UCLA MEDICAL GROUP / Managed Care Operations		UCLA Health
DEPARTMENT:	Utilization Management	POLICY NUMBER: **TBD**
SECTION:	UM Program	
TITLE:	**UCLA Medical Group Practice Guideline: Podiatry**	ISSUE: EFFECTIVE:
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1. Nail problems

A. Ingrown nails

1. If not infected, soak in warm water with Betadine, Epsom salts, or hydrogen peroxide; and, at the discretion of the PCP, attempt resection of the offending nail border. Alternatively, refer cases to podiatry.

2. If infected, begin soaks, and begin antibiotics. Antibiotics should be used in cases with cellulitic change, in diabetics, and in those who are immunocompromised. Topical agents or oral first generation Cephalosporins are adequate for the immuncompetent; expanding for gram negative coverage with Augmentin or Bactrim is advisable in diabetics and the immunocompromised. At the discretion of the PCP, attempt resection of the offending nail border. Refer any unresolved or
problem cases to podiatry ASAP.

3. If nail has been infected > 4 weeks, obtain X-ray to rule out osteomyelitis.

4. **Recurrent ingrown nail borders should be referred to podiatry for permanent correction by matrixectomy.**

B. Mycotic Nails

1. Treatment of onychomycosis should be considered in diabetic patients with recurrent ingrown nails or recurrent cellulitis. However, the benefits of treatment must be weighed on a case by case basis with potential toxicities. In non-diabetic patients, treatment may be considered cosmetic and the drug may not be covered by their insurance plan. The PCP should initiate treatment, if desired. Potential regimens include:

   a. Topical antifungal treatment with one of the liquid agents (Lotrimin, Tineacide, Jublia Mycocide, Penlac). This is less effective than oral therapy.

   b. Oral antifungal therapy with itraconazole or terbinafine. The PCP should discuss the potential benefits and complications with the patient, and treatment initiated if suitable. Appropriate lab work should be ordered (such as baseline LFTs and creatinine), if indicated, with the PCP to follow and monitor for systemic problems and clinical effectiveness.

   c. Laser treatment can be offered but it is generally not covered by insurance.

2. Podiatric referral is appropriate for reduction or debridement of painful nail plates or for permanent removal of the nail.

2. Structural deformities

A. Hallux abducto valgus (bunion) deformities

1. Patient education (genetic disorder, a "normal bone in abnormal position")

2. Over-the-counter arch supports

3. Shoe modifications (performed generally by shoemakers)

4. Over-the-counter bunion cushions or accommodations

5. Podiatric referral for orthotics, when symptomatic

6. Podiatric referral for surgical correction of deformity when nonsurgical care has failed to provide a satisfactory comfort level and symptoms are sufficient to warrant elective surgery.

B. Hammertoe deformities

1. Patient education (genetic disorder, a "normal bone in abnormal position")

2. Over-the-counter arch supports

3. Shoe modifications (performed generally by shoemakers)

4. Over-the-counter hammertoe cushions, crest pads or protective sleeves

5. Podiatric referral for orthotics

6. Podiatric referral for surgical correction of deformity when non-surgical care has failed to provide a satisfactory comfort level and symptoms are sufficient to warrant elective surgery.

3. Forefoot pain

A. Neuroma / metatarsalgia: refer for ultrasound examination for the presence of neuroma

1. Metatarsal pads

2. Soft insoles

3. Over-the-counter arch supports

4. Shoe modifications

5. Podiatric referral for orthotics or injection of cortisone or alcohol.

6. Podiatric referral for surgical excision of neuroma or metatarsal osteotomy when nonsurgical care has failed to provide a satisfactory comfort level and symptoms are sufficient to warrant elective surgery.

4. Heel pain

A. Plantar fasciitis (with or without heel spurs)

1. Consider an X-ray (lateral weight-bearing view) to rule out other bony abnormalities such as fracture or arthritis. The only significance of the presence of a heel spur is that it indicates chronic fasciitis. The treatments are the same with or without the presence of a spur, unless the heel spur has broken off, and then it is treated as a broken bone.

2. Patient education (see attachment)

3. Stretching program

4. Over-the-counter heel cups / heel lifts

5. Over-the-counter arch supports

6. Physical therapy referral

7. NSAIDs

8. Podiatric referral for steroid injection therapy

9. Podiatric referral for orthotics if symptoms recur or persist

10. Podiatric referral for (EPAT) shockwave treatment (not covered by insurance)

5. Skin lesions

A. Corns or callouses

1. Manual debridement

2. Accommodation of lesion with over-the counter pads / cushions

3. Follow guidelines for structural deformities (see #2)

B. Plantar warts

1. Acid therapies

2. Liquid nitrogen treatment

3. Podiatric referral for excision or Bleomycin injection of recalcitrant or non-improving isolated lesions.

6. Ankle

A. Sprains, rice treatment and x-rays
B. Fracture x-rays, immobilize and non-weight bearing.

NOTE: All foot problems associated with **diabetes**, such as ulcer treatment or management of charcot arthropathy, should be referred immediately. For these and other urgent cases, please call the Podiatry office so the patients may be accommodated.

REVISION / REVIEW HISTORY:

Date	Action	Reason	Author
9/16/2021	Guideline revision by Dr. Alan Singer	Page1 C. and Page 6. Ankle	Stacey Cathcart-Greene