



Medica Central Utilization Management Policy

Policy Name: Extended Hours of Home Care (Private Duty Nursing) MP9766 (Ill-HOM.01)

Effective Date: September 19, 2025

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this medical policy see Provider Communications for additional information. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses MCG™ Care Guidelines, 29th edition, 2025: *ORG: PDN-2001 (HC), Private Duty Nursing.*

Note: The services addressed in this policy are referred to using a number of different terms.

- For commercial products, The Health Plan defines extended hours home care as continuous and complex skilled nursing services provided in the member's home.
- MCG Care Guidelines call these services private duty nursing services, which they define as follows: "Private duty nursing (PDN) services are for patients with acute complex medical needs that exceed the scope of intermittent care."



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BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for extended hours home care (private duty nursing). Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's plan document.
 - Extended hours of home care (private duty nursing) may be excluded from coverage. Please refer to the member's plan document.
 - The number of services and/or covered hours of care may be limited per the member's plan document.
 - If more than one type of home health service occurs in a day, a separate copayment/coinsurance applies to each service.
3. The request must comply with the requirements related to the member's homebound (or confined to the home) status, per the member's plan document.
4. The following services are generally excluded from coverage. Refer to member's plan document for details.
 - Companion and homemaker services
 - Custodial/supportive care and other nonskilled services
 - Respite care or rest care except as otherwise covered in Hospice Services
 - Services provided in an inpatient facility, outpatient facility, hospital, physician's office or other medical care setting.
 - Private duty nursing defined as skilled or unskilled services provided by an independent nurse who is ordered by the member or the member's representative, and not under the direction of a physician.
5. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.
6. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at:
 - <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>
 - Medicare Benefit Policy Manual. Chapter 7: Home Health Services:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html>

DOCUMENT HISTORY

Effective date: 09/19/2025

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Original Effective Date	Created 03/20/2024; Effective 06/01/2024
MPC Endorsement Date(s)	
Began use of MCG™ Care Guidelines	05/01/2024
MCG Care Guidelines Edition Updates (<i>The Health Plan Effective Date</i>)	05/01/2024, 29 th edition 09/19/2025
Administrative Update(s)	06/20/2024