Quality Assurance at NEMT, Inc.

Quality Assurance Policy

NEMT prides itself on the excellence of quality within every level of the company. We strongly believe in the benefits of continued education and growth. Part of the "value added" service provided by NEMT is a full Quality Assurance Program. We have designed our program to be more than just an evaluation of acceptable standards. Our QA Program addresses every aspect of ensuring the utmost service and document quality. Medical documents are legal documents and must therefore be of the highest integrity. The quality of the document is our number one priority.

Prevention: We place importance on preventing quality issues by working with our workforce right at the onset. We start with experienced Medical Transcriptionists and then educate and assist them on the technology platform as well as the Account Specifics providing extensive supervision along the way. All work is reviewed 100% until the MT is released to blanks only. The MT has clear documentation of procedures and Account Specifics provided by their account manager. The MT has constant 24/7/365 access to a management team member for support at all times.

Maintenance: We have a Quality Review process that is directly related to production. The document is not delivered until it is complete, correct, and available to the medical facility. We take every available action to provide the best quality document. MTs are required to question any uncertainty or discrepancy. Any document with blanks or questions is sent to Review for resolution. Documents in Review are resolved and feedback provided to the MT daily with explanation, clarification, and direction.

The medical facility also has 24/7/365 access to the management team for support and to address any questions or concerns in a timely manner.

Measurement: QA Audits are done as part of the measurement of accuracy for the Medical Transcriptionist as well as for the Transcription Service. NEMT uses a documented auditing review process for all MTs specific to each medical facility. We contractually commit to an accuracy rate of 98% or higher.

Errors are valued on a weighted-point measurement system based on importance and repetition to determine a value of total error points. The error value is then divided by the total number of lines to reach an Accuracy Score. The MTs are evaluated on medical content, the ability to follow procedural directions provided in the Account Specifics, consistency of format and style. The MT must maintain an accuracy score of **98%**. Failure to

comply with defined quality standards will result in Action, which may include increasing frequency of audit review, limiting work access, and possibly removal from account or termination.

Quality Assurance Procedure:

NEMT has a policy that a 98% or higher accuracy rate must be maintained, regardless of skill level, based on requirements provided by the medical facility. Designated QA staff conduct audits from random reports and maintain documented results. All identifiable patient information is removed and MTs are notified of the results.

Reports are reviewed randomly after MTs have been released from the Orientation Program, to determine a baseline score. Based on that score, MTs are then reviewed 30 days from release of the Orientation Program and then quarterly after that. The routine QA procedure includes documents from each MT quarterly which is proofed to voice, checked for accuracy and appropriate use of medical terminology, English grammar, spelling, punctuation, formatting, and patient demographic information. These documents may or may not include reports sent for further review by the MT. When a report that has been sent to further review is selected for random assessment, the question or blank(s) for which the report was originally sent to review will not count as an error toward the total accuracy score. Feedback will be provided for education and to prevent recurrence of errors for these documents.

Audit Schedule Guidelines:

I. **New MTs:** Any new MT with NEMT will enter the Orientation Program and will be:
   - A. Taught technically as well as procedurally based on Account Specifics.
   - B. Reviewed 100% until 98% or better accuracy score with complete understanding of Account Specifics.
   - C. Counseled to improve and supported through education.
   - D. May be removed from account if inadequate skill level is determined.

II. **30-Day Audit:** MTs released from Orientation Program:
   - A. Randomly audit 350 lines to obtain accuracy score.
   - B. If accuracy score is 98% or higher, MT will be
     1. Congratulated on performance and given additional accuracy pay if no critical errors are found.
     2. Provided results.
     3. Scheduled for review within 120 days.
   - C. If MT's accuracy score is below 98%:

1. Procedures & Guidelines in the Account Specifics will be reinforced.
2. Follow-up audit will be scheduled within 14 days.
3. Account Manager will call the MT for verbal counseling including a 2-week warning.
4. MT must improve with their follow-up audit.
5. If MT does not improve on an audit; MT will be placed under guidelines (D) below.

D. If MT does not pass follow-up audit:

1. Procedures & Guidelines in the Account Specifics will be reinforced.
2. QA manager and account manager will discuss further action. MT has option of entering Orientation Program or 1-week followup.
3. If MT enters the Orientation Program they will be audited in 1 week. If they pass they will be released from Orientation Program. No further action required. If MT fails, they are given 1 final week and are given a verbal 1-week corrective review warning by Human Resources. If they fail, removal from account or termination may occur.
4. If MT chooses a 1-week followup, MT will be given a verbal 1-week corrective review warning by Human Resources. If MT passes, no further action required. If MT fails, removal from account or termination may occur.

III. **Quarterly Audits:** MTs who are established with a facility.

A. Randomly audit 350 lines to obtain accuracy score.

B. If accuracy score is 98% or higher, MT will be

1. Congratulated on performance including a bonus if no critical errors are found.
2. Provided results.
3. Scheduled for review within 120 days.

C. If accuracy score is below 98%, MT will be

1. Procedures & Guidelines in the Account Specifics will be reinforced.
2. Follow-up audit will be scheduled within 14 days.
3. Account Manager will call the MT for verbal counseling including a 2-week warning.
4. MT must improve with their follow-up audit.
5. If MT does not improve on an audit; MT will be placed under guidelines (D) below.

D. If MT does not pass follow-up audit, MT will be

6. Reinforced the procedures & guidelines in the Account Specifics. MT has option of entering Orientation Program or 1-week followup.

7. If MT enters the Orientation Program they will be audited in 1 week. If they pass they will be released from Orientation Program. No further action required. If MT fails, they are given 1 final week and are given a verbal 1-week corrective review warning by Human Resources. If they fail, removal from account or termination may occur.
8. If MT chooses a 1-week followup, MT will be given a verbal 1-week corrective review warning by Human Resources. If MT passes, no further action required. If MT fails, removal from account or termination may occur.

Definition of Errors

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Points deducted for errors depend on their severity in the context where they occur; any error can range from "Critical" to "For Your Information".
-Critical (Cr) errors may be given up to 2 points if they threaten the safety of the patient.
-Major (Ma) errors are those which affect the integrity of the document, but do not pose a risk to patient safety. They are assessed in the 1- to 1.5-point range.
-Minor (Mi) errors are recommended areas of improvement, for which a deduction of 0.25 to 0.75 points is made.
-No points are deducted for errors labeled "For Your Information" (FYI) as they are intended only to be instructional.

If misuse is repeated throughout the entire report, it will be counted as only one error, since it reflects one wrong piece of information on the part of the transcriptionist.

Error 1. Medical terms

Medical word misuse. This category may include wrong drug names or test names. It also includes incorrect forms of medical words, failure to use combining forms, and incorrect entries from text expanders.

Error 2. Verbiage

A. Omissions

Omissions may include the absence of entire passages, phrases, or single words. Minor omissions may include inconsequential errors like missing articles or conjunctions, or words missed because of typing too fast. Clipped sentences are allowed as dictated if the account specifics stipulate verbatim transcription.

B. Inclusions

Additions to the text that were not dictated are categorized as Inclusions. In verbatim accounts, less license to edit and re-write is allowed than in accounts that welcome MT changes. At times, however, it may be necessary to make changes in order to make sense of the dictation, and this is acceptable.

C. Substitutions

Typing the wrong words because they were not heard correctly, or because they do not fit the context, or for whatever reason, will be recorded as mistakes.

Error 3. Spelling

This category includes misspellings of either technical or non-technical words. (Medical word misspellings are often critical, and are usually entered under Error #1.) Errors may occur with singular/plural endings, possessive endings and tricky words like the following: *followup/follow up; elicit/illicit; dissent/descent/ affect/effect/ apprise/appraise.*

Affect as a noun means “emotion.”
Affect as a verb means to “influence or alter.”
Affective means “pertaining to emotions.”

Effect as a noun means “result.”
Effect as a verb means “bring about.”
Effective means “bring about.”

Error 4. Abbreviations

Industry rules and the Dangerous Abbreviation List in the AAMT Book of Style p. 461 help to avoid errors in using abbreviations. This category includes failure to expand abbreviations when necessary, or expanding when the account specifics do not require it. Apostrophe placement in abbreviations can cause problems, too. Errors in the misuse of acronyms and symbols are included here.

Error 5. Format/Protocol/Style

This category covers problems occurring with account specifics, NEMT specifics, or medical transcription industry style. Commonly-made errors include changing the patient's name to "the patient" when not required, use of forbidden symbols, template choice, time protocol, paragraphing, spacing, formatting, outlining rules, boldface use, and auto-numbering problems.

Error 6. Capitalization

This category includes generic vs. trade names, upper and lower case used in headers, and other problems with capitalization.

Error 7. Numbers/Data

Errors can occur when the NEMT number policy is not consulted. Other number errors may include incorrect values, the use of numerals vs. words, Roman vs. Arabic numbers, and inconsistency between decimals and American numbering.
Serious problems may be caused by incorrect data like patient information, account information, the misuse of proper names, titles, doctor names, places, or dates. Medical dosage figures or procedure errors can often be critical errors.

Error 8. Grammar

Errors in grammar may affect the integrity of the document or cause a lack of clarity. Subject-verb agreement, verb tense confusion, pronoun misuse, and errors in the use of articles, prepositions, and adverbs, as well as sentence structure, all occur frequently.

Error 9. Punctuation

A large number of errors are found in punctuation; however, punctuation errors seldom affect the integrity of the document. Nevertheless, faulty punctuation can convey the wrong information, and

the most commonly-found errors are as follows: comma splice, comma-and rule, semi-colon use, hyphens, multi-word adjectives, use of the apostrophe in possessive endings, and plural endings.

Error 10. Typographical errors

Often errors occur because of excessive speed in typing. If they do not affect the document's integrity or patient safety, they are not charged many error points, but careful proofreading should pick these up.

CR = Critical MA= Major MI= Minor FYI= For Your Information.

Type of Error	CR	MA	MI	# Errors	Total Points
1. Medical Terms					
2. Verbiage: A. Omissions					
B. Inclusions					
C. Substitutions					
3. Spelling					
4. Abbreviations					
5. Protocol/Style/Format					
6. Capitalization					
7. Numbers/Data					
8. Grammar					
9. Punctuation					
10. Typographical errors					
Total Error Points					
Total Lines minus errors divided by total lines (ex: 368-2/368)					
Grade					

Quality Audit Calculations:

The QA Manager is responsible for ensuring QA Audits are completed within schedule guidelines determined by accuracy score. This is outlined above in Quality Assurance Procedures. Documents are re-listened to 100%. Errors are identified and corrections made. All edits are compiled in a document titled AUDIT-(MT Name)-(Date). All identifiable patient information is removed from the QA Audit document.

After this step is completed, the Account Manager then grades the QA Feedback using the Audit Review Calculation form. This identifies the Job ID# audited; the # of lines per document; total # of lines; the value of the error; # of occurrences; and calculates the total error points.

The accuracy score is calculated as follows: Total lines minus total error points divided by total lines equals accuracy score.

Example: 368 – 2.5/368 = 99.32%.