Strategies for Improving the Inaccuracy of Codefication of Medical Record Files Outpatient Patients Based on ICD-10 with PDCA at Sukodono Lumajang Health Center

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ABSTRACT

The disease classification system is a grouping of similar diseases with the International Statistical Classification of Diseases and Related Health Problem Tenth Revisions (ICD-10) for the term of illness and health related problems. Coding applications must match ICD-10 to obtain accurate code because the results are used for the indexing of disease logging, national and international reporting of morbidity and mortality, health care financing analysis, and for Epidemiological and clinical research. The purpose of this research is to determine the strategy to improve the inaccuracy of the medical record file the patient's patient records by identifying factors causing inaccuracies in file coheracies with 5M (man, method, machine, material, money) and then Using the methods of CARL (Capability, Accessability, Readiness, Leverage) to determine the priority of problem solving and using PDCA (Plan, Do, Check, Action) to prepare the correction of inaccuracy improvement of the patient's medical record file Road. The type of research used is qualitative, data collection through interviews to 4 informant, observations, and documentation. The results showed that the cause of inaccuracy in the patient's outpatient medical record was the absence of officers or coder in the background of medical records, the absence of a codefecation tool in the form of ICD-10, and no Used as a working guideline. The suggestion to correct the inaccuracy of the outpatient medical record is the holding of a coding tool in the form of ICD-10 Volume 3 and Volume 1, manufacture of codefation SOP and socialization of codefation SOP to the coder.

Keywords: Coding, Medical Record, CARL, PDCA