# Part B Insider (Multispecialty) Coding Alert

## In other news

What's the difference between a "recommended" advance beneficiary notice (ABN) and a "required" ABN? That difference could be thousands of dollars in lost revenue if you don't keep up with CMS requirements.

**Background:** Earlier this year, if you provided outpatient therapy services to a patient who had exceeded the therapy cap, the beneficiary was automatically responsible for the non-covered services, and CMS had encouraged therapists to issue a voluntary ABN as a courtesy, even though it wasn't required.

Fast forward to Sept. 6, when CMS issued MLN Matters article MM8404, which states that this rule has changed. "Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable," the article advises. "ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges."

Of course, as in the past, if you are providing therapy services that aren't reasonable and necessary, you must get the patient to sign an ABN, regardless of the patient's status with the therapy cap.

To read the complete article, which includes examples of phrases you can use in a therapy cap-related ABN, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8404.pdf.