Scanning & Chart Label Policy
Effective Date: 4/24/18

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.

To ensure all records have appropriate patient identifiers on each page. To provide correct clinic FIN's and bar codes on each document that allows for efficient and electronic scanning.

II. Definitions
Chart Label: Labels containing patient identifiers, FIN number corresponding to division and bar code for scanning.
HIM: Health Information Management
S DRV: Storage drive used for each division to store outside records
EMR: Electronic Medical Record
Scanning - the scanning and uploading process that enables a document to become part of the patient chart.
MRN – Medical Record Number
Patient Care Documents – Records that are created from your 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
Scanning
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:**
  - Divisions are required to have patient chart labels on every document sent to HIM for scanning into the EMR. The first page of a document must have a chart label, regardless if there are already patient identifiers. Each subsequent page must have a minimum of two patient identifiers for HIM to upload. If a document does not contain two patient identifiers, a chart label is required.

- **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 40 pages unless otherwise approved by HIM and the Clinical Enterprise leadership team.

Chart labels
1. Chart labels are required for the following documents:
   - All documents created/received during clinic.
   - Any documents sent via email to the PedSHIM@hsc.utah.edu email.
   - Any document that does not have three patient identifiers.
   - Any document needed for billing.
2. Exceptions:
   - Records from the SDRV, where the provider has communicated to HIM via PowerChart message center to upload the following pages will not require a chart label
     - **All exceptions must be approved by HIM**
3. Identifying FIN’s for your chart label:
   - Always use your division’s clinic FIN.
     - This can be past or future, select most appropriate for your document.
   - If you do not have a clinic FIN to choose, a HX FIN is appropriate.
     - This should be used less and less as we get further in iCentra.
   - If document is needed for billing select appropriate DOS/FIN
4. Documents received via hard copy or via e-mail without a chart label or without appropriate patient identifiers will be returned.
5. Documents that need to be faxed but do not have appropriate identifiers will be faxed to prevent patient care delays. However, it will be returned to the division to add chart labels if upload is necessary.

IV. Procedure
1. Divisions are responsible for determining who should place chart labels on their documents outside of clinic.
2. MA’s are responsible for placing chart labels on documents received and or created during clinic.

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.
**Outside records**
All records will be uploaded into iCentra according to the type of document and date the service was provided. Documents from/or already available in Help2/iCentra 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 center.
   c. Records will be stored for 30 days after the completed new patient visit or 30 days after the message notification.

2. Paper documents:
   a. Each page of any paper document to be scanned into the EMR should be initialed by the provider.

**HIM Processes**
1. HIM staff will review all documents prior to uploading for the following:
   a. Appropriate identifiers as noted above.
   b. Chart label
   c. Legibility of the document.
   d. Duplication.

2. If documents do not have the appropriate patient identifiers, the document will be returned to the division/provider/identified representative.
3. All hard copy documents received by HIM are saved for 30 days.
4. Pediatric HIM completes random audits on all scanned images.