



MEDQUIST QUALITY STANDARDS

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MedQuist's Position on Quality in Healthcare Documentation

MedQuist's greatest mission is to contribute to the quality of life and longevity of our friends and neighbors. They are the patients served by thousands of esteemed healthcare institutions that look to MedQuist for healthcare documentation services and technology.

MedQuist has the distinct privilege of being a trusted partner of these facilities. Our contribution to patient safety, document integrity, healthcare institutions' long-term financial viability, and availability of quality patient care in our local communities is a commitment we treat with seriousness and respect.

MedQuist is proud to employ some of the industry's finest, most educated, experienced, and talented medical transcriptionists (MTs) and quality assurance support staff. These professionals take great pride in their profession, work product, and service to physicians and patients.

Along with our transcriptionists, MedQuist recognizes the Association for Healthcare Documentation Integrity (AHDI) as a trusted source for standards in measuring medical transcription quality. The standards listed in the *AHDI Metrics for Measuring Quality in Medical Transcription* are leveraged throughout the MedQuist Quality Standards Program. The American Society for Testing and Materials (ASTM) document "Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription" (Designation: E 2117 – 06) is also leveraged.

Definition of Quality and Quality Assurance Process Goals

Quality of transcription, or voice-to-text conversion, is defined as consistently clear, accurate, and complete patient healthcare documentation derived from a dictator's vocal input. Transcription quality may be affected by the audio quality of the dictator's voice, education, or skills, as well as the education and experience of the transcriptionist.

An advanced, structured quality assurance (QA) process provides regular performance improvement and results in consistently clear, accurate, and complete patient healthcare documentation. Patient safety and document integrity are preserved by the diligent application of intelligence, discernment, and process improvement.

The quality assurance process has two main goals:

- Improved documentation through error identification and explanation.
- Improved dictator, MT/ME, MME and quality support staff skills through error pattern identification, evaluation, and follow-up education.

MedQuist enables continuing education policies that increase MT/ME, MME and quality support staff knowledge and discernment, and will also highlight dictator communication skill issues that need to be addressed. Quality review communication and methods must be consistently thorough, fair, easily understood, and actionable for all participants. Also, the ASTM standard indicates that the MT and quality support staff need a forum to challenge the review's results, which may reveal opportunities for process improvement.

Scope of Transcription Quality Program

The scope of MedQuist's National Quality Program is limited to voice-to-text conversion. The ASTM Medical Transcription Quality Standard identifies five areas of interest applicable to transcription:

- **Voice capture** encompasses the document identification process, dictation equipment usage, dictator education, and the dictation's content, confidentiality, and security.
- **Voice-to-text conversion** encompasses healthcare document production based on the voice capture methodology.
- **Voice and text distribution** includes efficient, secure, and timely document distribution management based on the department's needs and the MT's skills.
- **Interfacing** includes confidential, secure, and efficient document identification element exchange and record importing and/or exporting.
- **Management support** includes HIPAA compliance enforcement, timely problem resolution, and audit trail provisions.

These areas are vitally important to MedQuist and its healthcare partners. This document addresses policies, procedures, and standards for **voice-to-text conversion**.

Classification of Errors and Error Values

AHDI (AAMT) recommends specific error categories, error values, and conversion factors for error values in line length situations. Following the recommendations creates a true definition of quality in the medical transcription industry and allows for proper comparative assessments. AHDI (AAMT) recommends that the following error classifications be applied to these error types relative to their impact on patient care.

- **Critical Errors:** Defined as those that impact patient safety. Specifically, AHDI (AAMT) identifies the following: medical word misuse, incorrect drug or drug dosage, incorrect lab values and test names, omitted dictation, and patient identification errors, including incorrect choice of the patient name or specific patient visit.
- **Major Errors:** Defined as those that impact document integrity. Specifically, AHDI (AAMT) identifies the following: medical word misspelling, English word misspelling, incorrect verbiage, failure to flag a document, abuse of flagging documents, protocol failures.
- **Minor Errors:** Specifically, AHDI (AAMT) identifies the following: grammar, punctuation, typographical errors, formatting errors.
- **Dictation Flaws:** Specifically, AHDI (AAMT) identifies the following: critical, major, and minor as defined by patient safety and document integrity impact. It is crucially important to realize the impact that auditory quality of the dictation has on the transcribed document. Recognizing and documenting occurrences allows for identification of flaws and an opportunity for assisting dictators in their quest for patient safety and document integrity.

Definition of Dictated or Transcribed Errors and Error Values

CRITICAL ERRORS (PATIENT SAFETY RISK): A critical error is given the highest negative point value because of the seriousness of its consequences. With 98 percent accuracy as a benchmark, a report containing a critical error should not pass QA. A critical error should be reserved for only those errors that directly compromise patient safety.

• **Error #1: Medical Word Misuse – 3.0 pts**

This category includes wrong drug or drug doses, wrong lab values, and/or wrong test names that directly compromise patient safety. For instance, a wrong disease could be incorrectly attributed to a patient and then carried in the medical record for life, causing incorrect treatment and incorrect medical decisions, as well as inaccurate billing of the patient's accounts. Similarly, a wrong lab value could result in a patient not receiving treatment or further testing when such treatment or testing is warranted. If a misuse is repeated throughout the entire report, it should be counted as only one error in the report, since it reflects one wrong piece of information on the part of the transcriptionist. This category also includes improper use of abbreviations, acronyms, and symbols that are not to be used according to the client profile.

• **Error #2: Omitted Dictation – 3.0 pts**

This category covers dictated information of a critical nature that was either carelessly omitted by the transcriptionist or deliberately omitted because the transcriptionist did not understand what was being said. Examples include omission of an entire laboratory finding because the value itself could not be heard, deleting negative or normal findings, or omitting

entire sentences because the main part of it could not be understood. Creative transcription is also included in this category. This refers to “making up” dictation (words and/or phrases) when what is dictated is not clear. Consideration should be given for difficult authors or dictation of poor quality.

Research, assistance from others, flagging the report, and leaving a blank constitute appropriate actions rather than omission. This category does not apply to missing words that are inconsequential, such as articles or conjunctions. It also does not apply to what appear to be words missed (adjectives, adverbs) from typing too fast, unless they have serious consequences to the medical meaning. In these types of situations, the error would be downgraded to major or minor, depending on the consequence to the document. Clipped sentences are allowed if they reflect the dictator’s style. This category is meant to apply to purposeful and/or serious omissions and/or fabrication(s).

☛ **Error #3: Patient Identification Error – 3.0 pts**

A patient identification error is one in which the wrong patient information is tied to the dictation. For example, a report that is dictated for 50-year-old John E. Doe (male) but is attributed to a chart for 20-year-old Joni Do (female). As with the other critical errors in this category, the error must directly compromise patient safety in order to be assessed this error weight (see error #12).

☛ **Error #4: Upgrade of Major or Minor error due to patient safety impact – 3.0 pts**

This category is for major or minor errors from the categories below that directly compromise patient safety. For example, “failure to flag” is considered a major error worthy of 1.0 pt., but a right/left discrepancy that poses a risk management issue and is not flagged by the transcriptionist could be upgraded to a critical error.

MAJOR ERRORS (DOCUMENT INTEGRITY RISK): A major error carries a higher negative point value because of the impact it has on the integrity of the document. Major errors in this category do not pose a risk to patient safety. A major error that impacts both the integrity of the document *and* patient safety should be upgraded to a critical error.

☛ **Error #5: Abuse of Flagging/Blanks – 2.0 pts**

This category covers blanks left that, through research, the transcriptionist could have resolved. This is sometimes referred to as “tossing it over the fence” – when a transcriptionist clearly chooses to leave a blank rather than research a term. The purpose of this category is to limit abuse of blanks for the sake of speed, which reflects a lazy attitude or desire for higher line counts in a production environment. Obviously, students and entry-level transcriptionists will leave more blanks in the beginning, and this is preferred to guessing. This error should be used only in those cases where the blank or flag is truly considered abusive.

☛ **Error #6: Medical Word Misspelling – 1.5 pts**

In addition to any medical words or medications that are misspelled, this category includes the use of an incorrect form of a medical word. An example would be “lingula” instead of “lingular” or “femur” instead of “femoral.” This also includes failure to use combining forms, and incorrect entries from text expanders. For instance, an author dictates that the patient is to see physical therapy (dictated as PT) for follow-up; transcriptionist uses “pt” to expand for “patient” and the final copy of the report reads, “the patient is to see patient for follow-up.” (However, if an incorrect expansion results in a critical error, such as incorrect diagnosis, this would be upgraded to a critical error.)

☛ **Error #7: English Word Misspelling – 1.5 pts**

In addition to misspelling English words, this category refers to misuse errors, which have more serious consequences, such as nouns, verbs, or important qualifying adjectives and adverbs (e.g., elicit/illicit, dissent/descent, affect/effect, apprise/appraise). These errors directly impact the integrity of the report. For instance: “the risks and complications were given allowed (aloud).”

☛ **Error #8: Incorrect Verbiage – 1.5 pts**

This category refers to dictation that is transcribed differently than dictated, but without significant impact on the medical meaning. This includes inappropriate/excessive editing. Care should be taken to remain true to the dictator’s style while still maintaining accuracy. Therefore, this does not pertain to changes made for the purpose of correcting grammar or word usage. This also differs from creative transcription (see error #2).

☛ **Error #9: Failure to Flag – 1.0 pt**

This category pertains to times when a report should be flagged for clarification and the transcriptionist fails to do so. Examples of failure to flag include gender, age or right-vs.-left discrepancies that should have been recognized by the transcriptionist and flagged, but were not.

☛ **Error #10: Protocol Failure – 1.0 pt**

A protocol failure is one in which a transcriptionist fails to follow a specific protocol or facility preference. For example, a facility may require the date of service be filled in on each document, and the transcriptionist fails to include this.

☛ **Error #11: Upgrade of Minor Error due to impact on integrity of document – 1.5 pts**

This category is used to upgrade a minor error that compromises the integrity of the document. For instance, a physician dictates an inflammatory or derogatory remark about the patient that puts the physician at risk for a lawsuit, and the transcriptionist fails to edit these remarks.

☛ **Error #12: Downgrade of Critical Error due to less than critical impact – 1.5 pts**

This category is used to downgrade a critical error that does not compromise patient safety but still impacts the integrity of the document. An example would be using the wrong medical word (medical word misuse) without directly affecting patient safety (stating there is a family history of “corporal” tunnel syndrome, for example).

☛ **Error #13: Improper Encounter – 1.5 pts**

This category is used when the correct patient is chosen, but the wrong visit or encounter is selected.

MINOR ERRORS: A minor error is meant to point out recommended areas of improvement for the transcriptionist. These errors do not compromise patient safety or the integrity of the report. The primary goal of a minor error designation is instructional.

☛ **Error #14: Grammar Error – 0.5 pt**

Grammar errors may include incorrect subject-verb agreement, incorrect use of medical abbreviations, use of the wrong part of speech, incorrect use of singular and plural nouns, use of the wrong verb (e.g., laying/lying) or verb tense, failure to correct redundancies and inconsistencies, and failure to edit slang or inflammatory remarks when appropriate.

☛ **Error #15: Miscellaneous/Other – 0.5 pt**

This category covers errors that do not fit into the other categories. For instance, improper capitalization, addition of words that were not dictated but that do not significantly affect the meaning of the sentence or report, and errors of questionable cause when the recording quality is poor or a foreign accent is at fault. This category also covers formatting errors.

☛ **Error #16: Downgrade of Error due to minimal impact – 0.25 pt**

This category can be used to downgrade any error that has little to no impact on the integrity of the report and does not compromise patient safety. An example would be omission of the word “the” in “The patient was in acute distress.”

☛ **Error #17: Punctuation and Typos – 0.0 pt**

Punctuation errors may include misplaced commas that do not alter the meaning of the sentence, misplaced periods, and the improper use of colons, semicolons, or quotation marks. This category also includes typographical errors that do not significantly affect the meaning of the dictation.

NEGATIVE DICTATOR EFFECT ERRORS: These errors have no point values but are used to recognize a transcriptionist's error or difficulties in the context of poor dictation.

☛ **Error #18: Critical Negative Dictator Effect – 0.0 pt**

This category would be used to point out an error of a critical nature that was clearly attributed to poor dictation. For example, omitted dictation based on difficulty interpreting a very heavy accent. Another example would be incorrect patient identification due to inaccurate or insufficient information given by the dictator. This error may be utilized whether or not the transcriptionist flagged the document, since the purpose is to determine the difficulty encountered in producing an accurate document.

☛ **Error #19: Major Negative Dictator Effect – 0.0 pt**



This category would be used to address a documentation error in any of the major categories that was obviously incurred because of poor dictation quality or inaccurate information given by the dictator. Once again, this error may be utilized whether or not the transcriptionist flagged the document, since the purpose is to determine the difficulties in producing an accurate document.

• **Error #20: Minor Negative Dictator Effect – 0.0 pt**

This category would be used to draw attention to a minor flaw caused by poor dictation. For example, the dictator has used the wrong form of a verb, which may or may not have been corrected by the transcriptionist.

Scoring Methodology

Random & Customer Audits: Once the errors have been identified, appropriately classified, and the weighted point value assigned to the errors, mathematical computations are done to calculate the accuracy percentage. Due to the impact of potential transcription errors on patient care, AHDI (AAMT) recommends a minimum score of 98 percent accuracy be required for all documents. This percentage is calculated by subtracting the total point value from the total number of payroll lines, then dividing that number by the total number of payroll lines. Example: If the report is 150 lines and the total value of errors is 2 points, $150 \text{ lines} - 2 \text{ errors} = 148$ divided by 150 lines = 98.7 percent.