F SRRR (Seated Segmental)
FPR Treatment of the lumbar vertebral 1-5-L3 E SRRR (Seated Segmental)

Location: Rib 12, count L1-3
REGIONS OF APLICATION
C, T, RIBS, L, S, P, UE, LE, GROSS MUCLE, OR JOINT SPECIFIC VISCEROSOMATIC? LYMPHATIC? DISCOGENIC?

QUESTIONS?
Coding Slides below from John Wolf DO, FACOFP
OMT documentation and coding

OMT in the Hospitalized Patient

Rebecca J. Bowers D.O.
2014 CMS Reimbursement

• 99213 - $70.61 Estab Office visit
• 99214 - $104.36

• 98925 - $25.82 OMT 1-2 Regions
• 98926 - $38.85 OMT 3-4 Regions
• 98927 - $51.24 OMT 5-6 Regions
• 98928 - $65.51 OMT 7-8 Regions
• 98929 - $78.77 OMT 9-10 Regions
OMT Regions - CPT defined

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Abdomen and Viscera
- Lower Extremities
- Upper Extremities
- Ribs
Office E&M Coding

- 99214: 4 HPI, 2ROS, 1PMHx
- Exam – 5 organ systems
- MDM – Dx, Data, Risk

- Is NOT DIFFICULT to document 99214 !!!
- Read this article: “Coding Level-IV Visits without Fear”. www.aafp.org/fpm
Efficiency: 3 Regions, 3 Minutes

- Procedure: OMT
  - Trained and certified
  - No additional equipment required
  - Already in the CPT book and on CMS fee schedule.
Documentation

❖ T – Tissue Texture Changes
   ❖ Temp differences, swelling, hyperesthesia, firmness

❖ A – Asymmetry of bony landmarks
   ❖ SI joint, ASIS, leg lengths

❖ R – Restriction of Motion
   ❖ Spine segments, joint range

❖ T – Tenderness
EMR Templates - Physical Exam

• KISS

• “Paraspinal muscles with TTCs on R L at “
  ▫ Example: On R at C5-7 and T 1-6 with...

...ROM restriction in Cervical, Thoracic and Lumbar spine
  ▫ Or can be more specific (C4 Right Rotation, etc)
TIME OUT

• At this point, if fairly certain only dealing with a musculoskeletal problem (Somatic Dysfunction), most likely will just treat (perform a procedure)

• Not the most efficient way to bill but still billable!
EMR Templates – Procedure (PLAN)

• KISS – 3+ Regions is realistic goal

• “OMT discussed with pt, pt consented to Tx, OMT to spine with good results”
  ▫ Example: C/T/L spine
  ▫ Example: Rt ribs, Thoracic Outlet, Pelvis

Can be more specific: Muscle Energy, HVLA, etc
Or: Cranial techniques and OMT to spine.....
EMR Template: Procedure

• Important to document OMT as a procedure (plan)
• If insurance company declines payment for OMT, want it documented properly

• If payment declined, recommend also sending CPT book page which describes OMT as “a form of manual Tx applied BY A PHYSICIAN to alleviate somatic dysfunction and related disorders”.
Link Dx to Procedure

- You link Wart Dx to Cryo procedure
- You link HTN Dx to ECG procedure
- You link Asthma Dx to PFT
- You link Osteoporosis Dx to DEXA

- You link Somatic Dysfunction Dx to OMT

- Example 1: Dx – Cervical Sprain – S13.4
  Somatic Dysfunction Cervical -M99.01
- Example 2: Dx – cholecystitis - K81.0 -with viscero-somatic reflex at T7
  Somatic Dysfunction Thoracic - M99.02
OMT in the Hospitalized Patient

by Bowers

by Rebeca J Bowers, DO
OMT in the Hospitalized Patient

Rebecca J. Bowers, D.O.
NMM/OMM resident, 3rd year
Mercy Health Partners: Muskegon, MI
Lecture Topics

• The ABC’s: Autonomics, Breathing, & Circulation
• Adjunct treatment
• Common G.I. complaint
• Cautions
• Documentation
  – Osteopathic Musculoskeletal Examination of the Hospitalized Patient
  – Consent
  – Procedure Note
• Coding
• Consulting an OMM service
Review Of Terms

• Myofascial Release (MFR)
  – System of diagnosis and treatment that engages continual palpatory feedback to achieve release of myofascial tissues

• Balanced Ligamentous Tension (BLT)
  – A variant of myofascial release in which the ligaments are poised between physiologic neutral and the tension created by the strain. This pathologic neutral point is held while the body resolves the strain and a release is felt.
Think ABC’s

• Patient is hospitalized for acute problems
• Focus exam & treatment on the acute needs
• Autonomics
  – Sympathetics
  – Parasympathetics
• Breathing
  – Ribcage
  – Associated respiratory structures
• Circulation
  – Lymphatics
  – Vascular
• Not exclusive from each other or the rest of the body
Autonomics

- Acute insult increases sympathetic activity
- Imbalance between the sympathetics & parasympathetics interferes with healing process
- Mechanisms:
  - Viscerosomatic reflexes:
    - Facilitation
    - Chapman’s reflexes
  - Psychosomatics
  - Somatosomatics
Facilitation

- Facilitation is the maintenance of a pool of neurons in a state of partial or subthreshold excitation needing less additional stimulation to discharge impulse
- Heightened nervous system arousal can cause non-harmful stimuli to be perceived as a threat
- Acute on chronic facilitation can cause chronic problems to flare
Finding Facilitation

Levels of Facilitation

- **HEENT**
  - T1-4; CNs III, VII, IX
- **Heart**
  - T1-5; CN X
- **Lungs**
  - T2-7; CN X
- **Foregut**
  - T5-9; CN X
- **Midgut**
  - T10-11; CN X
- **Hindgut**
  - T12-L2; S2-S4
- **Adrenals**
  - T10
- **Kidneys**
  - T10-11; CN X
- **Bladder**
  - T11-L2; S2-S4
- **Gonads**
  - T10-11; CN X
- **Uterus & cervix**
  - T10-L2
- **Prostate**
  - T12-L2
- **Upper Extremity**
  - T2-T8
- **Lower Extremity**
  - T11-L2

Gently drag fingers along the paravertebral area looking for TART

**Acute facilitation:**
- boggy, warm, moist

**Chronic facilitation:**
- condensed, cool, dry

Treat with MFR or rib raising
Chapman’s Reflexes

• Visceral, afferent-induced reflexes that can be specifically mapped out
• Anterior & posterior points
• Gangliform contractions
  – Deep to the skin & subcutaneous alveolar tissue
  – On the deep fascia or periostium
  – 2-3mm smooth, firm cyst-like structure
  – Can be grouped in to patches
• Tender to palpation
• Most often treated with gentle rotary MFR
Collateral Sympathetic Ganglia & Adrenal Points

- **Ganglia points:**
  - Contraction overlying the linea alba
  - Celiac ganglion
    - Foregut
    - Spinal level= T5-T9
  - Superior Mesenteric Ganglion
    - Midgut
    - Spinal level= T10-T11
  - Inferior Mesenteric Ganglion
    - Hindgut
    - Spinal level= T12-L2

- **Adrenal points:**
  - Lateral to linea alba & 2-2.5 inches above umbilicus
  - Spinal level= T10
Parasympathetics

- Cranial:
  - Vagus (CN X) exits the skull at the jugular foramen between the occiput & temporal
  - Eliminate restrictions at the occipital-mastoid sutures & OA
  - Suboccipital release
- Sacral:
  - Eliminate sacral restrictions
  - Lumbosacral decompression
- Treat the sympathetics before the parasympathetics
The Importance of Optimizing Breathing Mechanics

• Acquisition of Oxygen
• Release of CO2
• Discourage atelectasis & pulmonary infections
• Alternating intrathoracic pressures assist venous return & lymphatic flow
• Sympathetic chain ganglia “massage”
• Important structures either pass through or reside within the thorax
Optimize Breathing Mechanics

- **Bones**
  - Ribcage
    - 1-5: Pump handle
    - 6-10: Bucket handle
    - 11-12: Pincer
  - Thoracics
  - Junctional Zones
    - OA
    - CT
    - TL
    - Sacrum
Optimize Breathing Mechanics

Nerves
• Phrenic
  – C3-5
• Autonomics
  – T2-7; CNX

Muscles
• Scalenes & Levator Scapula
• MFR, BLT, or Muscle Energy
Inferior Thoracic Outlet - Diaphragm

- **Attachements:**
  - Xiphoid process
  - Costal arch= Ribs 7-12
  - Transverse process of L1
  - Anterior bodies of:
    - Left= L1-L2/3
    - Right= L1-L3/4

- **Treatment:**
  - Doming the diaphragm
BLT of Right Hypochondrium
BLT of Left Hypochondrium

Gray's Anatomy, 40th Ed.
Thoracic Inlet

- **Bones**
  - T1
  - 1st ribs
  - manubrium

- **Angulus Venosus**

- **Treatment**
  - BLT using the UE
Lymphatics

Lymphokinetics

- Pressure Gradients
- Active Pumps
  - Heart
  - Lymphangions
    - 2-3 layers of spiral muscles
    - Contract at a rate of 5-8/min at rest
- Passive Pumps
  - Respiration
    - Negative intrathoracic pressure during inspiration
  - Skeletal muscle contractions affect the deep circulation, but not the superficial lymph just below the dermis
  - Active or passive limb motion
  - Peristaltic contractions of smooth muscles (viscera & adjacent arteries)
  - External compression

Silent Waves- Theory and Practice of Lymphatic Drainage Therapy. Second Ed.
Lymphatic Drainage

- **Thoracic Inlet**
  - Thoracic/Lymphatic Duct

- **Diaphragm**
  - Thoracic duct lies by the right crus & passes through the aortic hiatus
  - Peritoneal lymph can travel through the diaphragm itself

- **Femoral Triangle**
Traditional Lymphatic Techniques

- Thoracic Pump
- Pedal pump
  - Aka Dalrymple Maneuver
Adjunct Treatment

Keep vascular-lymphatic circulation moving

– Encourage ambulation
– Ankle pumps
– Elbow pumps
– Breathing devices: incentive spirometry & flutter valves
– Lower extremity compression devices

Supplementation
– Magnesium
– Vit. C & zinc
– Vit. D
– Probiotics
Aggressive Magnesium Sliding Scale

Normal magnesium blood level (at our lab) = 1.6-2.8 Only 1% of total body magnesium is in the plasma Essential for proper nerve & muscle functioning

Magnesium plasma level (mg/dL) Magnesium sulfate / normal saline

<table>
<thead>
<tr>
<th>Level</th>
<th>Concentration</th>
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<tbody>
<tr>
<td>&lt;= 1.5</td>
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<tr>
<td>1.6-1.7</td>
<td>6 grams/250 mL</td>
</tr>
<tr>
<td>1.8-1.9</td>
<td>4 grams/250 mL</td>
</tr>
<tr>
<td>2.0-2.1</td>
<td>3 grams/150 mL</td>
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<tr>
<td>2.2-2.3</td>
<td>2 grams/100 mL</td>
</tr>
<tr>
<td>2.4-2.5</td>
<td>1 gram/50 mL</td>
</tr>
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</table>

• Give IV at rate of 1 gram/hour

Do NOT use this scale in pregnant patients, children, or those with renal insufficiency
Constipation

• Can be contributing factor to back pain
• Many hospital patients are on narcotics
• May see evidence of it on imaging
• Feel along the length of the colon and find where it is full of stool

• Viscerosomatic reflexes:
  – Facilitation:
    • T12-L3 & S2-4
  – Chapman’s points:
    • Colon
    • G.I. peristalsis
    • Superior Mesenteric ganglion
    • Inferior Mesenteric ganglion

• Consider:
  – Lumbosacral decompression
  – MFR at bottleneck
  – Mesenteric release

FOM, 2nd ed.
Mesenteric Release

- Intestines are gently moved at right angles to the attachment of its mesentery
- Use ulnar aspect of hands
- Direct techniques:
  - Direct MFR with respiratory assist
  - Direct MFR with recoil
Cautions

• HVLA & ME in sick patients
• Direct MFR near recent incisions
• Manipulation in area of known or suspected thrombus
• Cranial manipulation in a patient with stroke or head trauma
• Cancer (theoretical)
• Workplace ergonomics: Don’t hurt yourself
  – Adjust the bed
    • Vertical & horizontal
    • Bed rails & headboard
  – Reposition the patient
• Pay attention to what is under your hands
  – Lines
  – Tubes
  – Wounds
  – Anatomical parts

* This is not an inclusive list
Osteopathic Musculoskeletal Examination of the Hospitalized Patient
OMT is a Procedure

• Informed consent required
  – Does not need to be written consent

• Procedure note required
  – What was done and were there any complications

• Example Note:
  – OMT discussed with patient & verbal consent obtained prior to treatment. All questions addressed. Gentle osteopathic manipulation applied in the following manner: For X region(s), Y OMT type(s) were performed. OMT tolerated without complication.
ICD-9 Codes- Diagnosis

• ICD-9 Codes Body Regions
  – 739.0 Head region
  – 739.1 Cervical region
  – 739.2 Thoracic region
  – 739.3 Lumbar region
  – 739.4 Sacral region
  – 739.5 Pelvic region
  – 739.6 Lower extremities
  – 739.7 Upper extremities
  – 739.8 Rib cage
  – 739.9 Abdomen and other sites
CPT Codes- Evaluation & Management

• Code encounter & procedure separately based on their own merit

• CPT Codes for OMT
  – 98925: OMT; one to two body regions involved
  – 98926: OMT; three to four body regions involved
  – 98927: OMT; five to six body regions involved
  – 98928: OMT; seven to eight body regions involved
  – 98929: OMT; nine to ten body regions involved

• 25 modifier to bill for a procedure on the same day as an evaluation
Appropriate Hospital NMM/OMM Consult

• Who can be consulted?
  – Any licensed physician comfortable with OMM & OMT

• What is the consult for?
  – Specific problem or evaluate and treat
  – Any medical condition- not just pain!!
  – Chronic pain may be an appropriate reason for consultation

• If you are a D.O. consulting another physician for OMM/OMT:
  – What somatic dysfunction did you find?
  – What OMT was attempted?
References

- Multicenter Osteopathic Pneumonia Study in the Elderly (MOPSE)
References Cont…

• Jorgensen, D. J. OMT Strategies To Boost Your Bottom Line. ACOFP.org
• Gray’s Anatomy, 40th ed.
• Dakwar, E., et. al. The anatomical relationship of the diaphragm to the thoracolumbar junction during the minimally invasive lateral extracoelomic (retropleural/retroperitoneal) approach. *J Neurosurg Spine.* 2012 Apr;16(4):359-64
Parting Thoughts

• “No man ever steps in the same river twice, for it's not the same river and he's not the same man.” - Heraclitus

• “It is good to have an end to journey toward; but it is the journey that matters, in the end.” – Ernest Hemingway

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