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The Relationship Between the Completeness of Emergency Anamnesis Forms and the Completeness of *External Cause* Codes in Traffic Accidents

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ABSTRACT

Objective: *The completeness of emergency anamnesis forms is one of the factors that influence the quality of medical record information, including in the determination of external cause codes in traffic accident cases that require complete information on the chronology of events. This study aims to determine the relationship between the completeness of emergency anamnesis forms and the completeness of external cause codes in traffic accident cases at dr. Mohammad Zyn Sampang General Hospital.* ***Method:*** *This study uses an analytical design with a cross-sectional approach. The study population consisted of 117 emergency anamnesis forms for traffic accident patients from the third quarter of 2025. A sample of 90 documents was selected using simple random sampling based on the Slovin formula. Data was collected through observation using a checklist and analyzed using the Chi-Square test. A total of 64 emergency medical history forms (71.1%) were classified as incomplete, and 26 forms (28.9%) were classified as complete. Regarding the completeness of external cause codes, 49 forms (54.4%) were classified as complete, and 41 forms (45.6%) were classified as incomplete.* ***Results:*** *The results of the Chi-Square test showed a p-value of 0.001 ($p<0.05$). The study results indicate that the significant relationship between the completeness of emergency anamnesis forms and the completeness of external cause codes.* ***Novelty:*** *Thoroughly documented information on the chronology of events facilitates the assignment of more specific codes in accordance with ICD-10, thereby supporting the quality of hospital morbidity data.*

INTRODUCTION

Traffic accidents remain one of the public health problems causing high rates of death, disability, and healthcare service burden in various countries. The *World Health Organization* (WHO) reports that around 1.19 million people die each year due to traffic accidents, with most cases occurring in low- and middle-income countries, including Indonesia [1]. In addition to causing injuries and deaths, the high number of traffic accidents also increases the need for accurate health data as a basis for formulating prevention policies, evaluating services, and monitoring injuries. Therefore, complete and quality medical record documentation is an important component in producing valid health information.

Medical records are documents containing patient identity, examination results, treatments, actions, and other services provided to patients in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Medical Records [2]. One of the functions of medical records is to provide accurate data to support morbidity reporting, research, financing, and decision-making in the health sector. In cases of injuries caused by traffic accidents, the coding process not only covers the primary diagnosis but also requires *coding external causes* according to ICD-10 Chapter XX (V01-Y98). External *cause* codes serve to describe the external causes

of injury so they can be used for epidemiological analysis, health statistics compilation, and accident prevention program planning.

The completeness of external cause coding is greatly influenced by the availability of chronological information documented in the emergency anamnesis form. Based on the WHO Injury Surveillance Guidelines [3], important information required includes *who* (who experienced the incident), *what* (the incident or type of injury experienced), *how* (the mechanism of injury occurrence), and *when* (time of the incident). This information serves as the basis for coding officers to determine *the most complete external cause* code , so the coding process has the potential to produce codes that are less specific or even cannot be optimally determined, thus impacting the quality of hospital morbidity data.

Preliminary study at dr. Mohammad Zyn Sampang Regional Hospital. Hospital data shows that during the period from September 2024 to August 2025, there were 136 traffic accident cases treated in the Emergency Room (IGD). Based on preliminary studies in the Casemix Unit, it was found that external cause coding has not been consistently applied because the coding focus is still directed at the main diagnosis related to INA-CBG's claims. Furthermore, observations of 10 medical record documents showed that 60% of emergency anamnesis forms were not fully completed, especially regarding the mechanism and timing of the incident. This condition has the potential to cause incomplete *external cause* coding and reduce the quality of morbidity data produced by the hospital.

Several previous studies have shown that the quality of medical record documentation plays an important role in supporting the process of coding diagnosis as well as *external cause codes.* Manalu *et al.,* [4] show that incompleteness of medical record documents is related to the low accuracy of injury diagnosis coding. Rahayu [5] also shows a significant relationship between the completeness of medical record documents and the completeness of injury diagnosis codes. In traffic accident cases, the completeness of the initial assessment affects the completeness of *external cause* coding [6]. These results are supported by Saragih *et al*., [7], who state that the completeness of filling out emergency anamnesis forms is related to the accuracy of accident case coding. Most studies still focus on the accuracy of diagnosis codes, coding accuracy, or factors influencing the coding process in general. Meanwhile, studies discussing the relationship between the completeness of emergency anamnesis information and the completeness of *external cause codes* in traffic accident cases are still limited. Meanwhile, chronological information on the incident serves as the basis for determining *complete and specific external cause* codes in accordance with ICD-10 principles, thereby improving the quality of medical record documentation and hospital morbidity data.

Based on this description, this study aims to analyze the relationship between the completeness of the emergency anamnesis form and the completeness of *external cause codes* in traffic accident cases at dr. Mohammad Zyn Sampang Regional Hospital. The results of the study are expected to serve as input for hospitals in improving the quality of medical record documentation, especially the completeness of filling out the emergency anamnesis form, thereby supporting *more complete external cause* coding and

producing accurate morbidity data as a basis for planning, evaluation, and decision-making in the field of health services.

RESEARCH METHOD

This study used an analytical quantitative design with *a cross-sectional approach* to determine the relationship between the completeness of emergency anamnesis forms and the completeness of *external cause codes* in traffic accident cases at dr. Mohammad Zyn Sampang Regional Hospital. The study was conducted from May to June 2026 using secondary data in the form of medical record documents of traffic accident patients during the third quarter of 2025. The study population consisted of 117 medical record documents and a sample of 90 documents selected using *simple random sampling* technique. Data collection was conducted through observation using checklist sheets based on *the WHO Injury Surveillance Guidelines* and ICD-10 Chapter XX. Data were analyzed univariately and bivariately using *the Chi-Square* test.

The assessment of the completeness of the emergency anamnesis form is based on four components of information in injury surveillance, namely *who* (who was injured), *what* (type or cause of injury), *how* (how the injury occurred), and *when* (when the incident occurred). The anamnesis form is considered complete if all four components are documented in medical records, while it is considered incomplete if one or more components are not documented. Furthermore, *the external cause code* in this study was obtained through coding simulations conducted by the researcher based on information in the medical record documents. The simulation results were then validated by the coder at dr. Mohammad Zyn Sampang Regional Hospital because the hospital had not specifically applied *external cause* coding for traffic accident cases. Code completeness assessment was carried out up to the 4th character. A code is considered complete if the code character up to the 4th character can be determined based on information available in medical record documents, while it is considered incomplete if there are characters that cannot be determined. This study has obtained ethical approval from the Health Research Ethics Commission of the Ngudia Husada Madura Foundation of Noor Huda Mustofa University with *Ethical Clearance number* 3235/KEPK/UNIV-NHM/EC/IV/2026 and the Health Research Ethics Commission of dr. Mohammad Zyn Sampang Hospital with Ethical *Clearance* number 17/RSMZ. KEP/EC/2026. All medical record data used is kept confidential by concealing patient identities and is only used for research purposes in accordance with the principles of health research ethics.

RESULTS AND DISCUSSION

Results

1. Completeness of Filling Out the Emergency Anamnesis Form for Traffic Accident Cases

The completeness of the emergency anamnesis form was assessed based on four components: *who*, *what*, *how*, and *when*. The assessment results of 90 medical record documents are presented in Table 1.

Table 1. Percentage of *who*, *what*, *how*, and *when components*

No	Components	Description	Category	
			Complete	Incomplete
1	Who	Victim's identity (name, age, gender)	51	39
2	What	Types of incidents or injuries experienced by the patient	71	19
3	How	Mechanism or chronology of the accident	88	2
4	When	Time of the accident	39	51

Source: Primary Data, 2026

Based on Table 1, *the how* component has the highest completeness, while the *when* component has the highest level of incompleteness. Based on the assessment results of these four components, the overall category of emergency anamnesis form completeness is determined as presented in Table 2.

Table 2. Percentage of completeness of emergency anamnesis forms

Emergency Anamnesis Form Completeness	Total	Percentage (%)
Complete (M)	26	28.9%
Incomplete (TL)	64	71.1%
Total	**90**	**100**

Source: Primary Data, 2026

Based on Table 2, the majority of emergency anamnesis forms fall into the incomplete category, while forms classified as complete are only found in a small portion of medical record documents.

2. Completeness of *External Cause* Codes for Traffic Accident Cases

The results of identifying the completeness of *external cause codes* in 90 medical record documents of traffic accident cases are presented in Table 3.

Table 3. Completeness of *external cause codes* for traffic accident cases at dr. Mohammad Zyn Regional Hospital Sampang

Completeness of *external cause codes*	Total	Percentage (%)
Complete (M)	49	54.4%
Incomplete (TL)	41	45.6%
Total	**90**	**100%**

Source: Primary Data, 2026

Based on Table 3, the category of *complete external cause* codes is more frequently found compared to the incomplete category. The identification results show that most medical record documents already have *external cause* codes that meet the coding completeness, although documents with *incomplete external cause* codes are still found.

3. The Relationship Between the Completeness of Emergency Anamnesis Forms and the Completeness of *External Cause* Codes in Traffic Accident Cases

The analysis of the relationship between the completeness of filling out the emergency anamnesis form and the accuracy of *external cause* codes in traffic accident cases was conducted using *the Chi-Square* test presented in the following table.

Table 4. The Relationship Between the Completeness of the Emergency Anamnesis Form and the Completeness of *External Cause* Codes in Traffic Accident Cases

Emergency Anamnesis Form Completeness	Completeness of *External Cause* Codes for Traffic Accident Cases				Total		*P-Value*
	Incomplete		Complete				
	N	%	N	%	N	%	
Incomplete	41	64,1%	23	35,9%	64	100%	
Complete	0	0%	26	100%	26	100%	0,000
Total	41	45,6%	49	54,4%	90	100%	

Source: Primary data processed using SPSS, 2026

Based on Table 4, documents with complete emergency anamnesis forms have higher external cause code completeness compared to documents with incomplete emergency anamnesis forms. The Chi-Square test results showed a p-value = 0.000 ($p < 0.05$), indicating a significant relationship between the completeness of the emergency anamnesis form and the completeness of external cause codes in traffic accident cases.

Discussion

1. Completeness of Filling Out the Emergency Anamnesis Form for Traffic Accident Cases

Most emergency anamnesis forms in traffic accident cases are still categorized as incomplete. These findings indicate that clinical information documentation in the Emergency Department (ED) has not fully met the expected completeness standards. Although *the how* component is the most frequently filled part, incompleteness is still found in the *who*, *what*, and especially *when components* , indicating that the documentation process has not been consistently carried out across all aspects of anamnesis.

This can be influenced by the characteristics of emergency room services that focus on patient safety. In emergency situations, healthcare workers are required to make clinical decisions quickly, so medical actions often take priority over medical record recording. In addition, traffic accident patients often come in pain, reduced consciousness, or without family support, making some information, especially the time of the incident, difficult to obtain during initial service. This condition causes documentation processes to not always be completed completely, even though this information is important for further services.

These findings align with Fitriah and Novratilova [8], who stated that incomplete anamnesis documentation for emergency patients still frequently occurs, especially in the chronology section of the incident. The high workload of healthcare workers and the demand for fast service are factors that affect the completeness of medical record completion. The completeness of clinical information is an important factor in producing accurate medical record data that can be utilized for hospital's services, reporting, and quality evaluation [9]. The completeness of the anamnesis, especially information about the chronology of events, incident location, and patient activity during injury, greatly determines the accuracy *of external cause coding* according to ICD-10. The more complete the documented information, the easier it is for coders to establish the most specific code [10]. The completeness of medical record documentation is also influenced by the supervision system implemented by the hospital. Medical record audits, regular monitoring, and providing feedback to healthcare workers are efforts that can improve compliance in document completion. *Siska et al.,* [11] state that routine evaluation of medical record completeness needs to be supported by hospital policies, including the preparation of SOPs and consistent evaluation mechanisms to maintain documentation quality.

This illustrates that efforts to improve the quality of medical records require the commitment of all health workers to ensure that every important piece of information is fully documented. From the hospital's operational side, the completeness of anamnesis forms will facilitate follow-up service processes and improve the quality of morbidity reporting data for hospitals. For the Medical Recorder and Health Information (PMIK) profession, complete information will also facilitate the process of medical record analysis, diagnosis coding and *external cause* codes, as well as produce more accurate data for statistical needs, service evaluation, and policy formulation in hospitals.

2. Completeness of *External Cause* Codes for Traffic Accident Cases

The assessment of the completeness of *external cause codes* in this study was carried out through coding simulations based on information contained in medical record documents, then the results were validated by coding officers at dr. Mohammad Zyn Sampang Regional Hospital. This approach was used because the hospital had not yet implemented *external cause coding* as part of the routine coding process. Therefore, the results of this study better illustrate the extent to which the information documented in medical records can support the complete determination of *external cause* codes according to ICD-10 guidelines, rather than to assess the performance of hospital *coder*.

Simulation results show that most documents contain sufficient information to produce complete *external cause* codes. However, there are still documents that can only be assigned general (*unspecified*) codes. This condition indicates that important information about the accident chronology is not always fully documented. Information such as the accident mechanism, type of vehicle involved, victim position, incident location, and patient activity at the time of the incident form the basis for determining *more specific external cause* codes. When this information is not yet fully available, the use of more general codes is the most appropriate choice according to ICD-10 guidelines.

This aligns with Nurhadi *et al*., [12] who explain that the accuracy of assigning injury and *external cause* codes is greatly influenced by the completeness of diagnostic information and the chronology of events listed in medical records. Incomplete information causes *coders* to have difficulty determining the most specific codes, so the use of general categories (*unspecified*) is still often found. Inaccuracies in injury case coding are not only influenced by the coder's ability but also by the quality of clinical documentation that forms the basis of coding. Unclear and incomplete documentation limits the coder's interpretation process , potentially reducing the quality of health information produced [13]. According to a literature study conducted by Susilowati *et al*., [14] related to *coding injury* and *external cause*, it was concluded that coding inaccuracies are most often caused by incomplete information in medical record documents, lack of hospital regulations regarding *external cause* coding, and suboptimal coder'*s understanding* of the use of the fourth and fifth characters of ICD-10.

The comprehensive implementation of *external cause* codes will add value to medical record management in hospitals. Information about externally documented causes of injury that is specifically documented can produce more accurate morbidity data, making traffic accident patterns easier to identify. This data is not only useful for preparing hospital reports but can also be used as material for service evaluation, injury surveillance, and accident prevention program planning. Therefore, collaboration among healthcare workers needs to be continuously improved to produce quality medical record data that can be utilized in reporting and decision-making.

3. The Relationship Between the Completeness of Emergency Anamnesis Forms and the Completeness of External Cause Codes in Traffic Accident Cases

The analysis results show a significant relationship between the completeness of the emergency anamnesis form and the completeness of *external cause* codes in traffic accident cases, indicating that the research hypothesis is accepted, so the completeness of anamnesis documentation plays a role in supporting the completeness of determining *external cause* codes. The more complete the information recorded on the anamnesis form, the greater the likelihood that code determination will be carried out completely and specifically according to ICD-10 classification chapter XX.

This relationship can be understood because the anamnesis form is the main source of information used by the *coder* in the coding process. Information about the accident mechanism, types of vehicles involved, victim positions, incident locations, and event chronology form the basis for determining categories and subcategories *of external causes*. If this information is fully documented, *the coder* has sufficient grounds to select the most specific code. Conversely, if the documentation is still incomplete, the choice of code becomes limited, making the use of general (*unspecified*) codes more difficult to avoid [15]. This statement is supported by research by Widyaningrum & Kurniawan [16], which states that completeness of medical information has a significant relationship with the accuracy of diagnosis coding and external causes (p=0.001), where incomplete documentation increases the risk of coding errors, especially in injury cases requiring detailed information about the mechanism of events.

This is in line with research conducted by Yulia *et al*., [17] which explain that completeness of medical information is related to the accuracy of diagnosis coding; the more complete the clinical information available, the easier it is for coders to determine codes appropriate to the patient's condition. Inaccuracies *in injury* and *external cause case coding are* influenced not only by coder's ability but also by the quality of clinical documentation, availability of supporting information, and the implementation of coding procedures in hospitals [18].

Nevertheless, 23 documents were still found with incomplete anamnesis forms but still produced complete *external cause* codes. These findings show that the process of coding *external causes* does not rely solely on the emergency anamnesis form. Coding officers can still obtain additional information from various other documentation sources in medical records, such as initial assessment sheets, medical resumes, incident chronology letters, and doctor's notes. This condition explains why some documents with incomplete anamnesis can still produce complete *external cause* codes.

These findings indicate that improving the quality of external cause coding is not enough through coder training alone but also needs to be supported by complete clinical documentation from the beginning of care. Collaboration between doctors, nurses, and Medical Recorders and Health Information Officers (PMIK) is necessary so that the information needed in the coding process can be well documented. Therefore, continuous improvement of medical record quality needs to be carried out through documentation audits, evaluation of coding results, providing feedback, and training for healthcare workers. Complete and accurate external cause data can support the compilation of morbidity statistics, injury surveillance, and accident prevention program planning.

CONCLUSION

Fundamental Finding : The completeness of emergency anamnesis forms in traffic accident cases at RSUD dr. Mohammad Zyn Sampang is still relatively low, with 64 out of 90 medical record documents (71.1%) categorized as incomplete and 26 documents (28.9%) categorized as complete. The *how* component is the most frequently filled out component, while *the when* component is the most frequently incomplete. Meanwhile, 49 documents (54.4%) have complete *external cause* codes and 41 documents (45.6%) are incomplete. **Implication :** The *Chi-Square test* results showed a significant relationship between the completeness of the emergency anamnesis form and the completeness of *external cause codes* with a *p-value* of 0.000 ($p<0.05$), indicating that the more complete the documentation of the anamnesis, the more complete the *external cause* code produced. **Limitation :** This indicates that the quality of medical record documentation is one of the factors supporting coding quality and contributes to providing accurate morbidity data. **Future Research :** Based on the research results, hospitals are advised to improve healthcare workers' compliance in filling out emergency anamnesis forms through regular monitoring and evaluation of medical record completeness, as well as strengthening collaboration between healthcare workers and Medical Recorders and

Health Information Providers (PMIK) to support *more complete and quality* external cause coding.

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