## Automatic Exception

Resident Name_____ Resident Number_____
Facility Name_____
Start of Care Date:_____ KX Modifier Effective Date_____

Discipline, Circle Disciplines:
Occupational Therapy Physical Therapy Speech-Language Pathology

The item checked below indicates the reason this patient qualifies for an automatic exception to the Part B therapy limitation:
Specific medical condition: ICD code:_____ Descriptor:_____
Specific medical condition: ICD code:_____ Descriptor:_____

Discharged from a hospital or SNF within 30 treatment days of starting this episode of therapy:
Date of discharge:_____ Name of hospital or SNF:_____

Generalized musculoskeletal conditions or conditions affecting multiple (not listed as automatically excepted by condition) that will directly and Significantly impact the rate of recover. List conditions and describe impact: _____
_____

Mental and cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery. List condition / disorder and describe impact:
_____
_____

Requires PT and SLP services concurrently.
Prior episode of outpatient therapy during this calendar year for a different condition. (For subsequent episodes of therapy for the same condition, a manual exception request must be completed). List dates of prior episode and condition:
_____

Treatment is required in order to return to a pre-morbid living environment:
Prior living environment:_____
Skills required in order to return:_____

Treatment is required in order to reduce Activities of Daily Living (ADL) Assistance or Instrumental ADL assistance to pre-morbid levels.
Current ADL/IADL status:_____
Pre-morbid ADL/IADL status:_____

The beneficiary does not have access to outpatient hospital therapy services; e.g., transportation is physical hardship, prevented due to consolidated billing (occupies Medicare certified bed), lack of therapy services at hospital in beneficiary's county.
_____

Therapist Name and Title: _____ Date: _____

Therapist Signature: _____