ASGE COVID-19 FREQUENTLY ASKED QUESTIONS

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GI Fellows Practice & Training Suggestions during COVID-19 Outbreak

Question 1: Can GI Fellows be involved in Telehealth?

ASGE Response: *Fellows can participate in Telehealth, PROVIDING the program and institution APPROVE AND if billing, an attending is required to be present.*

Question 2: Can a GI Fellow politely refuse to participate in elective cases or non-urgent consults that burden the medical staff OR take away resources?

ASGE Response: *Most institutions have reduced their endoscopies to urgent and emergent cases only. In this situation, only essential personnel should be in the procedure room. Hence, Fellows should participate in the procedure only if THEIR PARTICIPATION IS essential for the procedure.*

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Personal Protective Equipment (PPE) for the GI Endoscopy Unit

Question 1: What PPE should be worn during GI Endoscopy and endoscope cleaning and HLD for patients classified as Low Risk for COVID-19?

ASGE Response: Strictly follow CDC and OSHA standard precautions for blood and body fluids, along with any institutional guidelines. PPE worn during GI endoscopy for all patients should include gloves, mask, eye shield/goggles, face shields, and gown

Question 2: What PPE should be worn during GI Endoscopy and endoscope cleaning and HLD for patients classified as High Risk for COVID-19?

ASGE Response: *In addition to strict adherence to PPE requirements for blood and body fluids, additional PPE is to be worn throughout the entire Endoscopy procedure and cleaning/HLD process (ESGE/ESGENA). This includes the following: Hair protection, N95 mask or positive pressure respirator hood, Double Gloves (over/under gown), Water-resistant gown, Protective eyewear, and N-95 or Filtering Facepiece Respirator (FFP2/FFP3 respirator). In the case of certain respiratory PPE shortages, alternatives to respirators should be considered, such as FFRs, elastomeric half-mask, and full facepiece air purifying respirators.*

Question 3: How should Endoscopy Rooms be cleaned between patients?

ASGE Response: *Low-Risk Patients: For patients categorized as Low Risk undergoing GI Endoscopy, surfaces and equipment should be cleaned following the current institutional policy.*

High-Risk Patients: In addition to standard room cleaning recommendations, all environmental surfaces frequently touched by hand, including but not limited to bedside tables, stretchers, counters, cabinets, endoscopy equipment (video processor, tower, etc.), and floor should be considered heavily contaminated. These surfaces should undergo thorough disinfection after each patient.

Negative Pressure Rooms: All patients categorized as High Risk or Positive should undergo endoscopy in a negative pressure room. In order to minimize the potential for airborne particles to remain suspended, a delay of about 30 minutes between patients is recommended.

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Question 4: How should rooms be cleaned at the end of the day if a high-risk patient has had endoscopy in the room?

ASGE Response: *Follow institutional guidelines. Appropriate PPE should be worn as described above. This includes:*

- *Hair protection*
- *N95 mask or positive pressure respirator hood*
- *Double Gloves (over/under gown)*
- *Water-resistant gown*
- *Protective eyewear*
- *N-95 or FFP2/FFP3 respirator*

As COVID-19 is susceptible to the same cleaning agents used in routine terminal cleaning of rooms after performing endoscopic procedures, there is no recommendation for the use of bleach or other chemicals reserved for the eradication of disinfection-resistant spores such as C. difficle.

Question 5: How should endoscopy be performed on a high-risk patient if a negative pressure room is not available?

ASGE Response: *Follow institutional guidelines. Institutions should evaluate their ability or level of preparedness to provide flexible endoscopy to patient at High Risk or Positive for COVID-19 in the absence of negative pressure rooms suitable for endoscopic procedures. IF POSSIBLE, THESE PATIENTS SHOULD BE TRANSFERRED TO AN INSTITUTION WITH A NEGATIVE PRESSURE ENDOSCOPY ROOM ONLY IN EMERGENCY SITUATIONS. If patients are High Risk or Positive for COVID-19, require endoscopy, and a negative pressure room is not available, alternative measures for minimizing the potential for airborne virus remaining in the room include the following: diluting the air in a space with cleaner air from outdoors should be considered, and the room should be kept empty for at least 1 hour FOLLOWING DEEP CLEANING.*

Question 6: If COVID-19 is UV sensitive, could this be a potential method for either reprocessing unsoiled PPE or endoscopy room reprocessing?

ASGE Response: *Although there has been publicity on the efficacy of UV light technology to eradicate bacteria and the viruses similar in structure to COVID-19, the lack of CDC guidance and available data specific to COVID-19 and the endoscopy setting are insufficient for ASGE to make a recommendation at this time. Follow your institutional guidelines.*

COVID-19 Screening in the Endoscopy Unit

Question 1: If the use of N95 masks are not recommended for low-risk patients, what are the suggestions if patients are COVID19+ and asymptomatic?

ASGE Response: *If patients are COVID-19 positive and are asymptomatic, and if the procedure is of a time-sensitive nature, they fall under the high-risk patient category, and therefore it is important to wear all appropriate personal protective equipment including N95 masks. Given that COVID-19 positive, asymptomatic patients still have a risk of viral shedding and transmitting infection, they should be managed as if they were symptomatic COVID-19 positive patients. COVID unknown/untested may also be considered intermediate-high risk based on exposure and travel. In all such cases, N95 is recommended.*

Question 2: In light of the increasing prevalence of this infection and the presence of asymptomatic carriers, is there really a low-risk group?

ASGE Response: *Unfortunately, the true prevalence of the low-risk group is unknown at this time due to lack of widespread availability of testing, particularly since most areas are testing only symptomatic patients. However, as more widespread testing availability becomes accessible and there is increased testing of asymptomatic people, we may get a better understanding of the true prevalence in a community. We must continue to balance PPE inventory with risk. If there is extensive PPE inventory, universal use of N95 is favored, but most groups must be selective as defined by CDC*

Question 3: Given community spread is now widespread in the U.S., should we focus more on symptoms and exposure to known COVID patients rather than those who have traveled when we are risk assessing patients coming to the endoscopy lab?

ASGE Response: *This is a good question. As the pandemic evolves over time, the risk assessment questionnaire necessarily needs to evolve over time as well. At this time, it is important to focus on all these questions in your assessment. All patients should be asked about symptoms, exposure, and travel history as part of the pre-screening assessment prior to arriving at the endoscopy lab.*

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Question 4: What areas in the United States would be considered high-risk locations, thereby putting asymptomatic patients into the Intermediate-risk group?

ASGE Response: *At time of writing, high-risk areas in the U.S. include New York, Seattle, and northern California. However, this is an evolving situation, and as the pandemic progresses/more testing becomes available, more areas across the country may be designated high-risk locations in the future. We have found the frequently updated Johns Hopkins COVID-19 tracker an invaluable resource:*

https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6

Question 5: Do you screen the patient prior to them coming for procedures/office visit?

ASGE Response: *Yes. Office staff is instructed to call patients and perform a pre-screening questionnaire. If patients have symptoms, any recent travel, known exposures, or are coming from a high-risk area, these people are being asked not to come for their office visit or procedures unless it is a time-sensitive procedure, in which case we would consider moving their procedure into a properly equipped venue (such as a negative-pressure room, if available). For office visits, patients are strongly encouraged to switch to Telehealth visits (video or telephone call). Some patients may still need to be seen in the clinic based on physician discretion, provided the patient remains in the low-risk category (Repici article). CMS has mandated that Medicare pay for all Telehealth office visits. CMS notes that Medicare will reimburse Telehealth visits the same as an office visit. For detailed information on billing and coding for Telehealth visits, please refer to the Joint GI Society statement released on March 20th, 2020. The following link also delineates the Medicare waiver for Telehealth visits and loosening of HIPAA regulations.*

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Again, it should be noted that for procedures, all patients are pre-screened prior to coming to the endoscopy suite. Patients who are undergoing elective procedures that are not urgent or time sensitive are being wait listed for rescheduling at a future date.

Question 6: Do you have any insights into the safety of high-risk patients who are intubated?

ASGE Response: *Yes, according to the most recent guidelines from the American Society of Anesthesiologists, high-risk patients (those with confirmed or suspected COVD-19) should be intubated. Intubation allows for source control and limits infection spread from potential coughing. The following article elaborates on this further.*

Reference PDF from the American Society of Anesthesiology.

Any policies regarding intubation for upper airway procedures in high-risk patients should be discussed in a multidisciplinary fashion; for example, include the anesthesia service line director, peri-operative director, and others as appropriate.

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Question 7: If staff states they have GI issues, we should send them home, correct?

ASGE Response: *Staff should certainly not be expected to be at work if they are unable to do so because their illness precludes them from working productively and effectively. However, at this time there are no recommendations on whether staff with non-respiratory symptoms or other high-risk features should be precluded from working as it pertains to COVID-19. Although the virus can be found in fecal-oral contaminant, the rate of actual transmission without respiratory symptoms or aerosolization is unclear at this time.*

Question 8: If an ASC nurse tests positive, who needs to be quarantined?

ASGE Response: *Anybody who has come into close contact with a nurse that tests positive must be quarantined. The length of time for quarantine is typically 14 days from the last exposure, but this will depend on local and state health departments. As our understanding of the disease and availability of testing evolves, in the future it may be possible to test at-risk individuals to better risk stratify these people, who may have come into contact with COVID-19 positive individuals.*

Question 9: What if you have a staff member at your ASC diagnosed with COVID-19? You must close for 2 weeks, correct?

ASGE Response: *At this time, we do not know. However, certain reasonable measures should be taken. It is important to contact the local and state government health department regarding proper protocol in this setting. The following references may be helpful to maximize the likelihood of successful decontamination:*

https://www.osha.gov/SLTC/covid-19/controlprevention.html

https://www.cdc.gov/sars/guidance/I-infection/healthcare.html

Question 10: What is your recommendation for staff members who have traveled outside of the country and want to return to work? Should they self-quarantine for 14 days prior to returning?

ASGE Response: *It is reasonable to self-quarantine. Because this is a fluid situation, it is reasonable to follow guidance including local/state health department guidelines. It is important to note that at the time of writing, according to the CDC travel advisory, every nation worldwide is considered level 2 or higher travel advisory.*

https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html

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Question 11: Are there non-human reservoirs for COVID-19 (pets, wild animals, etc.)?

ASGE Response: *At this time, there are no known pet reservoirs for COVID-19. The links among wild animals, intermediate host(s), and humans are unclear at this time. Pets may serve as a surface contaminant when handled by infected/contagious individuals. Pets should be isolated from individuals who are at high risk. Consider soap/shampoo washing of pets frequently.*

https://www.cdc.gov/coronavirus/2019-ncov/prepare/animals.html

Question 12: Are any of your centers staggering physicians to protect from simultaneous exposures or infections?

ASGE Response: *Yes, many clinics, surgery centers, and hospital systems are limiting the number of physicians who are simultaneously in the same place to minimize exposure and spread of the virus. It would be prudent to preserve human resources in the setting that a physician contracts the virus or is exposed and must be quarantined. This will help preserve the work force.*

It may be useful to work closely with your local human resources and begin assigning "teams" of physicians and nurses to various parts of the practice (outpatient/inpatient), and cross train if necessary. For example, on the inpatient side, you may consider having "team 1" conduct all necessary hospital-based procedures, with "team 2" on standby away from the hospital in case one or more members of team 1 falls ill or needs to be quarantined. At-risk members of the team (e.g., elderly, immunosuppressed, cancer) may need to be reassigned to exclusively Telehealth to reduce their risk of exposure and serious complications. For limited essential services (e.g., ERCP), the practice may wish to have one endoscopist fill an entire schedule while the other(s) work from home, then rotate, as opposed to all physicians doing partial schedules.

Question 13: If exposed, should one use hydroxychloroquine prophylactically?

ASGE Response: *There are studies under way examining the use of hydroxychloroquine in symptomatic patients with confirmed COVID-19, but the FDA at this time has not approved the medication for use in COVID-19 patients. It is also important to note that the side effect profile of this medication may include cardiac toxicity.*

Question 14: What procedures are being done on COVID 19 positive patients?

ASGE Response: *Only highly urgent procedures are being performed on COVID-19 patients. No elective procedures are being performed at this time. Although COVID-19 patients may have GI symptoms, most do not require urgent endoscopy (diarrhea, nausea, vomiting). Normally urgent cases (cholangitis, GI bleeding with hemodynamic changes, food impactions) would typically be considered urgent, but there is sufficient time to perform the procedure in the safest possible environment.*

Reference: https://www.bsg.org.uk/covid-19-advice/endoscopy-activity-and-covid-19-bsg-and-jag-guidance/

Question 15: Is there any concern with using Ibuprofen in COVID patients?

ASGE Response: *While there are theoretical concerns with using Ibuprofen in COVID patients (due to an increase ACE-2 receptor regulation and kidney dysfunction), the World Health Organization (WHO) does not recommend against Ibuprofen based on currently available data.*

Question 16: Could PLAQUENIL or AZITHROMYCIN be used as a treatment?

ASGE Response: *There are several trials that have shown the efficacy of Plaquenil (Hydroxychloroquine) in vitro. One study has shown the rapid elimination of the virus in nasal swabs in patients with COVID - 19, but clinical outcomes were not reported.*

Reference: Gautret, et al. Hydroxychloroquine and azithromycin as a treatment of COVID-19: results of an open-label, non-randomized clinical trial. International Journal of Antimicrobial Agents - In Press 17 March 2020.

One open-label, non-randomized clinical trial of 36 patients was performed to evaluate drug efficacy against COVID-19; however, there are concerns about study methodology (for example, only 6/36 received hydroxychloroquine plus azithromycin), which may limit the applicability of results in broader clinical situations. Additionally, due to hydroxychloroquine's side effect profile (which includes QT prolongation), further studies are needed to confirm its clinical efficacy.

https://doi.org/10.1016/j.ijantimicag.2020.105949

https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html

Question 17: Ribavirin is felt to inhibit RNA-dependent RNA polymerase. Are there any reports of its use?

ASGE Response: *There is much interest in the use of antivirals in the treatment of COVID-19. Much of this interest arises from the use of other antivirals in the use of SARS/MERS previously. Currently, there are multiple studies of using an antiviral in vitro for COVID-19. (1) Most recently, an article in NEJM reported the use of Lopinavir–Ritonavir in eradicating COVID-19 in vitro. (2) There are also studies using Remdesivir in vitro, which has been shown to be effective. However, there are no known studies of using these antivirals or Ribavarin in humans infected with COVID-19.*

https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html

Reference: Cao, et al. A trial of Lopinavir-Ritonavir in Adults Hospitalized with Severe COVID-19. NEJM. March 18, 2020.

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Question 18: Does anyone have concerns about what seems to be unreasonable turnaround times for screening tests to get results? We are seeing wait times from 1 to 14 days in our area.

ASGE Response: *This is understandably a stressful clinical situation. Currently there are a wide variety of tests available with different turnaround times. At time of writing (March 21, 2020), the FDA has authorized the use of a rapid, "point of care" COVID-19 test that can deliver results in 45 minutes. As more testing options come online, we hope that we may move down the cascade list of patients to test, ideally even patients in tier 4 status.*

https://www.idsociety.org/news--publications-new/articles/2020/idsa-statement-on-covid-19-testing-recommendations/

Question 19: Any estimate on how long this epidemic may continue? How long may we need to close the ASCs?

ASGE Response: *Estimates of how long this pandemic may continue are not fully known. Much of this will depend upon the ability of our governments, health care, and society to contain the virus and flatten the curve in terms of how fast the virus is spreading.*

Based on current understanding, the infectivity potential (R0, or "r nought") of COVID-19 is 2.4, meaning one person can infect approximately 2.4 other people. https://doi.org/10.25561/77482

In comparison, the median R0 for various influenza pandemics in the past 100 years ranged from 1.46-1.80; while for seasonal influenza, the median R0 is 1.28.
https://bmcinfectdis.biomedcentral.com/articles/10.1186/1471-2334-14-480

HOWEVER, It is important to note that the R0 can change depending on multiple factors, including pharmacologic and non-pharmacologic (i.e., social distancing) interventions; generally speaking an outbreak begins to resolve once the R0 is below 1. That being said, a global effort is under way to tackle this problem (from therapeutic drug trials such as remdesivir, to plasma trials from convalescent COVID-19 patients, to phase 1 vaccine trials), and so the total duration of the disease remains to be seen.

To date, only China and South Korea appear to have passed the initial peak with approximately 2-3 months from first cases to substantial control; however, second waves may also occur.

Ambulatory Surgical Center (ASC) Suggestions During COVID-19 Outbreak and Future

Question 1: Are we to infer that ALL endoscopic procedures at ASCs should be canceled regardless of indication per CMS guidelines, even in low-impact zone?

ASGE Response: *Ability to perform procedures in ASCs will be dictated by city, state, and federal edicts, which at this time are fluid and highly dependent upon local and state stress on the healthcare system. Not all ASC procedures should be canceled. At this time, the TriSociety guideline recommends strongly considering rescheduling elective non-urgent procedures. Some non-urgent procedures may need to be performed (examples include cancer evaluation and evaluation of significant symptoms). Classification of procedures into non-urgent/postpone and non-urgent/perform may be helpful. The concept of performing elective procedures in a low-impact zone could be a component of your decision analysis. In light of multiple states declaring a state lockdown, this information should also be used in your decision analysis. This is a fluid situation, and changes can be expected on a more-than-incremental basis. Update yourself daily with respect to any changes in federal or local recommendations or mandates regarding performing non-emergent and non-urgent medical care doing this pandemic. The decision to perform non-urgent procedures must also take into account the local supply of PPE and the ability of surrounding entities to obtain PPE for an expected surge in COVID-19 cases.*

Question 2: If an ASC is just one independent site and elective cases have been canceled, would it be a good idea to just close it for the safety of the staff (by having them stay home) and let them know they may be called if a case needs to be done?

ASGE Response: *If the ASC is closed, staff should immediately seek unemployment benefits. Calling staff back periodically may impact those benefits. Depending upon the organization's policies, sick leave and vacation could be paid out but also may impact the ability to secure unemployment benefits. The federal-state unemployment compensation program is a federal fund, but each state has its own unemployment program with its own qualification guidelines, benefit amounts, and periods. As such, it is important to check with your state regulations. In some states, working 20% or less (1 day per week) will not impact full unemployment benefits during this crisis.*

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Question 3: If there are no cases scheduled in the ASC, should it be closed in the meantime for the safety of the staff?

ASGE Response: *Yes. The organization should establish a policy for those activities required to shut down (terminal cleaning, stock counts, scope washing, etc.) and also those activities required to reopen (terminal cleaning, stock counts, scope washing, etc.). IMPORTANT NOTATION: It is important to check with any state regulatory bodies regarding the rules surrounding closing an endoscopy center for any length of time and the re-opening of the previously closed center.*

Question 4: In our community, 2 of the 3 ASCs are closing for at least 2 weeks. Would that not drive patients to the hospital and burden them when they can least afford it?

ASGE Response: *The focus on endoscopic ASCs is largely the use of PPE. CMS has asked that elective procedures cease until such a time as they may be safely restored. The issue appears to relate to the consumption of personal protective gear and an assumption by CMS that ASCs stock ventilators that might be repurposed for critical care. Endoscopic ASCs do not typically stock ventilators of the kind used for critical care. The reaction of CMS remains to be seen once they understand the considerable variability in ASC resources.*

Question 5: Do any of you anticipate that ASCs might become crisis resources if hospitals become ICUs?

ASGE Response: *This is unknown at this time. A challenge to utilizing endoscopic ASCs for routine patient care would be low patient density compared with the staffing resources required to manage such a small patient cadre. Endoscopic ASCs typically have a ratio of beds:rooms of 4:1 or less. A 2-room ASC would have an available capacity of 8 beds plus 2 rooms. It is unlikely that, due to this low density, the use of small ASCs would be an efficient use of medical staff.*

Question 6: Are you recommending postponing all ASC procedures?

ASGE Response: *The ASGE is recommending that you follow state and federal guidelines for performing procedures in an ASC. Many states have developed rules that are stricter than CMS guidelines, resulting in fairly broad postponement of elective procedures.*

Question 7: Should ambulatory surgery centers perform surveillance colonoscopy exams, or should they shut down until further guidance is available?

ASGE Response: *Based on recommendations from the TriSociety guideline, screening colonoscopy should be postponed at this time. A very high percentage of surveillance colonoscopy can be postponed. Some surveillance colonoscopies could fall into the category of non-urgent, but should be performed. An example of this is first surveillance colonoscopy after treatment for colon cancer. Some physician judgment should and will apply in defining procedures to be elective non-urgent (postpone) and non-urgent (perform).*

Question 8: Have you considered alternative uses for ASCs to assist hospitals, etc?

ASGE Response: *ASCs must pay attention to changes in state and/or federal regulation. The ASC scope of practice changes may allow for alternative uses. Even if an ASC is capable of providing an alternative use, it is important there is executive or legislative allowance for such an alternative use. Until recently, every ASC was required to evaluate their capacity and resources and how they might fit within a regional disaster plan. Each ASC should begin with a review of their plan. In many situations due to limited space and resources, the result of the evaluation was to shift providers to the hospital and make supplies available as needed. ASCs should re-evaluate these plans in light of local needs specific to the COVID-19 challenge.*

Question 9: Should ASCs close, given that the cases performed are largely elective?

ASGE Response: *It is not necessary for ASCs to close. The decision to continue ASC operations should be based on projected volume of endoscopic procedures after eliminating elective non-urgent procedures. The federal-state unemployment compensation program is a federal fund, but each state has its own unemployment program with its own qualification guidelines, benefit amounts, and periods. As such, it is important to check with your state regulations. In some states, working 20% or less (1 day per week) will not impact full unemployment benefits during this crisis. A physician or physician team should review all scheduled procedures to determine which procedures should be performed. If the endoscopic volume is sufficient to operate a room(s) in the ASC, then administration needs to determine staff needs. Strongly consider forming staff and physician teams that can rotate to adequately staff the ASC.*

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Reimbursement in the era of COVID-19

Question 1: What CPT codes are you using for Telehealth?

ASGE Response: *see resource from ASGE.*

Question 2: Can providers use "phone only" to provide services?

ASGE Response: *Expect increased coverage of telephone services; possible parity with Telehealth is state by state, payer by payer, and evolving. Some non-Medicare payers have reimbursed for years, some never. Medicare still doesn't believe smart phones can be used for Telehealth service delivery, and G2012 virtual check-in is often a patient-initiated telephone service. Remember audio+video defines Telehealth in the broad sense. Bill as Telehealth if it starts that way and crashes partway through, completed by phone. Phone only is not Telehealth except MAYBE in California. Review the ASGE resource.*

Question 3: Any thoughts on how we can get small business loans? Is there a way we can delay rent payments etc., when there are cash flow and cash crunch issues?

ASGE Response: *This is evolving rapidly through new relief bills from Congress (see recently passed CARE Act). Many practices already have or can get lines of credit from the main bank they work with. There are provisions for borrowing from 401K and other pension plans. Approach your medical suite landlord about temporary abatement or deferral.*

Question 4: Most private payors do not have Telehealth codes active. Can we keep tabs on these visits and ask for reimbursements, and would the societies help in this to get reimbursed?

ASGE Response: *Most payers now cover Telehealth, whether voluntarily or by mandate, so we suggest just bill and seek reconsideration if denied. Any plans requiring preauthorization of an office visit would need same for Telehealth, but we expect this will become a non-issue.*

Question 5: How are you billing for new patient visits?

ASGE Response: *The follow-up patient is clear in that they are billed based on time. Reimbursement for new patients based on time is so low that it is difficult to do it from a financial perspective. We would not be worried about being audited on lack of physical exam for this period of time, so could use complexity (hx, medical decision making) or counseling/coord. of care time when is >50% of face-to-face*

encounter. Have your staff gather the usual data (demo., insurance, clinical, med lists) before the encounter.

Question 6: How is this affecting physician salary?

ASGE Response: *Estimate 50%-90% reductions of revenue, while overhead won't abate much, even with staff layoffs. Salaried docs may be subject to renegotiation. If you're RVU based, be sure your system has RVUs for the Telehealth, phone, and portal services, which carry reimbursement. Use chronic care management 99490-99491 when your staff and you manage appropriate patients with/without visit services. Use transitional care codes for urgent post hospital Telehealth, when other criteria are met.*

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Endoscopy Unit Operations During COVID-19 Outbreak and Future

Question 1: Should we be doing more Cologuard?

ASGE Response: *Your choice of screening test for colon cancer should not change during this time. The guidelines for choice of colon cancer screening tests should be followed as per your usual practice recommendations. Tier 1 of colon cancer screening tests include colonoscopy every 10 years or an annual fit test. Tier 2 screening options include a computed tomography colonography every 5 years, a fit fecal DNA every 3 years, or a flexible sigmoidoscopy every 5–10 years. Tier 3 option is a capsule colonoscopy every 5 years. It is clinically acceptable to postpone screening colonoscopy at this time. Colon cancer screening is not urgent. In the current environment, screening for colon cancer, regardless of the type of test used, should be considered elective.*

Question 2: Are practices alternating physician exposure to the hospital and endoscopy units to have back-up staff*?*

ASGE Response: *Practices are creating physician teams (pods) to adjust to the reduced workload and decrease the risk of potential exposure to high-risk patients. Staff teams (pods) are also being created for similar reasons. If you have not created teams (pods), assess the impact of the virus on your location and determine whether you need to create teams (pods) or have a plan to create teams (pods). Remain flexible during the rapidly changing environment.*

Question 3: Have all non-ASC or non-hospital-based practices closed (i.e., office-based endo)?

ASGE Response: *There is no mandate from the TriSociety guideline, state health departments, or the surgeon general to close all ASCs. Thus far, the orders, directives, and recommendations apply to elective non-urgent or urgent nature of procedures.*

Question 4: How long should a patient with a positive Cologuard or FIT wait for a colonoscopy? What about iron deficiency anemia?

ASGE Response: The TriSociety guideline states some non-urgent procedures are higher priority and may need to be performed. An example is cancer evaluation. Patients understand Cologuard is a test "looking" for colon cancer. If it is positive, this could create both emotional and physical distress for patients. It would be appropriate to perform colonoscopy for Cologuard-positive patients according to your usual standard of practice at your institution or practice.