Medicare Eating Disorder Plan (EDP)

People meeting the patient criteria will be eligible for Medicare subsidised eating disorder treatment with specialised clinical providers.

The Medicare EDP (Eating Disorder Plans) have been in place for over 12 months now and people are accessing a second/ subsequent plan.

There are more details to be aware of when accessing a subsequent plan. Please see below for further details regarding this.

Patient Criteria for the Eating Disorders Plan

eligible patient means a patient who:

(a) has a clinical diagnosis of anorexia nervosa; or

(b) meets the **eligibility criteria**, and has a clinical diagnosis of any of the following conditions:

(i) bulimia nervosa;

(ii) binge-eating disorder;

(iii) Other specified feeding or eating disorder (characterised by rapid weight loss or frequent binge eating or inappropriate compensatory behaviors (greater than 3 times per week))

eligibility criteria, for a patient, is:

(a) the patient has been assessed as having an eating disorder examination questionnaire score of 3 or more; **and**

(b) the patient's condition is characterised by rapid weight loss, or frequent binge eating, or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; **and**

(c) the patient has at least two of the following indicators:

(i) clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;

(ii) current or high risk of medical complications due to eating disorder behaviours and symptoms;

(iii) serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;

(iv) the person has been admitted to a hospital for an eating disorder in the previous 12 months;

(v) inadequate treatment response to evidence based eating disorder treatment over the past six months despite active and consistent participation.

The EDP can be created by a GP, Paediatrician or Psychiatrist. Most often GPs create and review EDPs.

Please note when booking to see a GPs they will require a double session to create or review a treatment plan. It may be helpful for the patient to bring this document with them to their appointment as many GPs are still learning about the Medicare components of the EDP.

The Eating Disorder Plan has two components:

1. Eating Disorder Dietetic Treatment Services
2. Eating Disorder Psychological Treatment Services

Eating Disorder Dietetic Treatment Service

- Max. 20 services (sessions with a dietitian) IN 365 days rather than a calendar year.
- Dietitian to report back to the GP after the 1st or 2nd session and the 20th session.
- Medicare has allocated rebate $55.10 per service. Please note if seeing a private practice dietitian there will be an out-of-pocket or “gap” expense.

- *For example, if dietitian charges $150 per session, the patient pays $150 on day and Medicare will transfer $55.10 into the patient’s bank account then the patient will be out of pocket $94.90 per session. This out-of-pocket amount goes towards the patient’s Medicare Safety Net which when reached will allow for greater Medicare rebates and less out-of-pocket.*

Eating Disorder Psychological Treatment Service (EDPT)

The Eating Disorder Plan must be reviewed by GP after every 10 psychological treatment services to ensure the patient is still eligible for rebate on further sessions.

When an Eating Disorder Plan is created the patient is automatically eligible for 10 services (sessions) with a psychologist or equivalent eating disorder psychological treatment service provider (EDPT). EDPT provider is required to feedback to the GP.

The GP may then review the EDP and refer the patient back to the EDPT provider for an additional 10 services (at this stage a total up to 20 services under the EDP). EDPT provider is required to feedback to the GP.

If more than **20 EDPT** services (sessions) are needed, the patient may be eligible for an additional 20 services (sessions) in a 365-day period then they must be reviewed by a **GP AND a Paediatrician or a Psychiatrist.**

Note: *Both health professionals must review the treatment and management plan before more treatment services can be provided to the patient hence it would be a* ***good idea to get a referral to a Paediatrian (if aged under 18) or Psychiatrist from the GP at the first review*** *if the patient is likely to require more than 20 services per 365-day period.*

After a 10 additional service (total 30 in 365 days). EDPT provider is required to feedback to GP. The patient needs to meet with the GP for another EDP review.

A further EDP review with GP then may allow the patient to access a further 10 EDPT services (sessions) – a total of 40 sessions per 365-day period. Again, the EDPT provider must communicate with the GP.

Medicare provided rebate with a Psychologist will be $86.15. Medicare provided rebate with a Clinical Psychologist will be $126.50 per service. Please note if seeing a private practice Psychologist or Clinical Psychologist there will be a gap payment.

Most Clinical Psychologists fees are around $220 per session/service (this can vary). The patient with the Medicare rebate is likely to be out of pocket approximately $90 per session. This

amount will vary as to how much the Psychologist charges. Importantly this out-of-pocket expense does contribute to the patient's Medicare Safety Net.

An **eating disorder psychological treatment service** must involve the provision of any of the following mental health care management strategies:

(a) family-based treatment (including whole family, parent based therapy, parent only or separated therapy)
(b) adolescent focused therapy;
(c) cognitive behavioural therapy;
(d) cognitive behavioural therapy-anorexia nervosa;
(e) cognitive behavioural therapy for bulimia nervosa and binge-eating disorder;
(f) specialist supportive clinical management;
(g) maudsley model of anorexia treatment in adults;
(h) interpersonal therapy for bulimia nervosa and binge-eating disorder;
(i) dialectical behavioural therapy for bulimia nervosa and binge-eating disorder;
(j) focal psychodynamic therapy.

*Please note:

Chronic Disease Management Plan and Team Care Arrangement Plan (Item 721 and 723)

- Patients can access up to 5 allied health services including dietetics (item 10954). However, this cannot be in addition to the Eating Disorder Plan 20 dietetic sessions. Any claim for dietic service under the Chronic Disease Management Plan (item10954) within the 12 months of the EDP being used will count to the allocation of 20 dietetic sessions.

GP Mental Health Plan (Item 2700, 2701, 2715 or 2717).

- Better Access to Mental Health Service Pathway. Psychological therapy services provided in the 12 months (within the same calendar year) prior to an EDP count towards the patients max. limit of 40 EDPT services in 12-month period.

Resources

Health Insurance (Allied Health Services) Amendment (eating disorders) Determination 2019
EDE-Q

Subsequent EDP

When assessing a second or subsequent EDP when your initial plan has expired it is important to be aware of some further requirements.

The EDP is valid for the 12 months from the **Date the GP creates and registers** the plan. The Plan will expire 365 days later - the same date the following year.

ie If you have a plan dated 4th January 2020 it will expire on the 3rd of January 2021 and as at the 4th of January 2021 you will no longer be eligible for a rebate.

You can see your GP for a review (please book a double appointment) and they can create a new plan **if** you still meet the above criteria.

You will then be able to access both components of the EDP:

1. Eating Disorder Dietetic Treatment Services
2. Eating Disorder Psychological Treatment Services

With the same review process in place as described above.

EXCEPT

To be eligible for a rebate you must have an in-date plan as described above.

You must also ensure you have not exceeded the **maximum** number of allocated sessions (20 for a dietitian/40 for a psychologist) in the 365 days preceding your appointment.

You will need to check this for each appointment, **before you attend**, for the second and subsequent EDP to ensure that Medicare will rebate the consultation. If you see a Dietitian for the 21st time in a 365-day period, even if your plan is in-date, Medicare will reject your claim.

For example (based on the Dietitian service component):

- The client had an EDP dated April 20th, 2020, and it expired April 20th 2021.
- In that time, they claimed for 20 dietitian appointments.
  They have a new EDP dated April 21st 2021 and are now eligible for 20 sessions with the dietitian that they will get a rebate from Medicare.

- The client books an appointment for May 1st, 2021, to see the dietitian and will need to double check how many Medicare rebated sessions they claimed for the dietitian from May 1st 2020 to May 1st 2021.

- If the client had claimed 20 sessions in that 365-day period prior Medicare **will not rebate** the session on May 1st 2021 even though they are eligible for 20 new sessions over the 12 months from April 20th 2021 to April 20th 2022.

  - Medicare report this is because the client has used the 20 maximum rebateable sessions in the proceeding 365-day year - based on a rolling 365 day period.

- The client can still attend the appointment and pay the full fee knowing that Medicare will not provide a reimbursement.
  OR
  the client can check when they had an appointment with the dietitian and claimed with Medicare in the preceding 12 months. If the client had an appointment on May 2nd, 2020 they can 'earn back' that rebate after May 2nd, 2021, and will be able to have a session after that date with the dietitian and be rebated by Medicare.

This does not tend to be an issue if people did not use all the possible sessions on their previous EDP or if the sessions claimed on the previous plan were evenly spaced over the preceding 12 months.

It can be an issue if someone had an EDP but did not actually claim it for several months after it was created by the GP and registered with Medicare. Then they used all the available sessions close to its expiry date and got a new EDP for the next 12 months.

Another example:

If the first EDP 20 dietetic sessions used within a 365-day period (not a calendar year) then there may be some period of time when the patients new EDP will not provide a rebate.

For example, in a patient that used 20 sessions from July 5th, 2020 – March 28th 2021 and has a new EDP plan on June 20th 2021 from their GP.

The patient will need to know the exact dates of when they saw the Dietitian that were rebated through their last EDP (available if they call Medicare).

If the patient saw a dietitian using their EDP on:

- July 5th 2020
- August 2nd 2020
- August 9th 2020
- August 18th 2020
- August 25th 2020

Then 15 other times within a 365-day period using the EDP with the last dietitian session on March 28 2021.

Then patient will have to wait until July 5th 2021 to have one session eligible for a Medicare rebate under their new EDP. Then their next appointment with a Medicare rebate can be from August 2nd 2021 onwards. It is a rolling 365-day calendar.

The other instance would be if patients' circumstances have changed, they do not have to use the appointments weekly in August and instead could "accumulate" 3 appointments and just access the dietitian after August 25th 2021. This would then allow the patient more flexibility instead of having to wait for certain dates and potentially spread their EDP dietetic services more evenly across 365 day or allow them to choose to access more of their EDP dietitian services more frequently in times of need.

This complicated part of the EDP was not effectively explained with its roll out. Consequently, some patients are finding that they have exceeded the 20 sessions per 365 days and will opt to pay for the dietetic sessions in the interim without a rebate. Also, for those who have used the appointment thinking they were per calendar year, might consider spreading them more evenly across the next 365 days.

If the patient did not use 20 sessions in a 365-day period it is unlikely to be an issue for them. However importantly the dietitian has no control over Medicare and often patients will find that they have exceeded the 20 sessions per 365 days by not getting a rebate. This can be distressing hence we are encouraging patients to document the dates of their dietetics sessions and call Medicare in advance if they are unsure.

Please note clients do NOT need to have an EDP in place to see a dietitian at Eat Love Live.

The client can still see a Dietitian if they have used all of your allocated sessions that attract a Medicare rebate.
The fee will remain the same and there will be no rebate from Medicare.

If the client has private health insurance extras that covers nutrition/ dietetics they can use this to claim part of the cost of the service.
Clients however cannot claim from Medicare and Private health for the same session; it needs to be one or the other.

Please contact us to discuss further if this needs clarification.