

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13783	Date: May 27, 2026
	Change Request 14437

SUBJECT: Creating Additional Medicare Secondary Payer (MSP) Error Codes to Better Identify Incoming MSP Claims that Conflict with MSP Records Found on the Common Working File (CWF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to add additional MSP error codes that better identify Part B and Durable Medical Equipment (DME) MSP claims that conflict with current MSP Group Health Plan (GHP) records in CWF.

EFFECTIVE DATE: October 1, 2026

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 5, 2026

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
R	5/20/20.4.3 - Operationalizing ORM for Liability, No-Fault, and Workers' Compensation Situations
R	6/40/40.8 - MSP Utilization Edits and Resolution for Claims Submitted to CWF

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:

**Business Requirements
Manual Instruction**

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	Note: CWF/BDS shall return trailers 03, 08, 39 for Utilization Error Code '6844'. Edit '6844' will be overridable at the detail.									
14437.3.1	The contractors shall accept the new 6844 error code. Note, the new edit only applies to HUBC and HUDC claims.		X		X					
14437.3.2	The Part B MACs shall create an 'I' Record when possible following 'I' record procedures when the 6844 error code is received. Note, for a Part B MAC if an "I" record is not possible because the record is missing vital information, then the Part B MACs and DME MACs submit an Electronic Correspondence Referral System (ECRS) request as necessary. Note, Action Code MT is used when appropriate.		X		X					
14437.3.3	The Part B and DME MACs shall submit an ECRS request to have the incorrect MSP Type end dated when another record is to be created with the correct MSP Type when the 6844 error code is received and an 'I' record cannot be created. Note: CWF secondary disposition of E or F is used depending on how the identified MAC wants the claim to suspend.		X		X					
14437.3.4	Part B and DME MACs shall use Claim Adjustment Reason Code (CARC) 16, Claim/service lacks information or has submission/billing error(s), with Group Code (GC) 'CO,' Contractual Obligation, to return the claim: Claim/service lacks		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	Error Code '6845'. Edit '6845' will be overridable at the detail.									
14437.4.1	<p>The contractors and DME MACs shall accept the new 6845 error code. Note, the new edit only applies to HUBC and HUDC claims.</p> <p>Note: The claim suspends for MAC review when the 6845 error code is received. An "I" record is created if there is enough information on the claim to create the CWF MSP record or the MAC will submit an ECRS Inquiry if further claim development is required. Part B MACs shall set up their CW screens to auto-create the "I" record for consistency and suspense reduction when "I" record creation is applicable.</p>		X		X					
14437.5	Part B and DME MACs shall test this change request as deemed necessary.		X		X					
14437.6	Part B MACs, DME MACs and the designated shared systems shall hold weekly meetings with CMS, as necessary, to discuss and resolve any testing issues and concerns before production is implemented.		X		X		X	X	X	
14437.6.1	There shall be a maximum of 60 minutes for each testing call with a total number of 4 calls held once a week. Please send your attendee contact information to Richard.Mazur2@cms.hhs.gov .		X		X		X	X	X	
14437.7	MCS shall create new functionality that aligns with CMS CR 13591-72155, which further enhances automation, allowing Part B MACs to		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Othe r
		A	B	HH H		FIS S	MC S	VM S	CW F	
	systematically override MSP CWF error codes that should be paid conditionally, specifically MSP error codes 6819 and 6833.									
14437.7.1	The new MCS override shall include mapping of the correct audit narrative message and systematically transmitting the claim back to CWF.						X			
14437.8	<p>The Part B MACs shall apply the following conditional payment informational messages to the claim per previous guidance in CMS CR BR 13591.5.3.1:</p> <ul style="list-style-type: none"> Remark M32 - Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service. Remark N4 — Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB. 		X				X			
14437.8.1	MCS shall include mapping of the narrative message.						X			

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

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

VI. CONTACTS

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

VII. 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: 0

Medicare Secondary Payer (MSP) Manual
Chapter 5 – Contractor MSP Claims Prepayment Processing
Requirements
(Rev. 13783 Issued: 05-27-26)

20.4.3 - Operationalizing ORM for Liability, No-Fault and Workers' Compensation Situations

(Rev. 13783; Issued: 05-27-26; Effective: 10-01-26; Implementation: 10-05-26)

The A/B MACs, DME MACs and shared system maintainers shall accept and process a revised MSP 03 trailer response from CWF that will now include the 1- byte ORM indicator with valid values.

The A/B MACs, DME MACs and shared systems shall accept and process the three (3) new overridable utilization error codes (68xx) when returned with an 08 trailer. These 3 new error codes will be for Liability (including self-insurance), No-Fault, and Workers' Compensation records on CWF. These error codes are:

6816 --"No-Fault record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed."

6817--"Workers' Compensation record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed. "

6818 - - "Liability record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed."

When determining whether to apply any of the above 3 new error codes, as applicable, CWF shall take the following steps by referencing the MSP auxiliary file:

- (1) Validate that the ORM indicator on the open MSP ORM record on CWF equals "Y"; and
- (2) Determine if the diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF.

If CWF determines that any of the 68xx error codes discussed in the previous paragraph above apply, it shall return them to the A/B MAC or DME MAC with disposition code equal to a UR. In addition, when CWF returns any of the 68xx edits to the A/B MACs and DME MACs, CWF shall also return a trailer 39 to the A/B MACs and DME MACs to make certain that, as applicable, they can determine to which service detail line the 68xx edit applies.

Additionally, CWF shall ensure that error code 68xx may be overridden by A/B MACs, DME MACs and shared systems as follows:

- Allow the 68xx to be entered in the claim header if applicable to the entire claims on which MSP NGHP diagnosis codes do not apply; or
- Allow for individual claim service lines on which MSP NGHP diagnosis codes do not apply to be overridden with an "N." (NOTE: In these cases, CWF shall not apply the line level override to the entire claim but only to the identified claim service detail lines.)

The A/B MACs, DME MACs and shared systems shall accept the three (3) new overridable utilization error codes (68xx) when returned via the 08 trailer.

When applying the 68xx editing logic to the applicable Liability, No-Fault, or Workers' Compensation record, CWF shall ensure that open NGHP MSP records with a "Y" ORM indicator are given precedence over another NGHP record, where all other variables except the ORM indicator match.

A/B MACs Claims Processing Instructions

When the A/B MACs (Part A), A/B MACs (Part HHH) and shared systems deny a claim, with an open ORM occurrence (with an indicator of “Y”), they shall create a “22” No Pay Code in the appropriate claim line and header of their HUIP, HUOP, HUHH, HUHC claim before sending it to CWF.

When the A/B MACs (Part B) and DME MACs and shared systems deny a claim, with an open ORM occurrence (with an indicator of “Y”), they shall create a “22” Payment Denial indicator in the HUBC and HUDC claim header transactions before sending them to CWF. In addition, they shall create a “22” in the claim detail pay process field before sending the claim to CWF.

Specified CARCs to Use in Denying Claims Due to ORM

The A/B MACs, DME MACs and shared systems shall include the existing Claim Adjustment Reason Codes (CARCs) 19, 20, and 21, as applicable, on the outbound 835 and the 837 crossover claims when denying claims due to ORM, together with CAS Group Code **CO**. These three (3) CARC codes are defined as follows:

CARC 19 -- “This is a work-related injury/illness and thus the liability of the Workers’ Compensation Carrier.” [Associated Remittance Advice Remark Code (RARC) is N728.]

CARC 20 – “This injury/illness is covered by the liability carrier.” [Associated RARC=N725.]

CARC 21 – “This injury/illness is the liability of the no-fault carrier.” [Associated RARC=N727.]

In conjunction with the three (3) CARCs mentioned above, the A/B MACs, DME MACs and shared systems shall make certain that the three (3) new Remittance Advice Remark Codes (RARCs) for a D, E, or L records—namely, N725, N727, and N728, —are matched up and applied to the corresponding CARC codes for these same types of records, as appropriate.

These 3 new RARC codes shall be applied to the outbound 835 Electronic Admittance Advices (ERAs) and 837 crossover claims when denying claims due to an ORM indicator of “Y” on an open NGHP MSP record.

NOTE: Additionally, three (3) new Medicare Summary Notices (MSN) messages have been developed specifically for the three (3) types of NGHP MSP ORM types of records. These will be communicated elsewhere in the IOM.

Exceptions to Denial of Claims Policy Due to ORM

The A/B MACs, DME MACs and shared systems shall **not** allow or make Medicare payments on open ORM occurrences that contain an ORM indicator of “Y,” unless the Claim Adjustment Reason Codes (CARCs) on the claim—specifically, CARCs 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, 242, 256, B1 (if a covered Medicare visit), and B14—permit Medicare to make a payment.

The A/B MACs, DME MACs and the shared systems shall make a payment, as appropriate, for those services related to diagnosis codes associated with the ORM MSP Auxiliary record when the claim’s service date falls outside the termination date on the MSP auxiliary record or deleted.

Possible A/B MAC and DME MAC Review of Suspended Claims

A/B MACs and DME MACs shall still be required, on occasion and part of normal process/procedures, to make determinations on claims that are suspended for review with an associated ORM occurrence if:

- (1) The ORM indicator on the CWF MSP record equals “Y”; and

- (2) The diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the MSP ORM record on CWF.

Reopenings and Appeals for ORM Situations

In a reopening or separate claim appeal situation where the appellant or individual initiating the reopening is stating that ORM no longer applies due to benefits exhaustion, A/B MACs and DME MACs shall continue to follow their current procedures for determining sufficiency of the information received as a basis for overturning or paying the claim at issue.

If an A/B MAC and DME MAC appeals or claims staff obtain an itemized schedule of payments from a third-party payer (ORM entity) that confirms exhaustion of available benefits as of a specified date, these individuals, together with internal MSP staff, shall take the following steps, as applicable:

- Appeals or claims staff shall contact your internal MSP personnel who regularly submit ECRS requests to the MSP Contractor to request that they alert the MSP Contractor that they have received documentation confirming exhaustion of benefits for a given MSP ORM occurrence.
- MSP staff shall initiate an ECRS Assistance Request using existing action codes that will alert the MSP Contractor that the benefits tied to a given MSP ORM occurrence have been exhausted.

(NOTE: A third party payer letter indicating benefits were exhausted without an accompanying itemized schedule of payments is not sufficient evidence for initiating an alert to the MSP Contractor via the ECRS process.)

Submitting ECRS Assistance Requests to the MSP Contractor For ORM-Related Matters

When submitting the ECRS Assistance Request to the MSP Contractor, the A/B MACs and DME MACs shall indicate this relates to an open MSP record with ORM indicator=Y and shall provide the following:

- The name of the third-party payer; and
- A request to apply a termination date of the record that equals the benefits exhaustion date, in accordance with the third-party payer's itemized schedule of payment notice.

From a claims processing scenario, should an A/B MAC and DME MAC obtain an incoming claim that contains PR*119 (benefits exhaustion) or any of the CARCs specified in CR 8821 they shall pay primary, in accordance with current procedures.

(NOTE: A/B MACs or DME MACs shall not initiate ECRS Assistance Requests to the MSP Contractor in these situations.)

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP)
Common Working File (CWF) Process
(Rev. 13783 Issued: 05-27-26)

40.8 - MSP Utilization Edits and Resolution for Claims Submitted to CWF
(Rev. 13783; Issued: 05-27-26; Effective: 10-01-26; Implementation: 10-05-26)

Error

Error Code	Error Description	Resolution
6801	GHP MSP indicated on claim - no MSP auxiliary record exists on CWF data base.	Prepare an "I" MSP maintenance transaction and resubmit claim to CWF. See §10.1 for criteria to submit "I". If "I" criteria is not met, submit an MSP inquiry via ECRS.
6802	GHP MSP indicated on claim - no match on MSP auxiliary file. <i>Applies to MSP types B (13 ESRD) and F (16 Federal Public Health).</i>	(1) Analyze CWF auxiliary file. (2) Create a new "I" MSP auxiliary record, or if "I" record criteria is not met, submit an MSP inquiry or CWF assistance request via ECRS; and (3) Resubmit claim.
NOTE: Match criteria: MSP types are equal, validity indicator equals "Y," dates of service are within MSP period and NO override code is indicated on claim.		
6803	GHP MSP auxiliary record exists - no GHP MSP indicated on claim but dates of service match a GHP occurrence.	(1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If you have documentation showing termination of the insurance coverage indicated in the CWF, MSP occurrence, process as follows: (2) Post a termination date; or (3) Resubmit claim as MSP. If the termination date is incorrect, submit a CWF assistance request via ECRS.
6805	GHP MSP conditional payment claim and matching MSP record with "I" or "Y" validity indicator not found for these dates of service.	(1) A/ B MACs only: Create an "I" MSP Auxiliary Record when it fits the criteria for adding an "I" record. (2) Submit MSP inquiry or CWF assistance request via ECRS. (3) Resubmit claim.
6806	MSP override code equals "M" and no GHP MSP record found with overlapping dates of service.	If record was deleted in error, request CWF assistance request. Do not recreate record with "I" validity indicator.
6810	Part A claim was processed and only a Part B (Insurer type = "K") matching record was found.	Part B (Insurer type = "K") matching record was found.
6811	Part B claim was processed and only a Part A (Insurer type = "J") matching record was found.	Part A (Insurer type = "J") matching record was found.
6815	WC Medicare Set-Aside exists (Insurer type= "W"). Medicare contractor payment not allowed.	

Error Code	Error Description	Resolution
6816	No-Fault over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6817	Workers' Compensation over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6818	Liability over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6819	A non-GHP ('D', 'H' or 'L') MSP auxiliary record exists, and no non-GHP MSP is indicated on the claim, but the Dates of Service match, the diagnosis on the claim is a match within the family of diagnosis codes OR a non-GHP ('E') MSP auxiliary record exists, and no non-GHP MSP is indicated on the claim, but the Dates of Service match, the diagnosis on the claim is an exact match or a match within the family of diagnosis codes.	
6821	Non-GHP MSP indicated on claim; no MSP Auxiliary file exists. This indicates no Non-GHP MSP file found.	
6822	Non-GHP MSP indicated on the claim; a Non-GHP match does not exist on MSP Auxiliary file.	
6823	Beneficiary has a non-GHP MSP Type record 'S' on the Auxiliary file; there is a matching diagnosis on the claim and auxiliary file, and the claim contains payment (full or conditional).	
6824	Beneficiary has a non-GHP MSP Type record 'T' on the Auxiliary file; there is a matching diagnosis on the claim and auxiliary file, and the claim contains payment (full or conditional).	
6825	Non-GHP MSP conditional payment claim, but a non-GHP MSP record with a Validity Indicator equal to 'I' or 'Y' is not present for these Dates of Service.	
6826	MSP Override Code is 'N' or Cost Avoid and no non-GHP MSP record is found with overlapping Date of Service.	
6830	Part A claim was processed and only a Part B (Insurer Type 'K') matching non-GHP record was found.	
6831	<i>DME and Part B - Part B and DMERC claims are processed, and only a Part A (Insurer Type 'J') matching non-GHP record was found.</i>	
6832	The non-GHP MSP occurrence ('D', 'E', 'H', 'L', 'S', 'T', or 'W') does not contain a diagnosis code.	
6833	The ICD-9 diagnosis on the claim is not an exact or Family match to the ICD-10 diagnosis on the open non-GHP MSP Aux record (Value Code '14' (MSP Codes 'D' or 'T'), Value Code '15' (MSP Codes 'E' or 'W'), Value Codes '47' (MSP Codes 'L' or 'S'), or the ICD-10 diagnosis on the claim is not an exact or Family match to the ICD-9 diagnosis on the open non-GHP MSP Aux record (Value Code '14' (MSP Codes 'D' or 'T'), Value Code '15' (MSP Codes 'E' or 'W'), Value Codes '47' (MSP Codes 'L' or 'S')).	
6834	When the claim is secondary and it shows there is a GHP insurer, but the MSP record on CWF has only a non-GHP MSP occurrence.	

- 6835 When the claim is secondary and it shows there is a non-GHP insurer, but the MSP record on CWF has only a GHP MSP occurrence.
- 6836 *DME and Part B - An MSP Auxiliary record exists, and GHP or non-GHP MSP is indicated on the claim. The claim From Date is prior to the MSP Start Date; or claim Thru Date is after the MSP Term Date.*
- 6837 *DME and Part B - An MSP Auxiliary record exists, and GHP or non-GHP MSP is indicated on the claim and at least one detail line does not match the MSP Auxiliary record.*
- 6838 *DME and Part B - An MSP Auxiliary record exists with more than one MSP type for the same claim dates of service. MSP is indicated on the claim.*
- 6839 *DME and Part B - A non-GHP ('D' or 'E') MSP auxiliary record exists without an ORM present and no non-GHP MSP is indicated on the claim. The Date of Service matches the non-GHP occurrence and the diagnosis codes on the claim are a match within the family of diagnosis or the diagnosis is an exact match. The Date of Service is less than or equal to 120 days before the claim receipt date. A non-GHP ('L') MSP auxiliary record exists without an ORM present and no non-GHP MSP is indicated on the claim. The Date of Service matches the non-GHP occurrence and the diagnosis codes on the claim are a match within the family of diagnosis or the diagnosis is an exact match. The Date of Service is less than or equal to 120 days after the Accretion Date on the MSP Auxiliary File.*
- 6840 *DME and Part B - The ICD-9 diagnosis on the claim is not an exact or family match to the ICD-10 diagnosis on the open non-GHP MSP Aux record ('D', 'E'). The ORM indicator is not present, and the Date of Service is less than or equal to 120 days before the Claim Receipt date. The ICD-9 diagnosis on the claim is not an exact or family match to the ICD-10 diagnosis on the open non-GHP MSP Aux record ('L'). The ORM indicator is not present, and the Date of Service is less than or equal to 120 days after the Accretion Date for the non-ORM NGHP on the MSP Auxiliary File. Or The ICD-10 diagnosis on the claim is not an exact or family match to the ICD-9 diagnosis on the open non-GHP MSP Aux record ('D', 'E'). The ORM indicator is not present, and the Date of Service is less than or equal to 120 days before the Claim Receipt. The ICD-10 diagnosis on the claim is not an exact or family match to the ICD-9 diagnosis on the open non-GHP MSP Aux record ('L'). The ORM indicator is not present, and the Date of Service is less than or equal to 120 days after the Accretion Date for the non-ORM NGHP on the MSP Auxiliary File.*
- 6841 *DME and Part B - The ICD-9 diagnosis on the claim is not an exact or family match to the ICD-10 diagnosis on the open non-GHP MSP Aux record ('D', 'E', 'L', 'S', 'T', 'W'). ORM indicator is present. Or The ICD-10 diagnosis on the claim is not an exact or family match to the ICD-9 diagnosis on the open non-GHP MSP Aux record ('D', 'E', 'L', 'S', 'T', 'W'). ORM indicator is present.*
- 6842 *DME and Part B - An incoming DMEPOS claim (HUDC) is received that contains an ICD-9 Diagnosis code that is not an exact or family match to the ICD-10 Diagnosis code on the open non-GHP MSP Auxiliary record ('S', 'T', or 'W'). Or an incoming DMEPOS claim (HUDC) is received that contains an ICD-10 Diagnosis code that is not an exact or family match to the ICD-9 Diagnosis code on the open non-GHP MSP Aux record ('S', 'T', or 'W').*
- 6843 *Applies only to the MSP G (43 Disabled) and A (12- Working Aged) MSP Types. The MSP error code performs the following functions:*
- *If there is an open GHP Record in HIMR;*
 - *The DOS is within the date of the open record at HIMR;*
 - *The MSP type on the claim does not match the MSP Type on the open record;*

- *The MSP Type on the claim does not match the patient age (i.e.: age 65 or greater and MSP Type on the claim is 43 or age less than 65 and MSP type on the claim is 12), the claim shall be rejected.*

6844 When there is an MSP open GHP Record in HIMR, the CWF Error Code sets when following occurs:

- *The DOS is within the date of the open record at HIMR;*
- *The MSP type on the claim does not match the MSP Type on the open record;*
- *The MSP Type on the claim is 43 or 13 and the patient's age is equal to or greater than 65;*
- *An 'I' Record should be created, if possible, if not possible the claim should reject because record was missing vital information.*

Note, if another MSP record is open with an incorrect MSP Type, the MAC will submit an ECRS request to have the incorrect MSP Type end dated. The MAC uses CWF secondary disposition of E or F depending on how the MAC wants the claim to suspend.

6845 When there is an open HIMR record, but there is not an open GHP Record in HIMR. The CWF Error Code shall set when the following occurs:

- *The claim shows GHP MSP on the claim;*
- *The claim suspends for MAC review.*

See discussion in [§40.4](#) above for proper use of override codes.