BLUE LINE
Psychological Services, PLLC

What?! Why Can't I Use My Insurance for Marital or Couples' Therapy?

Insurance Restrictions, Diagnostic Misrepresentation, and the Risk of Fraud

by Thomas Coghlan, PsyD
Owner, Blue Line Psychological Services, PLLC

Email From: Prospective Client | To: Psychotherapist
A friend referred me to you. My spouse and I have been having some difficulties, and we're interested in marital therapy. Are you accepting new couples?

Email From: Psychotherapist | To: Prospective Client
Yes, I'm currently accepting new couples. There are a few things you should know before we begin. First, I typically meet with each partner individually for an initial consultation, after which we begin working together. Second, although I am an in-network provider with your insurance company for individual psychotherapy, marital and couples counseling directed primarily toward relationship problems is generally not covered. Unless your particular plan provides otherwise, our sessions would be self-pay.

Email From: Prospective Client | To: Psychotherapist
What?! Why can't I use my insurance for marital therapy? You're in-network, aren't you? I don't understand. My friend went to marital therapy, and their therapist accepted their insurance. Why can't you accept mine?

A Common Confusion

The prospective client's confusion is understandable and illustrates a longstanding problem in the financing of mental health treatment. If a psychologist participates in an insurance network, provides psychotherapy, and is professionally qualified to treat individuals, couples, and families, why might marital or couples therapy be excluded from reimbursement? This confusion may be compounded when prospective clients encounter other providers who advertise or accept insurance for couples therapy without explaining that reimbursement may depend on identifying one partner as the patient and assigning that individual a qualifying psychiatric diagnosis. Although such an arrangement may be clinically and contractually legitimate when properly assessed and documented, failure to obtain adequately informed consent regarding the actual nature of the treatment presents a significant ethical concern. The American Psychological Association's (APA, 2017) *Ethical Principles of Psychologists and Code of Conduct* specifically addresses this obligation. Standard 10.01

BLUELINEPSYCH

requires psychologists to obtain informed consent to therapy, while Standard 10.02 requires clarification at the outset of which individuals are patients or clients, the psychologist's professional relationship with each participant, and the anticipated uses of the services and information obtained. Accordingly, when one spouse is designated as the identified patient and the other participates in that individual's treatment, the distinction should be explained rather than left to the couple's assumptions.

The problem extends beyond informed consent to the relationship between clinical necessity, psychiatric diagnosis, and insurance reimbursement. Marital distress can involve significant psychological suffering and impairment, even when neither partner independently meets diagnostic criteria for a mental disorder. Clawson et al. (2018) examined this problem directly, arguing that the personal and healthcare consequences of marital distress, together with the availability of empirically supported interventions, provide reasons for insurers to consider reimbursing couples therapy. Nevertheless, financial barriers remain an obstacle to obtaining treatment. Hubbard and Anderson (2022) identified treatment costs among the principal barriers reported by prospective clients. The resulting problem is both clinical and administrative: treatment may be appropriate and beneficial without satisfying an insurer's reimbursement criteria. More consequentially, the financial incentive to transform a noncovered relational service into an apparently covered psychiatric treatment introduces questions concerning diagnostic integrity, patient autonomy, professional ethics, and potentially fraudulent claims. Experimental research has demonstrated that psychologists' diagnostic decisions can be influenced by a prospective client's method of payment (Kielbasa et al., 2004; Lowe et al., 2007).

Why Marital and Couples Therapy May Not Be Covered

The distinction between clinical appropriateness and insurance reimbursement begins with the structure of healthcare benefits. Health insurance generally organizes psychotherapy coverage around treatment of a covered mental health condition, supported by appropriate assessment, diagnosis, medical necessity, treatment planning, and procedural coding. Marital or couples counseling intended primarily to improve communication,

BLUELINEPSYCH

resolve interpersonal conflicts, or address relationship dissatisfaction may fall outside these requirements, even when clinically appropriate (Clawson et al., 2018).

This does not mean that psychotherapy involving two spouses is categorically excluded. The Centers for Medicare & Medicaid Services (CMS, 2026) recognizes family psychotherapy when medically necessary for treatment of an identified patient's condition. Such treatment may address family interactions, maladaptive relational patterns, or participation by family members in the patient's care. For example, involving a spouse may be integral to treating depression, anxiety, or trauma-related symptoms. Commercial insurance arrangements may similarly cover qualifying family psychotherapy, although benefits and reimbursement requirements vary. Medicare local coverage determinations apply within their respective Medicare jurisdictions and do not independently establish commercial insurance requirements.

Medical Necessity in Practice: NYSHIP, NYC Employees PPO, and UnitedHealthcare

The distinction between marital counseling and medically necessary psychotherapy becomes clearer when examining actual insurance documents. Three arrangements, the New York State Health Insurance Program (NYSHIP) Empire Plan, the New York City Employees PPO (NYCE PPO), and UnitedHealthcare-administered programs, illustrate how health plans approach psychiatric diagnosis, treatment purpose, and reimbursement. Each helps explain why a clinician may be reimbursed for certain sessions involving spouses but not for treatment directed solely toward marital dissatisfaction.

***NYSHIP: The Empire Plan*.** NYSHIP's Empire Plan provides mental health and substance use treatment benefits for medically necessary services. Its Mental Health and Substance Use Program is administered through Carelon Behavioral Health, which coordinates participating providers and treatment benefits (New York State Department of Civil Service, 2026). The Empire Plan's published certificate for employees represented by the Public Employees Federation excludes services provided without an underlying behavioral

BLUELINEPSYCH

health condition when directed solely toward purposes such as marital counseling or personal growth (New York State Department of Civil Service, 2024).

The exclusion does not establish that every session involving spouses is ineligible. Rather, the existence of an underlying behavioral health condition and the clinical purpose of treatment become central considerations. A psychologist treating a patient with major depressive disorder may determine that involving the spouse is necessary to address interpersonal processes maintaining depressive symptoms. Such treatment may qualify if the documentation, procedural coding, and benefit requirements are satisfied. In contrast, a couple seeking assistance solely to improve communication may receive clinically appropriate treatment without meeting the criteria for reimbursable mental health care. The specific NYSHIP option, governing certificate, amendments, and member benefits must be verified before determining coverage.

NYC Employees PPO. The 2026 NYCE PPO *Summary Plan Description* provides an especially instructive example because it expressly identifies marriage counseling as a potentially covered service. Under its covered benefits, marriage counseling is included when it forms part of a behavioral health treatment plan (City of New York, 2026, p. 53). Its general exclusions separately exclude marriage counseling unless coverage is otherwise established elsewhere in the plan (p. 83). The provisions distinguish counseling incorporated into covered treatment from counseling that does not otherwise qualify for benefits.

The NYCE PPO also requires medical necessity for covered mental health treatment. Of particular relevance to diagnostic integrity, the plan specifies that a diagnosis changed after a payment denial will not be considered for benefits without supporting clinical records. Those records must include the patient's history and initial assessment and substantiate the revised diagnosis using applicable diagnostic criteria (City of New York, 2026, p. 66). A diagnosis revised following denial is not inherently improper, but the change must be supported by clinical evidence rather than reimbursement considerations alone.

BLUELINEPSYCH

This provision is especially significant because it demonstrates how a health plan may scrutinize diagnostic changes made in connection with reimbursement. It recognizes that a revised diagnosis requires more than a substituted code. The clinician must be able to demonstrate that the new diagnosis is supported by the clinical record.

NYCE PPO is a self-funded plan administered through third-party arrangements involving EmblemHealth and UnitedHealthcare. Consequently, the company processing or administering a claim does not independently establish the governing benefits. Although the plan's language provides a meaningful basis for considering reimbursement of marriage counseling incorporated into psychiatric treatment, its *Summary Plan Description* does not guarantee payment for CPT 90846 or 90847 in every circumstance.

UnitedHealthcare. UnitedHealthcare provides a useful comparison because its published materials demonstrate recognition of family psychotherapy codes within particular reimbursement programs. The 2026 Rocky Mountain Health Plans behavioral health value-based payment fee schedule, associated with a UnitedHealthcare company, lists CPT 90846, family psychotherapy without the identified patient present, and CPT 90847, family or couple psychotherapy. Under that Colorado Medicaid program, the published reimbursement amount for participating doctoral-level psychologists is $131.16 for either code (Rocky Mountain Health Plans, 2026). The schedule establishes that these procedures are recognized within that program's reimbursement framework. It does not establish equivalent payment rates or coverage requirements for UnitedHealthcare commercial plans in New York. Nor does a published fee schedule guarantee that a particular patient's treatment meets medical necessity or other benefit requirements. UnitedHealthcare-administered products may have different authorization, network, and contracting requirements.

The distinction is important because UnitedHealthcare operates across different insurance and administrative arrangements. Participation in one network does not automatically establish reimbursement eligibility under every UnitedHealthcare-administered plan. Recognition of CPT 90846 and 90847 must

BLUELINEPSYCH

therefore be distinguished from a patient's actual entitlement to benefits and the clinician's eligibility to receive payment.

Together, the three examples demonstrate why medical necessity cannot be reduced to the presence of a psychiatric diagnosis or the selection of an accepted CPT code. The relevant questions concern the patient's condition, the purpose of treatment, the evidence supporting medical necessity, the governing benefit contract, and the accuracy of the submitted claim. They also help explain why the prospective client's observation that another therapist accepted insurance for marital therapy does not establish that the same treatment or reimbursement arrangement applies to every couple.

Commercial-insurer guidance reinforces this distinction. EmblemHealth's (2026) behavioral health provider manual includes individual, group, family, couple, and collateral treatment among routine outpatient services for which preauthorization is generally unnecessary. However, absence of a preauthorization requirement does not guarantee payment. Eligibility, covered benefits, medical necessity, and claims reimbursement remain separate considerations.

Professional licensure presents another important distinction. New York Education Law § 7601-a expressly includes marital or family therapy within the authorized practice of psychology. A psychologist may therefore be qualified to provide marital therapy even when the patient's insurance contract excludes it. Professional authorization establishes the clinician's scope of practice, while insurance coverage depends on the governing benefit provisions and applicable law.

Procedural coding adds further requirements. Current Procedural Terminology (CPT) codes 90832, 90834, and 90837 describe psychotherapy services differentiated by duration, generally focused on an identified patient. Codes 90846 and 90847 describe family psychotherapy without and with the identified patient present, respectively. The distinction does not depend exclusively on the number of participants. Individual psychotherapy may involve family members when the intervention remains focused on the patient's treatment,

BLUELINEPSYCH

whereas family psychotherapy addresses family interactions or dynamics relevant to that condition. The clinical purpose, service performed, documentation, and applicable payer requirements determine which code is appropriate.

Magellan Healthcare's (2025) provider guidance illustrates how these distinctions arise during claims oversight. Its Special Investigations Unit identified patterns involving overlapping individual and family psychotherapy claims, including multiple claims for simultaneous encounters. Magellan emphasizes documentation of participants, session times, treatment objectives, and the intervention's relationship to the identified patient's treatment plan. It also cautions against submitting multiple individual claims for what was actually one family encounter.

Finally, a diagnosis such as Z63.0, *Problems in relationship with spouse or partner*, may accurately describe the presenting concern without establishing medical necessity for covered psychiatric treatment. A recognized diagnostic or encounter code does not automatically create an insurance benefit. This presents a practical dilemma: an accurate relational formulation may not support reimbursement, whereas a qualifying psychiatric disorder may. The clinician's obligation is to determine whether that disorder is genuinely present, not whether assigning it would facilitate payment.

When Couples Therapy Becomes Individual Treatment: The Identified Patient and Informed Consent

The distinction between couples therapy and psychotherapy directed toward an identified patient is more than administrative. It concerns the nature of the professional relationship. In marital therapy, the focus may be the relationship itself, including recurring interactional patterns, attachment difficulties, defensive processes, emotional withdrawal, and reciprocal contributions to distress. In identified-patient psychotherapy, the objective is treatment of an individual's psychological condition, even when the spouse participates. These approaches may overlap clinically, but they are not conceptually interchangeable.

BLUELINEPSYCH

APA Standard 10.02 recognizes that treating individuals who have an existing relationship creates obligations beyond the conventional individual therapist-patient arrangement. Psychologists must clarify who is receiving treatment, their professional relationship with each participant, and how information obtained during treatment may be used (APA, 2017). Standard 10.01 addresses informed consent concerning treatment, fees, third-party involvement, and confidentiality limitations. Similarly, the American Association for Marriage and Family Therapy's (AAMFT, 2026) revised *Code of Ethics*, particularly Standard 1.2, requires informed consent based on adequate disclosure of significant information concerning treatment and its potential risks and benefits.

Consider a couple seeking assistance for persistent conflict and deteriorating communication. The therapist accepts their insurance, identifies one spouse as the patient, assigns a psychiatric diagnosis, and conducts conjoint sessions addressing that patient's symptoms. If the diagnosis is clinically supported, the intervention is medically necessary, and the services are accurately billed, the arrangement may be appropriate. However, if the couple believes both partners are receiving relationship-centered psychotherapy without understanding that treatment is organized around one spouse's psychiatric condition, a distinct ethical concern emerges. The insurer may receive an accurate claim while the participants remain inadequately informed about the treatment arrangement.

Informed consent is not satisfied merely by obtaining signatures on standard intake documents. Clients should understand the treatment they are agreeing to receive, their respective roles, and the implications of the clinician's formulation. When one spouse participates in another person's treatment, the therapist's responsibilities, confidentiality practices, and documentation may differ from those associated with treating the couple jointly. These distinctions should be explained in accessible language, with sufficient opportunity for questions.

BLUELINEPSYCH

The clinician therefore has two separate responsibilities: transparency with the patient and accuracy with the insurer. Meeting one obligation does not automatically satisfy the other. An accurately submitted claim does not excuse inadequate informed consent, just as consent from both spouses cannot legitimize a knowingly false claim.

Diagnostic Integrity and the Consequences for the Identified Patient

The ethical implications of assigning an unsupported psychiatric diagnosis extend beyond reimbursement. Diagnosis is a clinical act with consequences for how patients understand their functioning, how treatment is organized, and how health information is documented and communicated. A diagnosis should emerge from assessment and clinical judgment rather than the administrative need to establish insurance eligibility.

This distinction is especially relevant when a couple's concerns are primarily relational. Two individuals may experience longstanding conflict, resentment, emotional estrangement, or incompatible expectations without either independently meeting criteria for a mental disorder. Assigning a psychiatric diagnosis solely for reimbursement risks converting a relational problem into an individual psychiatric condition without clinical justification.

Conversely, marital distress does not preclude a genuine psychiatric disorder. Assessment may reveal depression, anxiety, or another condition for which spouse involvement is clinically appropriate. The distinction depends on evidence, not whether the therapist practices from an individual, psychodynamic, systemic, or integrative orientation.

For the identified patient, an unsupported diagnosis can have implications beyond treatment. Diagnostic information may become part of the clinical record, appear in insurance claims, become available to other professionals through authorized disclosures, or influence subsequent healthcare decisions. These consequences depend on applicable confidentiality protections and the circumstances of disclosure. Nevertheless, an

BLUELINEPSYCH

individual should not unknowingly acquire a psychiatric diagnosis simply because the couple wishes to use insurance benefits for marital counseling.

The New York State Education Department (NYSED, n.d.-b) emphasizes adequate clinical evaluation, diagnostic justification, and treatment planning. Its guidance explains that records supporting reimbursement commonly include a diagnosis based on identifiable clinical features and a corresponding treatment plan. Although advisory rather than independently binding, these expectations complement New York's professional regulations. Specifically, 8 NYCRR § 29.2(a)(3) requires records that accurately reflect patient evaluations and treatment.

Similarly, APA Standard 6.01 addresses appropriate professional records, while Standard 6.06 requires accurate reporting to third-party payers. Together, these provisions reinforce the principle that diagnoses submitted for reimbursement should correspond to actual assessment and treatment.

The relevant distinction is between a diagnosis established through legitimate evaluation and one selected because it is expected to generate reimbursement. The former may be appropriate even when treatment involves both spouses. The latter, when knowingly unsupported, raises concerns regarding diagnostic integrity, professional ethics, and potentially insurance fraud.

When Reimbursement Influences Diagnosis: Empirical Evidence and Its Limits

The concern that reimbursement may influence psychiatric diagnosis has been examined empirically. Although some studies predate contemporary insurance arrangements, their findings remain relevant to understanding the relationship between financial incentives and diagnostic decision-making.

Kielbasa et al. (2004) examined whether psychologists' diagnostic decisions differed according to a prospective client's payment method. Independent practitioners evaluated hypothetical clients presenting with depression or anxiety symptoms. Some were told that payment would involve managed-care insurance, while others were told that clients would pay out of pocket. Psychologists considering managed-care reimbursement

BLUELINEPSYCH

were significantly more likely to assign psychiatric diagnoses, particularly adjustment disorder, than psychologists evaluating comparable self-paying clients. These findings demonstrated that payment arrangements could influence diagnostic judgments even when presenting information was otherwise comparable.

Lowe et al. (2007) extended this research using hypothetical clients presenting with subclinical symptoms associated with social phobia and attention-deficit/hyperactivity disorder. Again, diagnostic decisions varied according to payment method. Clients described as using managed-care benefits were more likely to receive psychiatric diagnoses than those described as self-paying. The inclusion of subclinical presentations makes this study particularly relevant because it examines decision-making when symptoms do not clearly establish a mental disorder.

These findings raise important questions about reimbursement and diagnostic integrity. However, both studies relied on hypothetical vignettes, not audited insurance claims or investigations of misconduct. They demonstrate that payment arrangements can influence diagnosis. They do not establish that participating psychologists knowingly fabricated diagnoses or committed insurance fraud.

More recent research provides a complementary perspective. Baslock et al. (2026) examined blended reimbursement arrangements in a community mental health system. Using electronic health record data involving 19,373 individuals and 173,889 observations, the researchers found that payment reform was associated with increased identification of co-occurring mental health and substance use disorders. Their findings suggest that reimbursement arrangements can influence recorded diagnoses in actual clinical systems. Importantly, Baslock et al. (2026) interpreted the increase as potentially reflecting improved recognition of previously underidentified conditions. Payment-related diagnostic changes therefore do not necessarily indicate inappropriate diagnostic inflation. Financial incentives may affect clinical decisions in different ways, including facilitating recognition of genuine disorders.

BLUELINEPSYCH

Taken together, these studies support a narrower conclusion than the claim that insurance requirements routinely produce fraudulent diagnoses. Reimbursement structures can influence clinical decision-making, but diagnostic changes must be evaluated against the underlying clinical evidence. Financial influence, unsupported diagnosis, and deliberate fraud remain distinct phenomena. The available research does not establish the prevalence of clinicians knowingly assigning fictitious psychiatric diagnoses to obtain reimbursement for otherwise noncovered marital counseling.

Confidentiality, Clinical Records, and the Participating Spouse

Insurance-funded relational treatment creates additional complications concerning confidentiality and clinical records. When one partner is the identified patient and the other participates, the individuals may not possess identical rights regarding access to records or disclosure of information. Obligations depend on the clinical relationship, applicable law, and confidentiality arrangements established at the beginning of treatment. APA Standard 4.02 requires psychologists to discuss relevant confidentiality limitations, while Standard 10.02 directs clinicians to clarify their professional roles when treating couples and families. The AAMFT (2026) similarly emphasizes informed consent, confidentiality, and protection of information obtained during relational treatment. These responsibilities become particularly important when a spouse provides sensitive information during an individual consultation, when a couple separates, or when treatment records are requested during matrimonial litigation.

New York State's professional guidance specifically addresses confidentiality in couples and group therapy (NYSED, n.d.-a). It recognizes that confidentiality in conjoint treatment may differ from individual psychotherapy and recommends informing participants about its limitations. It also discusses information obtained during separate individual meetings. These considerations are relevant to the opening hypothetical, in which the psychologist proposes individual consultations before conjoint treatment.

BLUELINEPSYCH

The Health Insurance Portability and Accountability Act (HIPAA) provides individuals with rights to access protected health information contained in designated record sets, subject to applicable exceptions. Such records may include diagnoses, treatment plans, ordinary progress notes, and billing information. Separately maintained psychotherapy notes receive additional protections and are distinguished from ordinary documentation under 45 C.F.R. § 164.501 (U.S. Department of Health and Human Services [HHS], n.d.). Applicable state law may impose additional requirements.

AAMFT Standards 2.2 and 2.3 provide further guidance concerning authorization to release information and access to records in couple, family, and group treatment. These provisions reinforce the importance of determining whether the clinician is treating both partners jointly or providing treatment to one identified patient with another person's participation. Neither attending the same session nor sharing a marital relationship necessarily establishes identical rights to another person's clinical records.

Identifying the patient is therefore not merely a billing decision. It may influence documentation, confidentiality expectations, access to information, and the clinician's responsibilities if the relationship deteriorates or litigation develops. Informed consent should address these implications as well as the therapeutic objectives.

Diagnostic Misrepresentation, Improper Billing, and Insurance Fraud

When marital or couples therapy is excluded from an insurance benefit, clinicians may encounter requests to submit claims through another reimbursable service category. Financial pressures, patient expectations, and the desire to preserve access to care can make these requests difficult. However, the obligation to represent services accurately does not depend on whether an insurer's restrictions appear reasonable or whether treatment would otherwise be unaffordable.

APA Standard 6.06 requires psychologists to take reasonable steps to ensure accurate reporting of services, fees, providers, findings, and diagnoses to third-party payers. Similarly, AAMFT Standard 8.4 requires truthful representation of services, while Standard 8.2 addresses written disclosure of financial policies,

BLUELINEPSYCH

including a client's potential responsibility when an insurer denies payment, to the extent permitted by law (APA, 2017; AAMFT, 2026).

Nevertheless, inaccurate billing, insufficient documentation, professional misconduct, and criminal fraud are not interchangeable. An incorrect CPT code may result from misunderstanding a service's requirements. An insurer may disagree with a clinician's assessment of medical necessity. Documentation may be insufficient to support an otherwise legitimate intervention. These circumstances can require correction, repayment, or administrative remedies without necessarily establishing deliberate deception.

More serious concerns arise when a clinician knowingly assigns an unsupported diagnosis, bills for services not rendered, or alters documentation to obtain reimbursement. New York Education Law § 6509 identifies fraudulent professional practice as professional misconduct. The Rules of the Board of Regents, particularly 8 NYCRR § 29.2(a)(3), require accurate evaluation and treatment records. New York Penal Law § 176.05 defines fraudulent insurance acts involving knowingly submitted materially false information or concealment, accompanied by intent to defraud.

Federal law provides additional enforcement mechanisms. Under 18 U.S.C. § 1347, criminal healthcare fraud involves knowingly and willfully executing or attempting to execute a scheme to defraud a healthcare benefit program. Section 1035 addresses certain materially false statements involving healthcare benefits. The federal False Claims Act, 31 U.S.C. § 3729, imposes civil liability for specified false claims involving government funds and includes actual knowledge, deliberate ignorance, and reckless disregard within its definition of knowledge.

Application of these provisions depends on the payer, the misrepresentation's materiality, the clinician's knowledge and conduct, and other statutory requirements. An inaccurate claim submitted to a private commercial insurer does not automatically fall within the federal False Claims Act.

Professional Discipline: The Arizona Dargon Matter

BLUELINEPSYCH

An instructive example appears in *In the Matter of Christine Dargon*, a disciplinary proceeding before the Arizona Board of Psychologist Examiners (2017). The proceeding consolidated three matters, Case Nos. 14-32, 15-02, and 16-50, and examined the psychologist's conduct in several treatment relationships. Issues included informed consent, confidentiality, professional boundaries, clinical records, and insurance billing.

The board's findings included discrepancies between conjoint psychotherapy encounters and individual claims submitted to insurers. In one family, progress notes reflected sessions involving three children together, yet the psychologist submitted separate individual psychotherapy claims. She maintained that she had conducted consecutive individual sessions, but the administrative decision rejected that explanation. The board also identified additional billing irregularities involving services and fees charged in connection with other family members.

Applying the administrative standard of a preponderance of the evidence, the board concluded that the billing discrepancies resulted in fees to which the psychologist was not entitled. It expressly found violations of Arizona Revised Statutes § 32-2061(15)(a), concerning obtaining fees by fraud or misrepresentation, and § 32-2061(15)(p), concerning falsely claiming professional services or charging for services not rendered as represented (Arizona Board of Psychologist Examiners, 2017).

The proceedings also documented deficiencies involving treatment records, informed consent, and confidentiality. In particular, the board found improper disclosure of confidential information between individuals involved in marital counseling. These findings illustrate how poorly defined treatment relationships, documentation deficiencies, and billing inaccuracies may become interconnected professional concerns. Following an evidentiary hearing and a recommended decision from an administrative law judge, the board voted on November 3, 2017, to adopt the findings, conclusions, and recommended revocation. The final order, filed November 7, 2017, revoked Arizona psychology license No. 4443. Revocation was based on a broader pattern of misconduct, including serious boundary violations and a separate matter involving the psychologist's

BLUELINEPSYCH

assumption of guardianship over a former patient. It would therefore be inaccurate to attribute revocation solely to the insurance billing findings.

The Dargon matter represents an adjudicated professional disciplinary action rather than an allegation or civil settlement. However, it was not a criminal insurance fraud conviction. The board's findings concerned misconduct under Arizona licensing law and were reached under an administrative standard of proof. Nor did the decision establish that the psychologist fabricated a spouse's psychiatric diagnosis specifically to obtain coverage for marital therapy. Its relevance lies in the documented discrepancy between conjoint treatment, services billed as individual psychotherapy, and the clinician's obligations regarding records and treatment relationships.

Civil Enforcement: The Connecticut Werner Settlement

A second example concerns Connecticut psychologist Arlene Werner. In July 2018, the U.S. Department of Justice announced that Werner had paid $126,760.09 to resolve allegations under federal and state False Claims Act provisions. The government alleged that she billed Connecticut Medicaid for psychotherapy services not provided and submitted family psychotherapy claims for multiple family members when an individual psychotherapy claim for one family member was appropriate (U.S. Department of Justice, 2018).

The alleged discrepancy differed from the article's central hypothetical. Rather than representing relationship counseling as individual psychotherapy, the government alleged that multiple family psychotherapy claims were submitted where a single individual claim should have been used. Nevertheless, the matter illustrates the importance of accurately identifying the service, patient, and number of reimbursable encounters.

Unlike the Arizona disciplinary decision, the Connecticut matter was resolved through a civil settlement. It should not be characterized as a criminal conviction or judicial finding that every allegation was proven. Its

BLUELINEPSYCH

significance is that disputed distinctions between individual and family psychotherapy claims can lead to substantial civil enforcement proceedings.

Implications for Clinical Practice

Together, the Arizona and Connecticut matters demonstrate how inaccurate psychotherapy claims may have consequences beyond routine insurance denials. They also illustrate why the legal status of each matter must be identified. An administrative disciplinary finding, civil settlement, and criminal conviction are different outcomes governed by distinct standards.

Commercial-insurer oversight reinforces these considerations. Magellan Healthcare (2025) identifies improper overlap between individual and family psychotherapy claims, emphasizing accurate documentation of participants, services performed, and whether multiple claims represent distinct interventions. Payer policies are not statutes or professional licensing regulations, but applicable contractual requirements may affect reimbursement, audits, and network participation.

New York State similarly distinguishes advisory guidance from binding law. In *Insurance Billing and Pitfalls*, NYSED (n.d.-c) advises psychologists to ensure that billing statements accurately reflect services and charges. The department expressly identifies the guidance as advisory, not an independent legal directive or basis for a misconduct charge. Enforceable obligations arise from applicable statutes and regulations, while professional guidance assists clinicians in interpreting those responsibilities.

The essential question is therefore not simply whether an insurer pays or denies a claim. It is whether the submitted information accurately represents the clinical encounter and, when an inaccuracy occurs, whether the evidence establishes error, insufficient documentation, unsupported judgment, or deliberate material misrepresentation. A clinician who appropriately diagnoses a psychiatric disorder and provides medically necessary treatment involving the patient's spouse may submit an eligible claim when payer requirements are

BLUELINEPSYCH

satisfied. A clinician who knowingly fabricates the diagnosis or misrepresents relationship counseling as individual psychotherapy faces a substantially different ethical and legal situation.

Clinical Responsibility and Best Practices

Clinicians providing marital and couples therapy should address reimbursement during informed consent and treatment planning rather than treating it solely as an administrative matter. Before beginning treatment, the psychologist should clarify the clinical purpose, determine whether a supported psychiatric diagnosis is present, identify who is receiving treatment, and review whether the service qualifies under the patient's insurance benefit.

A practical approach can be organized into seven areas of disclosure and documentation. The following framework is proposed as a synthesis of relevant ethical principles. It is not an independently validated instrument or a universally mandated checklist.

First, identify the patient or clients. Clarify whether treatment is provided to the couple jointly, to one identified patient with spouse participation, or through another clinically appropriate arrangement. This distinction should be established at the outset and reconsidered when treatment changes, consistent with APA Standard 10.02.

Second, explain the therapeutic purpose. Describe whether treatment primarily addresses an individual psychiatric condition, relational difficulties, or both. The clinical formulation should precede the decision about which insurance code to submit.

Third, explain the diagnosis and its justification. When a psychiatric diagnosis supports reimbursement, the identified patient should understand the diagnosis and its relationship to treatment. The diagnosis should reflect assessment rather than anticipated payment.

Fourth, clarify the billing arrangement. Explain whether services will be submitted as individual psychotherapy, family psychotherapy, or another accurately represented service, subject to payer requirements.

BLUELINEPSYCH

In-network participation should not be presented as a guarantee that every service is covered. As illustrated by NYSHIP, NYCE PPO, and UnitedHealthcare, clinicians should verify the governing benefits, coding requirements, medical-necessity criteria, and authorization procedures.

Fifth, discuss confidentiality and records. Clarify how information from each participant may be documented, the circumstances permitting disclosure to insurers, and limitations governing access to records. Particular attention should be given to separate individual consultations and the possibility of separation, divorce, or litigation.

Sixth, explain financial responsibility and alternatives. Discuss coverage limitations, anticipated out-of-pocket costs, payment arrangements, and clinically appropriate alternatives. APA Standard 6.04 and AAMFT Standard 8.2 provide relevant ethical guidance. Applicable law and provider contracts may also restrict when an in-network clinician can charge privately for particular services.

Seventh, document informed consent and revisit it when necessary. Records should reflect the treatment arrangement and participants' understanding of their roles. Changes in clinical focus, including a transition from individual psychotherapy to relationship-centered treatment, may require renewed discussion of consent and reimbursement.

In practice, the clinician's explanation need not be legally elaborate. A straightforward discussion may be sufficient:

Your insurance may cover psychotherapy when treatment is medically necessary for an identifiable psychiatric condition. If one of you has such a condition, and involving your spouse is clinically appropriate, some services may qualify for reimbursement. However, I cannot assign a psychiatric diagnosis simply to make marital counseling reimbursable, nor can I bill relationship counseling as individual psychotherapy when that is not the treatment I am providing. We can review your benefits and determine which services are clinically appropriate and accurately covered.

BLUELINEPSYCH

This explanation distinguishes clinically beneficial treatment from reimbursable treatment while establishing appropriate professional boundaries.

Discussion and Conclusion

The distinction between marital therapy and insurance-funded psychotherapy reflects a tension between relational approaches to treatment and reimbursement systems organized around identifiable patients, covered diagnoses, and medical necessity. Although psychotherapy involving spouses may be appropriate and reimbursable, the existence of a pathway to coverage does not diminish the clinician's obligations concerning diagnosis, informed consent, documentation, and accurate claims submission.

The comparison of NYSHIP, NYCE PPO, and UnitedHealthcare-administered programs demonstrates that coverage cannot be determined solely by labeling a service couples therapy. Some plans exclude marital counseling unrelated to an underlying behavioral health condition. Others include marriage counseling when incorporated into covered treatment. Still others publish reimbursement schedules recognizing family psychotherapy codes while leaving actual payment dependent on the member's benefits and clinical criteria. These differences require careful review of the governing plan rather than assumptions based on an accepted CPT code or another patient's successful claim.

The NYCE PPO requirement for documentation supporting diagnostic changes after denial is especially relevant to diagnostic integrity. It demonstrates that a revised diagnosis may require clinical evidence beyond the code appearing on a claim. Yet the existence of such safeguards does not establish that diagnostic misrepresentation is widespread.

Empirical studies by Kielbasa et al. (2004) and Lowe et al. (2007) demonstrate that payment arrangements can influence psychologists' diagnostic decisions, while Baslock et al. (2026) illustrates how reimbursement reforms may influence recorded diagnoses in clinical systems. These findings warrant attention

BLUELINEPSYCH

to financial influences on clinical judgment. They do not establish that reimbursement-related diagnostic changes necessarily constitute fraud.

Regulatory and enforcement records provide a different form of evidence. The Arizona Dargon matter demonstrates that a licensing board may find professional misconduct when conjoint sessions are inaccurately represented through individual claims. The Connecticut Werner settlement illustrates how disputed individual and family psychotherapy billing can generate civil False Claims Act allegations. Neither establishes the prevalence of fabricated diagnoses in marital therapy, and neither justifies characterizing every billing discrepancy as intentional fraud.

Two professional obligations remain central. Clinicians must explain the treatment arrangement accurately to the people participating in psychotherapy and represent the services truthfully to the insurer. These responsibilities are related but independent. A properly coded claim does not resolve an informed-consent problem when participants have not been adequately informed about who is being treated or how the intervention is conceptualized. Conversely, patient agreement to an inaccurate billing arrangement cannot make a materially false claim legitimate.

The problem is particularly consequential when marital therapy is clinically appropriate but excluded from insurance benefits. Such restrictions may limit access to care, but they do not justify unsupported diagnoses, inaccurate procedural representations, or fabricated documentation. At the same time, legitimate identified-patient treatment, good-faith diagnostic disagreements, and correctable billing errors must be distinguished from deliberate fraud.

Ultimately, the prospective client's question, *"Why can't I use my insurance for marital therapy?"*, deserves more than an explanation of benefits and exclusions. It requires an account of what treatment is being provided, who is receiving it, and what the insurer is being asked to reimburse. The clinician's responsibility is

BLUELINEPSYCH

not simply to obtain payment for appropriate care, but to ensure that the therapeutic formulation, informed consent, clinical record, and insurance claim accurately describe the same treatment.

References

American Association for Marriage and Family Therapy. (2026). *AAMFT code of ethics*. https://www.aamft.org/common/Uploaded%20files/Legal%20Ethics/AAMFT%20Code%20of%20Ethics.pdf

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code

Arizona Board of Psychologist Examiners. (2017, November 3). *In the matter of Christine Dargon, Ph.D.: Findings of fact, conclusions of law and order for revocation* (Case Nos. 14-32, 15-02, and 16-50; filed November 7, 2017). https://psychboard.az.gov/sites/default/files/documents/files/Dargon%20Suspension%20%26%20Revocation%20Orders.pdf

Baslock, D., Manuel, J. I., & Stanhope, V. (2026). Incentivizing co-occurring disorder diagnoses through blended payments. *Social Science & Medicine, 389*, Article 118849. https://doi.org/10.1016/j.socscimed.2025.118849

Centers for Medicare & Medicaid Services. (2026). *Local coverage determination: Psychiatry and psychology services (L33632)*. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33632

City of New York. (2026). *NYC Employees PPO plan: Summary plan description* (Effective January 1, 2026). https://member.nyceppo.com/content/dam/umr/umrpublicsite/nyc/en/documents/Book%2001-01-2026%2000.pdf

Clawson, R. E., Davis, S. Y., Miller, R. B., & Webster, T. N. (2018). The case for insurance reimbursement of couple therapy. *Journal of Marital and Family Therapy, 44*(3), 512–526. https://doi.org/10.1111/jmft.12263

EmblemHealth. (2026, April 30). *Behavioral health services: Provider manual, Chapter 26*. https://www.emblemhealth.com/providers/manual/behavioral-health-services

Hubbard, A. K., & Anderson, J. R. (2022). Understanding barriers to couples therapy. *Journal of Marital and Family Therapy, 48*(4), 1147–1162. https://doi.org/10.1111/jmft.12589

Kielbasa, A. M., Pomerantz, A. M., Krohn, E. J., & Sullivan, B. F. (2004). How does clients' method of payment influence psychologists' diagnostic decisions? *Ethics & Behavior, 14*(2), 187–195. https://doi.org/10.1207/s15327019eb1402_6

Lowe, J., Pomerantz, A. M., & Pettibone, J. C. (2007). The influence of payment method on psychologists' diagnostic decisions: Expanding the range of presenting problems. *Ethics & Behavior, 17*(1), 83–93. https://doi.org/10.1080/10508420701310141

Magellan Healthcare. (2025). Billing individual and/or family therapy sessions? Best practices to help ensure your claims reflect the important work you do. *Provider Focus*, Fall 2025. https://provider.magellanhealthcare.com/w/when-you-bill-for-individual-and/or-family-therapy

New York State Department of Civil Service. (2024). *The Empire Plan certificate: New York State Health Insurance Program, Public Employees Federation*. https://www.cs.ny.gov/employee-benefits/hba/shared/publications/certificate/2024/PEF_Certificate_2024.pdf

New York State Department of Civil Service. (2026, August 26). *Finding a provider for mental health and substance use in The Empire Plan*. NYSHIP Online. https://nyship.ny.gov/g/peret/hmo/articles/finding-provider-mental-health-and-substance-use-empire-plan
New York State Education Department. (n.d.-a). *Couples and group therapy confidentiality*. Office of the Professions. https://www.op.nysed.gov/professions/psychology/professional-practice/couples-and-group-therapy-confidentiality
New York State Education Department. (n.d.-b). *Diagnosis and treatment plans*. Office of the Professions. https://www.op.nysed.gov/professions/psychology/professional-practice/diagnosis-and-treatment-plans
New York State Education Department. (n.d.-c). *Insurance billing and pitfalls*. Office of the Professions. https://www.op.nysed.gov/professions/psychology/professional-practice/insurance-billing-and-pitfalls
Rocky Mountain Health Plans. (2026). *Behavioral health value-based payments: Fee schedule* (Effective January 2026). UnitedHealthcare. https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/co/behavior-health/CO-Value-based-fee-schedule2026.pdf
U.S. Department of Health and Human Services. (n.d.). *Your medical records*. https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html
U.S. Department of Justice, U.S. Attorney's Office, District of Connecticut. (2018, July 3). *Waterford psychologist pays $126,760 to settle allegations under the False Claims Act*. https://www.justice.gov/usao-ct/pr/waterford-psychologist-pays-126760-settle-allegations-under-false-claims-act

Legal Authorities

18 U.S.C. § 1035.
18 U.S.C. § 1347.
31 U.S.C. § 3729.
45 C.F.R. §§ 164.501, 164.508, and 164.524.
N.Y. Educ. Law §§ 6509 and 7601-a.
N.Y. Penal Law § 176.05.
8 N.Y.C.R.R. § 29.2(a)(3).
Ariz. Rev. Stat. § 32-2061(15)(a), (p) (provisions cited in the 2017 Dargon disciplinary order).

BLUELINEPSYCH