Anthem

Anthem Blue Cross and Blue Shield
Medicare Advantage

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Essential/everyday extras — Personal Home Helper

What are essential/everyday extras?
Essential/everyday extras is a Medicare Advantage benefit in which the member can choose from a list of optional services to tailor their plan to best suit their needs. This additional benefit is available on select plans in Georgia, Indiana, Kentucky, Missouri, Ohio, Virginia and Wisconsin.

The benefit options include the following:

- **Personal Home Helper** — This benefit provides in-home support for caregiver respite, home-based chores and activities of daily living (ADL) to address needs while recovering from injury or illness. It covers up to 4 hours per day for 31 days or 124 hours of care in a calendar year. Prior authorization is required.
- **Transportation** — Transportation to and from medical visits, SilverSneakers® locations and pharmacy visits is covered by this benefit. This benefit covers up to 60 one-way trips each calendar year. The service requires approval at least 48 hours in advance.
- **Assistive devices** — This provides a $500 allowance toward the purchase of assistive or safety devices, such as toilet seats compliant with *Americans with Disabilities Act (ADA)* standards, shower stools, hand-held shower heads, reaching devices, temporary wheelchair ramps and more.
- **Alternative medicine** — This benefit covers up to 24 medically necessary acupuncture or therapeutic massage visits each calendar year.
- **Healthy food delivery** — Members can receive meals to prevent, treat or avoid a health-related issue. Member must have a recent discharge and a BMI greater than 25 or an HbA1C greater than 9.0. Nutritional assessment and prior authorization are required.
- **Day center visits** — This benefit includes one visit per week for up to 8 hours. It also includes transportation to and from the adult day care location. To be eligible, the member must need help with at least 2 ADL and the benefit must be recommended by a clinician. The member must submit a request for reimbursement for a plan-approved, licensed facility. The maximum reimbursement is $80 per day.

If you are a provider who is also contracted to provide services through an LTSS plan, please see additional material on the provider portal for more information about Essential Extra options for your patients

Personal Home Helper FAQ

What does the Personal Home Helper benefit cover?
The Personal Home Helper benefit covers an in- home health aide to provide respite for caregivers and assist with home-based chores and ADL as needed, due to the member's health issues.

The help provided under Personal Home Helper benefit is not covered under any other Medicare benefit. The benefit covers up to 124 hours of care in a calendar year (up to 4 hours per day) with a maximum of 31 days in the calendar year. If less than 4 hours is used, it is still considered a day toward the 31 day maximum. The member has the entire calendar year to fully utilize the benefit.

In- home support services include:

- Help with bathing and showering.
- Help with dressing and grooming.
- Transferring or mobility help in the home.
- Light housekeeping (e.g., cleaning, laundry, dishes).
- Meal preparation.
- Assistance with incontinence/bathroom assistance.

What provider agency or person can a member use?
Members must use a plan-approved provider for services. Anthem Blue Cross and Blue Shield (Anthem) plans have contracted directly with providers to supply these services to its members. If you are interested in providing this benefit, please contact your Contract Manager or Provider Relations Representative.

Does the Personal Home Helper benefit require an authorization?
Yes. Anthem will be responsible for establishing member eligibility. Eligibility is based on the member requiring assistance with two ADL as certified by member's physician. On approval, Anthem will set up an authorization for these services for the requested provider. The authorization is valid for the remainder of the calendar year.

Please note that all of these steps will occur **before** the member has reached out to the requested Personal Home Helper provider.

Once the member has been approved for this benefit, they will be given authorization information in a letter. The Personal Home Helper provider can request the information from the member in order to verify eligibility with Anthem. It is highly recommended that the

Personal Home Helper provider contact the Provider Services department at Anthem to ensure that the authorization has been established properly on behalf of the member.

How is the Personal Home Helper provider contacted for services?

The member will contact the provider directly to schedule services one they have been notified by Anthem that they are approved for services. For LTSS providers, this process may differ. When collecting the member information be sure to get the full member ID beginning with 3 digit alpha prefix along with the numerical authorization #.

Is the provider required to report back to Anthem regarding changes to the member's condition that could affect eligibility?

No. The Personal Home Helper is not required to contact Anthem to report changes in the member's condition that could affect benefit eligibility. Once the medical requirement has been approved by Anthem, the member is eligible for full benefit up until the end of the calendar year so long as they remain an active plan member.

Does the Personal Home Helper provider need to include the authorization number on the claim submission?

The authorization number is not required, however it is helpful to ensure proper processing. Please note, the authorization is required to be on file with Anthem under the provider or organization's NPI for proper payments to be made.

How are claims to be filed?

- The submission of Personal Home Helper claims should follow the same general processes as other claim submissions made to Anthem. For questions on the general submission process, please reference documentation on claims submission or contact your Contract Manager or Provider Relations Representative.
- Providers must use the *UB-04* form and include the following information to ensure the is routed to the appropriate team within Anthem:

- Bill type — O34(plus occurence such as 1st occurence 0341) (Home Health Services not under a plan of Treatment)
  - CPT code:
    - T1019
  - Revenue code — 570
  - Modifier — UD
    - The UD modifier is **essential** as an identifier for Medicare claims. If this modifier is not present, the Anthem claim processing system will deny the claim.
  - **Diagnosis code : DX code R69**

How does this impact other Medicare or Medicaid benefits?

This is a separate benefit from what may be offered under traditional Medicare (home health care) and Medicaid. It is not intended to replace or augment those benefits.