Rule 22 Record Keeping Requirements (Effective 7-30-07)

Documentation of the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan must be reflected in the record keeping and written reports of the patient file. Records are required to be contemporaneous, legible, utilize standard medical terminology or abbreviations, contain adequate identification of the patient, contain adequate identification of the provider of service and indicate the date the service was performed. All professional services rendered during each patient encounter should be documented. Any addition or correction to the patient file after the final form shall be signed and dated by the person making the addition or correction. The following minimum components must be documented within the patient file:

A. Initial Patient Visit:

1. History:
    - a. Chief complaint(s) described in terms of onset, provocative, palliative, quality, radiation, setting, and timing.
    - b. Surgical, hospitalization, past/recent illness, trauma, family, social, past/recent system review, and past/recent allergies.
    - c. Non-prescription, prescription, botanical, homeopathic medicines, and vitamin supplements.
    - d. A reasonable effort should be made to obtain and review pertinent records as clinically indicated from other health care providers, imaging facilities, or laboratories.
2. Examination:
    - a. Vital signs as clinically indicated.
    - b. Document examinations or tests ordered or performed and the results of each as necessitated by the patient's clinical presentation consistent with common healthcare practices.
    - c. Document examinations of neuromusculoskeletal conditions using a format of inspection, palpation, neurological testing, range of motion, and orthopedic testing.
    - d. Document prognosis and/or outcome expectations.
    - e. When clinically indicated, treatment options/alternatives should be documented. f. When referring to another healthcare provider, correspondence may be provided for patient care coordination.

B. Established Patient Visit:

1. **Subjective Complaint:** The patient's description of complaints should be recorded at each visit indicating improvement, worsening, or no change.
2. **Objective Findings:** Changes in the clinical signs of a condition should be described by the chiropractor at each visit.
3. **Assessment or Diagnosis:** It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed, specifically documented and recorded in the daily entries. Changes in the patient's diagnosis should be recorded in the daily entries when clinically indicated. Prognosis and/or outcome expectations should be updated periodically consistent with the clinical presentation.
4. **Plan of Management:** A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient enters a new phase of treatment or has a diagnosis change. Changes in procedures should be documented and based on clinical assessment and reasoning.
5. **Procedures:** Daily recording of procedures performed should include a description of type and location of procedure. Units of time should be recorded when appropriate.

C. Ancillary Documentation:

1. Correspondence sent and received.
2. Specialty reports (diagnostic imaging, laboratory results, nerve conduction studies, etc.).
3. Communications (telephone conversations, dialogue with patient guardian or other healthcare providers).

D. Patient clinical records shall be maintained for a minimum of seven (7) years after the last date of treatment or examination, or at least two years after the patient reaches the age of eighteen, whichever occurs later. If patient records are maintained electronically, then a back-up and data recovery system must be in place.

E. When the destruction cycle is imminent, written notice to the patient's last known address, or notice by publication, must be made sixty (60) days prior to destruction allowing a thirty (30) day period wherein the patient may claim his/her records. When a patient claims such records, the records must be provided to the patient, or legal guardian, at no charge; however, recovery of appropriate postage and handling costs is permitted.

F. Records shall be destroyed in a manner that totally obliterates all information contained in the record such as by incinerating or shredding.

G. Records may not be withheld for outstanding/past due professional fees. A reasonable fee for copying records may be assessed to the requesting party.