

Everyday Extras — personal home helper

What are Everyday Extras?

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 Texas, Tennessee and New Jersey.

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 four 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 the *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, a BMI less than 18.5 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 eight hours. It also includes transportation to and from the adult day care location. To be eligible, the member must need help with at least two ADL, and a clinician must recommend the benefit. The member must submit a request for reimbursement for a plan-approved, licensed facility. The maximum reimbursement is \$80 per day. Prior authorization is required.
- **Health and fitness tracker** — Members can receive a wearable health and fitness tracker to help them achieve their health goals. Members are eligible for one device every two years. This benefit also comes with access to online programs to improve their physical health and brain skills. These programs include fitness and health coaching, as well as exercises that can improve their attention, memory and navigation abilities.
- **Healthy nutrition** — Members can get up to eight nutritional counseling sessions, plus monthly pantry staples (nonperishable) to help them make changes to their diet that would help a diagnosed chronic medical condition. This benefit is filed under CMS' guidelines for Special Supplemental Benefits for the Chronically Ill (SSBCI). Prior authorization is required.

- **Pest control** — Based on qualifying clinical criteria, members could have their home treated every three months to control pests if an infestation is having a direct impact on a diagnosed chronic medical condition. This benefit is filed under CMS' guidelines for SSBCI. Prior authorization is required.
- **Service dog support** — Members can get up to \$500 per year to help pay for items used to care for their ADA service dog, like leashes or vests. This benefit is filed under CMS' guidelines for SSBCI. Prior authorization is required.

If you are a provider who is also contracted to provide services through a long-term services and supports (LTSS) plan, please see the additional material on the provider website for more information about Essential Extra options for your patients.

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 dictated by the member's health issues.

The help provided under the 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 four hours per day) with a maximum of 31 days in the calendar year. If less than four hours are used, it is still considered a day toward the 31-day maximum. The member has the entire calendar year to fully use 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. Amerigroup plans have contracted directly with providers to supply these services to 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, Amerigroup will be responsible for establishing member eligibility. Eligibility is based on the member requiring assistance with two ADL as certified by the member's physician. On approval, Amerigroup 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 Amerigroup. It is highly recommended that the personal home helper provider contact the Provider Services department at Amerigroup 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 once they have been notified by Amerigroup that they are approved for services. For LTSS providers, this process may differ.

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

No, the personal home helper is not required to contact Amerigroup to report changes in the member's condition that could affect benefit eligibility. Once the medical requirement has been approved by Amerigroup, the member is eligible for full benefits 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 Amerigroup under the provider or organization's NPI for proper payments to be made.

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.

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 Amerigroup. 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 claim is routed to the appropriate team within Amerigroup:
 - Bill type: 034X (Home Health Services not under a plan of Treatment)
 - Revenue code: 570
 - Diagnosis: R69
 - CPT® code: T1019
 - Modifier: UD

- The UD modifier is essential as an identifier for Medicare claims. If this modifier is not present, the Amerigroup claim processing system will deny the claim.

Availity serves as our electronic data interchange (EDI) partner for your electronic claims.

Ways you can exchange EDI transmissions with Availity:

- Use your existing clearinghouse or billing company for your electronic claims. *Please work with them to ensure connectivity to the Availity EDI Gateway.*
- Become a Direct Trading Partner with the Availity EDI Gateway and submit your own electronic claims. Visit <http://www.availity.com> > Register.

Already registered with Availity?

Use your existing login and select My Providers > Enrollments Center.

Payer ID

The Payer ID (26375) must be used for your electronic submissions to Availity.

Contacting Availity

If you have any questions please contact Availity Client Services at 1-800-AVAILITY (1-800-282-4548) Monday-Friday 8 a.m.-7:30 p.m. ET.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at 1-866-805-4589.