Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Home health care services for Medicare Advantage members

Frequently asked questions for acute care, post-acute care and community-based providers

For Medicare Plus Blue℠ and BCN Advantage℠

Revised September 2026

Attention home health agencies

For information about working with tango, see the:

- Skilled home health provider page of the *tango and WellSky Provider Resource Center for Blue Cross and BCN**
- Home health care provider network management: Frequently asked questions document on **bcbsm.com**

The information in this document is intended for acute care, post-acute care and community-based providers.

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General information

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with tango to perform the following functions for Medicare Plus Blue and BCN Advantage members who have coverage through groups:

Function	Details
Manage the home health care provider network	**Starting March 2, 2026:** To provide in-network home health care services to Medicare Plus Blue and BCN Advantage members in Michigan, home health care providers must have a direct contract with tango. For more information, see the document titled Home health care provider network management: Frequently asked questions.
Coordinate referrals to home health care agencies	**For episodes of care starting on or after March 1, 2026:** tango will manage referrals to home health care. Referring providers (acute care, post-acute care and community-based providers) will be required to send referrals to tango using their existing discharge planning platform **starting Oct. 1, 2026**. Referring providers that don't use a discharge planning platform can use any of tango's referral management intake solutions to send home health referrals to tango. If the request meets medical necessity requirements, tango will place the referral with an in-network home health agency and issue the initial authorization. Referring providers may request that referrals be directed to a preferred home health agency based on the member's, the facility's or the provider's preference. For more information, see the "How do referring providers submit referrals?" section, which starts on Page 8.
Manage prior authorizations for home health care services	**For episodes of care starting on or after March 1, 2026:** tango manages prior authorizations for and supports the coordination of home health care services, such as skilled nursing and physical, occupational and speech therapies. Home health care providers must submit prior authorization requests for Medicare Plus Blue and BCN Advantage members who have coverage through groups. This requirement applies to members who are transitioning from any setting to home health care. Note: Prior authorization isn't required for Medicare Plus Blue and BCN Advantage members who have individual coverage. However, the home

Function	Details
	health care provider must be contracted with tango to be considered in network.
Process claims for home health care services	**For episodes of care starting on or after March 1, 2026:** Home health agencies should submit claims to tango for home health care services provided to Medicare Plus Blue and BCN Advantage members in Michigan. For additional information about the claims transition process, email tango at providerrelations@tangocare.com.

This home health care program is designed to:

- Use evidence-based guidelines and clinical documentation to make medical necessity determinations. When making determinations, tango uses Centers for Medicare & Medicaid Services national coverage determinations.
- Validate appropriate utilization and enhanced quality of care across home health services
- As needed, assist with coordinating member transitions from hospital to home
- Develop and optimize a statewide, value-based, incentivized network of home health providers aligned to deliver high-quality outcomes for members entering a post-acute episode of care
- Leverage a standardized performance scorecard to guide referral coordination and enable real-time performance measurement and management, focusing on high-impact value drivers and incentive alignment to drive optimal outcomes for members

Tango will also perform service validation outreach to ensure the services that have been ordered are delivered in accordance with the start of care date provided by the agency. If tango determines that services haven't started or aren't scheduled to start in a timely manner, tango staff will work with the member and the home health agency to ensure that services begin as soon as possible.

Note: The home health care program administered by tango doesn't apply to Blue Cross commercial plans, BCN commercial plans or Blue Cross Complete (Medicaid) members. It also doesn't apply to services that aren't provided through a home health agency.

Why did Blue Cross and BCN contract with tango?

Blue Cross and BCN are adding this program because we identified an opportunity to assist with members' transitions from hospital to home and to support a home-based center of care. The program will ensure that members receive the right type of services for the right amount of time, which will promote optimal recovery at home. For additional information, see Blue Cross Blue Shield of Michigan Partners with WellSky® and tango to Deliver High Quality Post-Acute Care Management.

What is the overall process for referring providers, tango and home health agencies?

The overall process varies based on the date.

From March 1 through Dec. 31, 2026

1. Home health care providers submit initial prior authorization requests directly to tango.
2. Tango verifies member eligibility.
3. Tango reviews the request and contacts the home health agency to obtain missing information as needed.
4. Tango issues the authorization.

Starting Oct. 1, 2026

The following table provides a high-level overview of the steps to get from referral to home health care through the start of care.

Overall process	
The referring provider…	
1.	Determines that the member needs home health services.
2.	Asks the member if they have a preferred home health agency.
3.	Submits a referral order to tango through an existing discharge planning tool, through referralrequest.com or by faxing to 1-877-612-7066.
Tango...	
4.	Receives the referral and order for home health care.
5.	Verifies member eligibility.
6.	Reviews referral information and contacts the referring provider to obtain missing information as needed.

Overall process	
7.	Notifies home health agencies of the available referral.
8.	Notifies the referring provider of the referral status and issues initial prior authorization.
Home health agencies…	
9.	Accept or decline the referral and provide an estimated start of care date.
Tango...	
10.	Selects a home health agency based on the following: • Member or provider preference, if stated • Start of care date offered by accepting agencies • Best agency match for the patient's needs
11.	Notifies the referring provider of the selected home health agency and the agency-provided start of care date.

This is where the referring provider's involvement ends. The remaining steps in the process, which are outlined below, are handled by the home health agency and tango:

- The home health agency initiates services and communicates the start of care date to tango. Once services are initiated, the agency submits re-authorization requests and claims to tango.
- Tango confirms the following with the member: the start of care, satisfaction with services and that their needs are being met. Tango also manages re-authorization requests and processes claims.

How will tango staff interact with referring providers?

The tango team interacts with referring providers through various modes of communication and training to support a positive provider experience.

Prior to the program launch, tango will provide training, tools and support to acute care, post-acute care and community-based providers and to home health agencies.

On an ongoing basis, tango will:

- Guide providers through the referral process
- Be available to answer questions and provide additional support

Will members' home health care benefits change when tango starts managing these services?

No, there won't be any changes to members' benefits or any additional charges to members as a result of tango managing the services.

However, members' benefits can change annually as employer groups revise them. In addition, members' coverage can change as they enter or leave a group or change individual coverage.

How can I contact tango?

Providers who refer members to home health care can contact tango as follows:

Contact method	Details
Email	referralsource@tangocare.com **Important:** Please don't send home health referrals or patient status updates to this email address.
Phone	1-877-206-5736
Fax	1-877-612-7066

Tango's contact center is available as follows:

- **Monday through Friday:** 8 a.m. to 8 p.m. Eastern time
- **Weekends and holidays:** 8 a.m. to 7:30 p.m. Eastern time

Are additional resources available for referring providers?

Yes. You can find additional resources by going to the Home health referring provider page on the *tango and WellSky Provider Resources site for Blue Cross and BCN.**

Referrals and initial prior authorizations

How will tango support referring providers during the transition to the tango operating model?

To support the transition to the tango operational model and mitigate disruption, there will be a 90-day grace period during which referring providers (acute care, post-acute care and community-based providers) won't need to submit referrals to tango for skilled home health. The grace period will end Dec. 31, 2026. Starting Oct. 1, 2026, referring providers will be required to submit referrals to tango.

During the grace period, home health care providers will submit initial prior authorization requests directly to tango.

This phased approach is intended to give:

- Referring providers ample time to connect with tango and complete all transition activities
- Discharge planners and care teams adequate time to learn and acclimate to the tango operational model without disrupting patients' transitions into skilled home health episodes

On Oct. 1, 2026, the transition to the tango operating model will be complete at which time referring providers will be required to submit referrals for skilled home health to tango. For referrals that meet medical necessity requirements, tango will issue an initial authorization to the home health agency.

Who submits referrals for home health care services?

Referring providers (acute care, post-acute care and community-based providers) submit referrals to tango for home health care services. If medical necessity requirements are met, tango will place the referral with an in-network home health agency and issue the initial authorization to the home health agency.

Note: There will be a grace period during which tango will accept initial prior authorization requests from home health agencies. See the "How will tango support referring providers during the transition to the tango operating model?" section above for more information.

What do I need to include when submitting a referral?

Include the following when submitting referrals:

- Signed or verbal order from an M.D., D.O., nurse practitioner or physician assistant
- Disciplines requested and a description of services needed in the home
- Supporting clinical documentation, as appropriate:
  - History and physical with ICD 10 code/diagnosis description
  - Discharge summary
  - Notes from hospital or skilled nursing facility, including any therapy notes
  - Physician or provider office notes
  - Wound care notes with measurements

How do referring providers submit referrals?

Referring providers can use the following methods to submit prior authorization requests:

- Acute care and post-acute care providers who use a discharge planning platform (for example, WellSky CarePort) can complete the referral process through their discharge planning platform.

  Note: tango is already active and available for use on WellSky CarePort. If your organization uses a different discharge planning platform, please reach out to referralsource@tangocare.com to ensure tango is active on your platform.

- Post-acute care providers and community-based providers who don't use a discharge planning platform on which tango is active can submit requests through referralrequest.com or by faxing to 1-877-612-7066.

Note: There will be a grace period during which tango will accept initial prior authorization requests from home health agencies. See the "How will tango support referring providers during the transition to the tango operating model?" section on Page 6 for more information.

What criteria does tango use to make determinations on referrals and prior authorization requests?

Tango uses CMS national coverage determination criteria to make determinations on prior authorization requests.

The factors used to determine medical necessity are in alignment with CMS. For more information, see the Medicare Benefit Policy Manual, Chapter 7 – Home Health Services.*

Does tango require a member to be homebound to qualify for home health care services?

Yes, homebound status is required for skilled home health care services. Tango follows CMS guidelines to determine homebound status.

To be considered confined to the home, CMS requires that members must meet the following two criteria:

1. The member must have an illness or injury and one of the following:
   - Need the aid of a supportive device (crutches, cane, walker or wheelchair)
   - Require the use of special transportation (such as an ambulance)
   - Require the assistance of another person to leave the home safely

- Have a condition that makes leaving the home medically contraindicated

2. The member must have a normal inability to leave the home and leaving the home requires a considerable and taxing effort.

Per CMS guidelines, there are situations where a person can leave the home and still be considered homebound. These situations include but aren't limited to attending:

- Adult daycare
- Outpatient kidney dialysis
- Outpatient chemotherapy / radiation appointments
- Religious services

Other absences from the home don't automatically disqualify the member, but the absences need to happen on an infrequent basis and over relatively short durations of time. These examples don't indicate that the member has the capacity to obtain health care outside of the home (per CMS):

- Attending church or other religious appointments
- Going to a hairdresser or barber
- Walking around the block
- Going for a short drive
- Attending a family reunion
- Attending a funeral
- Attending a graduation

For more information, see the following sections of Chapter 7 of the Medicare Benefit Policy Manual:*

- Section 30 — "Conditions Patient Must Meet to Quality for Coverage of Home Health Services"
- Section 30.1 — "Confined to the Home"

Note: tango recognizes that each member is unique and reviews requests on an individual basis. Tango will initiate the intent to deny process if homebound status is in question.

What is the turnaround time for referrals?

Turnaround times for referrals are outlined in the table below:

Type of request	Expected turnaround time
Standard initial prior authorization requests	**For requests from acute care providers** • Requests received **before 4 p.m. Eastern time** will be processed the same day, unless additional information is required or a peer-to-peer discussion is requested. • Requests received after **4 p.m. Eastern time** will be processed by noon the next calendar day, unless additional information is required or a peer-to-peer discussion is requested. **For requests from non-acute care providers:** tango will process within standard CMS timelines.
Expedited or urgent initial prior authorization requests	**For requests from acute care providers** • Requests received **before 4 p.m. Eastern time** will be processed the same day, unless additional information is required or a peer-to-peer discussion is requested. • Requests received after **4 p.m. Eastern time** will be processed by noon the next calendar day, unless additional information is required or a peer-to-peer discussion is requested. **For requests from non-acute care providers:** tango will process within standard CMS timelines.
Post-service request	Within 30 calendar days

How can the referring provider check the status of a referral?

Referring providers who submit requests through a discharge planning platform will receive status updates from tango through the discharge planning platform. Notifications will be sent when:

- The referral is received
- A decision is made
- An agency has been selected and a start of care date has been assigned

Within 24 to 48 hours, the status is also available in Blue Cross and BCN's e-referral system. For more information about the e-referral system, see the "Searching for a Referral or Authorization" section of the e-referral User Guide for more information.

For referrals that were submitted by phone or by fax, you can check the status by calling tango at 1-877-206-5736.

Can referring providers submit retroactive referrals for home health care services?

Yes. Referring providers can submit retroactive referrals for up to one year. However, tango expects referring providers to submit referrals prior to the start of services. This helps reduce the risk of claims being denied for lack of medical necessity.

Referrals that are submitted in a timely manner and are approved by tango will not warrant a retroactive review, which eliminates the risk of medical necessity denials for services already performed.

What is the process if tango determines that a service doesn't meet medical necessity criteria?

If tango determines that services don't meet medical necessity criteria, these are the next steps:

1. Intent to deny: Prior to tango making a final determination:
    a. A tango physician reviewer determines that the request doesn't meet medical necessity criteria and recommends a denial.
    b. The ordering physician or authorized practitioner is notified of the intent to deny via fax. The physician or practitioner can request a peer-to-peer discussion prior to tango issuing the final determination.
    c. If the physician or the authorized practitioner would like to discuss the case, they must request a peer-to-peer discussion by completing step 2 below. For standard prior authorization requests, the discussion must be requested within one business day of receiving notification of the intent to deny. For expedited requests, the discussion must be requested by 5 p.m. the same day.
    d. If the peer-to-peer discussion isn't requested within the timeframe listed above, tango will issue its final determination.
2. Peer-to-peer discussion: Prior to tango making a final determination:
    - The ordering physician or authorized practitioner requests a peer-to-peer discussion by contacting tango at 602-395-5101 and leaving a message on the dedicated secure line. The message must include the member's name and date of birth, a direct call back number and the provider's availability.

- If the peer-to-peer discussion is requested and occurs prior to tango issuing the final denial determination, the reviewer may change the denial recommendation and approve the request.
- If the peer-to-peer discussion isn't requested or the denial has already been issued, a peer-to-peer discussion may still occur. However, it won't result in the denial being overturned. To request reconsideration of the denial, the member or provider must submit a formal appeal.

3. Denial decision: If tango denies the authorization request, the ordering physician, member and servicing provider will be notified by oral or written notification in accordance with CMS guidelines. For additional information about CMS guidelines, see the CMS document titled Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*

For information about the appeals process, see "How do I submit appeals for denied referral requests?" on Page 12.

How can I talk to a physician reviewer at tango for a peer-to-peer discussion?

If a peer-to-peer discussion is needed, contact tango's secure, dedicated line as soon as possible by calling 602-395-5101 and leaving a message that includes the member's name and date of birth, a direct call back number and the provider's availability.

If the peer-to-peer discussion occurs prior to tango issuing a denial, the physician reviewer may change the denial recommendation and approve the request. A peer-to-peer discussion cannot overturn an adverse determination that has already been issued.

How do I submit appeals for denied referral requests?

To submit an appeal, follow the instructions in the denial letter.

The appeal process is not changing. Appeals of denied authorization requests are handled by the Grievance and Appeals units at Medicare Plus Blue and BCN Advantage.

- For additional information on the appeals process for Medicare Plus Blue members, see the Medicare Plus Blue PPO Provider Manual. Look in the section titled "Provider dispute resolution process."
- For additional information on the appeal process for BCN Advantage members, refer to the BCN Advantage chapter of the *BCN Provider Manual*. Look in the section titled "BCN Advantage provider appeals."

Note: Member appeals are handled by either Medicare Plus Blue's or BCN Advantage's Grievance and Appeals unit, as appropriate. For post-service provider appeals related to claims, call Blue Cross and BCN's Provider Inquiry. (For contact information, go to the Contact Us page on **bcbsm.com**, select *Blue Cross Blue Shield of Michigan* or *Blue Care Network* from the *I need to contact* field and then select *Provider Inquiry* from the *about* field.)

If the appeal is related to a Notice of Medicare Non-Coverage (NOMNC), the appeal should be timely submitted to the appropriate Quality Improvement Organization, or QIO.

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