PROPOSED RULE MAKING

CR-102 (June 2004)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Department of Health- Chiropractic Quality Assurance Commission

☒ **Preproposal Statement of Inquiry was filed as WSR** 07-20-038 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _ ; or**
☐ **Proposal is exempt under RCW 34.05.310(4).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR**
☐ **Continuance of WSR**

Title of rule and other identifying information: (Describe Subject)
WAC 246-808-560 - Documentation of Care Chiropractic Quality Assurance Commission. The proposal amends the documentation requirements to ensure chiropractors are providing thorough and timely documentation that reflects a patient's presenting condition, treatment plan, progress, etc. The proposal clarifies the existing documentation requirement for chiropractors.

Hearing location(s): Department of Health - Health Professions and Facilities
Point Plaza East Building - Rooms 152 and 153
310 Israel Road SW
Tumwater, WA 98501

Date: 2/11/2010 Time: 11:00 a.m.

Date of intended adoption: 02/11/2010
(Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Leann Yount, Program Manager
Address: Department of Health
PO Box 47852
Olympia, WA 98504-7852
Website: http://www3.doh.wa.gov/policyreview/
fax 360.236.2901 by (date) 02/04/2010

Assistance for persons with disabilities: Contact
Leann Yount by 02/04/2010
TTY (800) 833-6388 or () 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:
The Chiropractic Quality Assurance Commission (commission) is proposing rulemaking on the standards for documentation of care. There have been chiropractic disciplinary cases related to the frequency and legibility of documentation. The commission is amending the rules to clarify the standards for documentation.

Reasons supporting proposal:
The rules will assist chiropractors, ancillary staff, patients, and other stakeholders to understand the expectations of adequate care documentation which will further enhance public protection.

Statutory authority for adoption:
RCW 18.25.0171 and RCW 18.130.050

Statute being implemented:
Chapter 18.25 RCW

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

DATE 1/5/10

NAME (type or print)
Leann Yount

SIGNATURE Leann Yount

TITLE
Program Manager

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: January 05, 2010
TIME: 2:15 PM

WSR 10-02-079

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

None

Name of proponent: (person or organization) Department of Health - Chiropractic Quality Assurance Commission

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Leann Yount	310 Israel Rd SE Tumwater, WA 98501	360.236.4856
Implementation....	Leann Yount	310 Israel Rd SE Tumwater, WA 98501	360.236.4856
Enforcement.....	Leann Yount	310 Israel Rd SE Tumwater, WA 98501	360.236.4856

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

☐ Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone
fax
e-mail

☒ No. Explain why no statement was prepared.
A small business economic impact statement was not prepared. The proposed rule would not impose more than minor costs on businesses in an industry.

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name: Leann Yount
Address: Department of Health - Chiropractic Program
PO Box 47852
Olympia, WA 98504-7852

phone 360.236.4856
fax 360.236.2901
e-mail leann.yount@doh.wa.gov

☐ No: Please explain:

AMENDATORY SECTION (Amending WSR 96-16-074, filed 8/6/96, effective 9/6/96)

WAC 246-808-560 Documentation of care. ((~~(1) The recordkeeping procedures of a chiropractor shall be adequate to provide documentation of the necessity and rationale for examination, diagnostic/analytical procedures, and chiropractic services. The required documentation shall include, but not necessarily be limited to, the patient's history and/or subjective complaints; examination findings and/or objective findings; and a record of all chiropractic services performed.~~

~~(2) Chiropractic examinations shall be documented by specifying subjective complaints, objective findings, an assessment or appraisal of the patient's condition and the plan for care. Daily chart notes may be brief notations recorded in the patient's chart file between examinations. These notations shall indicate any changes in the care or progress of the patient and the chiropractic, diagnostic, or analytical services performed or ordered. Detailed entries need not be documented on every visit as long as examinations are performed at reasonable intervals and those examinations are documented as specified in this section.~~

~~(3) If a code is utilized by the doctor in connection with recordkeeping, a code legend shall be included in the records.~~)) A doctor of chiropractic must keep complete and accurate documentation on all patients and patient encounters. This documentation is necessary to protect the health, well-being and safety of the patient.

(1) The patient record must detail the patient's clinical history, the rationale for the examination, diagnostic or analytical procedures, and treatment services provided. The diagnosis or clinical impression must be contained in the patient record, not merely recorded on billing forms or statements. Subjective health status updates must be documented for every patient encounter.

(2) Documentation for the initial record must include at a minimum:

(a) The patient's history;

(b) Subjective presentation;

(c) Examination findings or objective findings relating to the patient's presenting condition;

(d) Any diagnostic testing performed;

(e) A diagnosis or impression;

(f) Any treatment or care provided; and

(g) Plan of care.

(3) Reexaminations, being necessary to monitor the progress or update the current status of a patient, must be documented at reasonable intervals sufficient to reflect the effectiveness of the

treatment. Reexaminations must also be documented whenever there is an unexpected change in the subjective or objective status of the patient. Reexamination documentation must include the subjective presentation and objective findings. This documentation shall also reflect changes in the patient's care and progress and in the treatment plan.

(4) Documentation between examinations must be recorded for every patient encounter. Documentation must sufficiently record all the services provided, as well as any changes in the patient's presentation or condition. The region(s) of all treatment and the specific level(s), if applicable, of chiropractic adjustments must be recorded in the patient encounter documentation.

(5) Patient records must be legible, permanent, and recorded in a timely manner. Documentation that is not recorded on the date of service must designate both the date of service and the date of the chart note entry. Corrections or additions to the patient's records must be corrected by a single line drawn through the text and initialed so the original entry remains legible. In the case of computer-organized documentation, unintended entries may be identified and corrected, but must not be deleted from the record. Errors in spelling and grammar may be corrected and deleted.

(6) Correspondence relating to any referrals concerning the diagnosis or treatment of the patient must be retained in the patient record.

(7) Patient records should clearly identify the provider of services by name, initials, or signature. If the chiropractor uses a code in the documentation, a code legend must be made available upon request.