KAISER PERMANENTE
Continuum of Care
Right Care, Right Time, Right Place

Kaiser Permanente Mid-Atlantic States Discharge Planning Guide 2022

Kaiser Permanente appreciates our ongoing relationship in providing exceptional clinical care to our members. We firmly believe our partnership enables us to deliver high quality, cost-effective care which Kaiser Permanente members have come to expect. Please utilize our Discharge Planning Guide as a resource to assist you in planning a safe, timely, and appropriate transitions of care in partnership with our Kaiser Permanente Physicians.

To access the full provider manual, go to:
http://www.providers.kaiserpermanente.org/html/cpp_mas/providermanuals.html

The Virtual Continuum Compass (VCC)

The Virtual Continuum Compass (VCC) is a 1-stop resource designed to support the hospital case management team.

Our team of navigators and clinical care consultants are available **7 days a week**, from **8:30am-6pm** at **301-879-6238**.

The VCC is ready to support the management and discharge of Kaiser Permanente members, to include:

- **Escalations**
  - Difficulty securing a facility or vendor within the KP premier network
  - Vendor-specific escalations for items/services required for discharge including O2, DME, etc.
- **Authorization Questions**
  - Pre-Service Authorization Status Checks
  - Authorization eligibility questions
- **Discharge support for complex patients**
  - VCC clinical care consultants are available for consultations to assist in the discharge of complex patients, except for Behavioral Health
  - Facilitating connections to specialized resources (EX: Complex Case Management, Outpatient Case Management, CHF program, Behavioral Health, etc.) within Kaiser Permanente to support our patient's post-discharge
- **Post-discharge follow-up appointment assistance**
  - For Behavioral Health, Kaiser Permanente Patient Care Coordinators will make post hospital follow up appointments prior to discharge
- **Transportation**
  - Authorization # for ALS/BLS Transportation

We value your partnership - Please start discharge planning on the day of admission

- Timely submission of requests for pre-service authorization will prevent delays
- Please submit requests for pre-service authorization **at least 24 hours prior to discharge**

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Kaiser Permanente Discharge Planning Guide 2022

V4.0, edited 12.16.22

Level of Care/Service	Contact/Providers/Process
Acute Rehab/ LTACH	• Hospital to fax authorization request: **855-414-2659** • Include cover sheet clearly indicating request, patient identification, return contact information, clinicals, and PT/OT/ST notes within 48 hours • Include vent settings/attempt to wean for **LTACH** • KP will notify requestor of next steps
Skilled Nursing Facility (SNF)	• Hospital identifies accepting SNF from our network **(Table 1.0)** • Hospital to Fax SNF Authorization Requests to KP @ **855-414-1707** • Kaiser Permanente to communicate with Hospital on status
Home Health	• Hospital identifies accepting HH agency from our providers **(Table 2.0) and** **confirms start of care date with the home health agency prior to discharge** • HH Agency to Fax HH Authorization Requests to KP @ **855-334-6902** • HH Agency to communicate with hospital on status
Hospice	• Hospital identifies accepting Hospice from our providers **(Table 3.0)** • Identified Hospice to fax KP authorization request @ **855-414-1707** • **Medicare Advantage**: No pre-authorization required • **Commercial and Medicaid**: No pre-authorization required for contracted agencies but notify KP within three days of admission
Durable Medical Equipment (DME)*	• Complete DME Authorization Request Form **Include Clinicals and WOPD****(1.0, 2.0 or 3.0) Follow attachment 4.0 DME Guidelines** • Hospital to fax DME Authorization Form and supporting documentation to Fax Number: **855-334-6917**
Transportation (BLS, ALS)	• Call the VCC at **301-879-6238** (7 days a week, 8:30am-6pm) • The VCC will provide an authorization # for ALS/BLS transport for the vendor **(Table 4.0)** • The hospital will contact the vendor, provide the authorization number, and coordinate the details of the ride with the vendor.
Non-Emergent Medical Transport (NEMT)	• SafeRide **(Medicare Advantage only)** @1-855-932-5412
Outpatient Infusion, Home Infusion (non-HH)	• Utilize providers **(see Table 5.0)**
Dialysis (HD/PD)	• Submit Admission Paperwork to Dialysis Central Admissions • For more contracted facilities call Renal Resource line and leave voicemail. • HD Dialysis Providers **(see Table 6.0/6.1)** • Renal Resource Line: **301-816-5955**
Post Hospital Discharge Follow Up Appointments	• To schedule call KP Line: **866-311-0531**
Inpatient Psychiatry	• For Patient's in the ED call Emergency Care Management (ECM) @ **844-552-0009** • **For Medicine Bed to Psych Bed Transition: Monday - Friday** o Call Page Operator @ **(703)-359-7460** for on-call psychiatrist to approve admission o Hospital to locate bed, use IP Psych Network **(see Table 7.0)** o Once bed is located, the hospital is to contact KP Behavioral Health UM for referral, Monday - Friday **(301) 552-1212** o Hospital arranges transport **Weekends/Holidays** o Call Page Operator @ **(703)-359-7460** for on-call psychiatrist to approve admission o Hospital to locate bed, use IP Psych Network **(see Table 7.0)** o Once bed is located, the hospital is to contact the Page Operator @ **(703)-359-7460** to speak with Behavioural Health Patient Care Coordinator for referral o Hospital arranges transport

The Virtual Continuum Compass (VCC) is available **7 days a week**, from **8:30am-6pm** at **301-879-6238** to support the hospital case management team

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Pediatric Level of Care/Service	Contact/Providers/Process
Skilled Nursing Facility or transfer to a skilled nursing level of care within an inpatient facility (SNF)	• Hospital identifies accepting pediatric SNF • Hospital to Fax SNF Authorization Requests to KP @ **855-414-1707** • Hospital and SNF to communicate on status
NICU to NICU transfer	• Call ECM at **844-552-0009**, contact repatriation physician with accepting physician/hospital information • ECM facilitates transport

To Schedule NICU post-discharge follow-up appointment	• VCC: **301-879-6238**
	• Please call at least 24-hrs prior to expected discharge with the following information:
	  ○ Patient demographics, contact information
	  ○ Expected date of discharge
	  ○ Fax discharge summary to **855-414-1704**
	  ○ Neonatologist specialist appointment recommendations
	  ○ Neonatologist and Hospital Case Management contact information
	• The VCC will facilitate the scheduling of the post-discharge follow-up appointment and other specialist appointments directly with the family

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TABLE 1.0, Skilled Nursing Facility Providers

Pre-Authorization Requirements for Skilled Nursing:

- Hospital Face Sheet History and Physical Document
- Therapy Evaluations – most recent therapy notes within the past 24-48 hours
- Most Recent Physician Notes within the past 24 hours
- Physician Orders Sheet/Medication List
- Post-Procedure Notes
- Nursing Admission Assessment

Skilled Nursing Facility (SNF) Providers		
Provider Name	City	Phone Number
BALTIMORE LOCATIONS		
WYE OAK HEALTHCARE OF ANNAPOLIS	900 Van Buren St. Annapolis, MD 21403	410-267-8653
FOREST HILL HEALTH AND REHAB CENTER	109 Forest Valley Drive Forest Hill, MD 21050	410-893-2468
FUTURECARE - IRVINGTON	22 S. Athol Ave. Baltimore, MD 21229	410-947-3052
LORIEN COLUMBIA NURSING AND REHAB	6334 Cedar Lane Columbia, MD 21044	410-531-5300
LORIEN TANEYTOWN NURSING AND REHAB CTR	100 Antrim Blvd. Taneytown, MD 21787	410-756-6400
NORTH ARUNDEL HEALTH AND REHAB CENTER	313 Hospital Drive Glen Burnie, MD 21061	410-761-1222
PROMEDICA SKILLED NURSING AND REHABILITATION	515 Brightfield Road Lutherville, MD 21093	410-296-1990
MANOR CARE ROSSVILE MD	6600 Ridge Road Baltimore, MD 21237	410-574-4950
PROMEDICA SKILLED NURSING AND REHAB TOWSON	509 E. Joppa Road Towson, MD 21286	410-828-9494
DISTRICT OF COLUMBIA AND SUBURBAN MARYLAND LOCATIONS		
THREE FORTY-SEVEN BALLENGER OPCO DBA AUTUMN LAKE	347 Ballenger Center Drive Frederick, MD 21703	301-663-5181
COLLINGSWOOD OPERATOR	299 Hurley Ave. Rockville, MD 20850	301-762-8900

CRESCENT CITIES SNF	4409 East-West Highway Riverdale, MD 20737	301-699-2000
DOCTORS COMMUNITY REHABILITATION AND PATIENT CARE CENTER	6710 Mallery Drive Lanham, MD 20706	301-552-2000
FUTURECARE – PINEVIEW	9106 Pineview Lane Clinton, MD 20735	301-856-2930
VITA HEALTHCARE GROUP	3227 Bel Pre Road Silver Spring, MD 20906	301-871-2000
AXIS HEALTH AT OAK MANOR OPCO	3415 Greencastle Road Burtonsville, MD 20866	240-970-5600
MANOR CARE OF POTOMAC MD	10714 Potomac Tennis Lane Potomac, MD 20854	301-299-2273
PROMEDICA SKILLED NURSING AND REHAB WHEATON	11901 Georgia Ave. Wheaton, MD 20902	301-942-2500
VIRGINIA LOCATIONS		
CARRIAGE HILL HEALTH AND REHAB CENTER	6106 Health Center Lane Fredericksburg, VA 22407	540-785-1120
DUNN LORING VA OPCO	8000 Iliff Drive Dunn Loring, VA 22027	703-560-1000
MANASSAS HEALTH AND REHAB CENTER	8575 Rixlew Lane Manassas, VA 20109	703-257-9770
POTOMAC FALLS HEALTH AND REHAB CENTER	46531 Harry Blvd Highway Sterling, VA 20164	703-834-5800
MANOR CARE OF ARLINGTON VA	550 S. Carlin Springs Road Arlington, VA 60005	703-379-7200
MANOR CARE FAIR OAKS OF FAIRFAX	12475 Lee Jackson Memorial Highway Fairfax, VA 22033	703-352-7172
WOODBINE REHAB HEALTHCARE	2729 King St. Alexandria, VA 22302	703-836-8838
WOODMONT CENTER	11 Dairy Lane Fredericksburg, VA 22405	540-371-9414

TABLE 2.0, Home Health Providers

Home Health Providers		
Provider Name	Service Area	Phone Number
BAYADA HOME HEALTH CARE	Baltimore/Maryland/Virginia	888-833-5706
HOMECENTRIS HOME HEALTH	Baltimore/Maryland/Virginia/DC	410-321-8448
JOHNS HOPKINS HOME HEALTH SERVICES	Baltimore/Maryland/Virginia/DC	410-288-8000
MEDSTAR HEALTH VISITING NURSE ASSOCIATION	Baltimore/Maryland/Virginia/DC	800-862-2166
PB HEALTH HOME CARE	Baltimore	410-235-1060
LHCG CXLIX / VNA OF MARYLAND	Baltimore/Maryland	410-594-2600
HUMAN TOUCH	Virginia/Maryland/DC	703-531-0540
PAVILION MEDICAL HOME CARE AND STAFFING	Virginia	703-299-9898
VIRGINIA HEALTHCARE SERVICES	Virginia	703-333-5288
REVIVAL HOMECARE AGENCY	Maryland/DC	888-225-6905
TRINITY HOME HEALTH (HOLY CROSS)	Maryland	301-754-7740

TABLE 3.0, Hospice Providers

Hospice Providers		
Provider Name	Service Area	Phone Number
BRIDGING LIFE	Maryland	410-871-8000
GILCHRIST HOSPICE CARE	Maryland	443-849-8200/8300
ACCENTCARE HOSPICE AND PALLIATIVE CARE	Maryland/DC	888-523-6000
HOSPICE OF THE CHESAPEAKE	Maryland/DC	410-987-2003
MONTGOMERY HOSPICE	Maryland/DC	301-921-4400
CAPITAL CARING HEALTH	Maryland/DC/Virginia	800-737-2508
VITAS HEALTHCARE CORP	Virginia	703-270-4300

TABLE 4.0, Transportation Providers

Transportation (ALS, BLS)				
State	Vendor Name	Transport Types	County Coverage	Phone Number
DC MD	BUTLER	BLS, ALS, Critical Care Ambulance	District of Columbia, Montgomery, Frederick, Carroll, Howard, Washington, Allegany and Garrett	410-602-4007
MD	AAA	BLS, ALS, Critical Care Ambulance	Anne Arundel, PG, St. Mary's, Charles, Eastern shores of MD Counties	301-952-1193
MD	PROCARE	BLS, ALS, Critical Care Ambulance	Baltimore County, Baltimore City, Harford and Cecil	410-823-0030
VA	LIFECARE	BLS, ALS, Critical Care Ambulance	All Virginia	540-752-5883

TABLE 5.0 Outpatient Infusion, Home Infusion (non-HH)

Contracted Infusion Services		
Provider Name	Service Area	Phone Number
BURKE PHARMACY (KAISER PERMANENTE) **Use Burke Pharmacy for all IV ABX and TPN** **Required Information:** Complete Home IV Fax Form in its entirety and fax to UMOC. Must include Nursing Agency information	Maryland, District of Columbia, & Virginia	**Use Attachment 6.0 Home IV Fax Order Form** and fax to UMOC at (855) 334-6902 Burke Home IV Pharmacy Phone: 703-249-7922
OPTION CARE **Only use for specialty infusion and IV ABX that Burke Pharmacy cannot accept** **(IVs, ABX, TPN, Milrinone)**	Maryland	Phone Number: 800-241-6163 Fax Number: 301-362-7847
	Virginia and District of Columbia	Phone Number: 703-230-4638 Fax Number: 703-230-4639
NATIONS **Only use for specialty infusion and IV ABX that Burke Pharmacy cannot accept** **(IVABX/TPN)**	Maryland, District of Columbia, & Virginia	Phone Number: 888-473-8376 Fax Number: 800-881-0546

TABLE 6.0 Hemodialysis Providers

Dialysis Centers		
Provider Name	City	Phone Number
BALTIMORE LOCATIONS		
CATONSVILLE DIALYSIS	BALTIMORE	410-242-7766
KIDNEY HOME CENTER	BALTIMORE	410-244-5638
NORTHWEST DIALYSIS CTR	BALTIMORE	410-265-0158
TRC HARFORD ROAD DIALYSIS CTR	BALTIMORE	410-444-1544
TRC BERTHA SIRK DIALYSIS CENTER	BALTIMORE	410-532-9311
TRC GREENSPRING DIALYSIS CENTER	BALTIMORE	410-523-3032
HOWARD COUNTY DIALYSIS	COLUMBIA	410-997-4244
DISTRICT OF COLUMBIA AND SUBURBAN MARYLAND LOCATIONS		
BMA OF COLUMBIA HEIGHTS	WASHINGTON, DC	202-829-0060
BMA OF DUPONT CIRCLE	WASHINGTON, DC	202-483-0176
BMA OF NORTHEAST DC	WASHINGTON, DC	202-832-4481
CAPITOL DIALYSIS LLC NE/NW	WASHINGTON, DC	202-636-9411
GWU SOUTHEAST DIALYSIS	WASHINGTON, DC	202-581-9440
TRC UNION PLAZA DIALYSIS CENTER	WASHINGTON, DC	202-842-3127
SILVER SPRING DIALYSIS	SILVER SPRING	301-608-8961
HOLY CROSS DIALYSIS SILVER SPRING	SILVER SPRING	301-754-7000
HOLY CROSS DIALYSIS CTR WOODMORE	SILVER SPRING	301-754-7560
RTC GERMANTOWN	GERMANTOWN	301-754-1919
DSI SILVER HILL DIALYSIS	DISTRICT HEIGHTS	301-967-9891
FMC PRINCE GEORGE COUNTY	HYATTSVILLE	301-429-3555
DAVITA LARGO TOWN CENTER DIALYSIS	LARGO	301-341-7480
RAI CARE CTRS OF CLINTON DBA RAI OLD ALE	CLINTON	301-877-3263
RAI-CHILLUM-HYATTSVILLE	HYATTSVILLE	301-927-8808
RTC-KIDNEY CARE OF LARGO	UPPER MARLBORO	301-925-4100
TRC RIVERTOWNE DIALYSIS	OXON HILL	301-839-3443

VIRGINIA LOCATIONS		
ALEXANDRIA DIALYSIS	ALEXANDRIA	703-823-7940
DAVITA ARLINGTON DIALYSIS	ARLINGTON	703-527-6360 703-527-0652
TOTAL RENAL CARE OF FAIRFAX DIALYSIS	FAIRFAX	703-724-3941 703-876-8445
TYSONS CORNER DIALYSIS	VIENNA	703-827-8644
B M A OF FAIRFAX	FAIRFAX	703-698-8070
RESTON DIALYSIS CENTER	HERNDON	703-437-0414
RENAL CARE PARTNERS OF RESTON LLC	RESTON	703-476-0605
RTC MID ATLANTIC FAIR OAKS DIALYSIS	FAIRFAX	703-385-5315
STERLING DIALYSIS	STERLING	703-444-8932
WOODBRIDGE DIALYSIS CENTER	WOODBRIDGE	703-897-7027
MANASSAS DIALYSIS	MANASSAS	703-257-5445

TABLE 6.1, Peritoneal Dialysis Providers

Dialysis Centers		
Provider Name	City	Phone Number
BALTIMORE LOCATIONS		
KAISER PERMANENTE WOODLAWN MEDICAL CENTER PERITONEAL DIALYSIS	7141 Security Blvd Baltimore, MD 21244	443-663-6074
DISTRICT OF COLUMBIA AND SUBURBAN MARYLAND LOCATIONS		
KAISER PERMANENTE CAPITOL HILL MEDICAL CENTER PERITONEAL DIALYSIS	700 2nd St NE Washington, DC 20002	202-346-3525
KAISER PERMANENTE LARGO MEDICAL CENTER PERITONEAL DIALYSIS	1221 Mercantile Ln Largo, MD 20774	301-386-6825
VIRGINIA LOCATIONS		
KAISER PERMANENTE TYSONS CORNER MEDICAL CENTER PERITONEAL DIALYSIS	8008 Westpark Dr McLean, VA 22102	703-287-1060

TABLE 7.0, Inpatient Psychiatry Providers

Contracted Inpatient Behavioral Health Hospitals		
Provider Name	City	Phone Number
VIRGINIA HOSPITAL CENTER	1701 N George Mason Dr Arlington, VA 22205	703-558-5000
DOMINION HOSPITAL	2960 Sleepy Hollow Rd Falls Church, VA 22044	703-536-2000
CHILDRENS NATIONAL MEDICAL CENTER	111 Michigan Ave NW Washington, DC 20010	888-884-2347
WASHINGTON HOSPITAL CENTER	110 Irving St NW Washington, DC 20010	202-877-7000
SHADY GROVE ADVENTIST BH	9901 Medical Center Dr Rockville, MD 20850	301-251-4500
FRANKLIN SQUARE HOSPITAL CENTER	9000 Franklin Square Dr Baltimore, MD 21237	443-777-7000
SHEPPARD PRATT	6501 N Charles St Baltimore, MD 21204	410-938-3000

For additional providers, please visit our online provider lookup tool:
https://kaisermidatlantic.providerlookuponlinesearch.com/search

The Virtual Continuum Compass (VCC) is available **7 days a week**, from **8:30am-6pm** at **301-879-6238** to support the hospital case management team

Attachment 1.0, DME Authorization Request Form

KAISER PERMANENTE® **Mid-Atlantic Region**

Authorization Request Form for Durable Medical Equipment Orders **Fax Number: 855-334-6917**

SECTION A – MEMBER DEMOGRAPHICS		
Patient Last Name:	**Patient First Name:**	**Patient Middle initial:**
DOB:	**KP Medical Record Number:**	
Patient Delivery Address:	**City/State:**	**Zip Code:**
Discharge Facility:	**Discharge Date:**	**Room/Bed:**
Facility Address:	**City/State:**	**Zip Code:**
Ordering Provider:	**Ordering Provider NPI:**	
Date of Face-to-Face:	**Diagnosis (ICD 10 Code/s):**	**Patient Ht. and Wt.:**
Case Manager:	**Phone:**	**Fax:**

SECTION B – DURABLE MEDICAL EQUIPMENT

OXYGEN	**ENTERAL NUTRITION**	**OSTOMY SUPPLIES**
□ Stationary & Portable O_2 @ _____ LPM via nasal cannula □ continuous □ w/ambulation □ during sleep □ Other: _____	Formula name: _____ □ Bolus _____cc _____x/day □ Gravity _____cc _____ x/day □ Pump _____cc/hr. x ____hrs./day □ Additives (i.e., Prosource): _____	Indicate brand & model # for supplies (i.e., Hollister, Coloplast, 2-piece, etc.) _____ _____ □ Adhesive Remover Wipes 25/mo. □ Skin Barrier Wipes 25/mo. □ Ostomy Deodorant 8oz/mo. □ Ostomy Paste (Pectin) 4oz/mo. □ Stoma Powder 2oz/mo.
CPAP or BiPAP	**UROLOGIC SUPPLIES**	**WOUND SUPPLIES**
□ CPAP @ _____cm H_2O □ BiPap w/out back-up (E0470) IPAP: ____ EPAP: ____ Ramp or C-Flex: ____ □ BiPap with Back-up (E0471) IPAP: ___ EPAP: ___ *Backup Rate*: _____ **Mask type:** □ Full Face Mask □ Nasal Pillows □ Nasal Cushions □ Other: _____ *All machines to include heated humidifier, heated tubing, disposable filters & supplies for specified mask*	Cause of Urinary retention: _____ Catheter Size: _____ French Catheter Tip: □ Straight □ Coudé □ Foley ___ Latex ___ Silicone *(Include: insertion kit, drainage bags, leg strap)* Frequency of Foley changes: _____ □ In & Out Cath ____x per day plus lubricant Other: _____	Type of wound (e.g., surgical, pressure ulcer, burn, etc.): _____ Wound Location: _____ Wound Measurements: Length (cm) _____ W (cm) ___ D (cm) ___ Drainage amount: _____ Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):_____ _____ _____ Frequency of changes: _____

WOUND VAC & SUPPLIES

Wound Vac **The Apria Negative Pressure Wound Therapy Form must be completed and faxed to Apria at 800-323-1882 & Kaiser Permanente at 855-334-6917*

Wound location: _____ Wound type: _____ Wound Length (cm) ____x width _____ x depth _____

□ Number or months: _____ Pressure Setting: _____ Dressing type: _____ Frequency of Dressing changes: _____

WHEELCHAIR	**WALKER**	**COMMODE**
□ Manual WC □ Heavy Duty WC (>250 lbs.) □ Hemi WC □ Lightweight WC □ Elevating Leg Rests □ Removable Arm Rests □ Other: _____	□ Standard Walker □ Front-wheeled walker □ Rollator (walker w/seat) □ Hemi-walker ___R ___ L □ Other: _____	□ Standard Commode □ Drop Arm Commode □ Heavy Duty (>300 pounds)
HOSPITAL BED	**PATIENT LIFT**	**OTHER**
□ Semi-Electric Hospital Bed □ Wide Bed for pt >350 pounds □ include trapeze attached to bed	□ Hydraulic Patient Lift with Sling	Other, *please describe*: _____ _____ _____

Attachment 2.0, DME Authorization Request Form Labor & Delivery and NICU

KAISER PERMANENTE® **Mid-Atlantic Region**

Authorization Request Form for Durable Medical Equipment Orders **Fax Number: 855-334-6917**

Labor & Delivery & NICU

SECTION A – MEMBER DEMOGRAPHICS		
Patient Last Name:	**Patient First Name:**	**Patient Middle initial:**
DOB:	**KP Medical Record Number:**	
Patient Delivery Address:	**City/State:**	**Zip Code:**

Discharge Facility:	**Discharge Date:**	**Room/Bed:**
Facility Address:	**City/State:**	**Zip Code:**
Ordering Provider:	**Ordering Provider NPI:**	
Date of Face-to-Face:	**Diagnosis (ICD 10 Code/s):**	**Patient Ht. and Wt.:**
Case Manager:	**Phone:**	**Fax:**

SECTION B – DURABLE MEDICAL EQUIPMENT

OXYGEN	ENTERAL NUTRITION	WOUND SUPPLIES
□ Stationary & Portable O_2 @ _____ LPM via nasal cannula □ continuous □ w/ambulation □ during sleep □ Other: _____	Formula name: _____ □ Bolus _____cc _____x/day □ Gravity _____cc _____ x/day □ Pump _____cc/hr. x ____hrs./day □ Extension Tubing 12" for use with pump □ Additives (i.e., Prosource): _____ □ NG Tube or MIC-KEY button (give size): _____	Type of wound (e.g., surgical, pressure ulcer, burn, etc.): _____ Wound Location: _____ Wound Measurements: Length (cm) _____ W (cm) ___ D (cm) ___ Drainage amount: _____ Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):_____ _____ _____ Frequency of changes: _____
APNEA MONITOR	**PULSE OX FOR INFANT**	**OTHER**
Apnea Monitor & Settings: High HR (bpm): _____ Low HR: (bpm): _____ Time delay (Sec): _____	Pulse Ox for Infant Settings: Low sat alarm %: _____ High HR (bpm): ____Low HR (bpm):_____ How long to wait until intervention? _____ Intervention: _____	Other, *please describe*: _____ _____ _____ _____ _____ _____ _____ _____
BILI BLANKET	**HOSPITAL GRADE BREAST PUMP**	
□ Bili blanket x ____ days (up to 5) **Delivery location required*	□ Hospital Grade Breast Pump **Authorization issued to Mom, not baby*	

Attachment 3.0, DME Authorization Request Form Trach or Vent Patient

KAISER PERMANENTE® **Mid-Atlantic Region**

Authorization Request Form for Durable Medical Equipment Orders **Fax Number: 855-334-6917**

Trach or Vent Patient

SECTION A – MEMBER DEMOGRAPHICS		
Patient Last Name:	**Patient First Name:**	**Patient Middle initial:**
DOB:	**KP Medical Record Number:**	
Patient Delivery Address:	**City/State:**	**Zip Code:**
Discharge Facility:	**Discharge Date:**	**Room/Bed:**
Facility Address:	**City/State:**	**Zip Code:**
Ordering Provider:	**Ordering Provider NPI:**	
Date of Face-to-Face:	**Diagnosis (ICD 10 Code/s):**	**Patient Ht. and Wt.:**
Case Manager:	**Phone:**	**Fax:**

SECTION B – DURABLE MEDICAL EQUIPMENT

OXYGEN	ENTERAL NUTRITION	Wound Supplies
□ Stationary & Portable O_2 @ _____ LPM via Trach Mask □ continuous □ w/ambulation □ during sleep **Note, O2 setting for vent is in Ventilator section* □ Other: _____ _____	Formula name: _____ □ Bolus _____cc _____x/day □ Gravity _____cc _____ x/day □ Pump _____cc/hr. x ____hrs./day □ Extension Tubing 12" for use with pump □ Additives (i.e., Prosource): _____ □ NG Tube or MIC-KEY button (give size): _____	Type of wound (e.g., surgical, pressure ulcer, burn, etc.): _____ Wound Location: _____ Wound Measurements: Length (cm) _____ W (cm) ___ D (cm) ___ Drainage amount: _____ Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):_____ _____ _____ Frequency of changes: _____

PULSE OX FOR INFANT / VENT PATIENT

Settings: Low sat alarm %: _____
High HR (BPM): _____ Low HR (bpm): _____
How long to wait until intervention? _____
Intervention: _____

TRACH SUPPLIES	COMPRESSOR FOR TRACH HUMIDIFICATION	SUCTION FOR TRACH PATIENT
Trach Size/Type/Brand: _____ _____ □ Cuffed (A7521) □ Un-cuffed (A7520) □ Fenestrated □Un-fenestrated □ Disposable Inner Cannulas (A4623) qty 2/day □ Trach Care Kits (A4629) qty 1/day □ Passey-Muir Valve (L8501) qty 1/2 mo. □ Other: _____ ** Requires 7-day lead processing time*	**Includes all the following:* -Compressor (E0565), -Lg Volume Nebulizer Kit (A7007) qty 2/mo. -Tubing (A7010) qty 100 ft/2 mo. -Aerosol Drainage Bag (A7012) qty 2/mo. -Trach Mask/Collar (A7525) qty 1/mo.	**Include all the following:* -Suction Machine (E0600), -Suction Caths- must indicate size in units French_____ (A4624) qty 90/mo. -Suction Cannisters (A7000) qty 8/mo. -Suction Tubing (A7002) qty 8/mo., -Oral/Yankauer Cath (A4628) qty 13/mo. -saline bullet 10 ml (A4216) qty 90/mo. -Ambu Bag (S8999) 1/year

VENTILATOR & SUPPLIES

Vent Mode: □ Volume Assist Control (A/C) □ Pressure Support (PS) □ Synchronized Intermittent Mandatory Ventilation (SIMV) □ Other: _____ Respiratory Rate: _____ (breaths/min) Tidal Volume (VT): _____ % Oxygen: _____ Amount of +PEEP: _____ Hours of Use: _____ Vent Make & Model Being Used in current Facility: _____ **Requires 7-day lead processing time*	***Includes:*** Ventilator (E0465) plus back-up vent (E0465), Heated Humidifier (E0562), Water Chamber (A7046) qty 2/yr., Vent Circuits (A4618) qty 1/week, O2 Stationary (E1390), O2 Portable (E0431), and included at no charge: Swivel Trach Adapter, External battery & Cable, Battery Charger, Humidifier Bracket, and Heater Pigtail

Attachment 4.0, **DME Orders Guidelines**

KAISER PERMANENTE® **Mid-Atlantic Region**

Durable Medical Equipment Guidelines

**Note, Ventilators & Trach Supplies require at least 7-days or greater lead time.*

Durable Medical Equipment Orders Guidelines:
All submissions MUST include the Face to Face, Physician Orders, History and Physical and specified documentation inclusive to Durable Medical Equipment processing.

- **Oxygen**
  1. O2 sat testing within last 72 hours (does not apply to COVID+)
     a. O_2 sat Room Air at Rest
     b. O_2 sat Room Air w/ exertion
     c. O_2 sat on prescribed amount of O_2 to show effectiveness
  2. Clinical Note listing clinical condition(s) causing hypoxia and need for Oxygen
  3. **WOPD** with O_2 liter flow & delivery method (i.e., NC, mask, etc.), hours of use, Length of need, MD signature, Date & NPI
- **Enteral Nutrition**
  1. Swallow study, if available
  2. Nutrition notes to support the requested formula & volume
  3. Clinical note listing clinical condition(s) that required placement of feeding tube, and if via pump, description of non-tolerance of gravity or bolus feeds, and that condition will be for an indefinite period of time or permanent
  4. **WOPD** with formula name, method of administration (i.e., pump, gravity, bolus), volume to be given, and additives, patient HT/WT, Length of need, MD signature, Date & NPI
- **Ostomy Supplies**
  1. Please attach WOPD & clinical information (i.e., Surgery notes or Wound, Ostomy, Continence Nurse notes)
- **CPAP or BiPAP**
  1. Face-to-face prior to Sleep Study that assesses for Obstructive Sleep Apnea
  2. Copy of Sleep Study (for mild sleep apnea, documentation of EDS, impaired cognition, mood disorder, insomnia or HTN, heart disease, or h/o stroke) and Titration Study, if performed
  3. **WOPD** to include machine type, machine settings, mask type, Length of need, patient HT/WT, MD signature, Date & NPI
  4. All machines include heated humidifier, heated tubing, disposable filters & supplies for specified mask
- **Urologic Supplies**
  1. Please attach WOPD & note including the above clinical information. See the specifics noted on the Authorization Request form.
- **Wound Supplies**
  1. Please attach WOPD & note including the above clinical information. See the specifics noted on the Authorization Request form.
- **Wound Vac**
  1. Please complete the Initiation of Negative Pressure Wound Therapy Form for Apria
  2. Fax the Apria form & clinicals to Apria at 800-323-1882; form & clinicals should also be submitted with the Kaiser Permanente DME Order Form

Attachment 4.0, DME Orders Guidelines (continued)

KAISER PERMANENTE® **Mid-Atlantic Region**

- **Wheelchair**
  1. Description of Mobility limitation(s) requiring WC that cannot be resolved with cane or walker,
  2. WC can be used in the home,
  3. Patient is willing to use WC and has Upper Extremity strength and mental ability to propel WC or caregiver able to assist with use of WC
  4. Additional:
     a. For Hemi WC, reason pt. requires lower seat height
     b. For Lightweight WC, note that pt. cannot self-propel standard WC but can propel Lightweight WC
  5. **WOPD** with type of WC and accessories, patient HT/WT, Length of Need, MD signature, Date & NPI
- **Walker**
  1. Description of Mobility limitation requiring walker
  2. Notation that walker can be safely used, and mobility deficit is resolved w/ use of walker
  3. **WOPD** with type of Walker, patient HT/WT, MD signature, Date & NPI
- **Commode**
  1. Patient is confined to single level or single room without a commode
  2. For drop-arm commode, needs drop arm for transfers or to accommodate greater width
  3. **WOPD** with type of commode, patient HT/WT, MD signature, Date & NPI
- **Hospital Bed**
  1. Description of Clinical condition(s) requiring Hospital bed, including need(s) for immediate position changes not feasible w/ ordinary bed (includes pain), and/or condition requiring HOB elevation >30°, and/or condition requiring change in bed height for transfers
  2. **WOPD** for Semi-Electric Hospital Bed, patient HT/WT, Length of need, MD signature, Date & NPI
- **Patient Lift**
  1. Description of Clinical condition(s) that, without the lift, would leave patient bed-confined
  2. **WOPD** for Hydraulic Patient Lift, patient HT/WT, and Length of need, MD signature, Date & NPI
- **Hospital Grade Breast Pump**
  1. Coverage of hospital grade electric breast pump is available when the mother is engaged in breast feeding and either the baby or mother have one of the following conditions **or** the pediatrician or OB documents that a hospital grade breast pump is medically necessary and that a single use electric pump will not suffice. *(Multiple reasons may apply)*
     - □ When a baby is hospitalized and the mother is not, such as babies **remaining in the NICU** after the mother is discharged or there is a medical need for separation of the mother and infant.
     - □ Baby is pre-term between **29 weeks and zero (0) days until 36 weeks and 6-day gestation**, a two-phase expression technology electric breast pump (i.e., Medela Symphony) is typically required **for one month**. *Please give **GESTATIONAL AGE.***
     - □ If baby < 29 weeks gestation, a two-phase technology pump (i.e., Medela Symphony) is typically required for 2 months. *Please give **GESTATIONAL AGE.***
     - □ Baby is low birth weight (< 2500 grams) *Please give **BIRTH WEIGHT.***
     - □ Baby has excessive weight loss (> 10% of birth weight) *Please give **% WEIGHT LOST.***
     - □ Multiple birth (twins, triplets, or higher order multiples) *Please give **MULTIPLICITY.***
     - □ Baby has poor latch with resultant hyperbilirubinemia
     - □ Baby has congenital ankyloglossia or other craniofacial anomalies e.g., cleft lip/cleft palate (also advise parents to purchase a Haberman feeder) *Please **DESCRIBE CONDITION.***

  2. WOPD for Hospital Grade Breast Pump, MD signature, Date & NPI

- **Apnea Monitor**
  1. Description of Clinical condition(s) requiring apnea monitor
  2. Must provide Settings: Time delay (Seconds), High HR (bpm), & Low HR: (bpm)
  3. WOPD for Apnea Monitor, Length of Need, MD signature, Date & NPI

Attachment 4.0, DME Orders Guidelines (continued)

KAISER PERMANENTE® **Mid-Atlantic Region**

- **Pulse Ox (Continuous) for Infant / Vent Patient**
  1. Indicate clinical reason for request (e.g chronic condition such as neuromuscular, airway issue, etc., Vent dependence, active weaning/titrating of oxygen, pediatric condition)
  2. Must provide **Settings**: Low O2 sat alarm %, High HR limit, Low HR alarm limit, how long to wait before intervening for specific alarms, & Intervention to take for specific alarms
  3. **WOPD** for Continuous Pulse Ox, Length of Need, MD signature, Date & NPI

- **FOR TRACHEOSTOMY PATIENTS**:
  1. **Trach Supplies** (information needed)
     - Trach Size/Type/Brand/Cuffed (A7521) or Un-cuffed (A7520)/Fenestrated or Un-fenestrated; typically, 4/yr. +1 PRN
     - If Disposable Inner Cannulas are needed (A4623); typically, 2/day
     - If Trach Care Kits are needed (A4629); typically, 1/day
     - If Passey-Muir Valve is needed (L8501); typically, 1/2 months
     - **WOPD** for Trach Supplies, Length of Need, MD signature, Date & NPI
  2. **Compressor for Humidification for Trach Patient**
     - ***INCLUDES:*** Compressor (E0565), Lg Volume Nebulizer Kit (A7007) qty 2/mo., Tubing (A7010) qty 100 ft/2 mo., Aerosol Drainage Bag (A7012) qty 2/mo., Trach Mask/Collar (A7525) qty 1/mo.
     - **WOPD** for Compressor & Supplies, Length of Need, MD signature, Date & NPI
  3. **Suction for Trach Patient**
     - ***INCLUDES***: Suction Machine (E0600), Suction Caths- must indicate size in units French (A4624) qty 90/mo., Suction Cannisters (A7000) qty 8/mo., Suction Tubing (A7002) qty 8/mo., Oral/Yankauer Cath (A4628) qty 13/mo., saline bullet 10 ml (A4216) qty 90/mo., Ambu Bag (S8999) 1/year
     - **WOPD** for Suction & Supplies, Length of Need, MD signature, Date & NPI
- **VENTILATOR for TRACH PATIENT** **(requires minimum 7–14-day lead time)*
  1. **Indicate Vent Settings:**
     - **Vent Mode** □ Volume Assist Control (A/C) □ Pressure Support (PS) □ Synchronized Intermittent Mandatory Ventilation (SIMV) □Other: _____
     - **Respiratory Rate:** _____ breaths/min)
     - **Tidal Volume (VT):** _____
     - **% Oxygen:** _____
     - **Amount of +PEEP:** _____
     - **Hours of Use:** _____
     - **Vent Make & Model Being Used in current Facility:** _____
  2. **Supplies to include** Ventilator (E0465) plus back-up vent (E0465), Heated Humidifier (E0562), Water Chamber (A7046) qty 2/yr, Vent Circuits (A4618) qty 1/week, O_2 Stationary (E1390), O_2 Portable (E0431), and included at no charge: Swivel Trach Adapter, External battery & Cable, Battery Charger, Humidifier Bracket, and Heater Pigtail

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Kaiser Permanente Discharge Planning Guide 2022

V4.0, edited 12.16.22

Attachment 5.0 Authorization Request Form Discharge Planning Home Care Orders

Authorization Request Form for Discharge Planning Home Care Orders **FAX Number: 855-334-6902**

SECTION A – MEMBER DEMOGRAPHICS		
Patient Last Name:	**Patient First Name:**	**Patient Middle Initial:**
DOB:	**KP Medical Record Number:**	
Discharge Address:		
City:	**State:**	**Zip Code:**
Patient Phone Number:		

SECTION B – HOME HEALTH CARE	
Home Health Face to Face Documentation	
Date of Face to Face (F2F) Encounter:	**Diagnosis (ICD 10 Code/s):**
Discharge Orders	
☐ S9122 – Home Health Aide ☐ S9123 – Nursing ☐ 99601 – Home NFS/Specialty Drug Adm. Per Visit ☐ S9128 – Speech Therapy ☐ S9129 – Occupational Therapy ☐ S9131 – Physical Therapy	*Please include **discharge orders** and **clinical documentation** from discharging facility.* *Failure to provide **BOTH** can result in cancellation of the referral.*
Date of Discharge:	**Start of Care Date:**
Ordering Physician (Full Name):	**Ordering Physician NPI:**
Discharging Facility:	
Discharging Facility Case Manager:	
Case Manager Phone Number:	**Case Manager Fax Number:**
Home Care Agency:	**Home Care Agency Contact (Full Name):**
Phone Number:	**Fax Number:**

Home care orders must be faxed to Kaiser Permanente upon acceptance by the home care agency

KAISER PERMANENTE

Kaiser Permanente Discharge Planning Guide 2022

V4.0, edited 12.16.22

Attachment 6.0 Home IV Fax Order Form – 9.30.2022

Kaiser Permanente Burke Admixture Pharmacy
5999 Burke Commons Road 4th floor
Burke, VA 22015

Phone (703) 249-7922
Fax (703) 249-7923
Hours 8 AM – 6 PM Mon-Fri

On weekends, evenings, and holidays, call the On Call Pharmacist through the page operator at 1- 888-989-1144

Order Date _____ /_____ /_____

Ordering Provider (full name) _____

Provider Telephone/Address_____

_____

_____

DOB_____ Height_____ Weight_____ Sex_____

Allergies_____

Diagnosis_____

Infecting Organism _____

Patient's Name_____

Kaiser Medical Record # _____

Patient Phone: Home (_____) _____

Work (_____) _____

Patient Address _____

_____

Patient Contact (caregiver) _____

Phone (_____) _____

Patient Homebound as defined by Medicare? _____ Yes _____No

Patient Location: _____ **Room#**_____

Anticipated Discharge Date/Time _____ / _____ / _____ _____AM / PM

Last Dose Given Date/Time_____ / _____ / _____ Time_____ IV Therapy to Begin Date/Time _____ / _____ / _____ _____AM / PM

Nursing Agency Assigned _____ Phone# (_____) _____Fax# (_____) _____

Send Drugs/Supplies to (address) _____ by _____Date_____

Name of Case Manager _____Phone (_____) _____

ADMINISTRATION:

- ☐ Peripheral
- ☐ PICC **circle one** Single Lumen or Double
- ☐ Groshong **circle one** Single Lumen or Double
- ☐ Central-Type:_____
- ☐ Sub-Q
- ☐ Other _____

TREATMENT TYPE:

- ☐ Antimicrobial
- ☐ Pain Control
- ☐ Hydration
- ☐ TPN
- ☐ Anticoagulation
- ☐ Cath Care
- ☐ Other _____

IV Line: Who Placed _____Date _____ Which Arm _____ Tip Location _____ Length _____

For Physician use only: **IV Order: State Drug, Dose, Route, Frequency, and Duration of Therapy for Each Drug Below**

Drug #1: Day#1- For days/ weeks

Drug #2: Day#1- For days/ weeks

Drug #3:_____Day#1-_____For_____days/ weeks

Flush: Heparin 10 u/ml and NACL 0.9% to flush per Home IV Patient Booklet Protocol for two years unless otherwise stated.

Laboratory Orders: (include frequency)

PHYSICIAN Signature_____ Date_____ / _____ / _____ Time _____AM/PM

** For order(s) using KP Provider (Core Facility): Confirmed with KP Provider that medication and lab order(s) in KPHC was routed to KP Burke Home IV

** For order(s) using Non-KP Provider (Non-Core Facility): Please attached medication and lab order(s) with fax form. If orders are written directly on this form or are printed and attached, the orders must include the provider's signature and date (either written or electronic)

**** Please ensure lab order(s) are sent and received by assigned Home Health Nursing (HHN) agency and request if samples can be brought to a KP lab for processing**

Additional Information: _____