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Review of Diagnosis Coding Based on Medical Terminology Terms in the Outpatient Department at the RSUD Kota Mataram

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ABSTRACT

Medical terminology is the science of medical terminology used as a means of communication both directly and indirectly by medical and non-medical personnel. Writing a diagnosis must use medical terminology terms to help coders select lead terms in coding a diagnosis. The purpose of this study was to review the coding of diagnoses based on medical terminology terms at the Mataram City Regional General Hospital. The research method was a combination (Mixed Methods). The population was 300 and the sample size was 75 medical records. The sampling technique was random sampling, with 4 informants through interviews. The results showed that from a sample of 75 outpatient diagnoses, there were 25 (33%) correct terminologies and 50 (67%) incorrect terminologies using abbreviations, Indonesian, and letter errors. Writing a diagnosis without medical terminology will make it difficult for coders to find lead terms and it will take more time to change the diagnosis term into a medical terminology term to make it easier to code the diagnosis.

KEYWORDS: Medical Terminology, Diagnostic Accuracy, Coding Constraints

INTRODUCTION

A patient's medical history is known by the medical information written in the medical record. Recording activities are very necessary fo rall activities in the hospital to obtain complete and accurate medical information. One of these recording activities is recording a diagnosis based on medical terminology rules. Healthcare professionnal in writing a diagnosis must use medical terminology language to be classified using ICD-10 (Almubarqah et al., 2022). The accuracy of writing a diagnosis that does not comply with the medical terminology in ICD-10 will result in coding officers having difficulty in determining the patient's disease diagnosis code (Pratama, 2020).

Medical terminology used in writing a diagnosis is said to be appropriate if it uses medical terms with ICD-10. Conversely, medical terminology in writing a diagnosis is said to be inappropriate if it uses medical terms that are not in accordance with ICD-10, such as using Indonesian terms or abbreviations (Pratama et al., 2020). The terms for diseases or health conditions listed in the nomenclature must be appropriate with the terms used in a disease classification system. Most medical term structures consist of 3 (three) word elements, namely prefix, root, and suffix. The structure of each word/term must have at least one root. Not all medical terms consist of three elements, such as prefix, root word, and suffix, sometimes one term only consists of two elements, namely prefix and root word or root word and suffix. (Irawan et al., 2022).

The problem of inaccuracy of medical terminology terms that are not appropriate with ICD-10 will cause coders to have difficulty understanding the diagnosis listed in the medical record file and it takes a long time to change terms from Indonesian to medical terms based on ICD-10. However, if the coding professional does not understand medical terminology, they will have difficulty, which will have an impact on choosing the right diagnosis code. Inaccuracy in writing medical terminology can also affect the quality of data, information, reports and the accuracy of patient care levels, so that reducing quality hospital (Heltiani et al., 2020). The use of inappropriate abbreviations found medical terminology abbreviations which are a mixture of Indonesian and English. Diagnosis written with Indonesian abbreviations, officers must translate them into medical terminology to determine the lead term (Hascaryani, Wariyanti, & Mulyono, 2024).

A preliminary study conducted by researchers in July 2024 at the Mataram City Hospital found that out of 60 medical record files, there were 38 (63%) diagnoses with inappropriate medical terminology terms, then 22 (37%) diagnoses with the correct terms. There are differences in writing diagnoses with medical terminology terms based on ICD 10. This means that the use of diagnostic terms is still incorrect with medical terminology, the use of diagnostic terms is still in Indonesian, typo, and even abbreviations that have not been determined. The understanding of coding officers regarding medical terminology is very much needed in translating diagnostic terms based on ICD 10, making it easier for coding officers to code diagnoses based on the writing of diagnostic terms by doctors. The obstacle of the diagnosis written don't use the correct medical terminology according to ICD-10, so coding officers will have difficulty in choosing the lead term in determining the diagnostic code which will affect the accuracy of the diagnostic code. In addition, it will also be difficult for coders to change diagnostic terms into terms that appropriate with medical terminology.

The term indonesian is katarak which should be in the medical terminology according to the ICD-10 disease classification is Cataract. Term katarak is stated to be inappropriate because in the term use of medical terminology the ICD-10 disease classification do not use Indonesian, but uses medical terminology. Based on this background, the author is interested in conducting a study entitled Review of Diagnosis Coding Based on Medical Terminology Terms in the Outpatient Department at the RSUD Kota Mataram. This study aims to determine the level of accuracy and inaccuracy of diagnosis based on medical terminology terms and the obstacles in coding medical terminology terms**.**

LITERATURE REVIEW

Medical Terminology

Medical terminology is a special language in the world of health used by medical personnel, both verbally and in writing, which functions as a communication tool, a source of diagnostic data and medical actions, and an important basis in classification systems such as ICD, ICOPIM, and ICHI which require high accuracy and precision. This data is also an authentic basis for morbidity and mortality statistics (Kurnianingsih et al., 2020). Medical terminology is a language used in health services to facilitate communication between medical personnel and must be appropriate with the terms used in the disease classification system

(Suryani et al., 2022). Medical terms in the disease classification system (ICD-10) consist of pure medical terminology and medical language. Not all medical languages are included in medical terminology, because medical terminology has basic elements such as root, prefix and suffix. Medical terms are usually written in Indonesian and English to facilitate understanding of the meaning of the term (Irawan et al., 2022).

Diagnosis and Coding

Diagnosis is a way to find out a disease by looking at the symptoms and looking for the cause. Diagnosis helps determine the type of disease, the patient's possible condition, and the right treatment. The word *diagnosis* comes from the Greek word meaning knowledge. Diagnosis also means grouping someone based on the disease or disorder they have. Obstacles to Coding Diagnosis Based on Medical Terminology (Aziz et al., 2019). Coding is the assignment of codes in the form of letters or numbers to represent data. Diagnoses and actions in medical records need to be coded so that information is easy to find and use for health planning, management, and research . The goal is to facilitate the recording and processing of health data (Arimbawa et al., 2022). Some of the obstacles in coding diagnoses based on medical terminology include inaccurate use of medical terms by doctors, writing diagnoses that still use abbreviations or unclear terms, and the use of language that is not fully in accordance with standard medical terminology (Setiyawan et al., 2023).

METHOD

This study uses a mixed methods method, which combines quantitative and qualitative approaches to understand the research problem. The study was conducted in December 2024. The quantitative population consisted of 300 outpatient medical record documents, with Simple Random Sampling as the sampling technique. The number of samples was determined using the Slovin formula, so that 75 documents were obtained. Qualitative information was obtained from outpatient coding officers as key and main informants, and the Head of the Medical Records Installation as supporting informants. The qualitative sampling technique used Purposive Sampling.

The instrument used in this study was a documentation study with a checklist sheet and interview guidelines. The checklist sheet used is an adaptation of the research by Chusnawati et

al. (2020) to assess the level of accuracy of diagnostic terms. Interview guidelines are used to explore obstacles in coding diagnoses based on medical terms.

Data analysis was carried out quantitatively to assess the accuracy of the diagnosis, and qualitatively namely data reduction, data display, and verification to understand the obstacles in the diagnosis coding process.

RESULT AND DISCUSSION

The accuracy and inaccuracy of appropriate and inappropriate medical terminology terms can be seen in (table 1) and (table 2)

Tabel 1. percentage of accuracy of medical terminology

No.	Diagnosis	Total (n)	Percentage (100%)
1	*Cystitis*	3	4%
2	*Esotropia*	1	1,3%
3	*Diabetic Retinopathy*	1	1,3%
4	*Keratitis*	1	1,3%
5	*Asthenopia*	1	1,3%
6	*Myopia*	1	1,3%
7	*Panuveitis*	1	1,3%
8	*Otitis Eksterna*	1	1,3%
9	*Hearing Loss*	1	1,3%
10	*Sinusitis*	1	1,3%
11	*Stroke Infark*	1	1,3%
12	*Hemiplegia*	1	1,3%
13	*Pneumonia*	1	1,3%
14	*Blighted Ovum*	1	1,3%
15	*Varicella*	1	1,3%
16	*Dermatitis*	3	4%
17	*Neurodermatitis*	2	2,6%
18	*Melasma*	1	1,3%
19	*Uveitis*	1	1,3%
20	*Myasthenia*	1	1,3%
	Total (n)	25	32,7 = 33%

Based on Table 1 above, it can be seen that the correct medical terminology terms based on ICD-10 at the Mataram City Regional General Hospital are 25 medical record files (33%). The accuracy of medical terminology terms based on ICD-10 are *Cystitis, Esotropia, Diabetic Retinopathy, Keratitis, Asthenopia, Myopia, Panuveitis, Otitis Externa, Hearing Loss, Sinusitis, Stroke Infarction, Hemiplegia, Pneumonia, Blighted Ovum, Varicella, Dermatitis, Neurodermatitis, Melasma, Uveitis,* and *Myasthenia.*

Tabel 2. Percentage of inaccuracy Medical Terminology

No.	Diagnosis	ICD-10	Total	Percentase (100%)
1	*ISK*	*Urinary Tract Infection*	6	8%
2	*KSI*	*Cataract Senilis Imature*	2	2,6%
3	*Tonsilitis Chronic*	*Tonsillitis Chronic*	1	1,3%
4	*Heavy Pneumonia*	*Pneumonia Acute*	1	1,3%
5	*Dermatitis Seborik*	*Dermatitis Seborrheic*	1	1,3%
6	*Cataract*	*Cataract*	7	9,3%
7	*Kidney Stone*	*Nephrolithiasis*	1	1,3%
8	*Kongjungtivitis allergies*	*Conjunctivitis Allergic*	1	1,3%
9	*Sriktur Uretra*	*Urethral Stricture*	1	1,3%
10	*Bladder calculi*	*Calculus of Bladder*	4	5,3%
11	*Stone Ureter*	*Calculus of Ureter*	3	4%
12	*Epilepsi*	*Epilepsy*	3	4%
13	*Pseudofakia*	*Pseudophakia*	2	2,6%
14	*Glaukoma*	*Glaucoma*	2	2,6%
15	*Keratopati*	*Keratopathy*	1	1,3%
16	*Odem Papila*	*Adema Papilla*	1	1,3%
17	*Celfalgia*	*Cephalgia*	2	2,6%
18	*Otomikosis*	*Otomycosis*	1	1,3%
19	*Disfagia*	*Dysphagia*	2	2,6%
20	*Urtikaria*	*Urticaria*	1	1,3%
21	*Onikomikosis*	*Onychomycosis*	1	1,3%
22	*Folikulitis*	*Folliculitis*	1	1,3%
23	*Skabies*	*Scabies*	1	1,3%
24	*Karbunkel*	*Carbuncle*	1	1,3%
25	*Sifilis*	*Syphilis*	1	1,3%
26	*Hidronefrosis*	*Hydronephrosis*	2	2,6%
		Total (n)	50	65,7 = 67%

Based on Table 2, the terms of medical terminology that are not appropriate based on ICD-10 at the Mataram City Regional General Hospital are 50 medical record files (67%). In writing the abbreviation terms, namely *UTI*, and *KSI*. Then for the inaccuracy in writing terms using Indonesian, there are *Severe Pneumonia, Chronic Tonsillitis, Seborrheic Dermatitis, Cataracts, Kidney Stones, Allergic Conjunctivitis, Urethral Sculpture, Bladder Stones,* and *Ureter Stones*. Then the inaccuracy in using terms is the presence of letter errors in *Epilepsy, Pseudophakia, Glaucoma, Keratopathy, Papillary Oedema, Cefalgia, Otomycosis, Dysphagia, Urticaria, Onychomycosis, Folliculitis, Scabies, Carbuncle, Syphilis,* and *Hydronephrosis.*

The data obtained from the interview are in the form of informant answers to questions asked by the researcher through an interview guide conducted face-to-face with the informant, which then presents the answer data in the form of interview excerpts related to the constraints of Coding Diagnosis appropriate with Medical Terminology. The excerpts from the interview results from the research informant are described and explained in more detail in the following research results.

1. There is difficulty in finding *lead terms.*

   From the interview results, it was discovered that there were difficulties in finding *lead terms* if the diagnosis was written without medical terminology. The following are answers from several informants.

   "…A little, but now most doctors write according to medical terminology, there are some Indonesian words, but not many." (Informant 1)

   "…….There are difficulties, but rarely one or two diagnoses in the abbreviation. If there are difficulties, we usually ask the nurse or the doctor. (Informant 2).

   "…… Not all of them are in Indonesian and have English, usually I use Indonesian translation... Google Translate" (Informant 3).

2. It takes time to find and change diagnostic terms.

   The interview results show that more time is needed to search for and change diagnostic terms into terms that are in accordance with medical terminology. The following are answers from several informants.

   "….Yes, but not too many because in this outpatient clinic, they always invite the same people, the diagnosis is ongoing, there are some that are added but not many" (Informant 1).

   "….Oh yes, there is time, maybe…additional time like that, maybe usually the abbreviation for, for example, what… Batu Bali-buli, we are usually confused, can we search on Google or in a

book what it is called? Yes, a list of abbreviations. Batu Buli-buli, we look for it like if calculus bladder is like that, the name of the child" (Informant 2).

"…. Yes, no, not too much, at most one minute for coding, most of the actions are in Indonesian, if the diagnosis is normal, more English is used ." (Informant 3).

"….Yes, we ask the officer directly, what's his name, sometimes to the nurse, so he's the one who tells the doctor what this means, what's that, this diagnosis." (Informant 4)

3. It is necessary to confirm with the doctor or nurse the diagnostic terms used.

The results of the interview showed that it was necessary to confirm with the doctor or nurse the diagnostic term in question to prevent differences in perception that would affect the accuracy of the diagnostic code. The following are answers from several informants.

"….We go back to.. asking the doctor again" (Informant 1).

"….Yes, we ask the nurse or doctor too, whether the diagnosis is correct or not, if that is the last option we ask the doctor. We open the billing first in the system, ee, we open the files one by one in the cppt section or the patient's medical resume, what is the disease, then we look for the correct diagnosis. If there is still doubt in what is in the medical resume, the medical resume is diagnosed, then we ask the nurse or doctor whether the diagnosis is correct or not, if it is not correct, maybe it can be changed or reassured by us as coding officers." (Informant 2).

4. *"…. We have to ask the doctor first, for example, what is the diagnosis, usually the doctor writes an abbreviation, if the abbreviation is not there, for example in the ICD, we ask the doctor directly. If not, the doctor asks the nurse, sometimes nurse and doctor is not certain "* (Informant 3).
5. *"….Yes, sometimes I find it in the doctor's room, eh to the doctor's assistant, then the assistant goes to the doctor* (Informant 4).

DISCUSSION

Inaccuracies in writing terms using Indonesian, namely: *Severe pneumonia, Chronic tonsillitis, Seborrheic dermatitis, Cataracts, Kidney stones, Allergic conjunctivitis, Urethral stricture, Bladder stones, and Ureteral stones*. The medical terminology language that corresponds to the ICD-10 disease classification is *Acute Pneumonia, Chronic Tonsillitis, Seborrheic Dermatitis, Cataract, Allergic Conjunctivitis, Urethral Stricture, Calculus Bladder, and Calculus Ureter.* The term is stated to be inappropriate because the medical terminology in the ICD-10 disease classification does not use Indonesian, but uses medical language.

The inaccuracy of letters in writing the diagnosis was obtained from the research results, namely the letters in *Epilepsy, Pseudophakia, Glaucoma, Keratopathy, Papillary Oedema, Cephalorrhea, Otomycosis, Dysphagia, Urticaria, Onychomycosis, Folliculitis, Scabies, Carbuncle, Syphilis,* and *Hydronephrosis.* The medical terminology language that corresponds to the ICD-10 disease classification is *Epsilepsy, Pseudophakia, Glaucoma, Keratopathy, Odema Papilla, Cephalgia, Otomycosis, Dysphagia, Urticaria, Onychomycosis, Folliculitis, Scabies, Carbuncle, Syphilis,* and *Hydronephrosis.* The term is stated to be incorrect because the term does not exist in the medical terminology based on the ICD-10 classification due to a letter error.

The results of the study are in line with research conducted by (Irawan et al., 2022)that the percentage of the correct use of medical terminology in writing diagnoses is 74 (82%) and the inaccuracy of the use of medical terminology terms is 16 (18%), namely the use of abbreviations, Indonesian, and letter/spelling errors. The diagnosis should be written with the correct medical terminology, has informative value so that it helps the coding officer to code the disease according to ICD-10. The disease classification system (ICD-10) medical terms used consist of pure medical terminology and medical language. Not all medical language is medical terminology, because in principle medical terminology can be broken down into elements of medical terminology, namely *prefix, root*, and *suffix* (Irawan et al., 2022).

Medical records must contain health information that is written consistently, including the use of medical language by doctors and nursing and midwifery personnel which ultimately becomes a means of communication between health workers, medical support, and other personnel working in the field of health services (Djusmalinar & Al Mubarokah, 2020). Doctors who treat patients have the duty and responsibility to enforcing and writing diagnoses by ICD-10. Diagnoses written in medical records must be complete, precise, and clear in accordance with medical terminology and the directions in the ICD-10 book. All diagnoses and procedures must be written in full, without symbols, with acceptable terms (Terminology). The purpose of writing medical terminology by ICD-10 is for language uniformity so that the medical terminology written in the patient's medical record file can be read and understood (Almubarqah, 2022).

2. Obstacles to Coding Diagnosis Based on Medical Terminology Terms

The implementation of diagnosis coding must be carried out very carefully, precisely, and accurately according to the diagnosis code in ICD-10. If there is an error in coding, it will

has a negative impact on patients and hospitals. However, in reality, obstacles are still found in the implementation of disease diagnosis coding based on ICD-10(Salehudin & Harmanto, 2021).

Based on the results of the research conducted, it was found that there are still inaccuracies in writing diagnoses based on ICD-10 because of the writing of diagnoses using abbreviations, Indonesian terms, and spelling errors. The results of this study are in line with research conducted by (Irawan et al., 2022) that the inaccuracy in the use of medical terminology terms is the use of abbreviations, Indonesian, and letter/spelling errors. The term diagnosis must use medical terminology language to be classified using ICD-10 (Almubarqah, 2022).

The results of the study showed that coding diagnoses that did not match medical terminology terms made it difficult for coders to find *lead terms,* so it took more time to change the terms. The results of the study are in line with research conducted by (Almubarqah, 2022) that coding diagnoses that did not match medical terminology terms would have an impact when coders coded diseases and would have difficulty finding *leads.* Term so it takes longer to change the term in Indonesian into the appropriate medical term first, to make it easier to determine the diagnosis code. The diagnosis is written with Indonesian abbreviations, so the officer must translate it into medical terminology to determine *the lead term* (Hascaryani et al., 2024). Another obstacle encountered in coding a diagnosis that does not comply with medical terminology is the use of new terms. Coding a diagnosis when a new term is encountered requires great accuracy from the coder. This will make it difficult for the coder to code if a new term is found (Suryani et al., 2022).

Differences in perception of writing diagnostic terms also become obstacles in coding diagnoses. These results are in line with research conducted by (Triatmaja, Wijayanti, & Nuraini, 2022) that differences in perception between coders and doctors will affect the inaccuracy of diagnostic codes. Inconsistency in writing diagnoses by doctors is also an obstacle in coding. These results are in line with research conducted by (Nugraheni, 2021) that the accuracy of diagnostic codes is the conformity of the diagnostic code set by the coding officer with the diagnosis written in the patient's medical record according to ICD-10 rules. The accuracy of the code of a diagnosis is influenced by the consistency of writing the diagnosis, inconsistency in determining the main diagnosis and secondary diagnosis will affect the selection of codes.

Efforts to overcome the inaccuracy of the use of medical terminology in writing diagnoses based on the results of interviews that have been conducted, namely the coder must reconfirm with the doctor or nurse. The results of this study are in line with research conducted by (Djusmalinar & Al Mubarokah, 2020) (Djusmalinar & Al Mubarokah, 2020)that to overcome the misunderstanding of the diagnosis between the coder and the doctor concerned if the coder finds a diagnosis that is not familiar, the coder asks the doctor concerned directly.

CONCLUSION

Inaccurate use of medical terminology terms according to the ICD-10 disease classification includes using abbreviations, using Indonesian, and there are typos. There are differences in writing diagnoses based on medical terminology terms according to the ICD-10 classification. Obstacles in coding diagnoses that are not by medical terminology, the use of new terms in diagnoses, differences in perception of diagnostic terms between coders and doctors, and inconsistencies in writing diagnoses. Understanding medical terminology is essential to facilitate the translation and coding of diagnoses based on medical terminology terms.

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