

WAC 246-808-560 Documentation of Care

A doctor of chiropractic must keep complete and accurate documentation on all patients.

Documentation shall serve to protect the health and well-being of the patient.

- (1) Initial documentation shall include at least the patient's history and/or subjective presentation, examination (exam) findings and/or objective findings sufficient to evaluate the patient's presenting condition. It shall include diagnostic testing performed, a diagnosis or impression, and treatment and/or care provided. Any referrals concerning the diagnosis or treatment of the patient shall be in the patient record.
- (2) Documentation shall be sufficiently detailed to reflect the patient's clinical history, the rationale for the exam, diagnostic and/or analytical procedures, and chiropractic services. The diagnosis or clinical impression shall be contained in the patient record, not merely recorded on billing forms or statements.
- (3) Chiropractic re-exams to monitor the progress and/or to update the status of a patient shall document subjective presentation, objective findings, and reflect changes in the patient's care and/or progress and in the treatment plan. Chart notes between exams may be brief but shall reflect the services provided, as well as any significant/unexpected changes in the patient's presentation or condition. The region(s) of treatment and/or of chiropractic adjustments should also be recorded. Progress exams must be documented at reasonable intervals, not to exceed 60 days or 18 office visits, whichever is less. Re-exams are also needed whenever there is an unexpected change in the patient's status.

- (4) For patients who seek asymptomatic, elective, preventive or maintenance chiropractic care, this section does not seek to mandate comprehensive objective exams at 60 day or 18 office visits. Timely subjective health status updates may be adequate. Changes in the health status of the patient may prompt further objective evaluation.
- (5) Chiropractic patient records must be legible, indelible, and timely recorded. Documentation that is not recorded on the date of service must show both the service and entry dates. Corrections and/or additions to the patient's documentation must be fixed by one line drawn through the text so the first entry remains legible. Incorrect computer-organized documentation entries may be identified and corrected. They can not be deleted from the record.
- (6) Records shall clearly identify the provider of services by name, initials, or signature. If a code is used by the chiropractor that ties in with the documentation, a code legend must be available upon request.