SENTARA RMH MEDICAL CENTER
ACCOUNT SPECIFICS

Platform:	eScription
Institution/Site Code:	rmh
Software Versions:	ESMT: Version 9.20 eMon: Version 9.20
Info/Resources:	ES SAMPLE SITE: *(add site here)* Log in with your EditScript login ID/PW
Customer Links:	**http://www.rmhonline.com/**

Version/Change Record

Version	Date	Responsible Person	Description of Version/Change
1.0	7/6/11	Implementation Team	
1.1	8/12/2011	Cathy Chiudina	Updates/changes since go-live
1.2	8/26/2011	Cathy Chiudina	Blanks and PA information added
1.3	8/30/2011	Cathy Chiudina	Clarified process for future dated visit IDs/HMA clarification
1.4	9/22/2011	Cathy Chiudina	Updating carbon copy information and added information regarding date for letters
1.5	10/13/2011	Cathy Chiudina	Updating Visit ID information
1.6	10/22/2011	Cynthia Harris	Updating change in expansion of abbreviations, change to letter format, title of reports
1.7	11/2/2011	Cynthia Harris	Updated cosigner and cosigner statements not being applicable to clinic work, reports with End of Treatment Tables to be pended to RMH.
1.8	01/2/2012	Cynthia Harris	Specific Copy requests, cosigning statement rule update, addendum rule update
1.9	1/30/2012	Cynthia Harris	Addendum rule update, date of dictation
1.11	04/24/2012	Bethanne Tuel	Upload protocols
1.12	05/16/2012	Bethanne Tuel	Time Stamps
1.13	08/22/2012	Bethanne Tuel	Demographics
1.14	09/26/2012	Bethanne Tuel	Version added
1.15	10/29/2012	Bethanne Tuel	Unknown patient
1.16	11/12/2012	Bethanne Tuel	Endoscopy Reports
1.17	01/14/2013	Bethanne Tuel	Unknown Patient/End of Treatment Tables
1.18	01/29/2013	Bethanne Tuel	Cosigner Statement
1.19	02/13/2013	Bethanne Tuel	PCP
1.20	03/31/2014	Bethanne Tuel	CC/Letters
1.21	04/01/2014	Bethanne Tuel	Work type changes/Blanks
1.22	08/06/2014	Bethanne Tuel	CC-Douglas Smith
1.23	08/18/2014	Bethanne Tuel	Addendums

TABLE OF CONTENTS

All subjects are listed in alphabetical order and are hyperlinked. Simply click on a subject to find the information.

NOTE: Utilize the AHDI Book of Style for any format information not contained in this document.

NON-DSP MT/QC
DSP MT/QC
RISK MANAGEMENT (Discrepancy in dictation)
NON-DSP MT/QC
DSP MT/QC
UPLOAD PROTOCOL
NON-DSP MT/QC
DSP MT/QC
TITLE OF REPORTS
WORK TYPES AND TAT

ABBREVIATIONS/ACRONYMS

Transcribe all abbreviations and/or acronyms as dictated.

- Do not expand unless they are dictated in their expanded state under all headings There are NO EXCEPTIONS.
- Do not abbreviate unless dictated as an abbreviation.

Example under DIAGNOSIS heading:
Dictated: COPD. Awaiting results from CT lung, CBC.
Transcribed: COPD. Awaiting results from CT lung, CBC.

Example under IMPRESSION heading:
Dictated: EKG evidence of MI
Transcribed: EKG evidence of MI.

Example under PLAN heading:
Dictated: Continue IV fluids
Transcribed: Continue IV fluids.

Clinicians often use abbreviations as complete words, such as “sat” for saturation, “vfib” for ventricular fibrillation, or “tox” for toxicity. Do not expand these short-hand indicators. Assume that, if the clinician wants you to expand any acronym or abbreviation, they will speak them in their expanded form.

OP NOTES: On operative notes, dictators will often want to have the PREOPERATIVE DIAGNOSIS text copied to the heading POSTOPERATIVE DIAGNOSIS by dictating: “Postoperative diagnosis, same.” **Do NOT transcribe the word "same"** Copy verbiage from PREOPERATIVE DIAGNOSIS and paste the entire contents after the POSTOPERATIVE section, adding anything additional after the word "same."

CC vs. mL: See JCAHO abbrev list. If dictated as cc, transcribe as mL.

For all other Latin acronyms not listed above: When the speaker dictates “q.” separate "q." from the rest of the phrase with a single space.

Correct	Incorrect
q. noon	q.noon
q. day	q.day or q.d.

Otherwise, write exactly what you hear the speaker say, even if there is an equivalent abbreviation.

Example: If speaker says q. 4 hours, this does not need to be shortened to q.4h.

Clinician Dictates	Correct	Incorrect
as needed	as needed	p.r.n.
twice a day by mouth	twice a day by mouth	b.i.d p.o

Standard Acronyms

Write acronyms, which are combinations of letters and numbers, in the usual manner:

- S1
- L4-L5
- CA-125 (Write “cancer antigen 125” if clinician speaks it as such)
- FESO4
- 2D (Write “two dimensional” if clinician speaks it as such)

Transcribe vertebral spaces literally, using the word 'to': “L5 to S1”, “S1 to S2”

- Do NOT use the ampersand (&) as part of an acronym.

Correct	Incorrect
CTA and P	CTA&P
H and H	H&H
H and P	H&P

JCAHO Prohibited Abbreviations

All of the JCAHO required AND optional do-not-use entries will be expanded. See list below.

U (unit)	Write "unit"
IU (International Unit)	Write "International Unit"
Q.D., QD q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* **(see note below)** Lack of leading zero (.X mg)	Write X mg Write 0.X mg
***Exception to above: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.**	
MS MSO_4 and $MgSO_4$	Write "morphine sulfate" Write "magnesium sulfate"
ug (for microgram)	Write "mcg"
h.s., H.S., Q.H.S., q.h.s.	Write out "half-strength" or "at bedtime"
T.I.W. (for three times a week)	Write "3 times weekly" or "three times weekly"
S.C. or S.Q. (for subcutaneous)	Write "Sub-Q", "subQ", or "subcutaneously"
D/C (for discharge or discontinue)	Write "discharge" or "discontinue"

cc (for cubic centimeter)	Write "mL" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears) O.S., O.D., O.U. (Latin abbreviation for left, right, or both eyes)	 Write: "left ear", "right ear" or "both ears" Write: "left eyes", right eyes" or "both eyes"

ALLERGY STATEMENTS

Uppercase for positive allergy statements; lowercase otherwise.

Example:
ALLERGIES:
No known drug allergies.

ALLERGIES:
PENICILLIN CAUSES A RASH.

BLANKS :

Blanks to be strictly denoted by 5 underscores. If pending the job to the facility or NTS for any reason, put time stamps in the pend note. Do not put any time stamps in the report itself.

CAPITALIZATION OF DEPARTMENT NAMES

Emergency Room or Emergency Department as well as any clinic name such as Dermatology Clinic, are the only departments to be capitalized. Do NOT capitalize any other department names.

CARBON COPIES

COPY REQUESTS - RULES

If unable to locate the name dictated in the database, there are multiple names to choose from, or if only the last name is dictated and there are multiple, create a new contact and send the job through. Do NOT pend the job for carbon copy verification.

Specific Copy Requests

1. Copy request to Dr. Douglas Smith
   The database at RMH has 2 matches for copy request, Dr. Douglas Smith. The 2 entries are Dr. B. Douglas Smith and Dr. J. Douglas Smith. If an initial is specified make sure the correct entry is selected. If the initial is not specified, create a new CC: Douglas Smith and upload.
2. Copy request to Dr. Ludica
   When a Dr. Ludica is dictated but no first name is specified, select Harrisonburg Family Practice as the copy entry as both Dr. Ludicas practice in that institution.
3. Copy request by Dr. Shank to Community Health
   When Dr. David Shank requests a copy to Community Health, select Harrisonburg Community Health Center.

HMA - HARRISONBURG MEDICAL ASSOCIATES

Please note HMA expands to Harrisonburg Medical Associates. You may find many matches with specialties and subspecialties associated with this contact that is most often dictated as "HMA." Please search for the same in the Alt+C list and you will find it. Do not create a new contact if it is already available.

LAST NAME	FIRST NAME
HARRISONBURG	PEDIATRICS

HARRISONBURG COMMUNITY	HEALTH CENTER
HARRISONBURG EMERGENCY	PHYSICIANS
HARRISONBURG FAMILY	PRACTICE
HARRISONBURG HEALTH AND REHAB	CENTER
HARRISONBURG INTERNAL	MEDICINE
HARRISONBURG MEDICAL	ASSOCIATES
HARRISONBURG MEDICAL	ASSOCIATES- CARDIOLOGY
HARRISONBURG MEDICAL	ASSOCIATES- GASTROENTEROLOGY
HARRISONBURG MEDICAL	ASSOCIATES- NEPHROLOGY
HARRISONBURG OB/GYN	ASSOCIATES
HARRISONBURG PHYSICIANS FOR	ANESTHESIOLOGY
HARRISONBURG ROCKINGHAM	ADULT PROTECTIVE SERVICES
HARRISONBURG SURGICAL	ASSOCIATES
HARRISONBURG-ROCKINGHAM	COMMUNITY SERVICE BOARD
HARRISONBURG-ROCKINGHAM	FREE CLINIC
HARRISONBURG-ROCKINGHAM HEALTH	DEPARTMENT

CC vs. mL: See JCAHO abbrev list. If dictated as cc, transcribe as mL.

CONTRACTIONS

Transcriptionists should expand contractions when they are spoken unless in a direct quote.

Examples:
Dictated: He's a vegetarian.
Transcribed: He is a vegetarian.
OR
Dictated: The patient was murmuring, "I'm a diabetic."
Transcribe: The patient was murmuring, "I'm a diabetic."

DATES

When a full date is dictated, which would include Month, Day & Year, such as January 27, 2010 or "the 27th of January, 2010, dates should be transcribed with padded numerics, forcing 4-digit year, in format xx/xx/xxxx ex: 01/27/2010.

If only Month and year, i.e., January of 2010, transcribe as January 2010.

If only Month and Day, i.e., January 27th, transcribe as January 27th or "17th of January", transcribe as dictated, NOT forcing numerics as above.

FUTURE DATES:

If you find a future date (after the dictation was dictated) as an account number in the grid, pend such reports to RMH. **RMH: Future date dictated.**

As an example, if the date of dictation is August 24, 2011, and the Visit ID number or account number dictated corresponds to August 25, 2011, please pend such reports.

DATES ON LETTERS:

If no date is dictated for the letter use the date of dictation as the date on the letter for all letters.

DEMOGRAPHICS

Change all information to match what is dictated if what populates differs, i.e., patient name, visit ID, dictator and pend to RMH with the old information placed in the pend note.
EXCEPTIONS:
1. Do NOT pend for change in work type.
2. If report comes in as Unknown Patient, leave as is for all Clinic BEs. Do not change the patient name and pend to the client with the name dictated in the pend note. If it is the Acute Care BE, change the information to match what is dictated and pend to the client.

Patient Name (Unknown patient) (Clinic BEs only): RMH: Unknown patient, John Doe dictated.
Patient Name (wrong patient): RMH: Unknown patient/incorrect patient changed from John Smith
Visit ID: RMH: Verify discrepancy in visit number populated did not match dictated. Always have what is dictated. If it is questioned leave as is and ask client to verify. RMH: Verify visit ID.
Speaker: RMH: Changed speaker from XXX to XXX

END OF TREATMENT TABLES

Reports containing "End of Treatment" Tables will need to be pended to RMH. See upload protocol instructions to DSP and nonDSP staff.

FORMATTING INSTRUCTIONS

AUTO-NUMBERING

No. Turn off auto-formatting feature.

FORBIDDEN CHARACTERS

Do NOT use the following characters. They are not accepted in the electronic interface: Pipe **|,** Caret **^,** Backslash **\,** Ampersand **&** or Tilde **~**

LETTER FORMAT:

August 4, 2011

Dr. ____ ____ (As dictated)

RE: first name last name
MR: XXXX

Dear Dr. _____:

Body of the letter.

Sincerely,

David Harris, MD

COSIGNERS FOR LETTERS

On letters dictated by PA/NP please place the cosign statement under the signature formatted as in

Sincerely,

Dana Landacre, PA-C,
Supervising physician, Nazir Adam, MD

PSYCHIATRIC SLIDING SCALE NORMAL

Note there is a normal in the system for this.

SPECIAL FORMATTING

Do NOT use bold, underline or italicize as requested by speaker. Do NOT change any of the special formatting that is part of a normal template you have pulled into your document.

TABS: Do not use TABS.

TIME FORMAT

Times may be spoken in many ways. It is important that they be formatted as uniformly as possible.

- Use the hour:minute format and use military hour time if the provider dictates as such. Note, there is no colon in military time, i.e., 1900, not 19:00.
- If dictated, add “a.m.” and “p.m.”
- Never include the word o'clock when talking about time. Use o'clock only if dictator is referring to anatomy, i.e., "...a lesion at the 8 o'clock position.)

Provider dictates:	Transcriptionist types:
I saw the patient at one fifteen.	I saw the patient at 1:15.
… quarter past one.	… 1:15.
… one fifteen p.m.	… 1:15 p.m.
… thirteen fifteen.	… 1315.
… thirteen hundred fifteen.	… 1315.
… around one o’clock.	… around 1:00.
… around thirteen hundred hours.	… around 1300.

VERBATIM VS. NON-VERBATIM

Verbatim. Small changes to grammar are expected, but keep to verbatim as much as possible. Any obvious discrepancies in dictation should be corrected or, if in doubt, should be flagged and pended to client for verification.

HEADINGS

Do NOT use **"/" or "&**" as any part of headings, i.e.,

CORRECT:
LABORATORY TESTS PROCEDURES AND RESULTS:

PAST FAMILY AND SOCIAL HISTORY:

INCORRECT:

LABORATORY TEST/PROCEDURES & RESULTS:

PAST FAMILY/SOCIAL HISTORY:

Heading followed by colon and 2 spaces with text immediately following on the next line underneath the heading.

SOCIAL HISTORY:
The patient denies history of alcohol use.

Double space between headings

MEDICATIONS:
None.

ALLERGIES:
No known drug allergies.

Subheadings: Paragraph format with individual in-paragraph headings all capped.
Note: This example is for Exam AND Review of Systems.

Do NOT use drop-down heading format.

PHYSICAL EXAMINATION:
HEENT: Unremarkable. SKIN: Warm and dry. HEART: Normal

Do **NOT** abbreviate headings, i.e.,
INCORRECT: GI:
CORRECT: GASTROINTESTINAL

Do not type any text that the clinician dictates which repeats the meaning of the heading.
Example:
DICTATED: Past medical history. The patient's past medical history is significant for asthma.
TRANSCRIBED: PAST MEDICAL HISTORY: Significant for asthma.

Always expand PCP when dictated as a heading to PRIMARY CARE PROVIDER and not Primary Care physician. This individual may not be a physician.

EMPTY (UNUSED) SECTIONS/HEADINGS
Delete any section or heading for which the dictator does not dictate information.

VAGUE SECTION HEADINGS
If speaker dictates “HISTORY,” expand to “HISTORY OF PRESENT ILLNESS” or PAST MEDICAL HISTORY”, PAST SURGICAL HISTORY as appropriate.

HEADER AND FOOTER INFORMATION

Do not repeat information in text that already appears in the header.

Exception: Date of Birth and/or Date of Admission and Date of Discharge should be transcribed in the body of the report if dictated.

LISTS

For any DIAGNOSIS, IMPRESSION or ASSESSMENT heading as well as MEDICATIONS, always enumerate whether or not dictated as such.

For all other lists,
Do not enumerate lists of items unless dictator explicitly requests so.
Instead, enter the sequence into a comma-separated list, as you would when listing a series of words in a sentence.

Example:
PAST MEDICAL HISTORY:
Diabetes mellitus, hypertension and hypercholesterolemia.

Listen for the following common phrases that a clinician uses to ask you to enumerate a list such as "Number two", "Number Next", "Next" or "Next item."

Enumerated lists will have the number, a period and 2 spaces. Do NOT use tabs.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Diabetes mellitus.

NUMERICS

Quantities: Write all quantities as Arabic numerals with the following exceptions:
Examples:
The patient has had 2 mammograms within the past 3 years.
But
Two small cysts were removed.
And
There was another one on the left side.
I observed hundreds of particles.

Numeric Units: Separate the number from its unit with a space.
Example 5 mg

Numeric Ranges: Identify numeric ranges by placing the word “to” between both numeric values
Example:
The patient will return for followup in 3 to 4 months.

Frequencies or number of times: Indicate frequencies or number of times by placing the ‘x’ separated from the number with a space.
Example:
The patient was alert and oriented x 3.

Dimensions: Indicate dimensions by using the ‘x’ with spaces, as follows.
Example:
CORRECT: The lipoma was 2 x 3 cm in size.
INCORRECT: The lipoma was 2x3 cm in size.

OB/GYN: When dictated as words, use commas to separate OB/GYN histories.
Example:
The patient is gravida 1, para 2.
When dictated as an abbreviation, leave a space.
Example:
The patient is G1 P2.

Roman Numerals vs. Arabic Numerals:

- Use Roman numerals for "grades" of conditions and diseases
  Example "Grade II/VI systolic murmur"
- Use Roman numerals for "stages" of conditions and diseases
  Example "Stage II cancer"
- Use Roman numerals for cranial nerve numbering
  Example "CN II-XII"
- Use Arabic numerals for "types" of conditions or diseases
  Example "diabetes mellitus type 2"

LABORATORY DATA AND VALUES

Platelets: Transcribe platelets as dictated, i.e., 236 or 236,000. No need to expand if not dictated.

Trailing zeros: Please see JCAHO Abbreviation List. Trailing zeros in laboratory values are acceptable to transcribe if dictated.

PATIENT NAME

It is completely acceptable to transcribe the patient's real name in the body of the text if dictated as such.

If a sentence begins with "patient" do NOT insert the article "the". Transcribe as dictated, either "Patient" or "The patient…"

NOTE: Any other identifying information, such as family names, phone #s and room #, is completely fine to transcribe as dictated.

TITLE OF REPORTS

If a report title is dictated, type it on the first line in the report for all worktypes in uppercase.

Example,
DICTATED: Progress note or initial consultation
TRANSCRIBE: PROGRESS NOTE or INITIAL CONSULTATION as the first line of text.

WORK TYPES

WORKTYPE
Transfer Summary (56)
History and Physical - Surgical (13)
Progress Note (14)
Consultation - General (3)
Consultation - Psychiatric (32)
Emergency Dept Letter (10)
Emergency Dept Report - Attending (17)
Emergency Dept Report - General (5)
History and Physical - General (1)
History and Physical - Psychiatric (31)
Interim Summary Report (11)
Discharge Summary - General (4)
Discharge Summary - Psychiatric (33)
Letter - Chemotherapy (99)
Letter - General (8)

Letter - Pain Mgt (52)
Letter - Rad Therapy (96)
Office Note - Chemotherapy (98)
Office Note - General (7)
Office Note - Pain Mgt (51)
Office Note - Rad Therapy (97)
Operative Report - Cardiothoracic (16)
Operative Report - General (2)
Operative Report - Inpatient (15)
Operative Report - Opthalmology (12)
Treatment Center Report (18)

PENDING RULES and UPLOAD PROTOCOL
Non-DSP MT

NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.* ***Time stamps should be used to indicate where issues are in the pend notes.***

Pend all notes to QC with note as follows:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

ADDENDUMS
Transcribe **ADDENDUM** in all caps as first line of text along with the verbatim statement dictated, i.e., "Addendum to Dr. Jenkin's note." Pend to:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

BLANKS
Pend all notes to QC with note as follows:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

CARBON COPIES:
Add CC dictated by creating a new contact with all provided information.
Pend to:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

CHANGES TO HEADER
If changes are made to any of the below, these dictations must be pended to RMH so pend to NTS according to below so the job can be pended to RMH after being reviewed.

Account Visit
Patient Name
Speaker
Signer

ACCT VISIT CHANGE
The MT should verify the correct account visit is selected. If a different account visit is selected, pend dictation as
Offshore -- NTS_IN: FOR REVIEW Account visit change
Onshore -- NTS_US: FOR REVIEW. Acct visit change

PATIENT NAME CHANGE
The MT should verify the correct patient is selected. If a different patient is selected, pend dictation as
Offshore -- NTS_IN: FOR REVIEW Patient name change from XXX
Onshore -- NTS_US: FOR REVIEW Patient name change from XXX

Do not change patient name if it comes in as Unknown Patient

SPEAKER CHANGE
The speaker should be verified by the MT. If the speaker's name needs changed, MT should change speaker to the correct name and pend as
Offshore -- NTS_IN: FOR REVIEW Speaker change from XXX

Onshore -- NTS_US: FOR REVIEW Speaker change from XXX

SIGNING CLINICIAN

If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be filled in with that name. The MT should verify this is the correct signer as spoken by the dictator.

If any changes are made to Signing Clinician, pend dictation as
Offshore -- NTS_IN: FOR REVIEW Signing physician change from XXX
Onshore -- NTS_US: FOR REVIEW Signing physician change from XXX

END OF TREATMENT TABLES

Reports containing end of treatment tables are to be pended as

Offshore -- NTS_IN: FOR REVIEW End of Treatment Table (**(With a timestamp where dictated)**

Onshore -- NTS_US: FOR REVIEW End of Treatment Table **(With a timestamp where dictated)**

ENDOSCOPY REPORTS

Reports containing endoscopy procedures are to be pended as

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

INCOMPLETE DICTATIONS

If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

MULTIPLE REPORTS ON 1 DICTATION

Transcribe/Speech Edit and Pend To:

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

NO DICTATION

MT/QC: Pend **exactly** as below
NO DICTATION

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to NTS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation.
   Example:
   "This is a re-dictation."
3. Omit comments that are NOT pertinent to the dictation.
   Example:
   "This is the third time I have dictated this chart! I won't dictate it a fourth time!"
   If in doubt, pend to QA.

SIGNING CLINICIAN

If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be blank. The MT should fill this in based on who the speaker states they are dictating for. If the speaker does not dictate a signer or if the signer cannot be found then the MT/QC should pend the document as below:

Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

Please always follow MT instructions regarding surrogate speakers if one exists for the dictation you have open!

The information listed below in this document pertains to MTs/QCs who have been granted Direct Send Privilege status. If you are not yet DSP'd, please follow pending rules and upload protocol instructions that are outlined above.

PENDING RULES and UPLOAD PROTOCOL
ALL DSP MTs & QCs

NOTE: *Please do not include personal notes or opinions in pend notes. Keep all comments direct, professional, and to the point.* ***Time stamps should be used to indicate where issues are in the pend notes on all jobs pended to the client.***

ADDENDUMS
Transcribe **ADDENDUM** in all caps as first line of text along with the verbatim statement dictated, i.e., "Addendum to Dr. Jenkin's note," and send the job through. Do NOT pend to the client unless there are issues with the demographics.

BLANKS
2 or less blanks may be uploaded directly to client without pending.

MTs: For more than 2 blanks pend to QC.
QCs: Do NOT pend to the client for blanks remaining only. Change the blanks to 4 underscores and send the jobs through.

CARBON COPIES:
For any contact not found in database, add CC dictated by creating a new contact with all provided information and send the job through. Do NOT pend to the client.

CHANGES TO HEADER
Make appropriate changes to header, do not leave incorrect information in the header. If changes are made to any of the below, these dictations must be pended to RMH:

Account Visit
Patient Name
Speaker
Signer

Place in the pend note what was changed and any other helpful information.

ACCT VISIT CHANGE
Verify the correct account visit is selected. If a different account visit is selected, pend dictation as
RMH: Acct visit change.

SPEAKER CHANGE

The speaker should be verified by the MT. If the speaker's name needs changed, MT should change speaker to the correct name and pend as
RMH: Speaker change from XXX

SIGNING CLINICIAN

If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be filled in with that name. Verify this is the correct signer as spoken by the dictator.

If any changes are made to Signing Clinician, pend the dictation as
RMH: Signing physician change from XXX

PATIENT NAME CHANGE

Verify the correct patient is selected. If a different patient is selected, pend dictation as
RMH: Patient name change from XXX

Do not change patient name if it comes in as Unknown Patient

END OF TREATMENT TABLES

Reports containing end of treatment tables are to be pended as
RMH: Pended per protocol, end of treatment table (With a timestamp where dictated)

ENDOSCOPY REPORTS

Reports containing endoscopy procedures are to be pended as
RMH: Pended per protocol, endoscopy procedure

HEADER CHECK

Pend notes to QC for any discrepancy or header checks as follows:
Offshore -- NTS_IN: Header check please.
Onshore -- NTS_US: Header check please

INCOMPLETE DICTATIONS

If dictation is incomplete, transcribe "DICTATION ENDS HERE" as last line of text and pend to client as
RMH*:* Incomplete dictation.

MULTIPLE REPORTS ON 1 DICTATION

Transcribe/Speech Edit and Pend To:
Offshore -- NTS_IN: FOR REVIEW
Onshore -- NTS_US: FOR REVIEW

NO DICTATION

For no dictation or a cancelation request by speaker, please pend to client as
RMH: No dictation.

RISK MANAGEMENT (Discrepancy in dictation)

1. MT to pend to NTS for discrepancies that cannot be resolved with complete confidence/competence.
2. Type comments that are pertinent to the dictation.
   Example:
   "This is a re-dictation."
3. Omit comments that are NOT pertinent to the dictation.
   Example:
   "This is the third time I have dictated this chart! I won't dictate it a fourth time!"
   If in doubt, pend to QA.

SIGNING CLINICIAN
If the speaker is someone who requires a signing clinician for their dictations then the signing clinician field in the header will be blank. The MT should fill this in based on who the speaker states they are dictating for. If the speaker does not dictate a signer or if the signer cannot be found then the MT/QC should pend the document as below.
Pend to client as such:

RMH: No signing clinician dictated.

VISIT ID
If there is a discrepancy or issue with the visit number (V number), pend the job with the following note:

RMH: Verify discrepancy in visit number, dictated V number xxxx, MRN yyyy, and service date mm/dd/yyyy

WRONG WORK TYPE
If job downloads with the incorrect work type, change to the correct work type and upload report directly to the client. Do not pend the job.