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An American National Standard

Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription[1]

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1. Scope*

1.1 This guide covers the establishment of a quality assurance program for dictation, medical transcription, and related processes. Quality assurance (QA) is necessary to ensure the accuracy of healthcare documentation. Quality documentation protects healthcare providers, facilitates reimbursement, and improves communication among healthcare providers, thus improving the overall quality of patient care. This guide establishes essential and desirable elements for quality healthcare documentation, but it is not purported to be an exhaustive list.

1.2 The QA personnel for medical transcription should have an understanding of the processes and variables or alternatives involved in the creation of medicolegal documents and an understanding of quality assurance issues as they pertain to medical transcription. Qualified personnel include certified medical transcriptionists (CMTs), quality assurance professionals, or individuals who hold other appropriately related credentials or degrees.

1.3 The medical transcriptionist (MT) and QA reviewer should establish a cooperative partnership so that the review outcomes are objective and educational to include corrective actions and remedies. Policies should be developed to minimize subjective review, which can lead to forceful implementation of one style at the expense of other reasonable choices. Objective review, including an appeals process, should follow organizational standards that have been agreed upon by the full team of QA personnel, MTs, and management staff.

2. Referenced Documents

2.1 *ASTM Standards:*[2]

E1762 Guide for Electronic Authentication of Health Care Information

E1902 Specification for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records (Withdrawn 2011)[3]

E1959 Guide for Requests for Proposals Regarding Medical Transcription Services for Healthcare Institutions

E2344 Guide for Data Capture through the Dictation Process

E2502 Guide for Medical Transcription Workstations

2.2 *Other Documents:*

Public Law 104–191 Health Insurance Portability and Accountability Act of 1996 (HIPAA)[4]

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Do Not Use Abbreviation List[5]

3. Terminology

3.1 *Definitions:*

3.1.1 *author, n*—the person(s) responsible and accountable for the creation, content, accuracy, and completeness of each dictated and transcribed event or health record entry.

3.1.2 *back-formation, n*—a verb formed from a noun, for example, *dialyze* (verb) from *dialysis* (noun).

3.1.3 *concurrent review, n*—quality review of transcribed reports performed while listening to dictation and comparing transcribed document content. Concurrent review is generally performed before reports are delivered to a patient's record, either in print form or electronically, and before they are made available for author signature.

3.1.4 *corrective action, n*—a process used to rectify a situation or problem.

3.1.5 *medical transcription, n*—the process of interpreting and transcribing dictation by physicians and other healthcare providers regarding patient assessment, workup, therapeutic procedures, clinical course, diagnosis, prognosis, etc., into readable text, whether on paper or on computer, in order to document patient care and facilitate delivery of healthcare services. **(AAMT Book of Style; E1959)**

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[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] The last approved version of this historical standard is referenced on www.astm.org.

[4] Available from U.S. Government Printing Office, Superintendent of Dcouments, 732 N. Capitol St., N.W., Mail Stop: SDE, Washington, D.C. 20401. See also http://aspe.hhs.gov/admnsimp.

[5] Joint Commission on Accreditation of Healthcare Organizations: www.jcaho.org.

***A Summary of Changes section appears at the end of this standard**

3.1.6 *originator*—see *author* .

3.1.7 *quality assurance audit, n*—examination and review of transcribed documents to verify accuracy of work type, patient and author identification, and that dictated content was appropriately transcribed and edited, with findings communicated to and reviewed with appropriate staff. A quality assurance audit is generally performed after reports are delivered to a patient's record and may also be called a retrospective review.

3.1.8 *quality assurance for medical transcription, n*—the process of review that is intended to provide adequate confidence that dictated patient care documentation is transcribed in a clear, consistent, accurate, complete, and timely manner and that it satisfies stated or implied requirements for dictated and transcribed documentation of patient care. A quality assurance program may also be called a quality improvement program.

3.1.9 *remedies, n*—alternatives for correcting a situation or problem at the MT or author level.

3.1.10 *retrospective audit, n*—quality review of transcribed reports performed after documents have been released for author signature and delivered to a patient's record. The voice file may no longer be available for comparison with the transcribed documents. It is preferable that retrospective audit be carried out with voice file.

3.1.11 *stat, adj*—of high priority, or urgent, such as dictation requiring immediate transcription and delivery.

3.1.12 *text expander, n*—computer software that allows a few letters or symbols to be expanded to a phrase or sentence in order to enhance productivity.

3.1.13 *turnaround time, n*—elapsed time beginning with the availability of dictation or voice file for transcription and ending when the transcribed document is delivered for authentication. **(E1959)**

3.1.14 *verbatim transcription, n*—documentation that has been transcribed exactly as dictated, without editing for accuracy, consistency, completeness, or clarity. See *The AAMT Book of Style*[6] for additional information.

3.2 *Acronyms:*

AAMT	American Association for Medical Transcription
CMT	Certified Medical Transcriptionist
HIPAA	Health Insurance Portability and Accountability Act of 1996
MT	Medical Transcriptionist; Medical Transcription
QA	Quality Assurance
RFP	Request(s) for Proposals

4. Significance and Use

4.1 This guide lists the essential components of a quality assurance program/quality improvement program for medical transcription and is applicable in all work environments. It describes factors that should be considered when evaluating the individuals and processes responsible for producing patient care documentation and for establishing procedures to address and resolve problems that may arise in dictation and transcription. It clarifies who has the authority to make decisions regarding transcription style and editing and to resolve conflicts.

4.2 This guide may be used to develop a quality assurance program for individual medical transcriptionists, medical transcription departments within healthcare institutions, medical transcription businesses, and authors of dictation. A quality assurance program verifies the consistency, correctness, and completeness of dictation and transcribed reports, including the systematic identification and resolution of inaccuracies and inconsistencies, according to organizational standards. Merely proofreading reports is not equivalent to a quality review process, which should involve comparison with the dictation at least part of the time and review for meaning of content all of the time.

4.3 Quality is fundamental to the patient record, and clear, complete, accurate patient care documentation helps control the rising cost of health care and contributes to patient safety. The quality of the final report is the responsibility of both the author and the medical transcriptionist. It is the result of teamwork between the person dictating and the individual transcribing. It should be noted that while production standards are important, their value is diminished if quality is lacking. Likewise, transcribing dictation verbatim may not result in quality documentation or clear communication. It is the transcriptionist's responsibility to recognize, identify, and report voice files that lack accuracy, completeness, consistency, and clarity for corrective action.

5. Dictation

5.1 There are four areas that should be addressed with every new author providing dictation, and with all authors at regular intervals, particularly when changes occur in policies, staffing, or equipment, or a combination thereof. These four areas are *(1)* education and orientation, *(2)* document and patient identification processes, *(3)* dictated content, and *(4)* confidentiality and security (See Guide E2344).

5.2 Quality assurance of medical transcription begins with the author of the dictation. The quality of transcribed documents is dependent on the quality of dictation. Authors should be educated and oriented in creating a timely, accurate, and understandable dictated report, with emphasis on avoiding the use or overuse of abbreviations, acronyms, back-formations, coined terms, jargon, profanity, short forms, and slang. Accuracy and completeness of document content are the responsibility of the author.

5.3 *Education and Orientation:*

5.3.1 Education and orientation of authors should include an overview of the report generation process, location and proper use of equipment, report types and arrangement of content, proper identification of the patient, and turnaround time requirements. Potential problems and procedures for their resolution should also be addressed.

5.3.2 To ensure accuracy, completeness, and consistency of documentation, regulatory requirements and organizational

[6] Tessier, Claudia, *The AAMT Book of Style for Medical Transcription*, American Association for Medical Transcription, 1995 (print), 1997 (CD-ROM).

policies and guidelines for report formats and organization of content should be followed.

5.3.3 A mechanism for feedback should be provided to the author regarding the dictation or the process to ensure that the author is aware of any problems that may preclude clear, accurate documentation or impede timely transcription. This includes the choice of a quiet and secure area in which to dictate; adequate preparation before beginning the dictation process; self-identification by spelling name and providing identification number; proficiency in the use of necessary equipment; and confirmation of patient identifiers by entering numbers correctly, providing pertinent dates, and accurately spelling patient names upon accessing the dictation system. Authors of healthcare documents should also correctly spell new or unusual terminology and medications as necessary to ensure accurate transcription. Authors should identify referring physicians, consultants, and those receiving courtesy copies, providing spelling, complete addresses, or other information that will facilitate delivery.

5.3.4 Priority of work types relative to dictation time and transcription turnaround time should be included as part of the orientation process. Turnaround time should be defined and expectations clarified. See Guide E1959 for the definition of turnaround time related to requests for proposals and outsourced transcription.

5.4 *Document and Patient Identification Process:*

5.4.1 Instruction should be provided on the document identification process, for example, how to access the dictation system, how to indicate a priority dictation using the appropriate dictation prompts, how to separate multiple reports in one session or call-in, and how to recognize technical problems and notify designated personnel, indicating from what location the system is being accessed and the nature of the technical issue.

5.4.2 The author of dictation should be aware that accurate and complete input of author identifiers, work type, and patient identifiers promotes efficiency and enhances turnaround time. Dictation of several reports on multiple patients using only one patient identifier limits the ability to track and locate specified patient documentation. Entry of incorrect work types often will delay transcription of stat or high-priority reports (See Guide E2344).

5.5 *Dictated Content:*

5.5.1 In order to document that the standard of patient care and all documentation requirements were met, authors should be aware of risk management issues when dictating. Authors should adhere to standardized organizational requirements for recommended or required report formats and order of contents to facilitate communication among healthcare providers and enhance patient safety.

5.5.2 Content should be free from asides, profanity, derogatory, and other inappropriate comments. Such comments may be called to the attention of risk management personnel.

5.5.3 Content should not include extensive use of abbreviations that obstruct communication. Authors should be aware that, when transcribed, abbreviations, acronyms, short forms, jargon, coined terms, and back-formations may be expanded according to organizational policy or regulations. See JCAHO Do Not Use Abbreviation List.

5.5.4 Content should not include any specific references that identify the patient. See Guide E1902.

5.6 *Confidentiality and Security*—Confidentiality and security of author and patient information should be emphasized. See Guide E1902 regarding dictation and transcription confidentiality and security.

6. Transcription

6.1 It should be the medical transcriptionist's responsibility to prepare patient care documents that are as accurate, complete, and timely as possible.

6.2 *Education and Orientation:*

6.2.1 Medical transcriptionists should strive to expand skills and knowledge by regular participation in continuing education and professional development activities. Relevant topics may include clinical diagnosis and treatment, medical and professional ethics, technology, professional practice and development, ergonomics, and industry trends.

6.2.2 MTs should participate in the development of a QA program and be responsible for assisting others in assuring quality documentation.

6.2.3 MTs should strive to prevent injuries by using sound ergonomic techniques, thus facilitating the timely and accurate production of transcribed documents (See Guide E2502).

6.2.4 Dictation should be accessed and evaluated by the medical transcriptionist to determine the extent to which it can be transcribed. If problems arise related to technical difficulties, author technique, or the individual MT's skill and experience, appropriate organizational policies and procedures should be followed.

6.2.5 MTs should not be responsible for affixing author signatures. Refer to Guide E1762 for more information regarding authentication.

6.2.6 MTs should be knowledgeable about the QA program, including the definition of errors, acceptable resources, and the resolution and reporting of inconsistencies, errors, and other aberrancies.

6.2.7 MTs should respond to feedback from the quality assurance process in a timely manner.

6.2.8 MTs should have the ability and opportunity to challenge QA review.

6.2.9 Organization shall provide a process for challenges of the QA review.

6.3 *Document Identification Process*—MTs should follow established procedures for verifying author and patient identification and demographics, resolving inconsistencies according to established policies.

6.4 *Transcribed Content:*

6.4.1 MTs should demonstrate appropriate and accepted use of grammar, punctuation, and language nuances and structure.

6.4.2 MTs should be encouraged to use accepted automated technologies, such as spellcheckers and text expanders, to help ensure accuracy.

6.4.2.1 Text expanders should be used with caution to ensure expansion of text is accurate.

6.4.3 MTs should use current resource materials.

6.4.4 MTs should avail themselves of tools provided for reasonable research.

6.4.5 MTs should appropriately call attention to dictation that cannot be translated or terminology that cannot be verified.

6.4.6 MTs should follow established format, style, and editing policies, including those related to the use of abbreviations, acronyms, back-formations, coined terms, jargon, profanity, short forms, and slang.

6.4.7 MTs should review and proofread documents, making appropriate corrections and revisions as necessitated by production of the report.

6.4.8 MTs should follow appropriate risk management policies, including established procedures for notifying authors of problems arising within their dictation.

6.5 *Confidentiality and Security:*

6.5.1 MTs should maintain confidentiality and security of patient care documentation. Refer to Guide E1902 for additional information.

6.5.2 MTs should notify appropriate personnel of confidentiality and security breaches (See HIPAA).

7. Management

7.1 Management should coordinate the integrated process of dictation, transcription, and the delivery of reports. To ensure quality documentation, management should provide adequate training and resources for healthcare providers, the medical transcription staff, and the quality assurance staff responsible for monitoring transcription. Management should orient new staff and provide continuing education to existing staff to assure maintenance of the QA program. Continuing education enhances the quality of patient care documentation by keeping MT and QA staff informed regarding healthcare issues, procedures, reimbursement, and technological advances that contribute to quality patient care.

7.2 Management should establish guidelines for identifying qualified medical transcriptionists and quality assurance staff. Management should attempt to identify candidates who are appropriate to the staff position and build a team with complementary strengths.

7.3 Policies should be developed to address difficult or problematic authors and how to work with them to ensure the accuracy and completeness of their reports.

7.4 Policies should be developed to manage workflow.

7.5 Management should develop a policy stating who will be responsible for determining the likelihood or possibility that a voice file can be transcribed with reasonable accuracy. Impediments to accurate transcription of such voice files include inaudible or broken dictation, heavily accented speech, rapid speech, or esoteric and uncommon terminology that is difficult to document.

7.6 Adequate resources for research should be available for transcription staff, and they should be updated regularly.

7.7 Format, style, and editing definitions and policies should be developed and implemented with input from the MT staff.

7.8 Access to subject matter experts and feedback are necessary if MTs are to continue to pursue quality documentation. Management should develop policies and procedures for MTs to communicate with or receive feedback from the author and others who may have pertinent information (for example, a pharmacist).

7.9 Management should apprise MT staff of risk management concerns and the procedures to follow for identification, correction, and referral.

7.10 Management is responsible for development of policies and procedures, with input from MT staff, in accordance with regulations regarding:

7.10.1 Errors, omissions, and inconsistencies prior to author authentication. See Guide E1762.

7.10.2 Errors, omissions, and inconsistencies subsequent to author authentication. See Guide E1762.

7.10.3 Prioritization of transcription and turnaround time requirements.

7.10.4 Acceptable quality or accuracy score requirements, or both.

7.10.5 Identification of technical support personnel.

7.10.6 Confidentiality and security related to dictation and transcription of patient care documentation. See Guide E1902.

7.10.7 Identification of the individual(s) with authority to resolve errors.

7.10.8 Determination of frequency and volume of work to be reviewed in the QA process.

7.10.9 Methods for responding to complaints.

7.10.10 Quality assurance statistics (for example, timeliness, accuracy, adherence to standards, production, workflow).

7.10.11 Continuing education for MTs and other professional staff.

7.11 Management should confer with MTs in the purchase of resource materials and should encourage MTs to use them appropriately.

7.12 Management should confer with MTs in providing an ergonomically correct work environment.

7.13 Management should develop and monitor a budget for quality assurance in medical transcription.

7.14 Management should ensure the maintenance of pertinent databases, such as physician names and addresses.

7.15 Management should develop performance review criteria related to quality assurance.

8. Quality Assurance

8.1 A quality assurance program verifies the consistency, correctness, and completeness of the process of converting dictation (voice) into text (transcribed reports), including the systematic identification and resolution of inaccuracies and inconsistencies, according to organizational standards. Merely reading reports is not equivalent to a quality review process, which should involve comparison with the voice file and review of content.

8.1.1 The acceptable quality or accuracy score should be determined prior to implementation of review for the QA program. Error types and relative importance or penalty weighting of errors should be clearly defined, reviewed, and updated on a regular basis.

8.1.2 Quality reviewers may identify content, punctuation and grammar, spelling, editing errors, word choice errors, omitted words, author compliance, and mechanical inconsistencies (for example, document types, formats, and incorrect use of identifiers). See Guide E2344.

8.1.3 The QA process should be based on auditing of transcribed reports with concurrent dictation. Concurrent review provides immediate feedback to the MT, who can promptly implement recommended changes before the document is authenticated.

8.1.4 Retrospective review should be done only when time constraints require it. A provider needing the document for patient care would take precedence over a routine random quality check.

8.1.5 Quality assurance review allows identification of continuing education topics for the entire staff based on review outcomes of the group.

8.1.6 The quality assurance guidelines should include a description of the way in which differences of opinion between MT and QA specialist will be resolved. There may be more than one acceptable way to transcribe a dictated phrase or sentence, and reasonable flexibility should be part of the QA program.

8.1.7 All MTs being reviewed should receive written guidelines about the QA program and what performance items are being measured. Performance standards and benchmarks should be clearly understood by MTs and QA staff.

8.1.8 QA personnel should report risk management concerns found on review to the risk management or other appropriate staff.

8.1.9 QA personnel should adhere to management's confidentiality and security policies and guidelines. See Guide E1902.

8.1.10 Consistency of productivity levels and compliance with required turnaround times affect the overall quality of transcription; both should be monitored as part of the QA process.

8.1.11 The frequency and timing of quality review should be based on organizational policies; they determine how work is selected for review.

8.1.12 The selection process by which documents are reviewed should be truly random or at least unpredictable. If an MT can easily predict which day or which transcribed documents will be selected for QA review, the integrity of the results will most likely be skewed or compromised.

8.1.13 Periodic audits should be performed on the dictation and feedback given to authors.

9. Keywords

9.1 accuracy; audit; author; consistency; dictated content; dictation; management; medical transcription; patient safety; quality assurance; review; transcribed content

SUMMARY OF CHANGES

Committee E31 has identified the location of selected changes to this guide since the last issue, E2117 – 00, that may impact the use of this guide. (Approved October 15, 2006)

(*1*) Revised the text throughout.