

The Relationship between the Completeness Medical Information and the Accuracy of Pneumonia Diagnosis Codes (J12–J18) in the Inpatient Unit of Citra Husada Hospital Jember

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ABSTRACT

Coding accuracy is an important aspect of medical record management because it affects the validity of data and hospital morbidity reporting. A preliminary study found that 12 (35.3%) medical records contained inaccurate pneumonia diagnosis codes (J12–J18), which were caused by incomplete and inconsistent medical information supporting diagnosis establishment. This study aimed to analyze the relationship between the completeness of medical information and the accuracy of pneumonia diagnosis coding (J12–J18) in the inpatient unit of Citra Husada Hospital Jember. This study employed a quantitative method with an observational analytic design and a cross-sectional approach. The sample consisted of 91 inpatient medical records with pneumonia diagnoses (J12–J18), selected using simple random sampling. Data were analyzed using the Chi-Square test and the Contingency Coefficient Correlation test. The results showed that, out of 91 medical records, 65 (71.4%) contained complete medical information, while 26 (28.6%) were incomplete. Accurate pneumonia diagnosis coding (J12–J18) was found in 75 (82.4%) medical records, whereas 16 (17.6%) records were coded inaccurately. Statistical analysis revealed a significant relationship between the completeness of medical information and the accuracy of pneumonia diagnosis coding (J12–J18), with a p-value of 0.000 (<0.05). The contingency coefficient value of 0.516 indicated a moderate relationship between medical information completeness and the accuracy of pneumonia diagnosis coding. The author recommends that the hospital conduct audits of medical information completeness and diagnosis coding accuracy as an evaluation of the internal verification and monitoring activities that have been implemented.

Keywords: *Completeness, Medical Information, Coding Accuracy, Pneumonia*