

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100001	Interim verbal orders		
100002	Physician/Non Physician (NPP) Admission Orders		
100003	Proof of Delivery		
100004	Referral for Diabetes Self-Management Training (DSMT) services and plan of care		
100005	Acute/post-acute care document to support home health eligibility		
100006	Acute/post-acute care document to support hospice eligibility		
100007	Addendum to record		
100008	Initial admission assessment or reassessment		
100010	CMS 2728 (End stage renal disease medical evidence report; Medicare entitlement and/or beneficiary registration)		
100011	Documentation to support continued medical need		
100012	Expected length of stay		
100013	Home health aide care plan		
100014	Home Health Plan of Care		
100015	Home Health start of care assessment		
100016	Home Health skilled nursing, home health aide, and rehabilitation therapy notes including initial evaluations, re-evaluations, progress notes, and actual therapy minute grids		
100017	Documentation that supports the beneficiary's need for the level and frequency of home health or hospice services provided, including any changes during the period under review.		
100018	Physician Certification/Recertification or Physician Certification/Recertification Statement (PCS) for all dates of service under review including period preceding dates of service and any justification for any delayed certifications		
100019	Physician certification/recertification that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the beneficiary's condition, or (2) diagnostic study		
100020	Signed and dated initial and subsequent plan of care/amendment including, short and long term goals with any updates to the plan of care		
100021	Signed election statement		

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Document Code	Document Description	Action	Release
100022	Physician consultations		
100023	CLIA certificate		
100024	Diagnostic tests, radiological reports, lab results, pathology reports, and other pertinent test results and interpretations		
100025	Results of preadmission testing and laboratory results		
100026	X-ray findings and/or bone cultures		
100027	Discharge summary from Hospital, Skilled Nursing, Continuous Care, and/or Respite Care facilities		
100028	Documentation to support evidence of follow up assessment of the beneficiary at one week, one month and three months postoperatively. This must include discussion of the beneficiary's procedure; response, prognosis and necessary follow up		
100029	Admitting diagnosis along with any diagnosis of comorbid disease and the psychiatric diagnosis if applicable		
100030	All records that justify and support the level of care received		
100031	Beneficiary body surface area (BSA) used to calculate dose given		
100032	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/are reasonable and necessary		
100033	Cardiac Risk Factors Assessment		
100034	Cardiac and/or pulmonary rehab session documentation and/or Cardiopulmonary exercise testing		
100035	Current adjunctive treatment		
100036	Description of the onset of illness and the circumstances leading to admission		
100037	Documentation of Face-to-Face Encounter and signed Attestation		
100038	Documentation of complaints, pain level including objective pain scale or function assessment (e.g., Numeric Rating Scale (NRS), Visual Analog Scale (VAS), Roland Morris Disability Questionnaire (RDQ)), and activities of daily living (ADL) limitations	Modified	Apr 2026
100039	Documentation supporting the attitudes and behaviors with estimation of intellectual functioning, memory functioning, and orientation.		

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Document Code	Document Description	Action	Release
100040	Documentation supporting the services billed are subject to a waiver/alternative payment model (APM)		
100041	Documentation to support National Coverage Determination (NCD), Local Coverage Determination (LCD), Policy Article, and/or Standard Documentation Requirement Article (A55426) requirements		
100042	Documentation to support a systemic condition, neuropathy, vascular impairment, onychogryphosis and/or onychauxis.		
100043	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 to eight weeks		
100044	Documentation to support care is being provided under the care of a physician		
100045	Documentation to support each of the Health Insurance Prospective Payment System (HIPPS) code(s) billed, including but not limited to any of the following related to each of the assessment reference date(s) (ARD); admission assessments/evaluations, orders, nurse notes, progress notes, history and physical(s), medication records, treatment records, acute hospital records.		
100046	Documentation to support information entered on the IRF PAI		
100047	Documentation to support overactive bladder syndrome (OBS) and beneficiary is a candidate for PTNS		
100048	Documentation to support severe peripheral involvement.		
100049	Documentation to support that the entire body was exposed to the oxygen increased atmospheric pressure and administered in a chamber		
100050	Documentation to support time in/out or actual time spent.		
100051	Emergency Room records		
100053	Evaluation of foot structure, vascular and skin integrity		
100054	Functional Independent Measure (FIM) records		
100055	History and Physical reports (include medical history and current list of medications)		
100056	Documentation to support homebound status		
100057	Hospital records that validate a qualifying stay		

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Document Code	Document Description	Action	Release
100058	Hyperbaric Oxygen (HBO) Therapy logs/treatment record		
100059	In hospital to hospital transfers, medical reason beneficiary could not be treated at first or initial hospital		
100060	Include an inventory of the beneficiary's assets in descriptive, not interpretative fashion		
100061	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)		
100062	Individual and group psychotherapy and beneficiary education and training		
100063	Individualized treatment plan for psychiatric services with updates		
100064	Initial hospital inpatient care		
100065	Initial psychiatric/psychological evaluation/mental status exam		
100066	IRF PAI (Patient Assessment Instrument)		
100067	Listing of most current beneficiary medications		
100068	Medical documentation detailing prior course of treatment, including all interventions and/or evaluations		
100069	Medication Administration Record (MAR) and/or Infusion Flowsheet documenting the quantity administered include a dose, route, and frequency given and/or Medication invoice or evidence of free drug program if applicable		
100070	Complete neurological examinations and/or including cognitive scales and/or documentation of unified Parkinson's disease rating scale (or equivalent) and/ or documentation of clinical tremor rating scale (or equivalent)		
100071	Office visit/E&M documentation if billed on same date of service under medical review		
100072	Outcomes assessment		
100073	Photographs showing visual impairment		
100074	Documentation to support the medical necessity of service and DRG billed		
100075	Post admission assessment/post admission physician evaluation completed within the first 24 hours of admission and supporting medical necessity of admission		
100076	Preadmission screening/notes		
100077	Pre-Hospital documentation		

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Document Code	Document Description	Action	Release
100078	Prior Level of Function (PLOF)		
100079	Psychiatric diagnostic evaluation or psychotherapy face-to-face encounter, including the time spent in the psychotherapy encounter		
100080	Psychiatric evaluation and all behavioral/psychological/psychiatric tests that have been performed		
100081	Psychosocial Assessment		
100082	Record of mental status		
100083	Records of conservative measures trialed for treatment of service provided		
100084	Respiratory treatments and oxygen therapy records		
100085	Review of beneficiary prior and current medical and functional conditions and comorbidities		
100086	Social service records - including interviews with beneficiary, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history		
100087	Subsequent hospital inpatient care		
100088	Therapy logs that show services, dates and times for code billed		
100089	Treatment plan		
100090	Types and duration of precautions (e.g., constant observation x 24 hours due to suicidal plans, restraints).		
100091	Visual field measurement/documentation		
100092	Date/time of administration of associated chemotherapy		
100093	Documentation to support the E/M service was significant and separately identifiable from the nail debridement	Modified	Apr 2026
100094	Dialysis treatment sheets		
100095	Documentation to support reason not transporting to nearest facility		
100096	Documentation to support type and amount of contrast given		
100097	Documented pharmacologic management to include prescription and dosage adjustment/changes		
100098	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.)		

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Document Code	Document Description	Action	Release
100099	Information for any clinical trial name, enrollment documentation, sponsor of the clinical trial, and sponsor-assigned protocol number		
100100	Documentation to support nasal endoscopy on the same day with more than one provider		
100101	Operative/procedure report		
100102	Paring or cutting procedures on the skin		
100103	Signed requisitions for lab services		
100104	Stage of treatment for accurate dose administration calculation for the drug; (i.e. First dose or subsequent dosing)		
100105	Wound care assessment and supporting documentation		
100106	Social Worker initial assessment		
100107	All group psychotherapy notes including number of participants		
100108	Breakdown of hours if nurse and aide visits combined are more than two times a day		
100109	Caregiver Notes		
100110	Documentation to support the beneficiary has diabetes, a lower extremity wound due to diabetes, the wound is classified as Wagner grade III or higher, and has failed a course of standard wound therapy	Modified	Apr 2026
100111	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		
100112	All documents needed to support Home Health services including physician's order or referrals		
100113	Interdisciplinary Group (IDG) Reviews for dates of service under review and the benefit period preceding dates of service under review		
100114	If nurse visits are daily or more, statement of endpoint when nurse visits are expected to decrease to less than seven days a week		
100115	Initial nursing facility visit		
100116	Subsequent Nursing Facility Visit(s)		
100117	All documents needed for a Nursing Home Review		
100118	Progress reports written by the clinician-services related to progress reports are to be furnished on or before every 10th treatment day		

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Document Code	Document Description	Action	Release
100119	Physical Therapy (PT)/Occupational Therapy (OT)/Speech Language Pathology (SLP) – Initial evaluation/re-evaluation, plans of care, progress reports, treatment encounter notes, therapy minute logs, and discharge summary		
100120	Therapeutic activities program for beneficiary		
100121	Office visit with injection		
100122	Diagnostic/Vascular studies		
100123	Nutritional evaluation, consultations, and progress notes		
100124	Documentation of presurgical conservative measures/treatments		
100125	Ambulance records for the billed date of service including run sheets, Physician Certification Statements (PCS), Physician Medical Necessity Certification (PMNC) Statements, procedures and supplies used, base rate and cost per mile and any other documentation to warrant transport		
100126	Medical justification for transport and/or transfer.		
100127	P9603 One Way Mileage		
100128	All medical record documentation must have at least two identifiers to include, at a minimum, the beneficiary name and date of service.		
100129	Coding query form		
100130	Advance Beneficiary Notice of Non-Coverage (ABN)/Notice of Medicare Non-Coverage (NOMNC)		
100131	Advance Beneficiary Notice		
100132	Assignment of Benefits		
100133	Demand bill- notice of non-coverage indicating request for Medicare to review		
100134	Facility Denial Letter		
100135	FISS Page 7 screen print/copy of ADR letter		
100136	Hospital-issued notice of non-coverage (HINN) on file		
100137	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		
100138	Local 911 Ambulance Dispatch Protocols		
100139	Notice of non-coverage		
100140	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		

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Document Code	Document Description	Action	Release
100141	Beneficiary identification, date of service, and provider of the service should be clearly identified on each page of the submitted documentation		
100142	Pictures where necessary		
100143	Quality Improvement Organization (QIO) letter		
100144	Questions related to ADR		
100145	Revocation Statements		
100146	Signature log or signature attestation for any missing or illegible signatures within the medical record (all personnel providing services)		
100147	Initial DME Information Form (DIF), and any recertification and/or revised DIFs		
100148	Initial Certificate of Medical Necessity (CMN) and any recertification and/or revised CMNs		
100149	If the beneficiary has same or similar equipment, documentation indicating the reason new equipment is necessary		
100150	Documentation of the request for refill		
100151	Physician, Technician, Sleep Center and/or Laboratory Accreditation Certification in Sleep Medicine		
100152	Physician/Non-Physician Practitioner (NPP) certification of Plan of Care for Claim Period Including Justification when the Certification is Delayed More than 30 Days		
100153	RESNA Certification of Assistive Technology Professional (ATP)		
100154	OASIS documentation (certifications, recertifications, follow-ups and significant change).		
100155	Facility Utilization Review Plan (ONLY if used in lieu of Certifications or Recertifications for Extended Care Services)		
100156	Physician/Nonphysician (NPP) coding queries		
100157	Medical clearance		
100158	Chaplain initial assessment		
100160	Therapy treatment plan and notes that demonstrate failed behavioral and/or pharmacologic therapies		
100161	Manufacturer's invoice containing make, model number, quantity and cost of item provided		
100162	Cost invoice for all supplies		
100163	Supplier or Licensed/Certified Medical Professional (LCMP) Attestation		
100164	Supplier beneficiary information forms		

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Document Code	Document Description	Action	Release
100165	List of all personnel billing services under your NPI. List credentialing, training, licensure, etc., of all personnel performing services under your NPI.		
100166	On Site Home Evaluation		
100167	Documentation of procedures for emergency management of beneficiaries		
100168	Electrocardiogram (ECG) and response by monitoring entity		
100169	Summary report at the end of the monitoring episode		
100170	Documentation of plan for quality control for electrocardiogram (ECG) surveillance		
100171	Documentation of plan to ensure uninterrupted 24/7 surveillance of beneficiaries		
100172	Beneficiary Care Instructions for a Hospice Aide/Homemaker		
100173	Records of nursing, aide, home maker visits to support times and dates billed		
100174	DME Information Form (DIF)		
100175	DME Documentation of continued Need and Use		
100176	Plan of Care/Updates and Interdisciplinary Team/Group (IDG/IDT) notes with full list of participants and clear distinction of professional disciplines to cover all days in this billing period, which may include the latest update prior to this billing period		
100177	Sleep Oximetry Study Results		
100178	Polysomnography Results		
100179	Epworth Sleepiness Scale		
100180	Download of Usage Data from PAP Device		
100181	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 (all 5-day assessments); and documentation supporting the look back period under review based on the Assessment Reference Date (ARD)		
100182	Documentation to support each of the look back periods which may fall outside the billing period under review		
100183	Documentation up to 30 days prior to the first assessment reference date		
100184	Date the beneficiary started therapy		
100185	Photograph and/or detailed description of service		

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100186	Eye exams showing deterioration of visual acuity, lesion progression and/or lesion growth not only the OPT treatment notes		
100187	All Visual Field Testing		
100188	Comprehensive preoperative ophthalmologic evaluation including but not limited to: examination/testing, best corrected Snellen visual acuity and corrected vision with glasses or contacts		
100189	Documentation to support impairment of visual function due to cataract, which impacted activities of daily living	Modified	Apr 2026
100190	Physician supervision and evaluation		
100191	Anesthesia records (including pre- and post-anesthesia).		
100192	Preoperative evaluations including anesthesia evaluation		
100193	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		
100194	Initial evaluation/re-evaluation signed by ordering physician or practitioner		
100195	Initial evaluation (intake notes), including all beneficiary questionnaires		
100196	Specific Skilled Procedures and Modalities		
100197	Medical records for any previously tried medical treatment for obesity, including structured dietary programs.		
100198	Medical literature that supports off label drug use		
100199	Urinary and Fecal Incontinence Diaries, Voiding Diaries and/or Urodynamic Studies		
100200	SPECT/Cardiac Perfusion Studies		
100201	Previous SPECT results		
100202	PET Scan reports and results		
100203	Imaging studies including, but not limited to, CT, MRI, PET		
100204	Complete neurological examination		
100205	Evidence of trial test stimulation results		
100206	Test Stimulation Results		
100207	Diagnostic Studies, including visual acuity and glare tests		
100208	Evaluation and biometry		
100209	Practitioner, nurse, and ancillary progress notes		

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Document Code	Document Description	Action	Release
100210	Signed Consent Form		
100211	Surgical recommendation		
100212	Documentation of the product, NDC, strength		
100213	Electrocardiogram (EKG) report		
100214	Stress Test report		
100215	Echocardiogram report		
100216	Documentation of pain, comprehensive evaluation of pain source, asymmetry/misalignment, range of motion (ROM), tissue/tone (PART) if no x-ray available		
100217	Trans Thoracic Echocardiogram (TTE) report		
100218	Telemetry Tracings		
100219	Electrophysiology Studies (EPS)		
100220	24-Hour Holter Monitor report	Modified	Apr 2026
100221	Physician Directed Home Treatment Regimen		
100222	Alternative Treatment Consideration		
100223	Description of the Device used in the Procedure		
100224	Documentation to support the skilled nature of care during the admission		
100225	Documentation for the 30 days immediately prior to the acute hospital and/or skilled care admission		
100226	The most recent Minimum Data Set (MDS) prior to the start of therapy services		
100228	Documentation supporting the diagnosis code(s) required for the item(s) billed		
100229	Orthotist or prosthetist's functional evaluation documentation supporting the need for a custom fabricated device		
100230	Preadmission Notes		
100231	Referral for echocardiography services		
100232	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		
100233	Documentation supporting comorbid condition(s) related to obesity		
100234	Documentation of beneficiary BMI		
100235	Documentation supporting previous medical weight reduction treatments prior to the surgery		
100236	Counseling Records		

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Document Code	Document Description	Action	Release
100237	Documentation to support that the beneficiary is enrolled in an approved prospective clinical study		
100238	Full Itemization of Services		
100239	Authorization of Benefits		
100240	Beneficiary Election form		
100242	Documentation Supporting Clinical/Facility Hours of Operation		
100243	Multidisciplinary evaluation prior to the surgery		
100245	Beneficiary identification data including legal status		
100246	Documentation of the devices, implants, biological products used		
100247	RAP (Request for Anticipated Payment)		
100248	Rent/purchase option		
100249	Statement of Endpoint, if nurse visits are daily or more frequently		
100250	Hospice Notice of Election and addendum		
100251	Hospice Certification of Terminal Illness (Initial, subsequent to cover billed dates of service and for the benefit period preceding dates of service under review), from Certifying Physician and Attending Physician (if applicable) including written and oral/verbal certification (if applicable) and Physician's narrative		
100252	Physician/Non Physician (NPP) order or evidence of intent to order		
100253	Documentation supporting wastage of medication		
100254	Names, credentialing, and privileges within the facility of consulting physicians related to utilization management. (need for IRF, IPPS, and surgical services)		
100255	Vital sign records, weight sheets, care plans, treatment records		
100256	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.		
100257	Referral Documentation		
100258	The beneficiary's response to the therapeutic interventions provided by the PHP		
100259	Treatment goals for coordination of services to facilitate discharge from the PHP/CMHC.		
100260	Behavior monitoring flow sheets		

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Document Code	Document Description	Action	Release
100261	Treatment team, person-centered active treatment plan, and coordination of services		
100262	Any other supporting/pertinent documentation		
100263	Written documentation on the costs of the item to include design fabrication, assembly and materials and labor of those performing the customization		
100264	Written documentation to support necessary use of custom design fabrication, assembly and materials		
100265	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		
100266	Documentation to meet LCD criteria for beneficiaries entering Medicare		
100267	Home assessment indicating the power mobility device is able to access all rooms of the home		
100268	A complete facility-based, attended polysomnogram		
100269	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		
100270	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		
100271	Statement of Certifying Physician for Therapeutic Shoes		
100272	Documentation from the prescribing/ordering physician		
100273	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 oxygen therapy records)		
100274	Confirm that intention to bill either modifier PA (surgery, wrong body part), PB (surgery, wrong beneficiary), or PC (wrong surgery on beneficiary) for this service		

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Document Code	Document Description	Action	Release
100275	Documentation supporting the medical necessity of NPLATE(TM)(ROMIPLOSTIM) where there is insufficient response to corticosteroids, immunoglobulins, or splenectomy and the administration record		
100276	The clinical indication/medical necessity for the injection including the number and location of injections as well as dosages and medications used		
100277	The topical corticosteroid(s) given previously to beneficiary for ocular inflammatory condition prior to current treatment		
100278	Documentation showing enrollment in the touch prescribing program		
100279	Touch program certificate (indicating the beneficiary has been approved by the program to receive TYSABRI)		
100280	Documentation to support the assay was approved by the Food and Drug Administration (FDA)		
100281	Documentation to support the assay was developed by the laboratory		
100282	Provide the following information if this is a modified FDA approved assay		
100283	Describe the modification or change and submit the study performed to validate the modification		
100284	Complete description of the test performed		
100285	Description of the disease		
100286	Meaning of a positive test result		
100287	Meaning of a negative test result		
100288	Statement regarding test limitations		
100290	Interpretive statement, which specifically explains the test results and how it will be used in the beneficiary's care		
100291	Method(s) used		
100292	Documentation that supports the clinical significance of the test performed		
100293	Documentation that show the cross-walked codes previously used to bill this service		
100294	Full text peer reviewed articles		
100295	Society guidelines		
100296	Physician referral (prescription, treatment or diagnostic test)		

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Document Code	Document Description	Action	Release
100298	Detailed billing sheet for all charges associated with this visit, identifying the items, ICD-10 and/or PCS codes billed		
100299	Hospital purchasing invoice showing rate per unit paid by hospital for the unlisted drug billed		
100300	Any applicable invoices for services performed or supplies (e.g., fiducial markers)/devices		
100301	Documentation supporting beneficiary is a candidate for anticoagulation therapy		
100302	The number of days the beneficiary has received warfarin, in the anticoagulation regimen for which the pharmacogenomic testing was ordered		
100303	Documentation supporting previous tests results for CYP2C9 or VKORC1 alleles		
100304	Itemized breakdown of charges and subtotals per specific revenue code range(s) including the total charges of all revenue codes billed		
100305	Explanation/reason for noncoverage		
100306	Proof of phone calls		
100307	Certified mail pertinent to the NCC		
100308	Proof of the representative's right to sign the NNC (for the beneficiary if necessary) and the request checked for intermediary review		
100309	Power of attorney paper or health surrogate papers		
100310	Face sheet(s)		
100312	Blood level for plasma cotinine and/or arterial carboxyhemoglobin		
100313	Documentation indicating use of smoking or nicotine products		
100314	Documentation to support therapeutic program adherence		
100315	A statement by the treating physician documenting the special need for performing IMRT on the beneficiary 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		
100316	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		

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100317	Radiation oncologist review of dose-volume histograms for all targets and critical structures		
100318	Description of the number and location of each treatment step/rotation or portal to accomplish the treatment plan		
100319	Documentation of dosimetric verification of treatment setup and delivery, signed by both the radiation oncologist and the medical physicist		
100320	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		
100321	Admissions face sheet		
100322	The diagnosis of neovascular (wet) macular degeneration has been firmly established (fluorescein angiogram)		
100323	Documentation of a second opinion of a psychiatrist who is not involved in the care of the beneficiary		
100324	Beneficiary's compliance, and response to treatment		
100325	Documentation supporting contraindication to conventional endoscopy		
100326	Please advise us as to which OSCAR you wish to have payment made		
100327	Assistant Surgeon Additional Documentation Request needed to support exceptional circumstance and establish medical necessity.		
100328	All other records that support medical necessity for the two surgeons		
100329	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		
100330	This additional development request is a review of co-surgeon charges.		
100331	Diagnostic testing results related to the unlisted code		
100332	Itemized statement/bill/invoice		
100333	Any other documentation related to the unlisted code billed and claim services		
100335	Medicare Card		
100336	Documentation showing provider number you want used to bill claim (multiple provider numbers for same NPI)		

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100337	Our records indicate that more than one number exists that corresponds to your national provider identifier (NPI). Please advise which legacy number type you wish to have payment made, and correspondence sent for this claim.		
100338	Documentation that support a fire, flood, earthquake, or other unusual event that caused extensive damage to an agency's ability to operate		
100339	Documentation of an event that produced a CMS or CGS data filing problem which was beyond the agencies control		
100340	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		
100341	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		
100342	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		
100343	Documentation in support of the hospice exception request for filing the NOE more than 5 calendar days after the hospice admission date		
100344	WPATH criteria-specifically which criteria and how it was met		
100345	Documentation of hormone or other medication regimen		
100346	Documentation to support that the service provided was medically necessary and not cosmetic		
100347	Documentation to clearly identify the unlisted procedure/medication		
100348	Invoice showing amount you paid for the implantable device/DME		
100349	Clearly marked documentation to support the beneficiary received the items invoiced		

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100350	Observation greater than 48 hours		
100351	An itemized medical supply list if supplies are billed		
100352	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.		
100353	Ra prepayment review demonstration project MS-DRG 312 - syncope and collapse - 2-day LOS or less. New York state providers only		
100354	Explanation of the beneficiary's medical conditions/circumstances that make usage of a custom piece of durable medical equipment necessary.		
100355	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.		
100356	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.		
100357	Warranty(s)		
100358	Explanation of why the parts and labor billed should be considered as included in the warranty		
100359	5601/overlap letter		
100360	List of all personnel billing services under your NPI. List credentialing, training, licensure, etc., of all personnel.		
100361	Wound care notes		
100362	Travel Log		
100363	Signature and credentials of all personnel providing services. Include a signature log or signature attestation for any missing or illegible signatures within the medical record.		
100364	List of all non-standard abbreviations or acronyms used, including definitions		
100365	Signed pick up slips		
100366	Documentation from treating practitioner and/or supplier for servicing, repair, or replacement of DMEPOS		
100367	Clinical information supplied to the lab by the ordering physician, including diagnosis codes and narratives		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100368	Itemized statement of all billed charges (including charge code descriptions)		
100369	Documentation of therapeutic activities		
100370	Diagnostic/other tests and results		
100371	Multi-discipline treatment plan		
100372	Billing Forms, all that apply		
100373	All behavioral/psychological/psychiatric tests that have been performed.		
100374	Transfer sheet		
100376	Discharge summary from acute care		
100377	Hospice Plan of Care (initial and updates) covering all specified dates of service plus two qualifying periods		
100378	Hospital documentation (during qualifying period)		
100379	Discharge orders		
100381	Transfer, Discharge, and/or revocation documentation		
100382	Hospice initial and comprehensive assessment, and updated assessments covering all specified dates of service		
100383	Chaplain Records		
100385	Policies and Procedures for Management and Disposal of Controlled Drugs		
100386	Documentation that demonstrates the medical necessity of the chiropractic treatment		
100387	Treating practitioner's written order		
100388	Total number of beneficiaries transported by ambulance together		
100389	Time of day for each operative session for this beneficiary on this date		
100390	Imaging reports prior to the visits or treatments		
100391	Latest hemoglobin and hematocrit levels prior to the administration of medication(s)		
100392	Legible fluorescein angiography or OCT reports including photographs and descriptions of the lesion(s)		
100393	Documentation to support National Coverage Determination (NCD), Local Coverage Determination (LCD) and/or Policy Article		
100394	Election of Religious Nonmedical Health Care Institution (RNHCI) Benefits Questionnaire response as described in CMS IOM Publication number 100-2 Medicare Benefit Policy Manual, Chapter 1, Section 130.2		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100395	Copy of Prior Authorization decision letter which includes assigned UTN		
100396	Documentation to support virtual service(s) provided: Telehealth, E-Visit(s), Virtual Check-In		
100397	Standard Written Order (SWO)		
100398	Written Order Prior to Delivery (WOPD)		
100399	Documentation to support caregiver availability to assist the beneficiary with ADLs, per LCD for the DMEPOS item billed		
100400	Any other documentation supporting the hospice terminal illness and related conditions, and the six-month terminal illness prognosis		
100401	Documentation that supports lymphedema being unresponsive to other clinical treatment over the course of a required four-week trial		
100402	Medical record documentation that describes in detail the underlying medical condition, treatment interventions, and effectiveness of the treatment		
100403	Medical record documentation that justifies the use of a pump		
100404	Medical record documentation that adequately describes the medical condition requiring the special nutrient formula		
100405	Documentation that provides sufficient information to verify the item provided was a product that has received coding verification review from the PDAC and is listed in the Product Classification List on the PDAC web site		
100406	Medical record documentation of knee exam with objective description of joint laxity (e.g., Varus/valgus instability, Lachman test, anterior/posterior Drawer test)		
100407	Documentation that supports a certified orthotist or specialized trained individual performed custom fitting of the item and describes the custom fitting that was performed to fit the item to the individual beneficiary		
100408	Medical record documentation that describes and supports other treatment(s)/medication(s) was tried and failed or was considered and ruled out		
100409	Copy of the beneficiary's testing log or treating practitioner's record, which adequately documents the frequency at which the beneficiary is actually testing blood sugar.		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100410	Documentation from the treating practitioner that certifies that the beneficiary has a severe impairment requiring the use of the special monitoring system.		
100411	Documentation that support the concurrent presence of at least one of the signs/symptoms/lab findings listed in LCD criteria and at least two urine culture results that confirm a UTI		
100412	Medical record documentation that supports the specific reason the treating practitioner ordered a frequency/quantity that exceeds utilization guidelines		
100413	Supplier documentation for custom molded shoes/inserts with information regarding taking impressions, making casts, or obtaining CAD-CAM images of the beneficiary's feet that will be used in creating positive models of the feet.		
100414	Supplier's documentation that verifies that the beneficiary has appropriate footwear into which the inserts can be placed, if separate inserts were dispensed independently of diabetic shoes.		
100415	Documentation of the supplier in-person evaluation, prior to or at the time of selection of items, that includes exam and measurements of the feet with description of the abnormalities needed to be accommodated by the shoes/inserts/modifications		
100416	Documentation supporting the reason and diagnosis associated with all previous stem cell treatments and outcome		
100417	Documentation to support the code(s) and modifier(s) billed		
100418	Mini mental status exam (MMSE) or similar test score		
100419	Ocular Photodynamic Therapy (OPT) treatment notes, including initial and subsequent treatments		
100420	Detailed Product Description (DPD)		
100421	Supplier's record documentation showing the reason for item(s) being replaced		
100422	Supplier documentation of in-person visit and evaluation and measurements prior to selection of item(s)		
100423	Supplier documentation of objective assessment at the time of in-person delivery		
100424	Reason and results for Duplex Study		
100425	Reason and result for the Nerve Conduction Study		
100426	Pre, post, or intra-operative diagnostic studies		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100427	Medical documentation detailing prior course of treatment, but not limited to, frequency and number of past injections, non-surgical/non-injection care involved, duration and effectiveness of treatment		
100428	CEAP Classification and VCSS score including the date(s) of exam and diagnostic evaluation, as appropriate		
100429	Documentation regarding prior interventions provided and the effectiveness of treatments		
100430	Documentation that provides detailed medical information, including but not limited to objective description of the patient's signs/symptoms, relevant history, medical condition, mobility, functional, and mental status before and after the ambulance trip, as well as other on-scene information, assessment/exam, treatment/specific monitoring, patient's response to interventions, change in patient's condition, and any other special circumstances		
100431	Documentation that shows the name and total calculated dosage (mg) of the photodynamic therapy drug administered, the patient's body surface area on which the dose of the drug is based, and the amount of drug wasted		
100432	Documentation that supports special program involved		
100433	Initial Hyperbaric Oxygen Therapy (HBOT) evaluation/consultation		
100434	Pharmacy Record		
100435	Proof of attempts if the required physician certification statement could not be obtained		
100436	Biopsy results must be included		
100437	Any other documentation prior to the course of treatment such as but not limited to intraaortic balloon pump (IABP) therapy and/or left ventricular ejection fraction (LVEF)		
100438	Manufacturer's serial/lot/batch or other unit identification number of the skin substitute material		
100439	Medical documentation indicating that the beneficiary is mobile in the home		
100440	For initial supply of drugs, documentation to support the drugs were furnished on or after the date of discharge from the hospital following a covered organ transplant		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100441	Medical record documentation that supports the drugs were prescribed following one of the covered transplants outlined in applicable Medicare National and/or Local Coverage Determination (NCD or LCD)		
100442	Documentation that supports non-healing		
100443	Documentation that supports greater than half of the total care provided was nursing care, delivered by an RN/LPN/LVN		
100444	New York Heart Association (NYHA) Classification of heart failure		
100445	Documentation of skin substitute utilized, how the product was supplied and wastage		
100446	Medical record that supports beneficiary had in-person visit with the treating practitioner to evaluate diabetes control and/or adherence to the CGM regimen and diabetes plan		
100447	Organ Procurement and Transplantation Network (OPTN) heart transplant waitlist documentation		
100448	Forms containing Beneficiary/Authorized representative signature		
100449	Cardiac imaging and/or Cardiac catheterization report		
100450	Medical record documentation to support beneficiary having two or more chronic conditions (expected to last at least 12 months) with significant risk of death, functional decline, exacerbation, or decompensation		
100451	Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE) or comprehensive Evaluation and Management (E/M) performed prior to billing CCM services for a beneficiary new to Chronic Care Management (CCM) or for beneficiaries not seen by the billing provider within the last 12 months		
100452	Verbal consent or a written consent signed by beneficiary or caregiver and must include the following; description of the Chronic Care Management (CCM) services, ability to revoke/right to stop CCM services, responsibility for cost sharing and if verbal consent obtained for CCM, documentation to support narrative discussion and prior permission acceptance		
100453	Comprehensive care plan with measurable goals was established, implemented, revised, or significantly monitored and a copy was provided to the beneficiary and/or caregiver		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100454	Medical record documentation to support time spent on services for the CPT level of code billed		
100455	Documentation to support availability of services 24-hours-a-day, 7-days-a-week		
100456	The medical necessity for the use of in vitro testing if used, including the measurement (in mm) of reaction sizes of both wheal and erythema response		
100457	Clinical indication(s) and management that necessitate the need for a PET study		
100458	Documentation to support bypassing condition of payment prior authorization for emergent need		
100459	Acute/post-acute care document to support IRF/SNF eligibility		
100460	Documentation to support the staging of the tumor		
100461	Documented to support the reason for the defibrillator		
100462	Documentation to include maximum urinary flow rate (Qmax), International Prostate Symptom Score (IPPS), and Transrectal Ultrasound (TRUS)		
100463	Documentation to support drug-induced sleep endoscopy (DISE) procedure was performed and the results	Modified	Apr 2026
100464	If face-to-face visit conducted via telecommunication technology, documentation also supports the visit was completed using acceptable audio/visual equipment permitting two-way, real-time interactive communication between the beneficiary and the physician or other allowed practitioner		
100465	CMS Health Insurance Claim Form		
100466	Hospice Election Statement and addendum		
100467	CT Coronary Angiography report		
100468	Documentation to support two-way, real-time audio/visual communication for billed codes	Modified	Apr 2026
100469	Documentation to support the service was audio-only and not related to an E/M visit provided within the prior 7 day or 24 hours after the DOS for billed codes	Modified	Apr 2026
100470	Names, licenses and NPI's for the medical directors, physicians, and advanced practice providers active during the review period		
100471	All Physician Orders, including medications, level of care changes such as General Inpatient (GIP),		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
	Continuous Homecare (CHC), Routine Homecare (RHC), Respite care, and any DME		
100472	All documentation to support the medical necessity of the services billed, such as but not limited to: Hospital discharge summaries, any recent History & Physical Exams, Consultations, and all skilled nursing, home health, or other facility notes, Pathology reports and other diagnostic imaging or tests, Records from the referring physician, Medication administration record (MAR), weights and measurements, and treatment administration record (TAR) for the period under review, if available		
100473	If the beneficiary qualified for a waiver of the qualifying hospital stay (QHS) due to Accountable Care Organization (ACO), documentation of the ACO physician evaluation and approval for admission to the SNF within three days of admission		
100474	Physician's order with signature and date, evaluation and approval for admission to the SNF within three days of admission		
100475	Documentation to support the necessity of medications administered		
100476	Minimum Data Set (MDS) submission validation report and UB04/CMS-1450 form		
100477	Documentation of wound care assessments to include measurements, evidence of healing or non-healing and photographic evidence if applicable	New code added	Apr 2026
100478	Documentation of application frequency, clinical justification for repeat applications, and response to prior treatment	New code added	Apr 2026
100479	Summary of conservative measures attempted, treatments provided, and response supporting medical necessity	New code added	Apr 2026
100480	Documentation to support the vial size and number of vials used for administration of drug	New code added	Apr 2026
100481	Documentation to support the unit(s) billed	New code added	Apr 2026
100482	Response to provocative tests (e.g. thigh thrust test, compression test, Gaenslen's test, distraction test, Patrick's sign, posterior provocation test)	New code added	Apr 2026

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
100483	Medical record documentation to support the beneficiary would be bed confined without the use of the patient lift	New code added	Apr 2026
100484	Medical record documentation to support the beneficiary requires supine positioning for transfers	New code added	Apr 2026
100485	Home Health Aide supervisory assessment documentation	New code added	Apr 2026
100486	Documentation of sleep staging ,including electroencephalogram (EEG),Electrooculogram (EOG),submental electromyogram (EMG) results	New code added	Apr 2026
100487	Documentation to support continuous positive airway pressure (CPAP) failure or CPAP intolerance	New code added	Apr 2026
150001	More documents requested, please refer to the PDF copy of the ADR Letter		
150002	Please refer to the PDF copy of the ADR Letter for requested documents		
150003	Documents requested are yet to be assigned a code, please refer to the PDF copy of the letter		
700001	From initial admission to current		
700002	1 year to date of service		
700003	Date of service-on admit		
700004	Admit to discharge		
700005	From bene enrollment		
700006	DOS if SNF, different for outpatient therapy		
700007	Start of therapy		
700008	DOS		
700009	Years to DOS		
700010	Most recent to DOS		
700011	DOS and 7 day look back period		
700013	Prior to admit		
700015	Most recent		
700016	DOS billed/admit		
700017	Admit/initial evaluation		
700018	Most recent notes		
700019	All recent		
700020	Most recent notes containing information		
700022	Initial evaluation/start of therapy		

eMDR Document Codes List (April 2026 Release)

Document Code	Document Description	Action	Release
700023	Admit		
700024	DOS billed and look back period		
700025	DOS billed/when given if SNF demand		
700026	Most recent being used to support		
700027	DOS billed/when received		
700029	Most recent-could be years prior to DOS billed		
700030	Most recent note with information		
700031	For the dates of service billed on the claim		
700032	30 days prior to the dates of services billed		
700033	Due Date		
700034	within the required time-frame		
700035	as outlined in the NCD, LCD and/or LCA		
800001	if applicable		
800002	Ordering Provider NPI		
800003	Ordering Provider Name		
800005	PHP Services		
800006	Extended Care Services		
800007	Unlisted Code		
800008	Provenge treatment		
800009	IPPS		
800010	For both surgeons		
800011	Home Health Aid		
800012	PACU		
800013	Consultant		
800014	Including preoperative ophthalmologic		
800015	General Inpatient (GIP), Respite and/or CHC documentation		
800016	Units of service billed		
800017	Including but not limited to serial hemoglobin and hematocrit levels, serum iron, transferrin saturation, ferritin, or bone marrow storage		
900001	Special OTHER parameter request - Refer to letter		
900002	Special TIME-BASED parameter request - Refer to letter		