Centers for Medicare & Medicaid Services

Restructured BETOS Classification System Methodology

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1. Introduction

Since the 1980s, the Centers for Medicare & Medicaid Services (CMS), policymakers, and researchers have relied on the Berenson-Eggers Type of Service (BETOS) Taxonomy to understand shifts in Medicare physician spending over time.

In 2020, the CMS Office of Enterprise Data and Analytics (OEDA) introduced the Restructured BETOS Classification System (RBCS), an updated taxonomy grounded in the BETOS 2.0 design. Since its introduction, CMS has continued to enhance the RBCS Taxonomy, releasing annual updates to ensure its relevance and precision.

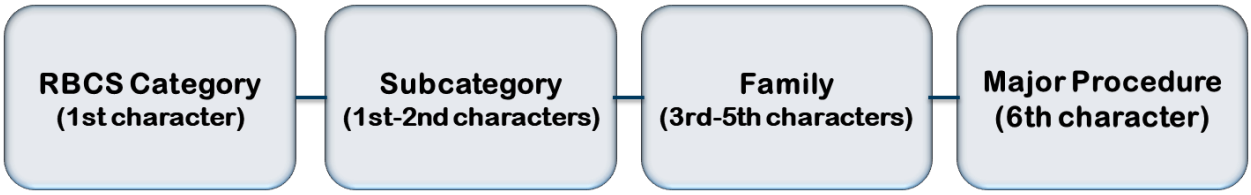
1.1 RBCS Taxonomy Overview

Like the BETOS classification system that preceded it, the RBCS Taxonomy is hierarchically structured with several levels of granularity. The various groupings within each level of the hierarchy (categories, subcategories, and families), as well as major procedure indicators were developed to ensure they are clinically meaningful and informative. The RBCS hierarchy has RBCS categories at the highest level, followed by RBCS subcategories, followed by RBCS families. Each lower level of the Taxonomy is fixed and nested within the higher-level grouping; a subcategory cannot include HCPCS (HCPCS Level I) codes from different categories, and families cannot include HCPCS codes from different subcategories. This structure is designed to allow various levels of granularity for researchers interested in analyzing Medicare allowed spending and utilization.

In addition, HCPCS codes in the “procedures” category are further assigned an indicator designating the code as either a “major procedure” or an “other procedure.” Any HCPCS code in the “procedures” category can be designated as a “major procedure” regardless of its subcategory or family. HCPCS codes not listed in the “procedures” category are assigned an indicator designating the code as a “non-procedure.” This RBCS Taxonomy feature is carried over from the original BETOS and allows researchers to focus on procedures that require more work or are more likely to be performed in inpatient settings.

Like the original BETOS and BETOS 2.0, the RBCS assignment for a given HCPCS code is condensed into a single RBCS identifier. This RBCS identifier is six characters in length with each character or group of characters conveying important information about the identifier’s place in the RBCS Taxonomy. The RBCS category is identified by the first character, the subcategory is identified by the combined first and second characters, the family is identified by the third, fourth, and fifth characters, and the major procedure designation is identified by the sixth character.

Figure 1: RBCS Identifier Schema



2. Methodological Changes for the Current Release Year

The following subsections describe the additions to the RBCS taxonomy that were new in the 2025 RBCS Release Year (RY).

2.1 Refined Classification of Chemotherapy and Non-Chemotherapy Drugs

During the review of HCPCS code categories and subcategories, inconsistencies in subclassifying chemotherapy vs. nonchemotherapy drugs were identified. For example, in the 2024 RBCS RY, oral medications - regardless of their therapeutic intent - were often grouped under 'Treatment - Miscellaneous.' Additionally, certain drugs commonly used alongside chemotherapy, like anti-nausea agents, were sometimes placed under 'Chemotherapy' despite not being chemotherapeutic agents.

In this report, we clarify the classification of drugs as chemotherapy or non-chemotherapy (see list of examples in Appendix Table E), and apply the following logic to the 2025 RBCS RY:**Error! Reference source not found.**

- All chemotherapy agents, whether oral or injectable, are grouped in the subcategory “Chemotherapy”
- Supportive oral medications are grouped in the subcategory “Treatment - Miscellaneous”
- Injectable supportive meds are grouped in the subcategory “Injections and Infusions (Non-Oncologic)”

2.2 New Family

As part of the 2025 RBCS RY, a new family titled “Chronic, Principal, and Transitional Care Management” is introduced to better align with Centers for Medicare & Medicaid Services (CMS) guidance on evaluation and management (E&M) care management codes. In the 2025 RBCS RY the new family replaces the family, “Chronic and Transitional Care Management”, and “Chronic and Transitional Care Management” is effectively retired. CMS maintains a publicly available list of recognized E&M care management services through the Medicare Learning Network.[1]

This new family consolidates all CMS-recognized chronic, principal, and transitional care management HCPCS codes into a single RBCS family. Specifically, it includes codes defined by CMS as Chronic Care Management (CCM), Principal Care Management (PCM), or Transitional Care Management (TCM). All other codes previously grouped under the broader “Chronic and

[1] https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Transitional Care Management" family that do not meet CMS's definitions are reclassified to "No RBCS Family" to ensure consistency across the Taxonomy.

- Replacing the family with "Chronic, Principal, and Transitional Care Management" more precisely reflects the scope of the family and eliminates ambiguity. Relocating unrelated codes to "No RBCS Family" reduces classification noise and enhances consistency. The result is a streamlined, CMS-aligned RBCS family that maintains compliance with family-level spending thresholds. Appendix Table F lists the codes included in the new family.

2.3 Inclusion of HCPCS codes from the additional year of claims after the 5-year claims window

Inclusion of HCPCS codes from claims with Medicare allowed spending one year after the 5-year claims window is a new feature that aims to improve the comprehensiveness of the RBCS Taxonomy. For the 2025 RBCS RY, the 5-year claims window is 2019 through 2023; one year beyond the claims window is 2024. At the time of the claims analysis (early 2025), 2024 claims have a shorter run-out period than claims from years 2019 – 2023. To ensure stability of the Family spending thresholds, HCPCS codes with spending in 2024 are not assigned a Family classification as the 2024 claims have less maturity (i.e., they may have been adjusted after early 2025). These codes are only assigned an RBCS Category or Subcategory classification. In the 2025 RBCS RY, 44 codes are included in the Taxonomy by assessing HCPCS codes in claims that are in 2024, or one year after the 5-year claims window. In following RBCS Release Years, the spending for these codes will be re-assessed and Families may be assigned if applicable.

The assignment of RBCS IDs for these HCPCS codes necessitates the addition of a new Taxonomy variable, described in the next section.

2.4 New Taxonomy Variables

The RBCS Taxonomy structure includes six new variables in the 2025 RBCS RY. The introduction of the new variables allows users to identify: 1) the analysis period associated with the RBCS ID assignment; 2) the most recent RBCS ID assigned to the HCPCS; and 3) whether the RBCS ID was assigned using an alternative assignment methodology.

2.4.1 Alternative Assignment Method

A new variable, alternative assignment method (i.e., ALT_ASSIGNMENT_METHOD), identifies when an RBCS ID was assigned using an alternative assignment methodology outside of the standard 5-year claims or 6-year fee schedule process. This binary variable has a value of 0 when a HCPCS code is included in the Taxonomy through the standard process for assigning RBCS IDs (using 5 years of claims or 6 years of fee schedule history). The variable has a value of 1 when the standard process was not used to assign RBCS IDs. A HCPCS code will have an alternative assignment method value of 1 if the HCPCS code was not paid by Medicare on a Part B fee schedule (e.g., HCPCS code is specific to a CMMI demonstration, HCPCS code does not have a national coverage determination) but had a positive allowed spending amount one year after the 5-year claims window utilized for the Taxonomy. When HCPCS codes do not use the standard process, we do not assign a family to the RBCS ID. All other components (i.e., category, subcategory, major procedure indicator) of the identifier are assigned following standard processes.

In the 2025 RBCS RY, there are 44 codes included in the Taxonomy and assigned RBCS IDs using an alternative assignment methodology. In following Release Years, these codes will be re-assessed for allowed spending (using claims with longer runout) and any changes in paid status on Part B fee schedules. If the codes have retained a positive allowed spending amount once claims have been adjudicated, or if the codes become eligible for payment on a Part B fee schedule, the alternative assignment variable will be updated to a value of 0, and the code may be assigned to an RBCS Family if applicable.

2.4.2 Additional Variables to Assist with RBCS ID Selection

The RBCS Taxonomy changes over time, so HCPCS codes may have more than one RBCS ID assignment. Generally, RBCS users should select the latest RBCS ID for their analysis; however, users can select RBCS IDs based on a desired timeframe. *Table 1* lists the variables in the taxonomy to help match RBCS IDs to specific periods.

These variables replace the RBCS Release Year, RBCS Reassigned, and the Final CY Prior to Reassignment variables.

Table 1: RBCS Taxonomy Variables to Allow Users to Select the Appropriate RBCS ID

Variable Name	Variable Description
FIRST_RBCS_RELEASE_YR	The first (i.e., earliest) Release Year that the RBCS ID was assigned to a HCPCS code. This variable serves as a way to "version" the taxonomy.
RBCS_ANALYSIS_START_DT	The earliest date that users can apply the RBCS ID to a HCPCS code.
RBCS_ANALYSIS_END_DT	The latest date that users can apply the RBCS ID to a HCPCS code.
RBCS_LATEST_ASSIGNMENT	A value of "1" indicates the latest RBCS ID assignment for a HCPCS code. A value of "0" indicates that the RBCS ID assignment for a HCPCS code had a previously assigned RBCS ID that differs from the latest assignment.
RBCS_ID_EVER_REASSIGNED	A value of "1" indicates that the HCPCS code has more than one RBCS ID assignment. A value of "0" means that the HCPCS code only has one RBCS ID assignment.

When analyzing data using the RBCS taxonomy, users may encounter situations where the date ranges defined by RBCS_ANALYSIS_START_DT and RBCS_ANALYSIS_END_DT overlap for a particular HCPCS code. This overlap is intentional and designed to give analysts the flexibility to choose the RBCS ID assignment that best fits their specific analytical needs. To ensure consistency and accuracy in analysis, CMS recommends users select the most recently assigned RBCS ID. This can be identified by locating the assignment where RBCS_LATEST_ASSIGNMENT = 1. By following this approach, users can be confident that they are utilizing the latest and most relevant assignment for their analysis. For reference, *Table 2* below details the analysis windows used for each year of the RBCS Taxonomy.

Table 2: Analysis Windows Used in Each RBCS Taxonomy Release Year

RBCS ID Release Year	Part B Claim 5-Year Period	Fee Schedule Year Add On	Part B Preliminary Claim 6th Year Add On	RBCS Analysis Year Window
2020	2014 – 2018			2014 – 2018
2021	2015 – 2019			2015 – 2019
2022	2016 – 2020			2016 – 2020
2023	2017 – 2021	2022		2017 – 2022
2024	2018 – 2022	2023		2018 – 2023
2025	2019 – 2023	2024	2024	2019 – 2024

3. Data Sources

The following subsections describe the data sources used in the 2025 RBCS RY.

3.1 HCPCS Code Dictionary

Internal reference tables are created using the comprehensive list of HCPCS codes available in the CMS Internal Data Repository (IDR). Extracted from this table are the long code descriptions, start dates, and end dates for all HCPCS codes. The reference tables are later combined with fee schedule information and Medicare claims spending data to assess HCPCS codes for inclusion/exclusion in the RBCS Taxonomy.

3.2 Part B FFS Claims

The following subsections describe the Part B FFS claims data source.

3.2.1 Claims History

Historically, annual updates were made to the RBCS Taxonomy using 5 years of Medicare Part B claims data. The 2025 RBCS RY utilized an extra year beyond the 5-year claims window. The RBCS only categorizes HCPCS codes from the claims data with an allowed spending amount greater than $0 that are paid through Medicare Part B. The development of the 2025 RBCS RY uses Medicare fee-for-service Part B institutional and non-institutional claims for calendar years 2019 to 2024 available from the CMS Chronic Conditions Data Warehouse. For every RBCS update, and for HCPCS codes that follow a “standard process” for RBCS ID assignment, five years of claims data are combined and analyzed as a single unit. This broad timeframe smooths out variation in spending and utilization and increases data stability. Spending and utilization are used during the family creation process and the major procedure identification process, both of which are covered in more detail below. By using a large, multi-year dataset, the Taxonomy adjusts to changing trends and healthcare practice patterns over time but does so slowly, giving the RBCS Taxonomy the stability needed to be a useful research tool. The RBCS claims date range is selected to ensure that the final year of claims data being used to construct the Taxonomy is complete when the RBCS update process begins.

Claim lines with an allowed spending amount greater than $0 are included in the RBCS update process. Allowed spending amounts represent the total liability owed to the provider for the rendered service, including Medicare liability, patient deductibles, and patient co-pays. The allowed spending amount provides a more accurate representation of the true cost of a given service rather than the Medicare paid amount alone. This is because it combines all liabilities owed to the provider for a given service, not just what is paid by one party. Allowed spending amounts are used whenever they are available in the data. When they are not available, an allowed spending amount equivalent is calculated by combining the Medicare paid amount with the patient responsibility amount.

3.2.2 Unbundling Claims

Bundled payments present a challenge for the RBCS methodology because allowed spending amounts for individual HCPCS codes are a critical part of the family assignment process. When services are paid as part of a bundle, reimbursement is not directly linked to each specific service on a claim. Rather, bundled payments capture multiple services that are paid as part of a package with providers being paid a set rate for the entire package instead of being paid for each individual service. In these instances, HCPCS codes that are part of the bundle may have a line-level payment amount of $0 even if Medicare covers them. Therefore, the RBCS update process included steps to “unbundle” bundled claims and allocate spending to the HCPCS codes included in the bundled payment. This process focuses on three broad types of bundled claims:

1. Bundled Ambulatory Payment Classifications (APC) claims paid through the Outpatient Prospective Payment System (OPPS),
2. Federally Qualified Health Center (FQHC) claims, and
3. Rural Health Clinic (RHC) claims.

Though different mechanisms are used to identify the payments and bundled codes for each of these bundled types, the process of unbundling the payment is the same.

Medicare pays for most hospital outpatient services under the OPPS using APCs. APC claims must meet the following criteria to be included in the unbundling process: at least one claim line contains an APC code (where the revenue center payment method indicator is equal to 1), and at least one claim line contains a HCPCS code (where the revenue center payment method indicator is equal to 9).

FQHCs are safety net providers that typically provide services in an outpatient clinic. FQHCs are not reimbursed by Medicare through the PFS or OPPS like other comparable providers of Medicare Part B services. Rather, Medicare pays FQHCs based on the FQHC PPS. Bill type codes are used to identify FQHC claims. Bundled payments for these claims are taken from lines with FQHC-specific procedure codes, and bundled lines are identified as non-denied claim lines with $0 allowed spending. Claim lines that do not have FQHC-specific procedure codes but have greater than $0 in allowed spending are considered non-bundled services and are excluded from the unbundling process.

RHCs do not receive reimbursement from Medicare's PFS or OPPS like comparable providers of Medicare Part B services. Instead, CMS pays an all-inclusive rate (AIR) payment per visit throughout the clinic’s fiscal year, which is then reconciled at the end of the year. Bill type codes are also used to identify RHC claims. Bundled payments for these claims are taken from claim lines with a “CG” procedure code modifier (primary reason for the medically necessary visit), and bundled lines are identified as non-denied claim lines with $0 allowed spending. Claim lines

that do not have a “CG” procedure code modifier but have greater than $0 in allowed spending are considered non-bundled services and are excluded from the unbundling process.

For all claim types, charged amounts from the bundled lines are used to allocate the bundled payment on the claim. The bundled payments are allocated to each bundled line according to the proportion of the overall charged amount accounted for by a given claim line. An example of how this process works is provided in *Table 3***Error! Reference source not found.**.

In the example shown in *Table 3***Error! Reference source not found.**, the entire paid amount for the claim ($9,163) is on Claim Line 4 (see the “Provider Payment Amount” column) and Claim Lines 1, 2, 3, 5, and 6 have Provider Payment Amounts of $0. To estimate the Provider Payment Amount for each claim line, percentages are calculated for each line based on the proportion of the overall total charged amount (total sum of the “Charged Amount” column) a given line accounted for (see the “Percent of Charged Amount” column). In this example, the total charged amount equals $22,783. Claim Lines 4 and 6 accounted for the largest percentage of the overall charged amount (66.7% and 27.6%, respectively), while Claim Lines 1, 2, 3, and 5 accounted for a relatively small percentage of the overall charged amount (2.4% to 0.7%).

These percentages are multiplied by the total Provider Payment Amount ($9,163) so that each line is allocated a proportion of the paid amount equal to the proportion of the charged amount. This amount is listed in the “Unbundled Paid Amount” column. In this example, Claim Line 4 was allocated $6,120 of the paid amount because it accounted for 66.7% of the overall charged amount (66.7% of $9,163 is $6,120), and Claim Line 6 was allocated $2,534 of the paid amount because it accounted for 27.6% of the overall charged amount (27.6% of $9,163 is $2,534). Claim Lines 1, 2, 3, and 5 were allocated between $227 and $66 of the paid amount because they accounted for between 2.4% and 0.7% of the overall charged amount. When summed, the total of the “Unbundled Paid Amount” column equals the total of the “Provider Payment Amount” column.

The unbundling process is restricted to HCPCS codes covered by at least one fee schedule. Non-covered or expired HCPCS codes are occasionally included in a service bundle on a claim, but they are not always identified as non-payable codes by the payment and status indicators. To prevent such codes from entering the Taxonomy or influencing the allocation of spending among covered codes in the bundle, codes that are not covered by a fee schedule are excluded from the unbundling process.

For claims with more than one bundled payment, the bundled payments are summed and divided among the bundled claim lines as if all bundled lines on the claim are reimbursed as part of a single payment.

Table 3: Example of the Process of Unbundling Bundled Payments

Claim Line	HCPCS Code	Provider Payment Amount	Charged Amount	Percentage of Charged Amount	Unbundled Paid Amount
1	96365	$0	$337	1.4%	$136
2	96375	$0	$200	0.8%	$80
3	C1713	$0	$565	2.4%	$227
4	C1776	$9,163	$15,216	66.7%	$6,120

Claim Line	HCPCS Code	Provider Payment Amount	Charged Amount	Percentage of Charged Amount	Unbundled Paid Amount
5	73560	$0	$164	0.7%	$66
6	27447	$0	$6,301	27.6%	$2,534

*Line 4: Bundled Payment
*Lines 1 – 6: Bundled Codes
*Percentages in the “Percent of Charged Amount” are rounded and therefore sum to 99.6% instead of 100%.
*Unbundled Paid amounts in this example were calculated using non-rounded percentages

3.3 Medicare Fee Schedules

Beginning with the 2023 RBCS RY, Medicare fee schedules are used in addition to claims data to identify HCPCS codes for inclusion in the RBCS Taxonomy. The 2025 RBCS RY evaluates fee schedules covering January 1, 2019, through December 31, 2024. These dates correspond with the 5-year timeframe used to select the claims data for the RBCS update process (2019-2023) plus one additional year (2024). The RBCS update process accounts for changes to the payment status indicators of HCPCS codes in Medicare fee schedules. Any codes that had a paid status at any point in time within the fee schedule review period (2019 – 2024) are included in the Taxonomy.

Adding fee schedule data benefits the RBCS in two primary ways. First, using fee schedules as a data source makes the RBCS more comprehensive by capturing HCPCS codes paid by Medicare that may not account for any spending in the claims data. It is possible that some HCPCS codes that are paid by one of the Medicare fee schedules are not billed on a claim, or are billed, but do not account for any allowed spending. Using fee schedules ensures those HCPCS codes are included in the RBCS Taxonomy. Second, adding an additional year of fee schedule data makes the RBCS more current by including HCPCS codes issued in the year following the end of the RBCS claims date range.

The following fee schedules are used in the RBCS update process.

3.3.1 MPFS Relative Value Unit (RVU) File[2]

Codes from the MPFS RVU file with status codes listed in ***Error! Reference source not found.****Table 4* are considered paid by Medicare.

Table 4: MPFS National Physician Fee Schedule Relative Value File Status Code (RVU)

Status Code	Description
A	Active code

2 https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files

Status Code	Description
B	Bundled code
C	MACs priced code
J	Anesthesia services
R	Restricted coverage
T	Paid as only service

3.3.2 Outpatient Prospective Payment System (OPPS) Addendum B[3]

Codes from the OPPS Addendum B with status indicators listed in *Table 5***Error! Reference source not found.** are considered paid by Medicare.

Table 5: Outpatient Prospective Payment System (OPPS) Status Indicators

Status Indicator	Description
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines
G	Pass-through Drugs and Biologicals
H	Pass-through device categories
J1 – J2	Hospital Part B services paid through comprehensive Ambulatory Payment Classifications (APC)
K	Non-pass-through drugs and non-implantable biologicals Therapeutic Radiopharmaceuticals Brachytherapy Sources Blood and Blood Products
L	Flu/PPV/COVID-19 vaccine
N	Items/services packaged into APC rates
P	Partial Hospitalization
Q1-Q4	Packaged Services Subject to Separate Payment under OPPS Payment Criteria
R	Blood and Blood Products

3 https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates

Status Indicator	Description
S	Significant Procedure, Not Discounted when Multiple
T	Significant Procedure, Multiple Reduction Applies
U	Brachytherapy Sources
V	Clinic or Emergency Department Visit
X	Ancillary Services

3.3.3 Ambulatory Surgical Center Payment Rates Addenda AA, BB, and FF[4]

Codes in Ambulatory Surgical Center (ASC) Addenda AA, BB, and FF are considered paid if they did not have a status indicator listed in *Table 6***Error! Reference source not found.**.

Table 6: Excluded Ambulatory Surgical Center (ASC) Payment Indicators

Payment Indicator	Description
B5	Alternative code may be available; no payment made
D5	Discontinued codes
E5	Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation, and/or statute
K5	Surgical procedure/item not valid for Medicare purposes

3.3.4 Durable Medical Equipment Parenteral and Enteral Nutrition (DMEPEN)[5]

All codes listed in the DMEPEN fee schedule are considered paid by Medicare.

3.3.5 Durable Medical Equipment Prosthetics, Orthotics, & Supplies (DMEPOS)[6]

All codes listed in the DMEPOS fee schedule are considered paid by Medicare.

4 https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

5 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

6 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

3.3.6 Clinical Lab Fee Schedule (CLFS)[7]

All codes listed in the CLFS are considered paid by Medicare.

3.3.7 National Drug Code (NDC) Drug and Biological Average Sales Price (ASP NDC), Average Wholesale Price (AWS NDC), Outpatient Prospective Payment (OPPS NDC), and COVID-19 NDC Crosswalk[8]

All codes in the ASP NDC, AWS NDC, OPPS NDC, and COVID-19 NDC files are considered paid by Medicare.

3.3.8 Federally Qualified Health Center Codes

Additionally, all FQHC payment codes[9] listed in *Table 7* are considered paid by Medicare.

Table 7: Federally Qualified Health Center (FQHC) HCPCS Codes

HCPCS Code	Description
G0466	FQHC visit, new patient
G0467	FQHC visit, established patient
G0468	FQHC visit, IPPE, or AWV
G0469	FQHC visit, mental health, new patient
G0470	FQHC visit, mental health, established patient
G0511	Chronic Care Management for FQHCs
G0512	RHC or FQHC only, psychiatric collaborative care model
G0071	5+ minutes of virtual (non-face-to-face) communication between an RHC or FQHC practitioner
G2025	Payment for a telehealth distant site service furnished by a RHC or FQHC only

4. RBCS Identifier Assignment

The following subsections describe the criteria for RBCS Identifier assignment.

[7] https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files

[8] https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files

[9] https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center

4.1 Inclusion Criteria

The 2025 RBCS RY Taxonomy includes HCPCS codes that are covered by a Medicare Fee schedule or codes on claims with allowed Medicare Part B payments greater than $0 in the specified 6-year claim history.

4.2 Exclusion Criteria

HCPCS codes that do not meet the inclusion criteria are excluded from the RBCS Taxonomy update. Beyond this, the RBCS Taxonomy also excludes codes within the following groups: assessment codes, dental codes ("D" codes), codes paid by commercial insurers ("S" codes), CPT II codes (codes ending in "F"), and certain hospice codes in the range Q5001 – Q5010. These exclusions help keep the RBCS focused on services covered under Medicare Part B. *Table 8***Error! Reference source not found.** presents these criteria, the types of codes affected, and the rationale for their exclusion.

Table 8: Exclusion Criteria

Exclusion Criteria	Description	Rationale
HCPCS codes beginning with 'S'	Temporary national codes for non-Medicare insurers	These codes are used by commercial payers and are not applicable to Medicare billing or analysis
HCPCS codes with 'F' in the 5th position	Quality reporting and performance measurement codes	These CPT II codes support data collection and are not used for reimbursement, making them irrelevant to RBCS's service-based classification
HCPCS codes Q5001-Q5010	Hospice care location codes	These codes pertain to hospice services billed under Medicare Part A and do not reflect Medicare Part B utilization
HCPCS codes beginning with 'D'	Dental procedure codes	Routine Dental services are not covered under Medicare Part B; therefore, these codes are excluded from analysis
Assessment codes (e.g., certain G-codes)	Administrative or care management reporting codes	These codes represent activities such as health risk assessments, care coordination or quality program participation and are not direct clinical services reimbursed under Medicare Part B

4.3 Category and Subcategory Assignment

A category, which is identified as the first character of the RBCS identifier, is the highest level of the Taxonomy and represents broad concepts such as "Procedures," "Tests," and "Imaging." In the RBCS Taxonomy, there are eight categorical groupings that give shape to the overall structure of the Taxonomy and help guide subsequent RBCS assignments. *Table 9* lists the specific categories and rules used to assign HCPCS codes to RBCS categories.

Table 9: Category Decision Rules

Category	Rule
Anesthesia	All anesthesia HCPCS codes are placed in the anesthesia category.

Category	Rule
DME	HCPCS codes for products and supplies are classified as Durable Medical Equipment (DME).
Evaluation and Management (E&M)	All HCPCS codes identified as evaluation and management visits are classified as E&M. HCPCS codes for physical examinations to obtain specimens for subsequent testing are assigned to the E&M category.
Imaging	If the primary purpose of a HCPCS code is to obtain an image, it is classified as imaging in the RBCS Taxonomy. For situations in which a HCPCS code appears to combine imaging and a procedure, if the primary purpose is to produce an image for interpretation, the HCPCS code is assigned to imaging.
Other	HCPCS codes for ambulance, enteral and parenteral feeding and nutrition services and supplies, and vision, hearing, and speech services are classified as Other.
Procedures	If the primary purpose of a HCPCS code is to perform a procedure at a single time and place, it is classified as a procedure. For situations in which a HCPCS code appears to combine imaging and a procedure, if the primary purpose is to produce an image to facilitate a procedure, the HCPCS code is classified as a procedure. HCPCS codes for obtaining biopsy or measurement information are assigned as a procedure.
Treatments	If the medical intervention described by a HCPCS code is intended to be delivered repeatedly as part of a series over time, it is classified as a treatment. HCPCS codes linking an E&M process with a treatment modality are classified as treatments.
Tests	If the purpose of the procedure is to obtain test results, the HCPCS code is classified as a test.

The subcategory is the first and second characters of the RBCS identifier. Subcategories are the mid-level of the Taxonomy, further dividing categories into specific service groups or organ systems. For example, the “Procedures” category contains subcategories specific to organ systems, such as “Breast,” “Cardiovascular,” or “Skin.” The “Tests” category contains subcategories that are specific to test type, such as “Anatomic Pathology” and “Pulmonary.” Like categories, well-structured rules are used to determine how HCPCS codes are classified into the various subcategories. These rules are outlined in *Table 10*.

Table 10: Subcategory Decision Rules

Category	Subcategory Assignment Rules
Evaluation and Management (E&M)	Subcategory distinctions remain based primarily on place of service. Most E&M (care management/coordination) spending is in "visits," with substantial variation by place of service. Certain E&M activities specific to a clinical domain (e.g., ophthalmology and behavioral health) are retained. E&M activities that do not require in-person patient encounters and are recognized for PFS payments gave rise to a subcategory for care coordination/management activities. As such HCPCS codes increase in number, they may need to be grouped into additional subcategories and families in the future.
Procedures & Treatments	Neither technical modality (e.g., endoscopy) nor service location (e.g., office or ambulatory surgical center) are deemed clinically important distinctions for creating subcategories. Rather, organ system remains the sole basis for procedure subcategories, and type of treatment remains the basis for treatment subcategories. Blood products and preparation for transfusion including laboratory HCPCS service codes are categorized to Procedure – Hematology. All chemotherapy drugs, regardless of route of administration, are included in the Treatment – Chemotherapy subcategory. Oral non-chemotherapy drugs, used in both cancer and non-cancer treatments, are categorized as Treatment – Miscellaneous. Injectable non-chemotherapy drugs, used in both cancer and non-cancer treatments, are categorized as Treatment – Injections and Infusions (Non-oncologic). Administration of preventive vaccines covered by Medicare are categorized as Treatment –for example, injection for influenza, pneumococcal, and Hepatitis B vaccines. Component services for dialysis and supplies are grouped as Treatment – Dialysis
Imaging	The original BETOS imaging subcategories continue to effectively present the different imaging modalities.

Category	Subcategory Assignment Rules
Tests	HCPCS codes for travel allowance and collection of specimens are categorized as Test – Laboratory, such as collection of venous blood by venipuncture. Venipunctures and arterial punctures for withdrawal of blood for diagnosis are categorized as procedures.
Anesthesia	Spending is not analyzed inside this broad category, and no subcategory or family designations are created.
Durable Medical Equipment (DME)	Medical/Surgical Supplies are assigned to items thrown away after use or not used with equipment. Other DME is assigned to reusable medical equipment that can withstand repeated use. Drug and supply dispensing fees paid to a pharmacy are categorized as Other DME. Orthotic Devices include HCPCS codes for prosthetics.
Other	Other – Enteral & Parenteral category includes items such as formula, tubes, supply kits, and all services and supplies related to enteral and parenteral nutrition.

The full list of RBCS categories and subcategories is presented in *Appendix C: RBCS Categories and Subcategories*.

4.4 Family Decision Rules

The family classification is the third, fourth, and fifth characters of the RBCS identifier. Families represent the lowest level of the RBCS hierarchy and divide the subcategories into groups of HCPCS codes based on clinical similarity based on allowed spending amounts. For example, the “Digestive/Gastrointestinal” subcategory of the “Procedures” category contains families such as “Cholecystectomy – Laparoscopic” and “Upper GI Endoscopy.” The “Anatomic Pathology” subcategory of the “Tests” category contains families such as “Immunohistochemistry” and “Surgical Pathology Examination.” Clinical and coding experts, as well as the AMA CPT section and subsection headings, are the primary means by which similar HCPCS codes are grouped.

The 2025 RBCS RY Taxonomy includes 179 named families, listed in *Appendix D: RBCS Families and Allowed Spending*.

While all HCPCS codes in the RBCS Taxonomy are given a category and subcategory, not all HCPCS codes are assigned to a family. The RBCS family development process begins by identifying the highest spending among non-anesthesia HCPCS codes that, when combined, account for 90% of total allowed spending in the claims data being reviewed. These high-spend HCPCS codes (referred to below as “start codes”) are used as starting points to build RBCS families.

Once the start codes are identified, all HCPCS codes are reviewed, and clinically similar codes are grouped into candidate families. Formal families are created from candidate families when two conditions are met: 1) the candidate family contains at least 1 start code, and 2) the combined spending of all codes in the candidate family accounted for at least 0.1% of non-anesthesia allowed spending in the claims data. Because the combined spending of all codes in a candidate family is evaluated against the 0.1% spending threshold, some families contain HCPCS codes that do not account for any spending in the claims data. HCPCS codes that could not be grouped into formal families are not assigned to an RBCS family and have a family number of "000" in the RBCS ID.

The use of spending and utilization patterns in the family development process helps ensure the RBCS Taxonomy is consistent with changing practice trends and can be used to identify HCPCS codes that are spending outliers. As practice patterns change or new HCPCS codes are introduced, spending will increase for groups of procedures with higher utilization and will decrease for groups with lower utilization. In this way, new families are introduced, and old families are retired. This RBCS Taxonomy process has dual benefits such as capturing emerging healthcare trends and pruning families that experience decreased utilization.

4.4.1 Family Retention Period

As spending fluctuates from year to year, families that are close to the 0.1% spending threshold could be dropped and added repeatedly over time. To ensure stability and minimize confusion for users, the RBCS implements a five-year retention period that prevents the premature retirement of a family. Families are retired only after failing to meet the spending threshold for five consecutive years. If a family enters the retention period but subsequently exceeds the threshold in any given year, the five-year retention period restarts.

If a new RBCS family is created, this new RBCS family then begins the five-year retention period and could potentially be dropped if sufficient spending is not accumulated over the next five years.

As of the 2025 RBCS RY, 21 families are in the family retention period, as shown in *Table 11*. Two families are in the fifth and final year of the retention period and thus are at risk of retirement in RY 2026 if similar spending patterns persist:

- Procedure → Vascular → Transvascular Stent
- Other → Enteral and Parenteral → Enteral Feeding and Formula

Table 11: Families in the Retention Period, 2025

Family	Category	Subcategory	Years in Retention Period
Enteral Feeding and Formula	Other	Enteral and Parenteral	5
Transvascular Stent	Procedure	Vascular	5
Home Health Skilled Services	E&M	Home Services	4
Pacemaker Removal	Procedure	Cardiovascular	4

Family	Category	Subcategory	Years in Retention Period
Hernia Repair - Open (inguinal)	Procedure	Digestive/Gastrointestinal	4
Vitrectomy - Mechanical	Procedure	Eye	4
Percutaneous Vertebroplasty	Procedure	Musculoskeletal	4
Bronchoscopy	Procedure	Other Organ Systems	4
Lymph Node Biopsy	Procedure	Other Organ Systems	4
Transluminal Angioplasty - Venous	Procedure	Vascular	4
Vascular Embolization	Procedure	Vascular	4
Hyperbaric Oxygen	Treatment	Treatment - Miscellaneous	4
A-V Fistula Creation	Procedure	Vascular	3
Injection - Growth/Hormone Factor	Treatment	Injections and Infusions (nononcologic)	2
Knee Orthosis	DME	Orthotic Devices	1
Lumbar Sacral Orthosis Brace	DME	Orthotic Devices	1
Cardiac Stent	DME	Other DME	1
Computerized Ophthalmic Imaging	Imaging	Imaging - Miscellaneous	1
Breast Biopsy	Procedure	Breast	1
Arthroscopy - Lower Extremity	Procedure	Musculoskeletal	1
Immunosuppressive Drugs - Non-injectable	Treatment	Treatment - Miscellaneous	1

4.5 Major Procedure Decision Rules

The major procedure designation is the sixth character of the RBCS identifier. In the last step of the RBCS update process, all HCPCS codes in the “Procedures” category are evaluated to determine if they are major or non-major procedures. Major procedures are assigned an “M,” and non-major procedures are assigned an “O” (other). An “N” (not a procedure) is assigned to all non-procedure HCPCS codes.

Unlike other levels of the RBCS Taxonomy, the major procedure designation is not hierarchical in nature. All HCPCS codes in the “Procedures” category can be classified as major procedures, regardless of subcategory. The major procedure identification process uses relative value units

(RVUs) and service setting to differentiate procedure type. Major procedure HCPCS codes are identified in four ways:

1. HCPCS codes assigned an RVU greater than or equal to 9.0 are identified as a major procedure.
2. HCPCS codes assigned an RVU greater than or equal to 5.5 but less than 9.0 and used in an inpatient setting greater than 15% of the time are identified as a major procedure.
3. HCPCS code descriptions beginning with “unlisted” that occurred in an inpatient setting with a frequency greater than 15% are classified as a major procedure. The RVU requirement is not included for unlisted HCPCS codes because RVUs are not assigned to these codes.
4. Add-on HCPCS codes are identified as major procedures when all their associated primary HCPCS codes are major procedures. Add-on HCPCS codes represent procedures where the bulk of the effort is concentrated in the primary HCPCS code. For this reason, add-on HCPCS codes are generally not identified as major procedures using RVU rules, even if they occur within the context of a major procedure. This rule was developed to account for situations where all primary HCPCS codes for a given add-on HCPCS code are major procedures. This rule is not applied in situations in which primary HCPCS codes for the add-on HCPCS code are a mix of major and non-major procedures or where the add-on HCPCS code is not in the “procedures” category.

RVU releases have been obtained from the CMS PFS Relative Value Files website[10] for the years covered by the RBCS Taxonomy revision timeframe. The most recent non-missing RVU is retained for situations in which a HCPCS code is assigned different RVUs across years.

4.5.1 Major Procedure Retention Period

In addition to these rules, a three-year retention period is used to enhance the stability of the major procedure identification indicator. HCPCS codes identified as major procedures in one year continue to be classified as major procedures unless they fail to meet the major procedure benchmarks for three consecutive years. If a major procedure enters the retention period one year and then exceeds the thresholds the next year, the three-year retention period restarts. Appendix table *B.7 HCPCS Codes Identified as Major Procedures RBCS Release Year* provides an overview of the number of HCPCS codes identified as major procedures and those retained from each Release Year. In the 2024 RBCS RY, the impact of the three-year retention period is evident as many HCPCS codes failed to meet or exceed the threshold, resulting in a decrease in the number of codes retained as major procedures from 221 to 48. In the 2025 RBCS RY, 40 of the 48 major procedure codes were retained as major procedures from Release Year 2024 and 69 major procedures codes were retained as major procedures since the HCPCS were end-dated prior to the 2025 RBCS RY analysis window.

10 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

5. Data Limitations

A notable limitation of the RBCS Taxonomy is its dependence on claims data, which may not fully capture the clinical nuances or context of services provided. Since the RBCS Taxonomy is designed primarily for analyzing Medicare Part B fee-for-service claims, its applicability to other populations or non-claim-based datasets may be limited. Additionally, the classification system may not always keep pace with advancements in medical technologies or changes in clinical practices, which can result in less precise categorization for recently introduced services and procedures. Users should be mindful that while the RBCS Taxonomy provides a structured way to categorize and analyze healthcare services, it may not reflect the full complexity of medical care or support all research or policy analysis needs without supplementary data or context.

6. RBCS Data Dictionary

Table 12 lists RBCS variables, term names, and their definitions.

Table 12: RBCS Data Dictionary

Variable	Term Name	Definition
HCPCS_CD	HCPCS Code	HCPCS code.
RBCS_ID	RBCS ID	RBCS identifier.
RBCS_Cat	RBCS Category	The first character of the RBCS ID, which represents the "Category".
RBCS_Cat_Desc	RBCS Category Description	The description of the RBCS Category.
RBCS_Cat_Subcat	RBCS Subcategory	The first 2 characters of the RBCS ID, which represents the "Subcategory".
RBCS_Subcat_Desc	RBCS Subcategory Description	The description of the RBCS Subcategory.
RBCS_FamNumb	RBCS Family Number	The third, fourth, and fifth characters of the RBCS ID, which represents the "Family".
RBCS_Family_Desc	RBCS Family Description	The description of the RBCS Family.
RBCS_Major_Ind	RBCS Major Procedure Indicator	The sixth character of the RBCS ID, which represents the type of procedure as Major (M), Other (O), or a non-procedure (N).
HCPCS_CD_Add_Dt	HCPCS Code Add Date	The start date that a HCPCS code is active.
HCPCS_CD_End_Dt	HCPCS Code End Date	The date that a HCPCS code is retired.
RBCS_Latest_Assignment	RBCS Latest Assignment	The latest RBCS ID assignment for a HCPCS code.

Variable	Term Name	Definition
First_RBCS_Release_Year	First RBCS Release Year	The first release year that the RBCS ID was assigned to a HCPCS code. This variable is essentially an RBCS Release Year "version" number.
RBCS_Analysis_Start_Dt	RBCS Analysis Start Date	The earliest claim calendar year that we recommend an RBCS ID is applied to a HCPCS code.
RBCS_Analysis_End_Dt	RBCS Analysis End Date	The latest claim calendar year that we recommend an RBCS ID is applied to a HCPCS code.
Alt_Assignment_Method	Alternative Assignment Method	A value of "1" indicates that the standard process (i.e., a 5-year claims or 6-year fee schedule window) was **not** used to create the RBCS ID assignment; whereas a value of "0" indicates that the standard process was used to assign the RBCS ID to the HCPCS code.
RBCS_ID_Ever_Reassigned	RBCS Ever Reassigned Flag	A value of "1" indicates that the HCPCS code has more than 1 RBCS ID assignment. A value of "0" means that the HCPCS code only has one RBCS ID assignment.

Appendix A: Glossary of Terms

Table 13 provides terms, abbreviations, and associated definitions for this document.

Table 13: Glossary of Terms

Term	Abbreviation	Definition
American Medical Association	AMA	The AMA owns the copyright to CPT codes (HCPCS Level I codes).
Ambulatory Payment Classifications	APC	An APC is a group of outpatient services that CMS uses to determine payment rates for hospitals and other healthcare facilities.
Ambulatory Surgical Center	ASC	ASC is the method of paying for surgical center services for the Medicare program.
Average Sales Price	ASP	ASP refers to the price at which an organization typically sells a certain class of goods or services. CMS uses manufacturer-reported ASPs, based on manufacturers' actual quarterly drug sales, to calculate provider payment amounts for these drugs. Federal law defines the price.
Average Wholesale Price	AWP	An AWP is an estimate of the price retail pharmacies pay for drugs from their wholesale distributor.
Berenson-Eggers Type of Service	BETOS	The BETOS coding system analyzes the growth in Medicare expenditures. The coding system covers all Healthcare Common Procedure Coding System (HCPCS) codes, assigns a HCPCS code to only one BETOS code, and consists of readily understood clinical categories that permit objective assignment.
Chronic Care Management	CCM	Chronic Care Management (CCM) refers to a set of Medicare-recognized services provided to patients with two or more chronic conditions expected to last at least 12 months (or until death), which place the patient at significant risk of death, acute exacerbation, or functional decline. CCM services are designed to help patients manage their health more effectively by providing ongoing, coordinated care outside of traditional office visits.
Clinical Laboratory Fee Schedule	CLFS	The CLFS describes how much Medicare pays for specimen collection for laboratory testing, transportation, and personnel expenses for trained personnel to collect specimens from homebound patients and inpatients (except hospital inpatients).
Centers for Medicare & Medicaid Services	CMS	CMS is a federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (CHIP), and health insurance portability standards.

Term	Abbreviation	Definition
Current Procedural Terminology	CPT	The CPT is a uniform coding system consisting of descriptive terms and identifying codes whose primary use is to identify medical services and procedures furnished by physicians and other health care professionals.
Certified Registered Nurse Anesthetist	CRNA	A CRNA is a nurse anesthetist who is licensed to administer anesthesia in the United States.
Calendar Year	CY	CY is the period of time beginning on January 01 and ending on December 31 of each year.
Durable Medical Equipment	DME	DME refers to equipment prescribed by a physician and used during treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc.
Durable Medical Equipment Prosthetics, Orthotics, and Supplies	DMEPOS	DMEPOS refers to durable medical equipment, prosthetics, orthotics, and supplies identified by CMS as necessary for medical treatment.
Fee-for-Service	FFS	FFS is the traditional method of reimbursing physicians, hospitals, and other healthcare providers for their services.
Federal Qualified Health Center	FQHC	An FQHC is a facility in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general supervision of a physician.
Healthcare Common Procedure Coding System	HCPCS	HCPCS is a set of healthcare procedure codes based on the American Medical Association (AMA) current procedural terminology (Commonly pronounced Hick-Picks).
Integrated Data Repository	IDR	The IDR is a single source database system containing CMS beneficiary, claim, and provider data.
Medicare Administrative Contractor	MAC	Jurisdictional MACs administer Medicare claims under CMS direction.
Medicare Physician Fee Schedule	MPFS	The Medicare Physician Fee Schedule (MPFS) is a comprehensive listing of fees used by the Centers for Medicare & Medicaid Services (CMS) to reimburse physicians and other healthcare professionals for services provided to Medicare beneficiaries. The MPFS covers thousands of medical procedures, services, and tests, each identified by a unique HCPCS or CPT code.
National Drug Code	NDC	The NDC is a code set that identifies the vendor (manufacturer), product, and package size of all drugs and biological products the FDA recognizes.

Term	Abbreviation	Definition
Office of Enterprise Data and Analytics	OEDA	OEDA is the division of CMS that establishes policies for maintaining the quality, privacy, and security of CMS enterprise data.
Outpatient Prospective Payment System	OPPS	OPPS is the system through which Medicare decides how much money a hospital or community mental health center receives for outpatient care provided to Medicare patients.
Principal Care Management	PCM	Principal Care Management (PCM) is a Medicare care management service designed for patients with a single, high-risk chronic condition. PCM was introduced by CMS to fill a gap in care management for patients who do not qualify for Chronic Care Management (CCM), which requires two or more chronic conditions. PCM focuses on comprehensive, disease-specific management for one complex condition expected to last at least three months and that places the patient at significant risk of hospitalization, acute exacerbation, functional decline, or death.
Restructured BETOS Classification System	RBCS	RBCS allows researchers to group Medicare Part B healthcare service codes into clinically meaningful categories and subcategories.
Relative Value Unit	RVU	A Relative Value Unit (RVU) is a standardized measure used in healthcare to quantify the value of medical services, procedures, or physician work. RVUs are the foundation of the Resource-Based Relative Value Scale (RBRVS), which is the methodology adopted by CMS to determine physician payment rates.
Transitional Care Management	TCM	Transitional Care Management (TCM) refers to a set of services provided to patients as they transition from an inpatient facility (such as a hospital, skilled nursing facility, or rehabilitation center) back to their community setting (i.e., home, assisted living). The goal is to ensure continuity of care, reduce the risk of complications or readmissions, and help patients navigate their recovery after discharge.
Technical Expert Panel	TEP	A TEP is a group of experts convened to provide input and guidance on the development, implementation, and maintenance of quality measures within CMS.
Virtual Research Data Center	VRDC	The Virtual Research Data Center (VRDC) is a secure, cloud-based analytic environment provided by CMS within the Chronic Conditions Data Warehouse (CCW).

Appendix B: Data Tables

B.1 RBCS Release Year

Table 14 lists total HCPCS codes, HCPCS codes new to the Taxonomy, and RBCS revisions by release year.

Table 14: RBCS Updates by Release Year

Statistic	RY 2020	RY2021	RY2022	RY2023	RY2024	RY2025
Total HCPCS Codes in the Taxonomy File	13,414	14,013	14,360	15,522	15,984	16,618
HCPCS Codes New to the Taxonomy		599	347	1,162	462	637
RBCS Reassignments (Category, Subcategory, Family)		300	815	304	389	252
RBCS Reassignments (Major Procedure Only)		1	10	5	189	27

B.2 Top 10 HCPCS Codes by Allowed Spending*

Table 15 lists the top 10 HCPCS codes by allowed spending.

Table 15: Top 10 HCPCS Codes by Allowed Spending

HCPCS	Code Description	Total Allowed Spending ($)
99214	Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more	60.7B
90999	Other inpatient or outpatient dialysis procedure	38.2B
99213	Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more	35.1B
J9271	Injection, pembrolizumab, 1 mg	18.8B
99285	Emergency department visit with high level of medical decision making	16.3B
J0178	Injection, aflibercept, 1 mg	16.2B
97110	Therapy procedure using exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes	14.9B
99232	Subsequent hospital care with moderate level of medical decision making, if using time, at least 35 minutes	14.2B
99233	Subsequent hospital inpatient or observation care with high level of medical decision making, if using time, 50 minutes or more	13.2B
66984	Removal of cataract with insertion of prosthetic lens	12.9B

*excludes spending from alternatively assigned HCPCS codes

B.3 Top 10 HCPCS Codes New to the Taxonomy in 2025 by Allowed Spending*

Table 16 lists the top 10 HCPCS codes new to the Taxonomy in 2025 by allowed spending.

Table 16: Top 10 HCPCS Codes New to the Taxonomy in 2025 by Allowed Spending

HCPCS	Code Description	Total Allowed Spending ($)
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]) vaccine, single dose	272,677,994
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	1,272,500
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	61,475
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	51,250
J9322	Injection, pemetrexed (bluepoint), not therapeutically equivalent to j9305, 10 mg	34,128
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	13,522
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection	5,051
96380	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional	5,022
J0874	Injection, daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg	3,672
E1629	Tablo hemodialysis system for the billable dialysis service	562

*excludes spending from alternatively assigned HCPCS codes

B.4 Top 10 Subcategories by Allowed Spending*

Table 17 lists the top 10 subcategories by allowed spending.

Table 17: Top 10 Subcategories by Allowed Spending

RBCS Category	RBCS Subcategory	Total Allowed Spending ($)
E&M	Office/Outpatient Services	149.4B
Treatment	Injections and Infusions (non-oncologic)	36.2B
Treatment	Chemotherapy	86.5B
Procedure	Musculoskeletal	57.8B

RBCS Category	RBCS Subcategory	Total Allowed Spending ($)
Treatment	Physical, Occupational, and Speech Therapy	49.4B
E&M	Hospital Inpatient Services	45.8B
Treatment	Dialysis	44.6B
Test	General Laboratory	42.2B
DME	Other DME	38.6B
Other	Ambulance	30.5B

*excludes spending from alternatively assigned HCPCS codes

B.5 Subcategories with New HCPCS Codes by Allowed Spending*

Table 18 lists the subcategories with new HCPCS codes by allowed spending.

Table 18: Subcategories with New HCPCS Codes by Allowed Spending

RBCS Category	RBCS Subcategory	Number of New Codes	Total Allowed Spending ($)*
Treatment	Injections and Infusions (non-oncologic)	86	272,691,882
Treatment	Chemotherapy	27	1,306,628
DME	Orthotic Devices	13	212,801
DME	Wheelchairs	2	13,522
Treatment	Dialysis	2	562
Other	Vision, Hearing, and Speech Services	1	504
Other	Ambulance	1	450
DME	Other DME	35	349
E&M	Hospital Inpatient Services	1	190
DME	Medical/Surgical Supplies	131	150
E&M	Home Services	1	55

*There is a total of 11 Subcategories that contain new HCPCS codes. The Allowed Spending represents the spending for those new HCPCS codes (i.e., not the total allowed spending for the entire subcategory).
*excludes spending from alternatively assigned HCPCS codes

B.6 HCPCS Codes and Allowed Spending Captured by RBCS Families

Table 19 lists HCPCS codes and allowed spending captured by RBCS families.

Table 19: HCPCS Codes and Allowed Spending Captured by RBCS Families

Statistic	RY 2020	RY 2021	RY 2022	RY 2023	RY 2024	RY 2025
Number of Families	158	158	172	176	179	179
HCPCS Codes Assigned to a Family	4,069	4,299	5,149	6,048	6,663	7,110
Percent of HCPCS Codes Accounted for in RBCS Families*	30.3%	31.5%	37.4%	40.8%	44.1%	42.8%
Total Spending Captured*	$981B	$1,022B	1,033B	$1,024B	$1,048B	$1,075B
Percent of Total Spending Captured*	88.5%	88.5%	89.9%	90.1%	90.9%	91.9%

*Anesthesia codes and spending excluded

B.7 HCPCS Codes Identified as Major Procedures RBCS Release Year

Table 20 lists the HCPCS codes identified as major procedures by RBCS release year.

Table 20: HCPCS Codes Identified as Major Procedures RBCS Release Year

Statistic	RY 2020	RY 2021	RY 2022	RY 2023	RY 2024	RY 2025
Total Major Procedures	3,485	3,470	3,480	3,512	3,331	3,385
% of HCPCS Codes in Procedures Category	55.9%	55.7%	55.8%	54.8%	51.4%	49.8%
Major Procedures Identified Using RVUs Alone	2,692	2,681	2,678	2,702	2,711	2,711
Major Procedures Identified Using Service Setting*	672	468	463	468	451	447
Major Procedures Identified as Add-On Codes	121	111	115	121	121	118
Major Procedures Retained	0	210	224	221	48	109

Appendix C: RBCS Categories and Subcategories

Table 21 lists the RBCS categories and subcategories.

Table 21: RBCS Categories and Subcategories

RBCS Category	RBCS Category Description	RBCS Subcategory	RBCS Subcategory Description
A	Anesthesia	AA	Anesthesia
D	DME	DA	Medical/Surgical Supplies
D	DME	DB	Hospital Beds
D	DME	DC	Oxygen and Supplies
D	DME	DD	Wheelchairs
D	DME	DE	Other DME
D	DME	DF	Orthotic Devices
D	DME	DG	Drugs Administered Through DME
E	E&M	EB	Behavioral Health Services
E	E&M	EC	Critical Care Services
E	E&M	EE	Ophthalmological Services
E	E&M	EH	Home Services
E	E&M	EI	Hospital Inpatient Services
E	E&M	EM	Care Management/Coordination
E	E&M	EN	Nursing Facility Services
E	E&M	EO	Observation Care Services
E	E&M	EP	Hospice
E	E&M	ER	Emergency Department Services
E	E&M	EV	Office/Outpatient Services
E	E&M	EX	E&M - Miscellaneous
I	Imaging	IC	CT Scan
I	Imaging	IM	Magnetic Resonance
I	Imaging	IN	Nuclear

RBCS Category	RBCS Category Description	RBCS Subcategory	RBCS Subcategory Description
I	Imaging	IS	Standard X-ray
I	Imaging	IU	Ultrasound
I	Imaging	IX	Imaging - Miscellaneous
O	Other	OA	Ambulance
O	Other	OB	Enteral and Parenteral
O	Other	OC	Vision, Hearing, and Speech Services
P	Procedure	PB	Breast
P	Procedure	PC	Cardiovascular
P	Procedure	PE	Eye
P	Procedure	PG	Digestive/Gastrointestinal
P	Procedure	PH	Hematology
P	Procedure	PM	Musculoskeletal
P	Procedure	PO	Other Organ Systems
P	Procedure	PS	Skin
P	Procedure	PV	Vascular
R	Treatment	RB	Spinal Manipulation
R	Treatment	RD	Dialysis
R	Treatment	RH	Chemotherapy
R	Treatment	RI	Injections and Infusions (nononcologic)
R	Treatment	RR	Radiation Oncology
R	Treatment	RT	Physical, Occupational, and Speech Therapy
R	Treatment	RX	Treatment - Miscellaneous
T	Test	TA	Anatomic Pathology
T	Test	TC	Cardiography
T	Test	TF	Pulmonary
T	Test	TL	General Laboratory

RBCS Category	RBCS Category Description	RBCS Subcategory	RBCS Subcategory Description
T	Test	TM	Molecular Testing
T	Test	TN	Neurologic
T	Test	TX	Test - Miscellaneous

Appendix D: RBCS Families and Allowed Spending

Table 22 lists the RBCS families and allowed spending.

Table 22: RBCS Families and Allowed Spending

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
DME	Drugs Administered Through DME	004	Vasodilator	1.18 BN	0.11%
DME	Drugs Administered Through DME	006	Bronchodilator	2.05 BN	0.19%
DME	Medical/Surgical Supplies	018	Skin Allograft	8.60 BN	0.80%
DME	Medical/Surgical Supplies	023	Wound Care Directed Dressings	1.96 BN	0.18%
DME	Orthotic Devices	003	Below Knee Orthotic	3.91 BN	0.36%
DME	Orthotic Devices	007	Lumbar Sacral Orthosis Brace	0.99 BN	0.09%
DME	Orthotic Devices	008	Intermittent Urinary Catheter	6.76 BN	0.63%
DME	Orthotic Devices	010	Ostomy	1.40 BN	0.13%
DME	Orthotic Devices	011	Knee Orthosis	1.12 BN	0.10%
DME	Orthotic Devices	019	Implantable Joint Device	6.34 BN	0.59%
DME	Other DME	001	CPAP (sleep apnea)	7.39 BN	0.69%
DME	Other DME	005	Home Ventilator	3.21 BN	0.30%
DME	Other DME	013	Cardioverter - Defibrillator	3.56 BN	0.33%
DME	Other DME	014	Cardiac Catheter	4.68 BN	0.43%
DME	Other DME	015	Implantable Neurostimulator	3.03 BN	0.28%
DME	Other DME	016	Pacemaker	2.02 BN	0.19%
DME	Other DME	017	Diabetic Supplies and Monitoring	5.30 BN	0.49%
DME	Other DME	020	Cardiac Stent	1.13 BN	0.11%
DME	Other DME	022	Orthopedic Screw	2.22 BN	0.21%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
DME	Oxygen and Supplies	002	Oxygen Concentrator	4.15 BN	0.39%
DME	Wheelchairs	009	Power Wheelchairs and Accessories	1.33 BN	0.12%
DME	Wheelchairs	021	Wheelchair Accessories	1.75 BN	0.16%
E&M	Behavioral Health Services	009	Psychotherapy - Nongroup	8.81 BN	0.82%
E&M	Behavioral Health Services	015	Psychotherapy - Group	1.35 BN	0.13%
E&M	Care Management/Coordination	021	Chronic, Principal, and Transitional Care Management	3.65 BN	0.34%
E&M	Critical Care Services	010	Critical Care E&M	7.49 BN	0.70%
E&M	Emergency Department Services	002	Emergency Department E&M	29.16 BN	2.71%
E&M	Home Services	017	Home E&M - New and Established	2.15 BN	0.20%
E&M	Home Services	018	Home Health Skilled Services	0.68 BN	0.06%
E&M	Hospital Inpatient Services	003	Hospital E&M - Subsequent	28.48 BN	2.65%
E&M	Hospital Inpatient Services	005	Hospital E&M - Initial	14.03 BN	1.30%
E&M	Hospital Inpatient Services	014	Hospital Discharge Management	3.32 BN	0.31%
E&M	Nursing Facility Services	008	SNF E&M	13.01 BN	1.21%
E&M	Nursing Facility Services	016	Rest Home E&M	2.05 BN	0.19%
E&M	Observation Care Services	012	Observation Care	6.44 BN	0.60%
E&M	Office/Outpatient Services	001	Office E&M - Established	108.50 BN	10.09%
E&M	Office/Outpatient Services	004	Office E&M - New	18.38 BN	1.71%
E&M	Office/Outpatient Services	006	Hospital Outpatient E&M - Facility Fee	9.60 BN	0.89%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
E&M	Office/Outpatient Services	011	Annual Wellness Visits	7.67 BN	0.71%
E&M	Office/Outpatient Services	013	FQHC E&M - Facility Fee	2.85 BN	0.26%
E&M	Office/Outpatient Services	020	Telephone Services	2.01 BN	0.19%
E&M	Ophthalmological Services	007	Ophthalmological E&M	10.66 BN	0.99%
Imaging	CT Scan	003	CT/CTA - Abdomen and Pelvis	11.57 BN	1.08%
Imaging	CT Scan	006	CT/CTA - Head and Neck	6.59 BN	0.61%
Imaging	CT Scan	007	CT/CTA - Chest	5.95 BN	0.55%
Imaging	CT Scan	021	CT/CTA - Spine	2.10 BN	0.20%
Imaging	Imaging - Miscellaneous	017	Computerized Ophthalmic Imaging	2.09 BN	0.19%
Imaging	Magnetic Resonance	009	MRI/MRA - Head and Neck	3.71 BN	0.35%
Imaging	Magnetic Resonance	010	MRI/MRA - Spine	3.49 BN	0.32%
Imaging	Magnetic Resonance	020	MRI/MRA - Lower Extremity	1.19 BN	0.11%
Imaging	Magnetic Resonance	022	MRI/MRA - Abdomen and Pelvis	1.59 BN	0.15%
Imaging	Magnetic Resonance	023	MRI/MRA - Other	1.18 BN	0.11%
Imaging	Nuclear	002	Myocardial Perfusion Scan	8.33 BN	0.77%
Imaging	Nuclear	008	PET- Oncology	6.60 BN	0.61%
Imaging	Standard X-ray	004	X-ray - Chest	4.73 BN	0.44%
Imaging	Standard X-ray	005	Mammography	6.30 BN	0.59%
Imaging	Standard X-ray	012	Angiography	2.92 BN	0.27%
Imaging	Standard X-ray	013	X-ray - Lower Extremity	3.22 BN	0.30%
Imaging	Standard X-ray	019	X-ray - Spine and Pelvis	1.43 BN	0.13%
Imaging	Standard X-ray	024	X-ray - Upper Extremity	1.53 BN	0.14%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Imaging	Standard X-ray	025	Contrast Agent	1.23 BN	0.11%
Imaging	Ultrasound	001	Echocardiography (TTE/TEE)	11.05 BN	1.03%
Imaging	Ultrasound	011	Ultrasound - Abdomen and Pelvis	2.54 BN	0.24%
Imaging	Ultrasound	014	Duplex Scan - Extremity Arteries	2.12 BN	0.20%
Imaging	Ultrasound	015	Duplex Scan - Extracranial Arteries	1.88 BN	0.17%
Imaging	Ultrasound	016	Duplex Scan - Extremity Veins	2.05 BN	0.19%
Imaging	Ultrasound	018	Ultrasound - Nonspecific	3.66 BN	0.34%
Other	Ambulance	001	Medical Transport - Ground Emergency	16.38 BN	1.52%
Other	Ambulance	002	Medical Transport - Ground	5.35 BN	0.50%
Other	Ambulance	003	Medical Transport - Mileage	5.25 BN	0.49%
Other	Ambulance	004	Medical Transport - Air	3.55 BN	0.33%
Other	Enteral and Parenteral	005	Parenteral Feeding and Formula	1.49 BN	0.14%
Other	Enteral and Parenteral	006	Enteral Feeding and Formula	0.97 BN	0.09%
Procedure	Breast	033	Mastectomy	1.50 BN	0.14%
Procedure	Breast	052	Breast Biopsy	1.15 BN	0.11%
Procedure	Cardiovascular	002	Percutaneous Transcatheterization	9.66 BN	0.90%
Procedure	Cardiovascular	003	Insertion/Removal/Replacement ICD	3.44 BN	0.32%
Procedure	Cardiovascular	008	Comprehensive Electrophysiologic Evaluation	5.71 BN	0.53%
Procedure	Cardiovascular	018	Pacemaker Insertion or Repair	2.06 BN	0.19%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Procedure	Cardiovascular	025	Pacemaker Removal	1.14 BN	0.11%
Procedure	Cardiovascular	031	Percutaneous Coronary Artery Angioplasty and Stenting	1.20 BN	0.11%
Procedure	Digestive/Gastrointestinal	004	Lower GI Endoscopy - Other	6.38 BN	0.59%
Procedure	Digestive/Gastrointestinal	006	Upper GI Endoscopy	6.63 BN	0.62%
Procedure	Digestive/Gastrointestinal	012	Colonoscopy - Lesion Removal	4.05 BN	0.38%
Procedure	Digestive/Gastrointestinal	026	Cholecystectomy - Laparoscopic	1.56 BN	0.15%
Procedure	Digestive/Gastrointestinal	043	Hernia Repair - Laparoscopic (any site)	1.68 BN	0.16%
Procedure	Digestive/Gastrointestinal	047	Hernia Repair - Open (inguinal)	0.75 BN	0.07%
Procedure	Eye	001	Cataract Surgery	15.98 BN	1.49%
Procedure	Eye	035	Intravitreal Injection	2.25 BN	0.21%
Procedure	Eye	046	Vitrectomy - Mechanical	1.06 BN	0.10%
Procedure	Eye	053	Fluid Flow and Drainage of Eye (Any Method)	1.75 BN	0.16%
Procedure	Hematology	034	Red Blood Cell Transfusion	1.26 BN	0.12%
Procedure	Musculoskeletal	007	Nerve Block Injection - Back	6.21 BN	0.58%
Procedure	Musculoskeletal	011	Neurostimulator - Back	4.11 BN	0.38%
Procedure	Musculoskeletal	014	Arthroplasty - Knee	7.83 BN	0.73%
Procedure	Musculoskeletal	015	Joint Injection	3.70 BN	0.34%
Procedure	Musculoskeletal	020	Arthrodesis - Spine	3.98 BN	0.37%
Procedure	Musculoskeletal	021	Arthroscopy - Upper Extremity	2.36 BN	0.22%
Procedure	Musculoskeletal	024	Laminotomy or Laminectomy - Lumbar	2.34 BN	0.22%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Procedure	Musculoskeletal	036	Destruction by Neurolytic Agent - Back	2.14 BN	0.20%
Procedure	Musculoskeletal	039	Arthroscopy - Lower Extremity	1.16 BN	0.11%
Procedure	Musculoskeletal	041	Percutaneous Vertebroplasty	1.06 BN	0.10%
Procedure	Musculoskeletal	044	Arthroplasty - Hip	3.95 BN	0.37%
Procedure	Musculoskeletal	054	Shoulder Repair or Replacement - Open	1.73 BN	0.16%
Procedure	Other Organ Systems	010	Cystourethroscopy	4.23 BN	0.39%
Procedure	Other Organ Systems	022	Calculus Removal - Urinary	2.64 BN	0.25%
Procedure	Other Organ Systems	027	Nasal/Sinus Endoscopy	1.78 BN	0.17%
Procedure	Other Organ Systems	040	Prostate Resection	1.72 BN	0.16%
Procedure	Other Organ Systems	045	Lymph Node Biopsy	0.55 BN	0.05%
Procedure	Other Organ Systems	050	Bronchoscopy	0.80 BN	0.07%
Procedure	Skin	009	Destruction Skin Lesion	5.07 BN	0.47%
Procedure	Skin	013	Debridement	4.24 BN	0.39%
Procedure	Skin	016	Skin Grafting	3.16 BN	0.29%
Procedure	Skin	017	Mohs Surgery	4.09 BN	0.38%
Procedure	Skin	023	Nail Procedure	2.25 BN	0.21%
Procedure	Skin	028	Wound Repair - All Levels	2.34 BN	0.22%
Procedure	Skin	032	Skin Biopsy	2.07 BN	0.19%
Procedure	Skin	038	Skin Lesion Excision	1.24 BN	0.12%
Procedure	Skin	051	Removal or Shaving of Skin Growth	1.62 BN	0.15%
Procedure	Vascular	005	Transluminal Angioplasty - Arterial	6.02 BN	0.56%
Procedure	Vascular	019	Venous Catheter Insertion	2.23 BN	0.21%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Procedure	Vascular	029	A-V Fistula PCI	2.77 BN	0.26%
Procedure	Vascular	030	Transluminal Angioplasty - Venous	0.10 BN	0.01%
Procedure	Vascular	037	A-V Fistula Creation	0.80 BN	0.07%
Procedure	Vascular	042	Varicose Vein Ablation	1.98 BN	0.18%
Procedure	Vascular	048	Vascular Embolization	0.57 BN	0.05%
Procedure	Vascular	049	Transvascular Stent	0.33 BN	0.03%
Test	Anatomic Pathology	002	Surgical Pathology Examination	10.58 BN	0.98%
Test	Anatomic Pathology	009	Immunohistochemistry	2.81 BN	0.26%
Test	Cardiography	003	Electrocardiogram	7.58 BN	0.70%
Test	Cardiography	010	External Electrocardiographic Monitoring	2.86 BN	0.27%
Test	General Laboratory	001	Clinical Chemistry	24.96 BN	2.32%
Test	General Laboratory	004	Blood Count	4.84 BN	0.45%
Test	General Laboratory	005	Drug Tests	3.74 BN	0.35%
Test	General Laboratory	006	Immunoassay	4.28 BN	0.40%
Test	General Laboratory	012	Venipuncture Blood Collection	1.68 BN	0.16%
Test	General Laboratory	013	Bacterial Culture	1.33 BN	0.12%
Test	Molecular Testing	011	Infectious Agent Detection by DNA/RNA	4.56 BN	0.42%
Test	Molecular Testing	014	Genetic Analysis	9.84 BN	0.91%
Test	Molecular Testing	016	COVID Specific	7.74 BN	0.72%
Test	Neurologic	007	Sleep Study	2.12 BN	0.20%
Test	Neurologic	008	Electrical Nerve Conductivity	1.57 BN	0.15%
Test	Pulmonary	015	Pulmonary Function Testing	1.41 BN	0.13%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Treatment	Chemotherapy	002	Chemotherapeutic Agent	81.07 BN	7.54%
Treatment	Chemotherapy	012	Chemotherapy Administration	5.13 BN	0.48%
Treatment	Dialysis	001	ESRD Related Services (not dialysis)	4.33 BN	0.40%
Treatment	Dialysis	028	Peritoneal Dialysis	1.18 BN	0.11%
Treatment	Dialysis	032	Hemodialysis	39.11 BN	3.64%
Treatment	Injections and Infusions (nononcologic)	004	Injection - Monoclonal Antibodies	35.37 BN	3.29%
Treatment	Injections and Infusions (nononcologic)	005	Injection - Macular Degeneration	16.39 BN	1.52%
Treatment	Injections and Infusions (nononcologic)	006	Injection - Colony Stimulating Factors	3.99 BN	0.37%
Treatment	Injections and Infusions (nononcologic)	008	Injection - Immune Globulin	10.39 BN	0.97%
Treatment	Injections and Infusions (nononcologic)	011	Vaccine - Toxoids	8.07 BN	0.75%
Treatment	Injections and Infusions (nononcologic)	013	Injection - Growth/Hormone Factor	0.00 BN	0.00%
Treatment	Injections and Infusions (nononcologic)	014	Injection Administration	3.71 BN	0.35%
Treatment	Injections and Infusions (nononcologic)	015	Intravenous Infusion, Hydration	4.54 BN	0.42%
Treatment	Injections and Infusions (nononcologic)	016	Erythropoiesis - Stimulating Agent	3.38 BN	0.31%
Treatment	Injections and Infusions (nononcologic)	018	Injection - Clotting Factors	3.10 BN	0.29%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Treatment	Injections and Infusions (nononcologic)	019	Injection - Immunomodulator	11.83 BN	1.10%
Treatment	Injections and Infusions (nononcologic)	022	Injection - Somatostatin	3.86 BN	0.36%
Treatment	Injections and Infusions (nononcologic)	023	Vaccine Admin - Flu, Pneum, and Hep B	1.85 BN	0.17%
Treatment	Injections and Infusions (nononcologic)	024	Injection - Tumor Necrosis Factor Blocker	4.24 BN	0.39%
Treatment	Injections and Infusions (nononcologic)	025	Injection - Hyaluronan or Derivative	3.20 BN	0.30%
Treatment	Injections and Infusions (nononcologic)	026	Injection - Vasodilator	1.99 BN	0.18%
Treatment	Injections and Infusions (nononcologic)	030	Injection - Anticoagulant	2.46 BN	0.23%
Treatment	Injections and Infusions (nononcologic)	031	Injection - Enzymes	2.23 BN	0.21%
Treatment	Injections and Infusions (nononcologic)	035	COVID-19 Vaccine Administration	3.42 BN	0.32%
Treatment	Injections and Infusions (nononcologic)	036	Platelet Stimulating Agent	1.25 BN	0.12%
Treatment	Physical, Occupational, and Speech Therapy	003	PT Treatment	39.70 BN	3.69%
Treatment	Physical, Occupational, and Speech Therapy	020	Speech Therapy	3.12 BN	0.29%
Treatment	Physical, Occupational, and Speech Therapy	021	Occupational Therapy	2.51 BN	0.23%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending ($)	Percent of Cumulative 5-Year Total Allowed Spending
Treatment	Physical, Occupational, and Speech Therapy	033	PT/OT Evaluation	4.09 BN	0.38%
Treatment	Radiation Oncology	007	Intensity Modulated Radiation Therapy	8.16 BN	0.76%
Treatment	Radiation Oncology	009	Conventional Radiation Treatment	7.20 BN	0.67%
Treatment	Radiation Oncology	010	Radiation Treatment Planning	6.45 BN	0.60%
Treatment	Spinal Manipulation	017	Chiropractic	3.47 BN	0.32%
Treatment	Treatment - Miscellaneous	027	Cardiac Rehabilitation	1.84 BN	0.17%
Treatment	Treatment - Miscellaneous	029	Immunosuppressive Drugs - Non-injectable	1.15 BN	0.11%
Treatment	Treatment - Miscellaneous	034	Hyperbaric Oxygen	0.92 BN	0.09%
Grand Total				**1075.39 BN**	**100.00%**

Appendix E: Examples of Changes in Classification of Chemotherapy and Non-Chemotherapy Drugs

Table 23 lists examples of changes in classification of chemotherapy and non-chemotherapy drugs.

Table 23: Examples of Changes in Classification of Chemotherapy and Non-Chemotherapy Drugs

Code	Drug	Old Subcategory	Old Family	New Subcategory	New Family
C9087	Injection, cyclophosphamide (auromedics), 10 mg	Injections & Infusions (Non-Oncologic)	No RBCS Family	Chemotherapy	Chemotherapeutic Agent
J8530	Cyclophosphamide; oral, 25 mg	Treatment – Miscellaneous	No RBCS Family	Chemotherapy	Chemotherapeutic Agent
J8700	Cyclophosphamide; oral, 25 mg	Treatment – Miscellaneous	No RBCS Family	Chemotherapy	Chemotherapeutic Agent
J8560	Etoposide; oral, 50 mg	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent
J8501	Aprepitant, oral, 5 mg	Chemotherapy	Chemotherapeutic Agent	Treatment – Miscellaneous	No RBCS Family
J1453	Injection, fosaprepitant, 1 mg	Chemotherapy	Chemotherapeutic Agent	Injections and Infusions (nononcologic)	No RBCS Family
C9145	Injection, aprepitant, (aponvie), 1 mg	Chemotherapy	Chemotherapeutic Agent	Injections and Infusions (nononcologic)	No RBCS Family
J1456	Injection, fosaprepitant (teva), not therapeutically equivalent to J1453, 1 mg	Chemotherapy	No RBCS Family	Injections and Infusions (nononcologic)	No RBCS Family
J7501	Azathioprine, parenteral, 100 mg	Drugs Administered through DME	No RBCS Family	Injections and Infusions (nononcologic)	Injection - Immunomodulator
J8510	Busulfan; oral, 2 mg	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent
J8520	Capecitabine, oral, 150 mg	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent
J8521	Capecitabine, oral, 500 mg	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent

Code	Drug	Old Subcategory	Old Family	New Subcategory	New Family
J8705	Topotecan,oral, 0.25 mg	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent
J8999	Prescription drug, oral, chemotherapeutic, nos	Treatment – Miscellaneous	Immunosuppressive Drugs – Non-injectable	Chemotherapy	Chemotherapeutic Agent

Appendix F: Codes Included in the New RBCS Family: Chronic, Principal, and Transitional Care Management

Table 24 lists the codes included in the New RBCS Family: Chronic, Principal, and Transitional Care Management.

Table 24: Codes Included in the New RBCS Family: Chronic, Principal, and Transitional Care Management

Code	Code Description
99424	Principal care management services for a single high-risk disease, first 30 minutes provided personally by qualified health care professional, per calendar month.
99425	Principal care management services for a single high-risk disease, each additional 30 minutes provided personally by qualified health care professional, per calendar month
99426	Principal care management services for a single high-risk disease, first 30 minutes of clinical staff time directed by health care professional, per calendar month
99427	Principal care management services for a single high-risk disease, each additional 30 minutes of clinical staff time directed by health care professional, per calendar month
99437	Chronic care management services for two or more chronic conditions, additional 30 minutes provided personally by health care professional, per calendar month
99439	Chronic care management services for two or more chronic conditions, additional 20 minutes of clinical staff time directed by health care professional, per calendar month
99487	Complex chronic care management services for two or more chronic conditions, first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex chronic care management services for two or more chronic conditions, each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99490	Chronic care management services, first 20 minutes of clinical staff time directed by health care professional, per calendar month
99491	Chronic care management services for two or more chronic conditions, first 30 minutes provided personally by health care professional, per calendar month
99495	Transitional care management services for problem of at least moderate complexity
99496	Transitional care management services for problem of high complexity
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month

Code	Code Description
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month). (use G2058 in conjunction with 99490). (do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491).
G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

Appendix G: RBCS Update Steps

The steps below were performed for the 2025 RBCS RY update.

1. Combined all fee schedules issued between January 1, 2019, and December 31, 2024, and identified HCPCS codes paid by Medicare.
2. Extracted HCPCS codes from carrier, DME, and outpatient files from the VRDC with service dates between January 1, 2019, and December 31, 2023.
3. Identified and unbundled FQHC, RHC, and APC bundled payments.

   Note: HCPCS codes that were not covered by a fee schedule during the 6-year window, such as retired HCPCS codes, were not allocated spending during the unbundling process.

4. Retained HCPCS codes with positive allowed spending over the five-year timeframe and HCPCS codes billed as part of a bundled payment.
5. Combined the list of paid HCPCS codes from the claims data with the list of HCPCS codes paid by one of the Medicare fee schedules, keeping all HCPCS codes that were either with positive allowed spending in the claims data or were covered by a fee schedule.
6. Removed excluded HCPCS codes from the combined file. Excluded codes fall into one of the following groups:
   - Assessment codes
   - Dental codes (HCPCS codes starting with “D”)
   - “S” codes (HCPCS codes starting with “S” are only paid by commercial insurers)
   - CPT II codes (HCPCS codes ending with “F,” which are used to capture measurements)
   - Hospice codes with HCPCS values between Q5001 and Q5010.
7. Applied the RBCS identifiers from the previous year to the new file.
8. Identified HCPCS codes that were not classified in the previous year.
9. Added category and subcategory classifications to any new HCPCS codes.
10. Identified newly added HCPCS codes for families.
    - Reviewed HCPCS codes to determine if new families needed to be created.
    - Reviewed retired and replacement HCPCS codes and identified existing families that did not meet the spending threshold so that they could be included on a separate list for tracking the five-year retention period.
11. Identified major and non-major procedures and created a separate list for HCPCS/ CPT codes that did not meet the major procedure requirements for tracking the three-year retention period.
12. Extracted HCPCS codes from carrier, DME, and outpatient files from the VRDC with service dates between January 1, 2024, and December 31, 2024. These codes were only assigned Categories and Subcategories.
13. Applied the following quality assurance checks:
    - Spot checks
    - HCPCS add-on code checks
14. Finalized the Taxonomy for Technical Expert Panel (TEP) review.
15. Conducted TEP review of the revised Taxonomy.
16. Finalized the RBCS Taxonomy for the current year.
17. Submitted the RBCS Final Report to CMS.