Jurnal Rekam Medis dan Informasi Kesehatan Indonesia
Volume. 4 Nomor. 2, Juni 2025
e-ISSN : 2828-5867; p-ISSN : 2829-341X, Hal. 71-77
DOI: https://doi.org/10.62951/jurmiki.v4i2.104
Tersedia: https://jurmiki.org/index.php/Jurmiki

Analysis of the Accuracy of Diagnosis and Coding in Patient Medical Records at the Mutiara Delima Clinic Sawoo, Ponorogo Regency

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Abstract*. This research aims to analyze the accuracy of diagnosis and coding in patient medical records at Mutiara Delima Sawoo Clinic, Ponorogo Regency, and to identify the factors influencing it. The research uses a descriptive method with a qualitative approach. Data were obtained through interviews with 1 medical records officer, observations with 1 medical records officer, 1 doctor, 3 midwives, 3 nurses, and the analysis of 260 medical record documents using instruments in the form of observation and interview sheets. The results show that out of the 260 patient medical records analyzed over one month, 31.54% were accurately coded with diagnosis and coding, 59.62% were diagnosed without coding, and 8.85% were neither diagnosed nor coded. The researchers recommend enhancing the training of medical personnel and strengthening the monitoring system to support service quality and insurance claims.*

Keywords: *Analysis; Coding; Diagnostic Accuracy; Medical Records; Patient Medical.*

1. INTRODUCTION

Coding is a procedure for assigning codes using letters and numbers. Coding activities include diagnosis coding and medical action coding. The important thing that must be considered by medical record personnel is the accuracy in providing diagnosis codes. Proper diagnosis coding will produce accurate and quality data. Accuracy in the provision and writing of codes is useful for providing nursing care, billing claim fees, improving service quality, comparing morbidity and mortality data, presenting the top 10 diseases, and other matters related to health services.

At the Mutiara Delima Sawoo Clinic, Ponorogo Regency, the results of initial observations show that there are still inaccuracies in the provision of diagnoses and coding that often occur in patient medical records. Based on data from the results of a one-month analysis at the Mutiara Delima Sawoo Clinic on patient medical record documents totaling 260 medical record documents, 59.62% of diagnoses were not recorded in the history of. examination results and in the codification section which should have been coded but were not coded and 8.85% were not given a diagnosis and were not coded in the history of examination results and coding for coding. This shows that there are still limitations in the implementation of the accuracy of recording diagnoses and coding and negligence in the coding process and the implementation of standard operating procedures (SOPs) has not been optimized.

Inaccuracies in the provision of diagnoses and coding can have a serious impact on the quality of health services as a basis for clinical decision making, administrative, BPJS claim processes, medical audits, and potentially affect the continuity of medical services. Therefore,

Naskah Masuk: 12 Mei 2025; Revisi: 29 Mei 2025; Diterima: 15 Juni 2025; Terbit: 30 Juni 2025

it is necessary to analyze the accuracy of the provision of diagnoses and codifications and the factors that influence the inaccuracy in the provision of diagnoses and codifications in order to formulate strategies to improve the quality of the accuracy of the provision of diagnoses and codifications in patient medical record documents.

This study aims to analyze the accuracy of diagnoses and coding in patient medical records and identify factors that influence the inaccuracy in providing diagnoses and coding in medical record documents. Patients at the Mutiara Delima Sawoo Clinic, Ponorogo Regency, as part of efforts to improve the quality of medical records and health services.

2. THEORETICAL STUDY

Medical Records are documents containing data on patient identity, examination, treatment, actions, data on other services that have been provided to patients. Medical records provide an overview of the quality standards of services provided by health facilities and by authorized health personnel.

Codification or coding in medical records is one of the activities of processing medical record data in providing codes using letters or with numbers or a combination of letters and numbers that represent data components. Coding is a system and procedure for medical record services organized to manage forms, records and reports used to record and record service outcome data in the form of diagnoses and actions.

The accuracy of the coding of a diagnosis is highly dependent on the medical record management process. The accuracy of diagnosis data is crucial in the field of clinical management, cost reinsurance billing, and other matters related to health care and services. In an effort to improve the consistent accuracy of coded data.

3. RESEACRCH METHOD

This research uses a descriptive type qualitative approach. This study is intended to analyze the accuracy of diagnoses and codifications in patient medical records. The qualitative method was chosen because it is able to explain how the accuracy of providing diagnoses and codifications in patient medical records both in the process of providing the accuracy of diagnoses and codifications using the object under study clearly, completely and according to the facts that can be observed, both through sight and hearing.

This research was conducted at the Mutiara Delima Sawoo Clinic, Ponorogo Regency, which is located at Jl.Raya Ponorogo-Trenggalek Ds. Sawoo Base, Ponorogo Regency. The object of this research is the patient's medical record file in the diagnosis and coding sheet section.

Respondents in this study are those who are considered to be able to provide relevant and in-depth information related to the focus of the research. These respondents are employees of the Mutiara Delima Sawoo Clinic, Ponorogo Regency in the section of providing diagnoses and codifications on patient medical records. Consisting of 8 respondents, as follows: 1 Medical Records Officer, 1 Doctor, 3 Midwives, 3 Nurses.

Data collection was done through two main techniques:

a. Interviews: conducted directly to respondents to find out more in depth how the explanation of the factors that influence the accuracy of diagnosis and coding.
b. Observation: directly observing the process of providing accuracy of diagnosis and coding, patient medical record documents and using observation sheets given to respondents.

The data analysis used in this research uses interviews and observations to obtain results, a clear and comprehensive understanding of the problem under study.

4. RESULTS AND DISCUSSION

Research Results

Distribution of Accuracy of Diagnosis and Coding of Patient Medical Records

Medical Records with Appropriate Diagnosis and Codefication. Medical records that were correctly diagnosed and coded amounted to 82 documents or equivalent to 31.54% of the total sample. This shows that one-third of medical records have met the standards in terms of recording diagnoses and codifications accurately. Medical records that were not given a diagnosis or codification were recorded as many as 23 documents, equivalent to 8.85%. This condition is an indicator of less than optimal medical documentation, which can have an impact on the accuracy of patient data and clinical and administrative decision making. Medical records that were given a diagnosis but not given the right codefication reached the highest number of 155 documents, equivalent to 59.64%. This percentage is quite significant and illustrates that the diagnostic process is carried out, but there are still many inaccuracies or omissions in the coding process.

Factors Affecting the Accuracy of Diagnosis and Coding in Patient Medical Records.

Completeness in Filling Medical Record Documents. In 260 patient medical record samples, it was found that the level of completeness in filling out medical record documents was uneven. The competence of medical personnel in filling out medical records and codifying diagnoses shows different data where the recording of medical records at the Mutiara Delima Clinic has followed the applicable operational standards (SOP), in recording patient identity, medical history, physical examination results, main diagnoses, additional diagnoses, and treatment plans. Of the total 260 medical records analyzed, 82 documents (31.54%) were given diagnoses and codifications. This shows that there are still limitations in the application of diagnosis codes according to the ICD. The quality of medical record documentation from 260 medical record documents analyzed was 155 patient medical record documents with a percentage (59.62%). This illustrates that there are problems in the completeness and accuracy of recording information on patient medical records. The facilities and infrastructure at the Mutiara Delima Clinic are quite helpful in the process of providing diagnosis codification. The technology used today has made it easier for officers to access medical record data but there is still a need for evaluation and coding audits to ensure the process of providing diagnoses and the resulting codes are accurate.

Discussion

The research findings show that the accuracy of diagnoses and codifications in patient medical records at the Mutiara Delima Clinic is not optimal in the implementation of providing diagnoses and codifications appropriately where of the 260 medical record documents analyzed, only 82 documents (31.54%) were obtained during a one-month period that were given the accuracy of diagnoses and codifications. This condition is reinforced by the theory of mangkunegara (2009), one of the important aspects in medical record management is the clarity and completeness of documented information. It is emphasized that incomplete or unclear medical records will hinder the coding process.

A total of 155 medical record documents (59.62%) only contained diagnoses without codification and 23 medical record documents (8.85%) contained neither diagnoses nor codification. codefication. These results indicate a significant problem with the accuracy and completeness of recording diagnoses and coding according to standards at the Mutiara Delima Clinic. This condition is reinforced by the theory of Azwar (2004) that in the health care system, incompletely recorded medical information will have a direct impact on the quality of service and clinical decision making. It is emphasized that inaccuracies or discrepancies in recording

diagnoses and codifications can reduce service quality, hinder the claims process, and have an impact on patient safety.

The competence of medical personnel in completing medical record documents needs to be improved by routine training and seminars on the ICD coding system and medical record management. Where the influencing factors are still dominated by personal factors of officers, lack of understanding and knowledge of the accuracy of diagnosis and coding.

Thus, the results of this study strengthen the data analysis of the accuracy of diagnosis and coding that supports the process of taking clinical data, providing actions, drugs, administration and health policies. Periodic audits and evaluations, improved communication between medical teams and optimization of the use of medical information systems need to be improved to ensure the accuracy of diagnoses and codifications that have been given in accordance with standard procedures.

5. CONCLUSIONS AND SUGGESTIONS

Based on the results of research conducted on the Analysis of the Accuracy of Diagnosis and Coding in Patient Medical Records at the Mutiara Delima Clinic, it can be concluded that the level of accuracy in providing diagnoses and coding medical records still has obstacles. Most medical record documents have been given a diagnosis quite well, but there is still inaccuracy in the provision of codes according to ICD-10 standards. This is due to several factors such as limited officer competence in coding, clarity of medical documentation from medical personnel, and supporting facilities and infrastructure that require improvement. Periodic evaluation is still needed to maintain consistency and accuracy in coding.

This study has limitations within the scope of one clinic so that the results obtained cannot be generalized to other health facilities on a larger scale. greater. This study only focused on analyzing the accuracy of diagnoses and coding without further assessing its impact on the overall quality of health services. The number of respondents is relatively small, so it does not illustrate a wider variation in the ability and understanding of health workers regarding the coding process. Therefore, it is recommended that the clinic provide training to medical record officers and other medical staff related to the provision of diagnostic accuracy and coding in patient medical records to maintain consistency and accuracy in providing diagnostic accuracy and coding in patient medical records. For future research, it is recommended that the scope be expanded to several health facilities with different types, and involve a larger sample size. Further research can explore the relationship between the accuracy of diagnosis and

coding with the effectiveness of health services and financial claims so that the results obtained are more comprehensive.

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