CERTIFICATE

STATE OF WISCONSIN
DEPARTMENT OF REGULATION AND LICENSING

TO ALL WHOM THESE PRESENTS SHALL COME, GREETINGS:

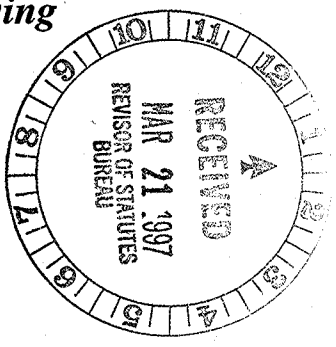
I, Alfred J. Hall, Jr., Director, Bureau of Health Service Professions in the Wisconsin Department of Regulation and Licensing and custodian of the official records of the Chiropractic Examining Board, do hereby certify that the annexed rules were duly approved and adopted by the Chiropractic Examining Board on the 20th day of March, 1997.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the board at 1400 East Washington Avenue, Madison, Wisconsin this 20th day of March, 1997.

Alfred J. Hall Jr.

Alfred J. Hall, Jr., Director, Bureau of Health Service Professions, Department of Regulation and Licensing



6-1-97

STATE OF WISCONSIN
CHIROPRACTIC EXAMINING BOARD

IN THE MATTER OF RULE-MAKING PROCEEDINGS BEFORE THE CHIROPRACTIC EXAMINING BOARD	:	ORDER OF THE CHIROPRACTIC EXAMINING BOARD ADOPTING RULES (CLEARINGHOUSE RULE 96-095)

ORDER

An order of the Chiropractic Examining Board to repeal Chir 6.015; to amend Chir 6.02 (27); and to create ch. Chir 11 relating to patient records.

Analysis prepared by the Department of Regulation and Licensing.

ANALYSIS

Statutes authorizing promulgation: ss. 15.08 (5) (b) and 227.11 (2), Stats., and s. 446.02 (7m), Stats., as created by 1995 Wisconsin Act 94.

Statutes interpreted: s. 446.02 (7m), Stats.

In this proposed rule-making order the Chiropractic Examining Board proposes to create Chapter Chir 11, relating to minimum standards of patient record keeping by chiropractors. Section 446.02 (7m), Stats., provides that a chiropractor shall create and maintain a patient record for every patient the chiropractor examines or treats. The patient record shall contain complete and comprehensive health care information as defined by the board by this proposed rule. This proposed rule specifies the minimum format and contents of patient health care records required to be created and maintained by chiropractors licensed and practicing in the state of Wisconsin.

Section Chir 6.015 is repealed and replaced by the new definition of "patient record" in new s. Chir 11.01 (1), for consistency with the terminology in s. 446.02 (7m) (a), Stats., and s. Chir 6.02 (27) is also amended for consistency with the term "patient record." The definition of "patient record" in proposed s. Chir 11.01 (1), includes a cross-reference to the term "patient health care records" as used and defined in ch. 146, Stats., to clarify that the terms "patient record" under the proposed rule and "patient health care records" are synonymous.

Section 446.02 (7m) (b), Stats., requires that a "chiropractor shall preserve a patient record created and maintained...for at least 3 years after the chiropractor makes his or her last entry or notation in the patient record *or for any longer period that is otherwise required by law.* (Emphasis added) Existing s. Chir 6.02 (27), created in January 1992, effective February 1, 1992, and as amended by this proposed order, requires that patient health care records be maintained for a minimum period of 7 years from the date of the last treatment or after the patient reaches the age of majority, whichever is later. Section Chir 6.02 (27) is not in conflict

with s. 446.02 (7m) (b), Stats., is unaffected, remains in effect as amended, and is intended to govern the minimum time period that a chiropractor is required to preserve patient health care records.

TEXT OF RULE

SECTION 1. Chir 6.015 is repealed.

SECTION 2. Chir 6.02 (27) is amended to read:

Chir 6.02 (27) Failing to maintain patient ~~health care~~ records for a minimum period of 7 years after the last treatment or after the patient reaches the age of majority, whichever is greater.

SECTION 3. Chapter Chir 11 is created to read:

CHAPTER Chir 11

PATIENT RECORDS

Chir 11.01 DEFINITION. As used in this chapter "patient record" means patient health care records as defined under s. 146.81 (4), Stats.

Chir 11.02 PATIENT RECORD CONTENTS. (1) Complete and comprehensive patient records shall be created and maintained by a chiropractor for every patient with whom the chiropractor consults, examines or treats.

(2) Patient records shall be maintained for a minimum period of 7 years as specified in s. Chir 6.02 (27).

(3) Patient records shall be prepared in substantial compliance with the requirements of this chapter.

(4) Patient records shall be complete and sufficiently legible to be understandable to health care professionals generally familiar with chiropractic practice, procedures and nomenclature.

(5) Patient records shall include documentation of informed consent of the patient, or the parent or guardian of any patient under the age of 18, for examination, diagnostic testing and treatment.

(6) Rationale for diagnostic testing, treatment or other ancillary services shall be documented in or readily inferred from the patient record.

(7) Significant, relevant patient health risk factors shall be identified and documented in the patient record.

(8) Each entry in the patient record shall be dated and shall identify the chiropractor, chiropractic assistant or other person making the entry.

Chir 11.03 INITIAL PATIENT PRESENTATION. Upon presentation of a new patient, patient records shall contain the following essential elements as relevant or applicable to the evaluation and treatment of the patient:

(1) History of the present illness or complaints, and significant past health, medical and social history.

(2) Significant family medical history and health factors which may be congenital or familial in nature.

(3) Review of patient systems, including cardiovascular, respiratory, musculoskeletal, integumentary and neurologic.

(4) Results of physical examination and diagnostic testing focusing on areas pertinent to the patient's chief complaints.

(5) Assessment or diagnostic impression of the patient's condition.

(6) Treatment plan for the patient, including all treatments rendered, and all other ancillary procedures or services rendered or recommended.

Chir 11.04 DAILY NOTES. For patient visits in which the chiropractor carries out a previously devised treatment plan, daily notes shall be made and maintained documenting all treatments and services rendered, and any significant changes in the subjective presentation, objective findings, assessment or treatment plan for the patient.

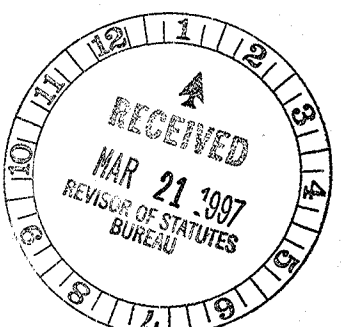
(END OF TEXT OF RULE)

The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register pursuant to s. 227.22 (2) (intro.), Stats.

Dated 3/20/97

Agency Jerry Freitag DC/a.j.H.
Chairperson
Chiropractic Examining Board

g:\rules\chir11
3/7/97



State of Wisconsin

DEPARTMENT OF REGULATION AND LICENSING

CORRESPONDENCE/MEMORANDUM

DATE: March 21, 1997

TO: Gary Poulson
Assistant Revisor of Statutes

FROM: Pamela A. Haack, Rules Center Coordinator
Office of Administrative Rules

SUBJECT: Final Order Adopting Rules

CHIROPRACTIC EXAMINING BOARD

Clearinghouse Rule 96-095

Attached is a copy and a certified copy of a final order adopting rules. Would you please publish these rules in the register.

Please stamp or sign a copy of this letter to acknowledge receipt.

Thank you.