C-Brace ®

Coding and Billing Tips [1-4]

Effective: September 24, 2018

Suggested Coding

Ottobock intends to apply for a new Healthcare Common Procedure Coding System (HCPCS) code to describe the C-Brace. Until we have new coding for the C-Brace, we recommend using the following miscellaneous code to describe it.

L2999	L2999 Ottobock 17KO1 C-Brace microprocessor stance and swing phase controlled orthosis (SSCO), includes real-time gait analysis, hydraulic, stance & swing phase flexion & extension resistance, stumble recovery, backward walking, control for sitting/standing transitions, and intuitive stance. Single/double upright, with carbon fiber (femoral & calf shells, foot plate), soft interfaces and any ankle component(s); includes diagnostic test orthosis; power supply and charger; custom fabricated.

Manufacturer Suggested Retail Price (MSRP)

2018	MSRP for the C-Brace is $90,000.00

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Billing Tips for the C-Brace

Narrative Section on the HCFA 5010 Claim[2]

Because L2999* is an unlisted (NOC) code, the claim must have additional information to describe the item. This will allow the payer to understand what you are billing them for. Most payers require a narrative be added to the claim (e.g. description, manufacturer, name & model#, serial number#, and MSRP). Please check with your software vendor and payer to confirm narrative placement.

Where to Put the Narrative for the L2999 Code

Electronic Claim	Loop 2400 Segment, Element SV101-07: Insert information here specific to the line item you are billing for. Example: Ottobock 17KO1 C-Brace Microprcsr Ctrl Hyd SSCO Custom Fab MSRP $_____ (add brief medical necessity) * Note Loop 2400 segments is limited to 80 characters (including spaces)
Paper Claim[3]	Enter entire narrative on Line 19 when submitting a hand-written paper claim (CMS-1500). Include the HCFA 1500 line number that the NOC code is located on. Line 2**:** L2999 Ottobock 17KO1 C-Brace Microprcsr Ctrl Hyd SSCO Custom Fab MSRP $_____ (add brief medical necessity)

What happens if the narrative is omitted?

If a narrative is not included, the required information is expected to be attached to the claim. If there is no narrative or attachment, your claim 1) will be rejected on the front end, or 2) will receive a denial that does not include appeal rights. Both types of denials require the claim be resubmitted with the requested information. Generally, standardized narratives enable carriers to recognize similar claims and assign pricing, thereby improving the process.

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Reimbursement Amount

The reimbursement methodology for miscellaneous codes is generally stated in your contract with the payer. Miscellaneous codes are sometimes referred to as Not Otherwise Classified (NOC), Not Otherwise Specified (NOS) or Non-Assigned codes. The most common methodologies are:

- MSRP minus ___%
- Cost plus ___%
- Usual and Customary (average amount that you bill for similar devices)
- Average Regional Amount billed for similar devices
- Lesser of the above

It is highly recommended to carefully review your contract with the payer when providing a miscellaneous coded product. If the information is not in your contract, provider relations may be able to help.

Medical Review

Sometimes codes requiring narratives are sent to Medical Review regardless of proper claim submission. If this happens, you will need to submit all documentation (including proof of medical necessity) as the claim will likely undergo medical necessity review. See Ottobock document titled "C-Brace Reimbursement Starter Packet" for additional information as to which documentation may be required.

Conclusion

Following these instructions will help you have a more successful outcome. For additional reimbursement information, or if you have questions about this material, please contact Otto Bock Reimbursement at 800.377.0338 or you can email your question to: Reimbursement911@ottobock.com.

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References

[1] The product/device "Supplier" (defined as an O&P practitioner, O&P patient care facility, or DME supplier) assumes full responsibility for accurate billing of Ottobock products. It is the Supplier's responsibility to determine medical necessity; ensure coverage criteria is met; and submit appropriate HCPCS codes, modifiers, and charges for services/products delivered. It is also recommended that Supplier's contact insurance payer(s) for coding and coverage guidance prior to submitting claims. Ottobock Coding Suggestions and Reimbursement Guides are based on reasonable judgment and are not recommended to replace the Supplier's judgment. These recommendations may be subject to revision based on additional information or alpha-numeric system changes.

[2] L2999 cannot be billed to Medicare for the C-Brace at this time

[3] The manufacturer's suggested retail pricing (MSRP) is a suggested retail price only. Ottobock has provided the suggested MSRP in the event that third-party and/or federal healthcare payers request it for reimbursement purposes. The practitioner and/or patient care facility is neither obligated nor required to charge the MSRP when submitting billing claims for third-party reimbursement for the product(s).

[4] Joint DME MAC. Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426). Not Otherwise Classified (NOC) BILLING INFORMATION. Updated May 7, 2018.

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