

Chapter 811 Division 15

811-015-0005

Records

(1) Failure to keep complete and accurate records on all patients shall be considered unprofessional conduct

(a) Each patient shall have exclusive records which shall be clear, legible, complete and accurate; as to allow any other Chiropractic physician to understand the nature of that patient's case and to be able to follow up with the care of that patient if necessary.

(b) Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record.

(c) Clear, legible, complete and accurate records contain the following:

(A) A description of the chief complaint or primary reason the patient sought treatment from the licensee.

(B) Documentation of any significant event that affects the chief complaint of the patient or the general history of the health of the patient.

(C) An accurate record of the diagnostic and therapeutic procedures that the licensee has employed in providing chiropractic services to the patient, including, but not limited to:

(i) Examinations and the results of those examinations;

(ii) Diagnoses;

(iii) Treatment plan, and any subsequent changes to the treatment plan and the clinical reasoning for those changes;

(iv) Dates on which the licensee provided clinical services to the patient, as well as the services performed and clinical indications for those services;

(v) Areas of the patient's body where the licensee has provided care;

(vi) Patient's response to treatment;

(vii) Therapeutic procedures must be clearly described including information such as providers involved, timing, setting and tools used as appropriate.

(D) Relevant information concerning the patient such as height, weight, and blood pressure.

(E) Documentation of informed consent for examination and treatment.

(F) Other clinically relevant correspondence including but not limited to telephonic or other patient communications, referrals to other practitioners, and expert reports.

(d) A chiropractic physician shall maintain billing records for services performed for which payment is received from or billed to the patient, an insurance company, or another person or entity who has assumed the financial responsibility for the payment of services performed to the patient. Such records will be maintained for same amount of time as other patient records. As a minimum, a billing record will include the date of the patient encounter or financial entry, a notation of the services performed either by description or code, common codes such as the AMA Current Procedural Terminology (CPT) codes may be used without additional explanation or legend, and the fee charged for the services billed. If third party payers are billed, the billing instrument (CMS 1500 form or its successor) should be retrievable. Such information may be maintained on a handwritten or printed ledger, with the assistance of a computer or other device either by direct entry or with a particular program or application, or by an alternative method. To the extent billing records do not contain patient health care records not kept elsewhere, they are not consider part of the clinical record.

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(e) Such information as described in section (d) must be readily available upon request of the patient, an agent of the patient, an insurance carrier or entity responsible for the payment of the services, or by the Board or other entity with a legal right to review such information.

(2) Practitioners with dual licenses shall indicate on each patient's records under which license the services were rendered.

(3) A patient's original health care and billing records shall be kept by the chiropractic physician a minimum of seven years from the date of last treatment. However, if a patient is a minor, the records must be maintained at least seven years from the time they turn 18 years of age.

(a) If the treating chiropractic physician is an employee or associate, the duty to maintain original records shall be with the chiropractic business entity or chiropractic physician that employs or contracts with the treating chiropractic physician.

(b) Chiropractic physicians shall be responsible for keeping an available copy of all authored reports for seven years from the date authored.

(4) If a chiropractic physician releases original radiographic films to a patient or another party, upon the patient's written request, he/she should create an expectation that the films will be returned, and a notation shall be made in the patient's file or in an office log where the films are located (either permanently or temporarily). If a chiropractic physician has radiographic films stored outside his/her clinic, a notation shall be made in the patient's file or in an office log where the films are located and chiropractic physician must ensure those films are available for release if requested by the patient.

(5) The responsibility for maintaining original patient records may be transferred to another chiropractic business entity or to another chiropractic physician as part of a business ownership transfer transaction.

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