

WAC 246-808-560 Documentation of care. A doctor of chiropractic must keep complete and accurate documentation on all patients and patient encounters. This documentation is necessary to protect the health, well-being and safety of the patient.

(1) The patient record must detail the patient's clinical history, the rationale for the examination, diagnostic or analytical procedures, and treatment services provided. The diagnosis or clinical impression must be contained in the patient record, not merely recorded on billing forms or statements. Subjective health status updates, whether or not symptoms are present, must be documented for every patient encounter.

(2) Documentation for the initial record must include at a minimum:

- (a) The patient's history;
- (b) Subjective presentation;
- (c) Examination findings or objective findings relating to the patient's presenting condition;
- (d) Any diagnostic testing performed;
- (e) A diagnosis or impression;
- (f) Any treatment or care provided; and
- (g) Plan of care.

(3) Reexaminations, being necessary to monitor the progress or update the current status of a patient, must be documented at reasonable intervals sufficient to reflect the effectiveness of the treatment. Reexaminations must also be documented whenever there is an unexpected change in the subjective or objective status of the patient. Reexamination documentation must include the subjective presentation and objective findings. This documentation shall also reflect changes in the patient's care and progress and in the treatment plan.

(4) Documentation between examinations must be recorded for every patient encounter. Documentation must sufficiently record all the services provided, as well as any changes in the patient's presentation or condition. The region(s) of all treatment and, if applicable, the specific level(s) of chiropractic adjustments must be recorded in the patient encounter documentation.

(5) Patient records must be legible, permanent, and recorded in a timely manner. Documentation that is not recorded on the date of service must designate both the date of service and the date of the chart note entry. Corrections or additions to the patient's records must be corrected by a single line drawn through the text and initialed so the original entry remains legible. In the case of computer-organized documentation, unintended entries may be identified and corrected, but must not be deleted from the record. Errors in spelling and grammar may be corrected and deleted.

(6) Correspondence relating to any referrals concerning the diagnosis or treatment of the patient must be retained in the patient record.

(7) Patient records should clearly identify the provider of services by name, initials, or signature. If the chiropractor uses a code in the documentation, a code legend must be made available upon request.

[Statutory Authority: RCW 18.25.0171 and chapter 18.25 RCW. WSR 10-15-084, § 246-808-560, filed 7/19/10, effective 8/19/10. Statutory Authority: Chapter 18.25 RCW. WSR 96-16-074, § 246-808-560, filed 8/6/96, effective 9/6/96.]