COVID-19 FAQs

Viewers of this material should review these FAQs with appropriate medical and legal counsel and make their own determinations as to relevance to their particular practice setting and compliance with state and federal laws and regulations. The ASA has used its best efforts to provide accurate information. However, this material is provided only for informational purposes and does not constitute medical or legal advice. This response also should not be construed as representing ASA policy (unless otherwise stated), making clinical recommendations, dictating payment policy, or substituting for the judgment of a physician and consultation with independent legal counsel.

Please submit your clinically related questions to covid19@asahq.org

updated March 26, 2020

GENERAL

1. Where can I find the ASA statement on treating COVID-19 and suspected COVID-19 patients?

- ASA guidance on treating COVID-19 and suspected COVID-19 patients . We also recommend using the US CDC website for additional materials on infection prevention .

2. What is the ASA position on cancelling or rescheduling elective surgeries?

- ASA-APSF Joint Statement on Non-Urgent Care During the COVID-19 Outbreak
- CMS released guidance on non-essential planned surgeries (PDF)
- Joint Statement from ASA, ACS and AORN on Surgical Triage Decision Making

3. What is the position of the ASA, APSF and AANA on the use of Personal Protective Equipment, including an N95 mask?

- The ASA, APSF, AAAA and AANA have released a joint statement on the use of Personal Protective Equipment . The document also references CDC guidance .

HOSPITAL & FACILITY ADMINISTRATION

1. My hospital believes that the APSF and ASA guidelines are too stringent or do not align with the CDC recommendations. Do the CDC recommendations include diagnostic, therapeutic or surgical patient considerations? How should I discuss anesthesia recommendations with my hospital?

- ASA recommendations are written to protect other patients, other health care workers and the anesthesia professional. They are derived from the CDC guidelines for health care workers regarding the current SARS-CoV-2 (COVID-19) virus as well as the interim guidance provided during the SARS outbreak in 2003-4. When the CDC investigated the SARS outbreak in the early 2000's, they found that the health care workers caring for these patients became infected with SARS despite using contact and droplet precautions. Droplet particles may become aerosolized into finer particles by coughing and sneezing or airway procedures such as laryngoscopy, intubation, suctioning, and bronchoscopy. These finer particles may become suspended in air currents and penetrate ordinary surgical mask barriers. The CDC has the same recommendation for patients if they have known or suspected of infection with the current SARS-CoV-2 virus, and for all diagnostic, therapeutic or surgical considerations.

- ASA recommendations call for the anesthesia professional to consider measures that limit the potential for aerosolization of droplet particles. These include:

    - Designating the most experienced anesthesia professional available to perform intubation, if possible.

    - Wearing personal protective equipment (PPE) including:

        - Either an N95 mask, for which one has been fit-tested, or a powered air-purifying respirator (PAPR);
        - A face shield or goggles;
        - A gown;
        - Gloves.

    - Avoid awake fiberoptic intubation unless specifically indicated.
    - Consider a rapid sequence induction (RSI) in order to avoid manual ventilation of patient's lungs and potential aerosolization. If manual ventilation is required, apply small tidal volumes.

2. Should our hospital convert our PACUs into makeshift ICUs?

- If the pandemic overcomes the capacity of a hospital ICUs, the PACUs can serve as overflow. Given the fact that PACUs are open units, the institution must decide if all the patients housed in the PACU will have COVID19 or non-COVID19 patients (but not both). Institutions will also need to draft a plan on who will provide medical care to these patients (e.g., Critical Care Anesthesiologists, Internists, Surgeons, ED Physicians, or combination).

3. Does the ASA have any kind of algorithm or decision tree on how to handle patients coming through for elective, urgent and emergent surgery? We are trying to maintain operations while having the ability to scale back as the situation around us may require.

- We have not produced an algorithm on how local hospitals should handle elective, urgent and emergent surgery. There are many contingencies that a hospital must consider, including, but not limited to, patient population, community COVID-19 spread, social distancing, equipment availability and type of elective procedure (will a delay cause more harm?). Hospitals, anesthesiology departments and other healthcare workers should work together to create their own institutional algorithm or decision tree based on these factors. Please also consider the "ASA-APSF Joint Statement on Non-Urgent Care During the COVID-19 Outbreak" .

4. What is the definition of elective cases? I am receiving pushback from my hospital, surgeons and others who believe that many of their cases are urgent or emergent.

- We are concerned that elective and non-essential surgeries appear to be continuing in locations where community spread is significant. While the Anesthesia Quality Institute definition of elective surgery is "a surgical, therapeutic or diagnostic procedure that can be performed at any time or date between the surgeon and patient," this definition doesn't reflect nuances that exist in scheduling operative procedures at the current time.

- Please review the ASA-APSF Joint Statement on Non-Urgent Care During the COVID-19 Outbreak as well as the Centers for Medicare and Medicaid Services (CMS) guidance on ***non-essential*** planned surgeries (PDF) .

- When working with surgeons on scheduling cases, consider reviewing the ACS statement that includes an Elective Surgery Acuity Scale (ESAS) that balances a patient's need or impact of a surgical procedure with available resources. Many cancer cases are considered time-sensitive. We recommend close collaboration between surgeons, anesthesiologists, and hospital administration to balance individual patient needs with system resource constraints.

5. I am concerned about intubating and extubating patients who could be asymptomatic carriers. I am concerned that current PPE guidelines do not reflect the transmission risks from asymptomatic individuals.

- ASA, APSF, AAAA and AANA have provided PPE recommendations highlighting the uncertainty of patients' COVID-19 status and the need for practitioner safety, addressing contingencies that anesthesiologists face at their local facilities. The decision on whether a patient is suspected of COVID-19 infection should be made individually based on clinical, history and testing criteria where possible. The suspicion of asymptomatic COVID-19 infection should be considered in areas with community spread. Ideally, anesthesiologists and other members of the healthcare team should have an adequate supply of N95 masks for caring of all patients whether symptomatic or not.

- We know that PPE is in short supply in many areas of the country. Therefore, limiting surgical case volume should help reduce the frequency of provider exposure. We further encourage physicians to discuss the availability of PPE and other resources with your local leadership n to balance resource constraints with need to protect all providers.

6. Many of us who work in Ambulatory Surgery Centers (ASCs) are struggling to understand why the ASC continues to operate while retail outlets, restaurants, bars and other public areas have already taken bold moves regarding social distancing.

- We share your concern about community spread and ensuring that those most at-risk are protected from COVID-19. The ASA, APSF, federal government and other organizations have called for the delay, if not cancellation, of non-essential surgeries, especially in those locations where there is community spread of COVID-19. See the ASA-APSF Joint Statement on Non-Urgent Care During the COVID-19 Outbreak . CMS has also released guidance on non-essential planned surgeries here (PDF) .

7. We are currently using CDC guidelines for at-risk patients. Is there any data on at-risk caregivers, such as those who are older or are immunosuppressed?

- Data indicate that older individuals and those with co-existing conditions are at increased risk of severe disease and have higher mortality if infected. There is reasonable concern about these anesthesiologists for providing care to COVID-19 patients and suspected COVID-19 patients. There are no national recommendations on mitigating exposure of higher risk physicians, and neither does ASA. These discussions need to occur on the local level addressing the specific issues and concerns.

8. Does the ASA have guidelines or recommendations for physicians who are pregnant? We are concerned about our increased risk for exposure.

- We do not have specific guidance on pregnant anesthesiologists, their risk of contracting COVID-19 or if it will affect their pregnancy. Please review the CDC website . Please review the American College of Obstetricians and Gynecologists for additional information on COVID and pregnancy . Please make sure to regularly check these websites for new information.

ANESTHESIA MACHINE & EQUIPMENT MAINTENANCE

1. Does the anesthesia machine need to be decontaminated after use on a COVID-19 patient? We have HEPA filters in the circuit and the gas sampling line.

- Please refer to ASA Guidance that states, "After the case, clean and disinfect high-touch surfaces on the anesthesia machine and anesthesia work area with an EPA-approved hospital disinfectant." The internal components of the anesthesia machine and breathing system do not need "terminal cleaning" if breathing circuit filters have been used as directed.

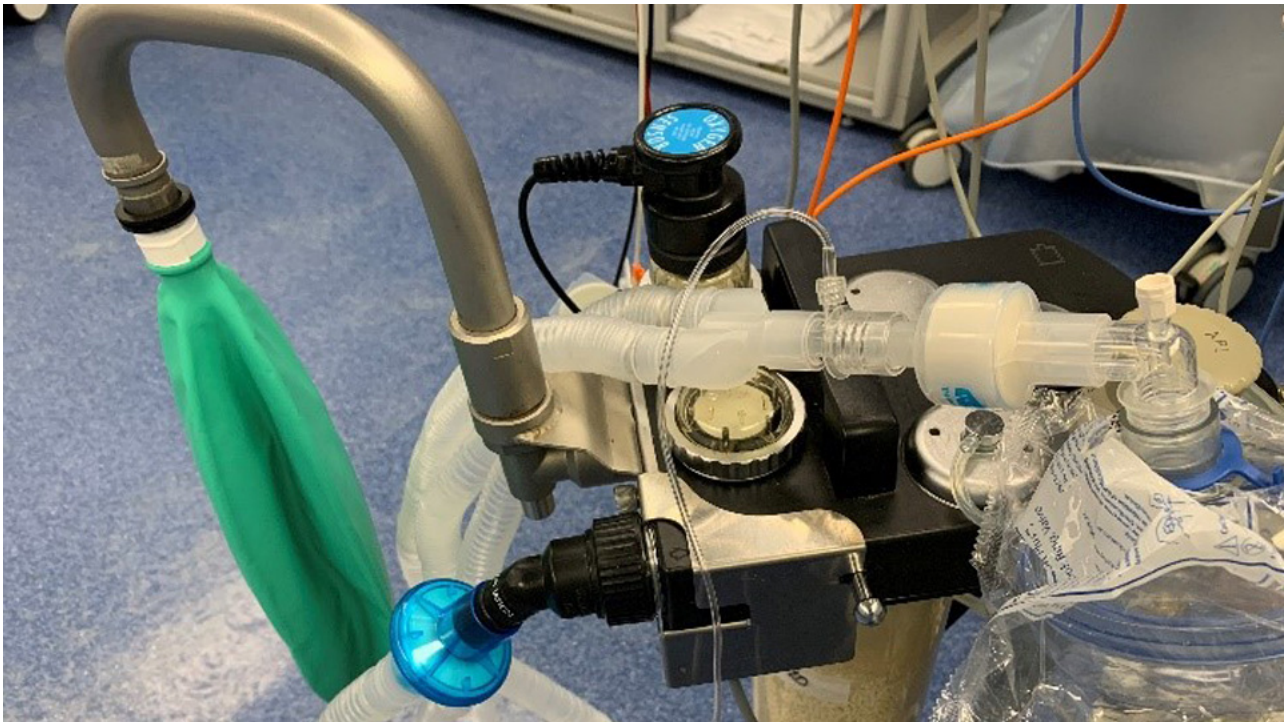
2. Should we repurpose our anesthesia machines from our operating rooms for use in ICUs?

- If the pandemic overcomes the capacity of the hospital ICUs to provide ventilators, unused operating room anesthesia machines can be repurposed for use in the ICUs. The breathing systems and user interfaces of anesthesia machine ventilators are very different from those of intensive care ventilators. Anesthesia machines are also unable to deliver some of the ICU-specific ventilation parameters and modes.
- Please check with your anesthesia machine manufacturer first for their recommendations on repurposing the anesthesia machine for ICU use. The APSF has also released guidance on filters and other features of the anesthesia machine for consideration.

3. Where in the anesthesia circuit should we place the HEPA filter? The gas sampling tubing should also be protected by a HEPA filter, and gases exiting the gas analyzer should be scavenged and not allowed to return to the room air. I'm having difficulty finding filters for our sampling lines. Any specific recommendations?"

- The gas sampling line should be protected by placing a HEPA filter at patient end after the Y-piece and then placing the sampling port on the side of the filter opposite to the patient. If ort on the patient side, it must be capped. Then, both the anesthesia he machine and the gas sampling are filtered.

- For example, please see the photo below.



- If the HEPA filter cannot be placed at this location, place it where the corrugated tubing connects to the expiratory port of the machine and be certain that sampled gases are scavenged and not returned to the surrounding air or back into the anesthesia machine breathing system.

4. Where can I buy HEPA filters? Where can I find compatible HEPA filters?

- Hospitals have supply chain managers who generally have established relationships with the contracted suppliers because breathing circuit filters are commonly used on ICU ventilators and anesthesia machines. Anesthesia supply businesses are a second option. The anesthesia delivery unit (anesthesia machine) manufacturers can also direct you or your managers to where to purchase breathing circuit filters.

5. We are placing our HEPA filter at the end of the circuit where the tubing attaches to the anesthesia machine. I haven't been able to find a small HEPA filter to attach to the sampling port. Do you know if such a product exists?

- Please see **"Where in the anesthesia circuit should we place the HEPA filter?"**. The sampling port delivers sampled gas to the analyzer, either a capnometer or multi-gas analyzer. A capnometer, typically used in ICUs and for procedural sedation, transfers the output gas into the room. Multi-gas analyzers, typically used with or integrated into anesthesia machines, transfer the output gas either into the operating room air, back into the anesthesia breathing system, or into the scavenging system and out of the hospital. If the effluent gas is discharged into the room, or back into the breathing system, then a breathing circuit filter should be placed between the patient and sample line, or the sample line should be filtered, to prevent cross-contamination. We cannot recommend a sample line filter.

6. We are using HEPA filters that filter 99.9999%. We also have HMEF filters that filter even more. Which filters should I use for patients? We don't want to exhaust all of our higher filtration filters if they are not necessarily required for patient care.

- Depending on the presence and level of community spread of COVID-19 in your area and levels of current supplies will help you determine how to best allocate scarce resources to provide the most good and least harm. Reserving the higher filtration HEPA filters for the patients with the highest viral titers seems appropriate. Note that a filter may have different filtering capabilities for different pathogens. Please also consult with your local infectious disease physicians and infection control staff.
- We also recommend you review the APSF website for a discussion on anesthesia machines .

7. With an incubation period of 14 days and the ability to shed the Coronavirus while asymptomatic, why is the ASA not recommending the use of HEPA filters for ALL general anesthetics since we don't know who is infected?

- Breathing circuit filters or combined heat and moisture exchange filters (HMEF) are already commonly used for all general anesthetics. This is best practice that should be adopted as standard policy in all practice locations now. The filters are HEPA rated, and we are not recommending better filters than those that are already commonly being used.

8. Should I be concerned that my anesthesia machine is a vector for transmission?

- Please review the APSF website for a discussion on anesthesia machines .

PERSONAL PROTECTIVE EQUIPMENT

1. We don't always know if patients are COVID positive. What PPE should we use?

- The ASA, APSF AAAA and AANA have released a joint statement on the use of Personal Protective Equipment . The document also references CDC guidance .
- Patterns of local COVID-19 infection that suggest transmission to a wider community-based pattern should lead to a reassessment of the risk profile of care provided to elective surgery patients without symptoms of COVID-19. Thus, inclusion of more effective PPE should be discussed with local experts in infectious diseases and infection control, considering local supply availability including N95 masks.

2. Can I reuse my N95 mask and other Personal Protective Equipment?

- The CDC and NIOSH have released guidance on reusing PPE and additional information . Anesthesiologists should also contact the manufacturer of devices and PPE to ensure that cleaning and reusing such devices and materials are safe and maintain their effectiveness.
- We recognize that personal protective equipment, including N95 masks, is in short supply and that anesthesiologists may need additional information on reusing or repurposing PPE. In one case, members of the anesthesia care team are planning to reuse disposable PAPR (Powered Air-Purifying Respirator) hoods after wiping them down as well as using available reusable military grade PAPR. The PAPR filter cartridges will also be reused with care to avoid contamination. Groups have also planned to create their own 'N95' utilizing an anesthesia circuit mask plus a Pall Ultipor® filter plus a strap to secure a makeshift solution. This may be helpful for short, but high-risk procedures. We also are aware of hospitals and [illegible] violet germicidal irradiation (UVGI) as a practical method to

decontaminate the N95 mask. We recommend members conduct literature reviews and assess the risks and benefits associated with such actions.

3. Because of a severe shortage of N95 masks, anesthesiologists are turning to the Internet/social media for solutions. What is ASA policy on reusing N95 masks and/or what are legitimate resources ASA can point to?

- At this time, ASA is not vetting or endorsing videos, products or other local solutions that individual physicians, hospitals or persons have created related to N95 or PPE. ASA offers links to websites for articles, training and information that have been published by specialty societies, peer-reviewed journals and other sources that have previously established their reliability. Please check the ASA additional resources webpage .
- The CDC has specific recommendations for extended use and limited reuse of N95 respirators

4. For what procedures does ASA recommend the use of N95 masks?

- ASA recommends as optimal practice that all anesthesia professionals should utilize PPE appropriate for aerosol-generating procedures for all patients, during all diagnostic, therapeutic, and surgical procedures, when working near the airway. More complete guidance can be found in the ASA-APSF-AAAA- AANA joint statement . Appropriate PPE for aerosol-generating procedures including airway protection with N95 masks or PAPRs.

5. Does ASA have any specific recommendations on hand hygiene for a patient with COVID-19 for the duration of a surgical case once the airway has been secured? Should providers continue to double glove and remove outer glove when soiled? Or should providers single glove and perform hand hygiene between glove changes?

- Hand hygiene should be rigorously followed in all cases and to the best of your ability. Any patient contact should require thorough and extensive hand washing per standard protocols. If available, double glove and removing outer gloves after patient contact .

6. Regarding gowns vs coveralls, is there any additional need for neck protection during airway manipulation of patients with known or suspected COVID-19 infection? Do we need a hood with neck cover for potential splashes of droplets during intubation or extubation?

- Please see ASA guidance . We recognize the risk that airway management has when a patient coughs during intubation or extubation, leading to contaminated mist and droplet formation. All authorities recommend that you do not touch your hands to your face. A face shield will protect your eyes and also the N95 mask from surface contamination. Some are using a surgical mask over the N95 mask.

7. We have received feedback that specifying protection Level 3 for isolation gowns for operating room cases and intubations would be helpful. “Gowns” alone seems vague since they have different levels of protection.

- We recommend that you review guidance materials found on the CDC website . We encourage you to have conversations with infectious disease consultants, infection control staff and supply chain managers who can inform your judgment concerning the best of alternative choices to protect all your patients and staff.

8. I have tried to put on clean masks and gloves prior to interviewing my patients. However, I have heard that this practice is not allowed by CMS. I feel that clean gloves and masks in all patient contact areas should be allowed to help in curtailing spread of this highly infectious virus.

- We are unaware of CMS guidelines or accreditation organizations that prohibit the use of masks or gloves outside an operating suite. However, this question highlights the need to be sensitive to resource utilization when critical shortages of supplies may occur. Current CDC recommendations do not include the use of PPE when in the presence of asymptomatic patients. In these patients, hand hygiene remains a cornerstone of good medical practice to prevent the spread of any infectious disease.

9. We need active communication from the ASA regarding our safety, precautions, N95 fitting and increasing the production of this equipment. I'm doubting the CDC that surgical masks are adequate.

- Please see "**For what procedures does ASA recommend the use of N95 masks?"** FAQ. The ASA, APSF, AAAA and AANA have released a joint statement on the use of Personal Protective Equipment . The document also references CDC guidance .

10. I have COVID-19. When can I return to work?

- Please review the CDC website for considerations on returning to work after a positive COVID-19 diagnosis .

11. At the end of the day, are our loved ones at home safe from infection when we return home?

- We realize this is a sincere and earnest concern among all ASA members. Unfortunately, there is no federal guidance on the risk of possible exposure of physicians' families.

CLINICAL CARE

1. Why are anesthesiologists being asked to perform more intubations in my facility when there are other physicians who are trained to do so?

- Anesthesiologists should work with their local hospitals to designate who has the responsibility to intubate COVID-19 and suspected COVID-19 patients. CDC and ASA have recommended hospitals "Designate the most experienced professional available to perform intubation, if possible" This is not a training opportunity for students. However, this should not be interpreted to mean that experienced ER and ICU physicians cannot perform routine intubations. Anesthesiologists would expect to be consulted when there are difficult intubations or to assist with a surge of patients . Anesthesiology departments should work istrators and other personnel who are trained in intubation (e.g. critical

care and emergency departments) on clear guidance that protects healthcare worker and patient safety. Stakeholders should conduct debriefings to discuss how to improve the process.

2. Does ASA recommend a specific course of action or treatment for COVID-19 patients in the Intensive Care Unit?

- As a medical association, we cannot make specific medical recommendations for patients. We likewise do not track how physicians treat or may have treated individual patients.

3. What should we do about "MAC" cases, with an open airway?

- If dispersion of potentially contaminated exhaled gases from an open airway (e.g. "MAC") is a risk, consider alternate anesthesia plans. Potential contamination of your workspace and the room should be considered. The safety of you and your colleagues is paramount.

4. Are there specific recommendations for EGD procedures and other procedures with a high risk of aerosolization?

- Decisions need to be based on an understanding of your local COVID-19 risk profile for community spread in your area in consultation with your local infectious disease and infection control experts. This information will help inform your own risk assessment development considering the patient, skill sets of the endoscopists and local resources. ETTs provide the most secure airway. Airway masks with apertures for gastroscopes such as a POM (Procedural Oxygen Mask by Curaplex) or similar masks may limit dispersion as an alternative when supplies of N95 are low. ASA has also released guidance for procedures where there is a high probability of aerosolization .

- Best practices may be in flux because of shortages of N95 masks, personal protective equipment and regional differences in known patients with COVID-19. As COVID-19 testing becomes more common, the regional risk profiles and supply chain limitations will help guide what is possible in a specific location.

5. With regard to COVID-19, does ASA have any recommendations for [illegible]rall and specifically related to epidurals and spinals?

- ASA members are encouraged to review the recent statement published by the Society for Obstetric Anesthesia and Perinatology (SOAP) regarding obstetric care. In general, we are unaware of coronavirus is a contraindication to a neuraxial block. Spinals and epidurals should take into consideration appropriate precautions, especially regarding COVID-19 patients or those suspected of having COVID-19 . Such precautions may include isolating the infected or suspected patient and placing them in rooms identified for that purpose as well as having a dedicated operating room. Ideally, these operating rooms would be negative pressure rooms. We also recommend the use of N95 masks, double gloves, gowns and protective eyewear as appropriate.

6. Given the concern for immunosuppressive during this time of COVID-19, I question whether or not to administer dexamethasone for PONV. According to one article, it doesn't look like in the doses we provide for PONV prophylaxis- that it would cause clinically significant suppression but was wondering if you might be able to comment.

- In general, low doses/single dose dexamethasone would not be regarded as clinically significant or sustained immunosuppression. Each patient is unique and we cannot comment on individual patient treatment options or anesthesia plans. To our knowledge, there is no clinical data on deciding whether to use or not use a single dose of dexamethasone in COVID-19 patients.

7. What is the ASA's stance on safety of regional anesthesia in appropriate patients (especially those many that haven't been tested) vs general anesthesia?

- We are unaware of coronavirus as a contraindication to a neuraxial block. Spinals and epidurals should take into consideration appropriate precautions, especially regarding COVID-19 patients or those suspected of having COVID-19 . For treating obstetric patients, please see guidance from the Society for Obstetric Anesthesia and Perinatology (SOAP) .

8. Is ASA advocating use of a video laryngoscope as first line for intubation? We have a very limited supply of sleeves at my institution.

- The recommendation is that providers perform intubations with the greatest chances of success on the first attempt. This must be balanced with the supply chain availability. Recommend close collaboration with your healthcare system to closely monitor the supply chain and determine how best to utilize limited resources. Please see the recommendations on intubating COVID and suspected (persons under investigation) COVID patients .

ADVOCACY

1. What is ASA's position on whether residents would continue to be paid (given the anticipated reduction in elective surgeries), student loan forbearance, how to treat possible quarantine of residents vis-a-vis their required number of residency hours. Can you please include in the advisory materials being developed?

- For questions related to residents and required number of hours, please review the American Board of Anesthesiology (ABA) website .

2. ASA should be advocating for financial support for anesthesiologists who have been affected by the financial downturn and the clinical implications COVID-19 have had on our groups and practices.

- We are concerned both about anesthesiologist safety and protection as well as the financial implications that COVID-19 is having on anesthesia groups and practices. ASA Advocacy is working with Congress and the White House on appropriate aid and assistance to physicians. We are exploring all avenues – regulatory and legislative to provide much needed support.

EDUCATION

LIVE CHAT

any simulation resources for COVID-19?

- ASA does not have specific COVID-19 simulation resources available yet. Healthcare institutions have created PPE donning and doffing videos that can be found online, but physicians must follow the specific protocols of their own institution. Some generally relevant ASA educational resources include:
    - Patient Safety Highlights 2018 - Fatigue Risk Management: Making Overnight Call Safer
    - Patient Safety Highlights 2018 - Situational Awareness and Crisis Management: Strategies to Improve Patient Safety in Anesthesia Practice
    - Patient Safety Highlights 2018 - Emergency Manual Implementations and Uses during Clinical Crises: Linking Research With Practice
    - Patient Safety Highlights 2019 - Central Line Insertion: State-of-the-Art in 2019 – part of full 2019 Highlights package (submitted by CC track)
    - Patient Safety Highlights 2018 - Situational Awareness and Crisis Management: Strategies to Improve Patient Safety in Anesthesia Practice
    - Patient Safety Highlights 2017 - Hand Hygiene, OR Attire, OR Traffic: What is the Data and Can We Make a Difference?

BILLING

1. How can an anesthesia group bill for ICU services? We may also need to use our CRNAs as overflow ICU nurses and anesthesiologists as intensivists.

- Regarding billing, these are services that anesthesiologists could report. At this time, the care provided would most likely be either hospital E/M services or critical care coding depending on the patient condition and need. Ventilation management may also come into play. We recommend you work with your coding department on appropriate documentation and billing.

2. Has CMS released any information on appropriate billing during this period or healthcare waivers?

- Yes, CMS has issued certain waivers allowing licensed providers to render services outside their state of enrollment for purposes of billing Medicare and Medicaid; temporarily suspending certain enrollment requirements under Medicare, postponing revalidation actions, and expediting pending or new applications and extending timelines for filing Medicare Parts B, C, and D appeals. See the Emergency Declaration Fact Sheet (PDF) and the MLN Matters Number: SE20011 (PDF).

3. I'm adding new providers to my group/practice. Where can I find more about Medicare Provider Enrollment Relief during the COVID emergency?

- CMS has updated its resources related to provider enrollment (PDF).

4. Has CMS suspended the Quality Payment Program and Merit-based Incentive Payment System (MIPS) reporting?

- CMS has delayed reporting MIPS data for performance year 2019 until April 30, 2020. Participants who have already submitted data to the Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR) do not have to submit additional data to AQI NACOR for 2019. If you reported 2019 data through another registry, please check with that registry for their process. If you are reporting via the CMS Web Portal, you now have until April 30, 2020 to submit your 2019 data.
- At this time, CMS has made no changes to MIPS reporting for 2020.

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