Scanning Policy
Effective Date: May 11, 2017

I. Purpose
To minimize the scanning and uploading of clinical and/or outside information into a patient’s electronic medical record and to maximize other methods of documenting in the electronic record.

II. Definitions
Scanning - refers to the scanning and uploading that enables a document to become part of the patient chart.
EMPI – Enterprise Master Patient Identifier
MRN – Medical Record Number
HIM – Health Information Management
Patient Care Documents – Records that are created from our care of the patient, e.g. home health orders, preauth forms, questionnaires or authorization to use and disclose forms to name a few.

III. Policy
Pediatric Health Information receives a variety of patient records from multiple sources. Documents might be faxed in or generated from clinical care.

- Patient care documents:
  - Should be reviewed for appropriate patient identifiers and necessity for upload prior to delivering to HIM.

- Outside records:
  - Providers should review all outside records and select only the documents that are important to the patient’s ongoing care within their sub-specialty.
  - Documents that are not typically uploaded and should be shredded prior to delivery to HIM:
    - Illegible documents
    - Demographic sheets
    - Fax Cover sheets
    - Help2/iCentra documents
    - Documents that have been identified as a tool for dictating notes.

Scanning of outside records will be limited to 20 pages unless otherwise approved by HIM and the Clinical Enterprise leadership team.

Recommendations:
In order to prevent duplicative work we ask that you respond electronically when records are housed on the University shared drive. To ensure back end processes are completed.
if printing is absolutely necessary, please identify that the original record resides on the shared drive. Call 801-213-3597 if you require assistance.

IV. **Procedure:**

**Patient care documents**
Documents can be placed in the hanging file folders for your division or placed in the appropriate division cubby on the 4th floor of the Eccles building HIM station.

1. All documents to be uploaded must include the following:
   a. Patient’s full name
   b. Patient’s date of birth
   c. Epic MRN or EMPI number
   d. Date of service or date signed

**Outside records**
All records will be uploaded into Help2 according to the type of document and date the service was provided. Documents from/or already available in Help2 will not be uploaded.

1. Providers will be notified records are available:
   a. New patients: Appointment notes for new patients (e.g. REC S:DRV).
   b. Return patients: Notification will be sent to the provider via message log.
   c. Records will be stored for 30 days after the completed new patient visit or 30 days after the message log notification.

2. Paper documents:
   a. Each page of any paper document to be scanned into the EMR should be initialed by the provider.
   b. See above “patient care documents” for delivery methods.

3. Electronic Documents:
   a. Providers can respond to or send a message log to the HIM team identifying the specific PDF pages that are necessary to their care.

**HIM Processes**
1. HIM staff will review all documents prior to uploading for the following:
   a. Appropriate identifiers as noted above.
   b. Legibility of the document.
   c. Printed documents from/or already available in Help2 will not be uploaded.

2. If documents do not have the appropriate patient identifiers, the document will be returned to the division/provider/identified representative.

3. Paper and electronic copies are stored for 30 days after they are received/identified for upload.

4. Pediatric HIM completes random audits on all scanned images.

Approved by: HIM Solutions Committee & Ambulatory Division Chiefs 5/11/17