

GP SERVICES COMMITTEE
CHRONIC DISEASE MANAGEMENT INCENTIVES

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Society of
General
Practitioners

Chronic Disease Management (CDM) Payments

This program is a continuation of the Full Service Family Practice Condition Payment introduced in 2003. The program payments recognize that additional work, beyond the office visit payments, of providing guideline based care to patients over a year. The purpose of the condition based payments is to improve patient care. Effective January 1, 2009, there must be at least 2 encounters or visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

They are payable in recognition of the work that has been done and are not payable in advance of the work being done. The program was enhanced in 2006 through an increased annual bonus amount for provision of clinical guidelines based diabetes and congestive heart failure care (from \$75 to \$125 per person) and introduction of a \$50 bonus payment for clinical guidelines based hypertension management.

Additionally, effective September 15, 2009, a new CDM incentive for Chronic Obstructive Pulmonary Disease has been introduced. With this condition payment, there is no flow sheet, but the patient must be given a copy of their COPD Action Plan (template included in appendix 1). As a part of enhancing the management of COPD patients, the GPSC has also introduced a telephone/e-mail follow up management fee for these patients payable up to 4 times in the 12 months following the successful billing of the 14053.

Eligibility:

These payments are available to:

All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and:

- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who has provided the patient the majority of their longitudinal general practice care over the preceding year, and
- Has provided the requisite level of guideline-based care.

G14050 Annual Chronic Care Bonus – Diabetes Mellitus

Notes:

- i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) **Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.***
- iii) **Applicable only for patients with confirmed diagnosis of diabetes mellitus.***
- iv) **Care provided must be consistent with the BC clinical guideline recommendations for Diabetes Mellitus and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- v) **Claim must include the ICD-9 code for diabetes (250).***
- vi) **This item may only be claimed once per patient in a consecutive 12 month period.***
- vii) **Payable when other CDM items G14051 or G14053 have been paid on the same patient.***
- viii) **If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.***

G14051 Annual Chronic Care Bonus – Congestive Heart Failure

Notes:

- i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.***
- iii) *Applicable only for patients with confirmed diagnosis of congestive heart failure.*
- iv) ***Care provided must be consistent with the BC clinical guideline recommendations for Congestive Heart failure and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- v) *Claim must include the ICD-9 code for congestive heart failure (428).*
- vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
- vii) *Payable when other CDM items G14050 or G14053 have been paid on the same patient.*
- viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14052 Annual Chronic Care Bonus – Hypertension

Notes:

- i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.***
- iii) *Applicable only for patients with confirmed diagnosis of hypertension.*
- iv) ***Care provided must be consistent with the BC clinical guideline recommendations for Hypertension and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet in order to facilitate patient self management.***
- v) *Claim must include the ICD-9 code for hypertension (401).*
- vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
- vii) *Not payable if G14050 or G14051 claimed within the previous 12 months.*
- viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14053 Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease- COPD

Notes:

- i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.***
- iii) *Applicable only for patients with confirmed diagnosis of COPD.*
- iv) ***Care provided must be consistent with the BC clinical guideline recommendations for COPD and may only be billed after one year of***

care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their personalized COPD care plan in order to facilitate patient self management.

- v) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
- vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
- vii) *Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.*
- viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14073 COPD Telephone/Email Management Fee

This fee is payable for 2-way communication with eligible patients or the patient's medical representative via telephone or email for the provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

- i) *Payable to a **maximum of 4 times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053).***
- ii) *Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053).*
- iii) *Telephone/Email Management requires two-way communication between the patient or the patient's medical representative and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals.*
- iv) ***Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician.***
- v) *G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14016.*
- vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016.*
- vii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.*

BILLING PROCEDURE

The chronic care incentive payments may be applied for once continuity of monitoring the patient's chronic conditions using GPAC guideline informed care has been established as indicated below in the flow sheet section.

The CDM incentives are submitted through the MSP claims system the same way you would submit an MSP fee-for-service claim. The submission must include the relevant ICD-9 code (**250** for diabetes; **428** for congestive heart failure; **401** for hypertension; **491, 492, 494 or 496** for COPD).

FLOW SHEETS & ACTION PLANS

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding

year. Chronic Care flow sheets are a useful tool for tracking care provided to patients over time. The GPSC requires physicians to track and document adequately the care provided to their patients to ensure they are providing guideline informed care. While it is not mandatory to utilize official GPAC flow sheets, if you use a different flow sheet, all essential elements from the GPAC guideline must be included. There are other requirements that are incentive specific as outlined below:

- **Diabetes Patient Care Flow Sheet**
Fee item 14050 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, this is highly recommended to assist in patient self management by the GP Services Committee.
- **Congestive Heart Failure Care Flow Sheet**
Fee item 14051 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, this is highly recommended to assist in patient self management by the GP Services Committee.
- **Hypertension Care Flow Sheet**
Fee item 14052 may be billed after the patient has been provided guideline informed care for one year. To assist in patient self management the patient **must** be given copies of their flow sheet for the year to assist in patient self management.
- **COPD Patient Action Plan**
Fee item 14053 may be billed after the patient has been provided guideline informed care for one year. There is no flow sheet for the 14053, however, to facilitate self management, the patient must be provided with their COPD Action plan which has been jointly developed between the patient and GP, and is to be reviewed and updated regularly.

FREQUENTLY ASKED QUESTIONS

1. How do I claim the condition-based payments?

Effective September 15, 2009, in addition to the existing codes for diabetes (14050) congestive heart failure (14051) and hypertension (14052), code 14053 has been added for COPD.

The incentive payments are payable if the patient has a confirmed diagnosis of diabetes mellitus (*please note this incentive payment is not payable for pre diabetes patients*), congestive heart failure, hypertension or chronic obstructive pulmonary disease. Only one payment per diagnosis is payable per patient per year. The bonus 14052 (hypertension) is not payable if a bonus payment 14050 (diabetes mellitus) or 14051 (congestive heart failure) has been paid for the patient in the preceding year. 14052 (hypertension) is payable in addition to 14053 for those patients who also have COPD. 14052 (hypertension) is only billable for patients with hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.

Condition-based bonus claims are submitted through the MSP Claims system the same way you would submit a MSP fee-for service claim. The submission must include the relevant ICD 9 codes:

Congestive heart failure - 428;
Diabetes mellitus – 250;
Hypertension – 401;
COPD – 491 or 492 or 494 or 496.

2. Is it possible to claim all Chronic Disease Management fees in the same patient?

If a patient has any of the three conditions diabetes mellitus, congestive heart failure, and/or COPD and criteria are met for each condition, each annual incentive bonuses may be billed

separately. If a patient has hypertension, the 14052 cannot be billed in addition to Diabetes or CHF, as management of hypertension is included in the guideline for these 2 conditions. If the patient has hypertension and COPD without diabetes or CHF, then both the 14052 and 14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

| | 14050 | 14051 | 14052 | 14053 |
|-------|-------|-------|-------|-------|
| 14050 | | Yes | No | Yes |
| 14051 | Yes | | No | Yes |
| 14052 | No | No | | Yes |
| 14053 | Yes | Yes | Yes | |

3. When should the incentive bonus be billed?

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient’s longitudinal general practice care over the preceding year. The Chronic Care Incentive bonus fees may be billed the patient has been provided guideline informed care for one year for that particular condition.

Although you are not required to give the patient a copy of the flow sheet for diabetes (G14050) or CHF (G14051), this is highly recommended to assist in patient self management by the GP Services Committee. For the billing of the hypertension CDM (G14052), it is mandatory to provide the patient with a copy of their flow sheet or other documentation self management documentation that covers all guideline specific information. For the billing of the COPD CDM (G14053), there is no flow sheet, but it is mandatory to provide the patient with a copy of their jointly developed COPD Action Plan.

Once successfully billed, the CDM incentives may be billed on or about the anniversary date of the initial billing, provided guideline informed care has continued to be provided in the intervening 12 months.

4. Does obstructive sleep apnea qualify for the COPD CDM (G14053)?

No. COPD and obstructive sleep apnea are two different conditions. Criteria for the diagnosis of COPD are included in the COPD fee description.

5. Will payment item G14050, G14051, G14052 and G14053 replace the usual visit fees for those patients who have diabetes, congestive heart failure, hypertension or COPD?

No. Billing for office visits should continue as usual. This bonus is billed *in addition to* any other fees incurred by usual patient care. It is a management bonus, intended to compensate for the time taken to maintain patient care plans in accordance with the BC clinical guidelines.

6. Do I have to see the patient to bill the payment?

You will have to see the patient to provide care according to the guidelines, but you do not have to see the patient to fill in the flow sheet or on the day of billing the payment. However, effective January 1, 2009, there must be at least 2 visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

7. Do I have to provide all follow up care to the patient face to face?

After successfully billing the G14053, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14073 COPD up to 4 times in the following 12 months (in addition to at least 2 face to face visits).

8. Can I still bill if the patient is in a long-term care facility?

Patients in long-term care facilities are eligible; however clinical judgment may be needed about the appropriateness of following these guidelines in patients with dementia or very limited life

expectancy. If the COPD incentive (14053) is billed for resident in a long-term care facility a personalized Clinical Action plan must be entered in the patient's chart.

9. Where can I find the clinical guidelines and flow sheets?

The full Diabetes Care, Heart Failure Care, and the Treatment of Essential Hypertension guidelines are found on the Guidelines and Protocols page of the Medical Services Plan web site, along with all other current guidelines.

<http://www.bcguidelines.ca><http://www.healthservices.gov.bc.ca/msp/protoguides/gps/index.html>

A link is also provided on the BCMA web site, <https://www.bcma.org/gpsc-chronic-disease-management>

The link to information about the flow sheets is also found on the same site. Should you wish to receive a pad of pre-printed flow sheets, please fax your request at the following toll-free fax number 1-800-952-2895.

10. Will other flow sheets be admissible for the bonus?

Other flow sheets can be used if they are consistent with the BC clinical guidelines for diabetes, heart failure, and/or essential hypertension management, and contain the same information included in the patient flow sheets that are part of the BC clinical guideline. It is a requirement to give hypertension patients a copy of their flow sheet as an aid to patient self management. Physicians are not required to submit the completed flow sheets to the Ministry of Health in order to receive the incentive payment. Instead, this program will be subject to the usual process of random audit through the Ministry of Health's Billing Integrity Program. Therefore, it is important that you keep all of your completed patient flow sheets on file.

11. Where can I find the COPD Action Plan template?

As part of the patient self management handout, a COPD Care plan template can be found at the end of this document.

12. Can I bill the payment even if the clinical or laboratory objectives have not been met?

The payment is provided for the provision of guideline-based care, and is NOT a payment simply because the patient has a diagnosis of diabetes, congestive heart failure, or hypertension. However, you may still claim for the payment if you have attempted to provide guideline based care but for some reason care objectives have not been met. If this is the case, however, for audit purposes you must have clear chart entries that show that you attempted to provide the recommended level of care and did not achieve targets, or you explicitly established different targets based on the unique circumstances of your patient.

13. Can I bill for patients covered by other provinces?

Patients covered by other provinces who are temporarily in BC are not eligible as their regular physician is in the other province. If they stay in BC and obtain coverage under the Medical Services Plan then they become eligible for the program. In a few border communities a BC physician may provide the majority of care for an Alberta or Yukon patient, and these patients will be eligible.

14. I have assumed the practice of another GP within the last 12 months. May I still bill for patients' Chronic Disease Management fees?

If the practice you assumed has provided the requisite care to the patient (see bullet 3 in this section) you may bill the Chronic Disease Management payment on its anniversary date, without having to wait a full 12 months from the time you assumed responsibility for the practice. You may not bill the Chronic Disease Management fees if a patient did not receive the requisite level of care, or a chronic disease management fee code has been billed for the patient in the preceding 12 months.

15. Are the payments eligible for the rural premiums?

No.

16. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the chronic care bonus payments?

Yes.

CDM Fee Values

| | | |
|---------------|--|-----------------|
| G14050 | Annual Chronic Care Bonus – Diabetes Mellitus | \$125.00 |
| G14051 | Annual Chronic Care Bonus – Congestive Heart Failure | \$125.00 |
| G14052 | Annual Chronic Care Bonus – Hypertension | \$50.00 |
| G14053 | Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease | \$125.00 |
| G14073 | COPD Telephone/Email Management Fee | \$15.00 |

Billing Scenario

Mr. William S is a 76 year old former smoker who has a past history of Diabetes, hypertension and COPD. You have been his family physician for the past 12 years. When the initial GPSC CDM incentive program began, you had pulled all your charts for eligible patients including Mr. S, and started utilizing the CDM flow sheets for following the care of his diabetes. You see have also been undertaking the complex care management planning visits with Mr. S and find he is due for a CPX as per the guideline recommendations. Mr. S was seen in February for follow up of his diabetes. The Complex Care Management Planning visit was provided in April of this calendar year. Mr. S has seen you in June and returns in September for his planned CPX in the same month as the anniversary date of his Diabetes CDM. You review his complex care plan and his diabetes management. As well, you provide him with a COPD Action plan for the coming winter. He returns in November for his annual seasonal flu shot given by your office nurse. Later that month, after a visit with his daughter and grandchildren he phones the office with some increased shortness of breath and a change in his sputum but no fever. You advise him on the management of his COPD according to his COPD action plan. You follow up with him at an office visit 2 weeks later. The billings for his management for this calendar year are:

| Date | Service Description | Fee Code | Diagnostic Code |
|-------------|---|-------------------------|------------------------|
| Feb | Office Visit | 17100 | 250 |
| April | Complex Care Management Planning Visit | 14033 17100 | R250 496 |
| June | Office Visit | 17100 | 250 |
| September | CPX plus CDM review and COPD Action Plan update Diabetes CDM COPD CDM | 17101 14050 14053 | 250 250 496 |
| November | Seasonal Flu shot by office nurse | 00010 | 33A |
| November | Phone Follow up of COPD | 14079 | 496 |
| December | Office Follow up of COPD | 17100 | 496 |

Chronic Obstructive Pulmonary Disease

A Guide for Patients

Adapted from 2005 GPAC COPD Guideline

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease includes respiratory disorders such as chronic bronchitis and emphysema that make breathing difficult. Smoking is the most important cause of these diseases. If you smoke, quitting will reduce the severity of the disease and help you improve the quality of life over a much longer time.

Chronic bronchitis and emphysema

In chronic bronchitis, inflammation occurring in the bronchial tubes may cause narrowing, which makes breathing difficult. A chronic cough that brings up sputum is present.

In emphysema, lung tissue and the small air sacs (alveoli) at the end of the airways become damaged and air becomes trapped in the lungs leading to shortness of breath.

COPD Exacerbations

An exacerbation is a worsening of the condition that includes the following signs:

- rapid increase in cough
- mucus production (especially if yellow or green)
- increased shortness of breath
- blue lips or fingers

Exacerbations can be serious and life-threatening. Prompt and effective treatment can help most people recover to the level of breathing before the exacerbation.

Diagnosis

A medical history, physical examination and breathing tests are used to diagnose COPD.

Treatment

Although there is no cure for COPD, the best way to slow the progression of the disease is to quit smoking. Medications may reduce or relieve symptoms. Counseling, education, and exercise can help improve quality of life. Pulmonary rehabilitation programs are available in some areas and these have been proven effective.

The use of a COPD Action Plan that has been jointly developed with your physician will assist you in managing your symptoms on a daily basis.

Quitnow by Phone

A free telephone service offering advice, information and support about quitting smoking. Call toll-free within British Columbia: 1 877 455-2233. The Quitnow Helpline is staffed from 10am to 6pm. After hours and on weekends, callers are invited to leave a message and a Quit Specialist will return the call during service hours.

The BC Smokers' Helpline service is tailored to the individual needs of each caller.

- **Smokers who want to quit** can get information about all the different methods, help with deciding what method may be best for them, and what to expect once they quit.
- **People who have just quit** may wish information about coping with withdrawal, and how to manage concerns about things like weight gain or sleep disturbance.
- **Smokers who are thinking of quitting** can discuss the pros and cons with a trained Quit Specialist. And the best thing is: no hassle, no pressure.
- **Smokers who wish to keep smoking** are also welcome to call the line; they don't push anyone to quit smoking and don't judge people for smoking, and a chat may provide useful information.

- **Friends and family members concerned about someone's smoking** are encouraged to call to discuss what they can do to help.

Living with COPD

Remove factors that can worsen your condition such as smoking. Balance exercise and rest periods. Participation in a pulmonary rehabilitation program or a chronic disease self-management program can be helpful. The BC Lung Association has a list of contacts for Better Breathers clubs in different areas of the province (see web site below) or call **1 800 665-5864** for further information including other programs such as Breathworks **1 866 717-2673**.

End of Life Planning

Planning for end of life circumstances is necessary for many patients in the advanced stages of COPD.

Consider discussing end of life concerns with your physician and writing a legal document (advance directive) that helps ensure your health care wishes will be respected. An advance directive contains your preferences for treatment, a living will and a power of attorney. More details related to end of life care can be found at the BC HealthGuide web site listed below.

British Columbia Internet Resources

The BC Ministry of Health Chronic Disease Management web site has more detailed information about the management of diseases such as COPD.

<http://www.health.gov.bc.ca/cdm/patients>

The BC HealthGuide Online provides detailed information on managing COPD and end of life planning.

<http://bchealthguide.org>

BC Lung Association offers excellent materials for the control of COPD.

<http://www.bc.lung.ca>

**Contact the BC Lung Association or your local Health Authority
for access to a Pulmonary Rehabilitation Program**



Patient Name: _____ Date: _____
PHN: _____ Date of Birth: _____
Family Contact: _____ Phone #: _____
Physician: _____ Phone #: _____
After Hours Phone #: _____

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 Flare up Plan is a written contract between you and your doctor about how you will manage your COPD flare ups. This Plan will help you and your doctor to quickly recognize and treat flare ups to improve your health.

COPD (chronic obstructive pulmonary disease) has 2 states:

When you are am stable:

1. Breathing without shortness of breath
2. Able to do daily activities
3. Mucous is easy to cough up
4. Sleep well
5. Able to exercise as directed by physician

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 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 normal level
3. Sputum changes from its normal 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:
(Your physician will check the desired action plan for you)***

- Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- Contact your family doctor immediately for a check up and medication review.
- 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.
- Other _____

If you are extremely breathless, anxious, fearful, drowsy or having chest pain, call 911 for an ambulance to take you to the emergency room.

Physician Signature _____

Patient/Caregiver Signature _____ ***Please turn over***

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____
 PHN: _____ Date of Birth: _____
 Family Contact: _____ Phone #: _____
 Physician: _____ Phone #: _____
 After Hours Phone #: _____

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

Physicians: Please fill in prescribed maintenance medications.

| Medication Prescribed | How Much to Take | When To Take |
|-----------------------|------------------|--------------|
| | | |
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| | | |
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| | | |

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 Date | Start Date / Finish Date | Start Date / Finish Date |
|-----------------------|--------------------------|--------------------------|--------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
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Make sure to take prescribed medication until all finished.