PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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http://www.medavie.bluecross.ca/msiprograms

NEW FEES

Note: Physicians holding eligible services must submit their claims from March 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

Effective March 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
ADON	52.89E	**Sentinel Lymph Node Biopsy for cancer:** This is an "add on" fee to surgical oncologic procedures, payable only for the staging of malignant disease (cancer). It is for the intra-operative identification and sampling of sentinel lymph nodes. The injection of non-radioactive dye is included, when performed. **Billing Guidelines** To be added on to surgical oncologic procedures with the diagnosis of "cancer". May be billed per drainage basin to a maximum of three basins in total **Specialty Restriction** None **Location** HOSP	50

Category	Code	Description	Unit Value	
MASG	28.54A	**Laser Photocoagulation for the treatment of Retinopathy of Prematurity:** This fee is for the treatment of extensive or progressive retinopathy of prematurity in premature infants up to the age of 6 months by laser photocoagulation.	160	6+T

Billing Guidelines
Base fee is for the treatment of one eye.

Specialty Restriction
Paediatric Opthalmology
Retinal Opthalmologist

Location
HOSP

Regions
Right, left, bilateral

Category	Code	Description	Unit Value
MASG	60.24C	**Transanal Endoscopic Microsurgery:** This fee is for the Transanal Endoscopic Microsurgical (TEM) resection of rectal lesion using a transanal operating proctoscope with visualization via the endoscopic camera, with full insufflation and pressure monitoring under general anesthesia. Includes the passage of a sigmoidoscope or proctoscope to ensure luminal patency **Billing Guidelines** 01.24C Rigid sigmoidoscopy not payable same patient same day. **Specialty Restriction** GNSG with colorectal and/or minimally invasive surgery (MIS) fellowship. **Location** HOSP	325 6+T

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM
Revised April 1, 2014

Please Note: You may now submit any claims since April 1, 2014 for the third chronic disease managed using the new **RP=CON3** *modifier. Physicians holding eligible services must submit their claims from April 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame. Claims for the first and second chronic disease managed with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014*

The current *Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentive* is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

The Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**

- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and,

- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram.

- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70

Required Indicators/Risk factors
Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

Common Indicators for Diabetes, IHD and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year

- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying *c*hronic disease (total payment of $175)
- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic diseases (s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
    - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
    - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
    - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).

BILLING REMINDERS

Exceptional Clinical Circumstances versus Independent Consideration

Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested. ***An example where EC would apply is when a procedure was performed that does not yet have a fee code.***

Independent Consideration

Independent consideration is applied to certain services that are assigned a health service code but where a wide variation in case to case complexity and time exists and no unit value is listed. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested. ***An example where IC would apply is HSC 98.11-Debridement of wound or infected tissue ME=COMP.***

The tariff for IC and EC services is agreed to by the Master Agreement Steering Group (MASG) on recommendation from the Fee Schedule Advisory Committee (FSAC) and increased with sessional rate increases as per the Master Agreement. Currently, they are as follows:

- 100 units per hour for surgical and interventional procedures.
- 70 units per hour for specialist, non-surgical, non-interventional services and this rate will increase with the yearly increases for sessional rates as per the Master Agreement.
- 60 units per hour will remain as the rate for any GP non-surgical, non-interventional services until such time as their sessional rate exceeds 60 units per hour.

Payment for surgical services is based upon the skin to skin time.

General Practice Evening and Weekend Office Visit Incentive Program - Reminder

MSI has recently become aware that some physicians are claiming the General Practice Evening and Weekend Office Visit Incentives for services provided at walk in clinics.

By way of reminder, this service may be claimed by eligible fee-for-service general practitioners who open their offices during week day evenings (between 6pm and 10pm) and/or weekends (between 9am to 5pm, Saturday and Sunday). Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be assessed and the encounter is recorded.

Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program and are subject to recovery for inappropriate claims for this incentive. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.

In situations in which a clinic provides both care to a stable roster of patients and walk-in clinic services, only physicians who maintain a stable roster of patients at that location may claim the incentive and only for individuals who belong to the stable roster of patients.

EXPLANATORY CODES

CC004 Service encounter has been disallowed as HSC 03.05 has previously been claimed. Documentation must be provided if re-assessment is required.

DE016 Service encounter has been refused as the third condition amount has already been approved for this year.

MA061 Service encounter has been refused as the patient is over 6 months old.

MJ044 Service encounter has been refused as HSC 01.24C has previously been billed for this patient on this day.

VA058 Service encounter has been refused as HSC 60.24C has previously been billed for this patient on this day.

VT124 Service encounter has been disallowed as an urgent hospital visit applies only when a physician travels from one location to another. Preamble 7.2.7(a). Resubmit with text stating details of the Physicians travel.

VT125 Service encounter has been refused as this claim does not meet the criteria for an urgent visit, per Preamble 7.2.7 (a),(b),(c).

VT126 Service encounter has been disallowed as an additional visit for an OPD or Emerg patient is only payable if the patient is under observation for more than 4 hours. Preamble 7.2.6 (a). Resubmit with text explaining the necessity of an additional visit.

UPDATED FILES AVAILABILITY

Updated files reflecting changes are available for download on Friday, May 23rd, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/Stroke ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD		Date / /	Date / /	Date / /	Date / /
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Immunizations Discussed and/or given				
ANNUALLY	Exercise/Activity				
REQUIRED COMMON INDICATORS FOR DIABETES and IHD		Date / /	Date / /	Date / /	Date / /
2/YR	Blood pressure				
ANNUALLY	Weight/Nutrition Counselling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
REQUIRED INDICATORS FOR DIABETES ONLY					
2/YR	HbA1C				
ANNUALLY	Renal Function ACR and eGFR				
ANNUALLY	Foot Exam Use 10-g monofilament				
ANNUALLY	Eye Exam Discuss and/or refer				
REQUIRED INDICATORS FOR IHD ONLY					
ANNUALLY	Anti-platelet Therapy Review				
ANNUALLY	Beta-blocker Review				
ANNUALLY	ACEI/ARB Review				
ANNUALLY	Discuss Nitroglycerin				
ANNUALLY	Consider further cardiac investigations				
REQUIRED INDICATORS FOR COPD ONLY					
1/YR	COPD Action Plan Develop. Review and complete annually				
RECOMMENDED ITEMS (Optional for CDM Incentive payment)					

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common Indicators: DM, IHD & COPD	Target	Comments
Smoking Cessation	Non-smoker	
Immunizations	Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years..	
Exercise/Activity	Discuss appropriate exercise/activity and possible referrals	For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk. For COPD: pulmonary rehab program
Common Indicators: DM & IHD	**Target**	**Comments**
Blood Pressure	IHD without DM or CKD: <140/90 DM: <140/80* DM and CKD: <130/80** In children: <95th %ile for age, gender and height	*In DM with no end organ damage ** Where this can be achieved safely without undue burden
Lipids	For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction For DM only LDL-C: < 2.6	Test every 1-3 years OR as clinically indicated
Weight/Waist circumference/ Nutrition counseling	BMI: <25 kg/m^2 or In children: <85th %ile for age Waist circumference: M: <102 cm, F: <88 cm	

Diabetes Indicators	Target	Comments
HbA1C	< 7%	-q 6 mo. In stable DM -q 3 mo. For all others Individualize HbA1C based on age, DM duration & co-morbidity
Renal Function	ACR: <2.0 for males; <2.8 for females eGFR: >60 mL/min	In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min
Routine foot examination	Annually	Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion.
Routine dilated eye examination	At diagnosis, then every 1-2 years based on degree of retinopathy.	By optometrist or ophthalmologist

IHD Indicators	Duration	Comments
Beta-blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACEI/ARB	Indefinitely unless low risk	ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI
Antiplatelet Therapy **ASA** 81 to 325 mg OD **Clopidogrel** 75 mg OD **Ticagrelor** 90 mg BID	**ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease **Clopidogrel: STEMI** - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. post drug-eluting stent **Clopidogrel: Non-STEMI** No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo. PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo **Ticagrelor** Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended.	**ASA** maximum dose 75-100 mg if on Ticagrelor **Clopidogrel: STEMI** Dependent on type of stent and risk profile **Clopidogrel Non-STEMI** Depends on risk of recurrent event & stent type **Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy.
Discuss Nitroglycerin		
Consider further cardiac investigations		

COPD Indicators	Target	Comments
COPD Action Plan	Include medications and emergency instructions for patient.	Copy given to patient.

PHARMACOTHERAPY IN COPD

INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT

MILD	MODERATE	VERY SEVERE
↓		
SABD prn ↓ Persistent dyspnea	**Infrequent AECOPD (average of <1 per year)** **LAAC *or* LABA + SABA prn** ↓ Persistent dyspnea	**Frequent AECOPD (≥1 per year)** **LAAC + ICS/LABA +SABA prn** ↓ Persistent dyspnea
LAAC + SABA prn or **LABA + SABD prn**	**LAAC + LABA + SABA prn** ↓ Persistent dyspnea **LAAC + ICS/LABA* + SABA prn**	**LAAC + ICS/LABA + SABA prn** ± **Theophylline**

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
   - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
   - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

COPD ACTION PLAN

(Review annually with your doctor)

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

COPD (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

When you are stable:

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

If any 2 or all of these symptoms persist for 48 or more hours do the following:

- ☐ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- ☐ Take your prescribed antibiotic for a COPD flare-up (see over).
- ☐ Take your prescribed prednisone for a COPD flare-up (see over).
- ☐ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- ☐ Call 811 if you have questions
- ☐ Other _____

IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.

Physician Signature_____

Patient/Caregiver Signature_____

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

Patients: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish	Start Date / Finish	Start Date / Finish

Make sure you take your prescribed medications until finished.

Please review this plan with your doctor at least annually.