Alabama Gastroenterological Society

March 30, 2020

Dear Colleagues,

The purpose of this letter is to update our members and offer some guidelines for our GI practices in Alabama during the Covid-19 pandemic. The Officers and Board members of the AGS discussed current practice changes we are enacting which we will share. We all agree these are very difficult times and are having to make many unwanted changes in our practices and to our office and endoscopy unit staff.

Most of us have severely limited office visits and are using telemedicine for most visits. Nearly all of the third-party payors are recognizing this and reimbursing these visits at some level. For specific billing methods please go to the individual payor websites. Some helpful information is also attached.

As for endoscopy, we have adopted the recommendations of the National joint GI societies. These include:

- postpone all non-emergent procedures such as screening and surveillance EGDs or colonoscopies.
- postpone semi-elective endoscopy even on symptomatic patients where symptoms can be controlled for 4-6 weeks. This includes patients with IDA, heme+ stool, positive FIT test and positive Cologuard test
- all staff to wear PPE

Other best practices are:

- good handwashing
- avoiding crowds
- limiting travel
- social distancing
- cough etiquette

I can assure you that everyone in the state is feeling the strain on our patients and practices. With some adjustments we will get through this together.

Stay safe everyone,

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Additional sources of information:

Gi.org- Joint GI Society Message on Covid-19

https://gi.org/2020/03/15/joint-gi-society-message-on-covid-19/

CDC.gov- Coronavirus Disease 2019

https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Chronscolitisfoundation.org

https://www.crohnscolitisfoundation.org/coronavirus/what-ibd-patients-should-know

Alamedical.org – Sustaining a Medical Practice During a Healthcare Crisis

https://masa.informz.net/masa/data/images/Sustaining%20a%20Medical%20Practice%20During%20a%20Healthcare%20Crisis.pdf

Patient verbal consent on all and must be in the patient record. These services have to be performed by the provider.

BCBS (Commercial and Blue Advantage)

Audio only – bill 99201-99203 or 99211-99213 or AWV (G code) if appropriate
(AWVs established patients only)
Audio and video – any CPT code on the approved list below with appropriate documentation Blue Advantage only

Medicare Government/Traditional and Tricare

Audio and video – any CPT code on the approved list below with appropriate documentation
Audio only – G2012

Aetna Commercial and Medicare Advantage

Audio only -99441 -99443 or G2012
99441, 99442, 99443 - Telephone E&M service provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours ; 99441: 5-10; 99442: 11-20; or 99443: 20-30 minutes of medical discussion
Audio AND video - any CPT code on the approved list below with appropriate documentation

Cigna and Cigna Healthspring

Commercial patients – Either Audio or Video – G2012 and any CPT code on the list approved below
Healthspring – Same as Government Medicare Except do NOT do AWVs

Humana

Either Audio only or Audio and video – any codes on the Medicare list below (except AWVs for now)

AL Medicaid

Either Audio only or Audio and video – 99211-99213

VIVA

Either Audio only or Audio and Video - 99201-99203 or 99211-99213
TCMs if MA (99495 and 99496)

UHC (Commercial and MA)

Audio only – 99201-99205 & 99211-99215

Audio and Video - any CPT code on the approved list below with appropriate documentation (AWVs and TCMs MA only)

Approved Medicare/Medicare Advantage Codes billed by Telehealth (audio AND video)

MEDICARE TELEHEALTH SERVICES			*fees rounded to $$*	
CY 2020 revised			**Mcare**	**BCBS**
Code	**Short Descriptor**	**wRVUs**	**Fee**	**Fee(1)**
99201	Office/outpatient visit new	0.48	$43	$47
99202	Office/outpatient visit new	0.93	$72	$79
99203	Office/outpatient visit new	1.42	$102	$112
99204	Office/outpatient visit new	2.43	$157	$171
99205	Office/outpatient visit new	3.17	$199	$215
99211	Office/outpatient visit est	0.18	$22	$23
99212	Office/outpatient visit est	0.48	$43	$46
99213	Office/outpatient visit est	0.97	$71	$77
99214	Office/outpatient visit est	1.50	$103	$113
99215	Office/outpatient visit est	2.11	$139	$152
99231	Subsequent hospital care	0.76	$38	$42
99232	Subsequent hospital care	1.39	$70	$77
99233	Subsequent hospital care	2.00	$101	$110
99307	Nursing fac care subseq	0.76	$43	$46
99308	Nursing fac care subseq	1.16	$67	$72
99309	Nursing fac care subseq	1.55	$88	$96
99310	Nursing fac care subseq	2.35	$130	$143
99354	Prolonged service office	2.33	$126	$137
99355	Prolonged service office	1.77	$96	$105
99356	Prolonged service inpatient	1.71	$90	$97
99357	Prolonged service inpatient	1.71	$91	$98
99406	Behav chng smoking 3-10 min	0.24	$15	$16
99407	Behav chng smoking > 10 min	0.50	$28	$30
99495	Trans care mgmt 14 day disch	2.36	$175	$170
99496	Trans care mgmt 7 day disch	3.10	$232	$240
99497	Advncd care plan 30 min	1.50	$83	$90
99498	Advncd are plan addl 30 min	1.40	$73	$79
G0438	Ppps, initial visit	2.43	$163	$179
G0439	Ppps, subseq visit	1.50	$110	$121
			(1) Select Fee	

Other code wRVUs: G2012 (.25), 99441 (.25), 99442 (.5), 99443 (.75)

BY VISIT TYPE

Transitional Care Management (TCMs) 99495 & 99496

Audio only – Humana, VIVA

Audio AND Video – BCBS (Advantage only), Government Medicare, Cigna Healthspring, Tricare, and UHC MA

Annual Wellness Visits (AWVs) G0438 & G0439

Audio only – BCBS

Audio AND Video – Government Medicare, Tricare, UHC

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99431 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

New York Society for Gastrointestinal Endoscopy
Guidelines for Endoscopy Units during the COVID-19 Pandemic
March 16, 2020

NYSGE continues to follow the evolving recommendations being presented by national GI societies regarding the practice of endoscopy amid the COVID-19 pandemic. On March 15, 2020 multi-society guidelines* were jointly published by AASLD, ACG, AGA and ASGE detailing updated information about presenting symptoms and GI symptoms in particular, diagnostic findings, and best practices for prevention. The leadership of NYSGE feels that more specific guidelines are needed for endoscopy practices regarding classification of elective procedures and the use of appropriate personal protective equipment (PPE).

The multi-society guidelines acknowledge that local and institutional recommendations may be evolving and should be closely monitored. NYSGE recognizes that the New York region is facing unique challenges compared to other areas of the country. We have learned from the solutions employed by our colleagues in other areas of the world who have, unfortunately, experienced the crisis that for us is now imminent.

NSYGE is known as a leader in endoscopic expertise, innovation, education, and research. In keeping with our commitment to members, our leadership in consultation with endoscopy unit leaders throughout the region have constructed adjunctive guidelines to address local needs and current restrictions. Most importantly, we hope that NYSGE's endorsement of these recommendations will help our members provide guidance to their institutions and facilitate measures to improve safety in the ongoing pursuit of optimal care for our patients.

Recommendations

A. NYSGE endorses the multi-GI society guidelines published on March 15, 2020 [https://www.asge.org/home/joint-gi-society-message-covid-19], as well as CDC and other federal guidelines as they evolve.

B. NYSGE recommends delaying elective procedures until the COVID-19 outbreak is considered over, using the following priority classification:

Elective Procedures that May be Delayed

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients
3. Evaluation of non-urgent symptoms or disease states where procedure results will not imminently (within 4-6 weeks) change clinical management (e.g., EGD for non-alarm symptoms, EUS for intermediate risk pancreatic cysts)
4. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

Urgent/Emergent Procedures that May Not be Delayed

1. Upper and lower GI bleeding
2. Suspected GI bleeding
3. Dysphagia significantly impacting oral intake

4. Cholangitis or impeding cholangitis
5. Symptomatic pancreaticobiliary disease
6. Palliation of GI obstruction (UGI, LGI and pancreaticobiliary)
7. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
8. Cases where endoscopic procedure will urgently change management
9. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

C. NYSGE recommends the following endoscopy unit workflow of urgent/emergent procedures with respect to personal protective equipment for patients and staff

Endoscopy Unit Staff Etiquette

1. All endoscopy staff should wear scrubs (endoscopists, nurses, techs, etc.) regardless of procedure type or duration. All staff should change from scrubs prior to leaving the hospital/AEC
2. All staff should have daily temperature checks on arrival at their endoscopy unit(s) and should follow institutional guidelines if febrile (>100.4F)
3. Front desk staff should wear surgical masks and gloves
4. Minimize the flow of staff throughout the unit, consider creation of kits for known positive patients and high-risk patients, minimize flow into large storage areas (consider assigning 1-2 individuals to staff these areas)
5. Restrict accompanying family members to 1 visitor (escort) and limit exposure in recovery areas
6. Enforce 6 feet separation between individuals in the waiting room or encourage family members to leave and return when finished
7. For endoscopy units in which bronchoscopy is performed, consider separating intake/recovery areas for these patients
8. NO vendors permitted

Patient Flow through Endoscopy Unit

1. All outpatients must be screened by CDC guidelines the day before by telephone
2. All outpatients will be warned of the possibility of exposure while in the endoscopy unit but that all protective precautions are being taken
3. Patients will get a temperature check (>100.4 considered febrile) by front desk staff on arrival to the endoscopy unit, followed by screening questions which will allow triage to “low risk” vs. “intermediate/suspicious risk”

Pre-Procedure

1. Patients classified as “low risk” to be admitted as per usual endoscopy practice, no mask required, maintain distance when possible such as while obtaining consent; maintain distance between patients in pre-procedure waiting area if possible
2. Patients classified as “intermediate/suspicious risk” should be admitted by staff wearing mask and gloves, using disposable pens if paper consent being obtained. When possible consider performing admission/consent/IV in procedure room (depends on unit resources for admission/recovery)

Procedural PPE recommendations stratified by infection risk and type of sedation

1. Anesthesia team to be encouraged to require that most skilled provider (i.e. Attending) perform intubation when required for the procedure (to minimize risk of aerosolization, shorten length of time for intubation, decrease the number of team members at risk of exposure)
2. Non-intubated, 'low-risk' patient: staff wear surgical mask, gown, gloves, face shield, hair net, shoe covers and scrubs
3. Non-intubated, "intermediate/high risk" patient: above plus N95 mask or equivalent
4. Intubated, "low-risk" patient: use surgical guidelines at institution
5. Intubated, "intermediate/high-risk" patient: as above plus N95 mask or equivalent
6. Known COVID-19 positive patients: follow institutional guidelines set forth by ID, DOH and CDC which call for intubation or procedures on these patients to be done in negative pressure rooms. Procedures on these patients should only be performed if emergent.

D. NYSGE recommends the following guidelines for trainee participation in procedures

1. Positive patients: no fellow participation (general or advanced)
2. "Intermediate/high risk" patients: no fellow participation (general or advanced)
3. Outpatient "low risk"' patients: fellow participation at the discretion of the Service
4. In-patient "low risk" patients: fellows may participate (rationale: they perform consults on same patient category)
5. At-risk fellows (personal medical conditions, pregnant, etc.): consider excusing them (defer to program directors)

E. NYSGE endorses the multi-GI society guidelines that stress strategic assignment of personnel to minimize simultaneous risk of exposure to as few team members as possible. Rotations should be considered for both interventional Attendings and general GI Attendings in order to limit number of team members at risk for simultaneous quarantine.

F. NYSGE recognizes that a distinction between hospital institutions and AEC/ASCs is not made in the multi-GI Society guidelines and it is understood that applicability of these recommendations may be difficult to transfer to the AEC/ASC setting. In general, however, NYSGE recommends following the same guidelines with respect to delaying of non-urgent cases and adherence to PPE standards. In addition, thought should be given to consolidation of resources and transferring cases to a hospital-based partner facility if available. Movement between facilities in which different precautions are being employed is not advisable.

G. NYSGE encourages our members to explore telehealth as an option for providing care to patients during these difficult times. Most insurance carriers and Medicare will cover telemedicine. Newer telehealth codes established for this year include 99441, 99442 and 99443. While these appear to be accepted by commercial carriers, Medicare does not yet recognize these codes. For Medicare, the standard E/M codes (with modifiers 95 or GT) are suggested.

Additionally, it is important to use the place of service code #2 (telehealth). More information can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf and https://www.mendfamily.com/telemedicine-billing-not-difficult-seems/

* https://www.asge.org/home/joint-gi-society-message-covid-19

Approved by the NYSGE Governing Council, March 16, 2020