STANDARDS OF SERVICE
FOR MEDICAL TRANSCRIPTION

VERSION 10

June 2005
VANDERBILT UNIVERSITY MEDICAL CENTER
STANDARDS OF SERVICE FOR MEDICAL TRANSCRIPTION
VERSION 10

Purpose

The purpose of this “Standards of Service for Medical Transcription” document is to ensure the most accurate, cost-effective, timely, HIPAA-compliant, and systems-compatible patient care and medical record dictation and transcription through transcription vendor pre-qualification.

Background

Typically in the past, except for the Vanderbilt Hospital Medical Information Services Department, medical transcription vendors have been selected primarily on the basis of their quoted per-line prices. Little, if any, regard was paid during the selection process to delivery, systems, invoicing, and other important standards or how to measure the performance of the vendors against such standards. The result was a hodgepodge of vendors, each significantly different from the others. Each of these vendors required special adaptations in the VUMC Informatics Center interfaces and software in order for VUMC to receive the transcription files and successfully deliver them to the StarChart electronic patient record system. The result was lower “quoted” prices, but very large hidden costs, major systems support problems, significant quality and billing issues, and document costs that did not always reflect the lower “quoted” prices. In the aggregate, there were no standards either for vendor selection or for determining a vendor’s overall performance.

An attempt was made to solve this problem of vendor hodgepodge by establishing a single “prime vendor” for medical transcription. This approach largely worked for some time. However, as vendors more aggressively sought new business with various departments by quoting lower prices and promising higher accuracy rates and speedy delivery times, the problems returned. Clearly, a medical transcription service standards document was needed to help departments appropriately select new vendors, monitor those vendors against an equitable standard, and eliminate those vendors who cannot consistently demonstrate strict adherence to the standards.

This need for a medical transcription service standards document is met with this “Vanderbilt University Medical Center Standards of Service for Medical Transcription” document. Questions about this document and its application should be addressed to:
Vanderbilt Medical Information Services, Attn: Director, B-334 VUH, Nashville, TN 37232-7350.
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Definitions

“Turnaround Time” is defined as “The elapsed time—measured in hours and tenths—beginning with the Vendor’s receipt of the dictator’s voice file and ending with the electronically acknowledged receipt of the electronic transcribed document on the designated Vanderbilt server.” The electronically acknowledged time of receipt on the designated Vanderbilt server shall exclude any Vanderbilt server response delay.

“Maximum Turnaround Time” is defined as “The turnaround time—set for each document type—beyond which the transcribed document shall be deemed late for purposes of turnaround time measurement, reporting, and penalties.”

“On-Time Document” is defined as “A document with a turnaround time less than or equal to the maximum turnaround time.”

“Late Document” is defined as “A document with a turnaround time greater than the maximum turnaround time.”

“Lost Document” is defined as “A document which has not been and cannot be transcribed and delivered by the Vendor because the Vendor cannot locate or recover the dictation voice file, and for which the dictator can supply a Vendor-provided confirmation that the voice file was received by the Vendor.”

“Stat Document” is defined as “Any dictated document requiring transcription turnaround in less time than the standard turnaround time specified in Table 1 for the specific document type.” “Stat” documents may be discharge summaries or any other approved document as needed in less than the standard turnaround time specified for the respective document types.

“Standard document header” is defined as “The first page of a delivered transcribed document and containing specific defined information in a prescribed exact format as required for the document’s acceptance by the Vanderbilt Medical Center’s StarChart electronic medical records system.”

“Quality Assurance” is defined as “The processes by which the transcription Vendor ensures the accuracy of the delivered transcribed documentation and which are in full compliance with the American Society for Testing and Materials (ASTM) ‘Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription.’ (ASTM Ref. #E2117-00, See Appendix “C”).”

“Transcription Services” are defined as “All Vendor services required to reliably receive and track medical dictation produced both by telephones and digital dictation recorders;
transcribe that dictation; systematically deliver a confirmed accurate, complete, and timely electronic document to Vanderbilt’s designated server; electronically confirm receipt of that document by Vanderbilt; generate an accurate invoice for these services; and produce the required productivity and quality assurance reports as defined by Vanderbilt.”

“Standard Services” are defined as “All Vendor support and services required to provide ‘Transcription Services’”

“Non-Standard or Extended Services” are defined as “All Vendor support and special services not included in ‘Transcription Services’ as defined above, and which may be separately provided by a second Vendor or even by Vanderbilt and therefore accounted for and billed separately.”

“Document Type” is defined as “The transcription work type of the dictated document.” The standard document types are listed in Table 1.

“98% Accurate” is defined as the minimum acceptable transcription accuracy level as defined by and measured in accordance with the “Vanderbilt Quality Assurance Worksheet” in Appendix “D.”

“Characters” are defined as any visible or place-holding letter, number, symbol, punctuation mark, space, or hard line return contained in the transcribed document. Visible characters are defined as ASCII characters: 9, 10, 12, and 32-126 only.

“Lines” are defined as sixty-five (65) “characters.” A “line” shall be calculated by counting all above-defined “characters” contained in a document and dividing that total number of “characters” by 65 to arrive at the number of 65-character lines in the document.

“Document” is defined as all “character” content inclusive of any “characters” included in text boxes, but exclusive of all “characters” contained in the standard document header.

Turnaround Time Requirements

The maximum turnaround times for the various document types are prescribed in Table 1 below. Documents delivered after their respective maximum turnaround times shall be late for purposes of individual document and overall turnaround time measurements and as well as for transcription charge penalty calculations. The Vendor shall schedule all routine hardware and software maintenance in such ways as to prevent interference with or limitation of the Vendor’s ability to meet the maximum turnaround time requirements.
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<table>
<thead>
<tr>
<th>DOCUMENT CODE</th>
<th>DOCUMENT TYPE</th>
<th>MAXIMUM TURNAROUND TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>STAT Report</td>
<td>2 Hours</td>
</tr>
<tr>
<td>HP</td>
<td>History and Physical</td>
<td>12 Hours</td>
</tr>
<tr>
<td>PO</td>
<td>Pre-Op History and Physical</td>
<td>6 Hours</td>
</tr>
<tr>
<td>OR</td>
<td>Operative Report</td>
<td>24 Hours</td>
</tr>
<tr>
<td>DS</td>
<td>Discharge Summary</td>
<td>24 Hours</td>
</tr>
<tr>
<td>CO</td>
<td>Consultation</td>
<td>12 Hours</td>
</tr>
<tr>
<td>AN</td>
<td>Admit Note</td>
<td>12 Hours</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department Note</td>
<td>6 Hours</td>
</tr>
<tr>
<td>CN</td>
<td>Clinic Note</td>
<td>24 Hours</td>
</tr>
<tr>
<td>RL</td>
<td>Referral Letter</td>
<td>24 Hours</td>
</tr>
<tr>
<td>CR</td>
<td>Client-Requested Revision</td>
<td>24 Hours</td>
</tr>
<tr>
<td></td>
<td>(Any Document Type)</td>
<td></td>
</tr>
<tr>
<td>RR</td>
<td>Radiology Report</td>
<td>6 Hours</td>
</tr>
<tr>
<td>PG</td>
<td>Pathology Gross Description Report</td>
<td>24 Hours</td>
</tr>
<tr>
<td>PD</td>
<td>Pathology Attending Diagnosis Report</td>
<td>3 Hours</td>
</tr>
<tr>
<td>RO</td>
<td>Radiation Oncology Report</td>
<td>24 Hours</td>
</tr>
</tbody>
</table>

*Table 1 – Maximum Turnaround Time by Document Type*
Per-Line Charge Penalty for Late Documents

A per-line transcription services charge penalty shall be imposed on the Vendor for each late document. The late-document per-line charge penalty shall be triggered at the moment the document becomes late (see Table 1 above) and shall escalate in accordance with Table 2 below for each additional whole or fraction hour the document is late. The per-line charge penalty shall not exceed the Vendor’s total charge for the document, which includes all per-line and all unit-priced charges. For example, a History and Physical document that is delivered in 15.3 hours as opposed to 12 hours (see Table 1) is 3.3 hours late and shall incur a one-half-cent-per-line-per-hour penalty times 4 hours (Table 2), for a 2-cent-per-line total charge penalty. If the document has 100 lines, the per-line charge is 13 cents, and the charge for the system-generated document header is 25 cents, the maximum charge penalty for the late document would be $13.25 (i.e., 100 x 0.13 plus 0.25). The Vendor shall automatically reduce the charge for late documents and clearly report the charge reduction consistent with the reporting requirements under the “Reporting” section.
<table>
<thead>
<tr>
<th>DOCUMENT CODE</th>
<th>LATE DOCUMENT TYPE</th>
<th>LATE-DOCUMENT PER-LINE CHARGE PENALTY PER HOUR LATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>STAT Report</td>
<td>3 Cents/Line/Hour</td>
</tr>
<tr>
<td>HP</td>
<td>History and Physical</td>
<td>0.5 Cent/Line/Hour</td>
</tr>
<tr>
<td>PO</td>
<td>Pre-Op History and Physical</td>
<td>1 Cents/Line/Hour</td>
</tr>
<tr>
<td>OR</td>
<td>Operative Report</td>
<td>0.25 Cent/Line/Hour</td>
</tr>
<tr>
<td>DS</td>
<td>Discharge Summary</td>
<td>0.25 Cent/Line/Hour</td>
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<td>Clinic Note</td>
<td>0.25 Cent/Line/Hour</td>
</tr>
<tr>
<td>RL</td>
<td>Referral Letter</td>
<td>0.125 Cent/Line/Hour</td>
</tr>
<tr>
<td>CR</td>
<td>Client-Requested Revisions (All Document Types)</td>
<td>0.25 Cent/Line/Hour</td>
</tr>
<tr>
<td>RR</td>
<td>Radiology Report</td>
<td>0.25 Cent/Line/Hour</td>
</tr>
<tr>
<td>PG</td>
<td>Pathology Gross Description Report</td>
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<td>PD</td>
<td>Pathology Attending Diagnosis Report</td>
<td>2 Cents/Line/Hour</td>
</tr>
<tr>
<td>RO</td>
<td>Radiation Oncology Report</td>
<td>0.25 Cent/Line/Hour</td>
</tr>
</tbody>
</table>

*Table 2 – Per-Line Charge Penalty by Document Type.* The “Late-Document Per-Line Charge Penalty Per Hour Late” for each document type is equal to 6 cents per line divided by the “Maximum Turnaround Time” from Table 1. For example, for a History and Physical (HP) document, 6 cents per line divided by 12 hours equals 0.5 cents per line per hour as above.
Penalty for Lost Documents

A one-hundred-dollars penalty shall be levied against the Vendor for each lost document. A “Lost Document” is defined as any document which has not been and cannot be transcribed and delivered by the Vendor because the Vendor cannot locate or recover the dictation voice file, and for which the dictator can supply a Vendor-provided confirmation that the voice file was received by the Vendor. A “Lost Document” is NOT a voice file that was cut off prematurely during dictation. It will be presumed by Vanderbilt that if the Vendor provides a confirmation of receipt of a dictation voice file, then it is reasonable to expect that the Vendor should incur a penalty if that file should become lost or destroyed prior to the Vendor’s transcription and delivery of the corresponding transcribed document. In each such instance of lost documents, the Vendor shall pay the dictator $100. Payment of the $100 penalty shall be directed to the dictator via the Vanderbilt Medical Center’s Information Services Department Transcription Services Coordinator in order to ensure that all such claimed instances are valid and logged. Frequent or major proven lost-document occurrences may be deemed sufficient reason to initiate cancellation of the Vendor contract. Justification for the severity of this lost-document penalty lies in the liability exposure each occurrence places upon Vanderbilt and in the time and effort required by the dictating physician to reproduce the dictation. (See also the “Dictation Voice File Receipt Confirmations” paragraph under “Reporting.”)
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Quality of Transcription

Quality of delivered transcribed documents must be maintained at no less than ninety-eight percent (98%) accuracy level as defined by and measured in accordance with the “Vanderbilt Quality Assurance Worksheet” (see Appendix “D”). The Vendor shall provide call-in help-desk assistance for each transcriptionist as well as optional routing to a proofreader for the purpose of achieving maximum quality on each document. Using a statistically valid, unbiased, whole-month sampling method agreed upon in writing by Vanderbilt, the Vendor shall monitor a minimum of one percent (1%) of all documents for the preceding month from each of its transcriptionists for adherence to the 98% accuracy quality assurance standard. For any transcriptionist whose one-percent (1%) statistically sampled work does not meet the minimum 98% accuracy standard, and for all transcriptionists newly assigned to the Vanderbilt account, the Vendor shall immediately begin monitoring a minimum of five percent (5%) of all that transcriptionist’s documents and shall continue to do so for a minimum probationary period of two months. If that transcriptionist’s 5% statistically sampled work does not consistently achieve the 98% accuracy standard by the end of the two-month probationary period, the Vendor shall remove that transcriptionist from the pool of transcriptionists serving the Vanderbilt account. Any transcriptionist failing at any time to meet the minimum 98% accuracy standard shall be provided additional training and assistance by the Vendor. Quality assurance reports showing the quality measurement results for each transcriptionist shall be provided by the Vendor to Vanderbilt on a monthly basis. These reports shall clearly show actions taken by the Vendor regarding new transcriptionists, any transcriptionists who have been placed on the 5%-sampling, two-month, work improvement probation, and transcriptionists who have been removed from the pool of those serving the Vanderbilt account.

Patient Demographics

To keep with the concept of quality in transcription, Vanderbilt requests that real-time patient demographics are sent via an HL7 ADT interface to the vendor. We know that mistakes can occur if we rely solely on a physician to dictate the MRN or patient name correctly and a transcriptionist needs to keypunch the data into the report. An HL7 interface will automatically post the demographics so dictation/keypunch errors are reduced. For current requirements, please contact the Chief Information Security Officer (CISO) or the HIPAA manager for information.
Pricing

The Vendor shall provide a complete per-unit base pricing schedule for both “standard” and “non-standard” transcription services. The purpose for this per-unit pricing schedule is to eliminate “hidden” charges and thereby help ensure that all service recipients clearly understand the cost for each provided service.

The Vendor shall also provide an electronic line-counting program with which the Vanderbilt Medical Center’s Information Services Department Transcription Services Coordinator can perform count audits at any time on the Vendor’s work. Alternatively at the vendor’s option, Vanderbilt may provide the vendor with an example electronic line counting program to demonstrate the counting algorithm.

Because of the extreme importance of consistently accurate document pricing and the historical industry-wide problem of inaccurate billing for transcription services, a document charge penalty shall be imposed for any documents incorrectly priced. The document charge penalty shall be equal to the erroneous price charged for each erroneously priced document. Repeated significant patterns of erroneous document pricing, in the absence of clear evidence of progressive and sustained improvement, shall constitute sufficient reason for contract termination.

“Standard Services” Pricing

Base “Per-Line” Pricing: For purposes of transcription services pricing, a “line” shall be defined as sixty-five (65) “characters.” A “character” shall be defined as any visible or place-holding letter, number, symbol, punctuation mark, space, or hard line return contained in the transcribed document. A “document” shall be defined as all “character” content inclusive of any “characters” included in text boxes, but exclusive of all “characters” contained in the StarChart document header. A “line” shall be calculated by counting all above-defined “characters” contained in a document and dividing that total number of “characters” by 65 to arrive at the number of 65-character lines in the document. To be billable, “characters” must be visually countable on the printed document. Also, only one space between words and sentences may be counted toward the total number of “characters” and no other use of spaces shall be billable. Hidden formatting instructions such as bolding, underlining, text boxes, printer configurations, etc. shall not be included in the total “character” count for billing purposes. For purposes of per-line pricing, all “characters” in the system-generated, unit-priced standard document header (see Appendix “A”) shall be excluded. (See also the “StarChart Standard Document Header Per-Document Pricing” paragraph below.)
Electronic Document Delivery Pricing: The electronic delivery of transcribed documents to a specified Vanderbilt server, the provision of an hourly electronic manifest of documents sent to the server, and the electronic cross-checking of that manifest against a return-receipt manifest from Vanderbilt are considered to be part of the transcription services covered by the Vendor’s base “per-line” pricing (see “Base ‘Per-Line’ Pricing” paragraph above). Because these services are required for every transcribed document, they shall not be separately priced. Electronic document delivery shall be included as part of the base per-line pricing. Additional requirements related to electronic document standard delivery are included in the “Document Delivery” section below.

StarChart Document Header Per-Document Pricing: The Vanderbilt StarChart electronic medical records system requires a fixed-format standard document header (See Appendix “A”) in order for documents to be accepted by the system. Because Vanderbilt requires that these standard document headers be auto-generated by the Vendor’s computerized systems, these headers shall be priced separately at an appropriately low fixed charge per document. This low per-document charge will be the same for all documents, regardless of document type, length, difficulty, or method(s) of delivery.

Surcharge Pricing for STAT Documents: STAT document surcharges shall be separately priced on a surcharge-per-line basis. The Vendor shall not levy a STAT surcharge for the standard document header lines that are required for all documents. The document type surcharge code for “STAT” documents shall be “ST” on the Vendor’s monthly invoices (see Appendix “E” example).

Surcharge Pricing for Special Document Formatting: Vanderbilt departments shall provide the Vendor with one or more standard document formats for each of the standard document types in Table 1. The per-line price for the first format per document type shall be the base “standard services” per-line pricing rate (see “Base ‘Per-Line’ Pricing” paragraph above). Second and subsequent document formats per document type shall be priced by the Vendor with a per-line surcharge that reflects the difficulty of transcriptionists in reproducing the specified format. The document type surcharge code for documents with special formatting shall be “F” on the Vendor’s monthly invoices (see Appendix “E” example).

Standard Reports Pricing (See “Reporting” Section): All reports specified in the “Reporting” section below shall be defined as “Standard Reports” and shall therefore be included in the Vendor’s standard pricing schedule.
“Other Standard Services” Pricing: Vendor services not specifically required by this standards document, but which are generally understood and accepted within the medical transcription industry as normally expected services to be included in standard pricing, shall be considered as “Standard Services” and therefore included in the Vendor’s standard pricing schedule. Other “Non-Standard” or “Extended” services shall be priced separately (see “Non-Standard or Extended Services’ Pricing” section immediately below).

“Non-Standard or Extended Services” Pricing

Remote Printing Pricing: An appropriately low separate per-document surcharge shall be established for printing documents remotely to networked printers at Vanderbilt locations. Remotely printed documents shall still be delivered electronically to Vanderbilt’s designated server (see “Document Delivery” section below). The special delivery surcharge code for remotely delivered documents shall be “RP” on the Vendor’s monthly invoices (see Appendix “E” example).

Courier Delivery Pricing: A separate per-document surcharge shall be established for delivery of pre-printed documents by courier to a specified Vanderbilt location. Courier-delivered documents shall still be delivered electronically to Vanderbilt’s designated server (see “Document Delivery” section below). The special delivery surcharge code for courier-delivered documents may be “PD” (i.e., “Print and Deliver”) on the Vendor’s monthly invoices (see Appendix “E” example).

One-Time and Other Special Reports Pricing (See “Reporting” Section): One-time and other special reports not specified in the “Reporting” section below shall be defined as “Non-Standard Reports” and may be separately and individually priced by the Vendor on a per-Vanderbilt-request basis.

One-Time and Other Special Services Pricing: Charges for special one-time and other special services shall be separately priced at specific hourly or unit rates. For example, prices shall be established for such services as re-sending documents that were verifiably previously sent and consulting and training services not universally recognized as expected to be included as part of standard transcription services.
Reporting

Specific standard reports shall be provided by the Vendor toward ensuring the accurate, complete, timely and systematic delivery of transcribed documents. These standard reports shall be priced as part of the Vendor’s standard pricing schedule (see “Pricing” section above). The Vendor shall submit templates for each of these standard reports as part of the pricing quotation package. The following reports shall be defined as standard reports.

1. **Monthly quality assurance reports** on each transcriptionist (see “Quality of Transcription” section above).

2. **Electronic delivery confirmation manifest** of all documents delivered during the previous hour to the Vanderbilt designated secure server (see “Document Delivery” section below).

3. **Monthly billing reports by dictator** to accompany all monthly invoices. These reports shall include at least the following data for each billed document: dictator name, dictator number, transcriptionist number, document type, date and time of dictation, date and time of completed document confirmed delivery, turnaround time for transcription in “hours.tenths” format, hours late in “hours.tenths” format, total document lines, standard per-line charge rate, per-line surcharge rate, per-line surcharge reason code(s), late-document per-line rate penalty, net per-line charge rate, total of per-line charges, StarChart document header charge, document surcharge(s), document surcharge code(s), and total of all per-line and per-document charges. The format of this report shall be such that it will clearly show the basis for each of the elemental parts of the total amount charged for the document’s transcription services. The report shall have a legend that defines each of the per-line and per-document surcharge codes. See the monthly billing report template example in Appendix “E.”

4. **Monthly graphic histogram (i.e., frequency) charts** of total number of documents by turnaround time and the cumulative percent of documents by turnaround time, each done by document type for all document types (see examples in Appendix “B”) and by dictator ID# for all dictators.

5. **Daily electronic manifests via secure mechanism, indicated by vendor in the Transcription Security Survey or approved by the Chief Information Security Officer (CISO) and the HIPAA manager.** These manifests shall be automatically sent at approximately 6:00 a.m. seven days per week via approved mechanism. These manifests shall provide at least the following for each of the dictator’s transcriptions completed and electronically delivered to Vanderbilt during the previous 24-hour
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period (i.e., since the last daily manifest was sent): dictator’s name and number, 
document job number, date and time of dictation, date and time of confirmed delivery, 
and the patient’s name and medical record number.

6. **Dictation Voice File Receipt Confirmations** shall be provided for (1) telephone 
dictation and (2) dictation voice files recorded on digital dictation recorders and 
subsequently uploaded to the Vendor via the dictator’s computer workstation and 
Internet connection. These individual dictation voice file receipt confirmations shall 
serve as the Vendor’s formal acknowledgment and assurance that the dictator’s 
respective dictation files were received, recorded, date and time stamped, and logged by 
the Vendor’s digital voice recorder (DVR) or other computerized system. In any 
instances of questions that might arise regarding whether a dictator actually dictated a 
specific, undelivered transcribed document, these receipt confirmations shall serve to 
confirm the Vendor’s receipt of the dictation and, therefore, that the dictator indeed 
dictated the document.

7. **Internet-Accessible Tracking and Status Reports** that enable authorized Vanderbilt 
faculty and staff to view dictation file and transcription work tracking and progress 
information in the Vendors’s database. Access shall be by secure Internet protocol. 
Access shall be restricted to those one or more selected faculty or staff in each 
Vanderbilt department who are responsible for ensuring the Vendor’s compliance with 
the standards for timely turnaround of dictation transcription. The Internet-accessible 
reports shall clearly provide at least the following information for each dictation file: 
dictator’s ID#, Vendor’s job ID#, patient’s medical record number, work type, date and 
time of dictation, dictation voice file length in minutes:seconds format, name or ID# of 
transcriptionist to whom the work is/was assigned, current document status, and date 
and time completed document was confirmed to be delivered to the designated 
Vanderbilt server (see “Document Delivery” section below).

8. **All Monthly Reports** shall be delivered electronically by the Vendor to various 
designated individuals, as applicable by report type and content. All monthly reports 
shall be delivered not later than ten (10) days following the last day of the reported 
month. Global reports (in contrast to department-level and dictator-level reports) shall 
be delivered both electronically and in hard copy to the Transcription Services 
Coordinator in the Vanderbilt Medical Center Information Services Department.
Document Delivery

**Standard Document Delivery:** All transcribed documents, each with an appropriate special StarChart document header in the Vanderbilt-required format (see Appendix “A”), and each with transcribed dictation for one and only one patient, shall be delivered electronically by the Vendor via a secure server link to a Vanderbilt-designated server. Hourly electronic manifests, in an electronic format prescribed by the Vanderbilt Informatics Department, shall be similarly delivered by the Vendor to the same designated server. The Vendor shall in turn receive an electronic response manifest from Vanderbilt that shall confirm all documents that were electronically received from the Vendor. The Vendor shall be continuously responsible, as part of its hour-by-hour standard transcription services, to automatically electronically cross-check the two manifests to ensure all documents that were sent were acknowledged as received. In any instances of one or more documents not so confirmed, the Vendor shall immediately resend the document(s) and list said documents on the next electronic manifest. In the instances of a repeating problem with one or more documents, the Vendor shall be responsible for immediately initiating a problem call to Vanderbilt to discern where the transmission breakdown occurred.

For all documents delivered to the designated Vanderbilt server, the server shall confirm the StarChart document header format and content upon receipt of each delivered document. If the Vanderbilt server rejects the electronically received document due to one or more StarChart document header format or content problems (see Appendix “A”), the Vanderbilt server shall alert the Vendor to that rejection and the reason(s) for the rejection on the reply electronic manifest. The Vendor shall be responsible for the immediate correction of the problem(s) and retransmission of the document within twenty-four (24) hours. The date and time each document is ultimately electronically confirmed to have been delivered and accepted by the designated Vanderbilt server shall be the date and time used by the Vendor and Vanderbilt in calculating the turnaround time from dictation to delivery and therefore also any late-document charge penalty.

For any documents dictated without the dictator’s having specified the patient’s name, medical record number, and/or date of service, the Vendor shall be no less responsible for accurate, complete, and timely transcription delivery. However, the Vendor shall not in such cases be penalized for the missing required data. The missing patient’s name, medical record number, and/or date of service shall be denoted by three asterisks (i.e., “***”) in the corresponding StarChart-required header field(s). Additionally, for purposes of communication to the dictator and/or his/her designee, the Vendor shall ensure that the StarChart header “Problem Description” field has an entry that begins with three corresponding asterisks. These three asterisks should be followed by a brief note explaining why the data is missing in the one or more StarChart-required fields. The Vendor’s recourse
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for resolution of repeating problems with the dictation of one or more dictators shall be the Vanderbilt Medical Center’s Information Services Department Transcription Services Coordinator, with appeal recourse to the Director of the Information Services Department.

“Standard Document Delivery” must comply with all the above requirements.

**Non-Standard Document Delivery:** Any other method of delivery of transcribed documents must be via a secure mechanism indicated by the vendor in the approved Transcription Security Survey or approved by the **Chief Information Security Officer (CISO) and HIPAA manager.**
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Job Maintenance

The Vendor shall provide an Internet based interactive access method for Vanderbilt’s Information Services Department to enable Vanderbilt’s Transcription Services Coordinator to modify job priorities, cancel jobs, modify work types, track jobs by dictator ID and work type, and play back dictation voice files and view their corresponding documents. This access method must be indicated by vendor in the Transcription Security Survey or approved by the Chief Information Security Officer (CISO) and HIPAA manager (see also “Voice Files and Data Warehousing” section below).

Voice Files and Data Warehousing

The Vendor shall maintain a secure database archive of all dictation voice files and their corresponding transcribed documents for a period not less than ninety (90) days from the date of dictation. The Vendor shall ensure that daily verified backups of the archival database are made and carefully secured. Though archived in the Vendor’s backup storage system(s), the voice and transcription files stored in these systems is the property of Vanderbilt University Medical Center. The Vendor shall not provide access to or provide any extracted, raw, or summary data from this archive other than as necessary to fulfill the Vendor’s service requirements as governed by this standards of service document. All access to and uses of the data warehoused by the Vendor as here specified shall meet all HIPAA requirements. The Director of Vanderbilt Medical Center’s Information Services Department shall serve as the authority for all Vendor questions about the use of all warehoused data. The vendor’s database archived method(s), backup method(s), and all related access security policies and practices shall be fully disclosed on the Vendor’s submitted and approved Transcription Security Survey or otherwise approved by the Chief Information Security Officer (CISO) and HIPAA manager.
Vendor Provided Training

The Vendor shall provide training services and materials for Vanderbilt Medical Center faculty and staff as applicable and necessary to ensure accurate and efficient dictation and transcribed document production via the Vendor’s services, systems, and interfaces. These training services and materials shall be made available to all dictators and their support staff as they begin using the Vendor’s transcription services and as necessary or helpful thereafter. The Vendor shall provide these training services and materials as part of the global transcription services included in the Vendor’s standard per-line transcription charge (see “Pricing” section above). These services and materials shall include, but not be necessarily limited to, providing training for at least the following:

1. Proper methods of dictation to produce audibly clear and understandable dictation that can be accurately and rapidly transcribed;
2. Proper and effective use of digital handheld digital dictation recorders or other digital dictation devices (e.g., PDAs);
3. How to upload voice files recorded on digital handheld recorders;
4. How to effectively manage digital voice files archival on upload computers;
5. How to track dictation through the transcription and final document delivery processes;
6. How to efficiently download and edit Vendor-delivered transcribed documents; and
7. How to properly and easily submit edited and approved documents to StarChart.
Security of EPHI (Electronic Protected Health Information)

Vendor shall keep all of Vanderbilt’s patient data secure via mechanisms as documented in the Transcription Security Survey and approved by the Chief Information Security Officer (CISO) and HIPAA manager. Approval must occur before execution of contract. The Transcription Security Survey is available on the VUMC HIPAA webpage at: http://www.mc.vanderbilt.edu/HIPAA.

Sufficient Causes for Consideration of Contract Termination

Repeated significant patterns of problems in meeting the requirements of this Standards of Service document, in the absence of clear evidence of progressive and sustained improvement, shall constitute sufficient reason for termination of the transcription services contract.
APPENDIX “A”

STARCHART
STANDARD DOCUMENT HEADER
FORMAT REQUIREMENTS

The StarChart standard document header is the required preamble to any document type in any format; it allows StarChart to process all documents in the various formats and extract the essential identifying, turnaround, and transcription services charge information. Without such information, documents will be rejected and will not be placed into the StarChart system. It is desirable, but not required, that the document header be placed on a separate page at the beginning of each document; this will facilitate printing the actual document from a word processor. Do not repeat the standard header as a page header! (In fact, page headers in documents should generally be avoided, because they may be incorporated by StarChart as if they were part of the text of the document). A file must contain one and only one patient’s document and therefore one and only one standard document header!

The bolded lines on the following page define the required template for the standard document header.
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@#$%

MARS PATIENT TRANSCRIPTION HEADER DOCUMENT

MRN:
PAT NAME:
DATE OF SERVICE:
SERVICE LOCATION:
PHYSICIAN NAME:
PHYSICIAN ID:
TYPE:
JOBID NUMBER:
TRANSCRIPTIONIST NUMBER:
SOURCE FILE:
PROBLEM DESCRIPTION:
DATE OF DICTATION:
TIME OF DICTATION:

@#$%
The following StarChart standard document header requirements must be met:

X The two "@#$%" sequences delimit the standard header, and MUST be present.

X Each field name must appear verbatim at the beginning of its respective line, without any extra spaces or other extraneous characters.

X All fields are mandatory and must appear in the exact sequence listed above on the preceding page.

X With the exception of the “PROBLEM DESCRIPTION” field, each field must have a value in its specific required format (see below).

X All fields must be present for the header to be valid and the document to be submitted to StarChart.

X With the exception of the “PROBLEM DESCRIPTION” field, each field must consist of a single line.

X Headers in which any of these fields do not have a value shall be rejected.

X A file must contain one and only one patient’s document and therefore one and only one standard document header!

The following is a more detailed explanation of the meanings of the required StarChart standard document header fields:

X **MRN** — VUMC Medical Record number, without dashes or spaces. Officially 9 digits; the leading 0 may be omitted, resulting in 8 digits.

X **PAT NAME** — Legal patient name (preferred: Last, First M.). Titles, etc. may follow the name.

X **DATE OF SERVICE** — The date of the encounter, in the format mm/dd/yyyy. Month and day may have only one digit; for Y2K reasons, the year must be specified as 4 digits.

X **SERVICE LOCATION** — The location where the service was performed. Legitimate entries will be provided on a list of approved service locations.

X **PHYSICIAN NAME** — Full name of the physician dictating the document.

X **PHYSICIAN ID** — Physician code (3 or 4 digits, usually).
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X **TYPE** — Type of document; e.g., "Clinic Note", "Stat Discharge Summary," etc. Allowed
document type names and codes appear in Tables 1 and 2. For example, the type code for a
"STAT" document is “ST” and for a “Clinic Note” is “CN” (See Tables 1 and 2). The
entries on this line may be either the document name or its code as specified in Tables 1 and
2. If a document is not of an approved type, its name shall be “SPECIAL” and “SP” shall
be its document code.

X **JOBID NUMBER** — Transcription company job number, if applicable.

X **TRANSCRIPTIONIST NUMBER** — Code that identifies the transcriptionist, if
applicable.

X **SOURCE FILE** — Name of the original voice or word processor file (may facilitate
communication with the transcription company in case of problems).

X **PROBLEM DESCRIPTION** — Any problem with the transcription, etc. should be listed
here, rather than in the body of the document (otherwise, the explanation shall be included
in the official patient record!). This is the only field that may consist of multiple lines or be
empty if no document problems.

X **DATE OF DICTATION** — The date on which the document was dictated in the format
mm/dd/yyyy. Month and day may have only one digit; for Y2K reasons, the year must be
specified as 4 digits.

X **TIME OF DICTATION** — The time of day that the document was dictated (for telephone
dictation) or was uploaded to the transcription company’s computer (for handheld digital
recorder voice file uploads). The time must be in 24-hour military format (as 1321 for 1:21
p.m.).
APPENDIX “C”

AMERICAN SOCIETY FOR TESTING AND MATERIALS (ASTM)

“Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription”
Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription

This guide covers the establishment of a quality assurance program for dictation, medical transcription, and related services. Quality assurance (QA) is necessary to ensure the accuracy of healthcare documentation. It also assists in proving healthcare providers' reimbursement, and reves communication among healthcare providers, thus improving the overall quality of patient care. This guide identifies essential elements for quality health care documentation, but it is not intended to be an exhaustive source.

The QA personnel for medical transcription should have a thorough understanding of the processes and variables of medical transcription. Qualification requirements should include certification of medical transcriptionists (CMTs), quality assurance provisions, or individuals who hold other appropriately relatedents or degrees. The medical transcriptionist (MT) and QA reviewer should have a cooperative partnership so that the review process is objective and educational. Policies should be established to minimize subjectivity, which can lead to full implementation of one style at the expense of other review styles. Objective review includes an appeals process and adherence to departmental standards that have been established by the full team of QA personnel, MTs, and management staff.

Referenced Documents

1. ASTM Standards:
   - 1959 Guide for Requests for Proposals Regarding Medical Transcription Services for Healthcare Institutions


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3. Terminology

3.1 Definitions:

3.1.1 abbreviation expander, n—computer software that allows a few letters or symbols to be extended to a phrase or sentence in order to enhance productivity.

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

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

3.1.4 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.

3.1.5 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: E 1959)

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.

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.

3.1.9 retrospective review, n—quality review of transcribed reports performed after documents have been released for author signature and delivered to a patient's record. The dictation may no longer be available for comparison with the transcribed documents.

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

3.1.11 turnaround time, n—elapsed time beginning with the
liability of dictation or voice file for transcription and
ing when the transcribed document is delivered for authen-
(E 1959)
.1.12 verbatim transcription, n—documentation that has
a transcribed exactly as dictated, without editing for accu-
racy, consistency, completeness, or clarity. See The AAMT
k of Style1 for additional information.
.2 Acronyms:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMT</td>
<td>American Association for Medical Transcription</td>
</tr>
<tr>
<td>CMT</td>
<td>Certified Medical Transcriptionist</td>
</tr>
<tr>
<td>MTS</td>
<td>Medical Transcriptionist, Medical Transcription</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposals</td>
</tr>
<tr>
<td>T</td>
<td>Turnaround Time</td>
</tr>
</tbody>
</table>

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Significance and Use

This guide lists the essential components of a quality
trance program for medical transcription and is applicable
to all work environments. It describes factors that should be
considered when evaluating the individuals and processes
responsible for producing patient care documentation and for
addressing problems that arise in dictation and transcription. It clarifies
how to make decisions regarding transcription style and
and to resolve conflicts.

This guide may be used to develop a quality assurance
program for individual medical transcriptionists, medical tran-
scription departments within healthcare institutions, medical
transcription businesses, and authors of dictation. A quality
transcription program verifies the consistency, correctness, and
complete of dictated and transcribed, including the
method of identification and resolution of inconsistencies and
inconsistencies, according to departmental standards. Merely
inferring reports is not equivalent to a quality review
process, which should involve comparison with the dictation at
part of the time and review for accuracy of content all of

Developing a transcription program is fundamental to the patient record, and clear,
complete, accurate patient care documentation helps control
risin cost of health care. The accuracy of the final report is
responsibility of both the author and the medical transcrip-
tist. It is the result of teamwork between the person
ating and the individual transcribing. It should be noted that
the production standards are important, their value is dimin-
sified if quality is lacking. Likewise, transcribing dictation
within may not result in quality documentation or clear
communication. It is the transcriptionist’s responsibility to edit
for accuracy, completeness, and consistency, 
facilitating communication.

Diction

There are four areas that should be addressed with every
author providing dictation, and with all authors at regular
rivals, particularly when changes occur in policies, staffing,
equipment, or a combination thereof. These four areas are
education and orientation, (2) document identification
use, (3) dictated content, and (4) confidentiality and

1 Forrester, Claro, The AAMT Book of Style for Medical Transcription, American
Association for Medical Transcription, 1995 (print); 1997 (CD-ROM).

5.2 Quality assurance of medical transcription begins with
the author of the dictation. The quality of transcribed docu-
ments is dependent on the quality of dictation. Authors
should be educated and oriented in creating a timely, accurate,
and understandable dictation report, with emphasis on avoiding
the use or oversite 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, and
turnaround time requirements. Potential problems and pro-
dures for their resolution should also be addressed.

5.3.2 To ensure accuracy, completeness, and consistency of
documentation, regulatory requirements and institutional poli-
cies 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 enter-
ning numbers correctly, providing pertinent dates, and accuracy
spelling patient names upon accessing the dictation system.

Authors of healthcare documents should also correctly spell
ew 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 E.1959 for the definition of
turnaround time related to requests for proposals and
sourced transcription.

5.4 Document Identification Process:

5.4.1 Instruction should be provided on the document iden-
tification process, for example, how to access the dictation
system, how to indicate a priority dictation using the appropri-
ate 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,
thereby improving patient care. 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.
5. Dictated Content:
5.1 In order to document that the standard of patient care all documentation requirements were met, authors should seize record content in a logical fashion and be aware of management issues when dictating. Authors should adhere to recommended or required report formats and organization of text in order to facilitate communication among healthcare workers.
5.2 Content should be free from asides, profanity, derogatory, and other inappropriate comments. Such comments may called to the attention of risk management personnel.
5.3 Content should not include excessive use of abbreviations that obstruct communication. Authors should be aware, when transcribed, abbreviations, acronyms, short forms, on, coined terms, and back-formations may be expanded aiding to policy or regulations.
5.4 Content should not include any specific references that affirm the patient. See Guide E 1902.


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

2. Education and Orientation:
2.1 Medical transcriptionists should strive to expand skills knowledge by regular participation in continuing education professional development activities. Relevant topics may include clinical diagnosis and treatment, medical and professional ethics, technology, professional practice and development, ergonomics, and industry trends.
2.2 MTs should participate in the development of a QA gram and be responsible for assisting others in assuring quality documentation.
2.3 MTs should strive to prevent injuries by using sound ergonomic techniques, thus facilitating the timely and accurate transcription of completed documents.
2.4 Dictation should be accessed and evaluated by the legal transcriptionist to determine the extent to which it can be transcribed. If problems arise related to technical difficulty, author technique, or the individual MT's skill and experience, appropriate policies and procedures should be followed.
2.5 MTs should not be responsible for affixing author names. Refer to Guide B 1762 for more about authentication.
2.6 MTs should be knowledgeable about the QA program, including the definition of errors, acceptable resources, and the dilution of inconsistencies, errors, and other aberrances.
2.7 MTs should respond to feedback from the quality assurance process in a timely manner.
2.8 MTs should have the ability and opportunity to challenge QA review.

3. Document Identification Process—MTs should follow established procedures for verifying author and patient identification and demographics, resolving inconsistencies according 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, to help ensure accuracy.
6.4.3 MTs should use current resources materials.
6.4.4 MTs should engage in reasonable research to verify difficult or questionable content.
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.
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 E 1902 for additional information.
6.5.2 MTs should notify appropriate personnel of confidentiality and security breaches.

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 transcriptionist, and the quality assurance staff responsible for monitoring transcription. Management should ensure 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 dictated document can be transcribed. Impediments to transcribing a document include inaudible or broken dictation, heavily accented speech, rapid speech, or esoteric and uncomprehensible 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
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Management should develop policies and procedures for MTs to communicate with or receive feedback from the patient and others who may have pertinent information (for example, a pharmacist).

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

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

10.1 Errors, omissions, and inconsistencies prior to author verification. See Guide E 1762.

10.2 Errors, omissions, and inconsistencies subsequent to or at the time of authentication. See Guide E 1762.

10.3 Prioritization of transcription and turnaround time requirements.

10.4 Acceptable quality or accuracy percentage requirements, or both.

10.5 Identification of technical support personnel.

10.6 Confidentiality and security related to dictation and transcription of patient care documentation. See Guide E 1902.

10.7 Identification of the individual(s) with authority to intervene.

10.8 Determination of frequency and volume of work to be reviewed in the QA program.

10.9 Methods for responding to complaints.

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

10.11 Continuing education for MTs and other professional staff.

11. Management should confer with MTs in the purchase, source materials and should encourage MTs to use them repeatedly.

12. Management should confer with MTs in providing an economically correct work environment.

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

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

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

Quality Assurance

1. A quality assurance program verifies the consistency, correctness, and completeness of the process of converting dictation (voice) into text (transcribed reports), including the emission identification and resolution of inaccuracies and inconsistencies, according to departmental standards. Merely trusting reports is not equivalent to a quality review process, which should involve comparison with the dictation majority of the time and review for meaning of content all the time.

1.1 The acceptable quality or accuracy percentage 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.

8.1.2 Quality reviewers may identify content, punctuation and grammar, spelling, editing errors, word choice errors, omitted words, and mechanical inconsistencies (for example, document types and formats).

8.1.3 The QA process should be based primarily 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.

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 E 1902.

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 departmental 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; quality assurance; review; transcribed content
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additional comments

This standard is subject to revision at any time by the responsible technical committee and must be reviewed every five years and if not revised, either approved or withdrawn. Your comments are invited either for revision of this standard or for additional standards and should be addressed to ASTM Headquarters. Your comments will receive careful consideration at a meeting of the responsible technical committee, which you may attend. If you feel that your comments have not received a fair hearing you should make your views known to the ASTM Committee on Standards, at the address shown below.

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APPENDIX “D”

QUALITY ASSURANCE WORKSHEET
### Transcription Quality Assurance Work Sheet

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<th>Error Types</th>
<th>Occurrences</th>
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</tr>
<tr>
<td>1. Patient's Name</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Medical Record Number</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Physician's Name</td>
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<td></td>
</tr>
<tr>
<td>4. Date of Service</td>
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</tr>
<tr>
<td><strong>Other:</strong></td>
<td></td>
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<tr>
<td>5. Pharmaceutical Name and/or Dosage</td>
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<td></td>
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</tr>
<tr>
<td>6. Wrong Medical Word</td>
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<td>1.000</td>
</tr>
<tr>
<td>7. Omission of Medical Word</td>
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</tr>
<tr>
<td>8. Spelling of Medical Word</td>
<td>2</td>
<td>0.750</td>
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</tr>
<tr>
<td>9. Spelling of English Word</td>
<td></td>
<td>0.250</td>
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</tr>
<tr>
<td>10. Reports Contain Greater than 3 Blanks</td>
<td>0.500</td>
<td></td>
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</tr>
<tr>
<td>11. PRD Error</td>
<td></td>
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</tr>
<tr>
<td>12. Lab Value/Error</td>
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<td>0.500</td>
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</tr>
<tr>
<td>13. Grammar</td>
<td></td>
<td>0.125</td>
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<tr>
<td>14. Miscellaneous:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Capitalization</td>
<td></td>
<td>0.125</td>
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</tr>
<tr>
<td>b. Numbers</td>
<td></td>
<td>0.125</td>
<td></td>
</tr>
<tr>
<td>c. Other (Specify Below)</td>
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**TOTALS:** 4 3.500

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<th>Pages</th>
<th>Calculated Lines</th>
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<th>Rating</th>
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<td>63</td>
<td>3.500</td>
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<td>94.4%</td>
</tr>
</tbody>
</table>

**Rating:**
- > 98% Exceeds Standards
- 98% Meets Standards
- 95% to 98% Two-Month Probation
- < 95% Remove from VUMC Pool

**Evaluator:** Kaye Smith 5/10/02
**Manager:** Sara Turner 5/10/02

**Comments/Recommendations**

Susan was removed from the VUMC transcriptionist pool on 5/10/02. She will be reinstated to the VUMC pool once she demonstrates a two-month sustained accuracy rating of 98% or above. If reinstated, Susan's work will be monitored with a 5% quality assurance sampling rate for two months to ensure she consistently maintains the 98% required accuracy rate. At the end of that two-month probation period, her work will return to a 1% quality assurance sampling rate.
APPENDIX “E”

EXAMPLE MONTHLY BILLING REPORT
TO ACCOMPANY INVOICE

Comments: The example monthly billing report on the following page contains a progressive breakdown of all the elements making up the total charge for dictation transcription. The content of this report matches the content in the Vendor’s system-generated document header, thus enabling the dictator and his/her staff to fully understand total transcription cost document-by-document. Such a document-by-document breakout of charges and what generated them will both enable and encourage the dictator to work toward reducing overall transcription costs. Such a breakout also helps ensure that the Vendor is held accountable for accurate billing for services rendered.
For: James J. Jamison, M.D. – Dictator Number 12345

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INVOICE TOTAL: $71.33

Legend:
Doc. Type Surcharge Codes:
F Special Format
ST STAT Document
Spec. Del. Surcharge Codes:
PD Print and Deliver
RP Remote Print