PROPOSED RULEMAKING

STATE BOARD OF CHIROPRACTIC

[49 PA. CODE CH. 5]

Patient Records

The State Board of Chiropractic (Board) proposes to amend §§ 5.1 and 5.51 (relating to definitions; and patient records) to read as set forth in Annex A.

Effective Date

The proposed rulemaking will be effective upon final-form publication in the *Pennsylvania Bulletin*.

Statutory Authority

The proposed rulemaking is authorized under sections 302(3) and 506(a)(15) of the Chiropractic Practice Act (act) (63 P. S. §§ 625.302(3) and 625.506(a)(15)).

Background and Need for the Amendment

A licensee who "[f]ail[s] to maintain chronological documentation of patient care in accordance with regulations prescribed by the Board" is subject to disciplinary action under section 506(a)(15) of the act. Section 5.51(c) currently requires that "[t]he patient record shall contain sufficient information to document the clinical necessity for chiropractic care rendered, ordered or prescribed." This language does not provide licensees with clear guidance as to what information would be sufficient to document clinical necessity.

Description of the Proposed Amendments

The proposed rulemaking amends § 5.51(c) to set forth in more detail what must be included in the patient record, to document diagnosis, as well as the clinical necessity for care and any treatment provided. In general, the record must contain sufficient information to document that treatment, care or service provided: (1) was reasonably expected to improve the patient's condition at the time it was rendered; (2) prevented the onset of any permanent disability; (3) assisted the patient to achieve maximum functional capacity in performing the patient's daily activities; (4) alleviated the patient's pain; (5) mitigated the severity of the patient's symptoms; (6) ameliorated the patient's condition; (7) prevented the worsening of the patient's condition; (8) slowed the natural progression of the patient's condition or disease; (9) was appropriate for the patient's symptoms, reinjuries, exacerbations and diagnoses of the patient's conditions or injuries; (10) was provided consistent with the treating doctor's diagnosis; or (11) was provided consistent with the patient's active symptomatology or abnormal physical findings, or both. The record concerning diagnostic tests must address: (1) the doctor of chiropractic's rationale for ordering the diagnostic test so that without the diagnostic test the doctor of chiropractic could not establish a differential diagnosis to a reasonable degree of chiropractic certainty; (2) the extent to which the diagnostic test facilitated the doctor of chiropractic's proper or effective management or control of the patient's condition, including monitoring of condition which may result in a change of treatment; or (3) how the diagnostic test quantified an objective status of the patient's condition or functional capacity.

The proposed rulemaking requires that the patient record contain documentation sufficient to demonstrate that therapeutic treatment, care or services was reasonably expected to improve, restore or prevent the progression of an illness, injury, disease, disability, defect, condition or the functioning of a body member. The record must demonstrate that any elective care was provided to enhance human performance and the sense of well-being. The record must demonstrate that any maintenance care sought to promote health or maintain functional status, or both. The record must demonstrate that any palliative care was rendered to relieve continued pain and to positively affect the patient's symptomatology, as well as demonstrate the need for the frequency of palliative care. The record for preventive service must include a history and documentation of examination, counseling and risk factor reduction. Finally, the record must demonstrate that supportive care was provided following an aggravation, exacerbation or recurrence following at least two trials of therapeutic withdrawal that have failed to sustain previous therapeutic gains, though the record need not demonstrate functional improvement beyond the previously established maximum therapeutic level.

Additionally, the proposed rulemaking amends § 5.1 (definitions) to define the terms "elective care," "exacerbation," "maintenance care," "palliative care," "preventative service," "recurrence" and "supportive care" for use in applying the proposed standards.

Regulated Community

The Board solicited input from and provided an exposure draft of this proposed rulemaking to professional associations, interested parties and other stakeholders. In addition, the Board considered the impact the proposed rulemaking would have on the regulated community and on public health, safety and welfare. The Board finds that the proposed rulemaking addresses a compelling public interest as described in this preamble.

Fiscal Impact and Paperwork Requirements

The proposed rulemaking will have no adverse fiscal impact on the Commonwealth or its political subdivisions. The proposed rulemaking will impose no additional paperwork requirements upon the Commonwealth or its political subdivisions. The proposed rulemaking will not impose additional paperwork requirements on the private sector, other than the regulated community.

Sunset Date

The Board continuously monitors the effectiveness of its regulations. Therefore, no sunset date has been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 20, 2006, the Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Consumer Protection and Professional Licensure Committee and the House Professional Licensure Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior

to final publication of the rulemaking, by the Board, the General Assembly and the Governor of comments, recommendations or objections raised.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding this proposed rulemaking to Deborah L. Smith, Administrator, State Board of Chiropractic, P. O. Box 2649, Harrisburg, PA 17105-2649 within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference No. 16A-4313 (patient records) when submitting comments.

JONATHAN W. MCCULLOUGH, DC,
Chairperson

Fiscal Note: 16A-4313. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 5. STATE BOARD OF CHIROPRACTIC

Subchapter A. GENERAL PROVISIONS

§ 5.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

***Elective care*—Treatment delivered in the absence of symptoms or positive findings following examination or testing.**

***Exacerbation*—A marked deterioration of the patient's condition due to an acute flare-up of the condition initially or currently being treated.**

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***Maintenance care*—Treatment after maximum therapeutic benefit has been achieved, which:**

(i) Does not positively affect the patient's symptomatology.

(ii) Is not based upon abnormal clinical findings.

(iii) Has not resulted in an improvement in the functional status.

(iv) Has not been established as justified for palliative or supportive care.

* * * * *

***Palliative care*—Treatment for a chronic or permanent condition that does not cure or make further improvement in the underlying injury or disease and is rendered without goals of functional improvement or expectation of slowing the natural progression of the condition.**

* * * * *

***Preventive service*—Service provided for a patient without symptoms or for a patient that has reached maximum improvement and does not need supportive or palliative care. A service provided based upon findings uncovered during a preventive service examination is not a preventive service.**

* * * * *

***Recurrence*—A return of the symptoms of a previously treated condition that has been quiescent.**

* * * * *

***Supportive care*—Treatment for a condition once maximum therapeutic benefit has been established and after therapeutic treatment has been withdrawn.**

* * * * *

Subchapter E. MINIMUM STANDARDS OF PRACTICE

§ 5.51. Patient records.

* * * * *

(c) The patient record **[shall] must** contain sufficient information to document **the diagnosis and** the clinical necessity for chiropractic care rendered, ordered or prescribed**, and any treatment, care or service provided**.

(1) Documentation of treatment, care or service provided must contain information that the treatment, care or service satisfies at least one of the following:

(i) Was reasonably expected to improve the patient's condition at the time it was rendered.

(ii) Prevented the onset of any permanent disability.

(iii) Assisted the patient to achieve maximum functional capacity in performing the patient's daily activities.

(iv) Alleviated the patient's pain.

(v) Mitigated the severity of the patient's symptoms.

(vi) Ameliorated the patient's condition.

(vii) Prevented the worsening of the patient's condition.

(viii) Slowed the natural progression of the patient's condition or disease.

(ix) Was appropriate for the patient's symptoms, re-injuries, exacerbations and diagnoses of the patient's conditions or injuries.

(x) Was provided consistent with the treating doctor's diagnosis.

(xi) Was provided consistent with the patient's active symptomatology or abnormal physical findings, or both.

(2) Documentation concerning diagnostic tests must address at least one of the following:

(i) The rationale for ordering the diagnostic test so that without the diagnostic test the doctor of chiropractic could not establish a differential diagnosis to a reasonable degree of chiropractic certainty.

(ii) The extent to which the diagnostic test facilitated the proper or effective management or control of the patient's condition, including monitoring of condition.

(iii) How the diagnostic test quantified an objective status of the patient's condition or functional capacity.

(3) Documentation must be sufficient to demonstrate that any therapeutic treatment, care or service was reasonably expected to improve, restore or prevent the progression of any illness, injury, disease, disability, defect, condition or the functioning of any body member.

(4) Specific treatment or care must be documented as follows:

(i) Regarding elective care, the patient record must demonstrate how human performance and the sense of well-being was enhanced.

(ii) Regarding maintenance care, the patient record must demonstrate how health or functional status, or both, was sought to be promoted.

(iii) Regarding palliative care, the patient record must demonstrate how the care was intended to relieve continued pain and to positively affect the patient's symptomatology, and to demonstrate the need for the frequency of palliative care.

(iv) Regarding preventive service, the patient record must include a history and documentation of examination, counseling and risk factor reduction.

(v) Regarding supportive care, the patient record must contain documentation of at least two trials of withdrawal of therapeutic treatment that have failed to sustain previous therapeutic gains following an aggravation, exacerbation or recurrence. The patient record need not demonstrate functional improvement beyond the previously established maximum therapeutic level.

* * * * *

[Pa.B. Doc. No. 06-1904. Filed for public inspection September 29, 2006, 9:00 a.m.]

STATE BOARD OF OCCUPATIONAL THERAPY EDUCATION AND LICENSURE

[49 PA. CODE CH. 42]

Orders

The State Board of Occupational Therapy Education and Licensure (Board) proposes to amend § 42.25 (relating to oral orders) to read as set forth in Annex A.

Effective Date

The proposed rulemaking will take effect upon final-form publication in the *Pennsylvania Bulletin*.

Statutory Authority

Section 5(b) of the Occupational Therapy Practice Act (act) (63 P. S. § 1505(b)) authorizes the Board to promulgate and adopt rules and regulations not inconsistent with law as it deems necessary for the performance of its duties and the proper administration of the act.

Background and Purpose

Board members and licensees have noted the lack of clarity to the organization of current § 42.25. The section heading is "oral orders" although it discusses both written and oral orders. To clarify the organization of § 42.25, the Board proposes to divide the text into two subsections: (a) written orders; and (b) oral orders.

Section 14 of the act (63 P. S. § 1514) authorizes an occupational therapist to implement direct occupational therapy to an individual for a specific medical condition based on a referral from a licensed physician, podiatrist or optometrist. The act does not require that the referral be written. Current § 42.25 requires that the referral be in the form of a written order unless the urgency of the medical circumstances requires immediate treatment, in which case an oral order may be accepted. While the Board continues to express a preference for written orders over oral orders for the implementation of therapy, the current language has proven needlessly restrictive and difficult to interpret by practitioners in the field. In a typical situation, the occupational therapist in a setting such as a long-term care facility may receive an oral order rather written order. It may be very desirable, although not necessarily urgent, to begin therapy. It may be impractical to receive a written order. The Board proposes to amend § 42.25 by adopting the standard for long-term care facilities that permits oral orders for medication or treatment to be accepted when "it is impractical for the orders to be given in a written manner by the responsible practitioner" as set forth in 28 Pa. Code § 211.3 (relating to oral and telephone orders).

Prior to adopting this proposed rulemaking, the Board sent an exposure draft of the rulemaking to various persons and entities identified as having an interest in its rulemaking. The Board received responses from the Department of Occupational Therapy of the School of Health and Rehabilitation Sciences of the University of Pittsburgh and from the Pennsylvania Occupational Therapy Association. Both supported the proposed rulemaking.

Description of Amendments

The proposed rulemaking renames and reorganizes § 42.25. The new heading is "orders" because the section includes both written and oral orders. Subsection (a) deals with written orders and subsection (b) deals with oral orders. Second, both subsections would permit an occupational therapist to accept a referral in the form of an order issued by a licensed physician, licensed optometrist or licensed podiatrist. Third, while subsection (b) maintains the preference for written orders over oral orders, receiving an oral order would be acceptable when it is impractical for a written order to be given by the responsible practitioner.

Fiscal Impact and Paperwork Requirements

The proposed rulemaking will not have a fiscal impact on, or create additional paperwork for, the regulated community or the political subdivisions of the Commonwealth.

Sunset Date

The Board continuously monitors the effectiveness of the regulations. Therefore, no sunset date has been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 20, 2006, the Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Consumer Protection and Professional Licensure Committee and the House Professional Licensure Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Board, the General Assembly and the Governor of comments, recommendations or objections raised.

Public Comment

Interested persons are invited to submit written comments, recommendations or objections regarding this proposed rulemaking to Herbert Abramson, Board Counsel, State Board of Occupational Therapy Education and Licensure, P. O. Box 2649, Harrisburg, PA 17105-2649 within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*.

ELLEN L. KOLODNER,
Chairperson

Fiscal Note: 16A-676. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 42. STATE BOARD OF OCCUPATIONAL THERAPY EDUCATION AND LICENSURE

MINIMUM STANDARDS OF PRACTICE

§ 42.25. **[Oral orders] Orders**.

(a) **[An occupational therapist shall accept a referral in the form of a written order from a licensed physician, licensed optometrist or licensed podiatrist in accordance with section 14 of the act (63 P. S. § 1514) unless the urgency of the medical circumstances requires immediate treatment. In these circumstances, an occupational therapist may accept an oral order for occupational therapy from a licensed physician, licensed optometrist or licensed podiatrist, if the oral order is immediately transcribed, including the date and time, in the patient's medical record and signed by the occupational therapist taking the order.**

(b) The countersignature of the licensed physician, licensed optometrist or licensed podiatrist shall be obtained within 5 days of receipt of the oral order in the case of an occupational therapist providing ordered services in a private office setting. In the case of an occupational therapist providing services in a setting that is independent of the prescribing physician's, optometrist's or podiatrist's office, the countersignature on a written copy of the order may be mailed or faxed to the occupational therapist.

(c) In the case of an occupational therapist providing services in a facility licensed by the Department of Health, the countersignature of the licensed physician, licensed optometrist or licensed podiatrist shall be obtained in accordance with applicable regulations of the Department of Health governing the facility, including 28 Pa. Code §§ 211.3 and 601.31 (relating to oral and telephone orders; and acceptance of patients, plan of treatment and medical supervision).]

***Written orders.* An occupational therapist shall accept a referral in the form of a written order from a licensed physician, licensed optometrist or licensed podiatrist.**

(b) *Oral orders.*

(1) An occupational therapist may accept a referral in the form of an oral order if it is impractical for the order to be given in writing by the responsible licensed physician, licensed optometrist or licensed podiatrist.

(2) An occupational therapist receiving an oral order shall immediately transcribe the order in the patient's medical record, including the date and time the order was received, and shall sign the medical record.

(3) The occupational therapist in a private office setting who has received an oral order shall obtain the countersignature of the practitioner who issued the order within 5 days of receiving the order.

(4) If the occupational therapist who receives an oral order provides services in a setting that is independent of the prescriber's setting, the occupational therapist may accept the countersignature of the ordering practitioner on a written copy of the order that is mailed or faxed to the occupational therapist.

(5) If an occupational therapist provides services in a facility licensed by the Department of Health, the countersignature of the ordering practitioner shall be obtained in accordance with the applicable regulations of the Department of Health governing the facility, including 28 Pa. Code §§ 211.3 and 601.31 (relating to oral and telephone orders; and acceptance of patients, plan of treatment and medical supervision).

[Pa.B. Doc. No. 06-1905. Filed for public inspection September 29, 2006, 9:00 a.m.]

STATE BOARD OF PHYSICAL THERAPY

[49 PA. CODE CH. 40]

Biennial Renewal Fees

The State Board of Physical Therapy (Board) proposes to amend § 40.5 (relating to fees) to read as set forth in Annex A. The proposed rulemaking increases the biennial license renewal fee for physical therapists from $37 to $90, increases the biennial renewal fee for certificates to practice physical therapy without a referral from $37 to $45 and increases the registration renewal fee for physical therapist assistants from $20 to $45.

Effective Date

The proposed rulemaking will be effective upon final-form publication in the *Pennsylvania Bulletin*. The increased fees will be effective for the renewal period beginning January 1, 2009.

Statutory Authority

Section 8(b) of the Physical Therapy Practice Act (act) (63 P. S. § 1308(b)) requires the Board to increase fees by regulation to meet or exceed projected expenditures if the revenues raised by fees, fines and civil penalties are not sufficient to meet Board expenditures.

Background and Purpose

The Board's current biennial license renewal fees for physical therapists and physical therapist assistants were adopted at 18 Pa.B. 4952 (November 5, 1988). The Board's current biennial renewal fees for certificates to practice physical therapy without a referral were adopted at 34 Pa.B. 3700 (July 16, 2004). Under section 8(b) of the act, the Board is required by law to support its operations from the revenue it generates from fees, fines and civil penalties. In addition, the act provides that the Board must increase fees if the revenue raised by fees, fines and civil penalties is not sufficient to meet expenditures over a 2-year period. The Board raises virtually all of its revenue through biennial renewal fees.

At Board meetings in January and March, 2006, the Department of State's Offices of Revenue and Budget presented a summary of the Board's revenue and expenses for Fiscal Year (FY) 2003-2004 and FY 2004-2005, and projected revenue and expenses through FY 2012-2013. The Offices of Revenue and Budget projected a deficit of $282,664.81 in FY 2007-2008, a deficit of $205,664.81 in FY 2008-2009, a deficit of $549,664.81 in FY 2009-2010, a deficit of $485,664.81 in FY 2010-2011, a deficit of $853,664.81 in FY 2011-2012 and a deficit of $814,664.81 in FY 2012-2013. The major reason for the deficits is that the renewal fees have not been increased since 1988. Those fees have carried the Board for almost 18 years. In addition, the need for an increase in fees is the result of an increase in the number of opened disciplinary cases over the last 3 fiscal years. In FY 2002-2003, there were 21 opened legal cases; in FY 2003-2004, there were 36 opened legal cases; and in FY 2004-2005, there was an all time high of 65 opened legal cases. As of May 11, 2006, there were 35 opened legal cases. The increase in the number of cases also resulted in an increase in hearing examiner expenses. As a result of the projected deficits, the Offices of Revenue and Budget recommended that the Board raise fees to meet or exceed projected expenditures, in compliance with section 8(b) of the act. The Budget Office anticipates that the proposed new biennial renewal fees will enable the Board to meet its estimated expenditures for at least 8 years.

Although the proposed fee increase is significant, it is not surprising. As already stated, the fees for physical therapists and physical therapist assistants have not been increased since 1988. Also, in spite of the proposed increases, the Board's new fees will still be lower than the surrounding states. For example, the following renewal fees are charged by neighboring states: biennial renewal fee for physical therapists in New Jersey is $110 and the biennial renewal fee for a physical therapist assistant is $100; in New York, physical therapists pay a triennial renewal fee of $155 and physical therapist assistants pay a triennial renewal fee of $50; in Delaware, physical therapists pay a biennial renewal fee of $90 and physical therapist assistants pay a biennial renewal fee of $90; physical therapists and physical therapist assistants pay a biennial renewal fee of $120 in Ohio; in West Virginia, physical therapists pay a biennial renewal fee of $120 and physical therapist assistants pay a biennial renewal fee of $80; and in Maryland, physical therapists pay a biennial renewal fee of $175 and physical therapist assistants pay a biennial renewal fee of $150.

Description of Proposed Amendments

Based upon the expense and revenue estimates provided to the Board, the Board proposes to amend § 40.5 to increase the fee for biennial renewal of licenses for physical therapists from $37 to $90, to increase the fee for biennial renewal of certificates to practice physical therapy without a referral from $37 to $45 and to increase the fee for biennial renewal of registrations to practice as physical therapist assistants from $20 to $40.

Fiscal Impact

The proposed rulemaking increases the biennial renewal fee for physical therapists, holders of a certificate to practice physical therapy without a referral and physical therapist assistants. The proposed rulemaking should have no other fiscal impact on the private sector, the general public or political subdivisions.

Paperwork Requirements

The proposed rulemaking will require the Board to alter some of its forms to reflect the new biennial renewal fees. However, the proposed rulemaking should not create additional paperwork for the private sector.

Sunset Date

The act requires that the Board monitor its revenue and cost on a fiscal year and biennial basis. Therefore, no sunset date has been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 20, 2006, the Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Consumer Protection and Professional Licensure Committee and the House Professional Licensure Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Board, the General Assembly and the Governor of comments, recommendations or objections raised.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding this proposed rulemaking to Robert Kline, Administrative Assistant, State Board of Physical Therapy, P. O. Box 2649, Harrisburg, PA 17105-2649 within 30 days of publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference No. 16A-6511, Biennial Renewal Fees, when submitting comments.

CHARLES E. MEACCI, PT,
Chairperson

Fiscal Note: 16A-6511. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 40. STATE BOARD OF PHYSICAL THERAPY

Subchapter A. PHYSICAL THERAPISTS

GENERAL PROVISIONS

§ 40.5. Fees.

The following fees are charged by the Board:

Physical therapist:

* * * * *

Biennial renewal..... $**[37]90**

* * * * *

Biennial renewal of Certificate to Practice Physical Therapy without a referral..... $**[37]45**

* * * * *

Physical therapist assistants:

* * * * *

Biennial renewal of registration..... $**[20]45**

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[Pa.B. Doc. No. 06-1906. Filed for public inspection September 29, 2006, 9:00 a.m.]

STATE BOARD OF VETERINARY MEDICINE

[49 PA. CODE CH. 31]

Recordkeeping

The State Board of Veterinary Medicine (Board) proposes to amend § 31.22 (relating to recordkeeping rationale) to read as set forth in Annex A. The proposed rulemaking provides greater specificity to the Board's existing recordkeeping regulation. In addition, the proposed rulemaking sets forth the proper procedures for a veterinarian who is retiring or closing an office. Finally, the proposed rulemaking provides mandates for veterinary medical records from vaccine clinics.

Effective Date

The proposed rulemaking will be effective upon final-form publication in the *Pennsylvania Bulletin*.

Statutory Authority

Section 27.1 of the Veterinary Medicine Practice Act (act) (63 P. S. § 485.27a) requires the Board to promulgate regulations setting forth recordkeeping standards.

Background and Need for Amendment

Through the adjudication of numerous disciplinary cases over the past several years, the Board has determined the need to set additional requirements in its regulation of veterinary medical recordkeeping.

The reasons for this proposed rulemaking are threefold. First, the proposed rulemaking mandates contents of medical records and further defines acceptable standards of veterinary medical recordkeeping practice in this Commonwealth. Second, the Board proposes minimum standards of records when veterinarians provide service in vaccination clinics. Finally, the Board proposes to add paragraph (10) to provide mandates for veterinarians who are retiring or closing their veterinary practices.

The Board is aware of the public health benefits of vaccination clinics. Public health vaccination clinics inoculate animals against diseases, such as rabies, that pose a threat to human health. Public health clinics are relatively common in this Commonwealth and serve to promote public health and safety. Animal health vaccination clinics inoculate animals against diseases, such as distemper, that pose a threat to animal health. Some animal owners do not obtain routine animal health vaccinations at a veterinary office. Thus, animal health vaccination clinics, while not ideal, serve to promote animal health and welfare.

Veterinarians have expressed confusion over the minimum recordkeeping requirements for these clinics. The proposed rulemaking recognizes that the acceptable and prevailing standards of practice for recordkeeping for public health and animal health vaccination clinics require only a minimum of information as compared to the entire veterinary medical record, of which vaccine history is but one part. The proposed rulemaking protects the public by mandating that a veterinarian who participates in a vaccination clinic provide a means for clients to obtain information should an adverse reaction occur.

Finally, the Board has received numerous inquiries regarding a veterinarian's recordkeeping responsibilities when closing a veterinary practice, which the Board also addresses in this proposed rulemaking.

Description of Proposed Amendments

The general requirement that records be kept so that a veterinarian may, by reading the record, proceed with the proper care and treatment of an animal has been moved from current § 31.22(1). The proposed rulemaking would adopt the problem oriented medical record (POMR) or similar recordkeeping system. POMR is a recognized standard form of all medical recordkeeping. It involves creation of a record listing subjective and objective data, assessment and evaluation and a treatment plan. POMR recordkeeping is taught in all schools of veterinary medicine as the standard for veterinary practice. The Board also proposes language to note that the Board reviews veterinary medical records to determine the advice given and treatment recommended and performed by a veterinarian. Current paragraph (1) is deleted.

Proposed paragraph (1) is a general provision that requires a separate veterinary medical record for each patient, herd or group, as appropriate. This requirement accounts for differences in practice between veterinarians whose patients are companion animals and veterinarians whose patients are production animals. Proposed paragraph (1) also requires that veterinary medical records be accurate, legible and complete, as more fully set forth in proposed paragraph (3). Finally, proposed paragraph (1) requires that the veterinary medical record identify the treating individual after each entry. This requirement assists in communication among members of a practice or a subsequent treating veterinarian and allows for accurate review of the treatment provided to an animal.

Proposed paragraph (2) sets forth specific requirements for identifying the patient, herd or group. This paragraph is drafted to apply to both companion and production animals.

Proposed paragraph (3) sets forth the specific requirements for documenting the animal's medical history, tests, diagnoses and treatment provided.

Proposed paragraph (4) sets forth requirements for documentation of client communication. This documentation is not mandated for production animal records. Production animal owners or herdsmen are generally knowledgeable and veterinarians for production animals often communicate telephonically with clients when veterinarians are not in offices where they could easily place notes in the clients' records. In these cases, the customary and acceptable practice is for veterinarians to record only that information that is medically significant. In addition, Federal law and regulation stringently regulate the recordkeeping requirements for these veterinarians. The Board concluded that it was not necessary to mandate that client communication be documented in production animal medical records.

The Board proposes to move the current mandate that veterinarians retain records for 3 years from current paragraph (1) to proposed paragraph (5).

The Board proposes to renumber paragraphs (2)—(4) as paragraphs (6)—(8). In proposed paragraph (8), the Board provides a time frame for the provision of veterinary medical records. The Board determined that a period of 3 business days from receipt of the client's written request for records was reasonable and would be workable even if the veterinarian were out of the office when the request was sent.

The Board proposes to add paragraph (9) regarding veterinary medical records for vaccination clinics. The proposed rulemaking balances the need for pertinent information with the need for brevity in the vaccination clinic setting by requiring only the most important information be recorded in that setting.

The Board proposes to add paragraph (10) to provide mandates for veterinarians who are retiring or closing their veterinary practices.

Regulated Communities

In drafting this proposed rulemaking, the Board solicited input from the State and regional veterinary medical associations. In addition, the Board specifically solicited input from production animal veterinarians.

Fiscal Impact

The proposed rulemaking should not have any fiscal impact on the Board's licensees or any other public or private group or sector.

Paperwork Requirements

The proposed rulemaking sets forth the existing acceptable standards of practice for recordkeeping. The proposed rulemaking does not enlarge the time that veterinarians must maintain veterinary medical records. There are not additional paperwork requirements created by the proposed rulemaking.

Sunset Date

The Board continuously monitors its regulations. Therefore, no sunset date has been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on September 20, 2006, the Board submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the Senate Consumer Protection and Professional Licensure Committee and the House Professional Licensure Committee. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Board, the General Assembly and the Governor of comments, recommendations or objections raised.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding this proposed rulemaking to Robert Kline, Administrator, State Board of Veterinary Medicine, P. O. Box 2649, Harrisburg, PA 17105-2649 within 30 days following publication of this proposed rulemaking in the *Pennsylvania Bulletin*.

THOMAS J. MCGRATH, D.V.M.,
Chairperson

Fiscal Note: 16A-5719. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 31. STATE BOARD OF VETERINARY MEDICINE

PROFESSIONAL CONDUCT

§ 31.22. Recordkeeping **[rationale]**.

Veterinary medical records serve as a basis for planning animal care and as a means of communicating among members of the veterinary practice. The records furnish documentary evidence of the animal's illness, hospital care and treatment and serve as a basis for review, study and evaluation of the care and treatment rendered by the veterinarian. **A veterinary medical record shall be kept in a problem-oriented or similar format that allows any veterinarian, by reading the record, to proceed with the care and treatment of the animal and allow the Board or other agency to determine the advice and treatment recommended and performed. This section does not apply to laboratory animal practice.**

(1) **[** ***Record retention.*** **A veterinarian shall maintain veterinary medical records of an animal so that any veterinarian coming into a veterinary practice may, by reading the veterinary medical record of a particular animal, be able to proceed with the proper care and treatment of the animal. Records shall be maintained for a minimum of 3 years from the date that the animal was last treated by the veterinarian.]**

Record required. **A veterinarian shall maintain a separate veterinary medical record for each patient, herd or group, as appropriate, which accurately, legibly and completely reflects the evaluation and treatment of the patient or patients. The**

veterinary medical record must identify the treating individual after each chart entry.

(2) *Identity of patient.* The veterinary medical record must include, at a minimum, the following information to identify the patient, herd or group:

(i) Client identification.

(ii) Appropriate patient identification, which may include species, breed, age, sex, weight, name or identity number or numbers, color and identifying markings, and whether neutered, spayed or intact.

(3) *Minimum content of record.* The veterinary medical record must include:

(i) Vaccination history.

(ii) Previous medical history, presenting symptoms and complaint.

(iii) Date of each examination.

(iv) Diagnosis.

(v) Results and findings of pathological or clinical laboratory examination.

(vi) Findings of radiological examination.

(vii) Medical or surgical treatment.

(viii) Other diagnostic, corrective or therapeutic procedures.

(ix) Documentation of drugs administered, prescribed or dispensed, including dosage.

(x) Documentation of surgical and dental procedures, including type and dosage of anesthesia, and dental charting.

(4) *Communication with client.* The veterinary medical record of any animal, except a production animal, shall document communication with the client, including the client's consent to or rejection of recommended diagnostic tests, treatments and drugs.

(5) *Retention of records.* Records shall be maintained for a minimum of 3 years from the date that the animal was last treated by the veterinarian.

[(2)] (6) * * *

[(3)] (7) * * *

[(4)] (8) *Release of information to clients.* A veterinarian shall release a summary or a copy of the veterinary medical records of an animal to the client **[upon] within 3 business days of receipt of the client's** written request. A veterinarian may charge a reasonable fee for duplicating veterinary medical records and for preparation of veterinary medical record file summaries for release to clients. A veterinarian may not withhold the release of veterinary medical records or summaries to clients for nonpayment of a professional fee. The release of veterinary medical records or summaries to clients under these circumstances does not constitute a waiver by the veterinarian of the fee claimed.

(9) *Veterinary medical records for vaccination clinics.* A veterinarian providing veterinary medical services to the public for a public health vaccination clinic or an animal health vaccination clinic shall prepare a veterinary medical record that includes, at a minimum, an identification of the client and patient, the vaccine lot number, and the date and dosage administered. A veterinarian who provides veterinary medical services to a vaccination clinic shall provide a means for clients to obtain advice pertaining to postvaccine reactions for the 24-hour period immediately following the time of vaccination.

(10) *Veterinary records of retiring veterinarian or a veterinary practice that is closing.* A veterinarian shall notify clients, in writing, at least 30 days prior to the date of a planned retirement or closing of a veterinary practice. The written notice must include instructions on how to obtain copies of veterinary medical records from the veterinarian or other custodian of the records and the name, address and telephone number of the person purchasing the practice, if applicable. Veterinary medical records must remain available to clients for 3 years after the date the veterinarian retires or the practice is closed. If prior notice could not be provided, a successor veterinarian shall notify clients within 60 days of the date the successor takes over the practice.

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