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Examining The Causes Of Inaccurate Outpatient Diagnosis Codes In Order To Enhance Edelweis Hospital's Medical Record Reporting Quality

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Abstract : The goal of this study is to identify the contributing factors to the high rate of diagnosis code mistakes, which will subsequently lower the standard of reporting in medical records. This study takes a descriptive approach while using a qualitative method. Direct observation and interviews are the methods utilized to gather data. This study examines the factors of Man, Method, Material, Machine, and Money in order to identify the recurring issues. The author may identify a number of common issues in the findings, including: 1. a shortage of police; and 2. the doctor's readable handwriting. 3. Because the system is not integrated, it takes a while to review further diagnostic data, and so on. By enhancing the diagnosis coding in medical records, it is intended that this study will serve as a guide for bettering the process of preserving and managing health data.

IndexTerms **– Examining, Inaccurate, Diagnosis Codes, Medical Record Reporting.**

I. INTRODUCTION

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition implies that mental health is more than the absence of mental disorder or infirmity. WHO also states that health is the most fundamental right of every human being, without distinction of race, religion, political or socio-economic conditions.

According to WHO (1996), health services are efforts organized by an organization to maintain and improve health, prevent and cure diseases, and restore the health of individuals, families, groups, or communities. Health services can be organized individually or together.

WHO also defines a health system as a network of health service providers (supply side) and people who use these services (demand side) in each region, as well as countries and organizations that generate these resources, in human and material form.

According to WHO (World Health Organization), the definition of a hospital is an integral part of a social and health organization with the function of providing comprehensive services, curative treatment and preventive treatment to the community.

According to WHO (World Health Organization) in 2006, medical records are an important part of patient care in the present and future. Medical records are documents that contain information about a patient's health history, such as diagnosis, treatment, procedures, test results, and other notes related to patient care. They are a vital tool in healthcare that help with clinical decision-making, service coordination, quality and timeliness of care evaluation, research, legal protection, education, accreditation, and management processes.

Medical records can be in paper or electronic form and should be kept confidential by doctors, dentists, and healthcare facility management. According to the Ministry of Health's regulations, medical records can be kept for up to five years, and medical record summaries can be kept for a minimum of 25 years.

The Ministry of Health's 2022 Regulation No. 24 on Medical Records requires all healthcare facilities to have electronic medical records (EMR) by December 31, 2023. EMR is a subsystem of a healthcare facility's information system that connects to other subsystems. It's important to store medical records electronically while keeping data safe and confidential.

The World Health Organization (WHO) classifies and codes diseases to make the names and categories of diseases, injuries, symptoms, and factors affecting health more uniform. This classification is called the International Statistical Classification of Diseases and Related Health Problems (ICD). ICD-10 is the 10th revision of the ICD and has been used in Indonesia since 1997. ICD-11, the latest revision of the ICD, was adopted by WHO in 2019 and came into effect on January 1, 2022.

Coding in medical records is one of the activities of processing medical record data to provide codes with letters, numbers, or a combination of both that represent data components. This code can be used to facilitate services, presentation of information, planning, management, and research in the health sector.

According to the World Health Organization (WHO), data for medical record reporting can be collected routinely from patient index reports, daily censuses, and register books. The data can then be presented as organized text that is easy to understand.

Medical record reporting can be categorized into six types based on content:

Inpatient records, Outpatient records, Emergency records, Specialist records, Mass or ambulance treatment records, Disaster records.

Internal hospital reports can also be customized to meet the hospital's needs. These reports can include information on patient admissions, discharges, deaths, lengths of stay, and more

Additionally, internal hospital reports can be tailored to the facility's requirements. These reports may contain details regarding patient length of stay, length of admission, patient release, and more. Based on the aforementioned justifications, the author is able to identify a common theme—cited in scientific journals—that codification in the health service series is extremely important." analisis ketidaktepatan kode diagnosis penyakit hipertensi berdasarkan icd-10 pada pelayanan rawat jalan di puskesmas kedungkandang kota malang by zulkarnain, lala gayanti (2023)" mentioned that "Not only may medical services exhibit quality, but so do ancillary services like medical record administration. Coding is a step in the administration of medical records process. Low data validation due to inaccurate coding will undoubtedly lead to inaccurate reports, such as those on outpatient morbidity, the top 10 diseases, or financing claims. Therefore, in order to account for the report, the correct and accurate code needs to be received."

The author raises " **EXAMINING THE CAUSES OF INACCURATE OUTPATIENT DIAGNOSIS CODES IN ORDER TO ENHANCE EDELWEIS HOSPITAL'S MEDICAL RECORD REPORTING QUALITY** " as the author's scientific journal with the intention that what the author can present here at least can be used as material or reference for improving the quality of disease coding in the medical record work unit in the future. This further reinforces the idea of how important the accuracy of patient diagnosis codes is, especially when supporting hospital reporting.

II. RESEARCH METHODOLOGY

This study uses a qualitative method with a descriptive approach. The data collection technique used is by direct observation and interviews. This study focuses on the aspects of Man, Method, Maternal, Machine, Money to see the transition.

III. RESULTS AND DISCUSSION

a. Result

The findings from observations and interviews on the inaccuracy of diagnostic codes are viewed through the lens of the five Ms: money, man, material, machine, method, and technique. The investigator's investigation yielded multiple findings about anticipated outcomes and actual outcomes in the field, specifically:

Table 1. Analysis Result

Aspect	Definition	Compare	
		EXPECT	ACTUAL
Man	is a factor that refers to Human Resources that carry out the process of medical record activities and health data management.	The number of medical records officers is appropriate and they are capable of carrying out medical records and health data management activities.	The number of officers is still inadequate, what is meant is that there is still a shortage of human resources due to being chased by many authorities and tasks so that the execution of services and management as well as processing of health data is not carried out optimally.
Material	factors that refer to what materials are used in health services and medical record activities as well as health data management	all files are in digital form	Some files can only be filled in manually because there is still a lack of electronic data recording tools such as recording patient progress with graphs.
Machine	is a factor that refers to the technological devices used to carry out medical recording activities and health data management.	Technological devices are very supportive for the implementation of medical record activities and health data management.	The computers in the computer section are limited and are used only based on their job description, so they are considered to be less than capable of supporting the medical records unit activities optimally.
Method	The method itself refers to the system used in medical record activities and health data management.	All systems have been updated so that they are well integrated with each other.	There are only a few integrated systems so that only a few activities can be carried out in full integration with each other.
Money	refers to the management of financing of all activities in medical records such as procurement of equipment and materials.	Allocation of the amount of costs in the sectors required for the transition to RME such as server equipment, generators, and honorariums for expert technicians to carry out the transition and additional costs to improve soft skills in the form of participating in workshops and seminars.	Budget allocation funds are not provided for further development of electronic medical records.

b. Discussion

1. Review of analysis results and their impact on inaccuracy of diagnostic codes with medical record reporting.

The government has made it quite clear that hospital medical records must be kept in electronic format. In practice, field officers' experiences differ greatly from those of the government's suggestion, particularly for those officers who continue to rely on the manual system.

In the mutually binding standard rules or rules-based codification of illnesses. The time available to officers in the field is not comparable to the amount of time required to comply with these numerous rules due to their high processing times. Moreover, the conversion of manual medical records to electronic medical records significantly affects the codification process, which frequently results in incorrect diagnosis codes.

Since the majority of the data used in medical record reporting is derived mostly from disease coding, the state of medical record reporting undoubtedly has an impact on this as well. Whether you agree with it or not, the disease codification data needs to be accurate and reliable.

2. Analysis Aspect

- **Man Aspect**

Officers are still insufficient; by this, it is understood that there is still a deficiency of human resources as a result of their pursuit of numerous responsibilities and authority, which makes it difficult to provide services and manage and process health data. Regarding error, the diagnosis code is the most significant component. For what reason is that the case? Because the officers are the ones who perform the registration, reporting, and disease codification checks on medical records.

The author previously said that the rules in the codification are interrelated.In actuality, though, these rules require time to complete since the files can't wait any longer. As a result, this codification is done extensively, namely by "shooting" codes only when they are based on the primary diagnostic that the physician wrote.

Based on the aforementioned issues, the author argues that effective time management and resource allocation are crucial. In the field, there are insufficient human resources, which results in a lack of accuracy and a very short turnaround time. The declarative phase of the process, in particular, cannot be completed quickly without careful thought.

Therefore, the author suggests that one way to address issues in this Human Aspect is to think about adding human resources especially for disease coding and other related things.

- **Material Aspect**

Certain files are still devoid of electronic data recording capabilities, such as the ability to graph patient progress, therefore they can only be completed manually. Certain forms require handwriting and require manual entries. This is among the factors that lead to incorrect diagnosis codes. For what reason is that the case? Since some of us are aware that not all medical writers are literate.

The reader's misconception resulting from the doctor's illegible writing can lead to miss leading, especially when they are rushing or in a hurry, making it impossible for them to reevaluate the diagnosis based on additional supporting examinations. This reading problem is mostly responsible for diagnosis errors.

In response to what the author has just described, the author can state that creating a standard operating procedure (SOP) for writing manual medical records can be a solution because reading errors can also have fatal consequences. Therefore, it appears to be a way out if there are standard operating procedures and good writing guidelines so that everyone can better understand one another and the importance of carrying out their duties without creating unnecessary problems.

- **machine** & **method Aspect**

Since there are fewer computers in use and they are solely utilized in accordance with their job descriptions, it is thought that they are less able to support the activities of the medical record unit as effectively. It is designed to signify that the computer already has a job description and is not suited for any other use.

According to the author, there are four purposes for which computers are used: 1. for correspondence; 2. for input data assembly; 3. for coding; and 4. for reports. The remainder continue to rely on paper-based guides. And because authorities are pressed for time to double-check the medical data on paper first, this is typically the reason why information is missing.

According to the data above, the author believes that the electronic medical records are less flexible and efficient because they need to be accessible to anyone from any work unit (with credentials). If they are not flexible, what sets them apart from paper-based medical records is that if they can only be accessed in specific locations, it will obviously be more difficult to perform the primary tasks and functions. To make things more effective and convenient for officers, it would be ideal if every computer or laptop in the hospital had access to electronic medical records anywhere with credential records. Additionally, turn graphs into digital data—whether converted or not—in the hopes that all medical record data will eventually be digitized and require less upkeep and user-friendliness.

- **money Aspect**

Funds from the budget are not allocated to support the creation of more electronic health records. This may also be because the hospital does not allocate funds for the advancement of technology or officer knowledge, and officers do not receive the standard training that the hospital provides. It may also be because the hospital does not add technological devices to carry out medical record activities.

For the reasons listed above, it would be preferable to have workshops or seminars that could improve the soft skills of medical record activities in a hospital setting. This would help the hospital provide better health services by improving medical record activities, which would also benefit the medical recorders themselves.

IV. CONCLUSION

Based on the aforementioned reasoning, the author can deduce that there are numerous additional contributing causes to the diagnosis code's inaccuracy in addition to an incorrect or careless coding method.

the significance of the data generated for reporting hospital medical records, the author offers a number of recommendations that ought to be able to assist in enhancing the health data management procedure, such as expanding training, introducing new technology that unifies everything, and keeping officers' attention by providing more resources. That's what the writer hopes this journal will be able to communicate, and everybody who reads it can use it as a reference for self-improvement.

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