9/21/92

STATE OF MINNESOTA
COUNTY OF RAMSEY

BEFORE THE MINNESOTA BOARD OF CHIROPRACTIC EXAMINERS

In the Matter of the Adoption of A Rule Relating to Record Keeping

STATEMENT OF NEED AND REASONABLENESS

Pursuant to Minnesota Statutes 14.23 (1990), the Minnesota Board of Chiropractic Examiners (hereinafter "Board") hereby affirmatively presents the need for and facts establishing the reasonableness of proposed Minnesota Rules relating to the above mentioned area in the practice of chiropractic.

In order to adopt the proposed rule, the Board must demonstrate that it has complied with all procedural and substantive requirements for rulemaking. Those requirements are as follows: 1) there is statutory authority to adopt the rules; 2) the rules are needed and are reasonable; 3) all necessary procedural steps have been taken; and 4) any additional requirements imposed by law have been satisfied. This Statement demonstrates that the Board has met these requirements.

1. STATUTORY AUTHORITY

The statutory authority of the board to adopt this rule is as follows:

Minnesota Statutes, 148.08, subdivision 3 (1990), authorizes the Board to promulgate rules necessary to administer section 148.01 to 148.105. In particular, the Board wishes to promulgate rules that will define, clarify, or establish Board policies in regard to the above-mentioned areas in the practice of chiropractic.

2. STATEMENT OF NEED AND REASONABLENESS

Minnesota Statute 148.10 Subd. 1 (18) requires doctors of chiropractic to keep records justifying the treatment provided to their patients. What information is specifically required to be in the record to justify care is not listed either in statute or rules of the state. The establishment of specific standards by rule is necessary to protect the public's interest by clearly defining what a chiropractor must document to justify care and provide an appropriate record of treatment which can be used to evaluate the necessity of services received by patients. These treatment records are used by all health care professionals to assess any treatment a patient may have previously received. By ensuring that these minimal standards are complied with the patients health is protected when they receive treatment in the future. This standard in law will also ensure that regulatory agencies, the courts and all interested parties are provided a uniform base of information which will allow all parties to objectively and fairly evaluate the need for care which is provided by the doctor and received by the patient. A standard is clearly needed and reasonable.

Complete History To properly evaluate a patient's condition, it is necessary to list the contributing factors. Accurate diagnosis is dependent on the knowledge of past injuries, trauma, or any recurrent type of condition or presence of a hereditary type of condition in the family, which may have resulted in changed physiology or permanent injury. This requirement is needed and reasonable. Previous treatment may have had a long lasting effect on the physiology of the patient,

which will affect both the appropriate present diagnosis and the appropriate treatment. Past treatment, when either effective or ineffective, may direct a practitioner in the evaluation of need for and the type of current treatment. The determination of need for treatment in diagnostic texts indicate that the information listed under this section of the rule may all be factors which contribute to the formulation of a diagnosis. The diagnosis is of questionable value unless this information is obtained. Documenting this information provides others reviewing records the opportunity to accurately evaluate and comment on the diagnosis rendered by the practitioner who is generating the record. Requiring the documentation of this information establishes a standard which protects the public's interest. Therefore, this is reasonable and necessary.

Examinations Minnesota Statutes requires doctors of chiropractic to diagnose their patient's condition in order to determine "...the presence or absence of a chiropractic condition." (MS 148.01) in their patients. To determine the diagnosis a doctor must discover what objective signs the patient displays. Objective signs are elicited via examinations. The diagnostic process requires that both the presence and absence of signs be noted and used to rule in and rule out conditions when a test is performed during the course of an examination. A sign is either present, which is a positive test, or not present, which is a negative test. A combination of positive and negative test results elicited during examinations is information used to rule in and rule out specific diagnosis. In order to justify care given and the diagnosis stated, the examinations performed, as

well as the results of all tests done during the examination, must be documented. Therefore this rule is reasonable and necessary.

Many doctors utilize examination forms with symbols and abbreviations not taught in accredited chiropractic colleges. When these documents are reviewed by other parties, the symbols and abbreviations are ambiguous or even meaningless. When such symbols or abbreviations are used, a key which explains their meaning, in terms taught in accredited chiropractic colleges, will allow individuals reviewing the records an opportunity to understand the records. Understanding the records is necessary when determining whether the records justify care provided. Therefore this rule is reasonable and necessary.

MS 144.335 establishes a mechanism for copies of health records to be provided upon request of the patient. If a key is required to understand the health records itself, then a key must be provided with the copies when sent to the individuals reviewing the copies of the record. This provision makes the responsibility of enclosing a key with the copies clear and is therefore reasonable and necessary.

Diagnosis The description of the patient's condition is the diagnosis. Without a diagnosed condition, no treatment is justified. In order to evaluate compliance with the statutory requirement for recorded justification of treatment, a diagnosis must be contained in the patient record. To evaluate the accuracy of the diagnosis, as well as the necessity of the treatment which is based on the diagnosis, the diagnosis must be supported by both the objective and subjective findings found

within the patient record. Therefore, this rule is necessary and reasonable.

Treatment Plan Many different methods and frequencies of care may be used for any condition. In order to justify care that is provided, a doctor must have a plan for what will be provided. This is to include a description of procedures and therapies provided, as well as an estimate of how frequently and how long the patient will need care. This plan establishes the intent of the doctor and therefore is an integral pert of the justification for care. This record of what the intended care is allows the treating doctor and health care professionals who treat the patient in the future to evaluate patient compliance, effectiveness of the care provided and the overall case management provided by the practitioner. When the file is reviewed, that justification must be confirmed by others. Therefore, inclusion in the rule is reasonable and necessary.

Parameters used to justify future care differ with each technique and each condition. In order to evaluate the justification of any one parameter it must be clearly stated. Therefore this rule is reasonable and necessary.

Daily Notes At a minimum a patient's current subjective information must be noted each time a patient is seen. This information alerts a doctor to unexpected changes in a patient's condition and also confirms that continued improvement is or is not occurring at an expected rate. Documenting these findings allows the doctor to justify care for that day as well as future care. This information is the basis for re-evaluation, continued care and referral decisions as well as confirmation that care is

justified. Without documented subjective information, care is not justified. Therefore, this rule is reasonable and necessary.

A listing of what services were actually provided on any given day is necessary for both documentation and evaluation of the justification of treatment provided. Therefore this is reasonable and necessary.

Brief History If a patient experiences a trauma or unexpected change in signs or symptoms, the doctor must reevaluate the working diagnosis and treatment being rendered. A description of the incident resulting in trauma or description of what occurred that resulted in a change of signs or symptoms is necessary to evaluate the patient and change or verify the diagnosis. Documentation of this information allows the parties reviewing the records to accurately evaluate the diagnosis and treatment rendered. The accurate and objective evaluation of this information is necessary to protect the public, and therefore, this rule is reasonable and necessary.

Re-examination The goal of treatment is to restore health in patients. As treatment progresses, the condition of the patient changes. In order to continue to monitor a patient's condition, modify the diagnosis and thereby justify care as required by the statute, reexamination is required. If there is any sudden unexpected change in a patient condition a re-examination is required to establish a new diagnosis or verify that the existing diagnosis continues to be accurate. These re-examinations provide the objective information necessary to arrive at the diagnosis of the patient.

During the re-examination, tests which were positive must be re-checked to verify that they are still positive or establish that they are no longer positive. Positive tests which remain positive indicate that a diagnosis continues to be accurate. A positive test which becomes negative with treatment indicates that treatment is assisting in the improvement. This information justifies care and is therefore reasonable and necessary to include in this rule.

Other Examinations When the results of examinations performed by health care professionals other than the treating chiropractor are used to justify care being provided by the treating chiropractor, those results must be included in the records produced by the treating chiropractor. This data does not clearly relate to the care being provided by the treating chiropractor until it is incorporated in the records of that practitioner. As stated above, results of all tests and evaluations are used to verify the accuracy of the diagnosis provided, substantiate the value of treatment being provided and therefore justify the care being provided. Therefore this rule is reasonable and necessary to protect the interests of the public.

Following is a bibliography of materials used to support the requirements established within the rule:

Anderson, D.C., Jimmy G. "Workers Compensation" MCA Journal, August 1986, pp. 36-7.

Glisson, D.C., James E. "The Case for Documentation" The ACA Journal of Chiropractic, (March 1985), 68-71.

Gundersen, D.C., Bruce V. "The Case History" Orthopedic Brief, Council on Chiropractic Orthopedics, American Chiropractic Association, Inc., April-May 1989.

Gundersen, D.C., Bruce V. "The Diagnostic Work-Up" Orthopedic Brief, Council on Chiropractic Orthopedics, American Chiropractic Association, Inc., June-July 1989.

Haldeman, D.C., Scott "Importance of Record Keeping in Evaluation of Chiropractic Results" The ACA Journal of Chiropractic, IX, (September 1975), 108-14.

Pamer, D.C., David C. "The Case History" The ACA Journal of Chiropractic, IX, (September 1975), 115-6.

Priest, D.C., Gregory C. "The Regional Physical Examination: An Overview" ACA Journal of Chiropractic, 21, No. 10, (October 1987), 67-9.

Rake, D.C., F.A.C.O., George E., comp. " The Responsibilities of the Chiropractic Profession Where Third-Party Payors Are Involved" In Orthopedic and Neurologic Tests, American College of Chiropractic Orthopedists, Revised 1988.

Sawyer, D.C., Charles E. A Practical Approach to Integrated Chiropractic Health Care: Applying the Problem-Oriented Method in the Clinical Care and Education of the Chiropractic Patient, Mimeographed, Bloomington, Minnesota.

3. COMPLIANCE WITH PROCEDURAL RULEMAKING REQUIREMENTS

Minnesota Statutes, sections 14.05 to 14.12 and 14.22 to 14.28, specify certain procedures which must be followed when an agency adopts or amends rules. Procedures applicable to all rules, Minnesota Statutes, sections 14.05 to 14.12, have been complied with by the Board as noted below.

The Board proposes adoption of this rule as a noncontroversial rule in accordance with section 14.22 to 14.28, except that no public hearing is presently planned and need not be held unless 25 or more persons submit a written request for a hearing within the 30-day comment period.

The adoption of this rule will not require the expenditure of public money by local public bodies, nor does the rule have any impact on agricultural land. **See** Minn. Stat. 14.11.

Pursuant to Minnesota Statutes, section 14.23, the Board has prepared this Statement of Need and Reasonableness which is available to the public.

The Board will publish a Notice of Intent to Adopt Rules without a Public Hearing in the **State Register** and mail copies of the notice and proposed amendments to persons registered with the Board pursuant to Minnesota Statutes, section 14.14, subdivision 1a. The notice will include the following information: a) that the public has 30 days in which to submit comments on the proposed amendment and giving information pertaining to the manner in which persons may comment; b) that no public hearing will be held unless 25 or more persons submit a written request for a public hearing on the rule within the 30-day comment period; c) that the rule may be modified if modifications are supported by the date and views submitted; and d) that notice of the date of submission of the proposed amendment to the Attorney General for review will be mailed to any person requesting to receive the notice, and giving information on how to request the notice.

The Board will submit the proposed rule and notice as published, the rule as proposed for adoption, any written comments which have been received, and this Statement of Need and Reasonableness to the Attorney General for approval of the amendment as to legality and form.

This rule will become effective five working days after publication of a notice of adoption in the **State Register.**

4. ADDITIONAL REQUIREMENTS

Small Business Considerations. In preparing to propose this rule, the Board considered the methods for reducing the impact of the rules on small business as set forth in Minnesota Statutes, section 14.115, subdivision 2 (1990). The Board noted that the suggested rule changes better define requirements already established by statute. Therefore, the Board believes this rule will not have an economic impact.

Nevertheless, any small business which believes they may be affected by the proposed rule will have opportunity to participate in the rulemaking procedure. Further, a notice of the proposed rulemaking will be mailed to the Minnesota Chiropractic Association, an organization which will likely represent small businesses affected by the rule.

STATE OF MINNESOTA
BOARD OF CHIROPRACTIC EXAMINERS

Joel B. Wulff, DC
Executive Director

8-14-92
Date