



# Qualifying Condition Determination for ECHO-Referral



**Instructions:**

This application is to be completed by a **psychiatrist** (M.D. or D.O.), **clinical psychologist** (Ph.D. or Psy.D.) or **developmental pediatrician** (M.D. or D.O.) who is recommending services for Pervasive Personality Disorder (PDD) through ECHO. Information given must be current and based on recent contact with the patient and family. Receipt of **complete information** is critical for timely processing of this referral. Incomplete submission may result in delays.

Please provide the following documentation or complete this form and submit to the ECHO Case Manager:

- A. Psychosocial assessment/psychiatric evaluation by psychiatrist or psychologist or developmental evaluation by developmental pediatrician.
- B. Psychological testing, if available, including functional assessment, documenting:
  - Diagnosis and severity of disorder;
  - Specific areas of developmental delay;
  - Specific areas of functional impairment;
  - Level of intellectual/cognitive functioning; and
  - Coexisting developmental, cognitive or psychological conditions.
- C. School testing, school social history, and an Individualized Educational Plan (IEP), if available.
- D. Pertinent medical information or any additional information that will assist in determining the medical necessity for ECHO services.

<b>Patient's Name:</b>	<b>Sponsor SSN:</b>
<b>Completed By:</b>	<b>Date Completed:</b>
<p>1. Under which of the following qualifying conditions for ECHO are you recommending this beneficiary?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Moderate or severe mental retardation (IQ 55 or below) based on age-normed IQ testing</li> <li><input type="checkbox"/> Down Syndrome or Fetal Alcohol Syndrome in a beneficiary less than 3 years old</li> <li><input type="checkbox"/> A developmental delay demonstrated by standardized diagnostic psychometric tests measuring 2 standard deviations below the mean in adaptive, cognitive, or language function for a beneficiary less than 3 years old</li> <li><input type="checkbox"/> A complex physical or psychological clinical condition of such severity that it results in the beneficiary's being homebound</li> <li><input type="checkbox"/> A physiological disorder or condition or anatomical loss affecting one or more body systems, which has lasted, or with reasonable certainty is expected to last for a minimum period of twelve contiguous months and which precludes the beneficiary from unaided performance of breathing, cognition, hearing, seeing, and age-appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring and walking.</li> </ul> <p>The following are exclusions from ECHO:</p> <ul style="list-style-type: none"> <li>• Learning disorders</li> <li>• ADHD or any condition in the spectrum of disruptive behavior disorders that does not meet the above criteria.</li> </ul>	
<b>Provide a brief summary justifying your recommendation:</b>	



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<b>Patient's Name:</b>		<b>Sponsor SSN:</b>	
2. DSM IV Diagnosis or Diagnoses: Please validate all criteria with examples and descriptive level of severity, i.e. DSM diagnosis of autism displays 6 or more of 12 symptoms listed across 3 major areas-social interaction, communication and behavior. List symptoms and describe severity.			
3. Current Medications	Daily Dose	Start Date	Results
4. Patient's current placement:			
<input type="checkbox"/> Home <input type="checkbox"/> Other Family <input type="checkbox"/> Foster Setting <input type="checkbox"/> Other <input type="checkbox"/> Specify			
5. Describe patient's current family structure (living situation, parental roles, family support, areas needing strengthening):			
6. List agencies involved with this patient, and what is the scope of their involvement (special ed, social services, etc):			
7. Is Applied Behavioral Analysis therapy being requested? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Briefly describe treatment attempts in the past year.			
9. List goals you see as necessary and attainable for this patient/family in the next six months.			

**TriWest ECHO Case Management Hub Office Fax Numbers:**

- |  |                |
|--|----------------|
| Northwest Hub - Washington, Oregon, Alaska, N. Idaho   | 1-866-269-5881 |
| Southwest Hub - California, Nevada, Yuma Arizona   | 1-866-269-5828 |
| Mountain Hub - Arizona, El Paso Texas, New Mexico, Utah, Montana, S. Idaho                       | 1-866-269-5819 |
| Central Hub - Colorado, Nebraska, Minnesota, Iowa, N Dakota, S Dakota, Wyoming, Missouri, Kansas | 1-866-312-5840 |
| Hawaii Hub - Hawaii  | 1-866-269-5814 |

Provider Signature: \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_