Q&As – common questions from providers

Transition of the AADL medical surgical and benchmark mobility benefits to Alberta Blue Cross®

LAST UPDATED JANUARY 2023

Is it possible for an authorizer to register for the site without providing payment information?
Yes; payment information is not required. The website form is the only component required to be completed if you will not be submitting claims; we provision the authorizer based on the information provided in this form.

Can multiple users be signed into the system at the same time?
Yes; multiple users can be active in the system at the same time. For example, 2 or more physicians at the same clinic can use the system on their own computers simultaneously.

Is it possible to have a login ID for non-AADL authorizers?
No; only approved authorizers, vendors and specialty assessors can be registered. If approved authorizers would like administrative staff to submit on their behalf, they will need to share their credentials; however, the authorizer is fully responsible for anything submitted under their account.

Is the AADL medical surgical and benchmark mobility separate from vendors currently submitting prescription drugs through the Alberta Blue Cross pharmacy portal?
Yes; the AADL medical surgical and benchmark mobility benefits are separate and require a separate login ID.

Can providers separate payment claims according to location when all claims are paid into the same account?
Yes; to separate claims according to location, providers must simply ensure each location has its own separate login ID. If all locations use a shared login ID, there is no way to separate the records.

Is a client's current AADL status available on the Alberta Blue Cross system?
Yes; the client's current AADL status will be listed, indicating if they are eligible for AADL or if the coverage has ended.

ALBERTA BLUE CROSS®

Is a client's AADL cost-share status available on the Alberta Blue Cross system?

Yes; the client's AADL cost-share status will be listed for the previous, current and future benefit years. For full information on cost-share, please refer to the cost-share section in the applicable AADL policy manual.

We are pleased to offer an enhancement by providing up-to-date cost-share amounts in our predetermination process. This will allow providers to collect specific amounts remaining on the patient's cost share, eliminating the requirement for refund cheques for overcollection.

It will be the provider's responsibility to ensure that they are collecting the correct cost share amount from the client.

Is a client's cost-share status updated from cost share to cost-share exempt when the client has paid the $500 cost-share portion for the benefit period?

The Alberta Blue Cross patient inquiry screen only reflects true, income-based cost-share exempt status, which indicates the client will pay $0 cost share for the full benefit year guaranteed. Vendors can determine if a client has reached the $500 maximum by running a claim predetermination in the Online Health Portal. The predetermination should reflect a $0-cost share if the client has reached the maximum.

Is a client's AADL product consumption history available on the Alberta Blue Cross system?

Yes; the client's product consumption can be viewed by selecting the benefit type, product category and product.

What date is displayed for the anniversary date in the patient consumption history?

The anniversary date is based on the particular product or service selected. It will reflect the first date of the current frequency period when there is history found for the patient.

What are the expected turnaround times for authorization reviews?

Authorizations have been automated to provide real time results whenever possible. If an authorization requires manual review, there is no set turnaround time as it will be determined by the AADL. Although we cannot provide a specific timeframe, Alberta Blue Cross is committed to reducing delays by streamlining the processes.

Is the system able to catch duplicate claims?

Yes; Alberta Blue Cross uses systems to capture duplicate claims and authorizations. It does so by comparing submitted claim dates to existing claim dates in the system.

Is a signed client consent required for each benefit or authorization?

The Client Consent Form is not required for each authorization. It can be signed once and then kept as a copy to be used each time for that client.

Do clients no longer need to sign a 1250 or 1251 form?

For medical surgical and benchmark mobility benefits transitioning over this phase, the 1250 and 1251 forms will no longer be required.

What happens when a client switches to a new provider without notifying their old provider?

If a client switches to a new provider without notifying their previous provider, it may cause some confusion. Provider switches will require the collaboration of the patient, the old provider and the new provider to ensure that patient care is not affected.

How can a provider submit a change of vendor form?

Authorizations are not attached to the vendor and, therefore, a change of vendor form is no longer required. The client can select their vendor and the vendor can view their authorization in the reporting section of the Online Health Portal.

Will authorizers and vendors have the same communication pathways?

Authorizers and vendors will have the same communication pathways as they did before the transition. The transition involves changing the submission method of authorizations and claim requests and will not impact communication pathways.

Are Quantity Frequency Reviews requested through the provider portal?

Yes; these requests are submitted through the portal. Please note that fully completed Quantity Frequency Review forms are required documents that are to be uploaded with the request.

Can authorizations be backdated?

Backdating is no longer being completed.

Can products be terminated from an authorization if no longer required without terminating the entire authorization?

Yes, termination dates can be attached to the specific product. The date would be added to that product and the rest remains active.

Are claims adjudicated to the specific quantity and product requested in the authorization?

Yes, claims are adjudicated against the specific quantify and product that are approved in the authorization. If a product is not authorized, the claim will be ineligible. If the claim exceeds the authorized quantity, the claim will cut back to the allowable amount.

Will provider specialists who are allowed to prescribe over the posted APL amounts be able to select the higher amounts?

Yes, the system will adjudicate against provider classes to ensure they are eligible.