

Audit Koding Bronkitis (J20, J41, J42) Pasien Rawat Inap Anak RSUD dr. Abdoer Rahem Situbondo Tahun 2025 (*Coding Audit of Bronchitis (J20, J41, J42) in Pediatric Inpatients at RSUD dr. Abdoer Rahem Situbondo 2025*)

Demiawan Rachmatta P. M., S.ST., M.Kes (*Supervisor*)

Yara Putri Nur Azizah

*Diploma IV Health Information Management Study Program
Health Department*

ABSTRACT

Coding audits involve assessing the accuracy of assigned diagnosis codes based on clinical documentation and applicable coding rules. A preliminary study revealed inaccuracies in diagnosis coding for bronchitis. In 2024, acute bronchitis was the most prevalent condition, with 877 cases, ranking first among the top ten diseases. This study aimed to audit the coding of pediatric inpatient bronchitis cases at dr. Abdoer Rahem Regional General Hospital (RSUD), Situbondo. A descriptive quantitative approach was employed, utilizing a sample of 53 medical records from pediatric inpatients with bronchitis treated between July and September 2025. The results indicated an 84.9% inaccuracy rate in diagnosis coding; specifically, 8 records showed accurate coding, 36 showed inaccurate coding, and 9 showed inaccurate coding with additional documentation discrepancies. Discrepancies were identified in the initial assessment sheets (1 medical record), supporting examination result sheets (6 medical records), and medical summary sheets (3 medical records). An audit based on morbidity coding rules revealed 6 non-compliant records. These findings demonstrate persistent discrepancies in medical records and the application of morbidity coding rules for pediatric inpatient bronchitis diagnoses at the hospital in 2025. It is recommended that the hospital improve coding quality and clinical documentation through periodic coding audits, coder performance evaluations, and training for both medical staff and coders.

Keyword: *coding audit, clinical documentation, inaccuracy*