



The Centers for Medicare and Medicaid Services granted the LINX procedure a unique HCPCS Code for billing all Medicare fee-for-service. Effective January 1, 2014, Traditional Medicare (fee-for-service) hospital outpatient and ambulatory surgery center claims for LINX should be billed using the following C-code<sup>2</sup>:

***C9737 - Laparoscopy, surgical esophageal sphincter augmentation with device (eg. magnetic band)***

## COMMON DIAGNOSIS CODES

ICD-9	Description
530.11	Reflux Esophagitis
530.81	Esophageal Reflux

## PROFESSIONAL - PHYSICIAN

CPT Code <sup>1</sup>	Description	2014 National Medicare Average <sup>2</sup>
43289	Unlisted Laparoscopy procedure - esophagus	Payer/Carrier Priced

## HOSPITAL OUTPATIENT

	CPT/HCPCS Codes <sup>1</sup>	Description	APC	2014 National Medicare Average <sup>2</sup>
Medicare Fee-for-Service	C9737*	Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)	0174	\$8,595.40
Commercial Payers	43289	Unlisted Laparoscopy procedure - esophagus		Payer Priced
	L8699	Prosthetic implant, not otherwise specified		Payer Priced

\* C9737 is payable in the Ambulatory Surgery Center setting. The 2014 National Medicare Average is \$4,747.00

*Indication for Use - The LINX® Reflux Management System is indicated for patients diagnosed with Gastroesophageal Reflux Disease (GERD) as defined by abnormal pH testing, and who continue to have chronic GERD symptoms despite maximum medical therapy for the treatment of reflux.*



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## COMMON DIAGNOSIS CODES

ICD-9	Description
530.11	Reflux Esophagitis
530.81	Esophageal Reflux

## HOSPITAL INPATIENT

ICD-9	Description
44.67	Laparoscopic procedures for creation of esophagogastric sphincteric competence

MS-DRG	Description
326	Stomach, esophageal and duodenal procedures with MCC
327	Stomach, esophageal and duodenal procedures with CC
328	Stomach, esophageal and duodenal procedures without CC/MCC

Revenue Codes <sup>1</sup>	Description
278	Medical/surgical supplies, other implants
360	OR Services

1 American Medical Association, CPT® 2014, Professional Edition and HCPCS 2014, Professional Edition.

2 Centers for Medicare and Medicaid 2014 Hospital Outpatient Final Rule, Addendum B, November 27, 2013.

The information provided contains general reimbursement information only and is not legal advice nor is it advice about how to code, complete, or submit any claim for payment. The information provided represents Torax's understanding of typical current coding conventions. Information provided is not intended to increase or maximize reimbursement by any payer. Reimbursement amounts listed are based on Medicare fee-for-service national averages and do not reflect private insurance reimbursement rates, which vary by insurer and provider. Every reasonable effort has been made to ensure the accuracy of the information listed, however, the ultimate responsibility for selecting appropriate codes, charges, modifiers, and for submitting claims consistent with the insurer requirements, lies with the physician, clinician, hospital or other facility. Insurer coding, coverage, and payment policies change frequently and can vary considerably from one insurer to another. Torax strongly recommends that you consult individual payer representatives for guidance on coverage and claims reporting policies. Such policies can change over time.



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