Department of Health

Medicaid Program: Improper Payments for Certain Third-Party Cost-Sharing Claims

Report 2024-S-1 | November 2025

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine if Medicaid made overpayments to providers who reported claims with a PR 45 cost-sharing amount. The audit covered the period from December 2020 through May 2024.

About the Program

The Department of Health (DOH) administers New York State's Medicaid program. Medicaid members may have other sources of health care coverage, such as Medicare and group health plans (third-party insurers). Medicaid is considered the payer of last resort and, as such, providers are required to coordinate benefits with third-party insurers prior to billing Medicaid for services. After processing a claim from a provider, the third-party insurer issues an electronic remittance advice (ERA) statement to the provider, explaining the reason for any adjustments made to the claim amount. Claim Adjustment Reason Codes (CARCs) and group codes are standard codes on ERAs that detail the reason an adjustment was made to a claim and assign financial responsibility for the unpaid portion of the claim balance. Group codes include PR (patient responsibility) and CO (contractual obligation). CARC 45 occurs when the charge exceeds the maximum allowable fee. Providers can submit claims for unpaid cost-sharing, such as deductibles, copayments, and coinsurance, through eMedNY, DOH's automated Medicaid claims processing and payment system. Claims with a CARC PR 45 are currently configured to pay in eMedNY, while claims with a CARC CO 45 are not. All claims submitted for Medicaid members with Medicare and/or other third-party insurance must accurately reflect payments, adjustments (CARCs), and denials received from other insurers to allow correct calculation of Medicaid reimbursement amounts.

Key Findings

We found that DOH lacked adequate oversight of the coordination of benefits process, resulting in Medicaid overpayments to providers who misapplied CARC PR 45 on claims. During the audit period, we identified 69,166 claims totaling payments of almost $10.2 million billed with a PR 45. We sampled 58 claims and identified billing issues on each claim that resulted in Medicaid overpayments of $1,778,546, as follows:

- 17 claims totaling overpayments of $1,775,326 caused by an internal processing error at one Medicare Advantage plan
- 41 claims totaling overpayments of $3,220 for Medicaid claims not supported by the documentation provided

Key Recommendations

- Review the improperly billed claims we sampled that have not been adjusted and recover overpayments, as appropriate.
- Use a risk-based approach to review the remaining claims in our population.
- Develop controls to ensure claims submitted with a CARC PR 45 are accurately submitted by providers.

Office of the New York State Comptroller
Division of State Government Accountability

November 5, 2025

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Improper Payments for Certain Third-Party Cost-Sharing Claims*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
CARC	Claim Adjustment Reason Code	*Key Term*
CO	Contractual obligation	*Key Term*
EI	Early Intervention	*Key Term*
ERA	Electronic Remittance Advice	*Key Term*
eMedNY	Medicaid claims processing and payment system	*System*
PCG	Public Consulting Group	*Contractor*
PR	Patient responsibility	*Key Term*
X12	Standards development organization responsible for maintaining CARCs	*Organization*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (DOH). During the State fiscal year ended March 31, 2025, New York's Medicaid program had approximately 8.4 million members and Medicaid claim costs totaled about $93 billion. The federal government funded about 55.7% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3%.

Medicaid members may have other sources of health care coverage, such as Medicare and group health plans (third-party insurers). In such cases, per federal law and State regulations, Medicaid is always the payer of last resort.

After processing a claim from a provider, the third-party insurer issues an electronic remittance advice (ERA) statement to the provider, explaining the reason for any adjustments made to the claim amount. Adjustment reasons are reported through Claim Adjustment Reason Codes (CARCs). For instance, CARC 45 is the standard code used to indicate that the charge exceeds the fee schedule/maximum allowable or contracted/legislated fee arrangement. The remittance statement will also include a group code, which assigns financial responsibility for the unpaid portion of the claim balance, such as PR (patient responsibility) and CO (contractual obligation). Currently, claims with a CARC PR 45 code are configured to pay in eMedNY (DOH's Medicaid claims processing and payment system), while claims with a CARC CO 45 code are not.

Once claims are processed by all third-party payers, providers can submit the claim, including the reported CARC and group code, to eMedNY for payment of cost-sharing amounts (e.g., deductibles, copayments, and coinsurance). When Medicaid claims are processed by eMedNY, they are subject to various automated edits. The edits enable eMedNY to determine whether claims are eligible for reimbursement and the amounts claimed for reimbursement are appropriate, and to deny or pay the claim, as appropriate.

All provider claims submitted to eMedNY for services on behalf of Medicaid members with third-party insurance must accurately reflect payments, adjustments, and denials received from other insurers to allow correct calculation of Medicaid reimbursement amounts. In addition, according to X12, the standards organization responsible for maintaining CARCs, the CARC 45 adjustment amount "cannot equal the total service or claim charge amount."

Audit Findings and Recommendations

Errors when coordinating Medicaid coverage with other insurance, such as providers inaccurately reporting CARCs, group codes, or third-party payments, can result in improper Medicaid payments. We found that DOH has not established adequate controls over the coordination of benefits process to identify claims with such errors and prevent overpayments to providers. During the audit period, we identified 69,166 claims totaling nearly $10.2 million billed with a CARC code PR 45. We sampled 58 claims and found issues with all of them, resulting in Medicaid overpayments totaling $1,778,546. These issues included an internal processing error at one Medicare Advantage plan that caused providers to submit 17 claims with improper patient responsibility amounts, resulting in overpayments of $1,775,326. We also determined 41 claims were not supported by the documentation provided, resulting in overpayments of $3,220. Our findings are summarized in the table below:

Provider Identifier	Number of Sampled Claims	Amount Sample Claims Paid	Amount of Sample Overpayment
Overpayments Due to Medicare Advantage Plan Error			
A	7	$219,058	$218,209
B	1	89,308	89,003
C	5	724,794	723,576
D	2	308,980	308,980
E	1	347,391	334,941
F	1	100,617	100,617
Subtotals	**17**	**$1,790,148**	**$1,775,326**
Overpayments for Provider Claims That Do Not Match Supporting Documentation			
A	2	147	91
C	1	227	227
G	6	595	548
H	11	680	621
I	5	347	223
J	13	1,926	1,392
K	3	118	118
Subtotals	**41**	**$4,040**	**$3,220**
Totals	**58**	**$1,794,188**	**$1,778,546**

DOH relies on providers to report accurate information, and DOH officials stated eMedNY does not have mechanisms that would prevent a provider from inputting misstated information. However, DOH does not perform post-adjudication reviews to ensure CARCs are applied correctly. Officials also stated that they do not have the ability to review CARCs on all claims and do not have the authority to inform a third-party insurance provider that they are misusing a CARC. Further, if there was a billing issue or issue with CARC use, DOH would advise the provider to go back to the insurance company to resolve it, instead of intervening directly.

In response to our audit, DOH officials stated they did not know how Medicaid should pay claims containing a CARC PR 45, and they were conducting a review to understand the issue. Officials added that the review would include all CARCs in eMedNY to determine where updates or additional edits may be appropriate. This includes evaluating whether claim edits or post-payment review can be implemented to help detect and prevent the misuse of CARC PR 45.

Overpayments Due to Medicare Advantage Plan Error

Under Medicare Part C, private insurance companies administer Medicare benefits through different health care plans, known as Medicare Advantage plans (Plans), each with different requirements and member cost-sharing liabilities. We found one Plan misreported its members' cost-sharing liability on the documentation sent to providers, which resulted in higher reimbursement amounts on providers' claims submitted to eMedNY. Within the 69,166 claims totaling nearly $10.2 million, 212 claims totaling about $2.8 million were on behalf of members enrolled in this Plan. We sampled 17 claims from six providers (A, B, C, D, E, and F) and identified Medicaid overpayments totaling $1,775,326.

According to plan officials, the error stemmed from an internal code that was incorrectly applied to claims for individuals with Dual Eligible Special Needs Plans, which enroll individuals eligible for Medicare and Medicaid. As a result, incorrect patient responsibility amounts were included on the affected claims. Plan officials stated this issue was corrected in October 2023 and they are currently reprocessing claims with service dates between September 2022 and October 2023 to address this error. As of May 2025, Plan officials expected reprocessing to be completed by the end of the month. Once this reprocessing is completed, DOH will need to ensure the individual providers adjust their Medicaid claims to include the corrected patient responsibility amounts received from the Plan.

By the end of our audit fieldwork, six of the 17 claims we identified were voided or adjusted, resulting in Medicaid savings of $861,296, but action is needed on the remaining 11 claims totaling $914,030 in overpayments.

Overpayments for Provider Claims That Do Not Match Supporting Documentation

We identified 41 claims, from seven providers (A, C, G, H, I, J, and K), where the claim documentation did not support the claim information submitted to eMedNY, including some where the use of the CARC 45 on the Medicaid claim was contrary to the X12 definition of CARC 45. The X12 definition includes a usage statement "this adjustment amount cannot equal the total service or claim charge amount," which is not included in the definition in eMedNY, and eMedNY does not have an edit to identify or automatically deny such claims. In total, these 41 claims resulted in overpayments of $3,220. Some claims have multiple issues that result in the claim not matching the supporting documentation provided.

Prior to the end of our field work, one provider voided two claims and adjusted two others, saving Medicaid $228. However, the two adjusted claims still had inaccuracies in cost-sharing amounts that needed correction, and, therefore, actions were still needed to address 39 claims totaling $2,992.

Claims Submitted With an Altered CARC and/or Group Code

We found nine claims, from three providers (G, I, and J), where the third-party insurance-assigned CARC and/or group code was changed when the claim was billed to Medicaid. For example, Provider I was paid $347 for five claims. The supporting documentation provided for all five claims included a CARC CO 45 and did not include a PR 45. However, when the claims were submitted to Medicaid, the provider included a PR 45 matching the CO 45 amount from the supporting documentation and did not include a CO 45. Within eMedNY, an amount with a CO 45 is not configured to pay, while an amount with PR 45 is. As a result of changing the CARCs to PR 45, the provider received overpayments totaling $223.

According to DOH officials, there is no policy that allows providers to change the CARCs assigned by the primary insurer. However, Providers I and J stated they always convert CARC CO 45 to PR 45 when billing Medicaid. Furthermore, we found that Provider J's internal billing manuals instruct staff to convert a CO to a PR when billing Medicaid. While these two providers account for only 18 claims, totaling $2,273, in our sample of 58, within the total population of 69,166 claims, they account for 14,680 claims, totaling over $2 million. DOH should follow up with these providers to ensure they are appropriately submitting claims in accordance with billing requirements.

No CARCs or No CARC PR 45 on the Supporting Documentation but CARC PR 45 on the Medicaid Claim

For 34 claims, from seven providers (A, C, G, H, I, J, and K), the supporting claim documentation either did not include a CARC or did not include a CARC PR 45 assigning payment liability to the patient, but the provider nevertheless reported CARC PR 45 on the Medicaid claim. For example, for 10 of 13 claims from Provider J, the supporting documentation for the third-party claim that paid did not include any CARCs. However, all 10 Medicaid claims showed CARCs, including PR 45. Overpayments for these claims totaled $1,220. Provider officials were unable to explain why their claims included CARCs when the supporting documentation did not. They went on to state that they do not check for instances of misreported information due to the volume of claims processed.

Third-Party Insurer Liability on the Supporting Documentation Does Not Match the Medicaid Claim

We found 12 claims, from three providers (G, H, and J), where the amount paid by the third-party insurer on the supporting documentation was not accurately reflected in the provider's Medicaid claim. For example, Provider G submitted a claim to Medicaid totaling $213. The supporting documentation for this claim showed there was a coinsurance amount of $47 and a commercial third-party insurance payment to the provider of $110. However, the provider's Medicaid claim showed

no coinsurance and no payment by the third-party insurer and, furthermore, had a CARC PR 45 amount of $213. As a result, Medicaid paid the entire claim amount of $213, effectively allowing the provider to be paid twice, when it should have paid only $47—an overpayment of $166.

Prior to the end of our field work, one provider voided two claims and adjusted two others, saving Medicaid $228. However, the two adjusted claims still had inaccuracies in cost-sharing amounts that needed correction.

Overpayments for Early Intervention Services Claims

Public Consulting Group (PCG) is the State's fiscal agent for DOH's Early Intervention (EI) program. All EI providers are required to use PCG for their billing. Our sample of 58 included 20 claims for EI services from three providers (G, H, and K) totaling $1,393. We identified issues on all the claims we reviewed, including one of the examples highlighted above.

According to two of the providers, they are not able to bill claims; instead, claims are billed by PCG as the fiscal agent. PCG maintains these claims were submitted by the providers, and the issues were due to provider error. In total, our population includes 37,091 EI claims totaling $2.5 million. As of January 1, 2022, EI claims are no longer billed directly to third-party insurance, so the specific issues we identified will no longer occur. However, DOH should review the claims identified in our audit to ensure they were billed appropriately and recover inappropriate payments, as necessary.

Recommendations

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.
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.
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.

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.
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.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine if Medicaid made overpayments to providers who reported claims with a PR 45 cost-sharing amount. The audit covered the period from December 2020 through May 2024.

To accomplish our objective and assess related internal controls, we interviewed DOH, PCG, selected providers, and Medicare Advantage plan officials. We reviewed applicable State and federal guidance, laws, and regulations, and the eMedNY claims processing manual. We also contacted the Centers for Medicare and Medicaid Services and X12 regarding the application and use of CARC 45. In addition, we reviewed supporting documentation for selected claims and compared it to claim information in eMedNY and the Medicaid Data Warehouse. Based on the results of this review, we used the eMedNY claims processing manual to calculate Medicaid overpayments for each claim in our sample.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected judgmental samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the population. Our samples, which are discussed in detail in the body of our report, include:

- A judgmental sample of 50 of 69,166 Medicaid claims totaling about $10.2 million containing a CARC PR 45 that were adjudicated during the scope period and had third-party insurance coverage provided by commercial insurance or Medicare Part B or Part C. The claims were selected based on factors such as total amount paid to provider, number of claims submitted by the provider, whether they were enhanced fee, and how much the patient was responsible for.
- A judgmental sample of 8 claims identified as part of a prior audit (2023-S-9) and handled as part of this audit due to their relevance to the audit objective.

We relied on data from the Medicaid Data Warehouse and eMedNY that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. We also obtained data from the claim adjustment segment/coordination of benefits system and assessed the reliability of that data by tracing to and from source data. We determined the data from this system was sufficiently reliable for the purposes of this report.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of Medicaid payments for claims billed with a CARC PR 45 cost-sharing amount.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our response to one DOH remark is included in the report's State Comptroller's Comment, which is embedded in DOH's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

October 15, 2025

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

Dear Christopher Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2024-S-1 entitled, "Medicaid Program: Improper Payments For Certain Third-Party Cost-Sharing Claims."

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

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

Enclosure

cc: Melissa Fiore
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2024-S-1 entitled, "Medicaid Program: Improper Payments For Certain Third-Party Cost-Sharing Claims"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2024-S-1 entitled, "Medicaid Program: Improper Payments 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.

General Comments:

Audit Scope, Objective, and Methodology, Page 12, 3rd Paragraph

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected a judgmental sample. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the population.

Department Response to OSC Use of A Judgmental Samples

Judgmental sampling is based on a found problem. It doesn't accurately measure how many problems you have or how widespread they are. This method involves selecting specific cases based on the auditor's judgment rather than using a statistically valid, random sample. Such an approach is inherently prone to selection bias, meaning that, as the Report acknowledges, the resulting findings cannot be generalized to the broader population and may overstate the prevalence of any identified issues.

State Comptroller's Comment – DOH's statement is misleading. Judgmental samples—in this case, selected to focus on the highest risk—are routinely used and widely accepted to reach audit conclusions. As mentioned in the audit report, the sample reviews were supplemented with reviews of laws, regulations, guidance, and procedures; interviews with various DOH, PCG, Medicare Advantage Plan, and provider officials; assessments of internal controls; and data analysis to reach audit conclusions and recommendations.

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, 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. In keeping with this principle, OMIG will carefully analyze the OSC-identified payments and determine an appropriate course of action. 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, 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. In keeping with this principle, OMIG will carefully analyze the OSC-identified payments and determine an appropriate course of action. 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 will update the definition of CARC 45 in eMedNY to align with wording from X12. The Department wants to prevent overpayments on Medicaid secondary claims. This may be accomplished through strengthening existing edits or developing new edits. The Department will consider OSC's recommendation and determine if it is feasible to create the exact edit requested.

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 November 2024 issue, entitled *"Reminder: Coordination of Benefits Billing Protocols for Providers; New York State 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. The article can be found in Volume 40-Number 12.
https://www.health.ny.gov/health_care/medicaid/program/update/2024/no12_2024-11.htm#COB

The Department is also issuing an updated reminder in an upcoming Fall 2025 Medicaid Update. The Department is sending a formal notification to the identified providers 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.

Contributors to Report

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