Bulletin

February 2, 2010

Requirements for special transportation providers

Participating special transportation providers are reminded that all noninstitutionalized eligible Minnesota Health Care Programs (MHCP) Members must have a signed Physician Certification of Need on file before receiving transportation services, per Article IV.C of the Provider Service Agreement between Blue Plus and the provider. The signed Physician Certification of Need must also be faxed to **(651) 662-7362** before transportation is provided.

Special transportation services trip sheet

Providers must maintain a special transportation services (STS) trip sheet documenting each ride that is provided to eligible MHCP Members. The completed trip sheets must be filed in the provider's office and available for inspection and review by Blue Plus.

Reimbursement

Reimbursement for services will only be allowed, and should only be billed, when the transportation is to or from a covered medical or dental service for an eligible MHCP Member. Some examples of covered medical services are clinic visits, therapies, eye exams, etc. Appropriate modifiers must be used when billing for services. An eligible MHCP Member is defined as a Member who is physically or mentally impaired in a manner that keeps him/her from safely accessing and using common carrier transportation. If an eligible MHCP Member does not meet this definition and is in need of transportation, please refer them to BlueRide at **1-866-340-8648** to arrange for a ride.

Minnesota rule

Per Minnesota Rule 9505.0315 "One-way mileage for special transportation within the recipient's local trade area must not exceed 20 miles for a trip originating in the seven-county metropolitan area or 40 miles for a trip originating outside of the seven-county metropolitan area if a similar health service is available within the mileage limitation." Blue Plus requires that all applicable state and federal laws will be adhered to, per Article III, Section K of the Provider Service Agreement between Blue Plus and the provider.

These provisions, along with all Provider Service Agreement requirements are subject to audit at any time by Blue Plus.

Special transportation providers must submit the ZIP code for the point-of-pickup on all claims. This information should be submitted on an 837P transaction in the 2310D loop. If this information is not submitted, the services will be denied until we receive the correct point-of-pickup ZIP code.

Questions?

If you have questions, please contact provider services at **(651) 662-5200** or toll free at **1-800-262-0820**.

Enclosures which are also available on **providers.bluecrossmn.com**
Special Transporation: Certification Of Need
Special Transportation Services (STS) Trip Sheet

Distribution: All participating special transportation providers
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BlueCross BlueShield
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SPECIAL TRANSPORTATION: *CERTIFICATION OF NEED*

State law prohibits reimbursement of special transportation for Minnesota Health Care Program recipients without a current and approved Certification of Need form signed by the attending physician, nurse practitioner, clinical nurse specialist, or physician assistant working under the delegation of the attending physician.

Today's Date: _____/_____/_____

Blue Plus Member ID Number: _____

Blue Plus Member's Name: _____ **Date of Birth**: _____

Can the member be safely transported without escort by private auto, taxi or bus? ☐ **Yes** ☐ **No**
If yes, member may be eligible to receive transportation to covered **Blue Plus** appointments.

Special Transportation Provider ID Number: _____

Special Transportation Provider Name: _____

Phone Number: _____ **Fax Number**: _____

Special Transportation Provider Address: (If no **Blue Plus** Provider Number is available/known)

_____

_____

City: _____ **State**: _____ **ZIP**: _____

Blue Plus Provider ID Number: _____

Blue Plus Provider Name:_____
(attending physician, nurse practitioner, clinical nurse specialist, or physician assistant)

Diagnosis/ICD-9 Code: _____

Please specify member's physical or mental impairment requiring special transportation
(e.g., functional limitation such as mobility, cognition, etc.)

_____

_____

Check one:
☐ **permanent wheelchair** ☐ **temporary wheelchair** ☐ **ambulatory** ☐ **ambulatory w/assistance** ☐ **stretcher**
permanent impairment/disability: ☐ **Yes** ☐ **No** If no, expected duration of impairment/disability: _____

***First Ride Date**: _____ **End Date**: _____ (*if temporary*)

I certify that I have reviewed this member's Blue Plus history/condition, and that the member meets Minnesota Statute section 256B.0625, subdivision 17(b) criteria that the member has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi or other commercial transportation, or private automobile.

Blue Plus Provider Signature: _____ **Date**: _____/_____/_____

***Note:** Incomplete forms and forms submitted more than 30 days after the member's first ride date will not be accepted.

Submit the completed form prior to the first ride date to Fax Number: 651-662-7362

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Special Transportation Services (STS) Trip Sheet

This form is to be filled out by the driver for each STS trip and kept on file.

STS PROVIDER NAME	DRIVER NAME	STS PROVIDER UMPI

RECIPIENT FULL NAME			MHCP MEMBER ID NUMBER
ACTUAL PICK UP TIME ☐ A M ☐ P M	ACTUAL PICK UP ADDRESS	CITY/STATE/ZIP CODE	
ACTUAL DROP OFF TIME ☐ A M ☐ P M	ACTUAL DROP OFF ADDRESS	CITY/STATE/ZIP CODE	
FACILITY SIGNATURE (I certify that recipient has arrived for a medical appointment.)		TRIP DATE	ACTUAL TRIP MILEAGE

RECIPIENT FULL NAME			MHCP MEMBER ID NUMBER
ACTUAL PICK UP TIME ☐ A M ☐ P M	ACTUAL PICK UP ADDRESS	CITY/STATE/ZIP CODE	
ACTUAL DROP OFF TIME ☐ A M ☐ P M	ACTUAL DROP OFF ADDRESS	CITY/STATE/ZIP CODE	
FACILITY SIGNATURE (I certify that recipient has arrived for a medical appointment.)		TRIP DATE	ACTUAL TRIP MILEAGE

RECIPIENT FULL NAME			MHCP MEMBER ID NUMBER
ACTUAL PICK UP TIME ☐ A M ☐ P M	ACTUAL PICK UP ADDRESS	CITY/STATE/ZIP CODE	
ACTUAL DROP OFF TIME ☐ A M ☐ P M	ACTUAL DROP OFF ADDRESS	CITY/STATE/ZIP CODE	
FACILITY SIGNATURE (I certify that recipient has arrived for a medical appointment.)		TRIP DATE	ACTUAL TRIP MILEAGE

RECIPIENT FULL NAME			MHCP MEMBER ID NUMBER
ACTUAL PICK UP TIME ☐ A M ☐ P M	ACTUAL PICK UP ADDRESS	CITY/STATE/ZIP CODE	
ACTUAL DROP OFF TIME ☐ A M ☐ P M	ACTUAL DROP OFF ADDRESS	CITY/STATE/ZIP CODE	
FACILITY SIGNATURE (I certify that recipient has arrived for a medical appointment.)		TRIP DATE	ACTUAL TRIP MILEAGE

I certify that this tripsheet is an accurate account of the miles I actually drove, on the dates and at the times stated.

DRIVER SIGNATURE	DATE