Understanding the Basics of Insurance
A Practical Skills Guide for Emerging Therapists

For many emerging therapists, insurance feels intimidating, opaque, and frustratingly underexplained. Graduate programs often focus on clinical skills while leaving insurance to be learned informally, on the job, or through trial and error. As a result, therapists may feel unprepared to navigate insurance conversations, documentation requirements, or ethical responsibilities related to reimbursement.

Understanding the basics of insurance is not about becoming a billing expert. It is about practicing responsibly, communicating clearly, and protecting both client access to care and your professional integrity.

Why Insurance Literacy Matters for Counselors

Insurance directly shapes how clients access services, how often they attend, and what types of care are covered. It also influences documentation, treatment planning, and ethical decision-making. When therapists lack insurance knowledge, they may unintentionally provide misinformation, create financial harm for clients, or experience avoidable stress and burnout.

Insurance literacy supports informed consent, transparency, and ethical practice.

Core Insurance Concepts Every Counselor Should Understand

Health Insurance

Health insurance is a contract between a client and an insurance company that helps pay for covered medical and mental health services. Coverage varies widely by plan, even within the same insurance company. As a therapist, you are not responsible for knowing every plan in detail, but you are responsible for understanding the general structure and limits of coverage.

Insurance companies reimburse for services based on medical necessity, diagnosis, and documented treatment.

In-Network vs. Out-of-Network

In-network providers have a contract with an insurance company and agree to specific reimbursement rates and rules. Within the contract, providers are in-network with specific plans within the insurance company's umbrella of covered plans. Don’t assume you are in-network with all plans of a particular insurance company. Clients typically pay lower out-of-pocket costs when seeing in-network providers.

Out-of-network providers do not have contracts with the insurance company. Clients may pay upfront and seek partial reimbursement, depending on their plan.

Knowing your network status is essential for clear communication and ethical billing.

Deductible

A deductible is the amount a client must pay out-of-pocket each year before insurance begins to pay for covered services. If a client has not met their deductible, they may be responsible for the full session fee, even if the therapist is in-network.

Deductibles often reset annually and can cause confusion or frustration for clients.

Copay

A copay is a fixed amount a client pays per session after insurance coverage applies. For example, a client may pay a $25 copay for each therapy visit.

Copays do not count toward deductibles in all plans, which is important to clarify when clients ask questions.

Coinsurance

Coinsurance is a percentage of the session cost that the client is responsible for paying after the deductible is met. For example, an 80/20 plan means insurance pays 80% and the client pays 20%.

Coinsurance amounts vary and can fluctuate based on session fees and reimbursement rates.

Allowed Amount

The allowed amount is the maximum fee an insurance company will reimburse for a service. If your standard fee is higher than the allowed amount and you are in-network, you must accept the allowed amount as payment in full.

Medical Necessity

Insurance companies require that services be medically necessary. This means treatment must address a diagnosable mental health condition (usually there is a list of diagnoses that are accepted within your contract) and be appropriate in frequency, intensity, and duration.

Ask the insurance provider what their medical necessity requirements are per your billing code.

Diagnosis

A diagnosis is required for insurance reimbursement. It connects treatment to medical necessity. This can be ethically complex for emerging therapists, especially when clients present with situational distress or prefer not to be diagnosed.

Discussing diagnosis transparently with clients is part of informed consent and ethical care.

Procedure Codes (CPT Codes)

Procedure codes, often called CPT codes (Current Procedural Terminology), are the codes used to describe what service was provided during a session.

For insurance purposes, both a diagnosis code and a procedure code are required for reimbursement.

Modifiers

Modifiers are two-digit codes added to procedure (CPT) codes to give insurance companies additional context about how, where, or under what circumstances a service was provided**.**

Modifiers can affect reimbursement, claim approval, and audit risk. Understanding them at a basic level is essential for ethical billing, even if billing staff submit claims on your behalf.

Treatment Plan

Insurance companies expect a treatment plan that outlines goals, interventions, and progress. Treatment plans should be clinically meaningful, measurable when possible, and aligned with the diagnosis.

Treatment planning is not just paperwork. It guides care and supports ethical documentation.

Prior Authorization

Some insurance plans require prior authorization before services are covered. This means approval must be obtained before sessions begin or continue.

Failure to obtain required authorization can result in denied claims and financial burden for clients.

Claims

A claim is the request submitted to an insurance company for reimbursement. Claims include client information, diagnosis codes, procedure codes, and session details.

Errors in claims can lead to delays or denials, even when services are appropriate.

Denial

A denial occurs when an insurance company refuses to pay for a claim. Denials may be due to eligibility issues, lack of authorization, documentation concerns, or coverage limits.

Denials are common and not always a reflection of clinical quality, but they require follow-up.

Explanation of Benefits (EOB)

An EOB is a document sent to the client explaining what insurance paid, what the client owes, and why. It is not a bill, but it often causes confusion.

Clients may bring EOBs to session seeking clarification. Understanding them helps reduce anxiety.

Session Limits

Some plans limit the number of sessions per year or require review after a certain number. These limits can affect continuity of care and should be discussed with clients early.

Ethical practice includes helping clients plan around these constraints when possible.

Ethical Considerations Related to Insurance

Insurance involvement introduces ethical responsibilities around transparency, accuracy, and boundaries. Counselors must avoid misrepresentation, upcoding, or providing services under diagnoses that do not fit simply to secure coverage.

You are responsible for honest documentation, not for making insurance “work” at all costs.

Talking With Clients About Insurance

Clients often feel overwhelmed or embarrassed by insurance questions. Providing clear, compassionate explanations without overpromising coverage supports trust. It is ethical to clarify that ultimate coverage decisions rest with the insurance company, not the therapist.

Clear communication reduces financial harm and relational strain.