“No Shows”

written by Richard Leslie | May 24, 2016

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… A reader raised some questions related to the amount charged to a client or patient who does not show for the scheduled appointment (or who cancels) and who fails to give the therapist or counselor the amount or kind of notice that the practitioner has asked for in his or her disclosure or office policy statement. The reader asked about the propriety of charging different amounts for such “no shows” (missed sessions) for those patients who have insurance coverage and those who do not. This latter question reminds me of the somewhat broader question often asked about whether it is “okay” to charge patients who have insurance a higher fee than is charged patients who do not have insurance and thus pay “out of pocket.”

With respect to charging for missed sessions, practitioners must decide, among other things, how much prior notice they will require in order to excuse payment for the missed session, and whether there are any exceptions to the office policy that will require payment for missed or canceled sessions. Additionally, the amount charged the patient or client for the missed session must be determined. The client must, of course, be informed of the policy and should be informed of the rationale for the policy. Since this policy concerns fees, and since it is likely to bother some who are affected by it, the information regarding the policy should be given to the client in writing (a writing may be required by state law). This information is typically conveyed in the disclosure or informed consent statement that the therapist or counselor gives to the patient at the outset of treatment.

In terms of the enforceability of such a policy, I am aware that there are some small claims court judges who will not allow recovery in a lawsuit concerning charges imposed for a missed session. The judges’ position has been that the consumer is paying for professional health care services, and when those services are not rendered, the practitioner should not be entitled to a fee. While such results do occur, it is also true that many judges will allow recovery, provided that the policy is fair and reasonable, and provided that the patient has been adequately informed of the policy prior to being charged for the missed session.

Billing an insurance company and seeking reimbursement for a missed session must be approached with great care. It is generally considered fraudulent to bill an insurer and to therein represent that an hour of psychotherapy occurred on the date of the “no show.” Some patients have asked their therapists to do such billing, and some of those therapists, perhaps feeling a wee bit guilty for the effects of their policy on “no shows,” have agreed to cooperate with their patients. Such an agreement is a big mistake and will usually end poorly for the therapist, who will likely be charged with insurance fraud when the patient later complains against him or her. Some patients know that the billing constitutes fraud, and they know that they can use this information against the therapist if the need

arises at a later time. Beware!

The practitioner referred to in the first paragraph revealed that with respect to clients who have insurance coverage, he bills the client for the amount of the client's copayment for a first violation of the "no show" policy. Thereafter, he charges the client the amount that the insurance company would have paid him had a claim been submitted for the fifty minute session. For clients who pay out of pocket, they are charged his full hourly rate, which is greater than the rates paid by most if not all insurance companies. The rationale for the disparity, he explains, is that the fee structure is an attempt to be financially fair to the clients who rely on their insurance. My comment on this scenario is that I don't like it – for a number of reasons.

First, I don't understand why there would be the disparity in missed session fees between clients who have insurance coverage and those who do not. Why would there be a desire to be financially fair to clients who have coverage, but not to those who don't have coverage? Why should the latter be expected to pay more for a missed session? I would want to be fair to both those who have insurance and those who do not. I also don't understand the logic behind charging only the co-pay for the first "no show" and then a greater amount for the second and subsequent "no shows." How would this be put into a written policy statement? Would there be separate and distinct written policy statements for those who have insurance and those who do not? Additionally, this practitioner will be getting paid varying amounts for a missed session by those who have insurance coverage, since the amount of the copayment will vary from policy to policy, as will the amount that the insurer would pay for the session. This all seems to be rather awkward and unnecessary, at best.

I would think that generally, the fee for the missed session would be the same for each patient and that it would mirror the fee paid for a session that is held. The lesson that this fee policy is usually intended to teach is that the practitioner's time is valuable, and that the value is established as, for example, $100 per hour. Why should a patient who has insurance coverage pay only the amount of a co-payment, and the client without coverage pay perhaps two or three times more? Could it not be argued that the practitioner is exploiting the client who is without insurance coverage? Again, this method of billing seems awkward at best. Perhaps there are arguments why this manner of billing is appropriate, fair, and non-problematic, but I am not convinced!

My general advice is that mental health practitioners, as with physicians and other professionals, should decide upon their usual and customary fee, and should not have different fees for those who pay "out of pocket" vs. those who have insurance coverage. This does not preclude a therapist or counselor from reducing the fee or providing pro bono services as an exception to the general rule – usually for patients who have demonstrated a financial need for a reduced fee. However, when the fee is lowered, the insurance company should also get the benefit of the reduced fee. For example, if the practitioner lowers her fee from $100 to $50 because a patient is financially needy, the amount billed to the insurance company should be $50. It might be considered fraudulent for a practitioner, upon finding out that there is insurance coverage, to raise his/her fee. I have found this action to be all too prevalent. For those who may offer a sliding fee scale, and as I have previously written (the Avoiding Liability Bulletin –

August 2006), make sure you slide down – not up!