Older Adults and Mental Health Services in Long-Term Care

Thursday, Sept. 24, 2026

noon—1:30 pm EDT

Sponsored by the Medicare Mental Health Workforce Coalition



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Meeting Details

1. **Closed Captioning** is enabled, and attendees can turn CC on or off as they desire.
2. **Interpreter Phone Number: 305-224-1968 Webinar ID: 825 8632 4077 Passcode: 843197**
3. **Session Evaluation / Take our survey at the end of the webinar.** (CE credit for live attendance only)
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- National Council for Mental Wellbeing
- National Council on Aging
- Network of Jewish Human Service Agencies
- The Jewish Federations of North America

Learning Objectives

After this webinar, participants will be able to:

1. **develop** familiarity with practice settings relevant to older adults, with emphasis on long-term care environments.
2. **explore** how serving older adults in long-term care settings differs from other populations.
3. **discuss** unique ethical and practical considerations within geriatric mental health, including care planning and interdisciplinary collaboration.
4. **consider** critical knowledge base growth areas to maximize clinical effectiveness when providing services in senior living and long-term care facilities.





Continuing education of up to 1.5 credit hours is available for those who attend the live webinar.



Andrew Heck, PsyD, ABPP

Dr. Andrew Heck is a nationally recognized clinical geropsychologist , educator, trainer, and administrator with dual board certification in Clinical Psychology and Geropsychology through the American Board of Professional Psychology. He spent 17 years as a clinician and administrator at Piedmont Geriatric Hospital and has held clinical faculty appointments at Virginia Commonwealth University. Dr. Heck is a past president of the Council of Professional Geropsychology Training Programs (CoPGTP) and is a founding member of the American Board of Geropsychology (ABGERO) , and he has delivered national and international presentations on geriatric mental health. He is co-author of Psychologists in Long-Term Care (PLTC): Guidelines for Psychological and Behavioral Health Services in Long-Term Care Setting s and has extensive expertise in behavioral health services for older adults, with professional interests including long-term care, dementia evaluation, behavioral treatment, clinical training, and ethics in geriatric practice.

Older Adults and Mental Health Services in LTC

What You'll Want to Know to Be Effective

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Learning Objectives

Participants in this webinar will:

- **develop** familiarity with practice settings relevant to older adults, with emphasis on long-term care (LTC) environments.
- **explore** how serving older adults in LTC settings differs from other populations.
- **discuss** unique ethical and practical considerations within geriatric mental health, including care planning and interdisciplinary collaboration.
- **consider** critical knowledge base growth areas to maximize clinical effectiveness when providing services in senior living and LTC facilities.

Older Adults: Population Trends[1]

- **Current U.S. Population:** ~350 million (all ages)
- **Older adults**: 57.8 million adults aged 65+ (31.9 million women, 25.9 million men); about 15.5% of total population
- **Growth rate**: Grew by 38.6% over a recent 10-year census period, the fastest pace since the late 19th century
- **Future outlook**: Projected to hit 82 million by the year 2050, making up roughly 23% of the U.S. population

[1] https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

Practice Settings and Older Adults

- Outpatient (clinic- or office-based)
- Hospital
- Home-based
- Hospice facilities
- Long-term care facilities

The Long-Term Care (LTC) Context

LTC is not monolithic

- Independent living (IL)
  - House/cottage on campus
  - Apartment
- Assisted living (AL)
  - Apartment
  - Memory care?
- Skilled nursing facility (SNF)
  - “Nursing home”
  - Can be a shorter rehab stay or long-term residence
- Continued Care Retirement Communities (CCRCs)
  - All levels of independence/care under the same roof

The LTC Context, cont.

Each level of care is unique

- Institutional dynamics
- Oversight/regulatory agencies
- Pertinent laws/regulations/standards (local and federal)
- Funding/payment sources
- Staffing levels
- Physical capabilities of clients

How Does Geriatric Mental Health Differ From Other Age Groups?

- Atypical symptom presentation
- Medical complexity/comorbidities
- Phase-of-life issues
- Developmental considerations

Medical Complexity and Diagnosis

Comorbidities: Psychiatric conditions heavily overlap with chronic illnesses like Parkinson's disease, diabetes, or stroke.

Polypharmacy: Side effects from multiple daily prescriptions can induce or mimic psychiatric symptoms.

Diagnostic Confusion: Distinguishing between emotional, cognitive, and medical issues can be challenging

Phase-of-Life Issues

Grief & Loss: Seniors navigate frequent bereavement, losing spouses, friends, and peers.

Loss of Autonomy: Retiring, losing driving privileges, or moving to retirement communities or long-term care facilities can trigger identity crises.

Isolation: Extreme social isolation and loneliness are critical risk factors for mental health challenges in later life.

Developmental Considerations

Erik Erikson's Theory of Psychosocial Development

- **Stage 7: Generativity vs. Stagnation (ages 40–65)**
  - Focus on work and parenthood
- **Stage 8: Ego Integrity vs. Despair (ages 65+)**
  - Focus on reflection on life experiences and choices, planning future in new context
- **Stage 9: Gerotranscendence (oldest old—80s and 90s)**
  - Successful coping with extreme losses

Essential Knowledge for Working with Older Adults in LTC

- Prevalence and alternate presentations of psychiatric illness in older adults
- Types and prevalence of dementia in older adults
- Working knowledge of all classes of psychotropic medications
- Support and advocacy resources
- Practical considerations
- Ethical challenges/dilemmas

Prevalence of Psychiatric Illness in Older Adults[2]

Any Mental Illness (AMI): About 12.5% to 13.9% of adults aged 50 to 60+ experience any mental illness in a given year, with roughly 2% experiencing a serious mental illness

Depression and Mood Disorders: Mood and depressive disorders affect roughly 5% to 7% of older adults, though broader estimates including depressive symptoms range higher

Anxiety Disorders: Anxiety is among the most frequent conditions, impacting roughly 11% of older individuals

Substance Use Disorders (SUD): About 4% of older adults experience a past-year substance use disorder, commonly involving alcohol or prescription drugs

Note: As level of care increases, so do rates of depression and anxiety

[2] Reynolds, K., Pietrzak, R. H., El-Gabalawy, R., Mackenzie, C. S., & Sareen, J. (2015). Prevalence of psychiatric disorders in U.S. older adults: Findings from a nationally representative survey. *World Psychiatry*, *14*, 74–81.

How Symptoms Present Differently in Older Adults

Depression

Physical complaints: Focuses on unexplained body aches, headaches, or digestive issues instead of sadness

Apathy and irritability: Shows up as lack of motivation, flat mood, or crankiness rather than crying

Memory slip-ups: Mimics early dementia with confusion or slow thinking, sometimes called pseudodementia

Different Symptom Presentations, cont.

Anxiety

- **Bodily tension:** Often express worry through dizziness, a racing heart, or shaking rather than feeling nervous
- **Health fears:** Often fixate on physical health and failing body parts
- **Routine avoidance:** Often pull away from social events or stop doing daily tasks

Different Symptom Presentations cont.

Bipolar Disorder

- **Irritable highs:** Displays anger and agitation during manic phases instead of high energy or pure joy
- **Frequency, duration of manic episodes:** Episodes last longer and there is less time in between episodes
- **Neurological effects:** Lifelong Bipolar Disorder and some psychotic disorders (especially those that are poorly treated) often result in dementia-like cognitive impairment
    - gray matter reduction
    - subcortical atrophy
    - enlarged ventricles
- Bear in mind: Even when mania is stable, a certain amount of cognitive and behavioral disinhibition may remain present.

Prevalence of Dementia (Medicare) [3]

Overall Rate: About 14% of Medicare beneficiaries have received services for dementia-related illness; increasing age raises rates substantially

Mild Cognitive Impairment: Affects an additional 22% of older adults

Alzheimer's Disease (AD): Accounts for about 44% of diagnosed dementia cases

Vascular Dementia (VaD): Accounts for about 15% of all dementia cases

[3]Goodman, R. A., Lochner, K. A., Thambisetty, M., Wingo, T. S., Posner, S. F., Linget, S. M. (2016). Prevalence of dementia subtypes in U.S. Medicare fee-for-service beneficiaries, 2011–2013. *Alzheimer's Dementia*, *13*, 28–37.

Prevalence of Dementia, cont.

Dementia with Lewy Bodies (DLB): Accounts for roughly 5% of diagnosed dementia cases

Frontotemporal Dementia (FTD): A rarer form accounting for about 1% of cases

Other Dementia: Includes Creutzfeld-Jacob disease, Huntington's disease, and other rare forms; about 0.2% of all diagnosed dementia are in this category

Delirium

- “Clouding of consciousness”
- Temporary disruption of cognitive and emotional status typically due to medical reasons
- **Most common causes:**
  - Medication side effects or interactions
  - Medical conditions (e.g., infections—UTI, respiratory, skin)
  - Adjustment to new situations (e.g., transfer trauma)
- **Symptoms:** acute onset, disorientation, confusion, agitation, inattention
- Medical delirium requires resolution of the underlying medical condition
- Clients unlikely to benefit from psychotherapy until delirium resolves
- Do not equate delirium with dementia, although they may co-occur (dementia raises risk of delirium)

Psychotropic Medications

Beers Criteria

- Maintained by the American Geriatrics Society, it aims to reduce drug-related harm, confusion, and falls in aging patients
- Explicit, evidence-based list of potentially inappropriate medications that older adults should generally avoid or use with extra caution
- Most categories of medications have some representation on the Beers list
- Being listed on the Beers list does NOT prohibit a medication usage legally or even ethically in all cases—provides general caution and guidance

Psychotropic Medications, cont.

Antidepressants (SSRIs, SNRIs)

- Used for depression and anxiety
- Common first-line: Lexapro (escitalopram), Zoloft (sertraline), Prozac (fluoxetine)
- Others: trazodone (brand name: Desyrel; typically for sleep only), mirtazapine (brand name: Remeron; typically for sleep and/or appetite)
- Beers Criteria: tricyclic antidepressants (e.g., Elavil), some SSRIs (e.g., Paxil)

Psychotropic Medications, cont.

Anxiolytics

- Used for anxiety
- Common first-line: BuSpar (buspirone)
- **Beers Criteria:**
  - Most drugs in the benzodiazepine class (e.g., Xanax, Valium, Ativan)—high risk of falls, cognitive impairment
  - Barbiturates (e.g., phenobarbital)
- Many clients may have taken benzodiazepines for many years and have at least a psychological dependence on them (e.g., Xanax, Valium)

Psychotropic Medications, cont.

Mood stabilizers

- Many originally developed for and used as anti-seizure medications
- Used for Bipolar Disorder, other forms of behavioral disruption (off-label)
- Common first-line: valproic acid (Depakote), lamotrigine (Lamictal), gabapentin (Neurontin)
- Beers Criteria: carbamazepine (Tegretol)—confusion, falls, stroke risk

Psychotropic Medications, cont.

Antipsychotics

- Used for psychosis (FDA-approved), mood stabilization (some are FDA-approved), behavioral disturbance (off-label)
- First generation (rarely used now): Thorazine, Stelazine, Haldol, Prolixin
- New generation: Abilify (aripiprazole), Risperdal (risperidone), Seroquel (quetiapine), Zyprexa (olanzapine)
- Beers Criteria: Most antipsychotics are considered potentially inappropriate due to significant risk of side effects
- FDA: Black box warning for antipsychotics used for dementia-related psychosis (risk of premature death)
- Nursing facilities can be penalized for excessive or nonapproved use of antipsychotics

Support and Advocacy Resources

- **Critically important to families and patients/clients alike**
- **Codified resources vary by locale**
  - Adult Protective Services
  - Aging services agencies (e.g., Virginia: local Area Agencies on Aging)
  - State commissions
  - Ombudsman programs (typically AL and SNF)
  - Relationship between LTC facilities and public MH system (community MH centers, public psychiatric hospitals)

Support and Advocacy Resources, cont.

- **Know your state laws about mandated reporting**
  - Who is a mandated reporter?
  - What is required to be reported?
  - What is the process for making a report, and to whom?
- **Laws and processes for psychiatric hospitalization**
  - Voluntary vs. involuntary admissions/commitments
  - Criteria for hospitalization (e.g., imminent danger)

Practical Considerations for Working in LTC

- Role and scope of services
- Facility organizational structure
- Referral management
- Physical space/setting
- Navigating/operating within a multidisciplinary team context
- Billing considerations
- Recordkeeping requirements

Role and Scope of Mental Health Services

Therapist vs. MH consultant

- **Therapist**
  - Strictly limited to therapy intakes and appointments only
- **Consultant**
  - Therapy services
  - Case consultation (e.g., level of care recommendations, memory care admission input)
  - Policy development (e.g., suicide/self-harm operational procedures, special observation status guidelines)
  - Conducting staff training (e.g., dementia, depression, stress management)
- **Always formalize service agreements with a written contract**
  - Explicit scope of services
  - Time commitment (e.g., 4 hours/week on Wednesdays)
  - Resources needed (e.g., office space)
  - Requirements for contract termination (both sides; e.g., 60 days' notice)

Facility Organizational Structure

It is important to understand a facility's organizational structure so you know who to contact and for what purposes.

- **Chief Executive Officer**: highest level of oversight and management at the facility; rarely involved in MH services except in severe or high-profile incidents
- **Chief Operating Officer**: oversees contracts, physical plant maintenance, environmental services; typical involvement with MH providers is limited to contract management
- **Chief Nursing Officer** (or DON): in charge of nursing staffing, policies and procedures, nursing budget management

Facility Organizational Structure, cont.

- **Medical Director**: physician in charge of all medical services; typically a geriatrician and often doubles as practicing PCP
- **Clinic Director**: (for facilities that have medical clinics) typically a nurse who oversees clinic appointment coordination, supplies, clinic personnel, and contracted clinicians (e.g., dentist, optometrist, podiatrist, MH therapist)
- **Unit Director**: In charge of day-to-day operations in a specific facility area; very involved in generating MH referrals, important source of information about resident daily functioning
- **Rehab Director**: in charge of all rehab services, including PT, OT, SLPs; may be involved in some MH issues surrounding participation in rehab activity
- **Social Worker**: assists individual residents with practical issues, care coordination, family liaisonship; often very involved in individual MH care issues

Facility Organizational Structure, cont.

Know the difference between formal and informal authority at the facility

- Most referrals do not originate from the PCP, despite the PCP writing the order
- Unit nursing staff, unit directors, family members, and the residents themselves are often the original referral source
- Many medication recommendations originally come from non-prescribers (e.g., nurses, therapists), though the PCP will write the formal order

Referral Management

Always helpful to have a unitary liaison with the facility

- Administrative assistant
- Resident care coordinator
- Scheduler
- Clinic director
- Can be challenging in a CCRC with disparate levels of care

- Communicate regularly about upcoming client schedule (e.g., weekly emails with liaison and other relevant people)
- Give facility frequent updates about caseload size, wait times for new referrals
- **When possible, require a PCP referral for services**
  - Helps with referral tracking
  - Provides a referral question to be addressed (e.g., “Psychological consultation for new-onset depression”)

Physical Space/Setting

Clinic-based services, seeing clients in their own rooms, or a hybrid?

- **Advantages of a clinic model**
  - Centralized time and schedule management
  - Clear to facility who is being seen and when
  - Having clients report to an office for an appointment promotes client investment, commitment
- **Disadvantages of a clinic model**
  - **Privacy considerations**
    - Some residents don't want it known they're seeing a MH provider
    - Waiting areas are often in public view
  - **Workflow of MH services does not always resemble other medical services**
    - Documentation processes (covered later in presentation)
    - Length of appointments (45–50 min. vs. 15 min. appts)

Physical Space/Setting, cont.

Most often, skilled nursing residents must be seen in their rooms due to mobility limitations

- Usually not ergonomically ideal for psychotherapy
- Make use of bedside tables, rollators, etc.!
- **Residents with roommates (especially bedbound) can make privacy difficult**
  - Consider portable white noise generators to muffle discussions
  - May ask roommate to turn on television or music for privacy as well

“Team Work” in LTC

Interdisciplinary (ID) teams

- Disciplines are closely aligned, meet often (usually in person), and make integrated clinical decisions (e.g., PCP, social worker)
- Less common in LTC settings

Multidisciplinary teams

- Disciplines, although common in purpose, are more siloed—working separately and rarely meet in person as a group
- Communication is more often written than verbal (e.g., chart notes, emails)
- More common than ID teams in LTC

Team Work in LTC, cont.

MH privacy issues can be challenging in a multidisciplinary context

- Free/unrestricted communication with other clinicians about MH is not always possible due to confidentiality, legal records protections, etc.
- Clinicians need to be judicious and strategic when sharing clinical information with other disciplines (“minimum necessary”)
- Exception: When clients are deemed imminently dangerous to self or others, this obligates communication and coordination with other clinical leaders

Billing Considerations

Medicare

- Federal health insurance for 65+ and select others (e.g., kidney failure)
- 4 parts
  - Part A: Hospital insurance
  - Part B: Outpatient services
  - Part C: Medicare Advantage plans
  - Part D: Prescription drug coverage
- **Medicare claims are usually handled by a regional carrier**
  - Medicare Administrative Contractors (MACs): handle claims, provider enrollment, and local coverage policies for parts A and B
  - Most clinician dealings will be with MACs rather than Medicare itself

Billing Considerations, cont.

Providers can have different relationships with Medicare

1. **Participating providers** ("accepting assignment")

   Provider agrees to accept only Medicare rates for all enrollees

   Medicare pays 80% of Part B claims, clients pay remaining 20% with secondary insurance or out of pocket

2. **Non-participating providers**

   Provider only takes Medicare for some procedures/claims and not others

   Clients must pay provider up front and be reimbursed by Medicare

   Provider still must submit claim to Medicare, even if clients get the payment

   Lower reimbursement rates in general

3. **Opt-out providers**

   Out of Medicare entirely

   Must submit forms to Medicare to opt out

   Practice's success depends on target market/population

Billing Considerations, cont.

- **Medicare Advantage plans (Part C)**
  - Medicare pays a lump sum to a private insurer to manage all care
  - Often requires prior authorization—ex post facto authorization may not be reimbursed
  - Often much higher audit and claim denial rates
  - Very specific diagnosis/procedure code standards
  - Appeals process can be burdensome
  - Denied claims often cannot be charged to the client
- Providers who accept Medicare assignment are NOT required to accept Medicare Advantage plans

Billing Considerations, cont.

Most frequently used CPT codes in LTC

- 90791: Psychiatric Diagnostic Evaluation (i.e., intake; no time specifier)
- 90832: 30-minute therapy
- 90834: 45-minute therapy
- 90837: 60-minute therapy
- 90839: Crisis intervention (30–74 minutes; 90840 for each additional 30 minutes)
- 90847: Family therapy *with patient present* (26–50 minutes)
  - Client must be present
- 90846: Family therapy *without patient present* (26–50 minutes)

- Note: Medicare does not cover "general" couples therapy

Billing Considerations, cont.

- 90785: Interactive complexity add-on code
  - Paired with intake, therapy codes
    - Maladaptive communication
    - Caregiver interference
    - Sentinel event disclosure
    - Specialized communication barriers
  - Cannot be used with Crisis Therapy code

Billing Considerations, cont.

Billing strategies

- **Ensure diagnosis and code are compatible**
  - List “primary diagnosis” as the one that is the focus of therapy
  - Example: A client with a new diagnosis of Alzheimer’s disease
    - Primary diagnosis: Adjustment Disorder with mixed anxiety and depressed mood
    - Other diagnosis: Major Neurocognitive Disorder due to Alzheimer’s Disease
    - The syndrome being treated is the adjustment/coping deficit, not the dementia
  - Consult regional carrier guidelines for diagnosis and procedure compatibility
- **Be as specific as possible with coding**
  - *Adjustment Disorder, unspecified* may be denied due to lack of specificity

Recordkeeping Requirements for MH in LTC

Documentation requirements in LTC vary across settings

- Medicare
- Private insurance
- State agency regulations (e.g., DSS)
- Facility-specific

Recordkeeping, cont.

Medicare requirements (for clinician's record, not facility)

- Core patient encounter details
  - Patient ID
  - Dates and times
  - Provider info (signature credentials, NPI)
  - Location and mode (office vs. LTC, in-person vs. telehealth)
- Clinical and treatment documentation
  - Diagnostic evaluation (for initial 90791; DSM/ICD diagnosis)
  - Treatment plan (proposed type, measurable goals, estimated duration)
  - Progress notes (current symptoms, MSE, interventions used, patient response, progress toward treatment goals)
  - Medical necessity (why treatment must continue and lower levels of intervention are insufficient)

Recordkeeping, cont.

But what documentation must we submit to an LTC facility?

- Varies according to locale and level of care (IL, AL, SNF)
  - **Independent living:** Typically, there is not a centralized medical record for IL residents
    - However, clinic- or community-based referral sources may request copies of referred psychiatric diagnostic exams
    - Almost never would a clinician send psychotherapy notes for an IL resident to a PCP
  - **Assisted living:** Most often there is a centralized medical record
    - General guidance: submit a copy of a 90791 for the facility's record but do not send psychotherapy notes by default
  - **Skilled nursing facility:** There is always a centralized medical record
    - Same as AL: submit 90791 to the facility record, do not automatically send therapy notes
    - Exceptions: risk assessments, sentinel event reporting, other facility requests that make sense

Recordkeeping, cont.

If the facility absolutely requires documentation of every session in the record…

- Ensure that this requirement is addressed in the services contract
- Consider only including essential note elements (AKA “minimum necessary”) with no clinical content
  - Session type
  - Session length
  - Broad focus (e.g., coping with grief, medical illness)
  - Plan for future interventions

Make a commitment to facility and referral source that in-person clinical discussions are available as needed

Key Ethical Considerations

Safety vs. autonomy

- "Right to folly" vs. obligation to protect

Privacy

- Families seeking information about treatment
- Family, facility, or referral source attempts to guide treatment
- Always inform clients of privacy limitations (e.g., imminent harm, payor requests for documentation, judicial orders)

Role fidelity

- Who is the client?
- What is my "lane"?
- Practicing within areas of competence

Key Ethical Considerations, cont.

Distributive justice (allocating resources)

- Make services equally available regardless of payor source

Countering biases (ageism)

- Avoid automatically equating clinical symptoms with normal aging (e.g., depression)
- Balance legitimate cohort beliefs (e.g., MH skepticism) with optimism re: prognosis, ability to benefit from treatment (i.e., avoid “therapeutic nihilism”)

General Tips for Ethical Practice

- Utilize ethical decision-making framework
  - CORE-OPT[4]
  - Clinical Pragmatism[5]
- Maintain key awareness of when ethical principles clash with legal, regulatory, or policy issues
- Make liberal use of collegial consultation for difficult dilemmas

[4]Bush, S.S., O'Connell, M.A., & Denny, R.L. (2019). *Ethical Practice in Forensic Psychology: A Guide for Mental Health Professionals.* American Psychological Association.

[5]Fins, J.J., Bacchetta, M.D., & Miller, F.D. (1997). Clinical pragmatism: A method of moral problem-solving. *Kennedy Institute of Ethics Journal, 7,* 129-145.

General Tips for Ethical Practice cont.

Avoid being unnecessarily drawn into conflicts unrelated to MH services

- E.g., residents behind on paying facility bills
- E.g., conflict with children about resident assets

Useful Resources

Bush, S. S., Allen, R. S., & Molinari, V. A. (2016). *Ethical practice in geropsychology.* American Psychological Association.

Bush, S. S., & Heck, A. L. (Eds.). (2018). *Forensic geropsychology: Practice essentials.* American Psychological Association.

Lichtenberg, P., & Mast, B. (Eds.). (2015). *APA handbook of clinical geropsychology.* American Psychological Association.

Norris, M., Molinari, V., & Ogland-Hand, S. (Eds.). (2013). *Emerging trends in psychological practice in long-term care.* Taylor & Francis.

Zarit, S. H., & Zarit, J. M. (2011). *Mental disorders in older adults* (2nd ed.). Guilford Press.

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Reynolds, K., Pietrzak, R. H., El-Gabalawy, R., Mackenzie, C. S., & Sareen, J. (2015). Prevalence of psychiatric disorders in U.S. older adults: Findings from a nationally representative survey. *World Psychiatry*, *14*, 74–81.

Summary

- LTC practice is greatly needed and can be personally and professionally rewarding
- Understand dynamic differences between LTC practice and practicing in other outpatient community settings
- Continually assess your own KSAs and practice only within areas of competence and authority
- Have a low threshold for consulting with experienced geropsychology colleagues

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Greta Christ is a Licensed Professional Counselor, National Certified Counselor, Certified Dementia Practitioner, Certified Advanced Grief Counseling Specialist, and a PhD candidate in counseling education and supervision at Marymount University. She also holds a master's degree in clinical mental health counseling from Marymount University and a master's degree in psychology from Marietta College. Her clinical experience includes providing therapeutic services to individuals facing concerns surrounding anxiety, depression, life transitions, grief and loss, medical illness, aging, caregiving, spirituality, and interpersonal issues. She has provided counseling in group private practice, hospital, and senior living center settings. In addition to maintaining her own private practice, Ms. Christ is currently a Visiting Professor at Marymount University and the Clinical Coordinator at Marymount's Training Clinic, providing supervision to master's - level students working with underserved clients in the community.





Max Zubatsky, PhD, LMFT

Dr. Max Zubatsky is a Professor and Program Director of the Medical Family Therapy program at Saint Louis University. He's a Licensed Marriage and Family Therapist and AAMFT- approved supervisor. He is also the Director of the Family Center for Healthy Aging at SLU, helping co-direct the HRSA Geriatric Workforce Enhancement Program grant.



Greta Christ

MA, NCC, LPC



Max Zubatsky

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Questions and Answers

Resources



Critical Resources on Medicare Part B Coverage of Counselors, Social Workers, and MFTs

Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists

https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

How to Enroll in the Medicare Program

- **Medicare Enrollment for Providers and Suppliers**
  https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos
- **New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) FAQs (36 questions answered) Published Sept 2023**
  https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- **The Medicare Learning Network:**
  https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training
- **Web-Based Training:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining
- **Becoming a Medicare Provider (World of Medicare):**
  https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN9329634-WOM/WOM/index.html
- **Weekly Email Newsletter for Medicare Providers:**
  https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive



Critical Resources on Medicare Part B Coverage of Counselors, Social Workers, and MFTs (cont.)

Role of the Centers for Medicare and Medicaid Services (CMS)

- https://www.investopedia.com/terms/u/us-centers-medicare-and-medicaid-services-cms.asp
- https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

Medicare Mental Health Benefits for Beneficiaries

Medicare Mental Health:
https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf

Medicare Beneficiary Handbook:
https://www.medicare.gov/medicare-and-you



Critical Resources on Medicare Part B Coverage of Counselors, Social Workers, and MFTs (cont.)

Medicare Administrative Contractors (MACs)

https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac

Medicare Physician Fee Schedule

https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

Key Steps to Becoming a Medicare Provider

1. Register in the I&A System
2. Get an NPI
3. Enter information into PECOS
4. Decide if you want to be a participating provider

Form CMS-855I: Physicians and non-physician practitioners (PDF link)

