Home Health Agency FAQ

Blue Cross® Blue Shield® of Michigan and Blue Care Network Medicare Advantage

The purpose of this document is to address the most frequently asked questions regarding **tango's operational management**. It aims to provide clear and consistent information about key processes, responsibilities, and workflows that support tango's daily operations. By consolidating this information in one place, the document serves as a reference guide for team members and stakeholders to ensure alignment, efficiency, and transparency across all operational activities.

General Information

Who is tango?

- tango is the largest independent, risk-bearing, post-acute benefit management solution in today's marketplace. tango goes beyond traditional utilization management to improve access to care and deliver better patient outcomes.

What does tango manage?

- tango manages skilled home health referrals by placing referrals with high-quality providers, performing utilization management, and processing claims. tango also delivers performance-based analytics to its provider network and, in some markets, offers value-based incentives to drive quality outcomes and optimize the network.

Which Blue Cross Blue Shield of Michigan and Blue Care Network members require authorization through tango?

- Home health care providers must submit authorization requests for Medicare Plus Blue℠ and BCN Advantage℠ members
- When submitting authorization and re-authorization requests, tango's provider portal, ProNet Connect, alerts providers to authorization steps for the applicable member.

ProNet Connect & dina

What is ProNet Connect?

- This is our authorization portal for processing authorizations requests, which allows providers to track authorization status. It includes single sign-on access to our referral management platform, dina.

What if ProNet Connect is down?

- Visit the tango upload center at: https://tangocare.com/upload/.
- Choose the option that best suits the submission or request type.

What is dina?

- dina is tango's referral management platform, which allows referrals to flow seamlessly to home health agencies so they can review, accept, evaluate, or decline them. **This platform is used exclusively by tango's home health provider network.**

Do upstream referral sources submit referrals to tango through dina or ProNet Connect?

- No. Upstream referral sources do not use dina or ProNet Connect. Those tools are for home health agencies only.

Will the patient have freedom of choice for their home care provider?

- Yes, referral sources can add the patient's preferred agency when submitting the referral to tango.

How is tango educating upstream referral sources, like physician offices, acute care providers and SNFs?

- tango has a dedicated team to educate upstream referral sources. If the agency would like more information, such as a list of acute care and post-acute care facilities with which tango is actively engaged, email providerrelations@tangocare.com.

How does tango know my service area to receive referrals?

- Every agency is required to submit a service area document during the contracting process.
- If an agency's service area changes, the agency must submit an updated provider service area document to its assigned Provider Relations representative.

How are agencies notified of new referrals?

- Agencies receive notification via email or text message (if enrolled in text notifications) when they have been selected for a referral. If you need assistance enrolling in text notifications, please email providerrelations@tangocare.com or submit a FreshDesk ticket.

How quickly must agencies respond to referrals?

- Preferred agencies have 2 business hours to accept/decline referrals. Non-preferred agencies are expected to accept or decline referrals within 1 hour of receipt to remain competitive for placement.

We received a few referrals from tango but none of them were placed with us and now we have stopped getting referrals. Why is that?

- Clicking accept on the referral does not guarantee that you will be the provider selected. tango distributes referrals to agencies based on areas of coverage, so there may have been fewer referrals in your area recently.

What happens after an agency accepts a referral and is the selected provider?

- If your agency accepts a referral, you must wait until you are selected for the referral before initiating care for the member.
- If your agency is selected for the referral, the status will change from "accepted" to "provider selected" and the authorization will be available in ProNet Connect under your location and in dina.
- Agencies must accept or decline referrals within one hour of normal business hours. If an action is not taken, it will be considered abandoned and can negatively impact your quality score.
- After the agency has completed their SOC visit, please access dina and select one of the following within 5 business days:
    - **Admit** — confirming the actual SOC date.
    - **Not Admit** — if the member did not admit to your agency. Use the drop-down list to indicate why the member did not admit to your agency.

What happens if the hospital does not realize that the patient was already receiving home health services and sends an unattached referral to tango upon discharge?

- The tango intake team will see that the patient already has an open home health care authorization and will send the referral to that agency. The agency will then need to confirm whether they want to perform a Resumption of Care, or ROC.

Authorization Process

How is a Prior Authorization (PA) / New Start of Care (SOC) submitted?

- Referrals should be submitted by the acute facility to tango on October 1, 2026 using the referring facilities discharge planning tool, through https://referralrequest.com/, or via fax at 877-612-7066.
    - A grace period is in effect through **September 30, 2026**, during which agencies may continue submitting prior authorization requests directly to tango while acute care upstream referral sources are being onboarded.
- Agencies may continue to submit post-acute facility and community referrals to tango via the Prior Authorization process until further notice.
- Home health agencies can submit prior authorization requests via tango's provider portal, **ProNet Connect**, by selecting the "Create Prior Auth" button.
- Agencies have up to **five (5) calendar days from the start of care** to submit prior authorization requests
- Home health agencies that do not have access to tango's provider portal must submit authorization requests through tango's website.
    - Prior authorization: https://tangocare.com/upload/referral-auth-upload/

What is the purpose of the grace period during the transition to the new prior authorization workflow?

- The grace period is designed to ensure a smooth transition and prevent any delays in patient care.
- During this time, home health agencies may continue accepting direct referrals and initiating the prior authorization process themselves.
- This approach allows tango's onboarding team to continue educating upstream providers about the new workflow.
- Once most referral sources are familiar and comfortable with the new submission process, they will be required to submit prior authorization requests directly to tango.

Prior Authorization Retroactive Authorization

- tango considers requests that are submitted after the five-day submission window to be **retroactive authorization requests**.
- Retroactive requests should be submitted only for exception cases.
    - Examples of exception cases are:
        - A member's insurance changed during an active episode
        - The member failed to provide the correct insurance information in a timely manner
- Agencies can submit retroactive prior authorization requests for up to **one year from the date of servic**e, consistent with CMS timely filing guidelines, and must include evidence to justify the request.
- Retroactive requests are subject to medical necessity review and may result in a full or partial denial if the clinical criteria for skilled home healthcare is not met.

How do I update the dates on the Start of Care (SOC) Date in ProNet Connect?

- tango will update only the initial authorization period and this must be completed during the first 30 days of the authorization so it does not impact billing.
- Start of care (SOC) dates can updated during the following 2 processes:
    - During the 1st re-authorization request
    - By submitting a FreshDesk ticket to update the SOC date

Re-Authorization (RA) Process

- Select **"Re-auth"** in the patient's authorization card within **ProNet Connect** and upload clinical documentation with the request.
- Submit the re-auth **3-5 days in advance.**
- **tango does not accept retroactive requests for re-authorizations.**
- Home health agencies that do not have access to tango's provider portal must submit re-authorization requests through tango's website,
    - Re-authorization: https://tangocare.com/re-authorization-form/

What documentation is required for Re-Authorization requests?

Include the following documentation with re-authorization requests. Make sure all documents are current and accurately reflect the patient's condition and care needs.

- **Visit Notes**
  - Include all visit notes that have not been previously submitted for the requested discipline
- **OASIS Documentation**
  - Completed SOC (Start of Care), ROC (Resumption of Care), Recertification, or Transfer/Discharge OASIS forms
- **485 Plan of Care (POC)**
  - The plan of care does not need to be signed for the re-authorization request
- **Evaluations**
  - Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) evaluations must be included
- **PT Notes:**
  - Include details on the level of function for bed mobility, transfers, and ambulation
  - Note flexion and weight-bearing status if applicable
- **OT Notes:**
  - Document the level of function for transfers and activities of daily living (ADLs)
- **Wound Care Documentation:**
  - Wound Clinic/MD notes
  - Color photos of the wound, which should be dated and labeled
  - Measurements of the wound, including length, width, and depth
- **Foley Catheter Patients:**
  - MD order from Urology (if being followed by Urology) for catheter changes scheduled more frequently than monthly

What if my agency wants to request another discipline after the prior authorization request is approved?

- **PDGM: If the LUPA threshold has been met:**
  - Re-authorization is not required within the 30-day period. If an additional 30-day authorization period is necessary, follow the re-authorization process. Visits are discipline agnostic once the LUPA threshold has been met, under tango's PDGM authorization guidelines.
- **PDGM: If the LUPA threshold has not been met**
  - Use the Re-authorization process every 2 weeks until LUPA threshold has been met or a new 30 day period has started.
- **Fee For Service**:
  - Providers may submit a re-authorization request with a signed home health care order and supporting clinical documentation through ProNet Connect.
  - tango reviews clinical every 14-30 days.

Will additional authorized visit requests be required within the tango PDGM 30-day period if the LUPA threshold has been met?

- For providers operating under tango's Patient-Driven Groupings Model (PDGM) authorization process, once the total number of approved visits on the authorization meets or exceeds the LUPA threshold for the assigned HIPPS code, no additional authorization will be needed for that 30-day authorization period.

IV Infusion Therapy

- tango does not authorize infusion-only services except under rare circumstances.
- Home health agencies should be redirected to the patient's pharmacy for IV infusion nursing services.
- Pharmacies often have global or case-specific agreements to provide both medication and nursing services.

How do I request a Resumption of Care (ROC)?

- Submitted via a Re-Auth request, agencies are allowed to continue care if the patient has remaining visits. Agencies should submit a ROC Re-Auth only when/if the patient needs additional disciplines or visits.
- If the ROC (72-hour grace period) visit is within an open authorization period and the patient has visits remaining, resume care under the open authorization. If additional visits or disciplines are required, submit a ROC re-authorization request through ProNet Connect.
- If the patient does not have an active authorization that covers the ROC visit, a new authorization is required. Submit the ROC re-authorization request through ProNet Connect, through the Upload Center or via fax.

OASIS Information

- Providers must submit a completed **OASIS** prior to the first Re-Auth request
- Preferred submission method: Strategic Healthcare Programs (SHP)
- If your agency is not enrolled in SHP, the OASIS should be uploaded through the **ProNet Connect** portal
- Agencies that are not integrated and haven't signed a data share agreement with SHP will have a grace period until July 1, 2026.

Why should be agency submit the NOMNC to tango?

- This is a health plan requirement for Medicare Advantage members. The NOMNC must be delivered and signed by the patient or their representative at least 2 days before services end.
- If issued by phone, document the call details and provide the QIO number.
- tango will provide a copy of the health-plan-specific NOMNC with each auth determination, or agencies can use the CMS approved NOMNC.
- The NOMNC facilitates follow-up in tango's care coordination model for high-risk members.
- The issued NOMNC should be uploaded to the portal the same day it is issued. If the portal is down, fax the NOMNC to 602-475-9695.

Out of Area (OOA)/Nationwide Network of Blue Plans Process

- Authorization process: Prior authorization and concurrent authorization requests must be submitted to tango.
- Claims submission: Claims for these services must be submitted to the local (host) plan.

How do we contact tango to notify of a high-risk patient and learn about additional services that are available?

- tango has a care enablement program that focuses on enabling care for members by providing support for home health services.
- tango collaborates with medical providers, resolves DME barriers, schedules follow-up appointments, obtains new medications, connects patients to resources and health plan benefits, and supports end-of-life care planning. To connect with our care enablement team, email carecoordination@tangocare.com.

Claim Submission & Reimbursement

What is tango's Payer ID for EDI claims submissions?

- **26748**

Do I need to submit a Notice of Admission (NOA)?

- tango requires an NOA for Medicare Plus Blue and BCN Advantage members who receive home health services from in network providers. An NOA isn't required for FFS contracts.

How do I submit an NOA?

- The NOA must be submitted following traditional Medicare rules and within **5 calendar days** of the Start of Care (SOC).
- For late NOAs (e.g., with the first claim at Day 30), tango will reduce payment by **1/30th** for every day the NOA is late.
- The NOA must be submitted and fully processed and have with a status "A" accepted before the final claim is submitted.

How can I submit claims?

- Submit electronically using tango's Payer ID
- Upload claims via tango's provider portal
- Refer to the Provider Manual for more details on claims submission process

Do I need to include the HIPPS code on both FFS and PDGM claims?

- Yes. Agencies must include HIPPS codes on all claims submitted to tango.

What are the billing requirements for PDGM Medicare members with approved authorization?

- tango authorizes **in 30-day periods**.
- Although the authorization will include the disciplines and visits authorized, tango pays claims based on the total number of visits authorized and used (discipline agnostic) - so focus on the **total number of authorized visits**.
- The home health agency determines the appropriate **HIPPS code** for the authorization. If the **total number of authorized visits meets or exceeds the LUPA threshold**, no additional visit requests are needed during the 30-day authorization period.
- Once a claim is submitted, tango will adjudicate the claim using the HIPPS code provided, the total number of visits authorized within the authorization period, and the total visits billed. Again, if the total number of used and approved visits meets or exceeds the LUPA threshold, no additional visit requests are needed during the 30-day authorization period.
- **tango will accept only Final Bill claims** under PDGM authorizations.

What are the billing requirements for FFS Medicare members with an approved authorization?

- tango accepts the following frequency codes with bill type "32x"
  - 1 - Admit Through Discharge Claim – encompasses treatment
  - 2 - Interim for the First Claim – first of an expected series of bills
  - 3 - Interim for Continuing Claims – the initial bill has been submitted, but additional bills are expected
  - 4 - Interim for the Last Claim – the last of a series of bills
  - 7 - Replacement of a Prior Claim - please include the original claim number when resubmitting claims
  - 8 - Voiding or Canceling a Prior Claim
  - 9 - Final Claim for Home Health PPS
- Claims must be submitted on UB04 institutional claim forms.
- HIPPS codes are required on all claims.
- The National Provider Identifier billed on the UB04 claim must match the NPI on the approved authorization.
- Attending Physician Name and NPI are required.
- Revenue codes with applicable procedure codes (G codes) must be billed appropriately within the date range of the claim.

Where should I submit claims for non-home health care services provided during home health care visits?

- Home health care providers should continue to bill Blue Cross and BCN for non-home health care services provided during home health care visits. For example, home health care providers should bill Blue Cross or BCN for durable medical equipment and supplies provided in conjunction with skilled home health visits, home infusion therapy and stand-alone wound care.
- Only claims for skilled home health care services delivered through a home health agency should be submitted to tango.

Are claims affected if there are different diagnosis codes on the initial authorization and the re-authorization?

- Changing the diagnosis will not affect claims. Although authorizations are based on diagnoses, claims are based on dates of service. ICD 10 codes matter for PDGM visits that are required to meet the LUPA threshold. tango will consider the diagnosis code and what that means for the LUPA threshold when approving initial visits.
- Diagnosis code changes and additions are common because referring agencies do not always send correct or complete information. tango knows agencies will learn more information when they see the patient.

How do we obtain an Explanation of Payment (EOP)?

- tango offers multiple options:
    - Smart Data Solutions Electronic Remittance Advice (ERA) enrollment - free of charge
        - Allows agencies to download ERAs via Electronic Data Interchange (EDI) to post payments electronically or download ERAs to the system drive for manual application of payments/denials
    - Open a ticket via our provider portal to request a scheduled email to the agency's email address (can be multiple email addresses if needed) by provider agency NPI and employee's email address
    - Open a ticket and request an ad hoc Explanation of Payments (EOPs)

What is tango's process for corrected claim submission?

- For Medicare claims, the frequency bill type must be "7". Using this frequency code alleviates your claim from being denied as a duplicate claim. *Please note: For corrected claim submissions, you must include the original claim number for the claim to be accepted by tango's clearinghouse, SDS.*

What does “procedure quantity limit on referral reached” mean?

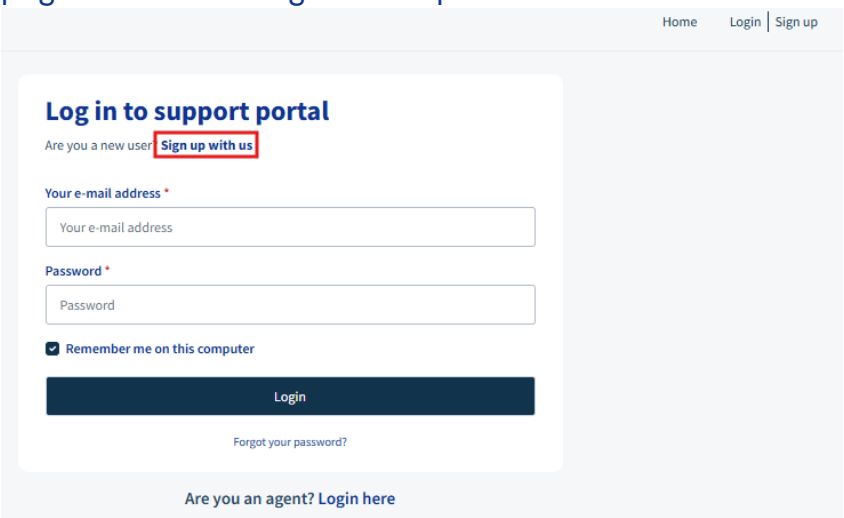
- The number of visits billed is greater than the number of visits authorized.

Why did my claim deny for no auth when I have an auth on file?

- Check the authorization date span to ensure that the date of service on the claim falls within the date span of the approved authorization. If the date of service falls within the date span of the approved authorization, open a ticket and attach the approval document you received for reconsideration of the claim.

How do I investigate a claim that was submitted?

- Open a Fresh Desk ticket at https://freshdesk.tangocare.com/ or use the headset icon on the provider portal.
- If you have not registered for FreshDesk, select “Sign up with us” on the main page to start the registration process.



I did not receive a check, as anticipated. Who do I contact?

- Open a FreshDesk ticket by clicking the headset icon on the provider portal or by going to https://freshdesk.tangocare.com/. Our claims team will work with accounting to locate or reissue payments as applicable.
- If you do not hear from our claims team within 72 hours, contact the Provider Relations team at providerrelations@tangocare.com and provide your ticket number.

How do I contact tango?

- Outreach to your dedicated Provider Relations Manager
- Call 877-206-5736
- Email ProviderRelations@tangocare.com