

1 **Clinical Practice Guideline:** **Drop Table Assisted Manipulation**

2  
3 **Date of Implementation:** **July 13, 2006**

4  
5 **Effective Date:** **January 29, 2026**

6  
7 **Product:** **Specialty**

8  
9  
10 **GUIDELINES**

11 American Specialty Health – Specialty (ASH) considers Drop Table Assisted Manipulation  
12 as medically necessary when used to assist in administering a high-velocity, low-amplitude  
13 (HVLA) spinal adjustment. As such, the base of peer-reviewed published literature  
14 supporting HVLA can be used to support the efficacy and favorable benefit: risk profile of  
15 drop table assisted manipulation.

16  
17 **DESCRIPTION/BACKGROUND**

18 There are several different manufacturers and commonly used drop table models, but they  
19 all have a common purpose and mode of action. The drop table is used to assist in  
20 administering a high-velocity, low-amplitude (HVLA) spinal adjustment (Cooperstein &  
21 Gleberzon, 2004). The therapeutic procedure begins with a downward pressure over the  
22 appropriate vertebral segment or contact point to adjust the involved joint of the patient  
23 positioned on the drop table. This section of the table will release or “drop” from one to  
24 several centimeters. This abrupt stop at the “terminal point” and the practitioner’s  
25 continued downward pressure results in inter-vertebral motion and/or joint cavitation.

26  
27 **EVIDENCE REVIEW**

28 Oh et al. (2018) examined the effects of flexion-distraction and drop techniques on  
29 disorders and Ferguson's angle in female patients with lumbar intervertebral disc  
30 herniation. Thirty female patients with lumbar intervertebral disc herniation were divided  
31 into an experimental group ( $n=15$ ) treated with flexion-distraction and drop techniques and  
32 a control group ( $n=15$ ) treated with spinal decompression therapy. Both groups were  
33 treated three times a week over an eight-week period. Results demonstrated that both  
34 groups showed statistically significant decreases in disorders and in Ferguson's angle.  
35 Authors concluded that flexion-distraction and drop techniques may be an effective  
36 intervention to improve disorders and Ferguson's angle in female patients with lumbar  
37 intervertebral disc herniation. Oh et al. (2019) performed a similar study looking at the  
38 effects of flexion-distraction technique and drop techniques on straight leg raising angle  
39 and intervertebral disc height of patients with lumbar intervertebral disc herniation. Thirty  
40 female patients between the ages of 20 to 60 years of age were assigned to the experimental  
41 group ( $n=15$ ) treated with flexion-distraction and drop techniques or to the control group  
42 ( $n=15$ ) treated with spinal decompression therapy. Both groups were treated three times a

1 week for 8 weeks. Both groups had a significant increase in straight leg raising angle and  
2 intervertebral disc height. The authors concluded that flexion-distraction technique and the  
3 drop technique may be effective interventions for straight leg raising angle and  
4 intervertebral disc height in patients with intervertebral disc herniations.

5  
6 There is no specific evidence of safety concerns using a drop table. It has been suggested  
7 that the drop table method may have a more benign safety profile, but this hypothesis has  
8 not been verified.

## 9 10 **PRACTITIONER SCOPE AND TRAINING**

11 Practitioners should practice only in the areas in which they are competent based on their  
12 education, training and experience. Levels of education, experience, and proficiency may  
13 vary among individual practitioners. It is ethically and legally incumbent on a practitioner  
14 to determine where they have the knowledge and skills necessary to perform such services.

15  
16 It is best practice for the practitioner to appropriately render services to a patient only if  
17 they are trained, equally skilled, and adequately competent to deliver a service compared  
18 to others trained to perform the same procedure. If the service would be most competently  
19 delivered by another health care practitioner who has more skill and expert training, it  
20 would be best practice to refer the patient to the more expert practitioner.

21  
22 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
23 process that is typically evidence-based and consensus driven and is recognized by a  
24 majority of professionals in a particular field as more effective at delivering a particular  
25 outcome than any other practice (Joint Commission International Accreditation Standards  
26 for Hospitals, 2020).

27  
28 Depending on the practitioner's scope of practice, training, and experience, a member's  
29 condition and/or symptoms during examination or the course of treatment may indicate the  
30 need for referral to another practitioner or even emergency care. In such cases it is prudent  
31 for the practitioner to refer the member for appropriate co-management (e.g., to their  
32 primary care physician) or if immediate emergency care is warranted, to contact 911 as  
33 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice  
34 guideline for information.

## 35 36 **References**

37 Cooperstein, R., & Gleberzon, B. (2004). *Chiropractic System Techniques: Thompson*  
38 *Technique*. In *Technique Systems in Chiropractic*. (pp. 243-249). London: Churchill  
39 Livingston.

- 1 Oh, H., Lee, S., Lee, K., & Jeong, M. (2018). The effects of flexion-distraction and drop  
2 techniques on disorders and Ferguson's angle in female patients with lumbar  
3 intervertebral disc herniation. *Journal of Physical Therapy Science*, *30*(4), 536–539.  
4 <https://doi.org/10.1589/jpts.30.536>  
5
- 6 Oh, H., Choi, S., Lee, S., Choi, J., & Lee, K. (2019). Effects of the flexion-distraction  
7 technique and drop technique on straight leg raising angle and intervertebral disc  
8 height of patients with an intervertebral disc herniation. *Journal of Physical Therapy  
9 Science*, *31*(8), 666–669. <https://doi.org/10.1589/jpts.31.666>  
10
- 11 Rhodes, D.W., Mansfield, E.R., Bishop, P.A., & Smith, J.F. (1995, July-August). The  
12 validity of the prone leg check as an estimate of standing leg length inequality  
13 measured by x-ray. *Journal of Manipulative and Physiological Therapeutic*, *(18)*:6,  
14 343-346