Practice Masters
INCORPORATED
CERTIFED CODING/COMPLIANCE EXPERTS

1032 Peninsula Drive Central City, PA 15926
Phone: (814) 754-1550 Fax: (814) 754-1553
On The Web: http://www.pmrcodingexperts.com

Michael D. Miscoe CPC, CHCC, CRA
mmiscoe@pmrcodingexperts.com

2568

October 12, 2006

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

To Tom Blackburn

~~Deborah L. Smith~~
Administrator, State Board of Chiropractic
P. O. Box 2649
Harrisburg, PA 17105-2649

Re: **COMMENTS AND SUGGESTIONS REGARDING PROPOSED RULEMAKING**
State Board of Chiropractic
Reference No. 16A-4313 (patient records)

Dear Ms. Smith:

Practice Masters is a compliance consulting firm that provides compliance and expert coding and documentation analysis to over 500 licensed DCs in Pennsylvania. Please treat this correspondence as Practice Master's comments and suggestions for correction to the State Board of Chiropractic's Proposed Rulemaking relating to Patient Records published at 49 Pa. Code Ch. 5. The Proposed Rulemaking was published at 36 *Pa. Bulletin* 5979 (September 30, 2006). Each issue and suggestion is addressed as follows.

BACKGROUND
The State Board of Chiropractic has proposed to amend §§5.1 and 5.51 of the licensure regulations according to an announcement of the Board in the Pennsylvania Bulleting (36 Pa.B. 5979, Saturday, September 30, 2006).

The proposed changes affect the definitions and patient records sections of the regulations. While not disclosed, recent HHS OIG CERT results claiming that 67% of DC claims to Medicare were non-compensable due to insufficient documentation is a likely the motivating force.

Poor documentation is the most common error assigned in postpayment claims analysis. Insurance companies nationwide, including CMS, have taken advantage of incomplete documentation as a means of arguing that care rendered was not medically necessary. While complete documentation does not guarantee that services are necessary, documentation does provide important evidence for making such a determination.

It is for this reason that such changes are necessary and I support the action of the Pennsylvania Board. While there are some minor semantic corrections that should be made to the proposed definitions and record content requirements, the proposal of the Board to require

DCs to document the necessity of care effectively is the right one. I hope that between the proposed regulation and the final version, the changes outlined below will be made so that the regulation achieves its purpose and does not create confusion.

RECOMMENDATIONS

Section 5.1 (Definitions) of the regulations adds several terms and definitions. Elective care, exacerbation, maintenance care, palliative care, preventive service, recurrence, and supportive care are defined.

A review of the proposed definitions of these terms reveals overlap between the definitions of Maintenance, Palliative, Preventive and Supportive care that could cause confusion. The confusion is easily resolved where the definitions of each care type are focused on the outcome intended by the treatment that is ordered or planned. Each type of care identified by the board is addressed as follows:

MAINTENANCE CARE

We will begin with the definition of maintenance care, which is defined in the proposed regulations as follows:

> *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.*

Comment:

The first element of the definition suggests that a patient receiving maintenance care has some degree of symptomatology that is not being positively affected by the treatment. Where this is the case, there is no apparent need to perform the service. Therefore, as written, the definition of maintenance care would suggest that care not expected to positively affect the patient's condition is appropriate to perform. It is not clear whether this was the board's intent.

The second element suggests that the care is being performed despite the lack of any abnormal clinical finding. This component of the definition is concerning as manipulation and/or therapy designed to maintain a patient's functional status is, in most cases, provided where abnormal clinical findings exist. Additionally, assuming there was no abnormal clinical finding, there is again no apparent need to provide any treatment.

The third element suggests that the ***failure to achieve*** a functional outcome renders the care maintenance in nature. Such an "after-the-fact" determination conflicts with the "reasonable expectation" of an outcome requirement that generally defines the type of care. The existence of this element could result in care that was medically necessary because the provider had a reasonable expectation of achieving a functional result becoming maintenance care after the fact because that result was not actually achieved. If this element were drafted as describing care "not reasonably expected" to result in an improvement in the patient's functional status, no such after the fact objection could occur.

The fourth element suggests that care that is not palliative or supportive is maintenance. This element excludes preventive care. As a result, this could be construed as meaning that preventive and maintenance care are the same. It is not clear whether this was the intent of the board. Providing separate definitions of these terms would suggest otherwise. The essence of maintenance care is that the care, either by virtue of the condition or the frequency of care, is ***not expected*** to improve the patient's condition or improve the patient's functional status. This is not to say that maintenance care is necessarily preventive or vice-versa. While in some cases, both maintenance of functional capacity and prevention of worsening in an underlying condition may both be anticipated, this is not necessarily always the case.

Based on the concerns expressed above, it is suggested that the definition of Maintenance care be amended as follows:

> ***Maintenance care***-- Treatment after the 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 preventive, palliative or elective.

PALLIATIVE CARE

The definition of palliative care is appropriate but conspicuously avoids the symptomatic focus of such treatment. The proposed definition is as follows:

> *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.*

Comment:

Theoretically, palliative care could be rendered for an acute condition or an exacerbation. Consider the case where the patient has an acute condition but refuses to present on a frequency of care that would permit the provider from having a reasonable expectation of causing substantive improvement. As a result, care is rendered simply to ameliorate the patient's symptoms. The key distinction of palliative care is again the outcome. Substantive or long-term functional restoration is not expected and as a result, the goal of care is simply to reduce the patient's symptoms. On this basis, the following change to the definition is suggested:

> ***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 CARE

Similar to the comments made with respect to palliative care, the definition of preventive care requires minor modification. The proposed definition is as follows:

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.

Comment:
The attempt here seems to be to define care based on what it is not. Either preventive care could be for an asymptomatic patient OR for a patient that has reached maximum improvement. Many patients reach maximum improvement without complete amelioration of symptoms and have a need for palliative care. Some patient's with treatable conditions that cause functional deficits do not have symptoms and may have a need for supportive care. Based on the proposed definition, neither of these scenarios is preventive care and I agree; however, this definition does not define what preventive care is but instead only tells us what preventive care is not. To eliminate the confusion, the following is suggested:

Preventive service--Service provided with the expectation of 1) preventing worsening in a patient's chronic condition; 2) preventing the onset of a condition; or 3) 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.

ELECTIVE CARE
The final type of care addressed in the proposed regulations is termed "Elective Care." The following definition is proposed by the Board:

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

Comment:
Once again, not only is the outcome expected from such care not disclosed, but also the definition raises the question as to why such care would be rendered. Where there are no symptoms or findings, presumably even subluxation, why would care be rendered? There is apparently nothing to treat. Such care might more appropriately be termed "Clinically Unnecessary Care." Such a conclusion, however, is not possible where the proposed changes to the patient record requirements are viewed. In that portion of the regulation, a provider must document elective care as follows: "*Regarding elective care, the patient record must demonstrate how human performance and the sense of well-being was enhanced.*" This would seem to suggest that the care has to have some impact on performance and well-being. The performance element would seem to suggest that a functional result was required. If this is so, how can a functional result be achieved where there is no symptom or condition identified from examination or testing?

Ultimately, it is not clear that a definition of "elective care" is necessary. Elective care generally defines care for which there is no clinical need. I doubt this is what the board intended; however, it is possible that the Board is attempting to define "Wellness Care." This is not clear. If this is the case, a component of maintenance care as defined by CMS should be utilized in the definition of elective care as follows:

> ***Elective Care***--Care provided with the expectation of improving the health, wellness or general well being of the patient.

Such care might be restoration of normal bio-mechanics or what is commonly called "corrective care" where such restoration is not necessary to restore the patient's capacity for activity. This type of care is rendered after the patient functionally plateaus or is already capable of performing daily, recreational, and occupational activities without significant risk of upset or injury.

As further support for the revised definitions provided, each is properly focused on the outcome intended and the nexus between palliative, preventive, elective and maintenance care is clear.

SUPPORTIVE CARE

Of the types of care that are generally considered "medically necessary" by most carrier standards, including CMS, the Board only attempts to define "Supportive Care." The term and definition proposed for supportive care is troublesome in several respects. First, it does not capture the expected outcome of such care and second, the terminology used may create difficulty with Medicare and private payor claims. True "supportive" care should be covered by Medicare; however, a recent change to the CMS definition of "Maintenance Care" includes the term "supportive." (Medicare Benefit Policy Manual, Pub 100-2 Chapter 15, Section 240.3). Based on the inclusion of this term in the CMS definition of maintenance care, CMS seems to have concluded either that all treatment for a chronic condition is maintenance or it has incorrectly assessed what supportive means. With respect to the former, the outcome of supportive care and maintenance care are clearly different and therefore they cannot be the same. Where the definition of "supportive" care is considered, we find this type of care should be covered under CMS program rules related to medical necessity. As a result, it is more likely that CMS's inclusion of the term "supportive" in its definition of maintenance care is based on a misunderstanding of what this type of care involves. For this reason, the terminology for this type of care should be changed to "Chronic Care" so that confusion is not created between this type of care and maintenance care based on the Medicare definition. The proposed regulations define "supportive care" as follows:

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

Once again, the problem with this definition is that it fails to define the outcome of this type of care. The following is suggested as a replacement, not only for the term, but the definition:

> ***Chronic Care***--Treatment of a chronic condition, which is not expected to improve or resolve the underlying condition but is nonetheless expected to result in improvement in the patient's functional status that has regressed after a withdrawal of care. Specifically, necessary chronic care is appropriate where: 1) The patient has reached maximum functional improvement from a course of conservative treatment and the underlying condition is not resolved or resolvable; 2) the patient's condition is such that there is no expectation of improvement from rehabilitative care or such care is contraindicated; 3) The patient's activity level exceeds their functional tolerance such that, over a period of time, and without an intervening acute event, the patient's condition and functional status is expected to regress

substantively without an intervening trauma; 4) After such substantive regression occurs, a course of care is provided that is reasonably expected to improve the patient's condition and/or restore the patient's functional capacity to a level of maximum improvement; and 5) Once maximum functional improvement is restored, the patient is dismissed.

OTHER UNDEFINED CARE TYPES

There are a number of other care types that are not defined in the Proposed Regulation. These include a definition for clinically necessary and medically necessary or restorative care.

CLINICALLY NECESSARY CARE

The intent of the definition changes would suggest that care that met any definition would be considered clinically necessary or appropriate care. If this is the case, the regulation should include the following term and definition:

Clinically Necessary Care--Any care that is rendered and may be defined as restorative, chronic, maintenance, palliative, preventive, or elective.

MEDICALLY NECESSARY/RESTORATIVE CARE

The most critical definition that is omitted from the Proposed Regulations is the definition of care that is considered "Medically Necessary" care. While a statutory/regulatory definition of medically necessary care is desirable, this term is often defined in both subscriber and provider contracts with insurance companies. To avoid confusion, the term "Restorative Care" is suggested. The following definition of restorative or medically necessary care is suggested:

Restorative/Medically Necessary Care--A course of care provided that is reasonably expected to substantively improve the patient's condition or the patient's capacity to function.

Comment:

The term "course of care" is suggested because such care cannot be evaluated in the microcosm of a single encounter. Substantive improvement is a necessary requirement from the standpoint of recognizing common requirements that the amount of care rendered be evaluated in relationship to the amount of improvement gained. Extensive amounts of care that result in minor improvements are not generally considered restorative or medically necessary.

RECOMMENDATION

It is recommended that the revised terms and definitions for the various types of care identified above be used in Section 5.1 of the regulations for the reasons stated.

CONDITION DEFINITIONS IN THE PROPOSED REGULATIONS

Of the many types of conditions that may require one of the various types of treatment, the Proposed Regulations at section 5.1 define only two: "Exacerbation" and "Recurrence." The proposed definitions are as follows:

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

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

Comment:
With respect to an exacerbation, it is important to note that the deterioration generally occurs suddenly, and there is generally a resultant worsening in the patient's functional status. This is not clear from the definition in the Proposed Regulations as written although this is plausibly inferred.

With respect to a recurrence, the definition does not specify a period of time for which a condition must be quiescent before it is considered a recurrence. While not clear that this is necessary, a thirty-day period is referenced in most texts that define this term. If the symptoms were quiescent for 30 days, the prior condition could be considered to have actually resolved. Resolution of the prior condition is the delineating element between a recurrence and an exacerbation. In addition, a recurrence differs from a chronic regression in the important respect that with a recurrence, the prior condition was treated and resolved. With a chronic condition that regresses, the prior condition was not resolved. Often with a recurrence there is an acute event or mechanism. This is generally not the case with a chronic condition that regresses naturally over time.

The types of conditions not defined are the most common; specifically, acute and chronic conditions. The following definitions are suggested as a complete list of possible conditions:

> ***Acute Condition*** - A patient's condition is considered acute when the onset of the condition and/or symptoms has occurred or substantively worsened within a six-week period prior to presentation and which is caused by some intervening event or trauma whether known or unknown.
>
> ***Chronic Condition*** - A patient's condition is considered chronic when the condition or symptomatology has existed for longer than six weeks. Classification of a condition as chronic in no way effects the expectation of whether the condition can be resolved or improved with treatment.
>
> ***Exacerbation*** - Exacerbation is 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.
>
> ***Recurrence*** - A recurrence is the return of an acute condition which was previously treated and resolved or stabilized and which has been quiescent for a period of time.

RECOMMENDATION
It is recommended that the terms and definitions identified above be included in Section 5.1 of the regulations for the reasons stated.

PATIENT RECORD DOCUMENTATION REQUIREMENTS
Section 5.51 (c) of the regulations has been revised to establish the minimum standards of documentation but does so only in a conceptual way. Subsection (1) requires information that suggests that the care meets one of the care types identified above.

RECOMMENDATION

It may be clearer if the elements of subsection (1) were associated with their respective condition types. The following changes to subsection (1) are therefore suggested as follows:

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

(i) Restorative Care and Necessary Chronic Care:

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

(b) Assisted the patient to achieve maximum functional capacity in performing daily, recreational, social or occupational activities;

(c) Improved the patient's condition;

(d) Was provided consistent with the treating doctor's diagnosis; or

(e) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(ii) Maintenance Care;

(a) Assisted the patient to maintain their capacity to perform daily, recreational, social or occupational activities;

(b) Was provided consistent with the treating doctor's diagnosis; or

(c) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(iii) Palliative Care;

(a) Alleviated the patient's pain;

(b) Mitigated the severity of the patient's symptoms;

(c) Was provided consistent with the treating doctor's diagnosis; or

(d) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(iv) Preventive Care; or

(a) Prevented the onset of a condition that might result in permanent disability;

(b) Prevented the worsening of the patient's condition;

(c) Reduced the risk of subsequent injury;

(d) Where appropriate was provided consistent with the treating doctor's diagnosis; or

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

(v) Elective Care;

(a) Was reasonably expected to improve the patient's level of health, wellness or general well being; or

(b) Where appropriate, was provided consistent with the treating doctor's diagnosis.

With subsection (1) restructured in this manner, subsection (3) of the proposed regulation can be eliminated. Even without the suggested changes to subsection (1), elimination of subsection (3) is necessary because it duplicates the requirements of subsection (4).

Subsection (2) is appropriate as written.

Subsection (4) (which would become subsection (3)) is titled "Specific treatment or care must be documented as follows:" and addresses (or should address) the necessity of documenting the outcomes for elective, maintenance, palliative and preventive care. The requirements for elective care speak in terms of outcomes achieved instead of outcomes anticipated. This section should also be amended to address restorative and chronic care.

RECOMMENDATION

Subsection (4)(i) as revised to subsection (3)(i) should be amended as follows:

(i) Regarding elective care, the patient record must demonstrate how care was intended to enhance the patient's level of health, wellness, or general well being.

SUPPORTIVE CARE

The proposed documentation requirements for "supportive care" at §5.51(c)(4)(v) confuse the critical distinction between necessary chronic care and the care necessary subsequent to acute events like a recurrence or an exacerbation. A recurrence presupposes that the prior instance of the condition was resolved. This is not the case with supportive/chronic care. Both a recurrence and an exacerbation are generally brought on by some intervening influence. Where this is the case, the two trials of withdrawal would not appear to be relevant. This section seems to suggest that a provider should deny provision of services to a patient presenting with an exacerbation or recurrence where there were not two prior therapeutic withdrawals. The concept of withdrawal to establish the need for ongoing chronic care is rooted in the requirement that in order for such care to be considered restorative, the provider must first demonstrate that the underlying condition is not only unresolvable, but is expected to regress naturally as a result of the stress of the patient's daily activities. Where care is withdrawn and the patient does in fact regress functionally, the basis for chronic restorative care is established.

RECOMMENDATION
The following revision to current subsection (4)(v), which will become subsection (3)(v) is suggested:

(v) Regarding chronic 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. The progression of the patient's condition from the prior dismissal to the current presentation should be documented to include the degree of functional decline. The course of care necessary to restore the patient's functional ability to maximum improvement must be documented and the specific functional outcomes should be identified. The patient record need not demonstrate functional improvement beyond the previously established maximum therapeutic level.

RESTORATIVE CARE
Based on the proposed revision to the definitions, it is necessary to define documentation requirements for restorative/medically necessary care.

RECOMMENDATION
The following addition to subsection (4), which will become subsection (3) is suggested:

(vi) Regarding restorative care, the patient record must 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 must 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 status 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 must be identified to include the clinical rationale for such changes. Where 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. Where the patient self-dismissed or otherwise terminated care, the documentation should so indicate and identify the rationale for termination and the results achieved if any.

CONCLUSION
While the changes suggested seem numerous, when implemented, the Board will have an end product that will appropriately delineate the types of care provided; will consistently define the type of care based on the outcome intended; and will create documentation requirements for each type of care that are consistent with the definitions of that care type. Additionally, the revisions to the condition definitions provide a more objective and consistent basis for defining the condition such that confusion will be avoided. Finally, as amended, the regulations will be consistent with documentation standards in the industry so that confusion is not created between payor system requirements and regulatory requirements. I have included as an attachment, a version of the Proposed Regulation that incorporates the changes suggested for review.

Please advise if you require any further information.

Sincerely,

Michael D. Miscoe BS, CPC, CHCC, CRA
President
Practice Masters, Inc.

Enclosure: Proposed Regulation - Revised

STATE BOARD OF CHIROPRACTIC

[49 PA. CODE CH. 5]

Patient Records

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:

***Acute Condition*--A patient's condition is considered acute when the onset of the condition and/or symptoms has occurred or substantively worsened within a six-week period prior to presentation and which is caused by some intervening event or trauma whether known or unknown.**

* * * * *

***Chronic Condition*-- A patient's condition is considered chronic when the condition or symptomatology has existed for longer than six weeks. Classification of a condition as chronic in no way effects the expectation of whether the condition can be resolved or improved with treatment.**

***Chronic Care*--Treatment of a chronic condition, which is not expected to improve or resolve the underlying condition but is nonetheless expected to result in improvement in the patient's functional status that has regressed after a withdrawal of care. Specifically, necessary chronic care is appropriate where: 1) The patient has reached maximum functional improvement from a course of conservative treatment and the underlying condition is not resolved or resolvable; 2) the patient's condition is such that there is no expectation of improvement from rehabilitative care or such care is contraindicated; 3) The patient's activity level exceeds their functional tolerance such that, over a period of time, and without an intervening acute event, the patient's condition and functional status is expected to regress substantively without an intervening trauma; 4) After such substantive regression occurs, a course of care is provided that is reasonably expected to improve the patient's condition and/or restore the patient's functional capacity to a level of maximum improvement; and 5) Once maximum functional improvement is restored, the patient is dismissed.**

***Clinically Necessary Care*--Any care that is rendered and may be defined as restorative, chronic, maintenance, palliative, preventive, or elective.**

* * * * *

***Elective Care*--Care provided with the expectation of improving the health, wellness or general well being of the patient.**

***Exacerbation* -- Exacerbation is 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 the 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 preventive, 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 1) preventing worsening in a patient's chronic condition; 2) preventing the onset of a condition; or 3) 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 recurrence is the return of an acute condition which was previously treated and resolved or stabilized and which has been quiescent for a period of time.**

***Restorative/Medically Necessary Care*--A course of care provided that is reasonably expected to substantively improve the patient's condition or the patient's capacity to function.**

* * * * *

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**.

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

(i) Restorative Care and Necessary Chronic Care:

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

(b) Assisted the patient to achieve maximum functional capacity in performing daily, recreational, social or occupational activities;

(c) Improved the patient's condition;

(d) Was provided consistent with the treating doctor's diagnosis; or

(e) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(ii) Maintenance Care;

(a) Assisted the patient to maintain their capacity to perform daily, recreational, social or occupational activities;

(b) Was provided consistent with the treating doctor's diagnosis; or

(c) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(iii) Palliative Care;

(a) Alleviated the patient's pain;

(b) Mitigated the severity of the patient's symptoms;

(c) Was provided consistent with the treating doctor's diagnosis; or

(d) Was provided consistent with the patient's active symptomatology, functional complaint, or abnormal physical findings.

(iv) Preventive Care; or

(a) Prevented the onset of a condition that might result in permanent disability;

(b) Prevented the worsening of the patient's condition;

(c) Reduced the risk of subsequent injury;

(d) Where appropriate was provided consistent with the treating doctor's diagnosis; or

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

(v) Elective Care;

(a) Was reasonably expected to improve the patient's level of health, wellness or general well being; or

(b) Where appropriate, was provided consistent with the treating doctor's diagnosis.

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

(i) Regarding elective care, the patient record must demonstrate how care was intended to enhance the patient's level of health, wellness, or general well being.

(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 chronic 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. The progression of the patient's condition from the prior dismissal to the current presentation should be documented to include the degree of functional decline. The course of care necessary to restore the patient's functional ability to maximum improvement must be documented and the specific functional outcomes should be identified. The patient record need not demonstrate functional improvement beyond the previously established maximum therapeutic level.

(vi) Regarding restorative care, the patient record must 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 must 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 status 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 must be identified to include the clinical rationale for such changes. Where 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. Where the patient self-dismissed or otherwise terminated care, the documentation should so indicate and identify the rationale for termination and the results achieved if any.

* * * * *