COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Scanning Documents into the Electronic Health Record		**HIM-012**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Health Information Management	**3/27/2017**	**8/2017, 5/2018, 8/30/2019, 12/1/20**
DEPARTMENT	REFERENCE	
Health Information Management	**See below**	

PURPOSE

To ensure the Mangum Regional Medical Center scanning procedures shall adhere to all applicable HIPAA regulations.

POLICY

The Hospital Electronic Health Record System supports scanning and storage of documents as images. The Health Information Management ("HIM") Department is responsible for the appropriate scanning and indexing of all image documents. Acceptable methods for authenticating a scanned document shall follow paper or electronic guidelines.

All entries to be scanned into the electronic health record must be made in black ink to facilitate legible reproduction of records. Entries should not be made in pencil. Paper records, as well as corresponding microfilm, shall be retained for the period of ten (10) years. Legibility of a sampling of records, including scanned records, are to be included in this hospital's quality control and performance improvement processes.

PROCEDURE

A. Scanning of Documents into the Electronic Health Record:
   1. Open the electronic health record system.
   2. Type in the patient's last name; select the correct patient using the date of birth and other identifier.
   3. Open the patient's medical record. Click on "scan documents".
   4. Place the paperwork into the scanner. Scan the document.
   5. Assign the paperwork. A particular tab must be selected for the scanned paperwork. Click the proper tab located on the electronic health record for the patient, and the paperwork will be located under the appropriate tab in the patient's electronic health record.
   6. Perform quality assurance and review images.

B. Store the hard copy documents, per policy and procedure.

C. Errors in Scanning Documents:
   1. If a document is scanned with wrong encounter date or to the wrong patient, the following shall be performed:
      a. Reprint the scanned document.
      b. Rescan the document to the correct date or patient, and void (delete) the incorrectly scanned document in the permanent document repository.

REFERENCES

American Health Information Management Association (AHIMA), e-HIM Work Group on Maintaining the Legal HER, *Update: Maintaining a Legally Sound Health Record-Paper and Electronic*, Journal of AHIMA 76, no.10 (November-December 2005): 64A-L, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509

REVISIONS/UPDATES

Date	Brief Description of Revision/Change
8/30/2019	Change in header, number, and font.
12/1/20	Change in header and spacing. Apply acronym. Use number word format. Add "References" section and move references. Add "Attachments" section. Add "Purpose" section and verbiage. Change number paragraph format.