# Kaiser Permanente Mid-Atlantic States Discharge Planning Guide 2024

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.

## 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**
  - VCC will arrange transportation and provide ETA

### 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**
- See the **NEW** Utilization Review Departments dedicated email: (instructions below tables)
  - MAS-UM-Teamkp.org@kp.org

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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

| Level of Care/Service | Contact/Providers/Process |
|---|---|
| **Acute Rehab/ LTACH** | • Hospital to fax authorization request: **855-414-2659**<br>• Include cover sheet clearly indicating request, patient identification, return contact information, clinicals, and PT/OT/ST notes within 48 hours<br>• Include vent settings/attempt to wean for **LTACH**<br>• KP will notify requestor of next steps |
| **Skilled Nursing Facility (SNF)** | • Hospital identifies accepting SNF from our network **(Table 1.0)**<br>• With Accessibility to our SNF Authorization Portal - Hospital to submit SNF Authorization Requests to KP via Anna, click here (https://anna.paanalytics.com/)<br>• With no accessibility to our SNF Authorization Portal - Hospital to Fax SNF Authorization Requests to KP @ 855-414-1707<br>• KP to communicate status determination with Hospital, for status questions call our VCC line |
| **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**<br>• HH Agency to Fax HH Authorization Requests to KP @ **855-334-6902**<br>• HH Agency to communicate with hospital on status |
| **Hospice** | • Hospital identifies accepting Hospice from our providers **(Table 3.0)**<br>• Identified Hospice to fax KP authorization request @ **855-414-1707**<br>• **Medicare Advantage**: No pre-authorization required<br>• **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<br>**Include Clinicals and WOPD****(1.0, 2.0 or 3.0) Follow attachment 4.0 DME Guidelines**<br>• Hospital/ SNF 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)<br>  o The VCC will arrange transportation and provide ETA.<br>  o Between 6pm and 8:30am, please contact ECM to arrange transportation |
| **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)** |
| **Inpatient Psychiatry** | • Link for full details: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/community-providers/mas/2022/behavioral-health-level-care-workflow-for-hospitals.pdf.<br>• **For Patient's in the Emergency Department (24/7)**<br>  o Call Page Operator at 703-359-7460 for on-call psychiatrist to approve admission<br>  o Hospital to locate the bed using the IP Psych Network **(see Table 7.0)**<br>  o Once bed is located, the hospital is to contact Emergency Care Management for referral entry and transport<br>• **For Medicine Bed to Psych Bed Transition (Monday – Friday)**<br>  o Call Page Operator at 703-359-7460 for on-call psychiatrist to approve admission<br>  o Hospital to locate bed using the IP Psych Network **(see Table 7.0)**<br>  o Once bed is located, the hospital is to contact Kaiser Permanente Behavioral Health UM for referral at 301-552-1212 (Monday-Friday)<br>  o Hospital arranges transport<br>**Weekends/Holidays**<br>  o Call Page Operator at 703-359-7460 for on-call psychiatrist to approve admission<br>  o Hospital to locate bed using the IP Psych Network **(see Table 7.0)** |
| **Post Hospital Discharge Follow Up Appointments** | • To schedule call KP Line: **866-311-0531** |

**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

| **Dialysis (HD/PD)** | • Submit Admission Paperwork to Dialysis Central Admissions<br>• For more contracted facilities call Renal Resource line and leave voicemail.<br>• HD Dialysis Providers **(see Table 6.0/6.1)**<br>• Renal Resource Line: **301-816-5955** |
|---|---|

| 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.<br>• Hospital to Fax SNF Authorization Requests to KP @ **855-414-1707**<br>• 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<br>• ECM facilitates transport |
| **To Schedule NICU post-discharge follow-up appointment** | • VCC: **301-879-6238**<br>• Please call at least 24-hrs prior to expected discharge with the following information:<br>o Patient demographics, contact information<br>o Expected date of discharge<br>o Fax discharge summary to **855-414-1704**<br>o Neonatologist specialist appointment recommendations<br>o Neonatologist and Hospital Case Management contact information<br>• The VCC will facilitate the scheduling of the post-discharge follow-up appointment and other specialist appointments directly with the family |

## The Utilization Review Department

As we strive to improve our efficiencies to serve our patients best and provide Care Without Delay, the Kaiser Permanente Inpatient Utilization Review Department has created a **NEW** outlook email box MAS-UM-Teamkp.org@kp.org where hospitals can send requests or inquires related to referrals and authorizations. This new option affords a streamlined process for timely response to inquiries, as the mailbox will be assigned to a UR Nurse 5 days a week, from 0830-5pm, Monday through Friday (excluding holidays). Turn-around-time for response will be 24 business hours. As we move forward with this go-live, please connect with the UM Management Team for any questions.

For all new patient notifications at Non-Core Hospitals, please continue to outreach ECM.

For any questions or clarifications, please contact a member of the UM Management Team

| Leader Name | Service Area | Contact |
|---|---|---|
| Alma Allen-Director | KP MidAtlantic | Alma.x.Allen@kp.org |
| Chavon Bailey-UM Manager | Baltimore | Chavon.Bailey@kp.org |
| Diana Lott-UM Manager | DCSM | Diana.w.Lott@kp.org |
| Stacie Lamour-UM Manager | DCSM | Stacie.Lamour@kp.org |
| Suzanne Beckham-UM Manager | NOVA | Suzanne.x.Becham@kp.org |

## SKILLED NURSING FACILITIES (SNFs)

**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

### CORE vs. PREFERRED SNFs

**Core Skilled Nursing Facilities –** Core skilled nursing facilities offer care from on-site Kaiser Permanente physicians. Having our physicians on site at your chosen SNF can provide numerous benefits for your health and recovery. We partner with several core SNFs where our physicians are staffed to provide continuity of care from the hospital to the rehab facility.

What are the key benefits of having Kaiser Permanente physicians on site?

- Improved patient outcomes: Our physicians are trained to provide high-quality, evidence-based care to our patients. Having our physicians on site helps ensure that you get the best possible care, which can lead to improved outcomes and faster recoveries.
- Timely access to care: Having our physicians on site helps ensure that you have timely access to care when you need it. This can help prevent unnecessary hospitalizations and reduce time spent away from your home and loved ones.
- Collaborative care: Our physicians work closely with other members of our care team, including nurses, therapists, and social workers. This ensures that you receive comprehensive, coordinated care that addresses your unique needs and preferences.
- Improved communication: Our physicians use the same digital health record system as our hospitals and clinics, so they have real-time access to your health information. This helps improve communication between your facility and Kaiser Permanente, which can lead to better care coordination and fewer errors.
- Management of complex medical conditions: Our core SNFs have the resources to care for members with complex medical conditions and prevent hospital réadmissions. The services offered may include hemodialysis, trach care, vent care, TPN (total parenteral nutrition), and more.

**Preferred Skilled Nursing Facilities –** Preferred skilled nursing facilities are high-quality SNFs that do not have Kaiser Permanente doctors on site but still provide a high level of care for our members.

Why choose a preferred post-acute provider?

- Kaiser Permanente physicians recommend skilled nursing facilities in our preferred post-acute care network. These facilities have shorter lengths of stay, fewer readmissions, and the highest quality rating in the region for Medicare[1].

**TABLE 1.0,** Core Skilled Nursing Facilities

| Baltimore Metro | Washington, DC, & Suburban Maryland | Northern Virginia |
|---|---|---|
| Advanced Rehab at Autumn Lake 410-296-1990 | Autumn Lake Healthcare at Oak Manor 240-970-5600 | Hill Valley Healthcare – Fair Oaks 703-352-7172 |
| Autumn Lake Healthcare at Baltimore Washington 410-761-1222 | Crescent Cities Nursing Rehabilitation Center 301-699-2000 | Potomac Falls Health Rehab Center 703-834-5800 |
| FutureCare Irvington 410-947-3052 | Layhill Nursing Rehabilitation Center 301-871-2000 | Vierra Falls Church 703-538-2400 |
| Towson Rehabilitation and Healthcare Center 410-828-9494 | Carriage Hill Bethesda 301-897-5500 | Woodbine Rehabilitation Healthcare Center 703-836-8838 |

**TABLE 1.5,** Preferred Skilled Nursing Facilities

| Baltimore Metro | Washington, DC, & Suburban Maryland | Northern Virginia |
|---|---|---|
| Autumn Lake Healthcare at Crofton 410-721-1000 | Autumn Lake Healthcare at Ballenger Creek 301-663-5181 | Carriage Hill Health & Rehab Center 540-785-1120 |
| Lorien Health Systems (Taneytown) 410-756-6400 | Collingswood Rehabilitation & Healthcare Center 301-762-8900 | Loudoun Rehabilitation and Nursing Center 703-771-2841 |
| Meadow Park Rehabilitation & Healthcare Center 410-402-1200 | Complete Care - Hyattsville 301-864-2333 | Manassas Health & Rehab Center 703-257-9970 |
| The Nursing and Rehab Center at Stadium Place 410-544-9890 | Doctors Community Rehabilitation and Patient Care 301-552-2000 | Woodmont Center 540-371-9414 |
| Rossville Rehabilitation and Healthcare Center 410-402-1200 | FutureCare - Pineview 301-856-2930 | Belmont Bay Rehabilitation & Healthcare Center 703-491-6167 |
| Sterling Care Forest Hill 410-893-2468 | | |

For a complete list of contracted Kaiser Permanente facilities, please visit www.kp.org/skillednursing/mas.

[1] In the NCQA Medicare Health Plan Ratings 2023, our Medicare plan is rated 4.5 out of 5, the highest rating in Maryland, Virginia, and Washington, DC. For information on current Medicare star ratings, please visit www.medicare.gov/car9-compare.

**TABLE 2.0,** Home Health Providers

| Home Health Providers | | |
|---|---|---|
| Provider Name | Service Area | Phone Number |
| AMERICARE IN HOME NURSING | Baltimore/Maryland/Virginia/DC | 800-296-9002 |
| BAYADA HOME HEALTH CARE | Baltimore/Maryland | 888-833-5706 |
| CENTERWELL HOME HEALTH | Baltimore/Maryland | 866-409-2145 |
| HOMECALL (LHCG) | Baltimore/Maryland/Virginia/DC | 301-417-2172 |
| HOMECENTRIS HOME HEALTH | Baltimore/Maryland/Virginia/DC | 410-321-8448 |
| HUMAN TOUCH HOME HEALTHCARE | Virginia/Maryland/DC | 703-531-0540 |
| JOHNS HOPKINS HOME HEALTH SERVICES | Baltimore/Maryland/Virginia/DC | 410-288-8000 |
| MEDSTAR HEALTH VISITING NURSE ASSOCIATION | Baltimore/Maryland/Virginia/DC | 800-862-2166 |
| PAVILION MEDICAL HOME CARE AND STAFFING | Virginia | 703-299-9898 |
| REVIVAL (ADORATION dba REVIVAL) | Baltimore/Maryland/Virginia/DC | 888-225-6905 |
| TRINITY HOME HEALTH (HOLY CROSS) | Maryland | 301-754-7740 |
| VIRGINIA HEALTHCARE SERVICES | Virginia | 703-333-5288 |
| VNA OF MARYLAND (LHCG CXLIX/VNA OF MARYLAND) | Baltimore/Maryland/Virginia/DC | 800-862-2166 |
| Pediatric Home Health Providers | | |
| Provider Name | City | Phone |
| AMERICAN CARE PARTNERS @ HOME INC | Fairfax, VA | 703-532-4356 |
| AMERICAN PEDIATRIC CONSULTANTS | Chantilly, VA | 703-961-0732 |
| COMPREHENSIVE NURSING SER | Nottingham, MD (Balt) | 410-529-5019 |
| HOME HEALTH CONNECTION INC | Reston, VA | 703-860-2519 |
| HOME HEALTH CONNECTION INC | Baltimore, MD | 301-718-7857 |
| HOME HEALTH CONNECTION INC | Bethesda, MD | 301-718-7857 |
| JOHNS HOPKINS-PEDS AT HOME CARE | Baltimore, MD | 410-288-8150 |

**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) Vendors & Contact Information | | | |
|---|---|---|---|
| Vendor Name | Transport Types | County Coverage | Phone Number |
| BUTLER | BLS, ALS, Critical Care Ambulance | **See Service Area & County Coverage in Grid Below** | 410-602-4007 |
| LIFESTAR | BLS, ALS, Critical Care Ambulance | | 410-290-8000 |
| LIFECARE | BLS, ALS, Critical Care Ambulance | | 540-752-5883 |
| PROCARE | BLS, ALS, Critical Care Ambulance | | 410-823-0030 |
| AEC | BLS, ALS, Critical Care Ambulance | | 833-232-6911 |

| Transportation Service Area & County Coverage Grid | | | | |
|---|---|---|---|---|
| **Baltimore Hospitals** | | | | |
| Hospital | County Name | Primary | Secondary | Backup |
| **BWMC**<br>**AAMC** | Anne Arundel | ProCare | Lifestar | Butler |

<table>
<tr><td rowspan="2">Grace Medical<br>Franklin Square Medical Center<br>Good Samaritan Hospital<br>Greater Baltimore Medical Center<br>Harbor Hospital<br>Johns Hopkins Bayview medical Center<br>Johns Hopkins Hospital<br>Mercy Medical Center<br>Northwest Hospital<br>Saint Agnes<br>UMMC Shock Trauma<br>Sinai Hospital<br>Union Memorial Hospital<br>Univ of Maryland Med Center-Midtown (MD general hospital)<br>Univ of MD St Joseph Medical Center<br>Univ of Maryland Medical System</td><td>Baltimore City</td><td>Lifestar</td><td>ProCare</td><td>Butler</td></tr>
<tr><td>Baltimore County</td><td>Lifestar</td><td>ProCare</td><td>Butler</td></tr>
<tr><td>Carroll County General Hospital</td><td>Carroll</td><td>Butler</td><td>ProCare</td><td>Lifestar</td></tr>
<tr><td>University of MD Upper Chesapeake</td><td>Harford</td><td>Lifestar</td><td>ProCare</td><td>Butler</td></tr>
<tr><td>Howard County General Hospital</td><td>Howard</td><td>Lifestar</td><td>ProCare</td><td>Butler</td></tr>
<tr><td>See Counties</td><td>Caroline, Kent, Queen Anne’s, Talbot, Wicomico, Worcester</td><td>N/A</td><td>N/A</td><td>Butler, Lifestar, ProCare</td></tr>
<tr><td colspan="5">DCSM Hospitals</td></tr>
<tr><td>Hospital</td><td>County Name</td><td>Primary</td><td>Secondary</td><td>Backup</td></tr>
<tr><td>Calvert Memorial</td><td>Calvert</td><td>ProCare</td><td>Lifestar</td><td>Butler</td></tr>
<tr><td>University of MD Charles Regional</td><td>Charles</td><td>ProCare</td><td>Lifestar</td><td>Butler</td></tr>
<tr><td>Frederick Memorial Hospital</td><td>Frederick</td><td>Butler</td><td>ProCare</td><td>N/A</td></tr>
<tr><td>Adventist Behavioral Health<br>Shady Grove Adventist ER<br>Shady Grove Adventist Hospital<br>Suburban Hospital<br>Holy Cross Hospital<br>Holy Cross Germantown Hospital<br>Manor Care- Wheaton<br>Medstar Montgomery Hospital<br>Walter Reed National Medical Center<br>White Oak Medical Center</td><td>Montgomery</td><td>Butler</td><td>Lifestar</td><td>ProCare</td></tr>
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|---|---|---|---|---|
| **Univ of MD Bowie Health<br>Luminis Health Doctors Community Hospital<br>Adventist Health care Fort Washington Medical Center<br>MedStar Southern Maryland Hospital<br>UM Laurel Medical Center<br>Univ of MD Capital Region** | Prince George's | ProCare | Lifestar | Butler |
| **MedStar St. Mary's Hospital** | St. Mary's | ProCare | Lifestar | Butler |
| **Meritus Medical Center** | Washington | Butler | ProCare | Lifestar |
| **Georgetown University Hospital<br>George Washington University<br>Howard University Hospital<br>Children's Hospital<br>WHC<br>United Medical Center<br>Washington DC VA Medical Center<br>Sibley Memorial Hospital** | Washington D.C. | ProCare | Butler | Lifestar |
| **NOVA Hospitals** | | | | |
| Hospital | County Name | Primary | Secondary | |
| **Inova Alexandria Hospital** | Washington | Butler | ProCare | N/A |
| **Manor Care- Arlington<br>VHC** | Arlington | Lifecare | AEC | N/A |
| **Inova Fairfax Hospital<br>Inova Fair Oaks Hospital<br>Reston Hospital Center<br>Inova Mount Vernon Hospital<br>Franconia/Springfield** | Fairfax | Lifecare | AEC | N/A |
| **Fauquier Hospital** | Fauquier | Lifecare | AEC | N/A |
| **Stafford Hospital<br>Mary Washington Hospital** | Fredericksburg City | Lifecare | AEC | N/A |
| **Inova Loudoun Hospital<br>Stone Spring** | Loudon | Lifecare | AEC | N/A |
| **Prince William Medical Center** | Manassas City | AEC | Lifecare | N/A |
| **Prince William Medical Center<br>Sentara Northern Virginia<br>Haymarket Medical Center** | Prince William | AEC | Lifecare | N/A |
| **Spotsylvania Regional Medical Center** | Spotsylvania | Lifecare | AEC | N/A |

| | | | | |
|---|---|---|---|---|
| **Stafford Hospital**<br>**Mary Washington Hospital** | Stafford | Lifecare | AEC | N/A |
| **Culpepper Regional Hospital**<br>**Warren Memorial** | Other | Lifecare | AEC | N/A |

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

| Contracted Infusion Services | | |
|---|---|---|
| Provider Name | Service Area | Phone Number |
| **BURKE PHARMACY (KAISER PERMANENTE)**<br>**Use Burke Pharmacy for all IV ABX and TPN**<br>**Required Information:**<br>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<br>Burke Home IV Pharmacy Phone: 703-249-7922 |
| **OPTION CARE**<br>**Only use for specialty infusion and IV ABX that Burke Pharmacy cannot accept**<br>**(IVs, ABX, TPN, Milrinone)** | Maryland | Phone Number: 800-241-6163<br>Fax Number: 301-362-7847 |
| | Virginia and District of Columbia | Phone Number: 703-230-4638<br>Fax Number: 703-230-4639 |
| **NATIONS**<br>**Only use for specialty infusion and IV ABX that Burke Pharmacy cannot accept**<br>**(IVABX/TPN)** | Maryland, District of Columbia, & Virginia | Phone Number: 888-473-8376<br>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 |
| FMC TOWSON | BALTIMORE | 410-321-1920 |
| FMC PIKESVILLE | BALTIMORE | 410-484-3128 |
| 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 |
| HOWARD COUNTY DIALYSIS | COLUMBIA | 410-997-4244 |
| DAVITA CEDAR LANE | COLUMBIA | 410-261-6783 |
| DAVITA GLEN BURNIE | ANNE ARUNDEL | 410-760-1040 |
| **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 |
| 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 |
| US RENAL FORT WASHINGTON | FORT WASHINGTON | 301-292-3610 |
| US RENAL OXON HILL | OXON HILL | 301-749-9307 |
| **VIRGINIA LOCATIONS** | | |
| FMC ALEXANDRIA DIALYSIS | ALEXANDRIA | 703-823-7940 |
| CDC SPRINGFIELD | SPRINGFIELD | 703-321-8530 |
| B M A OF FAIRFAX | FAIRFAX | 703-698-8070 |
| DAVITA ASHBURN | LOUDON | 571-223-0451 |
| DAVITA NEWINGTON | LORTON | 703-339-6059 |
| FMC MANASSAS | MANASSAS | 703-530-1006 |
| RENAL CARE PARTNERS OF RESTON LLC | RESTON | 703-476-0605 |
| RENAL CARE PARTNERS OF FAIRFAX | FAIRFAX | 703-691-7820 |

| | | |
|---|---|---|
| STERLING DIALYSIS | STERLING | 703-444-8932 |
| WOODBRIDGE DIALYSIS CENTER | WOODBRIDGE | 703-897-7027 |
| MANASSAS DIALYSIS | MANASSAS | 703-257-5445 |
| US RENAL ARLINGTON | ARLINGTON | 703-892-0250 |
| US RENAL FALLS CHURCH | FALLS CHURCH | 703-533-8247 |

**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

**To access the provider manual, go to:**
https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/provider-info#provider-manuals

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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

**Authorization Request/Physician Order Form for Durable Medical Equipment** **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:** |
| **Patient Emergency Contact Name:** | **Phone:** | |
| | | |
| **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** ***(O2 sat testing required)*** | **ENTERAL NUTRITION** ***(Nutrition notes required)*** | **OSTOMY SUPPLIES** |
| ☐ Stationary & Portable $O_2$ @ ______ LPM via nasal cannula<br>☐ continuous<br>☐ w/ambulation<br>☐ during sleep<br>☐ Other: ______________________________<br>______________________________________ | Formula name:<br>________________________________________<br>Alternative Formula: ______________________<br>☐ Bolus _______cc _______x/day<br>☐ Gravity _______cc _______ x/day<br>☐Pump ____cc/hr. x _____hrs./day<br>☐ Additives (i.e., Prosource):<br>________________________________________ | Indicate brand & model # for supplies (i.e., Hollister, Coloplast, 2-piece, etc.)<br>_____________________________________<br>_____________________________________<br>_____________________________________<br>☐ Adhesive Remover Wipes 25/mo.<br>☐ Skin Barrier Wipes 25/mo.<br>☐ Ostomy Deodorant 8oz/mo.<br>☐ Ostomy Paste (Pectin) 4oz/mo.<br>☐ Stoma Powder 2oz/mo. |
| ***MD Signature:** | **NPI:** | **Date:** |

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*V5.0, edited 12.01.24*

| **CPAP or BiPAP** *(Sleep study required)* | **UROLOGIC SUPPLIES** *(complete all fields)* | **WOUND SUPPLIES** *(wound notes and measurements required)* |
|---|---|---|
| □ CPAP @ ____________cm $H_2O$<br>□ BiPap w/out back-up (E0470)<br>IPAP: ____ EPAP: ____ Ramp or C-Flex: ____<br>□ BiPap with Back-up (E0471)<br>IPAP: ___ EPAP: ___ *Backup Rate*: _______<br>**Mask type:**<br>□ Full Face Mask □ Nasal Pillows<br>□ Nasal Cushions □ Other: _______________<br>*All machines to include heated humidifier, heated tubing, disposable filters & supplies for specified mask* | *Cause of Urinary retention:* ________________<br>*Catheter Size:* _____ *French*<br>*Catheter Tip:* □ *Straight* □ *Coudé*<br>□ *Foley* ___ *Latex* ___ *Silicone*<br>*(Include: insertion kit, drainage bags, leg strap)*<br><br>*Frequency of Foley changes:* __________<br>□ *In & Out Cath* ____*x per day plus lubricant*<br><br>*Other:* ________________________________ | *Type of wound (e.g., surgical, pressure ulcer, burn, etc.):* ___________________________<br>*Wound Location:* _____________________<br>*Wound Measurements:*<br>*Length(cm)* _____ *W(cm)* ____ *D(cm)*____<br>*Drainage amount:*<br>____________________________________<br>*Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):*___________________________<br>____________________________________<br>____________________________________<br>*Frequency of changes:* ________________<br>*Attach another sheet for additional wounds* |

| **WOUND VAC & SUPPLIES** *(Wound Notes & Surgery OP Notes required)* |
|---|
| **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*<br>Wound location: _____________________ Wound type: __________________________ Wound Length (cm) ____x width _____ x depth _____<br>□ Number or months: _____ Pressure Setting: _______ Dressing type: ________________________ Frequency of Dressing changes: _______ |

| **WHEELCHAIR** *(PT/OT clinicals required)* | **WALKER** *(PT/OT clinicals required)* | **COMMODE** *(OT clinicals required)* |
|---|---|---|
| □ Manual WC □ Heavy Duty WC (>250 lbs.)<br>□ Hemi WC □ Lightweight WC<br>□ Elevating Leg Rests<br>□ Removable Arm Rests<br>□ Other: ______________________ | □ Standard Walker<br>□ Front-wheeled walker<br>□ Rollator (walker w/seat)<br>□ Hemi-walker ___R ___ L<br>□ Other: ________________________ | □ Standard Commode<br>□ Drop Arm Commode<br>□ Heavy Duty (>300 pounds) |
| **HOSPITAL BED** *(PT/OT/ST clinicals required)* | **PATIENT LIFT** *(PT/OT clinicals required)* | **OTHER** *(supporting clinicals required)* |
| □ Semi-Electric Hospital Bed<br>□ Wide Bed for pt >350 pounds<br>□ Include trapeze attached to bed | □ Hydraulic Patient Lift with Standard Sling | Other, *please describe*:<br>____________________________________<br>____________________________________<br>____________________________________ |
| ***MD Signature:** | **NPI:** | **Date:** |

**The physician's signature, NPI and date on this form serves as the Written Order, it must be completed to ensure processing.*

**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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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

**Authorization Request Physician Order Form for Durable Medical Equipment** **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:** |
| **Patient Emergency Contact Name:** | **Phone:** | |
| | | |
| **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** *(O2 sat testing required)* | **ENTERAL NUTRITION** *(Nutrition notes required)* | **WOUND SUPPLIES** *(wound notes and measurements Required)* |
| □ Stationary & Portable $O_2$ @ ______ LPM via nasal cannula □ continuous<br>□ w/ambulation<br>□ during sleep<br>□ Other: ______________________________<br>____________________________________ | Formula name:<br>____________________________________<br>Alternative Formula: ________________<br>□ Bolus _____cc _____x/day<br>□ Gravity _____cc _____ x/day<br>□ Pump _____cc/hr. x ____hrs./day<br>□ Extension Tubing 12" for use with pump □ Additives (i.e., Prosource):<br>____________________________________<br>□ NG Tube or MIC-KEY button (give size):<br>____________________________________ | Type of wound (e.g., surgical, pressure ulcer, burn, etc.): ___________________________<br>Wound Location: ______________________<br>Wound Measurements:<br>Length (cm) _____ W (cm) ___ D (cm) ___<br>Drainage amount:<br>____________________________________<br>Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):______________________________<br>____________________________________<br>Frequency of changes: ___________________<br>*Attach another sheet for additional wounds* |
| ***MD Signature:** | **NPI:** | **Date:** |

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| **APNEA MONITOR** ***(complete all fields)*** | **PULSE OX FOR INFANT** ***(complete all fields)*** | **OTHER** |
|---|---|---|
| Apnea Monitor & Settings:<br>High HR (bpm): _____ Low HR: (bpm): ________<br>Time delay (Sec): _______ | Pulse Ox for Infant<br>Settings: Low sat alarm %: ________<br>High HR (bpm): _____Low HR (bpm):________<br>How long to wait until intervention? ________________________________________<br>Intervention: ________________________________________ | Other, *please describe*:<br>___________________________________________<br>___________________________________________<br>___________________________________________<br>___________________________________________<br>___________________________________________<br>___________________________________________<br>___________________________________________<br>___________________________________________ |
| **BILI BLANKET** | **HOSPITAL GRADE BREAST PUMP** | |
| □ Bili blanket x _____ days (up to 5)<br>**Delivery location required* | □ Hospital Grade Breast Pump<br>**Authorization issued to Mom, not baby* | |
| ***MD Signature** | **NPI:** | **Date:** |

**The physician's signature, NPI and date on this form serves as the Written Order, it must be completed to ensure processing.*

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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

**Authorization Request Physician Order Form for Durable Medical Equipment** **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:** |
| **Patient Emergency Contact Name:** | **Phone:** | |
| | | |
| **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** *(O2 sat testing required)* | **ENTERAL NUTRITION** *(Nutrition notes required)* | **WOUND SUPPLIES** *(wound notes and measurements required)* |
| □ Stationary & Portable $O_2$ @ ______ LPM via Trach Mask<br>□ continuous<br>□ w/ambulation<br>□ during sleep<br>**Note, O2 setting for vent is in Ventilator section*<br>□ Other: ______________________________<br>________________________________________ | Formula name:<br>________________________________________<br>Alternate Formula: __________________<br>□ Bolus _____cc _____x/day<br>□ Gravity _____cc _____ x/day<br>□ Pump _____cc/hr. x ____hrs./day<br>□ Extension Tubing 12" for use with pump<br>□ Additives (i.e., Prosource):<br>________________________________________ □<br>NG Tube or MIC-KEY button (give size):<br>________________________________________ | Type of wound (e.g., surgical, pressure ulcer, burn, etc.): ____________________________<br>Wound Location: _______________________<br>Wound Measurements:<br>Length (cm) _____ W (cm) ___ D (cm) ___<br>Drainage amount:<br>__________________________<br>Dressing Order (include TYPE of dressing, Size of dsg. Number to be used Per Dressing change):________________________________<br>____________________________________<br>____________________________________<br>Frequency of changes: _________________<br>*Attach another sheet for additional wounds* |

| **PULSE OX FOR INFANT / VENT PATIENT** *(complete all fields)* |
|---|
| Settings: Low sat alarm %: ___________________ High HR (BPM): _______ Low HR (bpm): _________<br>How long to wait until intervention? ______________________________________________________<br>Intervention: ______________________________________________________________________ |

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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

| **TRACH SUPPLIES** ***(complete all fields)*** | **COMPRESSOR FOR TRACH HUMIDIFICATION** | **SUCTION FOR TRACH PATIENT** ***(complete all fields)*** |
|---|---|---|
| Trach Size/Type/Brand - Provide item # written on Trach box (Vendor will not deliver without):<br>________________________________________<br>________________________________________<br>□ Cuffed (A7521) □ Un-cuffed (A7520)<br>□ Fenestrated □Un-fenestrated<br>□ Disposable Inner Cannulas (A4623) qty 2/day<br>□ Trach Care Kits (A4629) qty 1/day<br>□ Passey-Muir Valve (L8501) qty 1/2 mo.<br>□ Other: ______________________________<br>** Requires 7-day lead processing time* | **Includes all the following:*<br>☐ Compressor and supplies (E0565)<br>• Lg Volume Nebulizer Kit (A7007) qty 2/mo.<br>• Tubing (A7010) qty 100 ft/2 mo.<br>• Aerosol Drainage Bag (A7012) qty 2/mo.<br>• Trach Mask/Collar (A7525) qty 1/mo. | **Include all the following:*<br>☐ Suction Machine and supplies (E0600)<br>• Suction Caths- must indicate size in units French_____ (A4624) qty 90/mo.<br>• Suction Cannisters (A7000) qty 8/mo.<br>• Suction Tubing (A7002) qty 8/mo.,<br>• Oral/Yankauer Cath (A4628) qty 13/mo.<br>• saline bullet 10 ml (A4216) qty 90/mo.<br>• Ambu Bag (S8999) 1/year |

| **VENTILATOR & SUPPLIES** ***(complete all fields)*** | | |
|---|---|---|
| **Vent Mode:** □ Volume Assist Control (A/C) □ Pressure Support (PS)<br>□ Synchronized Intermittent Mandatory Ventilation (SIMV)<br>□ Other: ___________________________________________________________<br>Respiratory Rate: _____ (breaths/min) Tidal Volume (VT): ______<br>% Oxygen: _______ Amount of +PEEP: ______ Hours of Use: _______<br>Vent Make & Model Being Used in current Facility: ____________________<br>**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 |
| ***MD Signature:** | **NPI:** | **Date:** |

**The physician's signature, NPI and date on this form serves as the Written Order, it must be completed to ensure processing.*

**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

## Durable Medical Equipment Guidelines

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

**Durable Medical Equipment Orders Guidelines:** ***PT/OT/ST clinicals are required.***
*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 nontolerance 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)
  2. Please send member home with a few days of ostomy supplies to allow for delivery time
  3. Need very specific brand, name, and item # for the ostomy bag & wafer so member gets correct item (s)
- **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 send member home with a few days of urologic supplies to allow for delivery time
  2. Please attach WOPD & note including the above clinical information. See the specifics on the Authorization Request form
- **Wound Supplies**
  1. Need wound measurements
  2. Need specifics of wounds supplies used each dressing change so the appropriate qty is approved
  3. Please send member home with a few days of wound supplies to allow for delivery time
  4. 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

- **Wheelchair** ***(PT/OT clinicals required)***
  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** ***(PT/OT clinicals required)***
  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** ***(PT/OT/ST clinicals required)***
  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$^{0}$, 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** ***(PT/OT clinicals required)***
  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 <u>**or**</u> 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 (<**36 weeks and 6-day gestation**) a two-phase expression technology electric breast pump (i.e., Medela Symphony) *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
  3. **Normally approved for 3 months**

- **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

- **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)
  - Need the specific item # from the trach box (Vendor will not deliver without this info)
  - 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

  4. **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:** ____________________________________________
     - **<u>Supplies to include</u>** 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

*The Durable Medical Equipment Guidelines pages do not need to be faxed with your DME submission.*

## 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<br>☐ S9123 – Nursing<br>☐ 99601 – Home NFS/Specialty Drug Adm. Per Visit<br>☐ S9127 – Social Work<br>☐ S9128 – Speech Therapy<br>☐ S9129 – Occupational Therapy<br>☐ S9131 – Physical Therapy | *Please include **discharge orders** and **clinical documentation** from discharging facility.*<br><br>*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***

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# Kaiser Permanente Discharge Planning Guide 2024

*V5.0, edited 12.01.24*

## 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:** ________________________________________________________________

**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