CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2402	**Date: November 27, 2019**
	Change Request 11474

SUBJECT: Implementation to Adopt the Document Codes into the Post-Pay Electronic Medical Documentation Requests (eMDR) to Participating Providers via the Electronic Submission of Medical Documentation (esMD) System

I. SUMMARY OF CHANGES: CR 11003 implemented the changes required to receive and process the eMDR Registered Provider File. This file contains the latest status of the providers who have registered to receive eMDR. This was the first step required in order to exchange eMDR letters to registered Providers via the esMD system. CR 11142 implemented the changes required to generate and send the post pay eMDR Letter Package information to the Review Contractors who conduct the reviews via esMD. This CR is the last step in the process to implement the changes required to populate the appropriate/Standardized Document Codes while generating and sending the eMDR Letter Package information, by the Review Contractor to esMD.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020 - Analysis, Design, Coding; July 6, 2020 - Testing and Implementation

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2402	Date: November 27, 2019	Change Request: 11474

SUBJECT: Implementation to Adopt the Document Codes into the Post-Pay Electronic Medical Documentation Requests (eMDR) to Participating Providers via the Electronic Submission of Medical Documentation (esMD) System

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020 - Analysis, Design, Coding; July 6, 2020 - Testing and Implementation

I. GENERAL INFORMATION

A. Background: There have been several requests from Medicare providers to the Centers for Medicare & Medicaid Services (CMS) to enable the functionality to send Additional Documentation Request (ADR) letters electronically. CMS implemented a pilot supporting the electronic version of the ADR letter known as Electronic Medical Documentation Request (eMDR) via the Electronic Submission of Medical Documentation (esMD) system. Since the eMDRs may contain Protected Health Information (PHI) data being sent to the prospective provider, a valid consent is required from the authorized individual representing the provider along with the destination details including any delegation to their associated or representing organizations such as Health Information Handlers (HIHs). The sender will have to complete the required identity proofing and always make sure to check for any registration updates before sending out each eMDR. With the implementation of this CR, automation of eMDR registration and any corresponding updates will be done with esMD support.

CMS is requiring its review contractors to support sending ADR letters **(*for Medical and Non-Medical Review related*)** electronically as eMDRs, from January 2020.

Any Post-Pay ADRs generated based on Appeals, either Medical or Non-Medical review related, are excluded. Any participant, for whom the Post-Pay ADRs are generated by the *Medicare as Secondary Payer (MSP) contractor*, is excluded from the scope of this CR.

The purpose of this change request is to implement the changes required to populate the appropriate/Standardized Document Codes, as the business situation deems, while generating and sending the '*ADR Letter Package*' information, by the contractor, to esMD. The 'ADR Letter Package' comprises of the general information about the ADR Letter and the PDF copy of the ADR letter. The step of populating the Document Codes is essential, for the purpose of exchanging the Additional Documentation Request (ADR) letters to registered Providers via the Electronic Submission of Medical Documentation (esMD) system, in order to facilitate the systemic consumption at the Provider system end.

Assumptions

- Post-Pay ADRs generated based on *Appeals*, and Post-Pay ADRs generated by the *MSP* contractor, are excluded from the scope of this CR.
- Any Provider who intends to receive the ADR, and plans to respond with the supporting documents using esMD channel, has registered with esMD, either by themselves, or their HIH representative on behalf of the Provider.
- A provider (by National Provider Identifier (NPI)) registering for the first time to receive eMDR shall receive both electronically and by postal mail.

- A provider enrollment for Medicare Administrative Contractor (MAC) portals and Direct Data Entry (DDE) (Part A) are separate from eMDR enrollment and registration.
- A provider (by NPI) registering for eMDR will receive ADR letters electronically via esMD from all the participating contractors sending out Post Pay ADR letters.
- A provider (by NPI) registering for eMDR is applicable to receive eMDRs for all its Provider Transaction Access Numbers (PTANs).

Terminology:

1. **Document Code**: Represents the document to be requested from the Provider, in a codified form. A list of Standardized Document Codes will be sent to all the contractors who intend to participate in the Post Pay eMDR initiative, on a quarterly basis. The Document Codes and the associated descriptions will be shared with the provider community by publishing the information on the CMS website.

Note: All terminology definitions stated in *CR 11142*, remains the same.

B. Policy: The Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA) require the Secretary of the Department of Health and Human Services (HHS) to follow the Security standards general rules as in § 164.306(a) and § 164.306(b) in order to protect the secure exchange of PHI/PII sensitive information electronically.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11474.1	The contractors shall add an additional column to the currently existing *Post Pay eMDR Letter Record* layout mentioned in the spreadsheet/workbook, as a place holder element, for future use. **Workbook Name:** '*eMDR_Post Pay_Data_Elements_RCs_to_esMD.xlsx*' **Tab Name:** '*eMDR Data Construct - Post Pay*' ***Notes:*** • Please refer to the above mentioned workbook for the characteristics, the limitations on the number of times the element can be repeated, and the current populating rules.	X	X	X	X					RAC, esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The name of the column is, **Inquiry Text' (Usage - Optional)**and it is intended for future use.									
11474.2	The contractors shall receive, process and ingest the contents of the Document Code File (DCF) as provided in the mentioned workbook, sent via RC Client on a quarterly basis, for the purpose of populating the Document Code in ***Post Pay eMDR Letter Record.*** **Workbook Name:** '*DataElements_For_eMDR_Document_Codes_esMD_to_SSM-DC_and_RCs.xlsx*' **Tab Name for DCF record:** '*esMD to DC-RC - Docu Codes*' **Tab Name for Acknowledgement//Error Response:** '*Header-Trailer DC to esMD Ack*' ***Notes:*** • Please refer to the above mentioned tab (DCF Record) of the workbook for the layout of the elements, the associated data characteristics, and applicable populating rules. • The contractors are expected to process and send an Acknowledgement, back to esMD. The periodicity of sending the Document Code File (DCF) from esMD to RC is on a **Quarterly** basis, during the respective application release time. • The contractors are expected to use the successfully loaded previous DCF, when a failure is encountered in receiving/ingesting the current DCF. • The DCF consists of *Header*, *Detailed Body*, and *Trailer*. • The contractors are expected to utilize the Document Code, to map them, to associate it to the corresponding ADR, as per their business needs. • The Document Code list will be shared with the MACs/RACs by 1st week of May 2020.	X	X	X	X					RAC, esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Final DCF file shall be shared with all the contractors 2 months before the go-live date.									

11474.2.1	The contractors shall receive, process and ingest the contents of the Document Code File (DCF) as provided in the mentioned workbook, sent via RC Client on a quarterly basis, for the purpose of populating the Document Code in ***Post Pay eMDR Letter Record.***
	
	Tab Name for Acknowledgment//Error Response: '*Header-Trailer DC to esMD Ack*'
	
	Notes:
	
	• Please note the Document codes are intended/expected to be populated in the **eMDR Letter Flat File Record only** and this requirement **does NOT** imply any changes to the actual ADR letter or the PDF copy of the ADR letter itself. This statement holds good for all the sub-parts of this requirement.
	
	  • When the **first digit** of the Document Code (6-digit) DOES NOT start with 7, 8 or 9, it is to be considered as a 'Regular' Document Code.
	  • When the *first digit* of the Document Code (6-digit) DOES start with 7, 8 or 9, it is to be considered as a 'Parameter' Document Code (Parameter Document Code is meant to add a further granularity to the Regular Document Code).
	  • A given Document Code Slot (24 bytes) can accommodate a Regular Document Code (of 6 bytes) and 3 Parameter Document Codes (of 18 bytes).
	  • A Regular Document Code must be present in the first slot (first 6 bytes of the 24 bytes).
	  • A Parameter Document Code, when populated, can be in any of the next 3 slots (next 18 bytes of 24 bytes).
		X	X	X	X					RAC, esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Document Codes being populated in the eMDR Letter Flat File record are anticipated to be one of the unexpired codes from DCF contents (esMD does not apply any edits to verify the validity of the Document Codes).									
11474.2.2	The contractors shall process the DCF, and respond back to esMD, based on the rules stated below. Tab Name for Acknowledgement//Error Response: '*Header-Trailer DC to esMD Ack*' ***Notes:*** • Please refer to the above mentioned tab (Acknowledgement/Error) of the workbook for layout elements, situations, editing rules, and error codes, to send response back to esMD. • Acknowledgement is expected by esMD, from each Jurisdiction/Region, which receives the DCF. • Acknowledgement file is to indicate the outcome (success/failure) of the file processing, to esMD. • Please inform esMD Help Desk, when the DCF could not be read/corrupted, by raising a ticket, with the details indicating the entity/name and quarter of the file. • Acknowledgement is expected to indicate Rejection, when any of the records encounters any editing errors, during the processing of the file, to esMD. • In case of file/record level error(s), esMD will attempt to re-send the DCF, after the appropriate corrections are applied. • DCF processing is considered successful, when the file is readable, all the editing rules applied, and no errors were encountered across all records.	X	X	X	X					RAC, esMD
11474.3	The contractors shall create the *eMDR Structured File* (for Post-Pay ADRs), as defined in the record	X	X	X	X					RAC, esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	layout/workbook spreadsheet, by ***also populating*** the *Document Codes*, as deemed necessary. **Workbook Name**: 'eMDR_Post Pay_Data_Elements_RCs_to_esMD.xlsx' **Tab Name:** 'eMDR Data Construct - Post Pay' ***Notes:*** • The details regarding the data element set (termed as 'Required', 'Situational', and 'Optional') are defined in the requirements below. • The applicable edit rules related to each data element is mentioned in the column 'Comments / Rules' of the workbook. • The Usage Reg. of the element *Document Code*, under the '*Review Level*' section in the layout, has been termed as '**Required**', due to this change. • The populating rules relating to the *Document Code* element has been mentioned under the '*Type/Format/Values*' column of the mentioned layout/workbook spreadsheet.									
11474.4	The contractors shall contact the esMD helpdesk, when they require information (Error or Delivery status) regarding any of the eMDRs submitted. ***Notes:*** • The information is regarding the outcome of the delivery of the eMDRs, to the intended Provider, by HIH. • The Unique Letter ID and the Date of Submission shall be the key for any inquiry.	X	X	X	X					RAC, esMD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11474.5	The contractors shall participate during the 'User Acceptance Testing' (UAT) sessions, to ensure the expected changes are effected, in regards to *Post Pay eMDR* activities, inclusive of populating the Document Codes. (June 2020)	X	X	X	X					RAC, esMD
11474.6	The contractors shall attend the following one-hour coordination calls, to discuss and resolve any issues related to testing and the specification changes. • Up to 3 one-hour calls shall be scheduled between the contractors and the esMD team starting in April 2020. **Notes:** • TheesMD team shall schedule the calls and is responsible for providing the minutes. • Each contractor shall post the minutes of the meeting for their specific issues being discussed on the call (within 2 business days of the meeting in eChimp).	X	X	X	X					RAC, esMD
11474.7	The contractors shall provide the contact names and email addresses for the coordination calls to CMS at 'esMDBusinessOwners@cms.hhs.gov' within three (3) business days of the issuance of this CR.	X	X	X	X					RAC, esMD
11474.8	The esMD team and the contractors shall exchange the test files as per the schedule included in the attached document "***Testing Criteria-Post-Pay eMDR with Document Codes.docx***".	X	X	X	X					RAC, esMD
11474.9	The contractors shall be aware that the term *'Date of Service'* mentioned in the comment line below the CR 'Effective Date' has no functional impact to the requirements stated in this CR.	X	X	X	X					RAC, esMD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Melanie Jones, 410-786-5461 or Melanie.Jones@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 4

ID	Proposed Consolidate Doc names	#Bytes
100001	Interim verbal orders	21
100002	Detailed Written Order	23
100003	Dispensing Order	16
100004	Five Element Order signed and dated prior to delivery	53
100005	Physician Admission Orders	26
100006	Physician IRF admission order	29
100007	Physician Order for skilled services provided, including Physical/Occupational/Speech Therapy (PT/OT/SLP)	106
100008	Physician/clinician signatures and credentials	46
100009	Practitioner's written order, including the practitioner's National Provider Identifier	87
100010	Preliminary Dispensing Order (if item(s) was dispensed prior to obtaining a Detailed Written Order)	99
100011	Proof of Delivery	18
100012	Referral for DSMT services and plan of care	43
100013	Requesting Physician Order	26
100014	Signed order or intent to order in Physician note	49
100015	Supplemental Orders	19
100016	A substantiated diagnosis	27
100017	Acute/post-acute care document so support home health eligibility	65
100018	Acute/post-acute care document so support hospice eligibility	61
100019	Addendum to record	18
100020	Admission initial assessment	28
100021	All physician signed certifications & recertification’s since the initial evaluation	84
100022	Certificate of Terminal Illness	31
100023	Certifications supporting advanced/special training of personnel	64
100024	CMS 2728 (End stage renal disease medical evidence report; Medicare entitlement and/or patient registration)	109
100025	Critical Care	14
100026	Documentation to support continued medical need	47
100027	Expected Length of Stay	23
100028	Home health aide care plan	26
100029	Home Health Plan of Care	24
100030	Home Health Change of therapy (COT) records and assessments	59
100031	Home Health Physician certifications and recertifications assessment	68
100032	Home Health Start of care assessment	36
100033	Home Health skilled nursing, home health aide, or rehabilitation therapy notes including initial evaluations. re-evaluations, progress notes, and actual therapy minute grids	173
100034	Any other documentation supporting the beneficiary's need for the home health services being provided	101
100035	Physician Certification by the Hospice Physician and the Attending Physician	76
100036	Physician Certification/Subsequent Recertifications Statements for billed claim dates of skilled	210
100037	OASIS Assessment	16
100038	Physician certification of medical necessity of admission	57
100039	Physician Certification or Physician Certification Statement (PCS)	66
100040	Physician certification/recertification that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study	234
100041	Plan of Care or Treatment Plan	30

100042	POC updates	11
100043	PT/OT/SLP Plan of Care, including Therapy Frequency and Duration	64
100044	Record must include a signed, current plan of care/treatment plan stating the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals.	198
100045	Short-term and long-range goals	31
100046	Signed and Dated Physician certification/recertification form for skilled level of care	87
100047	Signed election statement	25
100048	Signed Plan of Care	19
100049	Consultation notes and/or reports	33
100050	Nutritional Evaluation, Consultations, and Progress Note	56
100051	Physician consultations	23
100052	CLIA certificate	17
100053	Radiological reports, lab results, pathology reports, and other pertinent diagnostic test results to support the medical necessity of the billed services	153
100054	Dianostic tests performed during SNF stay	41
100055	Lab reports/results to support medical necessity of medications.	64
100056	Laboratory reports pertinent to drugs administered	51
100057	Most recent total cholesterol, HDL and/or other lab results to support cardiac risk.	84
100058	Pathology report	41
100059	Results of preadmission testing and laboratory results	54
100060	X-ray findings and/or bone cultures	64
100061	Discharge Notes	15
100062	Discharge Summary	17
100063	Discharge Summary/s from Hospital, Skilled Nursing, Continuous Care, and or Respite Care facilities	99
100064	Documentation to support evidence of follow up assessment of the patient at one week, one month and three months postoperatively. This must include discussion of the patient's procedure; response, prognosis and necessary follow up	230
100065	Hospice Discharge Summary	25
100066	Hospital inpatient discharge summary	36
100067	IRF discharge summary	22
100068	Admission records and assessment	32
100069	Admitting diagnosis along with any diagnosis of comorbid disease and the psychiatric	94
100070	All records that justify and support the level of care received	72
100071	Beneficiary body surface area (bsa) used to calculate dose given	64
100072	Beneficiary weight used to calculate dose given	47
100073	Beneficiary's medical records (which may include ; practitioner medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) that support the item(s) provided is reasonable and necessary	248
100074	Cardiac Risk Factors Assessment	31
100075	cardiac/pulmonary rehab session documentation	45
100076	Clinic note for date(s) billed which summarizes the diagnosis, symptoms, functional status, focused mental status examination, treatment plan, prognosis and progress to date with the signature and credentials of personnel licensed by the state to render the service	265
100077	Complete General Inpatient Medical Records	42
100078	Completion within 60 hours of admission	39
100079	Copies of all protocols/standing order	38
100080	Current adjuntive treatment	64
100081	Describe attitudes and behavior	31
100082	Description of the onset of illness and the circumstances leading to admission	78

100083	Documentation of adjustment to HIPPS codes resulting from MDS corrections related to the dates of service under review.	119
100084	Hospice Face-to-Face Encounter Attestation Statement	52
100085	Documentation of face-to-face encounter	39
100086	Documentation of pain level and ADL limitations	47
100087	Documentation supporting the attitudes and behaviors with estimates of intellectual, memory and orientation functions	117
100088	Documentation supporting the services billed are subject to a waiver/alternative payment model (APM)	100
100089	Documentation that supports the reasonable and necessary, other statutory and regulatory requirements defined in the National Coverage Determinations (NCD) Manual, Chapter 1, Part 4.	182
100090	Documentation to support National Coverage Determination (NCD), Local Coverage Determination (LCD), and/or related Policy Article criteria	139
100091	Documentation to support a systemic condition, neuropathy, vascular impairment, onychogryphosis and/or onychauxis.	116
100092	Documentation to support a) compliance with and a failed trial of symptom- appropriate behavioral therapy of sufficient length to evaluate potential efficacy and b) compliance with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four (4) -eight (8) weeks	313
100093	Documentation to support care is being provided under the care of a physician	77
100094	Documentation to support each of the Health Insurance Prospective Payment System HIPPS code(s) billed, including notes related to each of the assessment reference date(s) (ARD)	176
100095	Documentation to support information entered on the IRF PAI	59
100096	Documentation to support overactive bladder syndrome (OBS) and patient is a candidate for PTNS	99
100097	Documentation to support severe peripheral involvement.	58
100098	Documentation to support that the entire body was exposed to the oxygen increased atmospheric pressure and administered in a chamber	132
100099	Documentation to support the beneficiary had a face-to-face examination with the physician, PA, NP, or CNS within six months prior to the date of the written order	163
100100	Documentation to support time in/out or actual time spent.	74
100101	Emergency Room Nursing Notes	28
100102	Emergency Room Records	22
100103	Estimation of intellectual functioning, memory functioning, and orientation	75
100104	Evaluation of foot structure, vascular and skin integrity	59
100105	Functional Independent Measure (FIM) records	44
100106	History and Physical reports (include medical history and current list of medications)	86
100107	Homebound / not homebound Status	32
100108	Hospital history and physical	29
100109	Hospital records that validate a qualifying stay	48
100110	Hyperbaric oxygen treatment records.	64
100111	In hospital to hospital transfers, medical reason patient could not be treated at first or initial hospital.	117
100112	Include an inventory of the patient's assets in descriptive, not interpretative fashion	87
100113	Include records for dates of service billed and the MDS look back period. This can be up to 30 days prior to the assessment reference date(s) of the MDS(s)	155
100114	Individual and group psychotherapy and patient education and training	69
100115	Individual and Group Therapy Notes	34
100116	Individualized Treatment Plan for Psychiatric Services with Updates	67
100117	Initial hospital inpatient care	31

100118	Initial psychiatric evaluation including	40
100119	Initial Psychiatric Evaluation with Axis I-V Diagnosis	54
100120	Initial psychiatric/psychological evaluation/mental status exam	63
100121	IRF PAI (Patient Assessment Instrument)	39
100122	Itemized list of charges including base rate and cost per mile.	72
100123	Listing of most current patient medications	43
100124	Medical and psychiatric history and physical/history of why the beneficiary is in treatment.	94
100125	Medical documentation detailing prior course of treatment.	64
100126	Medication Administration Record (MAR) and/or Infusion Flowsheet documenting the quantity administered	102
100127	Neurological Examinations	25
100128	Nutrition progress notes	24
100129	Observation orders and progress notes- each day	48
100130	Office visit / E&M documentation if billed on same date of service under medical review	88
100131	Other physician consultations related to this service	53
100132	Outcomes assessment	19
100133	Patient history and physical	28
100134	Patient history and physical, symptoms, diagnosis for therapy services	70
100135	Patient's height and weight	27
100136	Photographs showing visual impairment	41
100137	Please submit all documentation to support the medical necessity of services billed and the DRG code billed	107
100138	Post admission assessment / post admission physician evaluation completed within the first 24 hours of admission and supporting medical necessity of admission	158
100139	Preadmission evaluation screening completed or updated within 48 hours of admission	83
100140	Pre-Admission screening	23
100141	Pre-Hospital documentation	26
100142	Prior Level of Function (PLOF)	30
100143	Psychiatric diagnostic evaluation or psychotherapy face-to-face encounter, including the time spent in the psychotherapy encounter	135
100144	Psychiatric evaluation All behavioral/psychological/psychiatric tests that have been performed	94
100145	Psychosocial Assessment	23
100146	R.N. pre-admission and screening documentation	46
100147	Record of mental status	23
100148	Records of conservative measures trialed for treatment of service provided	74
100149	Records of patient’s condition before, during and after this billing period to support medical necessity & the reason the service was provided	142
100150	Records supporting skilled level of care; including, Physician clinic/progress notes, place for future care and complexity of services to be performed	150
100151	Rehab / PT /OT/ ST	18
100152	Rehabilitation records / evaluations	37
100153	Respiratory treatments and O2 therapy records	45
100154	Review of patient prior and current medical and functional conditions and comorbidites	86
100155	SNF history and physical performed by the physician.	52
100156	Social History and Physical reports	35
100157	Social service records - including interviews with patient, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history	210
100158	Subsequent hospital inpatient care	34
100159	Supporting documentation / medical necessity	44
100160	Supporting documentation of all applicable diagnosis codes.	61

100161	Therapy logs that show services, dates and times for code billed	67
100162	Therapy Minutes Documentation	29
100163	Treatment notes for each visit detailing the patient's response to the skilled services provided (may also serve as progress notes)	131
100164	Treatment plan and therapeutic goals for dates of the medical review.	69
100165	Treatment records to support prior failed conservative treatment	65
100166	Types and duration of precautions (e.g., constant observation x 24 hours due to suicidal plans, restraints).	108
100167	Visual field measurement / documentation	56
100168	Drug administration records	27
100169	Ambulance trip sheets and/or air ambulance flight records	57
100170	Cataract	8
100171	Chiropractic	12
100172	Chronic Care Management	23
100173	Date/time of administration of associated chemotherapy	54
100174	Debridement of nails with E&M	30
100175	Dialysis treatment sheets	26
100176	Documentation to support medical necessity of medications given.	65
100177	Documentation to support reason not transporting to nearest facility	69
100178	Documentation to support type and amount of contrast given	59
100179	Documented pharmacologic management to include prescription and dosage adjustment/changes	89
100180	Drugs & Biologicals	20
100181	ECG procedure reports	22
100182	Electrical stimulation	23
100183	Eye Exam	8
100184	G0480 Drug test def 1-7 classes	32
100185	G0483 Drug test def 22+ classes	31
100186	Hyperbaric Oxygen (HBO) logs/treatment record	45
100187	If the dosage for the drug under review is outside the allowed amount per the drug compendium, submit documentation to support the medical necessity of this dose variance (i.e. clinical trial, article, studies, etc.)	216
100188	Information for andy Clinical trial name, sponsor of the clinical trial, and sponsor-assigned protocol number	109
100189	Intraoperative record	21
100190	Medication administration records from date of service that include a dose, route, and frequency given.	103
100191	Nasal Endoscopy Same Day More than 1 Provider	45
100192	Operative / procedure report	53
100193	Paring or Cutting Procedures on the Skin	40
100194	Peri-operative record	21
100195	Prior Auth	10
100196	Procedure notes / reports	25
100197	Routine ECG 12 Leads	20
100198	Signed requisitions for lab services	36
100199	Stage of treatment for accurate dose administration calculation for the drug; (i.e. First dose or subsequent dosing)	117
100200	Vitamin D testing	17
100201	When modifier -JW is used to report that a portion of the drug or clearly document the amount administered and the amount wasted or discarded	141
100202	Physician Face-to-Face documentation	36

100203	Wound care progress notes	25
100204	Wound Care Assessment Notes	27
100205	Wound Care Consults	19
100206	Social work notes	17
100207	Case Management Notes	22
100208	Social Worker initial assessment	32
100209	Actual encounter note or progress note to support services billed	65
100210	All group psychotherapy notes including number of participants	66
100211	All progress reports since the initial evaluation	49
100212	Attendance/treatment records/dated therapy notes with the required information per LCD for this claim period, including dated therapy logs that identify each specific skilled modality provided, total treatment time, total timed codes treatment minutes and total time rendering untimed modalities.	296
100213	Breakdown of hours if nurse and aide visits combined are more than two times a day	82
100214	Caregiver Notes	15
100215	Diabetic lower extremity wounds-Wagner grade classification, diagnostic testing to support Wagner grade and documentation of prior failed treatment	148
100216	Discipline notes/summary for each visit	39
100217	Documentation to support beneficiary is being treated for a covered icd-10 diagnosis code that meets 1 or more of the 15 approved medicare conditions listed in the medicare national coverage determinations (NCD) manual section 20.29 (hyperbaric oxygen therapy).	261
100218	Documentation as required in LCD or NCD	39
100219	For all therapy services rendered submit attendance/treatment records for the claim period - must include total treatment time and identify each specific skilled modality provided	179
100220	Home Health Aid Visit Notes	27
100221	All documents needed to support Home Health services	53
100222	IDG reviews	11
100223	If nurse visits are daily or more, statement of endpoint when nurse visits are expected to decrease to less than seven days a week	130
100224	Initial evaluation of all therapies	37
100225	Non-physician progress notes	28
100226	Nursing progress notes	22
100227	Initial nursing facility visit	31
100228	Subsequent Nursing Facility Visit	33
100229	All documents needed for a Nursing Home Review	46
100230	Occupational Therapy Visit Notes	32
100231	Physical Therapy Visit Notes	28
100232	Physician / NPP Progress notes (signed)	39
100233	Physician and PPP clinic/progress notes	40
100234	Physician clinic/progress/consultation notes	45
100235	Prior antibiotic therapy, wound care and surgical interventions	63
100236	Progress notes and documentation of DSMT services/group sessions	74
100237	Progress reports with the required elements per the local coverage determination to support medical necessity at least once every 10 treatment days. Submit progress notes from the start of therapy through present claim period.	226
100238	Progress reports written by the clinician-services related to progress reports are to be furnished on or before every 10th treatment day	136
100239	PT/OT/SLP – Initial evaluation, plan of care, progress reports, treatment encounter notes, discharge summary, therapy minute logs	129
100240	Restorative Nursing Records	27
100241	Skin care / Wound care treatment records	40

100242	Social Worker Visit Notes	25
100243	Team Conference Notes	21
100244	Therapeutic activities program for patient	42
100245	Therapy progress notes that support services included in the therapy logs that show services, dates and minutes renders for the dates logs that show services, dates and minutes renders for the dates of service being billed and the lookback period of the MDS(s). Do not send copy(s) of MDS(s); however, they must be found in the repository	339
100246	Treatment records	17
100247	Visit notes (nursing, social worker, chaplain, etc.)	52
100248	Wound therapy prior to HBO treatment	51
100249	E&M / Home Visits	17
100250	E&M / Prolonged Care	20
100251	E&M / Hospital Visits	21
100252	E&M / Office Visits	19
100253	Office Visit with Injection	27
100254	Diagnostic/Vasc studies	24
100255	Nutritional Assessment	22
100256	Hospital records	16
100257	Referral Order	14
100258	Documentation of presurgical conservative measures/treatments	61
100259	Recovery room record	20
100260	Surgical reports (if any)	70
100261	All ambulance records for the dates of services billed.	72
100262	Ambulance Run Sheet including Total Mileage documentation	57
100263	Medical justification for transport and/or transfer.	72
100264	Physician certification describing: medical necessity for ambulance.	68
100265	P9603 One Way Mileage	23
100266	Abbreviation key	16
100267	Beneficiary name and date of service on all documentation	57
100268	Coding query form	17
100269	Copy of ABN / NOMNC / HHABN	27
100270	Advance Beneficiary Notice	26
100271	Copy of Assignment of Benefits	30
100272	Demand bill- notice of non-coverage indicating request for Medicare to review	77
100273	Facility Denial Letter	23
100274	FISS Page 7 screen print/copy of ADR letter	43
100275	Hospital-issued notice of non-coverage (HINN) on file	53
100276	If an electronic health record is utilized, include your facility's process of how the electronic signature is created. Include an example of how the electronic signature displays once signed by the physician	208
100277	Local 911 Ambulance Dispatch Protocols	38
100278	Medicare requires a legible identifier for all services ordered and provided. CMS signature guidelines, are described in the CMS Medicare Program Integrity Manual – (Pub. IOM 100-08), Chapter 3.3.2.4/Signature Requirements. Exceptions for signature requirements are also listed. These guidelines apply to all documentation required for this review	347
100279	Notice of non-coverage	22
100280	On the front page of each ADR please include the name of a contact at your facility who is available to answer questions if they arise	134
100281	Patient identification, date of service, and provider of the service should be clearly identified on each page of the submitted documentation	141
100282	Pictures where necessary	51

100283	Quality Improvement Organization (QIO) letter	45
100284	Questions related to ADR	24
100285	Revocation Statements	21
100286	Signature logs and attestation statements	41
100287	Signature logs to indicate the identity and credentials of the signers and/or printed names/credentials under hand-written signatures to support physician/NPP documentation	172
100288	Signature policy	16
100289	Initial DME Information Form (DIF), and any recertification and/or revised DIFs	80
100290	Initial Certificate of Medical Necessity (CMN) and any recertification and/or revised CMNs	91
100291	If the beneficiary has same or similar equipment, documentation indicating the reason new equipment is necessary	112
100292	Documentation to meet LCD and/or related Policy Article criteria for replacement equipment	90
100293	Documentation of the request for refill	39
100294	List of staff, including certifications and signature attestation	65
100295	Documentation of level of training and certification for qualified personnel	76
100296	Copy of Licenses and/or Certifications for Personnel Involved in Beneficiary Care	81
100297	Physician Certification in Sleep Medicine	41
100298	Sleep Center or Laboratory Accreditation Certification	54
100299	Physician Certification for PHP Services	40
100300	Physician certification statement for the specified dates of service plus two prior qualifying periods	102
100301	Physician/Non-Physician Practitioner (NPP) certification of Plan of Care for Claim Period Including Justification when the Certification is Delayed More than 30 Days	165
100302	RESNA Certification of Assistive Technology Professional (ATP)	62
100303	OASIS documentation (certifications, recertifications, follow-ups and significant change).	90
100304	Initial certification for Extended Care Services	48
100305	Initial Certification form	26
100306	14 day recertification for Extended Care Services	49
100307	Subsequent recertifications for Extended Care Services	54
100308	Facility Utilization Review Plan (ONLY if used in lieu of Certifications or Recertifications for Extended Care Services)	121
100309	Physician Recertification of Need	33
100310	Physician coding queries within 30 days of discharge	52
100311	Physician query	15
100312	Nursing home notes	18
100313	Nursing Home Records	20
100314	Medical Clearance Notes	23
100315	Medical clearance	17
100316	Chaplain initial assessment	27
100317	PMNC’s	6
100318	Delivery slips	68
100319	Signed delivery slip(s)	23
100320	Signed pick up slip(s)	22
100321	Itemized Delivery Slips	23
100322	Therapy treatment plan & notes (485 Form)	41
100323	Therapy Treatment Plan and Notes that demonstrate failed behavioral and/or pharmacologic therapies.	99
100324	Manufacturer’s Invoice containing Make, Model Number, Quantity and Cost of item provided	88
100325	Cost invoice for all supplies	29
100326	Supplier or LCMP Attestation	28
100327	Supplier Records	16

100328	Signature Attestation	21
100329	Supplier patient information forms	34
100330	Signature attestation of all personnel providing services	57
100331	List of all personnel billing services under your NPI. List credentialing, training, licensure, etc., of all personnel performing services under your NPI.	154
100332	On Site Home Evaluation	23
100333	7-Element Order	15
100334	Daily Physician Reports	23
100335	Physician contacts and responses	32
100336	Documentation of procedures for emergency management of patients	64
100337	Copies of ECG and response by monitoring entity	47
100338	Summary report at the end of the monitoring episode	51
100339	Documentation of plan for quality control for ECG surveillance	62
100340	Documentation of plan to ensure uninterrupted 24/7 surveillance of patients	75
100341	Patient Care Instructions for a Hospice Aide / Homemaker	56
100342	Records of Aide Visits, Times and Dates	39
100343	DME Information Form (DIF)	26
100344	DME Documentation of continued Need and Use	43
100345	Interdisciplinary Team Conference notes	39
100346	60-day summary/case conference notes.	37
100347	Please ensure that the documentation submitted also includes medical record information from the 30 days before the date of service and the 30 days after the date of service.	174
100348	Sleep Oximetry Study Results	28
100349	Refill Request	14
100350	Durable Medical Equipment Refill Request Documentation	54
100351	Polysomnography Results	23
100352	Physician Office Notes/Records	30
100353	Evaluation and Management/Office Notes, including Patient History prior to and after the procedure for the Date of Service Requested	132
100354	Office notes, including all patient questionnaires.	51
100355	Ancillary services notes	24
100356	Epworth Sleepiness Scale	24
100357	Download of Usage Data from PAP Device	38
100358	All Minimum Data Sets (MDS) to support the claim period under review.	69
100359	MDS Record	10
100360	MDS (5-day, 14-day, 30-day, 60-day and 90-day	45
100361	Documentation to support each of the Health Insurance Prospective Payment System (HIPPS) code(s) billed including the Minimum Data Set (MDS) Documentation (i.e. hardcopy version of each MDS related to claim period under review (e.g. 7-day, 14-day, 60-day, 90-day, and any off-schedule assessments); and documentation supporting the look back period under review based on the Assessment Reference Date (ARD)	408
100362	Documentation to support each of the look back periods which may fall outside the billing	110
100363	Documentation up to 30 days prior to the first assessment reference date;	73
100364	Documentation to support the dates of services billed;	54
100365	Date the patient started therapy.	33
100366	Photographs (prints, not slides)	32
100367	Photograph and/or detailed description of service.	50
100368	Visual Fields Studies	21
100369	All Visual Field Testing	24

100370	Comprehensive preoperative ophthalmologic evaluation including but not limited to: examination/testing, best corrected Snellen visual acuity and corrected vision with glasses or contacts	186
100371	Any additional documentation to support cataract removal	56
100372	Physician supervision and evaluation	36
100373	Any re-evaluations	18
100374	Anesthesia records (including pre- and post-anesthesia).	56
100375	Preoperative Evaluations Including Anesthesia Evaluation	56
100376	PACU notes	10
100377	Any other documentation a provider deems necessary to support medical necessity of services billed, as well as documentation specifically requested in the Additional Documentation Request (ADR) letter.	201
100378	Attendance/Treatment Records for this Claim Period-Must Include Total Timed Code Treatment Minutes, Total Treatment Time and Identify Each	138
100379	Copy of Current State License for Treating Therapist or NPIN and/or therapy provided “incident to” physician’s services, copy of performing therapist’s diploma and/or license	174
100380	Initial Evaluation/Re-evaluation including Plan of Care Signed by Ordering Physician or Practitioner	100
100381	Initial evaluation (intake notes), including all patient questionnaires.	72
100382	Specific Skilled Procedures and Modalities	42
100383	Dietician Notes	15
100384	Medical records for any previously tried medical treatment for obesity, including structured dietary programs.	110
100385	Medical literature that supports off label drug use	51
100386	Voiding Diaries	15
100387	SPECT/Cardiac Perfusion Studies	31
100388	Previous SPECT results	22
100389	Cardiac PET Scan Results	24
100390	Neuroimaging studies including, but not limited to, CT, MRI, PET	64
100391	Complete neurological examination, as appropriate	49
100392	Five Element Order or 5EO	25
100393	Notes that demonstrate documented behavioral, pharmacologic and/or surgical corrective therapy	94
100394	Pharmacy records	16
100395	Evidence of trial test stimulation results	42
100396	Test Stimulation Results	24
100397	Diagnostic Studies, including visual acuity and glare tests	59
100398	Evaluation and biometry	23
100399	History and Physical Report, including ADL status prior to surgery	66
100400	Physician/Non-physician Practitioner Progress Notes, including preoperative ophthalmologic	90
100401	Physician/Non-physician Practitioner Progress notes	51
100402	Surgical Consent Form	21
100403	Surgical recommendation	24
100404	Prior treatments, surgical interventions, or evaluations	56
100405	Documentation of the product, NDC, strength	43
100406	Prescriber Order	16
100407	Any additional documentation supporting necessity for the service	65
100408	Electrocardiogram (EKG)	23
100409	Stress Test	11
100410	Echocardiogram	14
100411	Documentation of P.A.R.T. if no X-ray available.	48

100412	Trans Thoracic Echocardiogram (TTE)	35
100413	Formal written report with interpretation of TTE	48
100414	Telemetry Tracings	18
100415	Electrophysiology Studies (EPS)	31
100416	24-Hour Holter Monitor	22
100417	Evaluation(s)	13
100418	This is not an all-inclusive list. Please submit all supporting documentation for items billed.	96
100419	Prior Conservative Treatment Notes	34
100420	Caregiver Availability	22
100421	Physician Directed Home Treatment Regimen	41
100422	Alternative Treatment Consideration	35
100423	Physician Monthly Reevaluation Notes	36
100424	Description of the Device used in the Procedure	47
100425	Documentation to support admission to the Skilled Nursing Facility and need for skilled care, i.e. hospital admission, inpatient care, and discharge records	156
100426	Documentation to support the skilled nature of care during the admission	72
100427	A copy of each Minimum Data Set (MDS) related to the billing period being reviewed, as well as discharge and re-entry tracking forms	132
100428	Records to support that all CMS and/or Plan documentation requirements were met	79
100429	Documentation for the 30 days immediately prior to the acute hospital and/or skilled care admission	99
100430	The most recent Minimum Data Set (MDS) prior to the start of therapy services	77
100431	The most recent annual MDS prior to the initiation of therapy	61
100432	All documentation to support the code/ service billed	53
100433	Medical records supporting a recent injury or surgical procedure on the knee(s)	79
100434	Medical records supporting that the patient is ambulatory and has knee instability	82
100435	Documentation from the treating physician's examination including an objective description joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test)	168
100436	Documentation supporting the diagnosis code(s) required for the item billed	75
100437	Documentation from the treating physician describing why the patient needs a custom fabricated knee orthosis instead of a prefabricated knee orthosis	149
100438	Orthotist or prosthetist's functional evaluation documentation supporting the need for a custom fabricated device	113
100439	Signature log or signature attestation for any missing or illegible signature within the medical record	103
100440	Preadmission Notes	18
100441	Any adjustments or revisions to the plan of treatment	53
100442	Treatment plan reviews	23
100443	Referral for echocardiography services	38
100444	Any other prior diagnostic evaluations and reports	50
100445	Complete study that contains: M mode and/or 2D measurements of LV end diastolic diameter, LV end systolic diameter, LV wall thickness, left atrial diameter, aortic valve excursion and a qualitative description of the LV function	228
100446	Intent to Order	15
100447	Documentation that supports the reasonable and necessary, other statutory and regulatory requirements defined in the National Coverage Determinations (NCD) Manual, Chapter 1, Part 4.	190
100448	Documentation supporting comorbid condition(s) related to obesity	65
100449	Documentation of patient BMI	28
100450	Documentation supporting previous medical weight reduction treatments prior to the surgery	90
100451	Counseling Records	18

100452	Clinical Study Enrollment Authorization	39
100453	Full Itemization of Services	28
100454	Authorization of Benefits	25
100455	Beneficiary Election form	25
100456	Assignment of benefits	22
100457	Documentation Supporting Clinical/Facility Hours of Operation	61
100458	Multidisciplinary evaluation prior to the surgery	49
100459	Documentation to support drug wastage billed	44
100460	Patient identification data including legal status	50
100461	Radionuclide scan reports	25
100462	Coronary Angiography reports	28
100463	Documentation of the devices, implants, biological products used	64
100464	Any additional documentation to support payment of the claim(s) on the attached Pull List	89
100465	RAP (Request for Anticipated Payment).	38
100466	Please submit the entire medical record to support the requested benefit period starting from admission through discharge listed on the attached Pull List. This includes interim SNF bill dates	192
100467	Verification of accurate processing of the order and submission of the claim	76
100468	Rent/purchase option	20
100469	Statement of Endpoint, if nurse visits are daily or more frequently	67
100470	Hospice Notice of Election	26
100471	Hospice Certification of Terminal Illness	41
100472	Medical evidence supporting the initial certification of a terminal condition	77
100473	Initial Evaluation	18
100474	OASIS Transfer Assessment HH	28
100475	Legible physician/clinician signatures and credentials for services provided. Signature logs and attestation statements should be submitted when physician and/or clinician signatures are illegible.	197
100476	Sending hospital discharge summary and/or emergency records	59
100477	Sending physician and nursing emergency department records	58
100478	Receiving hospital history & physical and/or emergency report if able to support medical necessity of the transfer by ambulance	127
100479	Physician orders	17
100480	Nurses notes	12
100481	Initial evaluation (only have related to therapy services in list)	66
100482	Diagnostic testing report	25
100483	Documentation supporting wastage of medication if provider is billing JW modifier.	82
100484	Most recent Physician clinic/progress notes pertaining to diagnosis/reason the medication is being given.	107
100485	Nurses notes related to the administration of the medication.	61
100486	Initial evaluation (only related to therapy services in list)	61
100487	Treatment plan (only related to POC for therapy in list)	56
100488	Physician individualized overall plan of care for IRF	53
100489	Names, credentialing, and privileges within the facility of consulting physicians related to utilization management. (need for IRF, IPPS, and surgical services)	160
100490	Summary report of therapy minutes for each day of IRF stay	58
100491	Nutrition notes, vital signs, and medication administration records for IRF.	76
100492	Nurses notes and treatment records for IRF	42
100493	Physician orders for dates of service billed for IPPS	53
100494	Procedure notes including those prior to claim date of service, if billed on the inpatient claim for IPPS	105

100495	Medication administration record, including start and stop times if applicable for infusion	91
100496	Treatment encounter note for each visit to support services billed for outpatient therapy.	90
100497	Vital sign records, weight sheets, care plans, treatment records for SNF	72
100498	Documentation for the look back and look forward period for each MDS billed. May be prior to or after the billing period to assess if a change of therapy assessment would be necessary.	185
100499	Credentials of physician interpreting the test results, the technician, and the facility.	89
100500	Physical examination upon admission (if not done within the past 30 days and/or not available from another provider) must be included in the medical record.	156
100501	A referral source	17
100502	Initial Psychiatric Evaluation/Certification.	45
100503	Physician Recertification Requirements. Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.	198
100504	The patient's response to the therapeutic interventions provided by the PHP	75
100505	Treatment goals for coordination of services to facilitate discharge from the PHP/CMHC.	87
100506	Treatment Plan	14
100507	Progress Notes	14
100508	Psychotherapy notes	19
100509	Group notes	11
100510	Behavior monitoring flow sheets	31
100511	Treatment team, person-centered active treatment plan, and coordination of services	83
100512	Manufacturer information (i.e., purchase invoice, package insert, brochures)	76
100513	Laboratory values or other diagnostic tests as required per policy	66
100514	Any other supporting documentation	34
100515	Any other documentation to support Local Coverage Determination (LCD) and/or related Policy Article criteria	109
100516	Justification to support the custom fitted or off the shelf orthosis code billed	80
100517	Documentation of home assessment and if applicable, documentation addressing any issues that may impair the use of the manual within the home such as the physical layout of the home, surfaces to be traversed, and obstacles	222
100518	Written documentation on the costs of the item to include design fabrication, assembly and materials and labor of those performing the customization	148
100519	Written documentation to support necessary use of custom design fabrication, assembly and materials	99
100520	Detailed description of each phase of the construction process and labor skills needed to fabricate or modify the item	118
100521	Treating physician's 7-element order for the power mobility device	66
100522	Home assessment indicating the power mobility device can access all rooms of the home; and,	91
100523	Face-to-face evaluation, completed prior to the 7-element order: *Documentation that supports the medical necessity for the power mobility device as described in the LCD and PA; and, *This evaluation should provide the condition and progression of disease over time. It should clearly indicate ambulatory status why a power mobility device is needed as compared to a cane, walker, or manual wheelchair, and address the medical justification for each accessory billed; and, *Other medical records (physical and occupational therapy notes, physician office records, hospital records, home health agency records, etc.) may be submitted to supplement the information in the face-to-face evaluation	**708**
100524	Medical records to support tube replacement, pump feedings, calories under 750 and over 2,000 and/or the need for special formula	129

100525	Documentation indicating the beneficiary had a mastectomy; and,	63
100526	Justification to support the ICD-10 code billed; and,	53
100527	Diagnosis codes relating to the specific coverage criteria as indicated in the LCD with medical records to support the diagnosis code; and,	139
100528	High utilization *Documentation from the treating physician's medical records containing the specific rationale justifying the additional quantities above the usual utilization guideline for that particular patient; and,*Documentation to support the beneficiary had an in-person visit with the treating physician within 6 months prior to the supplies being ordered, if initial order. For ongoing provision (refills) there must be documentation of an in person visit with the treating physician within 6 months prior to the date of service of each refill; and,*If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed; and,	**831**
100529	Requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain; or,	97
100530	Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration; or,	173
100531	Requires traction equipment, which can only be attached to a hospital bed; and,	79
100532	Beds other than fixed height: *Requires a bed height different from a fixed height to permit transfers to chair, wheelchair or standing position for a variable height hospital bed; or, *Requires frequent changes in body position and/or has an immediate need for a change in body position for a semi-electric hospital bed; and, *Meets weight requirements for the equipment according to the LCD guidelines.	422
100533	Medical records indicating: *The transplant date, *The facility where the transplant was performed; and, *The corresponding diagnosis code; and, *Justification the item continues to be used by the beneficiary.	233
100534	Documentation to support the functional level modifier used; and,	65
100535	Documentation of home assessment and documentation addressing any issues that may impair the use of the wheelchair within the home such as the physical layout of the home, surfaces to be traversed, and obstacles; and,	217
100536	The patient's medical records that support the medical necessity which should include, but not be limited to, the functional level assessment, and physical examination of the body systems responsible for patient's ambulatory difficulties;	238
100537	Treating physician's and/or prosthetist's medical records that document the beneficiary's current functional capabilities and expected functional potential, the timeframe to reach and maintain functional state, and the beneficiary's motivation to ambulate;	256
100538	Documentation describing the history, previous treatment regimens, and current wound management for which a NPWT pump is being billed; and,	139
100539	Documentation describing the wound evaluation and treatment recorded in the beneficiary's medical record, must indicate regular evaluation and treatment of the beneficiary's wounds; and,	186
100540	Documentation from the treating physician describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care; and,	171
100541	If using oral antiemetic drugs J8498 and/or J8597, *Documentation to support antiemetic drugs criteria as referenced in the LCD and Policy Article; and,	157
100542	Blood gas study results as defined by the LCD for each CMN; and,	64

100543	Patient's medical records to support: *The patient's condition meets LCD criteria; and, *The treating physician's office visit and evaluations; and, - 30 days prior to the initial certification; and, - 90 days prior to recertification *Alternative treatment measures have been tried or considered; and, *The item continues to remain reasonable and necessary (if applicable); and, *The DMEPOS item continues to be used by the beneficiary - Either beneficiary medical records or supplier records are sufficient; and,	**559**
100544	Treating physician must sign/co-sign the face-to-face clinical evaluation prior to the sleep test to assess the beneficiary for obstructive sleep apnea; and,	157
100545	Documentation of a sleep test that qualifies the beneficiary for use of PAP device per LCD criteria; and,	105
100546	Documentation that supports device instruction was provided; and,	65
100547	Documentation of the ordering physician's in-person visit within 30 days prior to the initial certification or required recertification; and,	141
100548	Documentation to support the medical justification for parenteral nutrition. Documentation may include (but is not limited to) operative reports, fecal fat test and date of the test, small bowel motility study, serum albumin and date and x-ray reports; and,	257
100549	Documentation to support the medical necessity of caloric intake outside the range of 20-35 cal/kg/day; and	107
100550	Documentation to support the medical necessity for protein order outside of the range of 0.8-1.5 gm/kg/day, dextrose concentration less than 10%, or lipid use greater than 1500 grams (150 unit of service code B4185) per month; and,	231
100551	Documentation of a sleep test that qualifies the beneficiary for use of PAP device per LCD criteria; and,	106
100552	Re-evaluation documentation after 3-month trial: *Face-to-Face clinical re-evaluation by the physician on/after the 31st day of therapy; and, *Objective evidence of adherence to use of the PAP device, reviewed by the treating physician; and,	251
100553	If for an E0470 device, documentation to support that an E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting; and,	188
100554	Documentation to meet LCD criteria for concurrent use of oxygen therapy with PAP therapy; and,	95
100555	Documentation to meet LCD criteria for beneficiaries entering Medicare; and,	76
100556	Face-to-face evaluation, completed prior to the physician's order; that supports the medical	643
100557	Home assessment indicating the power mobility device is able to access all rooms of the home; and,	98
100558	Detailed product description (DPD) listing all items/options/upgrades; and,	75
100559	For codes K0835-K0843; K0848-K0855; K0890-K0891; K0898: *The specialty wheelchair evaluation completed by the PT/OT or a physician trained in rehabilitation wheelchair evaluations (must be signed and dated by the attending physician if used as part of the face-to-face evaluation); and, *Documentation to support the practitioner completing the specialty evaluation has no financial relationship with the supplier; and,	430
100560	For codes K0835-K0843; K0848-K0855; K0890-K0891; K0898: *Documentation that the wheelchair is provided by a supplier that employs a RESNA-certified Assistive; and, *Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for that patient; and,	328

100561	A complete facility-based, attended polysomnogram; and,	55
100562	Documentation to support the treating physician has fully documented in the patient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.; and,	274
100563	Documentation to support the beneficiary has a clinical disorder group characterized as the following and also meets the LCD criteria for: *Restrictive Thoracic Disorders; or, *Severe COPD; or, *Central Sleep Apnea or Complex Sleep Apnea; or, *Hypoventilation Syndrome; and,	294
100564	Documentation to support the beneficiary was re-evaluated to establish the medical necessity of continued coverage by Medicare beyond the first three months. While the patient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which Medicare will base a decision to continue coverage beyond this time must occur no sooner than 61 days after initiating therapy by the treating physician. Medicare will not continue coverage for the fourth and succeeding months of therapy until this re-evaluation has been completed; and,	**581**
100565	Documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. Failure of the patient to be consistently using the E0470 or E0471 device for an average of 4 hours per 24-hour period by the time of the re-evaluation (on or after 61 days after initiation of therapy) would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for Medicare to deny continued coverage as not reasonable and necessary	**550**
100566	Documentation obtained by the supplier of a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24-hour period) and that the patient is benefiting from its use must be obtained by the supplier of the device for continued coverage beyond three months	405
100567	Any medical records from the place of services rendered, physician history and progress notes, diagnoses/conditions, physicals, diagnostic testing (including MRI, CT results, etc.), lab tests and any other pertinent information to document the medical necessity of the orthoses chosen. Include CPO documentation regarding evaluation, and fitting if applicable, signed and dated legibly	385
100568	Non-physician clinical assessments and progress notes from nurses, physical therapists, occupational therapists, and ancillary services	135
100569	Copies of supplier's records for dates of direct patient contact related to the evaluation, fitting, and delivery of the orthosis	129
100570	Formal evaluation by the SLP, supporting the reasonable and necessary criteria for each related accessory	105
100571	The manufacturer name and the product name/number. For multicomponent mounting systems, list each manufacturer and the product name/number	138
100572	Wound evaluation(s) indicating size, location, stage, depth and amount of drainage. (Note: The wound evaluation must be performed monthly)	138
100573	If codes A4649, A6261 or A6262 are billed, the claim must include a narrative description of the item (including size of the product provided), the manufacturer, the brand name or number, and information justifying the medical necessity for the item	249
100574	For a purchased TENS unit, a Certificate of Medical Necessity (CMN), which has been completed, signed and dated by the treating physician	137
100575	Documentation to support the patient's condition meets the LCD criteria	71

100576	Documentation to support the trial period as addressed in the LCD	65
100577	Documentation to support the purchase as addressed in the LCD	61
100578	FOR GARMENTS	12
100579	Documentation to support LCD criteria during the trial period	61
100580	Documentation to support LCD criteria for a purchase.	53
100581	Treating physician's written order including the prescribing physician's National Provider Identifier (NPI); and, *If the prescribing physician is the supplier, a separate order is not required, but the eitem provided must be clearly noted in the patient's record.	269
100582	Documentation to support in-person visit/evaluation made by the supplier that meets LCD criteria	96
100583	Statement of Certifying Physician for Therapeutic Shoes signed on or after the date of the in-person visit	106
100584	Documentation from the prescribing physician	44
100585	Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) to support the patient is being treated for one of the following conditions: neuromuscular diseases, thoracic restrictive diseases, or chronic respiratory failure consequent to chronic obstructive pulmonary disease	370
100586	Nursing Documentation (i.e. Nursing notes and admission assessment - Lines; Medication & IV administration records; nursing treatment sheets such as: Skin care/wound care treatment sheets. Respiratory treatments and O2 therapy records)	236
100587	Rehabilitation Documentation (i.e. Initial therapy evaluations and re-evaluations; Objective and measurable prior level of function and current level of function to support functional decline; Rehabilitation therapy notes including progress notes; Treatment records, grids or logs; Actual therapy minutes provided; and all therapy discharge summaries) --Line 214	362
100588	Complete Medical Record	23
100589	Any other relevant documentation to support the claim as billed	63
100590	Physician Documentation (i.e. Physician Certifications and Re-certifications ; Physician orders- line, including admission orders; Physician progress notes; Physician History and Physical- lines	196
100591	Confirm that you intended to bill either modifier PA (surgery, wrong body part), PB (surgery, wrong patient), or PC (wrong surgery on patient) for this service	159
100592	Documentation supporting the medical necessity of NPLATE(TM)(ROMIPLOSTIM) where there is insufficient response to corticosteroids, immunoglobulins, or splenectomy and the administration record	192
100593	The clinical indication/medical necessity for the injection	59
100594	The topical corticosteroid(s) given previously to patient for ocular	76
100595	inflammatory condition prior to current treatment	50
100596	Documentation showing enrollment in the touch prescribing program	65
100597	Touch program certificate (indicating the patient has been approved by the program to receive TYSABRI)	102
100598	Provide the following information if this an assay approved by the food and drug administration (fda)	101
100599	Provide the following information if this an assay that was developed by the laboratory	87
100600	Provide the following information if this a modified FDA approved assay	71
100601	Describe the modification or change and submit the study performed to validate the modification	95
100602	Complete description of the test performed	42
100603	Description of the disease	26
100604	Meaning of a positive test result	33

100605	Meaning of a negative test result	33
100606	Statement regarding test limitations	36
100607	Test results	12
100608	Interpretive statement, which specifically explains the test results and how it will be used in the patients care	113
100609	Method(s) used	14
100610	Documentation that supports the clinical significance of the test performed	75
100611	Documentation that show the cross-walked codes previously used to bill this service	83
100612	Full text peer reviewed articles	32
100613	Society guidelines	18
100614	Physician referral (prescription, treatment or diagnostic test)	63
100615	Diagnosis specific to the service(s)	36
100616	Drugs name	10
100617	Drugs strength	14
100618	Drugs dosage	12
100619	Drugs frequency	15
100620	Drugs duration	18
100621	Drugs indication	16
100622	Drugs NDC	9
100623	Detailed billing sheet for all charges associated with this visit, identifying the items billed	95
100624	Hospital purchasing invoice showing rate per unit paid by hospital for the unlisted drug billed	95
100625	Any applicable invoices for services performed or supplies (e.g., fiducial markers)/devices	91
100626	Is the beneficiary a candidate for anticoagulation therapy with warfarin	72
100627	The number of days the patient has received warfarin, in the anticoagulation regimen for which the pharmacogenomic testing was ordered	134
100628	Has the beneficiary been previously tested for cyp2c9 or vkorc1 alleles	71
100629	Itemized breakdown of charges and subtotals per specific revenue code range(s) including the total charges of all revenue codes billed	135
100630	Signed and dated order for the provenge treatment	49
100631	Explanation/reason for noncoverage	34
100632	Proof of phone calls	21
100633	Certified mail pertinent to the NCC	35
100634	Proof of the representative's right to sign the NNC (for the beneficiary if necessary) and the request checked for intermediary review	134
100635	Nursing progress notes pertinent to the dates surrounding the demand bill	73
100636	Power of attorney paper or health surrogate papers	50
100637	Face sheet of the claim	23
100638	Other pertinent information	27
100639	Blood level for plasma cotinine and/or arterial carboxyjemoglobin	65
100640	Patient smoking or using nicotine products	42
100641	Therapeutic program adherence	29
100642	Mars	4
100643	A statement by the treating physician documenting the special need for performing IMRT on the patient in question, rather than performing conventional or three-dimensional treatment planning and delivery. The physician must address the other organs at risk and/or adjacent critical structures	292
100644	Review (signed and dated) by the radiation oncologist of the CT or MRI based images of the target and all critical structures with representative isodose distributions that characterize the three-dimensional dose	212
100645	Radiation oncologist review of dose-volume histograms for all targets and critical structures	93

100646	Description of the number and location of each treatment step/rotation or portal to accomplish the treatment plan	113
100647	Documentation of dosimetric verification of treatment setup and delivery, signed by both the radiation oncologist and the medical physicist	139
100648	Other procedures performed during the episode of care must have documentation that supports the professional and technical components as applicable by identifying the place of service, the date of service, the supervising physician, and proof of work	250
100649	Admissions facesheet	20
100650	The diagnosis of neovascular (wet) macular degeneration has been firmly established (fluorescein angiogram)	107
100651	The patient does not have any contraindications to bevacizumab	62
100652	Include details about the pharmacotherapy and non-pharmacologic interventions (psychotherapy, ECT, etc.) Over the past 18 (eighteen) months	139
100653	Documentation of a second opinion of a psychiatrist who is not involved in the care of the beneficiary	102
100654	Patient's compliance, and response to treatment	47
100655	Physicians order for wireless capsule endoscopy of the esophagus	64
100656	Documentation supporting indication(s) for procedure	52
100657	Documentation supporting contraindication to conventional endoscopy	67
100658	Procedure notes with results of the WCE-ESO	43
100659	Documentation to support credentialing	38
100660	Please advise us as to which OSCAR you wish to have payment made	64
100661	Assistant Surgeon Additional Documentation Request needed to support exceptional circumstance and establish medical necessity.	127
100662	Assistant Surgeon Additional Documentation request if exceptional medical circumstances existed or the primary surgeon has an across-the board policy of never involving residents in the pre-operative, operative, or postoperative care of his or her patients.	261
100663	Operative reports for both surgeons	35
100664	All other records that support medical necessity for the two surgeons	69
100665	Documentation for surgical procedures is not required for co-surgeons where the specialties of the two surgeons are different. Please indicate the name and specialty of both physicians	185
100666	This additional development request is a review of co-surgeon charges.	70
100667	Surgical notes related to the unlisted code	43
100668	Office notes related to the unlisted code	41
100669	Medication administration records related to the unlisted code	62
100670	Diagnostic testing results related to the unlisted code	55
100671	Physician orders related to the unlisted code	45
100672	Itemized statement / bill / invoice	35
100673	Any other documentation related to the unlisted code billed and claim services	78
100674	All outside hospital records that support the required World Professional Association for Transgender Health (WPATH SOC) Transgender Surgery (examples: reports from two mental health professionals regarding diagnosis and appropriateness for surgery; age at diagnosis; length of time on hormone replacement therapy, etc...)	322
100675	Copy of Medicare Card	21
100676	Documentation showing provider number you want used to bill claim (multiple provider numbers for same NPI)	106
100677	Our records indicate that you have more than one number that corresponds to your national provider identifier. Please advise us as to which legacy number type you wish to have payment made, if applicable, and correspondence sent for this claim.	244

100678	Documents that support a fire, flood, earthquake, or other unusual event that caused extensive damage to an agency's ability to operate	135
100679	Documentation of an event that produced a CMS or CGS data filing problem which was beyond the agencies control	110
100680	Documentation to support an agency was newly certified and received notification after the Medicare effective date and may include the tie-in notice from CMS	157
100681	Documentation to support retroactive Medicare which must include: Proof of retroactive Medicare entitlement, Certification of Terminal illness that meets the criteria set forth in the Medicare Benefits policy manual chapter 9 section 20.1, and Hospice election statement that meets the criteria set forth in the Medicare Benefits policy manual chapter 9 section 20.2.1	368
100682	Documentation to support any other circumstance that the agency feels was beyond their control. This may include, but is not limited to, documentation showing a prior hospice's submission of an untimely notice of termination/revocation or sequential billing issues which required an agency to remove a timely filed NOE/Claims to allow a previous hospice to bill	361
100683	Provide the following documentation in support of the hospice exception request for filing the NOE more than 5 calendar days after the hospice admission date	161
100684	WPATH criteria-specifically which criteria and how it was met	61
100685	Documentation of hormone or other medication regimen	52
100686	Any other documentation to support that the service provided was medically necessary and not cosmetic	101
100687	Documentation to support that the service provided was medically necessary	74
100688	The patient is not a candidate for subtotal liver resection	59
100689	The patient's tumor(s) is less than or equal to 5 cm in diameter	64
100690	There is no macrovascular involvement	37
100691	There is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bone	113
100692	Documentation to clearly identify the unlisted procedure/medication	67
100693	Invoice showing amount you paid for the implantable device/DME	62
100694	Clearly marked documentation to support the patient received the items invoiced	79
100695	CMS IOM Publication number 100-2 Medicare Benefit Policy Manual, Chapter 1, Section 130.2 Election of RNHCI Benefits Questionnaire response required	148
100696	Overlapping claim return corrected UB-04 to MAC	47
100697	Dental code 21110 - effective 11/1/16 Please provide the following documentation in support of this claim: 1. Office notes - for the decision to perform the surgery 2. Operative report	187
100698	Cr8132 gap-fill lab codes need development for pricing information and data collection for future editing.	107
100699	Cr8132 gap-fill molecular lab codes 81400-81408 and 81479 need development for multiple assays in 1 HCPC and some tests may not be payable by Medicare. In addition this needs to be manually priced	197
100700	Observation greater than 48 hours	37
100701	All notes and flowsheets of each discipline billed	50
100702	An itemized medical supply list if supplies are billed	54
100703	Identify all caregivers and state whether they are your employees. If not, please provide the name of the company or person you are contracted with and supply a contact name, address and phone number.	200
100704	Ra prepayment review demonstration project MS-DRG 312 - syncope and collapse - 2 day LOS or less. New York state providers only	128
100705	This claim is under review by the program contractor	52
100706	Beneficiary's Address	21

100707	Beneficiary's Date of Birth	27
100708	Beneficiary's Medicare Identification Number	44
100709	Beneficiary's Name	18
100710	Beneficiary's Phone Number	26
100711	Billing Provider Identification Number (PIN)	44
100712	Correct Date of Service	23
100713	Date of Pacemaker Implantation	30
100714	Description of unlisted service	31
100715	Exact Dates of Service when date span submitted	47
100716	Investigational Device Exemption (IDE) number	45
100717	Location and Diameter of each lesion treated	44
100718	Mammography Certification Number	32
100719	MSP - Primary EOB	17
100720	MSP - Reason for primary payer's denial	39
100721	Number of Post-Operative Days	29
100722	Opt Out Provider - Was this claim filed in error?	50
100723	Opt Out Provider - Were services performed for an emergency or urgent situation?	80
100724	Patient Relationship to Provider (are they related?)	52
100725	Patient's Weight	16
100726	Place of Service	16
100727	Podiatry - Class Findings	25
100728	Podiatry - Date patient last seen by the attending physician	60
100729	Procedure Code	14
100730	Reason for Dosage	17
100731	Rendering Provider Identification Number (PIN)	46
100732	Signature of Next of Kin or Executor of Estate	46
100733	Time of Service	15
100734	Type of Service	15
100735	Surgery - Wrong Body Part	25
100736	Surgery - Wrong Patient	23
100737	Surgery - Wrong Surgery on Patient	34
100738	Telehealth Demonstration	24
100739	Did bene pay out of pocket?	27
100740	Pacemaker Insertion	19
100741	Explanation of the beneficiary's medical conditions/circumstances that make usage of a custom piece of durable medical equipment necessary.	141
100742	Explanation of how this item was uniquely constructed or modified for the beneficiary according to the description and orders of the physician. Include what makes this item different from all other pieces of durable medical equipment used for the same purpose.	260
100743	Itemization of the costs involved in the construction of this piece of customized durable medical equipment. The itemization must include a breakdown of the materials and labor.	177
100744	Warranty(s)	11
100745	Explanation of why the parts and labor billed should be considered as included in the warranty	94
100746	5601/overlap letter	19
150001	More documents requested, please refer to the PDF Copy of the ADR Letter	72
150002	Please refer to the PDF Copy of the ADR Letter for requested documents	70
150003	No Associated Document Code - Default Code for system use	57

Code	Document Parameters	Type: Time-based/Other Special Request
700001	From initial admission to current	Time-based
700002	1 year to date of service	Time-based
700003	Date of service-on admit	Time-based
700004	Admit to discharge	Time-based
700005	From bene enrollment	Time-based
700006	DOS if SNF, different for outpt therapy	Time-based
700007	Start of therapy	Time-based
700008	DOS	Time-based
700009	Years to DOS	Time-based
700010	Most recent to DOS	Time-based
700011	DOS and 7 day look back period	Time-based
700012	Most current	Time-based
700013	Prior to admit	Time-based
700014	DOS billed	Time-based
700015	Most recent	Time-based
700016	DOS billed/admit	Time-based
700017	Admit/intial evaluation	Time-based
700018	Most recent notes	Time-based
700019	All recent	Time-based
700020	Most recent notes info is in	Time-based
700021	DOS billed/most recent note	Time-based
700022	Initial eval/start of therapy	Time-based
700023	Admit	Time-based
700024	DOS billed and look back period	Time-based
700025	DOS billed/when given if SNF demand	Time-based
700026	Most recent being used to support	Time-based
700027	DOS billed/when received	Time-based
700028	Most recent/DOS billed	Time-based
700029	Most recent-could be years prior to DOS billed	Time-based
700030	Most recent note with information	Time-based
700031	For the dates of service billed on the claim	Time-based
700032	30 days prior to the dates of services billed	Time-based
700033	Due Date	Time-based
800001	if applicable	Other
800002	Ordering Provider NPI	Other
800003	Ordering Provider Name	Other
800004	Documentation as required in LCD or NCD	Other
900001	**Special OTHER parameter request - Refer to letter**	Other
900002	**Special TIME-BASED parameter request - Refer to letter**	Time-based

CR	Change Requested	Explanation/Purpose	Date
11474	All Post Pay RCs	In the tab (***esMD to DC-RC - Docu Codes***), the cell 1 A, has been updated. To indicate that the Post Pay RCs are exptected to receive, process, and send an acknowledgement file, back to esMD.	09/13/2019
EIC of 11473 and 11474	SSM - MCS	***Action Status*** element location has been moved up in the layout, as requested.	09/13/2019
EIC of 11473 and 11474		In the tab (***esMD to DC-RC - Docu Codes***), the cell 18 C, has been updated. The ***Action Date*** field format has been changed, from MM-DD-YYYY to CCYYMMDD. The length has been adjusted for the Starting position, and the number of ***Filler*** bytes in 19 D, and E.	09/18/2019
EIC of 11473 and 11474		In the tab (***Header-Trailer DC to esMD Ack***), the cell 15 F, has been updated. The statement mentioning the situational condition for the Error Code 222, has been added.	09/18/2019
EIC of 11473 and 11474		In the tab (***Header-Trailer DC to esMD Ack***), the cell 16 F, has been updated. The statement mentioning the situational condition for the Error Code 222, has been added.	09/18/2019
EIC of 11473 and 11474	STC	In the tab (***esMD to DC-RC - Docu Codes***), the cell 18 F, has been updated. A conditional statement on the ***Action Date*** has been added, indicating it cannot be a future date.	10/06/2019
EIC of 11473 and 11474	esMD	In the tab (***Header-Trailer DC to esMD Ack***), the cell 12F, has been updated. The sentence in the middle paragraph has been modified to state that count should match the 'Number of error records in the file'.	10/06/2019
EIC of 11473 and 11474	esMD	In the tab (***Header-Trailer DC to esMD Ack***), the cell 1A, has been added. A general statement has been added to indicate that the ***Post Pay RCs*** do need to respond back to esMD, with an Acknowledgement File.	10/06/2019

Details of the elements for the Header , Detailed body and Trailer while sending the eMDR Document Codes to Datacenter and RC, from esMD.

SSMs/RCs receiving the copy of this file, are expected to ingest and use the document codes, for the purpose of populating in the eMDR Letter Record / Flat File record.

RCs (Post Pay) are expected to perform the system processing of this file, and send an Acknowledgement file back, to esMD.

HEADER

Description	Usage Reg. R - Required S - Situationally required	Values / Formats	Starting position	Length	Comments	Justification / Fillers in esMD to SSM / DC flat file
Record Type Indicator	R	U'	1	1	Represents the Type of Record. (esMD to Datacenter/ RC - Header record)	
esMD Processing Batch Cycle Date	R	CCYYMMDDHHMMSS	2	14	Indicates the Date/Time when the esMD batch cycle ran to export the Document Codes file information.	
Type of Transactions	R	DOCUCODE'	16	8	Represents the Type of Records populated in this file.	
Filler	R	Spaces	24	1012	To fill out the full record length in the Header Record. The record length of the Detail Body for this file is 1035.	
				1035		

Detailed Body

Body shall have same number of Document Code records as indicated in the Trailer.

Description	Usage Reg.	Values	Starting position	Length	Comments	Justification / Fillers in esMD to SSM / DC flat file
Record Type Indicator	R	V'	1	1	Represents the Type of Record. (esMD to Datacenter/ RC - Detail record)	
Record Number	R	Number	2	7	Represents the sequence number of the record, in the Document Codes file.	Right justified, zero padded
Action Status	R	A, U, M, E	9	1	Represents whether the said document code is just added, remains as is from the previous iteration, updated, or, expired. Values: A - Code got Added (continue to use); U - Code remains Unchanged (continue to use); M - Code got Modified (continue to use); E - Code got Expired (discontinue the use)	
Document Code	R	Number	10	6	Standard Code representing the Document	
Document Description	R	Character	16	1000	The long description of the document which is getting requested	Left justified, space padded
Action Date	R	CCYYMMDD	1016	8	Date of Change of the current Action Status. ***Note: The value for this Date cannot be a future date***.	
Filler	R	Spaces	1024	12	Filler to enable possible future expansion	
				1035	Total length of the Detail Body record	

Trailer

Description	Usage Reg.	Values / Formats	Starting position	Length	Comments	Justification / Fillers in esMD to SSM / DC / RC flat file
Record Type Indicator	R	W'	1	1	Represents the Type of Record. (esMD to Datacenter/ RC - Trailer record)	
Total Number of Records	R	Number	2	7	The number of Document Codes in the file, sent from esMD to DC / RC.	Right justified, zero padded
Filler	R	Spaces	9	1027	To fill out the full record length in the Trailer Record. The record length of the Detail Body for this file is 1028.	
				1035		

Details of the elements for the Header , Detailed body and Trailer while sending the Acknowledgement file (for the Document Codes file) from Datacenter to esMD. **Data Centers are expected to receive, process, and send the Acknowledgement, back to esMD.** **RCs (Post Pay) are expected to receive, process, and send the Acknowledgement, back to esMD.**						
HEADER						
Description	**Usage Reg.** **R - Required** **S - Situationally required**	**Values / Formats**	**Starting position**	**Length**	**Comments**	**Justification / Fillers in SSM / DC flat file to esMD**
Record Type Indicator	R	X'	1	1	Represents the Type of Record. (Datacenter to esMD - Header record)	
esMD Processing Batch Cycle Date	R	CCYYMMDDHHMMSS	2	14	Indicates the Date/Time when the esMD batch cycle ran to generate the Document Code file information. Return the value in the corresponding Acknowledgement/Error file sent to esMD	
DC Batch Cycle Date	R	CCYYMMDDHHMMSS	16	14	Date/time the Document Codes batch file was processed by the Data Center.	
Type of Transactions	R	DOCUCODE'	30	8	Type of Records in this file.	
File Status	R	A, R	37	1	***Values:*** A - File Accepted => (None of the records encountered any edit error(s)) R - File Rejected => (Atleast one error was encountered in any of the records in the file)	
Filler	R	SPACES	38	8	To fill out the full record length for this file The record length of the detail body for this file is 46.	
				46		
Detailed Body					**Detailed Body record needs to be populated, only when the processing encounters at least ONE error, across the file.** **Detailed Body shall have same number of records as indicated in the Trailer record element *'Number of error records in the file'*.** **If there are no editing errors across the file, then, the Acknowledgement File shall contain only two records (Header and Trailer), to esMD.**	
Description	**Usage Reg.**	**Values**	**Starting position**	**Length**	**Comments**	**Justification / Fillers in SSM / DC flat file to esMD**
Record Type Indicator	S	Y'	1	1	Represents the Type of Record. (Datacenter to esMD - Detailed Body record) This element shall be populated if there is at least 1 error to be reported.	
Record Number	S	Number	2	7	Represents the actual sequence/record number as read by the process, while reading the input. Populate ***SEVEN ZEROS*** , when there is a mismatch in the total number of records mentioned in the Trailer and Total number of Records. (error code - 222)	
Document Code	S	Number	9	6	Represents the Document Code Populate the Document Code read in the input record. Populate ***SIX ZEROS*** , when the Document Code is missing or invalid. (error code - 510, 222)	
Error Code 1	S	510, 511, 512, 513	14	3	The ***First error*** identified in the record, is to be populated in this element 510 - Document Code is missing, OR, of invalid length, 511 - Document Description is missing, 512 - Action Status is missing, OR, invalid value 513 - Action Date is missing, OR, invalid value	
Error Code 2	S	511, 512, 513	17	3	The ***Second error*** identified in the record, is to be populated in this element. 511 - Document Description is missing, 512 - Action Status is missing, OR, invalid value 513 - Action Status is missing, OR, invalid value Note: If there is no Second error encountered for this given record, ***populate 3 SPACES*** .	
Error Code 3	S	511, 512,	20	3	The ***Third error*** identified in the record, is to be populated in this element. 511 - Document Description is missing, 512 - Action Status is missing, OR, invalid value Note: If there is no Third error encountered for this given record, ***populate 3 SPACES.***	
Error Code 4	S	513	23	3	The ***Fourth error*** identified in the record, is to be populated in this element 513 - Action Status is missing, OR, invalid value Note: If there is no Fourth error encountered for this given record, ***populate 3 SPACES*** .	
Filler	S	Spaces	26	20	Filler white space	
				46	Total length of the record	
Trailer						
Description	**Usage Reg.**	**Values / Formats**	**Starting position**	**Length**	**Comments**	**Justification / Fillers in SSM / DC flat file to esMD**
Record Type Indicator	R	Z'	1	1	Represents the Type of Record. (Datacenter to esMD - Trailer record)	
Number of records Received	R	Number	2	7	The number of Document Code records received by the Data Center for processing	Right justified, zero-padded
Number of records Validated	R	Number	9	7	The number of Document Code records validated by the Data Center. If this number is equal to the number of records received, the file is accepted. (All records successfully completed processing without encountering any errors.)	Right justified, zero padded
Number of error records in the file	S	Number	16	7	The number of Document Code records for which errors are encountered in this file. If this number is greater than ZERO, the file is rejected. (A given record, or, few records have encountered one or few errors)	Right justified, zero padded
Filler	R	Spaces	23	24	To fill out the full record length for this file The record length of the detail body for this file is 46.	
				46		

July 2020 Release

Criteria Required to Generate Test Files from MACs/RACs to esMD for CR 31434 (eChimp CR 11474)

*****esMD UAT Starts at the start of June 2020 *****

Testing support call schedule and expected attendees:

DPSM esMD Team would need to set up **3 calls**, starting in the month of **April 2020** to collaborate on the content of the ***Test Files/Test scenarios***. The goal of these calls it to ensure that the MACs/RACs discuss about any ***technical questions in regard to populating the Document Codes in eMDR Post-Pay ADRs.***

April	:	Technical Support Calls (MACs, RACs and esMD teams)
May	:	UAT Preparation Call (MACs, RACs and esMD teams)

Note:

Sharing the Unit Test files from esMD dev environment will not be possible, since the RC Mail boxes are currently setup in UAT and PROD environments.

The Technical Support Call will be organized, by the esMD technical teams, to address any ***technical clarifications*** related to RC Client API specifications.

During subsequent call, esMD would wish to ensure/provide the following, regarding the Post-Pay eMDR implementation.

a. The Providers information which would be used for testing, are all registered in NPPES system. (Test Provider NPIs in NPPES system)
b. The same Provider information has been shared with the associated *Health Information Handlers* (HIHs) who intends to participate in UAT.
c. esMD to provide UAT Test Plan to all the Participating Review Contractors. (MACs, and RACs)
d. For the Post-Pay testing (document code adoption), esMD team is recommending to use the ***same set of NPI's,*** those were used for testing purpose eMDR Post Pay initiative in January release.

April 2020 Release MACs and RACs Testing Plan:

Test Criteria – Steps - eMDR Post-Pay	When
DCF Creation and Execution: Step 1: esMD to send the Document Codes File (DCF) to VDCs. Step 2: Receive accept / reject notifications from VDCs. Step 3: Receiving helpdesk ticket in case of file level errors.	1st 2 weeks of UAT. (Starting June 2th 2020)
eMDR Testing: Step 1: esMD to receive, process, and respond back to RC. (Ack or Error) Step 2: Generate the Letter Package and Send it to HIH. Step 3: Receiving, Processing Acknowledgement from HIH, for the delivery.	From 2nd week onwards, until the UAT ends.
eMDR Package delivery outcome from HIH: Step 1: esMD receives eMDR delivery acknowledgement from HIH after esMD successfully sent the eMDR and ADR files to HIH. Step 2: esMD sends the success/failure delivery acknowledgement to RC's depending on whether esMD successfully/failed delivering to HIH.	From 2nd week onwards, until the UAT ends.

Unit/UAT Test POC details:

1. POCs from esMD team : TOSS_Testing@actionet.com; DPSM_esMD@cms.hhs.gov ; esmddevgroup@religroupinc.com
2. POCs from MACs team : **MAC Teams' information needed**
3. POCs from RAC team : **RAC Teams' information needed**

Note: Group Contact e-mail ID would be preferred, from each entity, for respective Business and Technical teams.

CR	Change Requested	Explanation/Purpose	Date
11142	esMD	Row 3 - The prefix (first 3 characters) of the [Unique ID] element note has been removed.	02/19/2019
11142	esMD	Row 4 - The date format has been made to 1 format. [Letter Date]	02/19/2019
11142	esMD	Row 37 - The date format has been made to 1 format. [Respond By]	02/19/2019
11142	RCs	Row 40 - A new section 'Review Level' has be included as a required section. Under this section, two elements are added. *Analysis ID* (Row 41) *Analysis Factor* (Row 42) *Document Code* (Row 43) - Has been moved from the Claim Details section to this section	02/19/2019
11142	esMD	Row 45 - For the element Case ID, a separate section has been made.	02/19/2019
11142	esMD	Row 54 - The elements (Procedure Code/Modifier) associated to the sampled claims has been moved from Claim Details section	02/19/2019
11142	esMD	Claims Header and Details sections are made into ONE section	02/19/2019
11142	RCs	Row 56 / 57 - The Dates of Service from both Claim Header and Detail has been made into ONE set as follows. Date Of Service (From) Date Of Service (To)	02/19/2019
11142	RCs	The element 'Reason Code' has been removed.	02/19/2019

11142	esMD	The length of the Unique Letter ID element has been increased to 40	03/07/2019
11142	RCs	Analysis Factor Limit is set to 25, per Analysis ID; Document Code limit is set to 100, per Analysis ID	03/07/2019
11142	esMD	Since the structured format is XML, padding with ZEROS or SPACES to fit the maximum length need not be done.	03/07/2019
11142	RCs	To be consistent across the layout, the date format of the elements 'Respond By' and 'Letter Date' has been updated as 'mm/dd/yyyy'.	03/07/2019

11142	esMD	Row 3, Column H, Rule 1 - The upper limit has been corrected to reflect 40 Characters.	03/22/2019
11142	esMD	Row 40, Column G - Section *Usage* has been updated to 'Required'. [*Analysis ID* element must be provided]	03/22/2019
11142	esMD	Row 41, Column D - A statement has been added to provide clarity, regarding the XML record hierarchy.	03/22/2019
11142	esMD	Row 46, Column H - The comment statement has been removed. [Claim information is expected for both Medical and Non-Medical Review baseds Post Pay ADRs.]	03/22/2019
11142	Based on the general suggestions made, the 'Provider Details' section (rows 24 to 32) shall remove the reference of the word 'Billing'. This Section shall have the details of the provider to whom the eMDR is 'Addressed To'.	In the following rows the striked out content has been modified / removed. **Row 24** Column B (ID / Section) , the content of this column has been modified as 'Provider details ~~(Billing Provider)~~' Column D (Description), the contents of this column has been modified as 'Provider to whom the intended eMDR is ~~**to be delivered**~~ **'Addressed To'** **Row 25** Column D (associated to Data Element - First Name), the description has been modified as 'First Name of the ~~Billing~~ Provider'. **Row 26** Column D (associated to Data Element - Middle Name), the description has been modified as 'Middle Name of the ~~Billing~~ Provider'. **Row 34** Column D (associated to Data Element - Provider NPI), the description has been modified as 'NPI of the eMDR Registered ~~Billing~~ Provider'.	07/08/2019
11142	Based on the recent suggestions made by OIT team.	The column named 'S.No.' in the tab 'eMDR Data Construct - Post Pay' has been updated with correct sequential numbers.	07/15/2019
XXXXX	esMD	In Row 43 (S.No 37), the Usage Reg. associated to the data element ***Document Code*** has been updated to '***Required***'	08/20/2019
XXXXX	esMD	In Row 44 (S.No 38), the data element '***Enquiry Text***' has been added for future use. (Usage Reg. termed as '***Optional***').	08/20/2019

S. No.	ID / Section	Data Element	Description	Type / Format / Values	Length	Usage Rec.	Comments / Rules	Question / Posv Pav RC responses.
1		Type of eMDR	To indicate the kind/type of eMDR	***Value:*** POST-PAY	8	R	***Rules:*** 1. Must be populated with the value provided in ***column E*** .	
2		Unique Letter Id	This represent the Identifier assigned by the Sender of the eMDR letter info (Non-MAC RC), to identify the ***eMDR letter record Uniquely,*** in their internal system. ***Note to esMD:*** This Identifier Value, 1. Shall be used by the esMD to track each eMDR uniquely. 2. Shall be Used by esMD, as a linkage element, to create the bundle of the structured eMDR and the PDF format of the letter (received from the RCs).	***Type:*** Character	40	R	***Rules:*** 1. Must be present and can be upto a limit of **40** characters in Length. 2. Must not contain any special characters.	
3		Letter Date	Date affixed on the ADR letter	***Format:*** mm/dd/yyyy	10	R	***Rules:*** 1. Must be valid date, in the specified format 2. Must not be later than the current system date	
	"Respond To" Details **(Occurs ONE time)**	N/A	**RC to whom the ADR response needs to be sent by the Provider**			R	***Section is Required.***	
4		Organization Name	Name of the Organization to which the ADR Response needs to be sent by the Provider.	***Type:*** Character	60	R	***Rules:*** 1. Name of the Organization must be present.	
5		Address 1	First Address Line of the RC, to which the documentation needs to be sent by the provider	***Type:*** Character	55	R	***Rules:*** 1. Address Line 1 of the Organization address must be present.	
6		Address 2	Second Address Line of the RC, to which the documentation needs to be sent by the provider	***Type:*** Character	55	O		
7		City	City associated with the RC address, to which the documentation needs to be sent by the provider	***Type:*** Character	30	R	***Rules:*** 1. City of the Organization address must be present.	
8		State	State associated with the RC address, to which the documentation needs to be sent by the provider	***Values*** : All standard 2 character value representation for US states	2	R	***Rules:*** 1. State of the Organization address must be present. 2. Must be valid State value in US	
9		Zip Code	ZIP Code associated with the RC address, to which the documentation needs to be sent by the provider	***Type:*** Character ***Formats:*** *99999* *999999999*	9	R	***Rules:*** 1. ZIP Code of the Organization address must be present. 2. Must be valid value in US.	
10		Telephone	Information to the provider to contact the RC in case of any questions.	***Type: Character*** ***Format:*** *9999999999* *(10 numerics)*	10	O	***Rules:*** 1. Must match the type/format, when submitted.	
11		Telephone Ext	Information to the provider to contact the RC in case of any questions.	***Type: Character*** ***Format: 99999*** *(5 numerics)*	5	O	***Rules:*** 1. Must match the type/format, when submitted.	
12		Fax number	Fax number to respond with documentation	***Type: Character*** ***Format:*** *9999999999* *(10 numerics)*	10	O	***Rules:*** 1. Must match the type/format, when submitted.	
	Sender Details **(Occurs ONE time)**	N/A	**RC who is generating/creating the ADR information package, to be sent to the Provider, electronically.** **Note: RC who is creating the ADR information package may not always be the same RC, to whom the Provider need to Respond To.**			S	***Condition:*** 1. If the RC who is sending the eMDR is different from, the RC to whom the ADR Response needs to be sent by the Provider, the ***Sender Details section*** is ***Required*** . ***Note:*** While sending the information in this ***section*** please follow the usage mention in ***column G*** for each element. 2. If the RC who is sending the eMDR is same as the RC to whom the ADR Response needs to be sent by the Provider, the ***Sender Details*** information ***need not be populated.*** ***Note:*** *If information is populated in both '* ***Respond To*** *' and '* ***Sender Details*** *' sections,* ***esMD system will NOT perform*** *any editing to ensure the details are the same across the sections, against respective elements.*	
13		Organization Name	Name of the Organization which is sending the ADR, to the Provider.	***Type:*** Character	60	R	***Rules:*** 1. Name of the Organization must be present.	
14		Address 1	First Address Line of the RC, who is sending the ADR letter, to the Provider.	***Type:*** Character	55	O		
15		Address 2	Second Address Line of the RC, who is sending the ADR letter, to the Provider.	***Type:*** Character	55	O		
16		City	City associated with the RC address, who is sending the ADR letter, to the Provider.	***Type:*** Character	30	O	***Rules:*** 1. City of the Organization address ***may be*** provided.	
17		State	State associated with the RC address, who is sending the ADR letter, to the Provider.	***Values*** : All standard 2 character value representation for US states	2	O	***Rules:*** 1. State of the Organization address ***may be*** provided. 2. Must be valid State value in US, when populated.	
18		Zip Code	ZIP Code associated with the RC address, who is sending the ADR letter, to the Provider.	***Type:*** Character ***Formats:*** *99999* *999999999*	9	O	***Rules:*** 1. Must match the type/format, when submitted.	
19		Telephone	Contact Telephone Number of the Sender of the ADR, to facilitate Provider enquiry, as need arise.	***Type: Character*** ***Format:*** *9999999999* *(10 numerics)*	10	O	***Rules:*** 1. Must match the type/format, when submitted.	
20		Telephone Ext	Contact Telephone Number extension of the Sender of the ADR, to facilitate Provider enquiry, as need arise.	***Type: Character*** ***Format: 99999*** *(5 numerics)*	5	O	***Rules:*** 1. Must match the type/format, when submitted.	
	Provider details	N/A	Provider to whom the intended eMDR is 'Addressed To'			R		
21		First Name	First Name of the Provider	***Type:*** Character	35	O		
22		Middle Name	Middle Name of the Provider	***Type:*** Character	25	O		
23		Last Name / Organization Name	Last Name of the Individual Provider OR Name of the Organization	***Type:*** Character	60	R	***Rules:*** 1. Name of the Organization OR the Last name of the Individual Provider, must be present	
24		Address 1	First Address Line of the Provider, to whom the ADR letter is getting sent.	***Type:*** Character	55	R	***Rules:*** 1. First address line must be present.	
25		Address 2	Second Address Line of the Provider, to whom the ADR letter is getting sent.	***Type:*** Character	55	O		
26		City	City associated with the Provider address, to whom the ADR letter is getting sent.	***Type:*** Character	30	R	***Rules:*** 1. City of the Organization address must be present.	
27		State	State associated with the Provider address, to whom the ADR letter is getting sent.	***Values*** : All standard 2 character value representation for US states	2	R	***Rules:*** 1. State of the Organization address must be present. 2. Must be valid State value in US	
28		Zip Code	ZIP Code associated with the Provider address, to whom the ADR letter is getting sent.	***Type:*** Character ***Formats:*** *99999* *999999999*	9	R	***Rules:*** 1. ZIP Code of the Organization address must be present, when Provider Detail information is provided. 2. Must be valid State value in US.	
29		Provider Number/ PTAN	Represents the Provider Number OR Provider Transaction Access Number (PTAN)	***Type:*** Alphanumeric	13	O		
30		Provider NPI	NPI of the eMDR Registered Provider	***Type:*** Numeric	10	R	***Rules:*** 1. Must be present and 10 numeric digit. 2. Must be a Valid eMDR Registered NPI, associated to the corresponding HIH.	
31		Fax	Fax number of the Provider / Provider Organization	***Type: Character*** ***Format:*** *9999999999* *(10 numerics)*	10	O	***Rules:*** 1. Must match the type/format, when submitted.	
	Letter Details **(Occurs ONE time)**	N/A	**Represent few of the dynamic elements that appears in the ADR letter**			R		
32		Respond By	Date by which the Response to the ADR is expected from the Provider, by the RC	***Formats:*** mm/dd/yyyy	10	R	***Rules:*** 1. The Date must be present and valid, 2. Must be in the mentioned format, 3. Must be a future date	
33		Jurisdiction / Zone of the RC	Represents the Jurisdiction or the Region to which the RC is associated.	***Type:*** Character ***Examples:*** 'QIO Area 1' 'RAC Region 1' 'UPIC Mid-Western'	40	R	***Rules:*** 1. Jursdiction OR Zone text must be present. ***Note:*** esMD system will neither maintain the values, nor, verify whether the populated value is valid.	
34		Program name (Line of Business)	Indicates the Name of the Program which is sending this ADR letter	***Type:*** Character ***Values:*** ***The following are suggested:*** Part A, Part B, DME, HHH	10	R	***Rules:*** 1. The Value must be present ***Note:*** esMD system will neither maintain the values, nor, verify whether the populated value is valid.	
	Review Level **(Section Can Repeat more than Once)**	**N/A**				R		

35		**Analysis ID**	**System Identifier assigned by the RC, to indicate a specific analysis/project.** **(Example: Reference #, Issue #, or Project ID)** ***(Analysis ID, Analysis Factor, Document Code, Case ID, Claim Details constitutes a block, and, can Repeat up to a limit of 100 times, for a given ADR Letter)***	***Type:*** Character	**40**	**R**	***Rules:*** 1. Must be present 2. Can contain special Characters ('Hyphen').	
36		**Analysis Factor**	**Data attribute used by the RC, to conduct the analysis/project with, OR the basis on which the analysis began.** **(Example: Procedure Code, DRG, etc...)** **(Can Repeat upto a limit of 25 for a given Analysis ID)**	***Type:*** Character	**30**	**O**	***Rules:*** 1. When populated, can contain special Characters (at least 'Dot', or, 'Hyphen'),	
37		**Document Code**	**Code to indicate the document to be requested.** **(Can Repeat upto a limit of 100 for a given Analysis ID)**	***Type:*** Character ***Formats:*** ***(999999),*** ***(999999999999),*** ***(999999999999999999), or*** ***(999999999999999999999999)***	**24**	**R**	***Rules:*** 1. When populated, must be in one of the stated formats, stated in **Column E.** ***Examples to the RCs:*** When RC wants to indicate 'Interim Verbal Orders', Populate as '***100001*** ' ; When RC wants to indicate 'Interim Verbal Orders' & 'if applicable' Populate as '***100001 800001*** ' ; When RC wants to indicate 'Interim Verbal Orders' & 'if applicable' & 'DOS on admit', Populate as '***100001 800001 700003*** ' ; When RC can use the whole length of 24 bytes, as need arise '***100001 800001 700003 900001***' (Document Code and 3 parameters)	
38		**Inquiry Text**	**Represents the possible query text, which needs to be sent to the Provider, at the Document Code level.** **This field has been included as a provision for future use.** **(Can Repeat upto a limit of 4 for a given Analysis ID)**	***Type:*** Character	**4000**	**O**	***Rules:*** 1. For ***April 2020 implementation*** , this element **need not** be present/populated in the input XML.	
	Claim Set Level **(Section Can Repeat more than once)**	**N/A**				**O**		
39		Case ID	Case ID reference for the letter (On some of the ADR letters it is the document #)	***Type:*** Character	35	O		
	Claim Details **(Section Can Repeat more than once)**	**N/A**	**Represents the elements whch are represented at the Clam details.** ***Note:*** **Section Could be repeated as many times as needed**			**R**		
40		Claim ID	The Claim Reference Number in CMS/RC system	***Type:*** Character	23	R	***Rules:*** 1. Must be present 2. Must exist in one of following formats 13 numeric characters in length, 14 numeric characters in length, 15 numeric characters in length, OR 17 – 23 variable (can include alphabets, numbers, dashes and spaces) characters in length	
41		Medical Record number	The reference number of the Beneficiary in Provider system.	***Type:*** Alphanumeric	25	O		
42		Beneficiary ID	Identifier of the Beneficiary who is receiving the Service	***Formats:*** Applicable *HICN* or *MBI* formats	12	R	***Rules:*** 1. Must be present	
43		Beneficiary First Name	First Name of the Beneficiary who is receiving the Service	***Type:*** Character	35	O		
44		Beneficiary Middle Name	Middle Name of the Beneficiary who is receiving the Service	***Type:*** Character	25	O		
45		Beneficiary Last Name	Last Name of the Beneficiary who is receiving the Service	***Type:*** Character	60	R	***Rules:*** 1. Last Name of the Beneficiary must be present	
46		Type Of Bill	Represent the Bill Type for institutuinal Claims	***Type:*** Charatcer ***Format:*** Numeric	3	O	***Condition:*** May be populated for Institutional Claims only. ***Rules:*** 1. Must be 3 numeric, when populated;	
47		Procedure Code & Modifier(s)	Procedure Code and/or associated Modifiers associated with the Claim	***Type:*** Charatcer ***Formats:*** ***(99999)*** ***(99999XX)*** ***(99999XXXX)*** ***(99999XXXXXX)*** ***(99999XXXXXXXX)*** *(HCPCS and CPT)*	5 + 8	O	***Notes:*** Can contain the Procedure code and upto a maxium of 4 Modifiers. esMD system will neither maintain the Procedure Code / Modifier values, nor, verify whether the populated value is valid.	
48		Date Of Service (From)	From Date of Service	***Format:*** mm/dd/yyyy	10	O	***Rules:*** 1. Must be a valid date, when populated;	
49		Date Of Service (To)	To Date of Service	***Format:*** mm/dd/yyyy	10	O	***Rules:*** 1. Must be a valid date, when populated, 2. Must later than the Date Of Service (From), when populated	