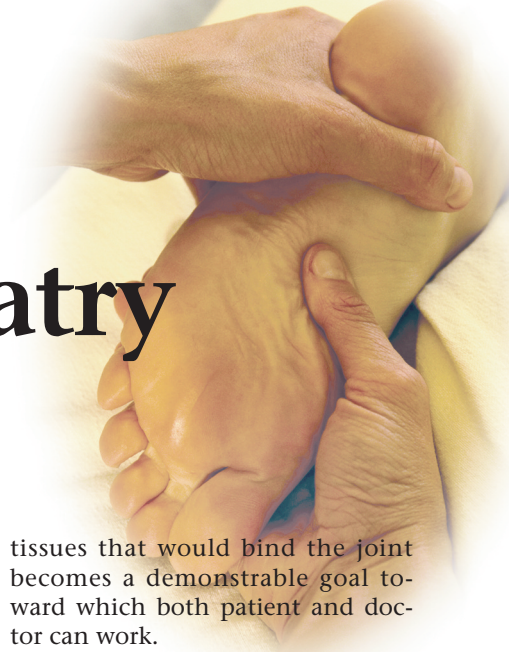

Massage and Podiatry

These conservative techniques can add to your armamentarium of treatment options.

By Jay D. Segel, DPM

A podiatrist, a patient, and a Medicare representative walk into a bar..., this may sound like the beginning of another bad joke on the lecture circuit, but what these individuals might say to each other could be quite surprising and beneficial to all. Medicare recognizes the benefits of massage as a form of physical and/or rehabilitative therapy and reimburses for this treatment for many conditions seen in the typical podiatric practice.

Medicare uses the "Scope of Practice" as a benchmark in deciding whether a specific code or bundle of codes should be part of the practitioner's fee schedule. Given that the podiatrist is the ultimate arbiter of the foot, and that massage within our anatomic boundaries is within the "standard of practice" and reimbursable, we should examine this established and well-appreciated practice and see where it might fit into our practices. For the purposes of this article on podiatry-based massage, the focus will be on the "Benefits and Indications," How To Chart It" and "How to Do It."

Benefits and Indications

Massage has long been used to aid healing, improve circulation, reduce pain, decrease swelling, increase range of motion, extend endurance, normalize gait, re-establish subluxed joints, nourish skin, and break up scar tissue. I have seen peripheral neuropathy patients consistently report more feeling in the lower limbs after massage treatment. Combined, these great benefits bring about improved posture, balance and confidence.

After the foot has been housed in an often cramped environment for long periods of time, it accommodates by contracting and existing in an almost tetany-like state. This condensed foot form is a poor shock-absorber and is less able to accommodate uneven surfaces. By massaging the foot to a relaxed state, more surface area is allowed to interact with the ground, improving function and shock absorption while making the foot and body less susceptible to macro-traumatic events such as falling. By relaxing the foot in this manner, the vasculature also eases, leading to increased lumen diameter and improved local arterial blood flow.

> ***For those patients or practitioners who may doubt the efficacy of massage, nothing proves the point like diagnostic ultrasound.***

The preventative medical and biomechanical benefits should not be underestimated. For those patients or practitioners who may doubt the efficacy of massage, nothing proves the point like diagnostic ultrasound. Image an arthritic joint in motion and demonstrate the narrowing or mal-aligned joint space; then, add retrograde traction and watch the joint space open up and range of motion increase. Stretching and re-educating those tissues that would bind the joint becomes a demonstrable goal toward which both patient and doctor can work.

For some time, podiatry schools have been emphasizing the concept of conservative treatment first. Malpractice carriers and lawyers also talk about exhausting non-invasive treatment regimens such as massage, ultrasound, electrical muscular stimulation, shoe change, and orthoses before reaching for the needle or the blade.

Many patient chief complaints can be resolved through a regular course of physical therapies, shoe intervention, and gait alteration. Disease processes I have treated with massage and have received Medicare reimbursement include: Degenerative joint disease, plantar fasciitis, tendonitis, vascular disease, diabetes mellitus, hallux rigidus, contracted digits, hallux abducto-valgus, Parkinson's disease, lymph edema, peripheral neuropathy, polymyalgia and seronegative arthropathies.

Massage, in conjunction with other therapeutic modalities, is also helpful for those patients with overuse syndromes, old injuries, and for status post foot/ankle surgical recipients. It's important to point out that in the patient with severe systemic problems in addition to the podiatric complaint, massage may be the only therapy option to consider since modalities like electrical muscular stimulation have a number of contraindications.

How To Chart It

You should also make a therapeutic care plan to include:

Continued on page 78

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Massage...

modality type or procedure, topicals used, level of function, duration and frequency of recommended treatment, medical necessity, long-term goals, patient comments and a home care plan. Care plan re-evaluation must be done at least every 30 days or after every 10 treatments. It should include all of the above plus changes to the plan and an assessment of progress by charting increases in range of motion and decreases in pain in scales such as a 1-10 system. For a more exacting description of charting requirements, see: http://www.ugsmedicare.com/providers/medical_review/documents/Final%20Therapy%20Guide%202006.pdf

Primary and Secondary Diagnostic Codes

Appropriate ICD-9 primary and secondary diagnostic codes are important to any medical billing process, and many patients will have multiple issues which may benefit from a medical massage treatment regimen. For example, arthritities are often seen in elderly patients with diabetes mellitus and are accompanied by an unsteady or antalgic gait, as well as acquired deformities such as hallux limitus and contracted digits. These diagnoses progressively impact the foot and/or mobility in a negative manner, and would ***seem to*** be considered viable reasons to treat the foot with massage—***check with your Medicare carrier or non-Medicare payer for their guidelines and requirements.***

Box 21 on the CMS-1500 is the appropriate space to indicate diagnoses. It is suggested to use all four diagnosis lines. So, in the above example, the practitioner might indicate an unsteady gait (781.2), as the primary diagnosis (diagnosis number one) followed by degenerative joint disease (715.17), hallux limitus (735.2) and diabetes mellitus (250.00) or contracted digits (735.8).

Another important piece of information to share with your staff and patients is that therapy codes carry with them a combined calendar year cap of $1,780 based on what Medicare approves, not the 80% they pay.

How to Do It

"First do no harm" is a common quotable among medical educators. The mantra for massage is "lay eyes before hands." In fact, the appropriate preludes to therapeutic massage are a systems update, meds review, allergy check, and a local exam. Assuming no breaks in the skin or other contraindications, ask for questions, inform and educate the patient on the care plan, topicals to be used and techniques to be employed.

Medicare neither suggests nor recommends one type of massage over another, just that it be medically necessary, charted appropriately and demonstrate quantitative results. Providing effective medical massage begins with a strong

Continued on page 79

Massage...

knowledge of anatomy, physiology, tissues planes and pathomechanics. Given that the foot is, for the most part, a logical appendage, and the facts are known or knowable, the technique often dictates itself. For example, an arthritic patient may benefit from a distraction focus massage with an anti-inflammatory topical, whereas a patient with overuse syndrome might respond better to deep tissue work with defatigant-style topicals.

Patients with edema usually respond well to vasodilatory topicals with drainage techniques; yet those same topicals, in a dependent leg position with percussive techniques, tend to yield an improved local blood perfusion. Often, patients present with multiple related pathologies, and so components of each massage discipline may be used to produce any number of beneficial results, such as an increase in circulation and range of motion while decreasing edema and pain, all of which lead to improved ambulation and a more stable gait.

Techniques

I use six basic techniques that I modify and/or combine based on patient history and complaint, along with my observations, assessments and diagnoses. These massage maneuvers are distraction, percussion, cradling, drainage, light touch, and myofascial release. These are based on anatomy, physiology, and biomechanic principles. Distractive techniques are used in almost every patient whom I see, because the foot is under constant stress secondary to imbalanced retrograde forces. Combine this with the extraordinary pressures of gravity, motion, shock and body weight and you have a prescription for burden, micro-trauma and the need for constant maintenance. Massage is maintenance and rehabilitation, for both foot use and misuse.

Distractive Massage

Distractive massage is the technique of choice for arthritics, but patients with contractures and peripheral neuropathy report benefit as well. The method involves traction of the joint to resistance with the addition of slow movement within the planes of motion. This is done repetitively and slowly to let the soft tissues relax and elongate much like runners are encouraged to stretch before activity. Two bones in space would have no reason to interact but for the sack that contains them (the foot) and the soft tissues that attach and cause them to function interactively. This imperfectly architectural "bag of bones" is a three dimensional appendage whose job it is to function on and adapt to uneven and unyielding surfaces. This leads to muscular imbalance, asymmetric joint spaces, scar tissue and ligamentous contraction. By making use of the elastic nature of ligaments, capsules, muscles, and tendons that hold joints in contraction and perhaps subluxation, distractive mas-

Continued on page 80

sage can increase range of motion while decreasing inflammation and pain during mobility.

Percussive Maneuvers

Percussive maneuvers are quick and repetitive physical interactions with the foot. Open-handed perpendicular techniques are meant to create an increase in circulation while "spider drumming" (alternating horizontal motions), are used on the long tendons of the foot to break up scar tissue and increase flexibility to promote neutral joint spacing and increases in range of motion. This is almost always included with pes cavus foot types and patients with compromised arterial systems.

Cradling

Cradling is a two-handed technique that is a favorite among patients. By marrying the three-dimensionality of your hands to the architecture of patients' feet, they are bathed with a sense of security, relaxation, and warmth. This is most often used on the medial longitudinal arch with plantar fasciitis, the lateral longitudinal arch with cuboid subluxations or peroneal dyfuction, and on a contracted tendo-Achilles secondary to surgery, short limb syndrome, polymyalgia, trauma, or equinus.

Drainage

Of all the methods used, drainage is probably the most dramatic visually. With the patient reclined comfortably and the foot higher than the heart, the edematous limb secondary to venous or lymphatic system insufficiency is manually drained with appropriate compression and very slow proximal motions. This is another two-handed position where the foot is often lifted higher than the patient's heart. The fluid and blood cells move from the interstitial tissue back into vessels to eventually release toxins and reoxygenate. In addition to treating edema, I find this technique to be quite useful when a patient is observed with venous distention or anterior lower limb staining as often occurs in diabetics.

Myofascial Release

For the podiatrist, myofascial release is, in part, deep tissue work, manipulation, and cross-fiber massage employed to stretch and ease the bonds between the integument, fascia, muscle and bones in the foot/ankle. The goal is to re-orient and reorganize the connective tissue fibers to an elongated and more flexible and functional arrangement to benefit gait. This practice is particularly good for patients with old injuries, localized pain, and imbalances.

Light Touch

Light touch is a finishing move that is more "Eastern medicine" but it's effective, and patients tend to love it. It is a good way to signal the ending of a session while releasing stress and providing some exercise

Continued on page 81

for the local sensory nerves. With the heel cradled in well lubricated hands and positioned above the patient's heart (when appropriate), allow the foot to return slowly to the footrest below, cushioned between the practitioner's hands and arms.

Topicals

All the above described massage types incorporate the use of topical medicines and remedies, both prescription and over-the-counter. Vasodilators, stimulants, relaxants, toners, nourishing massage lubricants, anti-inflammatories, pain relievers, anti-spasmodics and carrying vehicles are used to bring about the desired goals as stated above. Without endorsing any specific products, I use preparations with ingredients such as menthol, camphor, arnica, cortisone, DMSO, Emu Oil, lanolin, capsaicin, lavender, tea tree oil, grape seed oil, eucalyptus, aloe vera, skullcap, urea, waters, amino acids, minerals and vitamins, to name but a few.

The basic philosophy is to open the pores with dilators, then use carrying mediums for penetration of the beneficial active components. After the selected topicals have been worked into the local tissues by appropriate massage technique, I degrease and constrict the pores to seal in the medicines with a toning water spray and blot dry under mild traction. I often suggest such topicals for home use. This keeps the patient focused and actively involved in the treatment plan.

Whichever the techniques and topicals, you can and should revisit your choices based on results, patient response, and the time of the year. I often make changes after a reassessment of goals, results, and even foot temperature. For those of us practicing in cold climates, warming the foot and protecting the skin can make a difference between limb loss and limb salvage, especially in our diabetic, neuropathic and circulatory challenged patients. What we do therapeutically is very important. Patients tend to love this medical massage and appreciate you for it. I often hear that coming for their massage treatments is the highlight of their week. An eager and happy patient is a willing partner that, when matched with a skilled and caring practitioner, a welcoming treatment room, and an attentive staff, make for a good healing team that gets results. ■

Dr. Jay Segel graduated from the Ohio College of Podiatric Medicine in 1979. He completed his surgical residency at Cambridge City Hospital, a Harvard Teaching Affiliate. After residency, he moved to Martha's Vineyard, where he still practices. He is a member of the American Academy of Sports Medicine, has been an advisor to shoe companies and holds several utilities patents on footwear.