



ANCILLARY  
CARE  
SERVICES

# Provider Manual

Electronic version available at [www.anci-care.com](http://www.anci-care.com)

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# ANCILLARY CARE SERVICES

## Vision & Mission Statements

### Vision Statement

ACS will be an innovative leader committed to value creation within the ancillary healthcare industry. As a knowledgeable, trusted and responsive partner to our stakeholders, we will conduct ourselves with integrity and professionalism.

### Mission Statement

We are a knowledgeable and innovative partner with our clients. We deliver the most comprehensive, cost effective ancillary care services within the healthcare industry.

We are a valued, responsive partner with our providers. We are committed to delivering increased market share through expanded access to payors while reducing the providers' administrative costs through our innovative services.

We are committed to creating a culture that is a professional, rewarding environment for our employees. We create a dynamic, innovative team atmosphere where every employee is valued and respected for their contribution.

We are a growth company creating value for our shareholders.

We are committed to acting with integrity and always doing the right thing.

We will be best in class in all that we do.

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# WELCOME TO Ancillary Care Services!

Ancillary Care Services (ACS) is delighted to welcome you as a Participating Provider in the ACS national networks. Our clients include over **600 payor organizations** representing 1.1 million lives throughout the United States. For a complete listing of ACS clients, please visit our website at [www.anci-care.com](http://www.anci-care.com).

## ACS establishes our provider relationships upon:

**UNDERSTANDING** of your mission to deliver quality healthcare

**COMMITMENT** to increasing your administrative efficiency

**VALUE** delivered by leveraging over 46,900 sites to 600+ payors

Your organization will benefit from its relationship with ACS in the following specific ways:

- **Services at no cost** - ACS provides all of its administrative services at no cost to our Providers.
- **Administrative Support** - ACS employs a large staff of collection professionals who will aggressively pursue payment for your claims. We initiate claims appeals and handle dispute resolution matters on your behalf.
- **Higher productivity** - Because ACS consolidates and simplifies the administrative work associated with regional carriers, third party administrators and PPO contract relationships, your staff will spend less time on costly and time-consuming administrative tasks.
- **Shorter reimbursement cycles** - ACS is different from other networks because we are paid only if our Participating Providers are paid. This means ACS will work much harder to ensure your claims are paid promptly.
- **Electronic payment** and remittance advice functionality through "InstaMed".
- **Comprehensive Access** – to five distinct lines of business through a single agreement.

ACS is committed to a long-term, mutually beneficial business relationship with you and will work closely with your team to insure that your experience with our organization is a positive one.

**Once again, welcome to ACS!**

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# INTRODUCTION

## Definition of Our Business

Ancillary Care Services provides ancillary healthcare services that offer cost effective alternatives to physician and hospital-based services to our client base. The ancillary service market is estimated at \$574 billion, or 30% of total national health expenditures. Our providers offer services in over 32 specialty categories, including laboratories, dialysis centers, free-standing diagnostic imaging centers, ambulatory surgery centers, sleep centers as well as durable medical equipment, and many others.

ACS is the first national, publicly traded ancillary care network. ACS offers an array of national provider networks comprised of over 46,900 ancillary provider locations. The ACS network provides a complete outsourced solution for a wide variety of healthcare payors and plan sponsors including self-insured employers, indemnity insurers, PPOs, and, third party administrators. For additional information, please visit [www.anci-care.com](http://www.anci-care.com).

## Components of Our Success

- Efficient infrastructure
- Highly qualified staff
- Credentialed providers
- Ancillary services across 32 specialty service categories
- Competitive pricing
- Strong geographical access
- Broad product portfolio
- Excellent customer service
- Advanced technological capabilities
- Streamlined administrative and operational efficiencies

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# HealthSmart & ACS Relationship

For nearly 10 years HealthSmart used ACS as an ancillary network solution for its clients. In October 2014, ACS and HealthSmart announced a strategic change to its partnership.

ACS and HealthSmart entered into a management agreement in which HealthSmart provided oversight and leadership of ACS's day-to-day network operations. In June 2016, HealthSmart entered into an Asset Purchase Agreement with American CareSource Holdings, Inc. (which was subsequently assigned to HealthSmart Preferred Care II, L.P. prior to closing). In December 2016, this agreement was finalized.

The ACS office moved to HealthSmart's Headquarters in Irving Texas.

You will call the same toll free numbers for service inquiries. Your claims will be submitted as per usual and will continue to be re-priced in accordance to the ACS Provider Agreements. Email addresses will not change.

This new agreement will result in access to additional HealthSmart Benefit Solutions members and additional lines of business.

ACS and HealthSmart thanks you for your support.

# CONTACT INFORMATION

## ACS Corporate

**Address** HealthSmart Preferred Care II, LP d/b/a  
Ancillary Care Services (ACS)  
222 W. Las Colinas Blvd., Suite 500N  
Irving, TX 75039

**Telephone** 972-388-3115 (Main)  
844-516-3335 (Toll Free)

**Fax** 806-473-3228

## Credentialing Department

**Telephone** 844-516-3335 Option 4 then Select Option 2

**Fax** 806-473-3228

**email** [acs.credentialing@healthsmart.com](mailto:acs.credentialing@healthsmart.com)

## ACS Customer Service Center

**Telephone** 844-516-3335 Option 4 then Select Option 3

**Fax** 806-473-3228

**email** [customerservice@anci-care.com](mailto:customerservice@anci-care.com)

**Website** [www.anci-care.com](http://www.anci-care.com)

**Provider Account Management** [VIPproviders@anci-care.com](mailto:VIPproviders@anci-care.com)

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# ACS NETWORK SERVICE CATEGORIES

- **Acupuncture**
- **Behavioral Health**
- **Cardiac Monitoring**
- **Chiropractic**
- **Diagnostic Imaging**
  - CT Scan
  - Mammography
  - MRI
  - Open Bore MRI
  - Open MRI
  - Other Services
  - P.E.T.
- **Dialysis**
- **Durable Medical Equipment – General**
  - Burn Garments
  - CPM
  - Diabetic Supplies
  - Hospital Beds and Accessories
  - Infusion Pumps and Supplies
  - Ostomy Supplies
  - Other
  - Oxygen and Respiratory Equipment
  - TENS, Bone Stimulators
  - Wound Care Equipment & Supplies
- **Endoscopy**
- **Genetic Testing**
- **Hearing Aids**

- **Hospice**
- **Infusion Services**
- **Lab**
- **Lithotripsy**
- **Long Term Acute Care**
- **Massage Therapy**
- **Occupational Therapy**
- **Orthotics & Prosthetics**
- **Pain Management**
- **Physical Therapy**
- **Podiatry**
- **Rehabilitation**
  - Aquatic Therapy
  - Equipment – Custom
  - Inpatient and Outpatient
  - Physical, Occupational, Speech
  - Respiratory
- **Skilled Nursing Facilities**
- **Sleep Diagnostic**
- **Specialty Pharmacy**
- **Speech Therapy**
- **Surgery Center**
- **Transportation**
- **Urgent Care Center**
- **Vision**
- **Walk In Clinic**



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# CREDENTIALING

The purpose of the ACS credentialing process is to ensure that ACS participating providers meet and/or exceed established credentialing and recredentialing criteria for participation.

## Recredentialing Procedure

All participating providers for ACS must undergo re-credentialing every three (3) years or whenever an investigation is initiated for any reason. The recredentialing process verifies and ensures continued compliance with ACS's established credentialing criteria. Approval of the updated credentials of these providers by an ACS or an ACS approved credentialing program is a prerequisite for continuing participation in the ACS network. After a recredentialing decision has been made, the provider will have the right to appeal that decision, if desired. The recredentialing process will be completed within thirty (30) days from receipt of a completed recredentialing application/form. Incomplete recredentialing applications/forms will not be processed and will be returned to the provider for completion.

## Recredentialing Process

1. All providers are required to be re-credentialed every three (3) years. All providers will be targeted for review 90 days prior to the three (3) year anniversary of the contract effective date.
2. Providers due for re-credentialing will receive a new ACS Provider Application/Profile form and be requested to update copies of licenses, evidence of insurance coverage, etc.
3. Providers may complete the ACS Provider Application or go online to complete the process. Please visit our website at [www.anci-care.com](http://www.anci-care.com).
4. If any portion of the application/profile is not completed, a letter is forwarded or a phone call made to the provider indicating the application is incomplete and requesting the applicable forms be completed and returned to ACS.
5. Upon collection of pertinent data, the provider file will be reviewed for completion and adherence to the credentialing criteria. All provider records must meet the approval of the Credentials Committee.
6. Upon approval, the provider will maintain active status for ACS and its clients.
7. Any provider not satisfactorily meeting the minimum credentialing requirements will be notified of their termination from the ACS network within 10 days of the decision by the credentialing committee. The termination date will be based upon the terms of the contract.

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# PROVIDER DATA UPDATES

## **Changes and Additions of Providers, Facilities and Locations:**

This process applies to sites added through an existing Provider Agreement, as well as address or other demographic changes regarding facility and/or billing addresses.

The information contained in our provider database is shared with clients and is displayed in provider directories and on our website. This is the best way to share your organization's locations to the members we represent. In order to make sure that our clients have access to the most current information, we ask that multiple site providers update us routinely. Provider demographic updates can be done easily using our secured provider portal at [www.ancillarycare.com](http://www.ancillarycare.com). Site additions and changes can also be submitted to ACS via regular mail, email or fax. ACS updates its system within days of receiving documentation from the provider. If the Tax ID number is new or just changing you will also need to submit a copy of the new W-9 with all updated documentation.

We can coordinate monthly or quarterly updates where appropriate for larger organizations, using an Excel format (format requirements displayed on the following page).

## **Terminations of Sites and/or Providers:**

All provider or site terminations require a written notice from the provider on the provider practice letterhead. Your written notice can be submitted to ACS via mail, email or fax, and will be processed according to your ACS Provider Agreement. For those providers submitting routine Excel updates, there are columns for Termination Date and Reason.

If a site or office has closed the termination will be processed upon receipt of your notice.

# PROVIDER DATA FILE SPECIFICATIONS

Field Name	Field Description	Required?	Max-Length	Comments
<b>Change, Add, Terminate (CAT) Indicator (if no change leave blank)</b>	<b>Change, Add, Terminate indicator</b>	<b>Yes</b>	<b>1</b>	<b>C</b> = change to any information in an established record.
				<b>A</b> = any new added record. An effective date is required to be populated on network contracts for all additions.
				<b>T</b> = a terminated record. A termination date is always required on a terminated record.
<b>CAT EffectiveDate</b>	Facility open date or acquisition date	Yes	10	MM/DD/YYYY
<b>Term Date</b>	Termination date of facility	Yes	10	MM/DD/YYYY
<b>Term Reason</b>	Termination Reason	Yes		Examples: Closed, Out of Business, Moved, Insurance, License, Credentialing, Provider Requested
<b>ProviderID#</b>	Provider Identification	Condition	10	Required if available
<b>TaxId</b>	Tax ID	Yes	9	Example : 205498481 (Must have Nine Characters - No Dashes Please)
<b>NPI</b>	NPI #	Yes	10	National Plan Identifier - Required if available
<b>Facility/Provider Name</b>	Facility/Provider Name	Yes	60	Facility Name (Exactly match legal name or where provided the DBA on W9)
<b>FacilityAddress</b>	Facility Address	Yes	35	
<b>FacilityCity</b>	Facility City	Yes	35	
<b>FacilityState</b>	Facility State	Yes	2	
<b>FacilityZip</b>	Facility Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
<b>Contact Name</b>	Facility Contact	Yes	30	Put "General" as default if not populated.
<b>FacilityPhone</b>	Facility Phone	Yes	12	Example 972-308-6888
<b>FacilityFax</b>	Facility Fax	Optional	12	Example 972-308-6888
<b>FacilityEmail</b>				Primary Contact email address
<b>FacilityWeb</b>		Optional		Facility website address (www. .com/.net/.org)
<b>Medicare ID</b>	Medicare ID	Optional	50	
<b>Medicaid ID</b>	Medicaid ID	Optional	50	
<b>DEA</b>	DEA Number	Optional	50	
<b>LicenseNo</b>	License Number	Optional	50	
<b>JCAHO</b>	JCAHO Number	Optional	50	
<b>BillingName</b>	Billing Provider Name			Match Facility Name (Exactly match legal name or where provided the DBA on W9)

<b>BillingAddress</b>	Billing Address 1	Yes	35	If not populated, copy address from Parent
<b>BillingCity</b>	Billing City	Yes	35	If not populated, copy City from Parent
<b>BillingState</b>	Billing State	Yes	2	If not populated, copy State from Parent
<b>BillingZip</b>	Billing Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
<b>Billing Contact Name</b>	Billing Contact	Yes	30	Put "General" as default if not populated.
<b>BillingPhone</b>	Billing Phone	Yes	12	Example 972-308-6888
<b>BillingFax</b>	Billing Fax	Optional	12	Example 972-308-6888
<b>BillingEmail</b>				Primary Billing Contact email address
<b>BillingWeb</b>				Billing website address (www. .com/.net/.org)
<b>CorporateAddress</b>	Corporate Address	Yes	35	If not populated, copy address from Parent
<b>CorporateCity</b>	Corporate City	Yes	35	If not populated, copy City from Parent
<b>CorporateState</b>	Corporate State	Yes	2	If not populated, copy State from Parent
<b>CorporateZip</b>	Corporate Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
<b>Corporate Contact Name</b>	Corporate Contact	Yes	30	Put "General" as default if not populated.
<b>CorporatePhone</b>	Corporate Phone	Yes	12	Example 972-308-6888
<b>CorporateFax</b>	Corporate Fax	Optional	12	Example 972-308-6888
<b>CorporateEmail</b>	Corporate Contact email address			Corporate Contact email address
<b>CorporateWeb</b>				Corporate website address (www. .com/.net/.org)

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# BILLING AND COLLECTION PROCEDURES

Ancillary Care Services is committed to prompt and accurate claims payment. In order to achieve this result, we rely on providers to submit accurate claims.

Providers must submit original claims to the claims address listed on the back of the patient's insurance card according to your normal process (paper or electronic). **ACS requires that claims be billed using usual and customary charges.** We cannot price claims that are submitted with charges matching the contracted amount. Upon receipt of those claims from ACS providers the ACS Clients and their Payors immediately forward them to ACS electronically for processing.

At this time, the ACS TIN and address are added to the claims as the "Pay To" entity, as a billing service would be, and the discounted re-priced amount is calculated for the claim. **Most claims are re-priced and sent back to the Payor within minutes of ACS receiving them.** Claims that require review by our Quality Assurance Department are turned around on average within 24 hours of receiving them. After ACS has completed this process, your claims are returned to the Payor for adjudication.

**ACS begins the collections process immediately upon submission of your claim to our client.** We have Claims Resolution Specialists assigned to each payor, and they have an aggressive follow-up schedule that is customized for each account (based on their average payment time, complexity of adjudication, etc.). These staff members are familiar with the requirements for each Payor, and they act on your behalf and treat every claim as if it were their own. Remember – since there is no fee to participate in the network, ACS does NOT get paid unless we get your claims paid. If additional information is required in order to receive payment, they will contact your office via phone and/or mail (EOP).

All payments and EOBs for your claims are sent to ACS. These payments and denials are posted to our claim record, and go through a variety of edits to determine if it was paid accurately and according to the terms of its contract with the payor. **ACS will send you an Explanation of Payment (EOP) that details each payment or denial, reflecting all patient responsibility and non-covered services EXACTLY as determined by the Payor.**

If any claims are improperly paid or require appeal, ACS will begin the appeals process on behalf of the Provider.

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# PAYMENT CALCULATION EXAMPLE

Payments are calculated for each line item charge as follows:

	<b>Example</b>
Provider's ACS Negotiated Rate for line item	200.00
Less Patient Responsibility	-50.00
Less Non-covered items	00.00
Less Coordination of Benefits (primary insurance payment)	00.00
Total Payment to Provider	<u>150.00</u>
Collect from Patient	50.00

Although it does not occur often, there are times when no payment will be made. If any combination of the patient responsibility, non-covered services (not including the network discount), or COB add up to more than the ACS Contracted Amount, no payment is made.

Per contract, if at any time the patients' responsibility is more than the ACS Contract Amount for a service, the patient is only to be billed the Contract Amount. This situation is usually seen during the first part of the year when we see deductibles applied.

	<b>Example</b>
Billed Charge	300.00
Provider's ACS Contract Amount for line item	200.00
Patient Responsibility (per Payor)	<u>300.00</u>
Bill Patient	200.00

In this example, although the entire billed amount was applied to Patient Responsibility, the patient would be billed \$200 which is the ACS contract amount and the claim would be considered paid in full. The EOP will show the following remark code:

*122 – Patient responsibility is posted as adjudicated by the payor. However, per your contract with ACS, the patient cannot be billed for any balance above your contracted rate. Any difference should be posted to contractual allowance.*

# UNDERSTANDING YOUR EOP



**ANCILLARY  
CARE  
SERVICES**

COMPANY NAME  
PO BOX 141669  
  
DALLAS, TX 75240

**Ancillary Care Services, Inc.**  
222 W. Las Colinas Blvd.  
Suite 500N  
Irving, TX 75039

## EXPLANATION OF PAYMENT—FOR PROVIDER

CHECK DATE	: 10/12/2009
CHECK NUMBER	: 110094
CHECK AMOUNT	: \$114.18

1

### DISCLAIMER

2

This Explanation of Payment reflects payments and benefit determinations received by ACS as a result of your membership in the Ancillary Care Services Network. All patient responsibility and other benefit determinations have been made by the member's plan administrator and are reflected here exactly as they are on the member's original EOB. Payment is based on your contract fee schedule with ACS, less non-covered services, coordination of benefits and the portion due by the patient.

Contact the Anc-Care Service Center at 800-370-5594 with any questions. 3

Patient Name : JOHN DOE 4	Insured Name : JOHN DOE 5	Client : HealthMarkets 6
Patient Account: 123456789-1	Insured ID : 123456789	Payor : Mega Life and Health Insurance 7

Line	Date of Service	CPT Code	Billed Amount 8	ACS Contract Rate 9	Non Covered 10	Remark Reason Code 11	Patient Responsibility 12				COB 13	Payment 14
							Ded	CoPay	Coins	NonCov		
1	09/16/2009 - 09/16/2009	80090	\$171.67	\$85.84	\$175.42	C119	\$0.00	\$25.00	\$0.00	\$3.75	\$0.00	\$114.18
2	09/16/2009 - 09/16/2009	80061	\$42.08	\$14.96	\$58.93	C119 122	\$0.00	\$0.00	\$0.00	\$16.97	\$0.00	\$0.00
3	09/16/2009 - 09/16/2009	84153	\$118.75	\$27.78	\$150.01	C119 122	\$0.00	\$0.00	\$0.00	\$31.26	\$0.00	\$0.00
4	09/16/2009 - 09/16/2009	96403	\$227.25	\$39.00	\$271.13	C119 122	\$0.00	\$0.00	\$0.00	\$43.90	\$0.00	\$0.00
TOTALS			\$589.75	\$167.60	\$656.40		\$0.00	\$25.00	\$0.00	\$96.74	\$0.00	\$114.18

### Remark/Reason Code 15

Status	Description
C119	Benefit maximum for this time period or occurrence has been reached.
122	The contract amount is the result of being a member of the ACS network. The patient is not responsible for any balance above the contract rate. Any difference in the allowable currently reflected and your ACS contract rate should be posted to contractual allowance.

### Information Key

1. Check information: A. Check number and total amount will show if the EOP is accompanying a check. B. Check number and total amount will show a 0.00 if the EOP results in 0.00 payments.
2. ACS disclaimer—due to the unique work flow of our business model, it is often confusing to the business office personnel as to why our EOP may be different from the original EOB sent to the member by the payor. This section gives an explanation and should help with understanding how to post any differences, should they occur.
3. Anc-Care Service Center toll free contact number—live customer advocates are available for clarification or questions 8am to 5pm CST.
4. Patient Name and Account number, as it appears on your claim.
5. Insured Name and ID, as it appears on your claim.
6. Client—the payor, TPA, or PPO network that we work with to process your claims.
7. Payor—the actual payor/adjudicator of the claims.
8. Billed Amount—"Charges" from your original claim (box 24F).
9. ACS Contract Rate—for each procedure line, this will reflect the fee schedule rate or calculated rate based on your contract with ACS. \*This is not the amount allowed by the payor, as it is based solely on your contract terms.
10. Non-covered—the amount of charges that the payor determines are non-covered services or are disallowed, and you are not allowed to pass these charges on to the patient.
11. Remark/Reason Code—The HIPAA standard code assigned to the reason for the non-covered determination. \*Detailed description can be found in #15.
12. Patient Responsibility—breakdown of the payor adjudication and determination of charges that can be billed to the patient, including Deductible, Co-Pay, Coinsurance, and Non-Covered services.
13. COB—Coordination of Benefits—the amount that you received from a primary insurance carrier. \*This amount is subtracted from your ACS contract rate to calculate your payment.
14. Payment—the calculated amount for each line item that you are receiving from ACS (contract rate less patient responsibilities, non-covered charges, and COB).
15. Remark/Reason Code explanations—these refer back to #11.

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# ACS's CLAIMS FLOW PROCESS (TPA's)

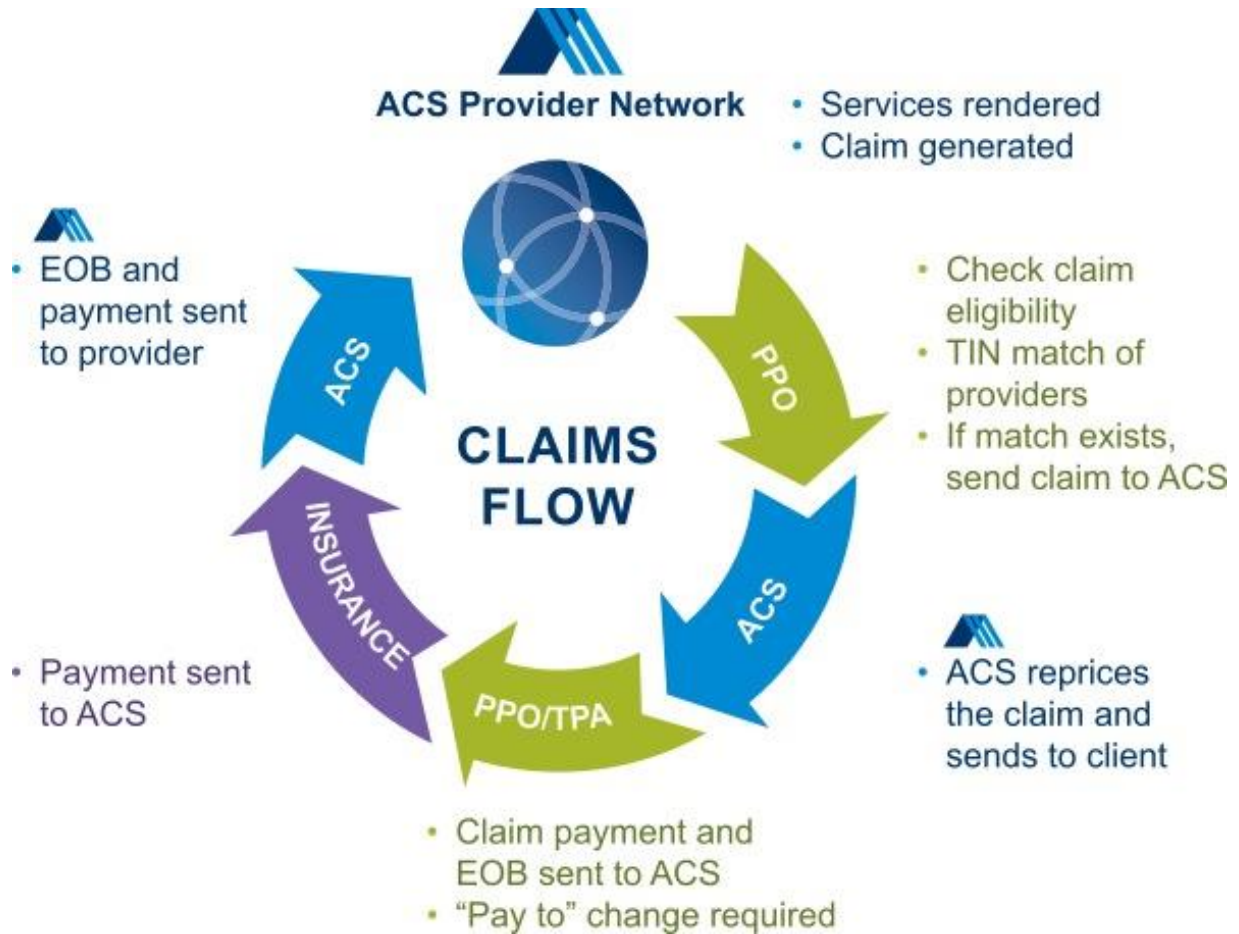


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The ACS Customer Service and Operations team manages all aspects of the claim flow process, including claim status look-up, dispute resolution and appeals management. ACS also offers electronic payment and remittance advice functionality through the InstaMed EFT program.



# ACS's CLAIMS FLOW PROCESS (PPO's)



The ACS Customer Service and Operations team manages all aspects of the claim flow process, including claim status look-up, dispute resolution and appeals management. ACS also offers electronic payment and remittance advice functionality through the InstaMed EFT program.

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# PROVIDER APPEAL PROCESS

Providers may access an appeal process if they disagree with the payment of services and/or explanation of benefits received. An appeal is warranted when there is a dispute between the health care provider and ACS for reason(s) including, but not limited to: contractual issues, timely filing, authorization, and notification of payment issues. Providers will not be penalized for filing an appeal, and there is no action required by the member in order to initiate an appeal. ACS will initiate the appeals process before you receive your payment if we note a discrepancy.

The provider may file an appeal up to 180 days after the paid date of the Explanation of Payment (EOP) by submitting a written request for review with a copy of the claim, the EOP, and any appropriate supporting documentation. Appeals should be mailed or faxed to:

**HealthSmart Preferred Care II, LP d/b/a Ancillary Care Services (ACS)**  
**Attn: Appeals**  
**222 W. Las Colinas Blvd., Suite 500N**  
**Irving, Texas 75039**  
**FAX: 806-473-3228**

The request will be reviewed to determine the appropriate action. If necessary, ACS will appeal the claim with the payor on behalf of the provider. If ACS or the payor need additional information, a letter will be sent to the provider within 15 days of receipt of the original appeal.

A determination letter will be sent to the provider upon receipt of complete appeal information. ACS must abide by the payor guidelines. Therefore, all benefit information will be furnished by the payor, and ACS will provide this information to the provider. The response will include the following information:

- Provider's name and Tax ID#
- Patient name and ID#
- Dates of service
- Written description of concern
- Determination

Each member's plan may have other voluntary alternative dispute resolution options. If a provider is dissatisfied with the appeal resolution (as furnished by payer), additional appeals may be filed as are allowed by the member's group. This should be a written appeal and should be submitted within 30 days of receipt of the first level determination letter.

If a provider is dissatisfied with an appeal resolution that deals strictly with ACS contractual obligations, a Second Level administrative appeal can be filed. This should be a written appeal and should be submitted within 30 days of receipt of the first level determination letter. The request will be reviewed jointly by the Operations and Provider Development areas and a determination letter will be mailed within 30 days.

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# PRODUCT DESCRIPTIONS

The lines of business supported by ACS extend your reach to markets and product segments otherwise difficult to penetrate and manage.

**Primary network:** The ACS primary group health network includes access to national & regional PPO networks as well as over 600 TPA payors and employer groups across the nation. ACS providers are given in-network status and paid in accordance with the highest benefit levels.

**Secondary network:** ACS's national secondary preferred provider network is used by the nation's 2<sup>nd</sup> largest network today. Providers are advantaged by holding a contract with ACS, especially when they are considered out-of-network by the payor. It provides predictability in revenue and improves DSO metrics. ACS Providers will be paid directly from the payor and there is absolutely **no Silent PPO activity!**

**Worker's Compensation:** ACS has a national network of providers with unparalleled specialty depth. ACS continues to expand our national network to better serve our client needs. The ACS worker's compensation clients use prospective, concurrent & retrospective delivery models.

**Auto liability network:** ACS connects its clients and their members with providers treating trauma-related injuries and post-trauma medical needs with maximum cost efficiency. ACS Providers will be paid directly from the payor for these patients.

ACS enables providers to further their mission by simplifying contracting and revenue cycle management for the mid-market payor segment.  
[www.anci-care.com](http://www.anci-care.com)

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# FREQUENTLY ASKED QUESTIONS

## **When did our Provider Agreement become effective with Ancillary Care Services (ACS)?**

The effective date is the day you are approved by the ACS Credentialing Committee. The Credentialing Committee meeting is scheduled the last Thursday of every month. You will receive a welcome packet from ACS that indicates your acceptance by the Committee and identifies your effective date.

## **How do I get a copy of my Provider Agreement with ACS?**

You may request a copy of your Agreement in writing on your practice letterhead that can be faxed, mailed or emailed to [providerrelations@anci-care.com](mailto:providerrelations@anci-care.com).

## **How does ACS get our claims/bills?**

Ancillary Care Services provides a download of all of our contracted providers to each of clients on a frequent basis. IF you are contracted with ACS, you are considered in-network by our clients. When the clients receive claims from an ACS Provider they automatically forward the claim to ACS for re-pricing. ACS re-prices the claims in accordance with your Provider Agreement and your re-priced claims are returned to the client and or payor within minutes of receiving them.

## **Do we send claims directly to ACS?**

All claims should be submitted in accordance with the instructions found on the patient's identification card.

## **How do we handle claim issues prior to the ACS contract becoming effective?**

Please contact the payor directly for any claims issues that took place before you became effective with Ancillary Care Services.

## **Why does ACS receive payments from its clients?**

We contract with PPO's, TPA's and Payors directly so you don't have to. Our clients pay ACS and we pay the provider according to their ACS contract. Ancillary Care Services has a dedicated collection team that starts calling on the claims immediately after billing on behalf of the provider. We also re-bill any claims not received and do appeals on behalf of the provider.

## **Who do we call for claims status?**

Please call our Service Center at 844-516-3335 select option 4, then option 3, and one of Service Center Advocates will assist you.

## **Where do we send additional claims information requested for pended claims?**

Send additional information request to the attention of the Appeals Department via Fax at 806-473-3228. However, for a substantial amount of paperwork please mail to ACS at 222 W. Las Colinas Blvd., Suite 500N, Irving, TX 75039, Attention: Appeals Department. You can also attaché this data electronically using the secured provider portal at [www.anci-care.com](http://www.anci-care.com).

## **What is the average turnaround time for claims to be re-priced and processed through Ancillary Care Services?**

The average turnaround time for re-pricing claims is less than 24 hours from the time the claim is received. Over 85% of all claims are re-priced and sent back to the payor within minutes. ACS begins calling on the claim two weeks from the time it is billed. The average time it takes for the provider to be paid from the date it submitted its claim to our clients is 30 days.

**How long should I wait to check the status of an appeal?**

Please allow 30 days for the appeal to be submitted to the payor and reprocessed before calling ACS for status.

**How frequently does ACS re-credential their Providers?**

Providers are re-credentialed every 3 (three) years. A profile is submitted to the providers to be updated along with a request of all current documents; license, certification, and insurance certificate. These items are verified through the Licensing Boards, the National Practitioner Databank and Certifications Boards to ensure the quality of the Credentialing Standards. You may re-credential with ACS using the secured provider portal at [www.anci-care.com](http://www.anci-care.com)

**What is the process to update my information?**

All updates are forwarded to the Provider Relations Department via fax to (214) 614-4307 or you can email to [providerrelations@anci-care.com](mailto:providerrelations@anci-care.com). All updates are processed within 2-5 business days. You may also update your demographics on our secured provider portal at [www.anci-care.com](http://www.anci-care.com).

**How can I obtain an approved ACS Payor list?**

Please visit [www.anci-care.com](http://www.anci-care.com) and log into the secured provider portal or simply contact us at 844-516-3335, select option 4.

**Why should I enroll with InstaMed?**

By enrolling with InstaMed ACS can provide you with enhanced EFT and ERA tracking and reporting. InstaMed and ACS are continuously enrolling providers on a national level. You must be registered with InstaMed in order to receive your electronic fund transfers appropriately. HIPAA guidelines have established how a 'Standard Transaction' is defined as an 'electronic' transmission. Therefore, Payers can now be required to supply Providers with encrypted claims remittance advice, and electronic payments. **You can enroll by visiting [www.anci-care.com](http://www.anci-care.com) and clicking "Go Now" under the Electronic Payment icon on the home page.**