Stabilize the Spine

ATM PRO 2

Active Rehab - Active Relief

Many DC's now use Decompression Therapy. The addition of the ATM2 with Decompression is especially beneficial as movement impairments, resultant of a loss of dynamic intrinsic muscular stability, are always co-conspiriators with disc lesions. The ATM2 creates relief and rehabilitation simultaneously by addressing inappropriate muscle activation patterns that create shearing and irritation that lead to the "sites" of pain including discs and facets.

Virtually all decompression patients can be transitioned to the ATM2 for the implementation of the all important Active phase of care.

The ATM2 assures that you not only address the disc but what caused it to go bad to begin with.

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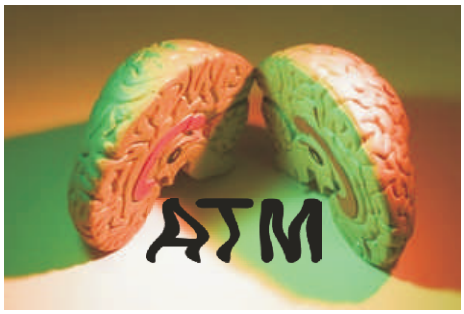
Getting your brain wrapped around ATM2 Active Therapeutic Motion Rehabilitation



Using the ATM2 is much easier than getting your brain wrapped around why it works so well.

Based on the Mulligan concept, you can normalize specific movement impairments (dynamic instabilities) by repositioning a particular joint related to the movement impairment.

Using the ATM2 you can simultaneously reposition and compress particular joints of the body to normalize most dynamic instabilities causing an immediate reduction of resultant irritation and shearing forces which contribute to dysfunction and pain. The patient is placed in an upright weight-bearing position that immediately and safely allows them to do fully resisted exercises in the direction and range of the previously impaired movement.

The Central Nervous System governs the dynamic movement stability components, namely the neural, passive, active (Panjabi, 1992) and emotional components (Vleeming & Lee, 2000). These components work throughout the anatomical structures of the musculoskeletal system. Normal dynamic stability provides the healthy body with the ability to perform normal, good quality, low-energy / high efficient movements. In the case of pain, the CNS will change its neuromuscular activation strategy, to a high energy / low efficient movement. This altered CNS movement control is clearly visible and recognizable in the presence of pain.

Decompression patients are at least 80% likely (Kennedy 2006) to have a dynamic instability as a "co-conspirator" of pain. In addressing only one of these pain generators ie. the disc (with decompression) leaves a significant population of patients with lingering low back or neck pain. Failing to understand the Direction of Susceptibility of Motion (DSM), often leads to poor or catastrophic postural choices. In studies, Active Therapeutic Motion Rehabilitation have been found to immediately reduce pain and increase range of motion (Moran, 2002). Additionally, clinical data demonstrates a significant reduction in the amount of treatments necessary to resolve various and non-specific lumbar disorders (Archambault, 2002). This is especially poignant in the managed care marketplace where a premium is placed on highly effective and short visit scenarios.

ATM Rehab. involves neutral-range active functional movements superimposed upon a specific positioning and holding. A few (10-30) movements are performed towards the impaired movement. The passive holding is an essential setup for the ATM Rehab. because it will ensure that the superimposed active movement will alter the CNS activation strategy from pathological to normal. In this starting position the active neuromuscular training will be of therapeutic value, and produce immediate pain reduction and improved range of motion. Perhaps due to improved CNS governed dynamic stabilization of the specific movement.

The ATM2 is a clinical device designed specifically to enable clinicians to prescribe quality user operated Rehab. Passive joint repositioning is obtained via restraining belts connected to ATM2 support pad to reduce the symptoms, and then specific ATM rehab. is performed via a harness connected to a resistance bar.

Compact in size, highly reimbursable (either 97530 or 97110), the ATM2 is an easy to use way to introduce effective dynamic rehabilitation to your practice. Once dynamic core function is restored then normally neutral spine exercise is prescribed to further strengthen the intrinsic musculature via planks, bird-dogs, gym balls etc.

The ATM2 is proving itself to be a truly front-line weapon in a modern forward-looking practice, is the perfect compliment to your DTS, and ... they make the ideal present for your practice!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Introduction…

This manual is meant as an in-depth introduction for Chiropractors interested in incorporating ATM2 (Active Therapeutic Movement device) into their practice. The ATM2 has it's beginnings in Physical Therapy and has become extremely popular in that market. Many Chiropractors are now beginning to discover it's distinct & dramatic benefits for their common clinical conditions. Couple this with its rapid and intuitive learning "curve" and we can confidently say ATM2 is perhaps the most *pertinent* & important treatment method introduced to the Chiropractic profession in decades. We hope the following information answers your questions and generates enough interest that you too become an ATM2 Proponent!

Review of the ATM2 theory…

Based in part on the work of Brian Mulligan PT (and other well established principals of spinal function) the ATM2 allows *cessation* of "movement" pain by strategically placed restraint belts & patient positioning. In a basic sense ATM2 reestablishes more appropriate *muscle activation patterns*. Through weightbearing "fixation" & compression of the painful area the CNS is afforded the ability to "right" the inappropriate, painful movement. Active pain relief and rehabilitation take place simultaneously via short-range resistance exercise. Long term relief is fostered by the new, more normal movement patterns…eliminating muscle substitution strategies…Over time phasic muscles re-gain endurance & strength. The ATM is both a front-line pain relief modality as well as a viable rehabilitation & exercise tool. (It is also well suited to quickly and safely improve lumbar extension strength & endurance like MEDX, Cybex or Lordex type machines).

The information presented here focuses on the lumbo-pelvic region & low back dysfunctions, however the ATM2 can effectively address mid back, shoulder, hip and cervical problems as well.

The When of ATM…

At least initially most Chiropractors tend to use ATM2 *after* the adjustment as a means to rectify *residual* pain/movement impairments left uncorrected…many clinics report this may be >50% of the patients. (The ATM2 treatment tends to address movement impairment pain remaining from processes inherently *unaffected by* manipulation/adjustment i.e. it isn't a redundant or *overlap* modality). It affords a larger percent of patients the distinct benefit of leaving the office pain-free!

<u>The rationale for this:</u>

1) You already have established patient protocols…it is best to not "disrupt" them initially… adding ATM2 to the specific patient population demonstrating the need, *after* your standard treatments, assures a truly beneficial and smooth transition. (As clinical experience is gained each doctor will obviously implement the treatment as they choose).

2) Adjusting tends to be a "neurological" phenomena as well as being at least somewhat *traumatic* (sometimes thrusts *may not* be well received by the body). As such if a thrust is delivered *after* a successful ATM treatment there may be an inadvertent "insult" to the motion "restored" during the *trauma-less* ATM. We believe it makes sense to end the patient visit with *less trauma*…and potentially *more* "active" relief via ATM. Finally the ATM2 is a "self-prognosticator"…i.e. if the patient cannot be positioned pain-free they are not a

ATM & Other Treatment Options…

Since Chiropractic practice usually involves the use of multiple *modalities* not just manipulation e.g. axial traction (Decompression), flexion distraction, ultrasound/laser/electric stimulation, massage and exercise… the ATM2 may appear to be a difficult *fit* into an already "crowded" practice… perhaps even unnecessary. This is far from the truth! In fact most clinicians using an ATM2 find many of their *other* modalities becoming less important. ATM2 has been added to many large & small practices without conflict in patient care or office flow. In fact virtually all the clinics using ATM2 tend to find:
1) Greater patient satisfaction…
2) Greater confidence addressing an actual *source* of common spinal problems (inappropriate muscle activation patterns)…not just "beating around the bush".
3) ATM2 creates relief and rehabilitation simultaneously.
Also most educated patients understand "muscles move bones"…they appreciate that the doctor recognizes this too!

A note on traction…

Many DC's now use Decompression (axial traction) therapy. The addition of ATM2 with Decompression is especially beneficial…as movement impairments are always *coconspirators* with disc lesions. The ATM2 can dramatically improve the outcome for many disc patients. The following comments are pertinent to traction & ATM use:

1. Movement disorders (dysfunction) always pre-exist disc syndromes however they may be "hidden" behind nerve tension signs/symptoms and pain may be worsened by standing still and/or when restrained. The clinical exam is key for ATM use at *this stage*. (ATM may take a "backseat" in some injury processes until inflammation reduces).

2. It is common for "complex" disc patients (uncontained disc w/nerve encroachment) to have pain or exacerbated symptoms with extension (posterior compression creating peripheral *radiculits*). Simple, uncomplicated discs tend to show relief with extension (Mckenzie maneuver). This differentiation of movement impairment vs. nerve provocation should be noted & qualified prior to ATM2 use.

3. If both flexion & extension reveal movement dysfunction, traction may rectify one direction…but usually not both. ATM2 is then indicated for that *direction*.

4. Virtually all decompression patients can be transitioned to the ATM2 as care progresses… not just for further relief *post-traction,* but implementation of the all-important Active phase of care. In other words the ATM2 is used as a front-line, pain relieving *co-modality* and subsequently as a primary choice for rehabilitation. The transition to ATM treatments is an extremely easy and positive experience (both from a clinical & financial aspect) for most clinics. At about 3'X4' it should fit in any office. Also keep in mind if only a 1/3rd of your patients were ideal candidates for ATM2 this would more than pay for the system and warrant it's place in the clinic…the number however is probably closer to 75%. If you examine the literature, "dysfunction syndromes" occur in upwards of 90% of the population…no other treatment can address the problem as quickly, effectively and

Patient selection Criteria…

The main focus of practice should be matching the patient to the proper therapy. Nothing works on everyone however the wrong therapy for the condition is never going to be much help.

The "proper doctors dilemma" states:

- Are we applying the proper therapy?
- Are we applying the therapy properly?
- Are we applying it to the proper patient?

These questions are imperative in clinical practice.

Typical signs/symptoms:

1) Patient has pain and limitations to global motion of their trunk, pelvis and/or skull. This pain and/or limitation of range-of-motion can be in any plane…flexion, extension, lateral, rotation or a combination.

2) The standing patient is checked in various motions for pain/limitations. These are noted and repeated to gain a distinct awareness and agreement with the patient that the motion indeed hurts in "…this ROM & at this point".

3) Additional tests to reveal pain/limitations are performed in the prone & supine positions: These tests will give the clinician a clear sign of the basic type & extent of the dysfunctional and/or derangement syndrome present.

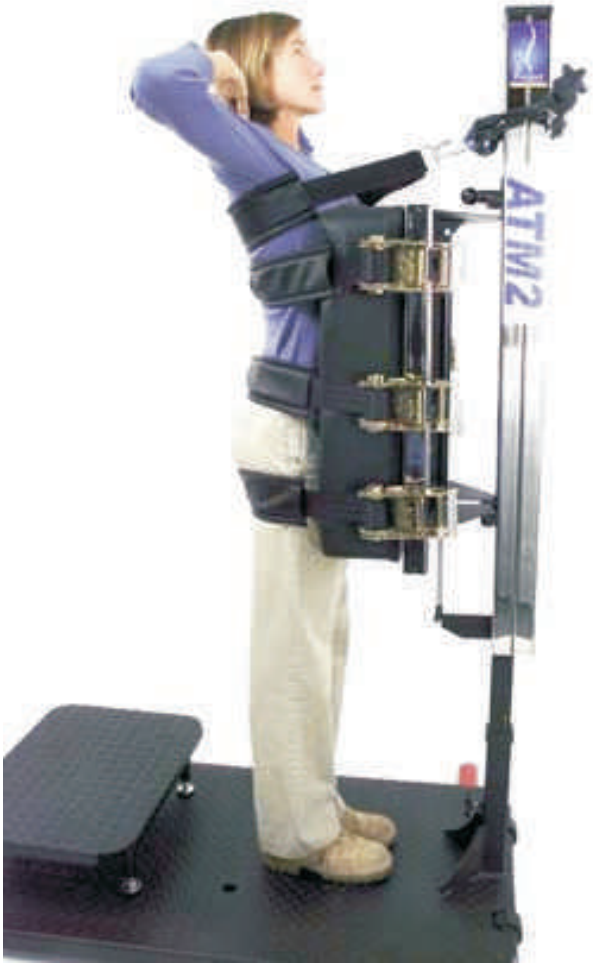
- Imaging tests of course can confirm disc lesions, though no specific imaging test will unequivocally reveal *dysfunction* (videoflouroscopy is still suspect).

The post-adjustment assessment…

The doctor will re-check the patient (having done the full initial evaluation) after the adjustment (or other modality) for indications of the need for the ATM2 treatment (our experience suggests a substantial proportion will still show the signs & symptoms for ATM). Movement impairment relief often tends to be fleeting after an adjustment alone…it's important to be sure your *post treatment* checks take this into account and the patient assessment is sufficient to verify a "long-term" positive effect before dismissing the need for ATM.

The findings for ATM2 will be *persistent* movement impairment/dysfunction either in the *initial exam* direction or, in some cases another direction. (Post the adjustment often one direction is improved and the other not). The prime pain direction is addressed first…if a relief position with the ATM2 restraints *can't* be found the *opposite* position (facing toward the unit is "prone", facing away is "supine") may be attempted. There may be attendant relief in *both* planes of motion post one direction of ATM…assessment & re-assessment is the key.

(Other procedures such as simple hip extensions & rotations can "free-up" movement also). If relief isn't realized with the restraints resistance exercise is NEVER added.



Review: Dysfunction vs. Derangement…

In a basic sense there are 3 categories for mechanical musculoskeletal *problems* (Robin Mckenzie PT):

A) Postural syndrome: shifts of the centers of mass of the skull, torso and/or pelvis from the central axis initiating tissue deformation.

B) Dysfunctional syndrome: movement impairment disorder resultant from persistent postural permutations/alterations and resultant tissue "shortening" and/or compression.

C) Derangement syndrome: effecting the disc shape and integrity…end result from persistent postural/dysfunction (and often from the addition of trauma). The simple Postureal teration *stage* (which tends to be insidious and painless) will lead to *permanent* "shortening" of tissues. This leads to pain when said tissues are "stretched" or pressured. Dysfunctional syndromes (movement impairments) also involve the CNS proprioception mechanisms & activation patterns creating permanent (or semi-permanent) *memories* of the dysfunction. Over time disc "derangements" occur (protrusion, degeneration, herniations, IDD etc) which usually present the most challenge clinically due to the degree of pain, neurological involvement and slow healing of the disc matrix. It is our experience many "disc" syndromes (somatic referral pain devoid of nerve signs or nuclear prolapse on an MRI) especially in younger, *healthy* people tend to give a *nebulous* clinical picture…few dramatic clinical signs. We find traction (decompression) & ATM2 treatment will quickly rectify the "subtle impairment" and relieve the pain. We term this: mild to moderate *inflammatory axial disc compression syndrome with attendant dysfunction.* As stated earlier we suggest new users treat their patients with their standard modalities (traction, adjustment etc.) First…until the ATM2 develops a specific place in the treatment *hierarchy based on the doctors* experience. (There will certainly be cases best treated immediately and solely by the ATM2 at some point). We want to impress the point that the ATM2 should quickly build its place in your existing treatment arsenal without any intimidation. The ATM2 is not presenting itself as a replacement for other treatments. Instead it can be an important addition to "fill the gap" in the relief phase of care AND add an effective transition to Active care i.e. functi on of motion & strength.

Reimbursement issues…

It is impossible (and perhaps inappropriate) to delve into reimbursement issues given the wide variance with insurance carriers and state law.

However here are some ideas:

a) Insurance reimburses ATM2 treatment with the billing codes 97530 (therapeutic activity to restore or improve daily functional activities) & 97112 neuromuscular reeducation (improvement in proprioception, posture & balance). We feel 97112 may be most accurate. 97110 (general exercise code) may be less accurate since the ATM theory suggests a "re-setting" of the CNS muscle activation strategies…not merely "exercise".

b) These codes are for 15 minute one-to-one contact. Less than 15 minutes a modifier can be added. However 15 minutes with pre-post assessment and rudimentary post ATM exercises (stepper, Theraband etc.) is easy to reach. Insurance law says 2 units can be billed when 24 total minutes (not 30) is reached. (It is difficult to imagine however 24 minutes actually "in" the ATM2!)

c) Cash: since patients are either *candidates* (they CAN be made pain-free with the restraints) or they are NOT…patient selection is quick & specific. This is a distinct advantage to cash patients! If they are responders to ATM2 about (4) sessions tends to give the doctor a reasonable prognosis and need for continued care (similar to most methods).

d) The ATM2 is perhaps one of the best palliative & maintenance treatments ever developed. As such "cash plans" for regular treatments can be easily created and enthusiastically accepted by patients.

e) Patients who have experienced the immediate relief & restoration of movement typical from ATM2 treatments are an excellent source for referrals.

f) Since the ATM2 is "new" to the Chiropractic market most MD's also have little knowledge of it either. It is apparent MD's don't like to deal with back pain. Our experience is Md's tend to refer to non-traumatic, logical treatments with reasonably rapid signs of improvement. Few have a real Chiropractic stigma anymore however many are hesitant to refer to harsh or haphazard *manipulators*.

g) General practice MD's and their ancillary staff of PA's & CRNP's can be a lucrative source of referrals…an open house can be a great introduction. Relieving their pain works wonders for referrals.

Review & Algorithm…

Initial Examination:

- Subjective pain assessment.
- Location, duration & provocation.
- Movement impairment analysis: patient tested for pain and/or limitation of motion in a) Flexion b) extension c) lateral flexion d) rotation e)combinations.
- Examination reveals primary or secondary movement impairment/dysfunctional syndrome…progress to applicable modalities and spinal adjustment… • Post treatment evaluation shows continued movement impairment…use ATM2 (initial implementation).
- Release& re-test previously painful motion.
- Enjoy the results!!

Epilogue…

The ATM2, like all treatments has it's limitations. However, unlike other presently "*more popular*" treatments, the ATM2 can address a primary "source" of pain & dysfunction in a majority of Chiropractic patients. The ability to re-set & reestablish more normal muscle activation patterns should be enthusiastically embraced by any Chiropractor who has ever said: "…I wish there was something more I could do for this particular group of patients…". Now there is…ATM2.

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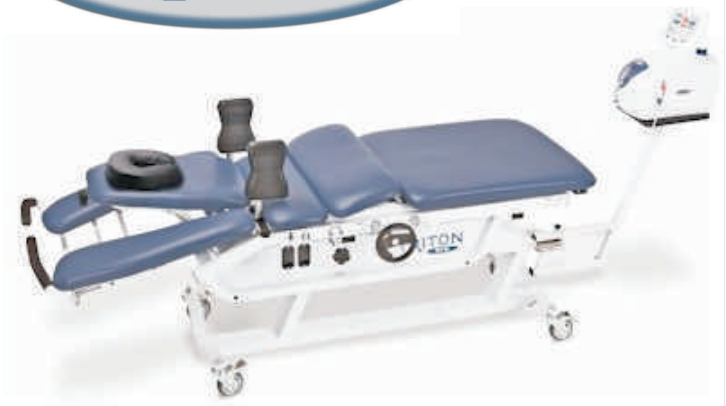

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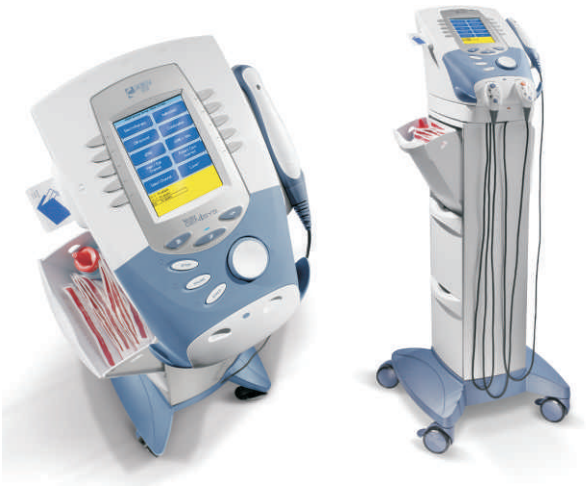

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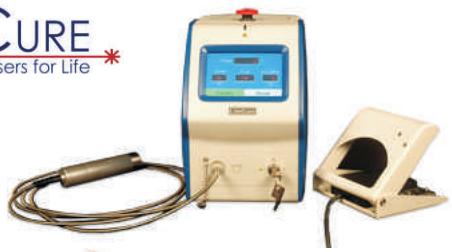

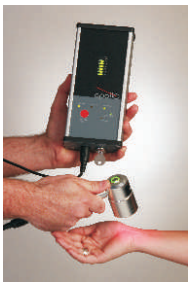

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