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

This standard is issued under the fixed designation E2117; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

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.

1.4 *This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.*

2. Referenced Documents

2.1 *ASTM Standards:*[2]

E1762 Guide for Electronic Authentication of Health Care Information (Withdrawn 2017)[3]

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.

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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/adminsimp.

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

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

3.1.5 *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)**

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

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

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