

Protocols For Osteopathic Manipulative Treatment (OMT)  
Revised July 1998

Osteopathic physicians utilize all recognized medical procedures and available technologies to provide comprehensive health care to their patients. The osteopathic profession is recognized by its distinctive philosophical approach.<sup>1,2,19,33,34,39</sup> This approach led to unique contributions by the osteopathic profession in the development of techniques used in osteopathic manipulative treatment, and by their integration into a physician-directed management of the total patient.<sup>3,4</sup> Osteopathic manipulative treatment involves the use by the physician of manual procedures to optimize patient health and function.<sup>5,6,32</sup> It should be emphasized that osteopathic manipulative treatment is a distinctive medical procedure and should not be confused with services provided by non-physicians.<sup>7</sup> Osteopathic manipulative treatment is a general term currently encompassing approximately twenty-five different types of physician-performed manipulative treatment.<sup>19</sup> Osteopathic manipulative treatment (OMT) is defined in the "Glossary of Osteopathic Terminology", the profession-wide accepted resource for osteopathic terminology, which is published by the American Osteopathic Association.

### Structural Dysfunction

Structural diagnosis involves the use of expanded observation and palpatory examination of the neuro-musculoskeletal system with its venous, lymphatic and pulmonary interactions,<sup>8, 9, 10,11, 12, 13, 14, 15, 25</sup> as part of evaluation of the entire patient. The goal is to identify the presence of significant impediments to health and well being in the entire patient through an understanding of the interrelationships between the musculoskeletal system and all other systems of the body.<sup>16,17</sup> This includes but is not limited to the identification of somatic dysfunction and related visceral disease/dysfunction.<sup>10,32, 38, 35</sup> The performance of the history and physical examination of a patient should not be viewed as an isolated examination of the musculoskeletal system since many organ systems are examined.<sup>18</sup> The definition of somatic dysfunction is correlated with the entire patient as follows:

Impaired or altered function of related components of the somatic (body framework) system; skeletal, arthrodiagonal and myofascial structures; and related vascular, lymphatic and neural elements.<sup>19, 21, 25, 36, 37, 38</sup>

During the process of diagnosis of altered structural function, somatic dysfunction is identified by one or more of the following physical findings: asymmetry of related parts of the musculoskeletal system, range of motion abnormalities, tenderness and/or tissue texture abnormalities.<sup>20, 21</sup> Alteration in the range of motion may be exhibited by either restricted or increased motion. Alterations in quality and range of motion are the most common and often most significant findings indicating the presence of somatic dysfunction.<sup>33, 39</sup> Pain or tenderness or their provocation can be of assistance in the diagnosis but their provocation is not diagnostic in and of itself. Somatic dysfunction is also made clinically relevant by interpreting the effects of personal injury history.<sup>19, 22, 23, 24, 25, 33, 39</sup>

### OMT Case Management

Osteopathic manipulative treatment involves the same principles utilized in diagnosing and treating any disease. This diagnosis must be specific. Once an accurate diagnosis is made, the physician will determine the appropriate techniques and treatment. It is not usually appropriate to create a "treatment plan" for OMT. Several different treatment techniques may be integrated for use in the same patient. Adjunctive modalities may be employed in the total case management of the patient's condition.

The choice of osteopathic manipulative technique is based on multiple factors. These include the age and physical condition of the patient, and the effectiveness of previous forms of treatment. The physician must also keep in mind his or her own experience and expertise in each of the treatment methods, and must choose those that can be performed effectively. Due to the complex interrelations of body systems, and the body's innate ability to make compensatory changes during each treatment, tissues both adjacent to and remote from the area of primary involvement may require concomitant treatment.

The three key components of an E/M service: history, examination and medical decision making are essential in the decision making process and management of the patient prior to the performance of subsequent OMT. Therefore it is appropriate for an E/M service to be performed at each follow-up patient encounter. An appropriate significant, separately identifiable E/M service, documented according to the E/M Documentation Guidelines should be provided and reported. This is all necessary in determining: If additional OMT needs to be provided and if so, 1) What body regions need to be treated, 2) What OMT technique(s) should be utilized, and 3) If OMT needs to be augmented with other medical services/procedures.

### Basic Treatment Concepts

- A. Patients who present with a dysfunctional somatic component to their condition may benefit from OMT.
- B. The primary goal of using OMT is to enable the patient to return to health and optimize function.

C. OMT should be performed at the appropriate effective frequency as determined through the on-going process of medical evaluation and management.

D. OMT should be performed for the minimum appropriate duration. This can be defined as that duration of time from the initiation of treatment which will result in continued improvement, and where additional treatment will not further benefit the patient.

E. Subsequent treatments may be an appropriate response to unstable or recurrent conditions as part of the overall management of the patient's condition. Every attempt is made to reach maximum improvement of the patient and OMT should be coupled with other appropriate medical and/or surgical interventions. Occasionally, less frequent, periodic treatment may be utilized effectively to help continue maximum medical improvement. The frequency of such treatment should be consistent with the phase of the patient's disease or dysfunctional process as determined by on-going evaluation and management of the patient's condition.<sup>26</sup>

Some stabilized conditions that acutely decompensate may require reinstitution of OMT.<sup>27</sup>

Subsequent evaluation and management in conjunction with OMT is appropriate for patients with long term conditions.<sup>28, 29</sup>

Passive physical medicine modalities should be combined with an active treatment program which emphasizes progressive exercises with a decreasing frequency of passive treatments. The modalities provided should be appropriate to the individual patient's presenting problem and their response to prior treatment. Prolonged application of physical medicine modalities beyond the acute phase of treatment should be limited in frequency and number of modalities utilized and should not be utilized as the sole form of treatment.

### OMT Parameters

The guidelines below are meant to be used as a basic reference for appropriate osteopathic manipulative treatment. They are not intended to set restrictive criteria that would override an osteopathic physician's good judgment in comprehensive case management. Most patients should fall within the parameters below and there should be sufficient latitude for physicians with varying treatment styles and approaches. Some patients have additional factors which complicate successful completion of treatment. Among these factors are the severity of the illness, duration or chronicity of the condition, as well as the existence and extent of comorbidities.<sup>30</sup>

**Acute, Post-acute and Chronic** refer to the phase of illness determined by the time elapsed from the onset of symptoms. Date of injury, diagnosis, acute exacerbation or surgery must be taken into consideration.<sup>31</sup>

**Initial** refers to the interval during which OMT is first utilized by a particular physician in the treatment process regardless of the phase. The initial use of OMT may occur through its use by the primary treating physician in the acute illness, or it may be first used in subsequent phases of the illness through appropriate referral. Patients are treated more frequently during the first several encounters regardless of the phase of the illness, with a subsequent decrease in treatment as appropriate.

**Subsequent** refers to the treatment period following the initial interval of treatment by a particular physician within an illness phase, and as continuing treatment through subsequent phases patient's progress to recovery or maximum medical improvement.

**Treatment of Recurrent Problems:** If a patient has multiple recurrent episodes related to their original complaint within one year, it should not be classified or treated as an acute problem. In this circumstance, it would be classified as a recurrent problem and secondary assessment and treatment methods should be used with an emphasis on active therapy and prevention strategies. Additional treatment may be necessary if repeated efforts to withdraw from treatment results in significant deterioration of clinical status. Patients with recurrent problems may require additional evaluation and interventions for psychosocial and ergonomic factors which may be contributing to the recurrent nature of the problem. A history of previous episodes of similar complaints should be considered as well as possible contributory factors such as chronic pain, depression, alcohol/substance abuse, smoking and extreme obesity. Supervised changes in physical activity and lifestyle should also be considered.

The routine scheduled provision of osteopathic manipulative treatment (OMT) would not be considered appropriate in the absence of acute or chronic problems.

### Parameters For Frequency Of Application Of Osteopathic Manipulative Treatment

## TREATMENT INTERVALS

**Phase of Illness\* Acute Post-acute Chronic**

**0-12 weeks 12 wks - 6 months 6 months or longer**

<b>Initial</b>	<b>1-3x/wk for 2 wks</b>	<b>1-3/wk for 2 wks</b>	<b>1-2x/wk for 2 wks</b>
<b>Subsequent</b>	<b>2-3x/wk for 2 wks</b>		
	<b>1-2x/wk</b>	<b>1-2x/wk</b>	<b>Once every 1-2 wks</b>

\*Phase of Illness is defined as the time elapsed from onset of symptoms.

### SOAP Note - New Patient Example

**S**

A patient complains of low back pain that began 3 days ago after he lifted a heavy object. Cannot straighten up when walking. Pain with change of position. Denies radiation of pain; it stays along the low back and waistline. Denies areas of numbness. Comfortable when lying down. Aspirin helps some. Has used heat with some help. No prior history of back pain or injury. Denies allergies. Medical/surgical history is unremarkable.

**O**

- Tenderness noted over lumbar and sacral regions
- Inability to extend lumbar spine when standing
- Flexion posture when standing
- Muscle spasms noted in paraspinals of the lumbar region
- Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing
- Neurological exam normal

**A**

1. Lumbosacral sprain. 846.0
2. Somatic dysfunction - lumbar, sacral 739.3 and 739.4

**P**

1. OMT (appropriate techniques used\*), applied to the lumbar and sacral regions
2. Continue aspirin
3. No lifting, bending or twisting
4. Follow up in two days to reevaluate patient progress

### CODING FOR THIS CASE

Evaluation/management; new patient 99203-25

OMT two body regions; lumbar/sacral 98925

\*See AOA Glossary of Osteopathic Terminology for appropriate techniques.

#### **SOAP Note - Established Patient Example**

##### **S**

Patient is here for re-evaluation. He states that the pain has decreased in his low back and that he can get around better. He states that he has no radiation of pain into his legs. He does state that he feels stiff and achy if he tries to do his normal daily activities. He is still taking aspirin with some relief.

##### **O**

- Tenderness with palpation and stretch of the erector spinae muscles
- Pain with extension and rotation left of L5
- Pain along with right SI joint with sacral extension
- No muscle spasms noted with active or passive range of motion
- Negative neurological exam of lower extremities

##### **A**

1. Lumbosacral sprain/strain; improving 846.0
2. Somatic dysfunction - lumbar, sacral; improving 739.3 and 739.4

##### **P**

1. OMT (appropriate techniques used\*), applied to the lumbar and sacral regions
2. Instructed on proper posture when lifting
3. Increase home activities gradually and to tolerance
4. Follow up if improvement does not continue

#### **CODING FOR THIS CASE**

Evaluation/management; established patient 99213-25

OMT two body regions; lumbar/sacral 98925

\*See AOA Glossary of Osteopathic Terminology for appropriate techniques

#### **SOAP Note - Established Patient Example**

##### **S**

Patient ambulating, non-smoker with chief complaint of deep cough and with occasional vomiting, x three weeks. Onset nasal congestion; hoarseness; cough; low grade temperature (100-101 degrees). Almost dry cough with occasional clear sputum. Pain in center chest with coughing and no radiation of chest pain. Patient did have right rib pain with deep inspiration and cough. Cough worse in PM with occasional insomnia. Occasional slight chills and sweats.

##### **O**

Temperature = 100 degrees; blood pressure = 120/80; pulse = 92; respiration = 18. Chest- diffuse insp. rales (fine and coarse). Heart - RRR without murmur. H& ENT - nasal congestion with TMs non-injected; pharynx-injected with cervical lymphadenopathy. Abdomen - non-tender, no splinting, negative Lloyds. Structural exam - resp diaphragm amplitude diminished with lateral rib restrictions R>L.

Sternal tenderness with palpation

T6-L1 (N) SB<sub>R</sub>RL

C3-7 SB<sub>R</sub>RAA R<sub>R</sub> OA SB<sub>R</sub>RL

Tentorium restricted with CRI

**A**

1. Pneumonia, prob mycoplasma 483.0

2. Somatic Dysfunction - head cervica, 739.0, 739.1, 739.2, 739.8, 739.9 thoracic, lumbar, rib cage, abdomen regions

3. Strained anterior cervical fascia

**P**

Treatment plan - Erythromycin 250 mg qid x 2 wks

Tessalon Perles: Two tablets q 6-8 hrs prn

Lab - CxR, CBC with diff, cold agglutinins

OMT - head, cervical, thoracic, lumbar, rib cage, abdomen regions (soft tissue and HVLA)

Lymphatic pump; rib raising

Call in 24 hrs; return in one wk for re-eval.

**CODING FOR THIS CASE**

Evaluation/management; established patient 99214-25

OMT, five to six body regions 98927

**SOAP Note - New Patient Example**

**S**

Patient presents with a chief complaint of achy, dull pain in the upper thoracic and lower cervical region, radiating into the posterolateral right arm. Patient has been having stiffness in the morning since then. He states the onset was two days ago, after golfing in cold weather. The symptoms have been gradually increasing since that time. The symptoms are aggravated while driving and working at his computer station; relieved when lying down. He denies anesthetics, paresthesias or weakness in the right fingers, hand or forearm. He has taken Tylenol with minimum relief.

PSH: Denies.

PMH: Noncontributory.

SH: Patient owns an insurance agency and spends several hours per day at a computer keyboard.

FH: Negative for rheumatologic problems.

Present Medications: Tylenol. No known drug allergies.

ROS: Cardiac, pulmonary and GI all negative

**O**

B/P 122/70

Pulse 64

Respirations 18

Weight 167

Heart has a regular rate and rhythm with no murmurs. Lungs are clear to auscultation bilaterally. Neurologic DTRs are +2/4 in the upper and lower extremities bilaterally. Sensation is intact and there is no evidence of weakness or atrophy in the upper extremities.

Structural Exam: T1 is rotated and sidebent right. C6 and 7 are sidebent left. T3 is rotated right with posterior displacement of the right 3rd rib. There is pain at the end point of range of motion of these areas. There are acute tissue texture changes and muscular hypertonicity in the upper right thoracic and lower cervical paravertebral muscles. Extension of the neck reproduces the patient's symptoms. The lumbar spine is sidebent left with secondary right rotation and significant restriction at the thoracolumbar and lumbosacral junctions. The sacral base declines to the right. 1.) Examination of the shoulders revealed negative impingement test, a negative drop arm test. 2.) The rotator cuff had normal motion both active and passive.

**A**

1. Somatic dysfunction - cervical, thoracic, costal, lumbar, sacral 739.1, 739.2, 739.4, 739.8.
2. Mild cervical nerve root irritation secondary to #1 above; suspect DJD. 353.2

**P**

1. OMT to above areas with excellent response.
2. Rx - Lodine 400mg to be taken one b.i.d. with food.
3. Recheck 1 week for signs and symptoms persist.

**CODING FOR THIS CASE**

Evaluation/management; new patient 99204-25

OMT five body regions; cervical, thoracic, lumbar, sacrum, ribs 98927

**SOAP Note - Established Patient Example**

**S**

Patient continues to experience achy and dull pain in the right lower cervical region, particularly with extension of the neck. It continues to radiate into the right lateral arm. He has experimented with some different positions of his car seat, which he feels has been helpful. He has tolerated the Lodine well and states that overall he feels somewhat improved. Further work history reveals improper placement of video screen at computer station and lack of wrist rest at keyboard.

**O**

B/P 126/64

Pulse 64

Respirations 18

Cardiac and pulmonary exam again negative. DTRs are +2/4 in the upper extremities bilaterally. No weakness or atrophy in the upper extremity. T1 and T3 are again rotated right with right 3rd rib dysfunction and hypertonicity of the right rhomboid muscles. The lower cervical segments are again sidebent left with tightness of the short restrictor muscles on the right. The lumbar spine is in better balance today with level sacral base. X-rays taken in the office today reveal an uncovertebral osteophyte at the C5-6 level on the right, causing mild foraminal narrowing. Radiologist report pending.

**A**

1. Somatic dysfunction - cervical, thoracic and costal, with secondary muscular

Hypertonicity. 728.8, 739.1, 739.2, 739.8

2. DJD cervical spine, 721.0

3. Mild cervical nerve root irritation 353.2

Secondary to #1 and 2 above.

**P**

1. OMT to above areas with good mobilization.
2. Continue Lodine,
3. Recommend changes in work station configuration,
4. Re-evaluate in 1 week.

**CODING FOR THIS CASE**

Evaluation/management; established patient 99214-25

OMT three body regions; cervical, thoracic, ribs 98926

The development of this document by the American Osteopathic Association was prompted by the growing need among non-osteopathic peer reviewers and entities for guidance in the appropriate frequency and uses of osteopathic manipulative treatment (OMT). While these materials provide a framework, they are not absolute rules and should not be used to set absolute restrictions or other restrictions criteria that would override an osteopathic physician's professional judgment on case management. As with all medical treatments, patients may present with a broad variety of complicating factors and physicians should be afforded sufficient latitude to apply varying treatment styles and approaches to patient care. **The use or omission of any of the techniques described herein for the purposes indicated herein should not be construed as adherence to the standard of care or failure to adhere to the standard of care. Finally, these materials are only a basic reference and can not substitute for the education and training of an osteopathic physician.** Use of the enclosed guidelines, accompanied by proper documentation from the physician, should provide the reviewer with the information necessary to make an accurate determination. For further information please consult the osteopathic profession's standard textbook: *Foundations for Osteopathic Medicine*, Robert C. Ward, DO, FFAO, Executive Editor, (Copyright 1997, Williams and Wilkins).