



Centers for Medicare & Medicaid Services (CMS)

Restructured BETOS Classification System Methodology

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Table of Contents

1. Introduction	4
1.1 RBCS Taxonomy Overview	4
2. Changes for the Current Release Year	5
2.1 Refined Classification of Injection and Infusion (non-oncologic) Drug Codes and Vaccine-Related Families	5
2.2 New Subcategory and Family – Skin and Soft Tissue Substitutes, Skin Substitute Products	6
3. Data Sources	6
3.1 HCPCS Code Dictionary	6
3.2 OM Part B Claims	7
3.2.1 Use of Part B Claims Data	7
3.2.2 Unbundling Claims	7
3.3 Medicare Fee Schedules	9
3.3.1 MPFS Relative Value Unit (RVU) File	10
3.3.2 Outpatient Prospective Payment System (OPPS) Addendum B	10
3.3.3 Ambulatory Surgical Center Payment Rates Addenda AA, BB, and FF	11
3.3.4 Durable Medical Equipment Parenteral and Enteral Nutrition (DMEPEN)	12
3.3.5 Durable Medical Equipment Prosthetics, Orthotics, & Supplies (DMEPOS) ...	12
3.3.6 Clinical Lab Fee Schedule (CLFS)	12
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	12
3.3.8 Federally Qualified Health Center Codes	13
4. RBCS Identifier Assignment	13
4.1 Inclusion Criteria	13
4.2 Exclusion Criteria	13
4.3 Category and Subcategory Assignment	14
4.4 Family Decision Rules	17
4.4.1 Family Retention Period	18
4.5 Major Procedure Decision Rules	20
4.5.1 Major Procedure Retention Period	21
5. Data Limitations	21
6. RBCS Data Dictionary	21
Appendix A: Glossary of Terms	24
Appendix B: Data Tables	28

Appendix C: RBCS Categories and Subcategories	35
Appendix D: RBCS Families and Allowed Spending	38
Appendix E: Examples of Changes in Classification of Injections and Infusions (nononcologic) Drugs	49
Appendix F: Codes Included in the New RBCS Subcategory - Skin and Soft Tissue Substitutes	50
Appendix G: RBCS Update Steps	72

List of Figures

Figure 1: RBCS Identifier Schema	4
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List of Tables

Table 1: Example of the Process of Unbundling Bundled Payments	9
Table 2: MPFS National Physician Fee Schedule Relative Value File Status Code (RVU).....	10
Table 3: Outpatient Prospective Payment System (OPPS) Status Indicators	10
Table 4: Excluded Ambulatory Surgical Center (ASC) Payment Indicators	12
Table 5: Federally Qualified Health Center (FQHC) HCPCS Codes	13
Table 6: Exclusion Criteria	14
Table 7: Category Decision Rules	14
Table 8: Subcategory Decision Rules	16
Table 9: Families in the Retention Period, 2026	19
Table 10: RBCS Data Dictionary	21
Table 11: Glossary of Terms	24
Table 12: RBCS Updates by Release Year	28
Table 13: Analysis Windows Used in Each RBCS Taxonomy Release Year	28
Table 14: Top 10 HCPCS Codes by Allowed Spending	29
Table 15: Top 10 HCPCS Codes New to the Taxonomy in 2026 by Allowed Spending.....	29
Table 16: Top 10 Subcategories by Allowed Spending	31
Table 17: Subcategories with New HCPCS Codes by Allowed Spending.....	32
Table 18: HCPCS Codes and Allowed Spending Captured by RBCS Families	34
Table 19: HCPCS Codes Identified as Major Procedures RBCS Release Year	34
Table 20: RBCS Categories and Subcategories.....	35
Table 21: RBCS Families and Allowed Spending.....	38
Table 22: Examples of Changes in Classification of Injections and Infusions (nononcologic) Drugs	49
Table 23: Codes Included in the New RBCS Subcategory: Skin and Soft Tissue Substitutes ...	50

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. Changes for the Current Release Year

The following subsections describe the changes to the RBCS taxonomy in the RBCS Release Year (RY) 2026.

2.1 Refined Classification of Injection and Infusion (non-oncologic) Drug Codes and Vaccine-Related Families

During the review of HCPCS/CPT code categories and subcategories, inconsistencies were identified within family assignments of codes included in the injection and infusion (non-oncologic) subcategory. The subcategory was reviewed in its entirety, and corrections were implemented across multiple families to improve clinical consistency and coding accuracy. In addition to correcting family assignments for individual codes, the vaccine-related families were restructured to better reflect the clinical distinction between vaccine products and vaccine administration services. Two new families, Vaccine Product and Vaccine Administration, were created, while the families Vaccine – Toxoids, Vaccine Admin – Flu, Pneum, and Hep B, and COVID-19 Vaccine Administration were retired. Codes previously assigned to Vaccine – Toxoids were reassigned to Vaccine Product, and codes previously assigned to Vaccine Admin – Flu, Pneum, and Hep B and COVID-19 Vaccine Administration were consolidated within the Vaccine Administration family. These changes improve the organization and interpretability of vaccine-related services by grouping codes according to their clinical purpose rather than specific vaccine types or administration settings. Additional examples of classification updates are available in *Appendix E: Examples of Changes in Classification of Injections and Infusions (nononcologic) Drugs*.

Examples of Classification Adjustments in RBCS RY 2026

- C9047, Injection, caplacizumab-yhdp, 1 mg
 - A monoclonal antibody drug designed to treat acquired thrombotic thrombocytopenic purpura (aTTP).
 - Moved from the family, Injection - Clotting Factors to Injection - Monoclonal Antibodies
- 91300, Severe acute respiratory syndrome coronavirus 2 (covid-19) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3ml dosage, diluent reconstituted, for intramuscular use
 - This code is for a covid-19 vaccine that is not clinically defined as a toxoid
 - Moved from the family, Vaccine – Toxoids to Vaccine Product
- 90480, Administration of severe acute respiratory syndrome coronavirus 2 (covid-19) vaccine by intramuscular injection, first component of each vaccine administered
 - This code is for the administration of a covid-10 vaccination
 - Moved from the family, COVID-19 Vaccine Administration to Vaccine Administration

2.2 New Subcategory and Family – Skin and Soft Tissue Substitutes, Skin Substitute Products

Skin and soft tissue substitute products are used in wound and soft tissue management and include both biologic and synthetic materials designed to replace, reinforce, or support tissue healing and regeneration. Prior to the 2026 RBCS RY, these products were grouped with durable medical equipment and medical/surgical supplies, even though they function as active treatment interventions.

During the RBCS RY 2025 SME Panel review, panelists raised concerns that classifying skin substitute HCPCS codes within the DME category and the Skin Allograft family did not adequately reflect the products represented by these HCPCS codes. Panelists noted that the existing structure included both biologic and synthetic technologies and products that extend beyond traditional allografts.

In response to these concerns, the RBCS RY 2026 Taxonomy introduces a new Skin and Soft Tissue Substitutes subcategory. Within this subcategory, the new Skin Substitute Products family encompasses HCPCS codes for products used in wound care and soft tissue repair, including biologic and synthetic materials that replace, reinforce, or support the regeneration of skin and other soft tissues.

HCPCS codes representing the application of skin substitute products have also been reassigned to the new Skin and Soft Tissue Substitutes subcategory. These codes remain categorized under No RBCS Family because aggregate spending for the group does not meet the RBCS family spending threshold required for family creation. The RBCS team will continue to monitor utilization and spending for these application codes in future Taxonomy years to determine whether the group warrants designation as a separate RBCS family.

These changes were approved by the RBCS SME panel and provide a more clinically appropriate classification structure for skin and soft tissue substitute technologies by aligning HCPCS code organization more closely with contemporary wound care treatment practices. The full list of HCPCS included in the new Skin and Soft Tissue Substitutes Category is available in *Appendix F: Codes Included in the New RBCS Subcategory - Skin and Soft Tissue Substitutes*.

3. Data Sources

The following subsections describe the data sources used in the RBCS RY 2026.

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 OM Part B Claims

The following subsections describe how OM Part B claims data are used in the RBCS Taxonomy update process.

3.2.1 Use of Part B Claims Data

The RBCS categorizes HCPCS codes associated with Part B services which are identified using OM claim lines with positive allowed spending. Allowed spending amounts are used to measure resource utilization and support HCPCS code classification activities throughout Taxonomy development. When allowed spending amounts are unavailable, an allowed spending equivalent is calculated using the Medicare paid amount and beneficiary responsibility amount.

Historically, for release years 2020-2024, annual updates to the RBCS Taxonomy were based on five years of OM Part B institutional and non-institutional claims data (termed the “standard process”). Beginning with RBCS RY 2025 and continuing in RBCS RY 2026, the annual update process incorporated an additional year of claims beyond the standard five-year review window. The additional year of claims supports the identification and incorporation of newer HCPCS codes while maintaining the stability provided by the established five-year analytic framework. For RBCS RY 2026, OM Part B institutional and non-institutional claims for calendar years 2020 through 2024 (standard process) and 2025 (additional year of claims) were reviewed.

HCPCS codes identified through the standard process are assigned the full RBCS ID. HCPCS codes identified in the sixth year of claims are only assigned RBCS categories and subcategories and are designated as “No RBCS Family.” These codes are subsequently reviewed during the next RBCS Release Year and considered for final family assignments using the standard methodology. Because these sixth-year assignments are based on claims with limited runout, a HCPCS code identified through the alternative assignment method may not meet the Taxonomy inclusion criteria when more mature claims data are reviewed in a subsequent release year.

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 1*.

In the example shown in *Table 1*, 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 1: 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
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 RBCS RY 2023, Medicare fee schedules are used in addition to claims data to identify HCPCS codes for inclusion in the RBCS Taxonomy. The RBCS RY 2026 evaluates fee schedules covering January 1, 2020, through December 31, 2025. 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 (2020 – 2025) are reviewed for category, subcategory, and family assignments and 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.

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

3.3.1 MPFS Relative Value Unit (RVU) File¹

Codes from the MPFS RVU file with status codes listed in *Table 2* are considered paid by Medicare.

Table 2: MPFS National Physician Fee Schedule Relative Value File Status Code (RVU)

Status Code	Description
A	Active code
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 B²

Codes from the OPPS Addendum B with status indicators listed in *Table 3* are considered paid by Medicare.

Table 3: 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

¹ <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files>

² <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates>

Status Indicator	Description
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
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 FF³

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 4*.

³ <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda>

Table 4: 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)⁴

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

3.3.5 Durable Medical Equipment Prosthetics, Orthotics, & Supplies (DMEPOS)⁵

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

3.3.6 Clinical Lab Fee Schedule (CLFS)⁶

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 Crosswalk⁷

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

⁴ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule>

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

⁶ <https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files>

⁷ <https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files>

3.3.8 Federally Qualified Health Center Codes

Additionally, all FQHC payment codes⁸ listed in *Table 5* are considered paid by Medicare.

Table 5: 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 AWW
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.

4.1 Inclusion Criteria

The RBCS RY 2026 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. HCPCS codes identified in the sixth year of claims and assigned using the alternative

⁸ <https://www.cms.gov/medicare/payment/prospective-payment-systems/federally-qualified-health-centers-fqhc-center>

assignment method are reassessed in subsequent Taxonomy updates as more mature claims data become available. As a result, a code that initially appeared to satisfy the inclusion criteria may later be excluded when additional claims runout indicates that it no longer meets those criteria. For example, 10 HCPCS codes included in RBCS RY 2025 (G1013, H0001, H0002, H0031, H0038, T1007, T1015, T1502, T2023, and 99512) were removed from RBCS RY 2026 because more mature claims data showed that the codes no longer had positive allowed spending and did not have Medicare fee schedule coverage.

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), performance measurement tracking codes ending in “F,” and hospice codes in the range Q5001 – Q5010. These exclusions help keep the RBCS focused on services covered under Medicare Part B. *Table 6* presents these criteria, the types of codes affected, and the rationale for their exclusion.

Table 6: 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

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 7* lists the specific categories and rules used to assign HCPCS codes to RBCS categories.

Table 7: Category Decision Rules

Category	Rule
Anesthesia	All anesthesia HCPCS codes are placed in the anesthesia category.
DME	HCPCS codes for products and supplies are classified as Durable Medical Equipment (DME).

Category	Rule
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 8*.

Table 8: 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

Category	Subcategory Assignment Rules
Imaging	The original BETOS imaging subcategories continue to effectively present the different imaging modalities.
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 character 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 and allowed spending. 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 RBCS RY 2026 Taxonomy includes 176 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. For HCPCS codes identified within the five-year standard claims window, five years of claims data are combined and analyzed as a single unit, and the RBCS family development process begins by identifying the highest-spending non-anesthesia HCPCS codes that, when combined, account for 90% of total allowed spending in the claims data under review. 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 account 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 remains aligned with evolving practice trends and can be used to identify HCPCS codes that are spending outliers. The broad claims window used in the annual update process smooths variation in spending and utilization, increases data stability, and allows the Taxonomy to adjust gradually to changes in healthcare practice patterns over time. As practice patterns evolve and new HCPCS codes are introduced, spending increases for groups of procedures with higher utilization and decreases for groups with lower utilization. As a result, new families are introduced, and existing families may be retired. This dynamic process provides two key benefits: it captures emerging healthcare trends while also pruning families that experience sustained declines in 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 instability and 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 RBCS RY 2026, 22 families are in the family retention period, as shown in *Table 9*. Two families, Transvascular Stent and Enteral Feeding and Formula have been retired as of RBCS RY 2026. Ten families are in the fifth and final year of the retention period and thus are at risk of retirement in RY 2027 if similar spending patterns persist.

Table 9: Families in the Retention Period, 2026

Family	Category	Subcategory	Years in Retention Period
Home Health Skilled Services	E&M	Home Services	5
Pacemaker Removal	Procedure	Cardiovascular	5
Hernia Repair - Open (inguinal)	Procedure	Digestive/Gastrointestinal	5
Vitrectomy - Mechanical	Procedure	Eye	5
Percutaneous Vertebroplasty	Procedure	Musculoskeletal	5
Bronchoscopy	Procedure	Other Organ Systems	5
Lymph Node Biopsy	Procedure	Other Organ Systems	5
Transluminal Angioplasty - Venous	Procedure	Vascular	5
Vascular Embolization	Procedure	Vascular	5
Hyperbaric Oxygen	Treatment	Treatment - Miscellaneous	5
A-V Fistula Creation	Procedure	Vascular	4
Knee Orthosis	DME	Orthotic Devices	2
Lumbar Sacral Orthosis Brace	DME	Orthotic Devices	2
Cardiac Stent	DME	Other DME	2
Breast Biopsy	Procedure	Breast	2
Arthroscopy - Lower Extremity	Procedure	Musculoskeletal	2
COVID Specific	Test	Molecular Testing	2
Vasodilator	DME	Drugs Administered Through DME	1
MRI/MRA – Lower Extremity	Imaging	Magnetic Resonance	1
Percutaneous Coronary Artery Angioplasty and Stenting	Procedure	Cardiovascular	1

Family	Category	Subcategory	Years in Retention Period
Skin Lesion Excision	Procedure	Skin	1
Peritoneal Dialysis	Treatment	Dialysis	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 website⁹ 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.

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 Original Medicare Part B claims, its applicability to other populations or non-claims-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.

In addition, assignments made using the alternative assignment method for HCPCS codes identified in the sixth year of claims should be interpreted with caution because subsequent review of more mature claims data may show that a code no longer meets the Taxonomy inclusion criteria.

6. RBCS Data Dictionary

Table 10 lists RBCS variables, term names, and their definitions.

Table 10: RBCS Data Dictionary

Variable	Term Name	Definition
HCPCS_Cd	HCPCS Code	HCPCS code.

⁹ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

Variable	Term Name	Definition
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 the HCPCS/CPT code. A value of "1" indicates that the RBCS ID is the most recent assignment for the HCPCS/CPT code. A value of "0" indicates that the RBCS ID is not the most recent assignment for the HCPCS/CPT code.
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

Variable	Term Name	Definition
		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 11 provides terms, abbreviations, and associated definitions for this document.

Table 11: 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).

Term	Abbreviation	Definition
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.
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.
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.
Fee-for-Service	FFS	Traditional Medicare payment model in which providers are paid separately for each covered service provided to beneficiaries.
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.

Term	Abbreviation	Definition
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.
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.
Original Medicare	OM	Original Medicare (OM) refers to the traditional Medicare Fee-for-Service (FFS) program covering Part A and Part B.
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.

Term	Abbreviation	Definition
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 12 lists total HCPCS codes, HCPCS codes new to the Taxonomy and RBCS revisions by release year.

Table 12: RBCS Updates by Release Year

Statistic	RY2020	RY2021	RY2022	RY2023	RY2024	RY2025	RY2026
Total HCPCS Codes in the Taxonomy File	13,414	14,013	14,360	15,522	15,984	16,618	17,174
HCPCS Codes New to the Taxonomy	-	599	347	1,162	462	634	566
RBCS Reassignments (Category, Subcategory, Family)	-	300	815	304	389	252	647
RBCS Reassignments (Major Procedure Only)	-	1	10	5	189	23	21

B.2 Analysis Windows Used in Each RBCS Taxonomy Release Year

Table 13 lists total HCPCS codes, HCPCS codes new to the Taxonomy and RBCS revisions by release year.

Table 13: 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
2026	2020 -- 2024	2025	2025	2020 – 2025

B.3 Top 10 HCPCS Codes by Allowed Spending*

Table 14 lists the top 10 HCPCS codes by allowed spending.

Table 14: 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	62,348,422,054
99213	Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more	34,283,074,323
90999	Other inpatient or outpatient dialysis procedure	32,713,551,533
J9271	Injection, pembrolizumab, 1 mg	21,681,118,608
99285	Emergency department visit with high level of medical decision making	15,926,542,490
J0178	Injection, aflibercept, 1 mg	15,604,522,378
97110	Therapy procedure using exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes	14,598,842,906
99232	Subsequent hospital inpatient or observation care with moderate level of medical decision making, if using time, 35 minutes or more	13,591,169,966
99233	Subsequent hospital inpatient or observation care with high level of medical decision making, if using time, 50 minutes or more	13,258,957,376
66984	Removal of cataract with insertion of prosthetic lens	12,511,281,478

*Excludes spending from alternatively assigned HCPCS codes

B.4 Top 10 HCPCS Codes New to the Taxonomy in 2026 by Allowed Spending*

Table 15 lists the top 10 HCPCS codes new to the Taxonomy in 2026 by allowed spending.

Table 15: Top 10 HCPCS Codes New to the Taxonomy in 2026 by Allowed Spending

HCPCS	Code Description	Total Allowed Spending (\$)
G9880	The mdpp beneficiary achieved at least 5% weight loss (wl) from his/her baseline weight in months 1-12 of the mdpp services period under the mdpp expanded model (em). this is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session	224,054

HCPCS	Code Description	Total Allowed Spending (\$)
G9879	Two Medicare diabetes prevention program (mdpp) core maintenance sessions (ms) were attended by an mdpp beneficiary in months (mo) 10-12 under the mdpp expanded model (em). a core maintenance session is an mdpp service that: (1) is furnished by an mdpp supplier during months 7 through 12 of the mdpp services period; (2) is approximately 1 hour in length; and (3) adheres to a cdc-approved dpp curriculum for maintenance sessions. the beneficiary achieved at least 5% weight loss (wl) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12	39,716
G9881	The mdpp beneficiary achieved at least 9% weight loss (wl) from his/her baseline weight in months 1-24 under the mdpp expanded model (em). this is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session	16,465
G9882	Two Medicare diabetes prevention program (mdpp) ongoing maintenance sessions (ms) were attended by an mdpp beneficiary in months (mo) 13-15 under the mdpp expanded model (em). an ongoing maintenance session is an mdpp service that: (1) is furnished by an mdpp supplier during months 13 through 24 of the mdpp services period; (2) is approximately 1 hour in length; and (3) adheres to a cdc-approved dpp curriculum for maintenance sessions. the beneficiary maintained at least 5% weight loss (wl) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15	6,936
G9883	Two Medicare diabetes prevention program (mdpp) ongoing maintenance sessions (ms) were attended by an mdpp beneficiary in months (mo) 16-18 under the mdpp expanded model (em). an ongoing maintenance session is an mdpp service that: (1) is furnished by an mdpp supplier during months 13 through 24 of the mdpp services period; (2) is approximately 1 hour in length; and (3) adheres to a cdc-approved dpp curriculum for maintenance sessions. the beneficiary maintained at least 5% weight loss (wl) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 16-18	6,705

HCPCS	Code Description	Total Allowed Spending (\$)
G9884	Two Medicare diabetes prevention program (mdpp) ongoing maintenance sessions (ms) were attended by an mdpp beneficiary in months (mo) 19-21 under the mdpp expanded model (em). an ongoing maintenance session is an mdpp service that: (1) is furnished by an mdpp supplier during months 13 through 24 of the mdpp services period; (2) is approximately 1 hour in length; and (3) adheres to a cdc-approved dpp curriculum for maintenance sessions. the beneficiary maintained at least 5% weight loss (wl) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21	5,684
G9885	Two Medicare diabetes prevention program (mdpp) ongoing maintenance sessions (ms) were attended by an mdpp beneficiary in months (mo) 22-24 under the mdpp expanded model (em). an ongoing maintenance session is an mdpp service that: (1) is furnished by an mdpp supplier during months 13 through 24 of the mdpp services period; (2) is approximately 1 hour in length; and (3) adheres to a cdc-approved dpp curriculum for maintenance sessions. the beneficiary maintained at least 5% weight loss (wl) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 22-24	4,761
A2027	Matriderm, per square centimeter (add-on, list separately in addition to primary procedure)	3,344
0022A	Intramuscular administration of single severe acute respiratory syndrome coronavirus 2 (covid-19) vaccine, dna, spike protein, chimpanzee adenovirus oxford 1 (chadox1) vector, preservative free, 5x10 ¹⁰ viral particles/0.5ml dosage; second dose	33
J0799	FDA approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified	23

*Excludes spending from alternatively assigned HCPCS codes

B.5 Top 10 Subcategories by Allowed Spending*

Table 16 lists the top 10 subcategories by allowed spending.

Table 16: Top 10 Subcategories by Allowed Spending

RBCS Category	RBCS Subcategory	Total Allowed Spending (\$)
E&M	Office/Outpatient Services	151,615,837,471
Treatment	Injections and Infusions (nononcologic)	149,798,849,475

RBCS Category	RBCS Subcategory	Total Allowed Spending (\$)
Treatment	Chemotherapy	86,244,045,728
Procedure	Musculoskeletal	59,501,268,479
Treatment	Physical, Occupational, and Speech Therapy	50,576,872,157
E&M	Hospital Inpatient Services	44,556,450,274
Test	General Laboratory	41,199,680,627
DME	Other DME	40,629,086,960
Treatment	Dialysis	38,675,282,680
Other	Ambulance	30,101,561,499

*Excludes spending from alternatively assigned HCPCS codes

B.6 Subcategories with New HCPCS Codes by Allowed Spending*

Table 17 lists the subcategories with new HCPCS codes by allowed spending.

Table 17: Subcategories with New HCPCS Codes by Allowed Spending

RBCS Category	RBCS Subcategory	Number of New Codes	Total Allowed Spending (\$)*
E&M	Care Management/Coordination	15	304,320
Treatment	Skin and Soft Tissue Substitutes	66	3344
Treatment	Injections and Infusions (nononcologic)	90	33
Treatment	Treatment - Miscellaneous	7	23
Other	Vision, Hearing, and Speech Services	1	23
E&M	E&M - Miscellaneous	12	4
Treatment	Chemotherapy	27	0
Procedure	Musculoskeletal	8	0
Test	General Laboratory	38	0
DME	Other DME	14	0
Procedure	Skin	13	0

RBCS Category	RBCS Subcategory	Number of New Codes	Total Allowed Spending (\$)*
Imaging	CT Scan	2	0
DME	Orthotic Devices	19	0
Procedure	Digestive/Gastrointestinal	9	0
Procedure	Other Organ Systems	39	0
Procedure	Cardiovascular	25	0
Test	Molecular Testing	55	0
Procedure	Eye	2	0
Treatment	Radiation Oncology	2	0
Imaging	Ultrasound	3	0
Imaging	Nuclear	2	0
Procedure	Vascular	1	0
E&M	Behavioral Health Services	13	0
Imaging	Magnetic Resonance	1	0
Test	Cardiography	14	0
DME	Drugs Administered Through DME	1	0
DME	Medical/Surgical Supplies	7	0
DME	Wheelchairs	3	0
Procedure	Breast	3	0
Imaging	Imaging - Miscellaneous	10	0
Procedure	Hematology	4	0
Test	Test - Miscellaneous	4	0

*There is a total of 32 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.7 HCPCS Codes and Allowed Spending Captured by RBCS Families

Table 18 lists HCPCS codes and allowed spending captured by RBCS families.

Table 18: HCPCS Codes and Allowed Spending Captured by RBCS Families

Statistic	RY 2020	RY 2021	RY 2022	RY 2023	RY 2024	RY 2025	RY 2026
Number of Families	158	158	172	176	179	179	176
HCPCS Codes Assigned to a Family	4,069	4,299	5,149	6,048	6,663	7,110	7,423
Percent of HCPCS Codes Accounted for in RBCS Families*	30.3%	31.5%	37.4%	40.8%	44.1%	42.8%	44.2%
Total Spending Captured*	\$981B	\$1,022B	1,033B	\$1,024B	\$1,048B	\$1,075B	\$1,095B
Percent of Total Spending Captured*	88.5%	88.5%	89.9%	90.1%	90.9%	91.9%	91.5%

*Anesthesia codes and spending excluded.

B.8 HCPCS Codes Identified as Major Procedures RBCS Release Year

Table 19 lists the HCPCS codes identified as major procedures by RBCS release year.

Table 19: HCPCS Codes Identified as Major Procedures RBCS Release Year

Statistic	RY 2020	RY 2021	RY 2022	RY 2023	RY 2024	RY 2025	RY 2026
Total Major Procedures	3,485	3,470	3,480	3,512	3,331	3,385	3,399
% of HCPCS Codes in Procedures Category	55.9%	55.7%	55.8%	54.8%	51.4%	49.8%	49.4%
Major Procedures Identified Using RVUs Alone	2,692	2,681	2,678	2,702	2,711	2,711	2,715
Major Procedures Identified Using Service Setting*	672	468	463	468	451	447	441
Major Procedures Identified as Add-On Codes	121	111	115	121	121	118	117
Major Procedures Retained	0	210	224	221	48	109	126

Appendix C: RBCS Categories and Subcategories

Table 20 lists the RBCS categories and subcategories.

Table 20: 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

RBCS Category	RBCS Category Description	RBCS Subcategory	RBCS Subcategory Description
I	Imaging	IM	Magnetic Resonance
I	Imaging	IN	Nuclear
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

RBCS Category	RBCS Category Description	RBCS Subcategory	RBCS Subcategory Description
T	Test	TA	Anatomic Pathology
T	Test	TC	Cardiography
T	Test	TF	Pulmonary
T	Test	TL	General Laboratory
T	Test	TM	Molecular Testing
T	Test	TN	Neurologic
T	Test	TX	Test - Miscellaneous

Appendix D: RBCS Families and Allowed Spending

Table 21 lists the RBCS families and allowed spending. ****Note:** Cumulative 5-Year Allowed Spending excludes spending for codes in the Anesthesia category. Consequently, the Percent of Cumulative 5-Year Total Allowed Spending does not total 100%, with the remaining percentage attributable to codes that are not assigned to an RBCS family ("No RBCS Family").

Table 21: RBCS Families and Allowed Spending

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$)**	Percent of Cumulative 5-Year Total Allowed Spending**
DME	Medical/Surgical Supplies	023	Wound Care Directed Dressings	2907754947	0.24%
DME	Oxygen and Supplies	002	Oxygen Concentrator	4200334955	0.35%
DME	Wheelchairs	009	Power Wheelchairs and Accessories	1367841425	0.11%
DME	Wheelchairs	021	Wheelchair Accessories	1883190019	0.16%
DME	Other DME	001	CPAP (sleep apnea)	7806104342	0.65%
DME	Other DME	005	Home Ventilator	3257533831	0.27%
DME	Other DME	013	Cardioverter - Defibrillator	3261782797	0.27%
DME	Other DME	014	Cardiac Catheter	4807077100	0.40%
DME	Other DME	015	Implantable Neurostimulator	3024824493	0.25%
DME	Other DME	016	Pacemaker	1927284985	0.16%
DME	Other DME	017	Diabetic Supplies and Monitoring	6891659839	0.58%
DME	Other DME	020	Cardiac Stent	991120921	0.08%
DME	Other DME	022	Orthopedic Screw	2323121314	0.19%
DME	Orthotic Devices	003	Below Knee Orthotic	3653648497	0.31%
DME	Orthotic Devices	007	Lumbar Sacral Orthosis Brace	796212996	0.07%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
DME	Orthotic Devices	008	Intermittent Urinary Catheter	8843223249	0.74%
DME	Orthotic Devices	010	Ostomy	1541835519	0.13%
DME	Orthotic Devices	011	Knee Orthosis	924579511	0.08%
DME	Orthotic Devices	019	Implantable Joint Device	7195527645	0.60%
DME	Drugs Administered Through DME	004	Vasodilator	1156639687	0.10%
DME	Drugs Administered Through DME	006	Bronchodilator	1875177734	0.16%
E&M	Behavioral Health Services	009	Psychotherapy - Nongroup	8887343571	0.74%
E&M	Behavioral Health Services	015	Psychotherapy - Group	1267606413	0.11%
E&M	Critical Care Services	010	Critical Care E&M	7407678227	0.62%
E&M	Ophthalmological Services	007	Ophthalmological E&M	9702572759	0.81%
E&M	Home Services	017	Home E&M - New and Established	2721126389	0.23%
E&M	Home Services	018	Home Health Skilled Services	654373806	0.05%
E&M	Hospital Inpatient Services	003	Hospital E&M - Subsequent	27913956471	2.33%
E&M	Hospital Inpatient Services	005	Hospital E&M - Initial	13320175082	1.11%
E&M	Hospital Inpatient Services	014	Hospital Discharge Management	3321355886	0.28%
E&M	Care Management/Coordination	021	Chronic, Principal, and Transitional Care Management	4362758899	0.36%
E&M	Nursing Facility Services	008	SNF E&M	13830142025	1.16%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$)**	Percent of Cumulative 5-Year Total Allowed Spending**
E&M	Nursing Facility Services	016	Rest Home E&M	1540728811	0.13%
E&M	Observation Care Services	012	Observation Care	5492697091	0.46%
E&M	Emergency Department Services	002	Emergency Department E&M	28385123339	2.37%
E&M	Office/Outpatient Services	001	Office E&M - Established	110127047303	9.20%
E&M	Office/Outpatient Services	004	Office E&M - New	18361212019	1.53%
E&M	Office/Outpatient Services	006	Hospital Outpatient E&M - Facility Fee	9638174814	0.81%
E&M	Office/Outpatient Services	011	Annual Wellness Visits	8015186630	0.67%
E&M	Office/Outpatient Services	013	FQHC E&M - Facility Fee	2810550795	0.23%
E&M	Office/Outpatient Services	020	Telephone Services	2262375613	0.19%
Imaging	CT Scan	003	CT/CTA - Abdomen and Pelvis	11594326338	0.97%
Imaging	CT Scan	006	CT/CTA - Head and Neck	6653756172	0.56%
Imaging	CT Scan	007	CT/CTA - Chest	6064708589	0.51%
Imaging	CT Scan	021	CT/CTA - Spine	2149175203	0.18%
Imaging	Magnetic Resonance	009	MRI/MRA - Head and Neck	3653742000	0.31%
Imaging	Magnetic Resonance	010	MRI/MRA - Spine	3418813450	0.29%
Imaging	Magnetic Resonance	020	MRI/MRA - Lower Extremity	1165868333	0.10%
Imaging	Magnetic Resonance	022	MRI/MRA - Abdomen and Pelvis	1701391860	0.14%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
Imaging	Magnetic Resonance	023	MRI/MRA - Other	1190439037	0.10%
Imaging	Nuclear	002	Myocardial Perfusion Scan	8362483027	0.70%
Imaging	Nuclear	008	PET- Oncology	7577012444	0.63%
Imaging	Standard X-ray	004	X-ray - Chest	4549809994	0.38%
Imaging	Standard X-ray	005	Mammography	6199420580	0.52%
Imaging	Standard X-ray	012	Angiography	2773879441	0.23%
Imaging	Standard X-ray	013	X-ray - Lower Extremity	3219927959	0.27%
Imaging	Standard X-ray	019	X-ray - Spine and Pelvis	1390646808	0.12%
Imaging	Standard X-ray	024	X-ray - Upper Extremity	1546006875	0.13%
Imaging	Standard X-ray	025	Contrast Agent	1209629932	0.10%
Imaging	Ultrasound	001	Echocardiography (TTE/TEE)	11004714270	0.92%
Imaging	Ultrasound	011	Ultrasound - Abdomen and Pelvis	2431263548	0.20%
Imaging	Ultrasound	014	Duplex Scan - Extremity Arteries	2040429525	0.17%
Imaging	Ultrasound	015	Duplex Scan - Extracranial Arteries	1761750580	0.15%
Imaging	Ultrasound	016	Duplex Scan - Extremity Veins	1990479023	0.17%
Imaging	Ultrasound	018	Ultrasound - Nonspecific	3548463995	0.30%
Imaging	Imaging - Miscellaneous	017	Computerized Ophthalmic Imaging	2111612445	0.18%
Other	Ambulance	001	Medical Transport - Ground Emergency	16285648167	1.36%
Other	Ambulance	002	Medical Transport - Ground	5089024759	0.43%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
Other	Ambulance	003	Medical Transport - Mileage	5108252904	0.43%
Other	Ambulance	004	Medical Transport - Air	3618635147	0.30%
Other	Enteral and Parenteral	005	Parenteral Feeding and Formula	1552658583	0.13%
Procedure	Breast	033	Mastectomy	1489028090	0.12%
Procedure	Breast	052	Breast Biopsy	1136938589	0.10%
Procedure	Cardiovascular	002	Percutaneous Transcatheterization	9282096416	0.78%
Procedure	Cardiovascular	003	Insertion/Removal/Replacement ICD	3423949133	0.29%
Procedure	Cardiovascular	008	Comprehensive Electrophysiologic Evaluation	5996547925	0.50%
Procedure	Cardiovascular	018	Pacemaker Insertion or Repair	1994393917	0.17%
Procedure	Cardiovascular	025	Pacemaker Removal	1184182788	0.10%
Procedure	Cardiovascular	031	Percutaneous Coronary Artery Angioplasty and Stenting	1117106936	0.09%
Procedure	Eye	001	Cataract Surgery	15776468919	1.32%
Procedure	Eye	035	Intravitreal Injection	2308533333	0.19%
Procedure	Eye	046	Vitrectomy - Mechanical	1034997290	0.09%
Procedure	Eye	053	Fluid Flow and Drainage of Eye (Any Method)	1616644401	0.14%
Procedure	Digestive/Gastrointestinal	004	Lower GI Endoscopy - Other	6340533681	0.53%
Procedure	Digestive/Gastrointestinal	006	Upper GI Endoscopy	6531342169	0.55%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
Procedure	Digestive/Gastrointestinal	012	Colonoscopy - Lesion Removal	4212324239	0.35%
Procedure	Digestive/Gastrointestinal	026	Cholecystectomy - Laparoscopic	1518804727	0.13%
Procedure	Digestive/Gastrointestinal	043	Hernia Repair - Laparoscopic (any site)	1687162189	0.14%
Procedure	Digestive/Gastrointestinal	047	Hernia Repair - Open (inguinal)	713954512	0.06%
Procedure	Hematology	034	Red Blood Cell Transfusion	1213489953	0.10%
Procedure	Musculoskeletal	007	Nerve Block Injection - Back	6003511404	0.50%
Procedure	Musculoskeletal	011	Neurostimulator - Back	4253042160	0.36%
Procedure	Musculoskeletal	014	Arthroplasty - Knee	8539986846	0.71%
Procedure	Musculoskeletal	015	Joint Injection	3740878745	0.31%
Procedure	Musculoskeletal	020	Arthrodesis - Spine	3855411553	0.32%
Procedure	Musculoskeletal	021	Arthroscopy - Upper Extremity	2325474682	0.19%
Procedure	Musculoskeletal	024	Laminotomy or Laminectomy - Lumbar	2286491635	0.19%
Procedure	Musculoskeletal	036	Destruction by Neurolytic Agent - Back	2199089632	0.18%
Procedure	Musculoskeletal	039	Arthroscopy - Lower Extremity	1080830213	0.09%
Procedure	Musculoskeletal	041	Percutaneous Vertebroplasty	996568679	0.08%
Procedure	Musculoskeletal	044	Arthroplasty - Hip	4565058568	0.38%
Procedure	Musculoskeletal	054	Shoulder Repair or Replacement - Open	2175566516	0.18%
Procedure	Other Organ Systems	010	Cystourethroscopy	4198921485	0.35%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
Procedure	Other Organ Systems	022	Calculus Removal - Urinary	2688649427	0.22%
Procedure	Other Organ Systems	027	Nasal/Sinus Endoscopy	1801525646	0.15%
Procedure	Other Organ Systems	040	Prostate Resection	1720352514	0.14%
Procedure	Other Organ Systems	045	Lymph Node Biopsy	641579188	0.05%
Procedure	Other Organ Systems	050	Bronchoscopy	866835046	0.07%
Procedure	Skin	009	Destruction Skin Lesion	5180333863	0.43%
Procedure	Skin	013	Debridement	4270734774	0.36%
Procedure	Skin	016	Skin Grafting	2371683515	0.20%
Procedure	Skin	017	Mohs Surgery	4217064747	0.35%
Procedure	Skin	023	Nail Procedure	2129948442	0.18%
Procedure	Skin	028	Wound Repair - All Levels	2406574574	0.20%
Procedure	Skin	032	Skin Biopsy	2066886613	0.17%
Procedure	Skin	038	Skin Lesion Excision	1177491605	0.10%
Procedure	Skin	051	Removal or Shaving of Skin Growth	1643510010	0.14%
Procedure	Vascular	005	Transluminal Angioplasty - Arterial	5532107989	0.46%
Procedure	Vascular	019	Venous Catheter Insertion	2180369827	0.18%
Procedure	Vascular	029	A-V Fistula PCI	2445640756	0.20%
Procedure	Vascular	030	Transluminal Angioplasty - Venous	96420108	0.01%
Procedure	Vascular	037	A-V Fistula Creation	729083749	0.06%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$)**	Percent of Cumulative 5-Year Total Allowed Spending**
Procedure	Vascular	042	Varicose Vein Ablation	1940244079	0.16%
Procedure	Vascular	048	Vascular Embolization	650977670	0.05%
Treatment	Spinal Manipulation	017	Chiropractic	3348635630	0.28%
Treatment	Dialysis	001	ESRD Related Services (not dialysis)	4001390472	0.33%
Treatment	Dialysis	028	Peritoneal Dialysis	1084148078	0.09%
Treatment	Dialysis	032	Hemodialysis	33577843704	2.81%
Treatment	Chemotherapy	002	Chemotherapeutic Agent	81303436483	6.79%
Treatment	Chemotherapy	012	Chemotherapy Administration	4812896836	0.40%
Treatment	Injections and Infusions (nononcologic)	004	Injection - Monoclonal Antibodies	46068272741	3.85%
Treatment	Injections and Infusions (nononcologic)	005	Injection - Macular Degeneration	20185292129	1.69%
Treatment	Injections and Infusions (nononcologic)	006	Injection - Colony Stimulating Factors	3688304470	0.31%
Treatment	Injections and Infusions (nononcologic)	008	Injection - Immune Globulin	11258160161	0.94%
Treatment	Injections and Infusions (nononcologic)	013	Injection - Growth/Hormone Factor	1299790547	0.11%
Treatment	Injections and Infusions (nononcologic)	014	Injection Administration	3637492124	0.30%
Treatment	Injections and Infusions (nononcologic)	015	Intravenous Infusion, Hydration	5222029107	0.44%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$)**	Percent of Cumulative 5-Year Total Allowed Spending**
Treatment	Injections and Infusions (nononcologic)	016	Erythropoiesis - Stimulating Agent	1520591643	0.13%
Treatment	Injections and Infusions (nononcologic)	018	Injection - Clotting Factors	3107781882	0.26%
Treatment	Injections and Infusions (nononcologic)	019	Injection - Immunomodulator	5954493153	0.50%
Treatment	Injections and Infusions (nononcologic)	022	Injection - Somatostatin	4090414557	0.34%
Treatment	Injections and Infusions (nononcologic)	024	Injection - Tumor Necrosis Factor Blocker	4219833333	0.35%
Treatment	Injections and Infusions (nononcologic)	025	Injection - Hyaluronan or Derivative	2932942664	0.25%
Treatment	Injections and Infusions (nononcologic)	026	Injection - Vasodilator	1753574662	0.15%
Treatment	Injections and Infusions (nononcologic)	030	Injection - Anticoagulant	2351167301	0.20%
Treatment	Injections and Infusions (nononcologic)	031	Injection - Enzymes	2519913192	0.21%
Treatment	Injections and Infusions (nononcologic)	036	Platelet Stimulating Agent	1344646406	0.11%
Treatment	Injections and Infusions (nononcologic)	038	Vaccine Product	9505521333	0.79%
Treatment	Injections and Infusions (nononcologic)	039	Vaccine Administration	5780231265	0.48%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$)**	Percent of Cumulative 5-Year Total Allowed Spending**
Treatment	Radiation Oncology	007	Intensity Modulated Radiation Therapy	8222253857	0.69%
Treatment	Radiation Oncology	009	Conventional Radiation Treatment	7037760524	0.59%
Treatment	Radiation Oncology	010	Radiation Treatment Planning	6484289540	0.54%
Treatment	Physical, Occupational, and Speech Therapy	003	PT Treatment	40500839648	3.38%
Treatment	Physical, Occupational, and Speech Therapy	020	Speech Therapy	3174490298	0.27%
Treatment	Physical, Occupational, and Speech Therapy	021	Occupational Therapy	2561328739	0.21%
Treatment	Physical, Occupational, and Speech Therapy	033	PT/OT Evaluation	4188008497	0.35%
Treatment	Treatment - Miscellaneous	027	Cardiac Rehabilitation	1788859921	0.15%
Treatment	Treatment - Miscellaneous	029	Immunosuppressive Drugs - Non-Injectable	1411247012	0.12%
Treatment	Treatment - Miscellaneous	034	Hyperbaric Oxygen	915041264	0.08%
Treatment	Skin and Soft Tissue Substitutes	037	Skin Substitute Products	18506486187	1.55%
Test	Anatomic Pathology	002	Surgical Pathology Examination	10484509823	0.88%
Test	Anatomic Pathology	009	Immunohistochemistry	2870544485	0.24%
Test	Cardiography	003	Electrocardiogram	7642415623	0.64%
Test	Cardiography	010	External Electrocardiographic Monitoring	2881072982	0.24%

Category	Subcategory	Family #	Family Description	Cumulative 5-Year Allowed Spending (\$) **	Percent of Cumulative 5-Year Total Allowed Spending **
Test	Pulmonary	015	Pulmonary Function Testing	1459509041	0.12%
Test	General Laboratory	001	Clinical Chemistry	24239872267	2.03%
Test	General Laboratory	004	Blood Count	4693548013	0.39%
Test	General Laboratory	005	Drug Tests	3323601947	0.28%
Test	General Laboratory	006	Immunoassay	4348187683	0.36%
Test	General Laboratory	012	Venipuncture Blood Collection	1950642124	0.16%
Test	General Laboratory	013	Bacterial Culture	1268851362	0.11%
Test	Molecular Testing	011	Infectious Agent Detection by DNA/RNA	5501052763	0.46%
Test	Molecular Testing	014	Genetic Analysis	10975771138	0.92%
Test	Molecular Testing	016	COVID Specific	7826306671	0.65%
Test	Neurologic	007	Sleep Study	1926038066	0.16%
Test	Neurologic	008	Electrical Nerve Conductivity	1520791614	0.13%
Grand Total				1,095B	91.5%**

Appendix E: Examples of Changes in Classification of Injections and Infusions (nononcologic) Drugs

Table 22 lists examples of changes in classification of nononcologic injections and infusions.

Table 22: Examples of Changes in Classification of Injections and Infusions (nononcologic) Drugs

Code	Code Description	Old Subcategory	Old Family	New Subcategory	New Family
90662	Influenza vaccine split virus, preservative free	Injections and Infusions (nononcologic)	Vaccine - Toxoids	Injections and Infusions (nononcologic)	Vaccine Product
G0008	Administration of influenza virus vaccine	Injections and Infusions (nononcologic)	Vaccine Admin - Flu, Pneum, and Hep B	Injections and Infusions (nononcologic)	Vaccine Administration
90480	Administration of severe acute respiratory syndrome coronavirus 2 (covid-19) vaccine by intramuscular injection, first component of each vaccine administered	Injections and Infusions (nononcologic)	COVID-19 Vaccine Administration	Injections and Infusions (nononcologic)	Vaccine Administration
C9047	Injection, caplacizumab-yhdp, 1 mg	Injections and Infusions (nononcologic)	Injection - Clotting Factors	Injections and Infusions (nononcologic)	Injection - Monoclonal Antibodies
J1940	Injection, furosemide, up to 20 mg	Injections and Infusions (nononcologic)	Injection - Enzymes	Injections and Infusions (nononcologic)	No RBCS Family

Appendix F: Codes Included in the New RBCS Subcategory - Skin and Soft Tissue Substitutes

Table 23 lists the codes included in the New RBCS Family: Skin and Soft Tissue Substitutes

Table 23: Codes Included in the New RBCS Subcategory: Skin and Soft Tissue Substitutes

Code	Code Description	RBCS Family
15015	Application of skin cell suspension self skin graft to wound and donor sites to trunk, arms, legs, first 480 sq cm or less	No RBCS Family
15016	Application of skin cell suspension self skin graft to wound and donor sites to trunk, arms, legs, each additional 480 sq cm	No RBCS Family
15017	Application of skin cell suspension self skin graft to wound and donor sites to face, scalp, eyelids, mouth, neck, ears, eye sockets, genitalia, hands, feet, and/or multiple fingers/toes, first 480 sq cm or less	No RBCS Family
15018	Application of skin cell suspension self skin graft to wound and donor sites to face, scalp, eyelids, mouth, neck, ears, eye sockets, genitalia, hands, feet, and/or multiple fingers/toes, each additional 480 sq cm	No RBCS Family
15271	Application of skin substitute graft to wound of trunk, arms, or legs, 25.0 sq cm or less of wound 100.0 sq cm or less	No RBCS Family
15272	Application of skin substitute graft to wound of trunk, arms, or legs, each additional 25.0 sq cm of wound 100.0 sq cm or less	No RBCS Family
15273	Skin substitute graft to wound 100.0 sq cm or more of trunk, arms, or legs, 100.0 sq cm or 1% body area for infants and children, or less	No RBCS Family
15274	Skin substitute graft to wound 100.0 sq cm or more of trunk, arms, or legs, each additional 100.0 sq cm or 1% body area for infants and children, or less	No RBCS Family
15275	Application of skin substitute graft to wound of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, 25.0 sq cm or less of wound 100.0 sq cm or less	No RBCS Family

Code	Code Description	RBCS Family
15276	Application of skin substitute graft to wound of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, each additional 25.0 sq cm of wound 100.0 sq cm or less	No RBCS Family
15277	Skin substitute graft to wound 100.0 sq cm or more of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, 100.0 sq cm or 1% body area for infants and children, or less	No RBCS Family
15278	Skin substitute graft to wound 100.0 sq cm or more of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, each additional 100.0 sq cm or 1% body area for infants and children, or less	No RBCS Family
A2001	Innovamatrix ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2002	Mirragen advanced wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2004	Xcellistem, 1 mg	Skin Substitute Products
A2005	Microlyte matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2006	Novosorb synpath dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2007	Restrata, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2008	Theragenesis, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2009	Symphony, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2010	Apis, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2011	Supra sdrm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2012	Suprathel, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
A2013	Innovamatrix fs, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2014	Omeza collagen matrix, per 100 mg	Skin Substitute Products
A2015	Phoenix wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2016	Permeaderm b, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2017	Permeaderm glove, each	Skin Substitute Products
A2018	Permeaderm c, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2019	Kerecis omega3 marigen shield, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2021	Neomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2022	Innovaburn or innovamatrix xl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2023	Innovamatrix pd, 1 mg	Skin Substitute Products
A2024	Resolve matrix or xenopatch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2025	Miro3d, per cubic centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2027	Matriderm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2029	Mirotract wound matrix sheet, per cubic centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2030	Miro3d fibers, per milligram	Skin Substitute Products
A2031	Mirodry wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2032	Myriad matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
A2033	Myriad morcells, 4 milligrams	Skin Substitute Products
A2034	Foundation drs solo, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2035	Corplex p or theracor p or allacor p, per milligram	Skin Substitute Products
A2036	Cohealyx collagen dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2037	G4derm plus, per milliliter	Skin Substitute Products
A2038	Marigen pacto, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A2039	Innovamatrix fd, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
A4100	Non-sheet form skin substitute, fda cleared as a device, not otherwise specified (list in addition to primary procedure)	Skin Substitute Products
C1832	Autograft suspension, including cell processing and application, and all system components	No RBCS Family
C1849	Skin substitute, synthetic, resorbable, per square centimeter	Skin Substitute Products
C5271	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	No RBCS Family
C5272	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	No RBCS Family
C5273	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	No RBCS Family

Code	Code Description	RBCS Family
C5274	Application of low cost skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	No RBCS Family
C5275	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	No RBCS Family
C5276	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	No RBCS Family
C5277	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	No RBCS Family
C5278	Application of low cost skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	No RBCS Family
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (surgimend collagen matrix), per 0.5 square centimeters	Skin Substitute Products
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (surgimend collagen matrix), per 0.5 square centimeters	Skin Substitute Products
C9363	Skin substitute, integra meshed bilayer wound matrix, per square centimeter	Skin Substitute Products

Code	Code Description	RBCS Family
C9364	Porcine implant, permacol, per square centimeter	Skin Substitute Products
Q4100	Skin substitute, not otherwise specified	Skin Substitute Products
Q4101	Apligraf, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4102	Oasis wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4103	Oasis burn matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4104	Integra bilayer matrix wound dressing (bmwd), per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4106	Dermagraft, per square centimeter	Skin Substitute Products
Q4107	Graftjacket, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4108	Integra matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4110	Primatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4111	Gammagraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4112	Cymetra, injectable, 1 cc	Skin Substitute Products
Q4113	Graftjacket xpress, injectable, 1 cc	Skin Substitute Products
Q4114	Integra flowable wound matrix, injectable, 1 cc	Skin Substitute Products
Q4115	Alloskin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4116	Alloderm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4117	Hyalomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4118	Matristem micromatrix, 1 mg	Skin Substitute Products

Code	Code Description	RBCS Family
Q4121	Theraskin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4122	Dermacell, dermacell awm or dermacell awm porous, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4123	Alloskin rt, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4124	Oasis ultra tri-layer wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4125	Arthroflex, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4127	Talymed, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4128	Flex hd, or allopatch hd, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4130	Strattice tm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4132	Grafix core and grafixpl core, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4134	Hmatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4135	Mediskin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4136	Ez-derm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4138	Biodfence dryflex, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	Skin Substitute Products
Q4140	Biodfence, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4141	Alloskin ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4142	Xcm biologic tissue matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4143	Repriza, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4145	Epifix, injectable, 1 mg	Skin Substitute Products
Q4146	Tensix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4149	Excellagen, 0.1 cc	Skin Substitute Products
Q4150	Allowrap ds or dry, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4151	Amnioband or guardian, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4152	Dermapure, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4153	Dermavest and plurivest, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4154	Biovance, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4155	Neoxflo or clarixflo, 1 mg	Skin Substitute Products

Code	Code Description	RBCS Family
Q4156	Neox 100 or clarix 100, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4157	Revitalon, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4158	Kerecis omega3, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4159	Affinity, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4160	Nushield, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4161	Bio-connekt wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4162	Woundex flow, bioskin flow, 0.5 cc	Skin Substitute Products
Q4163	Woundex, bioskin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4164	Helicoll, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4165	Keramatrix or kerasorb, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4166	Cytal, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4167	Truskin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4168	Amnioband, 1 mg	Skin Substitute Products
Q4169	Artacent wound, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4170	Cygnus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4171	Interfyl, 1 mg	Skin Substitute Products
Q4173	Palingen or palingen xplus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4174	Palingen or promatrix, 0.36 mg per 0.25 cc	Skin Substitute Products

Code	Code Description	RBCS Family
Q4175	Miroderm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4176	Neopatch or therion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4177	Floweramnioflo, 0.1 cc	Skin Substitute Products
Q4178	Floweramniopatch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4179	Flowerderm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4180	Revita, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4181	Amnio wound, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4182	Transcyte, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4183	Surgigraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4184	Cellesta or cellesta duo, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	Skin Substitute Products
Q4186	Epifix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4187	Epicord, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4188	Amnioarmor, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4189	Artacent ac, 1 mg	Skin Substitute Products
Q4190	Artacent ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4191	Restorigin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4192	Restorigin, 1 cc	Skin Substitute Products

Code	Code Description	RBCS Family
Q4193	Coll-e-derm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4194	Novachor, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4195	Puraply, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4196	Puraply am, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4197	Puraply xt, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4198	Genesis amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4199	Cygnus matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4200	Skin te, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4201	Matrion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4202	Keroxx (2.5g/cc), 1cc	Skin Substitute Products
Q4203	Derma-gide, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4204	Xwrap, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4205	Membrane graft or membrane wrap, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4206	Fluid flow or fluid gf, 1 cc	Skin Substitute Products
Q4208	Novafix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4209	Surgraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter	Skin Substitute Products

Code	Code Description	RBCS Family
Q4211	Amnion bio or axobiomembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4212	Allogen, per cc	Skin Substitute Products
Q4213	Ascent, 0.5 mg	Skin Substitute Products
Q4214	Cellesta cord, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4215	Axolotl ambient or axolotl cryo, 0.1 mg	Skin Substitute Products
Q4216	Artacent cord, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4217	Woundfix, biowound, woundfix plus, biowound plus, woundfix xplus or biowound xplus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4218	Surgicord, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4219	Surgigraft-dual, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4220	Bellacell hd or surederm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4221	Amniowrap2, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4222	Progenamatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4225	Amniobind or dermabind tl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4226	Myown skin, includes harvesting and preparation procedures, per square centimeter	Skin Substitute Products
Q4227	Amniocore, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4228	Bionextpatch, per square centimeter	Skin Substitute Products

Code	Code Description	RBCS Family
Q4229	Cogenex amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4230	Cogenex flowable amnion, per 0.5 cc	Skin Substitute Products
Q4231	Corplex p, per cc	Skin Substitute Products
Q4232	Corplex, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4233	Surfactor or nudyn, per 0.5 cc	Skin Substitute Products
Q4234	Xcellerate, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4235	Amniorepair or altipty, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4236	Carepatch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4237	Cryo-cord, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4238	Derm-maxx, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4239	Amnio-maxx or amnio-maxx lite, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4240	Corecyte, for topical use only, per 0.5 cc	Skin Substitute Products
Q4241	Polycyte, for topical use only, per 0.5 cc	Skin Substitute Products
Q4242	Amniocyte plus, per 0.5 cc	Skin Substitute Products
Q4244	Procenta, per 200 mg	Skin Substitute Products
Q4245	Amniotext, per cc	Skin Substitute Products
Q4246	Coretext or protext, per cc	Skin Substitute Products
Q4247	Amniotext patch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4248	Dermacyte amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4249	Amniplly, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4250	Amnioamp-mp, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4251	Vim, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4252	Vendaje, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4253	Zenith amniotic membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4254	Novafix dl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4255	Reguard, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4256	Mlg-complete, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4257	Relese, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4258	Enverse, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4259	Celera dual layer or celera dual membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4260	Signature apatch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4261	Tag, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4262	Dual layer impax membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4263	Surgraft tl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4264	Cocoon membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4265	Neostim tl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4266	Neostim membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4267	Neostim dl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4268	Surgraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4269	Surgraft xt, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4270	Complete sl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4271	Complete ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4272	Esano a, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4273	Esano aaa, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4274	Esano ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4275	Esano aca, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4276	Orion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4277	Woundplus membrane or e-graft, per square centimeter	Skin Substitute Products
Q4278	Epieffect, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4279	Vendaje ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4280	Xcell amnio matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4281	Barrera sl or barrera dl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4282	Cygnus dual, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4283	Biovance tri-layer or biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4284	Dermabind sl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4285	Nudyn dl or nudyn dl mesh, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4286	Nudyn sl or nudyn slw, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4287	Dermabind dl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4288	Dermabind ch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4289	Revoshield + amniotic barrier, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4290	Membrane wrap-hydro, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4291	Lamellas xt, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4292	Lamellas, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4293	Acesso dl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4294	Amnio quad-core, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4295	Amnio tri-core amniotic, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4296	Rebound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4297	Emerge matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4298	Amniocore pro, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4299	Amniocore pro+, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4300	Acesso tl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4301	Activate matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4302	Complete aca, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4303	Complete aa, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4304	Grafix plus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4305	American amnion ac tri-layer, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4306	American amnion ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4307	American amnion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4308	Sanopellis, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4309	Via matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4310	Procenta, per 100 mg	Skin Substitute Products
Q4311	Acesso, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4312	Acesso ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4313	Dermabind fm, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4314	Reeva ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4315	Regenelink amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4316	Amchoplast, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4317	Vitograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4318	E-graft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4319	Sanograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4320	Pellograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4321	Renograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4322	Caregraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4323	Alloply, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4324	Amniotx, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4325	Acapatch, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4326	Woundplus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4327	Duoamnion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4328	Most, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4329	Singlay, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4330	Total, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4331	Axolotl graft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4332	Axolotl dualgraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4333	Ardeograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4334	Amnioplast 1, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4335	Amnioplast 2, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4336	Artacent c, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4337	Artacent trident, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4338	Artacent velos, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4339	Artacent vericlen, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4340	Simpligraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4341	Simplimax, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4342	Theramend, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4344	Tri-membrane wrap, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4345	Matrix hd allograft dermis, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4346	Shelter dm matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4347	Rampart dl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4348	Sentry sl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4349	Mantle dl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4350	Palisade dm matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4351	Enclose tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4352	Overlay sl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4353	Xceed tl matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4354	Palingen dual-layer membrane and dual-layer palingen x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4355	Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4356	Abiomend membrane and abiomend hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4357	Xwrap plus, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4358	Xwrap dual, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4359	Choriply, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4360	Amchoplast fd, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4361	Epixpress, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4362	Cygnus disk, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4363	Amnio burgeon membrane and hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4364	Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4365	Amnio burgeon dual-layer membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4366	Dual layer amnio burgeon x-membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4367	Amniocore sl, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4368	Amchothick, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4369	Amnioplast 3, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4370	Aeroguard, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4371	Neoguard, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4372	Amchoplast excel, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4373	Membrane wrap lite, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4375	Duograft ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4376	Duograft aa, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4377	Trigraft ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4378	Renew ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4379	Amniodefend ft matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4380	Advograft one, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4382	Advograft dual, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Code	Code Description	RBCS Family
Q4383	Axolotl graft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4384	Axolotl dualgraft ultra, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4385	Apollo ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4386	Acesso trifaca, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4387	Neothelium ft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4388	Neothelium 4l, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4389	Neothelium 4l+, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4390	Ascendion, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4391	Amnioplast double, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4392	Grafix duo, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4393	Surgraft ac, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4394	Surgraft aca, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4395	Acelagraft, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4396	Natalin, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products
Q4397	Summit aaa, per square centimeter (add-on, list separately in addition to primary procedure)	Skin Substitute Products

Appendix G: RBCS Update Steps

The steps below were performed for the 2026 RBCS RY update.

1. Combined all fee schedules issued between January 1, 2020, and December 31, 2025, 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, 2020, and December 31, 2024.
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:
 - 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, 2025, and December 31, 2025. These codes were assigned RBCS Categories and Subcategories only.
13. Applied the following quality assurance checks:
 - Spot checks
 - HCPCS add-on code checks
14. Finalize the Taxonomy for Technical Expert Panel (TEP) review.

15. Conduct TEP review of the revised Taxonomy.
16. Finalize the RBCS Taxonomy for the current year.
17. Submit the RBCS Final Report to CMS.