From: Florida Podiatric Medical Association <importantinfo@fpma.com>
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Subject: Editorial from FPMA Public Health Advocate

EDITORIAL: My Perspective on COVID-19

Dear FPMA Members,

Since FPMA President Samir S. Vakil, DPM published his clarifications of Executive Order (EO) 20-72 regarding Non-Essential Elective Medical Procedures (**FPMA Alert: FPMA Presidential Message Concerning Executive Order 20-72**), the FPMA office has been deluged with individual questions regarding what procedures, especially those in-office, are considered elective and which are not. The purpose of the EO is twofold: 1) to limit and reduce the spread of coronavirus (COVID-19), and 2) to conserve critical resources and supplies that are essential in combating the current COVID-19 outbreak or any other medical emergency.

I want to make it clear that the following is *my* read of what procedures would be considered elective versus non-elective, based upon the EO and what CMS has put out regarding Adult Elective Surgery and Procedures Recommendations (**https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf**), and some basic common sense.

First, I am suggesting that all offices screen their patients, and if they are medically sick and/or relate they are experiencing symptoms of COVID-19 infection, you are telling them to stay home. And in the waiting room, that you have redesigned it so your patients can practice some degree of social distancing, and that you and your staff are taking personal protective measures when seeing your patients. Consider using telehealth for following your patients at home. As many of the public health experts have suggested, you should consider treating all patients as if they could potentially already be infected with coronavirus.

Second, the CMS guideline states that surgical services and procedures should only be provided to "those whose condition requires emergent or urgent attention to save a life, preserve organ function, and avoid further harms from underlying condition or disease." Many of our patients most frequently fall under the latter category of patient. And the same guideline also states that "Decisions remain the responsibility of local healthcare delivery systems, including state and local health officials, and those surgeons who have direct responsibility to their patients." As you are already aware, in Florida, your hospitals and surgi-centers have already asked you to postpone/reschedule/not schedule non-essential, non-emergency elective medical and surgical procedures.

Acute conditions, trauma, and monitoring of those with serious chronic disease are exempted, as they should be in your office as well. In Dr. Vakil's communication, he indicated that E & M codes for office visits are not affected, so you will continue to be paid for the office visit. He also indicated other permissible procedures:

- I & D and amputations for infection
- Wound debridement
- Post-operative care

I think all of us have good medical sense and understand the difference between elective and non-elective procedures, but I understand there might be some grey areas. A very few hospitals have mistakenly (in my estimation) identified wound care as non-essential, and if your institution has defined it as such, there are some resources in the wound care community being implemented to help change their minds. But in an office setting, wound care and debridement are essential, as we are all familiar with the consequences.

Post-op care is a no brainer, for those procedures that were done before the EO and for those emergency procedures and trauma cases you have done since.

Some questions concerned the use of injections and procedures under local anesthesia. If a patient presents in acute pain from a neuroma, anything you can do to relieve that pain and discomfort, including injection, yes. Surgery to remove that neuroma, no. If a patient presents with an acute painful bursitis over a bony prominence, certainly an injection is indicated. An exostectomy, or in-office “bumpectomy” under local anesthesia, no, it can wait. If a patient presents with an acute, painful, perhaps fulminant ingrown great toenail, even if chronic, you should remove the offending portion of nail to provide relief, drain any exudate and potentially prevent osteomyelitis, yes! Matrixectomies across the board, no, it can wait. If a diabetic patient presents for care of gryphotic or mycotic nails, in my opinion this is essential. We know the possible negative consequences. Someone for routine nail care, no. In-office arthroplasties, bunionectomies, and other obvious elective procedures, no.

We do not know at this time what the state will do regarding enforcement of the EO, but I imagine if consequences are imposed, they will be significant.

And again, if a patient does not absolutely have to be in your office, they (and you) are being protected from possible exposure to coronavirus. In addition, you will be conserving critical protective personal equipment resources that will not be available as this pandemic continues to push the healthcare system to its limit. Also, we are critically aware of the economic hardship that this public health crisis is wreaking on our profession. With the recent legislation that has been approved, hopefully there will be some financial solutions available for our small businesses. I hope that this has been helpful.

Chet Evans, MS, DPM
FPMA Public Health Advocate