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 recovery. 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: ____________________________________