



# Department of Health

**KATHY HOCHUL**  
Governor

**JAMES V. McDONALD, MD, MPH**  
Commissioner

**JOHANNE E. MORNE, MS**  
Executive Deputy Commissioner

April 7, 2026

Christopher Morris, Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street – 11<sup>th</sup> Floor  
Albany, NY 12236-0001

Dear Christopher Morris:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2024-S-1 entitled, "Medicaid Program: Improper Payments for Certain Third-Party Cost-Sharing Claims."

Please feel free to contact the Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Johanne E. Morne".

Johanne E. Morne, M.S.  
Executive Deputy Commissioner

Enclosures

cc: Melissa Fiore  
DOH Audit

**Department of Health Comments on the  
Office of the State Comptroller's  
Final Audit Report 2024-S-1 entitled,  
"Medicaid Program: Improper Payment for Certain Third-Party Cost-  
Sharing Claims"**

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The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2024-S-1 entitled, "*Medicaid Program: Improper Payment for Certain Third-Party Cost-Sharing Claims.*" Included in the Department's response is the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

**Audit Recommendation Responses:**

**Recommendation #1**

Review the following improperly billed claims from our sample that were not adjusted by providers and recover overpayments, as appropriate:

- 11 claims totaling \$914,030 in overpayments due to the Medicare Advantage plan errors, and
- 39 claims totaling \$2,992 in Medicaid overpayments to providers for claims that did not match supporting documentation.

**Response #1**

In collaboration with the Department, OMIG has instituted robust procedures, continuously conducts comprehensive reviews of claims involving Third-Party Health Insurance coverage, and regularly requires claim adjustments or recovers provider overpayment to ensure that the Medicaid program remains the payer of last resort. OMIG is in the process of conducting audits to recover OSC-identified overpayments. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

**Recommendation #2**

Using a risk-based approach, review the remaining 69,108 (69,166 – 58) claims totaling \$8.4 million in our population prioritizing:

- Claims impacted by the Medicare Advantage plan error;
- Providers I and J, whose policy is to change CARCs from CO to PR when submitting claims to Medicaid;
- Claims for EI services; and
- Providers that received the highest amounts of payments.

## **Response #2**

In collaboration with the Department, OMIG has instituted robust procedures, continuously conducts comprehensive reviews of claims involving Third-Party Health Insurance coverage, and regularly requires claim adjustments or recovers provider overpayment to ensure that the Medicaid program remains the payer of last resort. OMIG is in the process of conducting audits to recover OSC-identified overpayments. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

## **Recommendation #3**

Update the definition of CARC 45 in eMedNY to align with wording from X12 and implement an edit to ensure full claim amounts cannot be charged to PR 45.

## **Response #3**

The Department has updated the applicable definition within the eMedNY system to more accurately reflect with the X12 definition of Claim Adjustment Reason Code 45.

At this time, due to system limitations, eMedNY is unable to receive or process detailed Explanation of Benefits information necessary to support automated edits. As a result, a system edit to automatically deny or adjust these claims is not yet in place. The Department is evaluating system enhancement options to address this limitation. Until then, the Department will continue to coordinate with OMIG to review such claims in a post-payment review process.

## **Recommendation #4**

Remind providers of the requirement to accurately reflect payments, adjustments, and denials received from other insurers to allow correct calculation of NYS Medicaid reimbursement amounts.

- Specifically, follow up with Providers I and J regarding their policy of changing CARCs from CO to PR when submitting claims to Medicaid.

## **Response #4**

The Department included a Medicaid Update article in the December 2025 issue, entitled "*Coordination of Benefits Billing Protocols for Providers: Medicaid is the Payer of Last Resort*", reminding providers that Medicaid claims involving third-party liability must include the appropriate Claim Adjustment Reason Code from the primary insurance. This article can be found in Volume 41-Number 12:

[https://www.health.ny.gov/health\\_care/medicaid/program/update/2025/no12\\_2025-12.htm#COB](https://www.health.ny.gov/health_care/medicaid/program/update/2025/no12_2025-12.htm#COB).

In addition, the Department sent a formal notification to the identified providers in November 2025 to reinforce that Claim Adjustment Reason Codes should not be changed from "CO" to "PR" when claims are submitted to NYS Medicaid.

### **Recommendation #5**

Develop a process to monitor claims submitted with a CARC PR 45 to ensure providers are properly submitting claims and patient responsibility is accurately reported.

### **Response #5**

The Department acknowledges the importance of monitoring claims submitted with Claim Adjustment Reason Code PR-45. Given the high volume of electronically adjudicated claims, manual pre-payment review is not operationally feasible. To address this risk, the Department will coordinate with OMIG to incorporate these claims into post-payment review processes. This approach allows for the collection of the primary insurer's Explanation of Benefits and enables the Department to determine if an overpayment occurred and take recovery action as appropriate.