I. **Title**  
*Scanning Protected Health Information to Epic*

II. **Policy**  
A. Approved paper documents are scanned and uploaded into Epic (via MyUTMB – the designated document management system) by the Health Information Management Department and by Clinical and Ancillary Departments.

B. The scanned electronic image of an approved medical record document becomes the original official UTMB document immediately after creation.

C. Original paper documents that were converted to electronic media (scanned or digitized) by the Health Information Management Department (HIM), or any other approved department, for incorporation into the official UTMB electronic medical record will be retained for a period of 90 days prior to destruction.

D. UTMB staff must complete formal scanning training through Information Services (IS) before they may scan approved paper documents into MyUTMB/Epic. Approved documents are listed on the Epic Scanned Documents List maintained by the Health Information Department.

E. The complete listing of approved document types may be found at [Master Epic Scanned Document List](#). If a document type does not exist for a document needing to be scanned, the document should be given to the clinic manager or supervisor for review. The manager should consult with HIM for proper disposition of questionable documents.

F. HIM will coordinate with the originating party to have the new scanning document type created.

G. Unauthorized scanning into Epic may result in formal disciplinary action.

III. **Procedures**  
A. Documents to be scanned and included in the UTMB electronic medical record must follow the policy for all loose document handling:  
   
   *All appropriate medical documents that are prepared for incorporation into the official UTMB medical record must contain complete and legible patient identification data, i.e., patient name and complete hospital medical record number (including alpha suffix).*

B. The HIM Department will determine if the documents are appropriate for the UTMB electronic medical record, where in Epic these documents will be available to view, to whom they will be available (utilizing the “roles” method within the Epic EMR) and the required turn-around-time between creation of the original paper document and the availability of the scanned image to approved users.
C. Remote electronic document creation by outlying clinical areas, and the uploading of the images to MyUTMB/Epic, will be coordinated between the HIM Department and Information Services to ensure accuracy, availability, and completeness.

D. Documents that should not be scanned:
   - Printouts from UTMB computer systems (MyUTMB, Epic, etc.)
   - Billing / coding documents
   - Duplicate copies
   - Unapproved documents

E. Outpatient clinical documents should be scanned within 72 hours of the document becoming complete. There may be specific document types that require scanning within no less than 24 hours from the date of service and these intra-departmental requirements will be specified by department / entity management / leadership. Any/all documents not otherwise specified should be scanned within 72 hours from the date of service.

F. Quality reviews on scanned documents are completed by the Health Information Management Department. An employee’s scanning access may be revoked if an excessive amount of errors are found or if other inappropriate scanning practices are discovered.

G. When ambulatory scanning errors are identified, the person who made the error along with their supervisor is notified. The document management system allows scanned documents to be either “corrected” or “deleted.” Correcting a document is replacing the incorrect document with the updated or correct document. A document is “deleted” if it was scanned to the incorrect patient or document type. “Deleting” a document moves the old document to the Order history and the link to the document is replaced with a flag indication that the previous document was scanned in error. Documents are rarely deleted from the Epic EMR.

H. Inpatient documents will be scanned by the Health Information Management Department.

I. Inquiries about scanning should go to the Health Information Management Department.

IV. Definitions

Unit Medical Record (UMR): The official UTMB legal medical record maintained by the Department of Health Information Management (HIM) that contains UTMB’s original/official patient care information. The UMR is designed to contain the written interpretations of all significant clinical information gathered for a given patient, whether as an inpatient, outpatient, or emergency care patient. The entire patient’s medical record is thus in paper and/or electronic form under one hospital number. UMR’s have a permanent retention schedule.

Source Data: Data from which interpretations, summaries, or notes are derived, regardless of media. This data includes health information stored in any original media. Examples of Source Data include, but are not limited to, paper diagnostic tests or tools, x-rays, videotapes, ultrasounds, fetal monitor strips, photographs (either conventional photos or digital images), and ancillary or supporting systems (e.g. pharmacy information systems and radiation oncology information systems). These forms of Source Data have unique retention schedules. The UMR must contain a written interpretation of all Source Data. Source Data is distinct from the written interpretations of significant clinical information that is included in the UMR and is not part of the official UTMB Legal Medical Record.
V. Related UTMB Policies and Procedures

IHOP - 09.02.15 Medical Record Documentation
IHOP - 06.01.05 Records and Information Management and Retention
IHOP - 06.02.10 Physical Protections Safeguards of PHI
Health Information Management “Scanning Do’s & Don’ts”

VI. Dates Approved or Amended

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VII. Contact Information

Health Information Management
(409) 772-1918