Chapter B: Healthcare Basics for Coders

Welcome

By Corrina R. Lynch. This beginner chapter explains the people, records and rules a new coder needs to recognize. Read one section at a time. The review questions have no answer key in this student copy.

What you will learn

Explain what a provider, coder, biller and payer do. Recognize basic insurance terms. Protect patient information. Describe how to handle missing documentation and a possible error.

Four important roles

The provider documents care and diagnoses. The coder chooses codes supported by the record. The biller prepares and follows claims. The payer reviews coverage and payment.

Professional and facility services

A physician and a hospital may bill different services for one visit. A coding credential shows knowledge. It does not authorize a coder to diagnose a patient.

Try it

A patient has an outpatient hospital procedure and receives two bills. What might the physician bill represent? What might the hospital bill represent?

1. Insurance and the claim

Insurance vocabulary

A premium keeps coverage in place. A deductible is the patient’s amount for services subject to it before the plan begins sharing those costs. A copay is fixed. Coinsurance is a percentage. The allowed amount is the amount the plan recognizes for a covered service.

Medicare and other plans

Part A mainly covers inpatient facility services and other qualifying care. Part B covers physician and outpatient services. Part C is Medicare Advantage. Part D is drug coverage. Medicaid is a separate federal/state program. Commercial coverage is private insurance.

Before billing

Check active coverage, network rules, any required referral or authorization, and which plan pays first. A referral comes from a provider. Prior authorization is the payer’s approval process. Approval does not guarantee final payment.

What is a claim?

A claim asks a payer to pay for reported services. An explanation of benefits, or EOB, explains claim processing to the member; it is not itself a bill. A remittance advice explains payment and adjustments to the provider.

Try it

A patient has Medicare and employer coverage. Why should staff verify payer order instead of assuming Medicare always pays first?

2. The medical record and accurate coding

What to read

Look for the reason for care, findings, provider assessment, plan and services. Notice the body site and side. Distinguish a current diagnosis from an old condition copied into a problem list.

Codes describe the documented care

ICD-10-CM reports diagnoses and reasons for care. CPT reports procedures and services. HCPCS Level II reports many supplies, drugs, equipment and other services. Use the appropriate instructions for each set.

When information is unclear

Follow the approved process to ask for clarification. Do not invent a diagnosis, pick a side from assumption, or change a diagnosis just to improve payment.

Professional behavior

Report accurately, protect confidentiality and seek help when a task exceeds your knowledge. Use current official references and continuing education.

Try it

The note says left-knee pain, but the assessment says right-knee pain. What should you do before choosing the code?

3. Patient privacy and safety

HIPAA and patient information

HIPAA sets rules for protected health information, called PHI, in covered settings. It applies to health plans, clearinghouses and providers that conduct covered standard electronic transactions. An outside coding company may be a business associate with specific responsibilities.

Patient rights

Patients generally can request access to their records, request an amendment, and ask for confidential communications. Rights have conditions and exceptions. Route requests to the designated process instead of changing or releasing records yourself.

Everyday safeguards

Use your own approved login. Open only records needed for legitimate work. Confirm recipients before sending information. Secure workstations and printouts. Use approved storage and communication systems.

If information goes to the wrong person

Report promptly through the organization’s privacy/security process. Preserve the facts and follow containment instructions. Authorized staff determine what assessment or notification is needed. Do not hide the mistake.

Try it

You recognize a friend’s name in the patient list. Is curiosity a reason to open the chart? Explain your answer.

4. Compliance: doing the work correctly

What compliance means

Follow applicable rules and the organization’s policies. Accurate records and codes help prevent improper claims. Upcoding means reporting a higher service than the documentation supports. Unbundling means separately reporting components that should be included together.

A basic compliance program

An organization needs written policies, responsible leadership, training, reporting channels, consistent standards, auditing/monitoring, and a response to problems. Training is one part of the program.

What is an audit?

An audit reviews work against defined criteria. Monitoring follows performance over time. When an error appears, confirm it, correct it through the proper process, address the cause and recheck. An error alone does not prove fraud.

What is the OIG Work Plan?

The Office of Inspector General publishes oversight work and risk themes. A compliance team can use it when planning reviews. It is not a code book or a guarantee of payment.

Try it

An audit reviews 20 claims and finds 4 unsupported services. What percentage of this sample has the issue? What should the team do after correcting the affected claims?

Chapter B Review: 10 Questions

Choose one answer. Bring your answers and questions to class. This printable practice does not submit an online grade.

1. Which factor determines whether a provider is a HIPAA covered entity?
A. Any health care job title B. Conducting covered standard electronic transactions C. Having a coding certificate

2. An outside company coding claims with PHI may be a:
A. Business associate B. Patient representative automatically C. Public data source

3. A patient generally may request:
A. Deletion of every diagnosis B. An amendment to the record C. A guaranteed insurance payment

4. Which is a technical safeguard example?
A. Office floor plan B. Access and audit controls C. A premium payment

5. After sending PHI to the wrong recipient, the coder should:
A. Hide the incident B. Wait 60 days C. Report promptly through the approved process

6. Compliance training is most effective when combined with:
A. Audits and corrective action B. Unsupported coding C. No reporting channels

7. Four unsupported claims out of a 20-claim sample equal:
A. 4% B. 20% C. 80%

8. The OIG Work Plan is:
A. An oversight planning resource B. A diagnosis code book C. A guarantee of payment

9. Medicare plus employer coverage requires:
A. Automatic Medicare-first billing B. Coordination-of-benefits verification C. Two identical primary claims

10. A coder facing pressure to raise an unsupported level should:
A. Increase the level B. Invent additional services C. Apply documented criteria and use the compliance process

References and class discussion

For this introductory chapter, focus on the meaning of each term and the appropriate next step. Your instructor will explain advanced requirements as the course progresses.

HHS covered entities and business associates

HHS patient rights

HHS security safeguards

HHS breach notification

OIG compliance fundamentals

OIG Work Plan

AAPC Code of Ethics

HealthCare.gov plan types

Medicare coordination of benefits

TRICARE overview

Original CPC preparation material by Corrina Lynch. Not an official AAPC publication. Sources reviewed October 13, 2026. Use current official rules for actual coding work.