STATEMENTS OF POLICY

Title 49—BUREAU OF PROFESSIONAL AND VOCATIONAL STANDARDS

STATE BOARD OF CHIROPRACTIC

[49 PA. CODE CH. 5]

Patient Records—Statement of Policy

The State Board of Chiropractic (Board) hereby adopts § 5.51a (relating to patient records—statement of policy) to read as set forth in Annex A.

A. *Effective Date*

This statement of policy will be effective upon publication in the *Pennsylvania Bulletin*.

B. *Statutory Authority*

Section 302(3) of the Chiropractic Practice Act (act) (63 P. S. § 625.302(3)) authorizes the Board to promulgate, adopt, and enforce in the manner provided by law the rules and regulations necessary to carry out the act.

C. *Background and Purpose*

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 (63 P. S. § 625.506(a)(15)). The Board's regulation in § 5.51(c) (relating to patient records) 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. The Board initially intended to amend its regulations to provide licensees with this guidance and had published a notice of proposed rulemaking. (*See*, 36 Pa.B. 5979) Upon reviewing comments from the public, the House Professional Licensure Committee (HPLC) and the Independent Regulatory Review Commission (IRRC) under the Regulatory Review Act (71 P. S. §§ 745.1—745.12), the Board concluded that it should not set a binding norm. Instead, the Board concluded that it should set aspirational guidelines of how a licensee should document in a patient record that chiropractic care was clinically necessary.

D. *Description of the Statement of Policy*

Subsection (a) provides definitions for various terms used in this statement of policy, including "acute condition," "chronic care," "chronic condition," "elective care," "exacerbation," "maintenance care," "palliative care," "preventive service," "recurrence," "restorative care" and "supportive care."

Subsection (b) provides that the patient record regarding restorative care should contain documentation of the development of the patient's symptoms to include the mechanism of onset and the functional limitations associated with the presenting symptoms. The documentation should additionally detail the diagnostic test results and examination findings/indications (diagnosis) that form the objective basis for the symptoms and functional limitations. The course of treatment necessary to ameliorate the patient's condition should be identified to include the specific therapeutic modalities or procedures to be utilized. The documentation must also identify the specific functional results or goals of treatment that are planned. Subsequent documentation should identify changes in the patient's subjective or objective state that provide evidence of the provider's continuing expectation that additional improvement will occur with additional treatment. Any changes in the plan of care or anticipated outcomes should be identified to include the clinical rationale for these changes. When the patient reaches a functional plateau, the documentation should detail the results obtained and whether the patient was transitioned to another form of care or was discharged. When the patient self-dismisses or otherwise terminates care, the documentation should so indicate and identify the rationale for termination and the results achieved, if any. For restorative and necessary chronic care, documentation should contain information that supports that the treatment, care or service was reasonably expected to improve the patient's condition at the time it was rendered; assisted the patient to achieve maximum functional capacity in performing daily, recreational, social or occupational activities; improved the patient's condition; was provided consistent with the treating doctor's diagnosis; or was provided consistent with the patient's active symptomatology, functional complaint or abnormal physical findings.

Subsection (c) provides that the patient record regarding maintenance care should demonstrate how the care sought to promote health or functional status, or both. For maintenance care, documentation should contain information that supports that the treatment, care or service assisted the patient to maintain the patient's capacity to perform daily, recreational, social or occupational activities; was provided consistent with the treating doctor's diagnosis; or was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

Subsection (d) provides that the patient record regarding palliative care should 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. For palliative care, documentation should contain information that supports that the treatment, care or service alleviated the patient's pain; mitigated the severity of the patient's symptoms; was provided consistent with the treating doctor's diagnosis; or was provided consistent with the patient's active symptomatology, functional complaint or abnormal physical findings.

Subsection (e) provides that the patient record regarding preventive care should include a history and documentation of examination, counseling and risk factor reduction. For preventative care, documentation should contain information that supports that the treatment, care or service prevented the onset of a condition that might result in permanent disability; prevented the worsening of the patient's condition; reduced the risk of subsequent injury; where appropriate was provided consistent with the treating doctor's diagnosis; or where appropriate was provided consistent with the patient's active symptomatology, functional complain or abnormal physical findings.

Subsection (f) provides that the patient record regarding elective care should demonstrate how care was intended to enhance the patient's level of health, wellness

or general well-being. For elective care, documentation should contain information that supports that the treatment, care or service was reasonably expected to improve the patient's level of health, wellness or general well-being; or where appropriate was provided consistent with the treating doctor's diagnosis.

Subsection (g) provides that the patient record regarding supportive care should 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.

Subsection (h) provides that documentation concerning diagnostic tests should address 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; the extent to which the diagnostic test facilitated the proper or effective management or control of the patient's condition, including monitoring of condition; or how the diagnostic test quantified an objective status of the patient's condition or functional capacity.

E. *Public Input*

The Board received a request from an attorney representing various licensees to promulgate a regulation that would establish medical necessity definitional parameters to assist licensees to discharge their regulatory documentation obligation and establish guidelines for peer review and utilization review concerning chiropractic care. The Board held a work session on March 7, 2002. After extensive discussion at public meetings over the ensuing months, the Board concluded that its rulemaking should be directed toward setting forth standards for medical records, not attempting to define what is medically necessary. The Board intended to amend its regulations to provide licensees with this guidance and published notice of proposed rulemaking at 36 Pa.B. 5979 (September 30, 2006) with a 30-day public comment period. The Board received written comments from the following members of the public: Michael D. Miscoe of PracticeMasters, Inc.; James H. Winer, DC and Raymond V. Vactor, DC. The Board also received comments from HPLC and IRRC as part of their review of proposed rulemaking under the Regulatory Review Act (71 P. S. §§ 745.1—745.12). The Board has considered all of these comments in drafting this statement of policy.

F. *Fiscal Impact and Paperwork Requirements*

There is no adverse fiscal impact or paperwork requirement imposed on the Commonwealth, political subdivision or private sector.

G. *Sunset Date*

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

KATHLEEN G. McCONNELL, DC,
Chairperson

(*Editor's Note*: The regulations of the Board, 49 Pa. Code Chapter 5, are amended by adding a statement of policy in § 5.51a (relating to patient records—statement of policy) to read as set forth in Annex A.)

Fiscal Note: Fiscal Note 16A-4319 remains valid for the final adoption of the subject regulation.

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 E. MINIMUM STANDARDS OF PRACTICE

§ 5.51a. Patient records—statement of policy.

This section provides guidance to licensees of how clinical necessity for chiropractic care under § 5.51(c) (relating to patient records) may be documented.

(1) *Definitions*. As used in this section, the following words and terms, have the following meanings, unless the context clearly indicates otherwise:

Acute condition—A patient's condition where the onset of the condition or symptoms, or both, has occurred or substantively worsened within a 6-week period prior to presentation and which is caused by some intervening event or trauma whether known or unknown.

Chronic care—Treatment of a chronic condition that is not expected to improve or resolve the chronic condition but is nonetheless expected to result in improvement in the patient's functional status that has regressed after a withdrawal of care.

Chronic condition—A patient's condition when the condition or symptomatology has existed for longer than 6 weeks. Classification of a condition as chronic in no way affects the expectation of whether the condition can be resolved or improved with treatment.

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

Exacerbation—A sudden, marked deterioration of the condition being treated, which causes a marked worsening in the patient's functional status, and which is caused by some intervening event or trauma, whether known or unknown.

Maintenance care—Treatment after maximum therapeutic benefit has been achieved from a course of treatment or care rendered for a chronic condition, which is not reasonably expected to improve substantively the patient's condition or functional capacity. Maintenance care is generally rendered on a predictable frequency and includes care for which the outcome is preventative, palliative or elective.

Palliative care—Treatment for an acute or chronic condition that is not reasonably expected to resolve or substantively improve the underlying injury, disease or defect and that is rendered with the sole expectation of ameliorating the patient's symptoms as opposed to significantly improving the patient's condition or capacity to function.

Preventive service—Service provided with the expectation of preventing worsening in a patient's chronic condition, preventing the onset of a condition, or reducing the risk of recurrence in a condition that has been treated and resolved. A service provided based upon findings uncovered during a preventive service examination is not a preventive service.

Recurrence—A return of an acute condition which was previously treated and resolved or stabilized and which has been quiescent for a period of time.

Restorative care—A course of active care provided that is reasonably expected to substantively improve the patient's condition or the patient's capacity to function.

Supportive care—Treatment for a condition once maximum therapeutic benefit has been established and after therapeutic treatment has been withdrawn two or more times with the patient failing to sustain previous therapeutic gains.

(2) *Restorative care.* The patient record regarding restorative care should contain documentation of the development of the patient's symptoms to include the mechanism of onset and the functional limitations associated with the presenting symptoms. The documentation should additionally detail the diagnostic test results and examination findings/indications (diagnosis) that form the objective basis for the symptoms and functional limitations. The course of treatment necessary to ameliorate the patient's condition should be identified to include the specific therapeutic modalities or procedures to be utilized. The documentation should also identify the specific functional results or goals of treatment that are planned. Subsequent documentation should identify changes in the patient's subjective or objective state that provide evidence of the provider's continuing expectation that additional improvement will occur with additional treatment. Any changes in the plan of care or anticipated outcomes should be identified to include the clinical rationale for these changes. When the patient reaches a functional plateau, the documentation should detail the results obtained and whether the patient was transitioned to another form of care or was discharged. When the patient self-dismisses or otherwise terminates care, the documentation should so indicate and identify the rationale for termination and the results achieved, if any. Documentation of restorative care and necessary chronic care should contain information to support that it satisfies at least one of the following:

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

(ii) It assisted the patient to achieve maximum functional capacity in performing daily, recreational, social or occupational activities.

(iii) It improved the patient's condition.

(iv) It was provided consistent with the treating doctor's diagnosis.

(v) It was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(3) *Maintenance care.* The patient record regarding maintenance care should demonstrate how the care sought to promote health or functional status, or both. Documentation of maintenance care should contain information to support that it satisfies at least one of the following:

(i) It assisted the patient to maintain the patient's capacity to perform daily, recreational, social or occupational activities.

(ii) It was provided consistent with the treating doctor's diagnosis.

(iii) It was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(4) *Palliative care.* The patient record regarding palliative care should 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. Documentation of palliative care should contain information to support that it satisfies at least one of the following:

(i) It alleviated the patient's pain.

(ii) It mitigated the severity of the patient's symptoms.

(iii) It was provided consistent with the treating doctor's diagnosis.

(iv) It was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(5) *Preventative care.* The patient record regarding preventive care should include a history and documentation of examination, counseling and risk factor reduction. Documentation of preventative care should contain information to support that it satisfies at least one of the following:

(i) It prevented the onset of a condition that might result in permanent disability.

(ii) It prevented the worsening of the patient's condition.

(iii) It reduced the risk of subsequent injury.

(iv) It was provided consistent with the treating doctor's diagnosis.

(v) It was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(6) *Elective care.* The patient record regarding elective care should demonstrate how care was intended to enhance the patient's level of health, wellness or general well-being. Documentation of elective care should contain information to support that it satisfies at least one of the following:

(i) It was reasonably expected to improve the patient's level of health, wellness or general well-being.

(ii) Where applicable, it was provided consistent with the treating doctor's diagnosis.

(7) *Supportive care.* The patient record regarding supportive care should 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.

(8) *Diagnostic tests.* Documentation concerning diagnostic tests should 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.

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