

Department of Health and Human Services
Office of Inspector General



Office of Audit Services

June 2026 | OAS-25-01-076

**California Claimed at Least
\$13.9 Million More in Medicaid
Reimbursements for Clinical
Diagnostic Laboratory Services Than
Was Allowed by Federal and State
Requirements**



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California Claimed at Least \$13.9 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements

Why OIG Did This Audit

- Prior OIG audits found that some States did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, the States submitted claims that exceeded the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements.
- We performed this audit because a recent OIG data analysis indicated that certain States, including California, are at risk for noncompliance with Federal and State requirements.
- This audit examined California's fee-for-service Medicaid payments for clinical diagnostic laboratory services provided during calendar years 2019 through 2023.

What OIG Found

California did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

- For 2,186,277 of the 3,123,613 services that we reviewed from a larger universe of claims, California paid providers more than they would have been paid under the Medicare program or the amounts allowed by State requirements.
- Additionally, for 211,171 services, California potentially paid providers more than they would have been paid under the Medicare program or the amounts allowed by State requirements.

These overpayments occurred because the State agency did not follow its procedures for reviewing and updating laboratory rates in its claims processing system. The State agency attributed this oversight to a clerical error. As a result, the Federal reimbursement that California claimed exceeded the rates allowed by the Federal and State requirements by \$13.9 million (\$7.6 million Federal share) and potentially exceeded the rates allowed by Federal and State requirements by an additional \$29.3 million (\$16.5 million Federal share).

What OIG Recommends

We made four recommendations, including that California refund \$7.6 million to the Federal Government, work with CMS to determine whether the potential overpayments of \$16.5 million complied with Federal and State requirements, and strengthen its existing policies and procedures for reviewing and updating rates in its claims processing system. The full recommendations are in the report.

California concurred with all four recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits found that some States did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, the States submitted claims that exceeded the amounts that would have been paid under the Medicare program or the amounts allowed by State regulations. We performed this audit because a recent OIG data analysis indicated that certain States, including California, are at risk for noncompliance with Federal and State requirements. Therefore, we conducted this audit of the California Department of Health Care Services' (State agency's) fee-for-service (FFS) Medicaid payments for clinical diagnostic laboratory services provided during calendar years (CYs) 2019 through 2023 (audit period). This audit is part of a series of audits that OIG is performing across multiple States.

OBJECTIVE

Our objective is to determine whether the State agency claimed Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with the payment limits set in Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State government jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the State agency administers the Medicaid program.

The Federal Government pays its share of a State's medical assistance expenditures (called Federal financial participation or the Federal share) based on the Federal medical assistance percentage (FMAP), which varies depending on the State. (During our audit period, California's FMAP ranged between 50 and 56.2 percent.) To claim the Federal share, States report their Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services provide information for the diagnosis, prevention, or treatment of disease or for the assessment of a medical condition. Clinical diagnostic laboratory

services involve the following types of examination of materials derived from the human body: biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of materials.

Clinical diagnostic laboratory services include tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests (*CMS State Medicaid Manual* § 6300.2).

Providers use CMS's Health Care Common Procedural Coding System (HCPCS) codes to claim clinical diagnostic laboratory services for payment by the State agency.¹ Annually, CMS furnishes to the Medicare contractors the proper amount to pay for each HCPCS code.² This information is available to the public on the CMS Web site.³ CMS also maintains the Medicare clinical laboratory fee schedules (CLFS), which are published regularly and available to the public on the CMS web site.⁴

Certain clinical diagnostic laboratory services are provided under the State's agency's genetic disease screening program (GDSP) as part of its prenatal screening program. Providers bill for these services using procedure codes that appear on Medicare's CLFS. The State agency claims Medicaid reimbursement for these services in accordance with the CMS-approved State plan and State Plan Amendments (SPA).

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$632,164,882 (\$345,122,316 Federal share) in FFS Medicaid payments for 36,252,751 clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period.⁵ We compared the amount that should have been paid according to Federal requirements to the amount that was actually paid.

¹ HCPCS codes are a collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers.

² The *Medicare Claims Processing Manual*, chapter 16, § 20.

³ CMS, "[CMS HCPCS Quarterly Update](#)." Accessed on Dec. 17, 2025.

⁴ CMS's official update of the Medicare CLFS is available at "[CLFS Files | CMS](#)." Accessed on Jan. 27, 2026.

⁵ We limited our audit to claim type codes 8013 (hospital outpatient), 8014 (hospital laboratory services provided to nonpatients), and 8700 (professional) with HCPCS codes listed on the Medicare fee schedules for each CY. Our audit did not include HCPCS codes without CMS-established payment limits.

We identified \$187,521,315 (\$102,977,680 Federal share) in FFS Medicaid payments for 11,342,462 clinical diagnostic laboratory services that potentially exceeded the amounts that would have been paid under the Medicare CLFS.⁶

We limited our review to \$107,508,910 (\$59,616,155 Federal share) in FFS Medicaid payments for 3,123,613 clinical diagnostic laboratory services.⁷ We determined whether the State agency claimed Federal Medicaid reimbursement in accordance with the payment limits set in Federal and State requirements. We provided these potentially overpaid claim lines to the State agency and confirmed the calculated overpayment amounts with the State agency.

We conducted this 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 objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDINGS

The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 3,123,613 services that were covered by this audit, Medicaid payments that the State agency made for 726,165 services did not exceed the amounts allowed by Federal and State requirements. However, for 2,186,277 services, the State agency paid providers more than they would have been paid under the Medicare program or more than amounts allowed by State requirements.

Additionally, for 211,171 services, the State agency potentially paid providers more than they would have been paid under the Medicare program or more than amounts allowed by State requirements for certain clinical diagnostic laboratory services provided under the State's GDSP, a prenatal screening program. We were unable to determine whether Medicaid payments for those services exceeded the amounts allowed by Federal and State requirements. Because these services were billed and paid prior to the effective dates of relevant SPAs, it is unclear whether CMS was aware of, or had approved, the higher payments for clinical diagnostic laboratory services provided under the GDSP before the SPAs were approved.

⁶ The remaining \$444,643,567 (\$242,144,636 Federal share) did not exceed the payment limits set in Federal requirements (\$632,164,882 minus \$187,521,315 equals \$444,643,567).

⁷ Due to the materiality of potential overpayments and high volume of services, we did not review all services that potentially exceeded the rates allowed under the Medicare program. For claim type codes 8013 (hospital outpatient), we limited our review to services with potential overpayments greater than \$3. For claim type code 8014 (hospital laboratory services provided to nonpatients), we limited our review to services with potential overpayments greater than \$2. For claim type code 8700 (professional), we reviewed all services with potential overpayments.

As a result, the Federal reimbursement that the State agency claimed exceeded the rates allowed by the Federal and State requirements by \$13,892,037 (\$7,576,103 Federal share), and potentially exceeded the rates allowed by Federal and State requirements by an additional \$29,319,373 (\$16,477,416 Federal share).

The Medicaid overpayments occurred because the State agency did not follow its policies and procedures for reviewing and updating rates in its claims processing system to ensure that the amounts it claimed for Federal Medicaid reimbursement for clinical diagnostic laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements. Specifically, the State agency did not properly update the reimbursement rates to reduce Medicaid payments that were above the allowable Medicare rates. The State agency attributed this oversight to a clerical error.

FEDERAL AND STATE REQUIREMENTS

No Federal financial participation is available for any amounts expended for clinical diagnostic laboratory tests that exceed the amounts recognized under Medicare (the Act, § 1903(i)(7) and CMS's *State Medicaid Manual*, § 6300.2).

Medicare clinical diagnostic laboratory tests are generally reimbursed based on the Medicare fee schedule published annually by CMS (the Act § 1833(h); CMS's *Medicare Claims Processing Manual*, chapter 16, § 20). For each HCPCS code, Medicare pays the lesser of: (1) actual charges, (2) the national limitation amount on the CMS fee schedule, or (3) the CMS fee schedule amount for the State or local geographic area.

For service dates from January 1, 2019, through to July 1, 2022, the State requirements generally state that Medicaid reimbursement for clinical diagnostic laboratory services must not exceed the lowest of the following: (1) the amount billed, (2) the charge to the general public, or (3) 80 percent of the lowest maximum allowance established by the Federal Medicare CLFS amount and Medicare physician fee schedule amount (or the lowest maximum allowance established by the Federal Medicare program for the same or similar services) (California State Plan, attachment 4.19-B, pages 3d, 3f, and 3f-1, effective July 1, 2015, through June 30, 2022; California Welfare and Institutions Code § 14105.22).⁸

Effective July 1, 2022, the State requirements generally state that the Medicaid reimbursement rate for clinical diagnostic laboratory services shall be the lowest of the following: (1) the

⁸ The State agency had several iterations of SPAs that applied throughout our audit period. However, prior to July 1, 2022, all applicable SPAs included a limitation for Medicaid payments for clinical laboratory tests to be paid at the lowest of certain specified amounts, one of which was 80 percent of the lowest maximum allowance established by Medicare for the same or similar service. The State agency stated that, for some services, providers were reimbursed at their billed amounts, which could be lower than 80 percent of the Medicare rate. However, to be conservative, we calculated the overpayments using the State limitation at 80 percent of the Federal CLFS amount.

amount billed, (2) the charge to the general public, or (3) the rate in effect on the State agency's fee schedule for the current State fiscal year, which must be the lowest of either: (a) the rate in effect on the State agency's fee schedule as of June 30 of the previous State fiscal year or (b) 100 percent of the lowest maximum allowance established by the Federal Medicare CLFS and Medicare physician fee schedule effective January 1 of the previous State fiscal year for the same or similar service (California State Plan Transmittal Number 22-0053, attachment 4.19-B, page 3d and 3f-1, effective date July 1, 2022; California State Plan Transmittal Number 23-0019, attachment 4.19-B, page 3d and 3f-1, effective date July 1, 2023; California Welfare and Institutions Code § 14105.22).⁹

Effective September 19, 2022, the California State Plan increased the Medicaid reimbursement rate for certain laboratory services that are provided under the State's GDSP as part its prenatal screening program. Specifically, effective September 19, 2022, CMS approved a higher reimbursement rate for laboratory services billed with HCPCS code 82105 (California State Plan Transmittal Number 22-0063, attachment 4.19-B, page 3Q, effective September 19, 2022).¹⁰ Additionally, effective October 1, 2022, CMS approved a higher reimbursement rate for laboratory services billed with HCPCS code 81420 (California State Plan Transmittal Number 22-0064, attachment 4.19-B, page 3 Q, effective October 1, 2022).¹¹ Therefore, Medicaid reimbursement for these services may exceed the Medicare laboratory fee schedule amounts.¹²

MEDICAID PAYMENTS EXCEEDED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. For 2,186,277 of the 3,123,613 services covered by this audit, the State agency paid providers more than they would have been paid under the Medicare program or more than amounts allowed by State requirements.¹³

⁹ Effective July 1, 2023, the reimbursement rate shall be the lower of the requirements effective July 1, 2022, or, beginning on July 1, 2023, and every three years thereafter, the weighted average of the lowest amount that third-party payers are paying for the same or similar services, but no less than 70 percent of the Medicare clinical laboratory rate and Medicare Physician rate effective January 1 of the previous State fiscal year for the same or similar service.

¹⁰ HCPCS code 82105 (maternal alpha-fetoprotein) is a laboratory test that screens for neural tube defects in pregnant women.

¹¹ HCPCS code 81420 (cell-free DNA) is a laboratory test that analyzes cell-free fetal DNA found in the maternal blood to screen for specific fetal chromosomal abnormalities.

¹² We excluded clinical diagnostic laboratory services provided under the GDSP from our audit scope if they were provided after the effective dates of the relevant SPAs (i.e., service dates after September 19, 2022).

¹³ For service dates from January 1, 2019, through July 1, 2022, we calculated the overpayments using the State limitation at 80 percent of the Federal Medicare CLFS amount. For services after July 1, 2022, we calculated the overpayments using the State limitation at 100 percent of the Federal Medicare CLFS amount.

Table 1: Summary of Medicaid Payments Exceeding Rate Limits

Year	Number of Services Reviewed	Paid Amount	Paid Amount (Federal Share)	Number of Services Exceeding Rate Limits	Overpayments	Overpayments (Federal Share)
2019	322,204	\$6,466,270	\$3,304,753	321,954	\$2,353,490	\$1,201,421
2020	550,761	11,044,020	6,206,653	42,120	300,192	168,708
2021	846,230	42,406,709	23,832,381	526,132	4,127,563	2,319,633
2022	674,916	32,734,495	18,391,783	566,569	3,614,985	2,030,509
2023	729,502	14,857,416	7,880,585	729,502	3,495,807	1,855,832
Total	3,123,613	\$107,508,910	\$59,616,155	2,186,277	\$13,892,037	\$7,576,103

In total, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by \$13,892,037 (\$7,576,103 Federal share).

Example of an Overpayment

During September 2020, a provider billed the State agency for one unit of service for HCPCS code 81455.* The State agency paid \$3,262.94 to the provider and claimed \$1,833.77 for Federal Medicaid reimbursement. On the Medicare fee schedule for 2020, the national limit was \$2,919.60 per unit for HCPCS code 81455. Because the State plan limited Medicaid reimbursement to providers to 80 percent of the current Medicare CLFS, we determined that the allowable payment was \$2,335.68 (\$2,919.6 multiplied by 80 percent) for one unit. As a result, we identified a Medicaid overpayment of \$927.26 (\$3,262.94 minus \$2,335.68). The Federal share of the overpayment is \$521.12 (\$927.26 multiplied by the 56.2 percent of FMAP).

* HCPCS code 81455 (targeted genomic sequence analysis) is used to bill for tests to analyze a patient’s genetic material for alterations that may be relevant to the diagnosis, prognosis, or treatment of cancer.

MEDICAID PAYMENTS POTENTIALLY EXCEEDED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

For 211,171 of the 3,123,613 services covered by this audit, the State agency potentially paid providers more than they would have been paid under the Medicare program or more than amounts allowed by State requirements for certain clinical diagnostic laboratory services provided under the State’s GDSP, a prenatal screening program. We were unable to determine whether Medicaid payments for those services exceeded the amounts allowed by Federal and State requirements. Because these services were billed and paid prior to the effective dates of relevant SPAs, it is unclear whether CMS was aware of, or had approved, the higher payments for clinical diagnostic laboratory services provided under the GDSP before the SPAs were approved. Although the State agency bills for GDSP services using procedure codes that appear on Medicare’s CLFS, it maintains that these services are covered outside of the Medicaid clinical

laboratory benefit and, therefore, are not subject to Medicare’s rate limitations for clinical laboratory services. Based on the CMS-approved SPAs and State plan, we could not determine whether these services are eligible for a higher reimbursement rate.¹⁴

Table 2: Summary of Medicaid Payments Potentially Exceeding Rate Limits

Year	Number of Services Reviewed	Paid Amount	Paid Amount (Federal Share)	Number of Services Potentially Exceeding Rate Limits	Potential Overpayments	Potential Overpayments (Federal Share)
2019	322,204	\$6,466,270	\$3,304,753	250	\$35,330	\$19,855
2020	550,761	11,044,020	6,206,653	663	86,594	48,664
2021	846,230	42,406,709	23,832,381	124,956	17,877,114	10,046,932
2022	674,916	32,734,495	18,391,783	85,302	11,320,335	6,361,965
2023	729,502	14,857,416	7,880,585	-	-	-
Total	3,123,613	\$107,508,910	\$59,616,155	211,171	\$29,319,373	\$16,477,416

In total, the Federal reimbursement claimed by the State agency potentially exceeded the rates allowed by Federal and State requirements by \$29,319,373 (\$16,477,416 Federal share).

Example of a Potential Overpayment
<p>During January 2022, a provider billed the State agency for one unit of service for HCPCS code 81508.* The State agency paid \$221.60 to the provider and claimed \$124.54 for Federal Medicaid reimbursement. On the Medicare fee schedule for 2022, the national payment limit was \$54.30 per unit for HCPCS code 81508. Because the State plan limited Medicaid reimbursement to providers to 80 percent of the current Medicare CLFS, we determined the potentially allowable payment was \$43.44 (\$54.30 multiplied by 80 percent) for one unit. As a result, we identified a potential Medicaid overpayment of \$178.16 (\$221.60 minus \$43.44). The Federal share of the potential overpayment is \$100.12 (\$178.16 multiplied by the 56.2 percent of FMAP).</p> <p>*HCPCS code 81508 (fetal congenital abnormality biochemical assay) is used to bill for tests to analyze specific proteins in a mother’s blood during pregnancy to assess the risk of certain fetal abnormalities.</p>

¹⁴ The SPAs state that these GDSP services are provided under attachment 3.1-A, section 13c, of the State plan, which provides for preventative services under the “other diagnostic, screening, preventive, and rehabilitative services” benefit. However, the State plan provision that sets forth the limited payment rates for “clinical laboratory or laboratory services” generally states that the services are provided under attachment 3.1-A, page 1, paragraph 3, which provides services under the “other laboratory and X-ray services” benefit.

THE STATE AGENCY DID NOT FOLLOW ITS POLICIES AND PROCEDURES

The Medicaid overpayments occurred because the State agency did not follow its policies and procedures for reviewing and updating rates in its claims processing system to ensure that the amounts it claimed for Federal Medicaid reimbursement for clinical diagnostic laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements.

During our audit period, the State agency maintained a table of Medicare reimbursement rates for clinical diagnostic laboratory services within its claims processing system. Medicaid payments for clinical diagnostic laboratory services were adjusted according to the allowable payment rates listed in this table. However, the State agency did not properly update this table to reflect the correct reimbursement rates and reduce Medicaid payments that were above the allowable Medicare rates listed in this table. The State agency attributed this oversight to a clerical error.

RECOMMENDATIONS

- We recommend that the State agency refund \$7,576,103 to the Federal Government.
- We recommend that the State agency work with CMS to determine whether potential overpayments of \$16,477,416 (Federal share) complied with Federal and State requirements and refund the Federal share of any overpayments to the Federal Government.
- We recommend the State agency review payments made after our audit period to identify any additional overpayments and refund the Federal share to the Federal Government. Additionally, the State agency should clearly identify any additional overpayments refunded as having been made in accordance with this recommendation.
- We recommend that the State agency evaluate and strengthen its existing policies and procedures for reviewing and updating rates in its claims processing system to ensure that the amounts claimed for clinical diagnostic laboratory services do not exceed the amount that would be paid under the Medicare program or the amounts allowed by State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all four recommendations and described the corrective actions that it has taken or plans to take to address them. For example, the State agency said that it is currently reviewing and standardizing its policies, procedures, and instructions governing the maintenance of the rate tables it uses when claiming reimbursement for clinical diagnostic laboratory services. The State agency stated that these improvements are intended to strengthen internal controls and

support accurate annual updating of the rate tables to ensure amounts claimed for clinical diagnostic laboratory services do not exceed the allowable amount under the Medicare program or allowed by State requirements.

The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$632,164,882 (\$345,122,316 Federal share) in FFS Medicaid payments for 36,252,751 clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period.¹⁵ We calculated the amount that should have been paid according to Federal requirements and compared it to the amount that was actually paid.

We identified \$187,521,315 (\$102,977,680 Federal share) in FFS Medicaid payments for 11,342,462 clinical diagnostic laboratory services that potentially exceeded the amounts that would have been paid under the Medicare CLFS.¹⁶

We limited our review to \$107,508,910 (\$59,616,155 Federal share) in FFS Medicaid payments for 3,123,613 clinical diagnostic laboratory services.¹⁷ We determined whether the State agency claimed Federal Medicaid reimbursement in accordance with the payment limits set in Federal and State requirements. We provided these potentially overpaid claim lines to the State agency and confirmed the calculated overpayment amounts with the State agency.

We did not assess the State agency's overall internal control structure. Rather, we limited our audit of internal controls to those applicable to our audit objective. Specifically, we limited our review of internal controls to those related to clinical diagnostic laboratory services payment limit requirements, such as policies and procedures for reviewing and updating rates in the State agency's claims processing system.

We established reasonable assurance of the authenticity and accuracy of the data extracted from the Transformed Medicaid Statistical Information System (T-MSIS) by comparing it with data obtained from the State agency's Medicaid Management Information System. We also established reasonable assurance of the completeness of the claim data by reconciling the clinical diagnostic laboratory services that the State agency claimed during the audit period on Form CMS-64 to the T-MSIS data.

¹⁵ We limited our audit to claim type codes 8013 (hospital outpatient), 8014 (hospital laboratory services provided to nonpatients), and 8700 (professional) with HCPCS codes listed on the Medicare fee schedules for each CY. Our audit did not include HCPCS codes without CMS-established payment limits.

¹⁶ The remaining \$444,643,567 (\$242,144,636 Federal share) did not exceed the payment limits set in Federal requirements (\$632,164,882 minus \$187,521,315 equals \$444,643,567).

¹⁷ Due to the materiality of potential overpayments and high volume of services, we did not review all services that potentially exceeded the rates allowed under the Medicare program. For claim type codes 8013 (hospital outpatient), we limited our review to services with potential overpayments greater than \$3. For claim type code 8014 (hospital laboratory services provided to nonpatients), we limited our review to services with potential overpayments greater than \$2. For claim type code 8700 (professional), we reviewed all services with potential overpayments.

We conducted our audit from February 2025 through March 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal and State laws, regulations, and guidance and the CMS-approved State plan
- Corresponded with the State agency staff to gain an understanding of the State’s procedures for claiming Federal Medicaid reimbursement for clinical diagnostic laboratory services
- Obtained all T-MSIS Medicaid paid claims data for clinical diagnostic laboratory services that the State agency submitted to CMS with HCPCS codes on the Medicare fee schedule and service dates during the audit period
- Reconciled the clinical diagnostic laboratory services that the State agency claimed during the audit period on Form CMS-64 to the T-MSIS data
- Determined the amount that the State agency was reimbursed more than the amounts allowed by State regulations and the amounts that would be paid under the Medicare program
- Specifically, for each service, we:
 - Computed what the Medicare payment limit should be by multiplying the Medicare CLFS rate by the number of units billed, per HCPCS code
 - Calculated the difference between the Medicaid amount claimed (paid amount) and the lower of the provider’s actual charge and the State and Medicare payment limit
- Evaluated the claims data to identify 3,123,613 Medicaid FFS clinical diagnostic laboratory services totaling \$107,508,910 (\$59,616,155 Federal share) for review and:
 - Determined whether the State agency claimed Federal Medicaid reimbursement in accordance with the payment limits set in Federal and State requirements
 - Provided these potentially overpaid claim lines to the State agency and confirmed the calculated overpayment amounts with the State agency

- Discussed the results of our audit with State agency officials

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.



4/30/2026
THIS LETTER SENT VIA EMAIL

Mr. Curtis Roy
Regional Inspector General Office for Audit Services
15 Sudbury Street
JFK Federal Building, Room 2300
Boston, MA 02203

DHCS' RESPONSE TO OFFICE OF INSPECTOR GENERAL'S DRAFT AUDIT REPORT
OAS-25-01-076

Dear Mr. Curtis Roy:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of the Inspector General's (OIG) draft audit report OAS-25-01-076, titled, "California Made at Least \$13.9 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements."

In the referenced draft audit report, OIG issued four recommendations for DHCS. DHCS has reviewed all of OIG's recommendations and has prepared a response describing the nature of the corrective actions taken or planned.

To strengthen internal controls, DHCS is revising and enhancing our policies, procedures, and staff training, in addition to standardizing templates to ensure the timely and accurate updating of system claim and reimbursement check mechanisms, reducing the risk of clerical errors and preventing potential overpayments going forward.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any questions, please contact the DHCS Office of Compliance, Internal Audits at (916) 261-0346.

Sincerely,

Signed by:

Michelle Baass

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Michelle Baass

Director

Enclosure

Cc: See Next Page

Director's Office

1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413
Phone (916) 440-7400 | www.dhcs.ca.gov

State of California
Gavin Newsom, Governor



California Health and Human Services Agency

Mr. Curtis Roy

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4/30/2026

Cc:

Tyler Sadwith
Chief Deputy Director, and
State Medicaid Director
Department of Health Care

Services
Tyler.Sadwith@dhcs.ca.gov

Lindy Harrington

Mr. Curtis Roy

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Assistant State Medicaid Director
Department of Health Care
Services
Lindy.Harrington@dhcs.ca.gov

Rafael Davtian
Deputy Director
Health Care Financing
Department of Health Care
Services
Rafael.Davtian@dhcs.ca.gov

Wendy Rasmussen, MPA
Chief
Internal Audits
Department of Health Care
Services
Wendy.Rasmussen@dhcs.ca.gov

Saralyn Ang-Olson, JD, MPP
Chief Compliance Officer
Office of Compliance
Department of Health Care
Services
Saralyn.Ang-Olson@dhcs.ca.gov



Report: “California Claimed at Least \$13.9 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements.”

External Entity: The Office of Inspector General

Report Number: OAS-02-01-076 (25-09) (California Clinical Laboratory Services)

Response Type: DHCS’ Responses to OIG’s Draft Audit Report

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Finding 1): The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

Recommendation 1

We recommend that the State agency refund \$7,576,103 to the Federal Government.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:

DHCS concurs with the recommendation that the State agency refund \$7,576,103 to the Federal Government, as a result of OIG's determination of overpayments related to clinical diagnostic laboratory service codes.

The overpayment associated with certain laboratory and pathology procedure codes resulted from an isolated clerical oversight incident. Instructions provided to the Fiscal Intermediary (FI) directed updates to the Medicaid base rates but inadvertently did not include updates to the secondary rate table governing maximum allowable reimbursement after State Plan-authorized adjustments. DHCS will issue instructions to the FI to update the Medicaid billing and payment system as needed and will work with the FI to address any related system configuration and business rules to prevent future recurrence of this issue.

DHCS acknowledges the rate tables for these services should be reviewed and updated annually to ensure compliance with Federal and State requirements. DHCS is currently reviewing and standardizing its policies, procedures, and instructions governing maintenance of rate tables used in claiming. These improvements are intended to strengthen internal controls, support accurate annual updates, and reduce the risk of clerical errors that could result in future overpayments.

DHCS remains committed to maintaining accurate reimbursement practices and full compliance with all Federal and State requirements.

Finding 1: The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

Recommendation 2

We recommend that the State agency work with CMS to determine whether potential overpayments of \$16,477,416 (Federal share) complied with Federal and State requirements and refund the Federal share of any overpayments to the Federal Government.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:

Although the Genetic Disease Screening Program (GDSP), a prenatal screening program, uses procedure codes that also appear on Medicare's Clinical Laboratory Fee Schedule, DHCS bills and reimburses these codes as preventive services under a separate Medi-Cal benefit category.

CMS previously approved State Plan Amendment (SPA) 22-0063 on November 4, 2022, and SPA 22-0064 on February 24, 2023, authorizing reimbursement rates for GDSP procedure codes that exceed Medicare's clinical laboratory rates. Due to these approvals, DHCS believes that GDSP services are appropriately classified as preventive services. DHCS will confirm with CMS that these approvals support classifying GDSP services as preventive services consistent with the State Medicaid Manual and Code of Federal Regulations.

DHCS will confirm with CMS that GDSP-related claims fall outside the Medicaid clinical laboratory benefit and should therefore be excluded from the overpayment analysis.

Because the audit did not determine that overpayment occurred, DHCS will work collaboratively with CMS to confirm the payments of \$16,477,416 (federal share) related to GDSP-related claims, complied with Federal and State requirements

Finding 1: The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

Recommendation 3

We recommend the State agency review payments made after our audit period to identify any additional overpayments and refund the Federal share to the Federal Government. Additionally, the State agency should clearly identify any additional overpayments refunded as having been made in accordance with this recommendation.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:

DHCS will review payments outside the scope of this audit to determine whether there are any additional overpayments.

DHCS conducts an annual review of all Medicaid laboratory rates to ensure that any rates exceeding 100 percent of the Medicare rate are adjusted accordingly.

If any additional overpayments are identified, DHCS will refund the applicable federal share consistent with OIG's recommendations.

Finding 2: State agency did not follow its policies and procedures for reviewing and updating rates in its claims processing system to ensure that the amounts it claimed for Federal Medicaid reimbursement for clinical diagnostic laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements.

Recommendation 4

We recommend that the State agency evaluate and strengthen its existing policies and procedures for reviewing and updating rates in its claims processing system to ensure that the amounts claimed for clinical diagnostic laboratory services do not exceed the amount that would be paid under the Medicare program or the amounts allowed by State requirements.

What is DHCS' Response to the Recommendation? Concurrence

DHCS' Response:

Within DHCS's claims payment system, DHCS currently maintains a Medicare rate cap table which lists laboratory and pathology procedure codes with their maximum allowed Medicare rates. This table is applied to a claim as the final step before payment is rendered. If a claim, after the application of all relevant rates add-on and policies exceed the allowable Medicare rate, the system automatically reduces the payment to the capped amount.

DHCS conducts annual reviews and updates of the clinical laboratory rate tables to ensure compliance with Federal and State requirements. In recent cycles, DHCS has worked closely with the fiscal intermediary to identify and prioritize needed system updates and clarify related business rules to ensure the table is updated accurately and to address any identified system issues. DHCS will continue collaborating with the fiscal intermediary to implement these updates and strengthen safeguards that prevent any future overpayment.

To further enhance these existing controls, DHCS will evaluate and strengthen its policies, procedures, staff training, and templates to ensure the timely and accurate updating of the rate table to ensure amounts claimed for clinical diagnostic laboratory services do not exceed the allowable amount to be paid under the Medicare program or the amounts allowed by State requirements.

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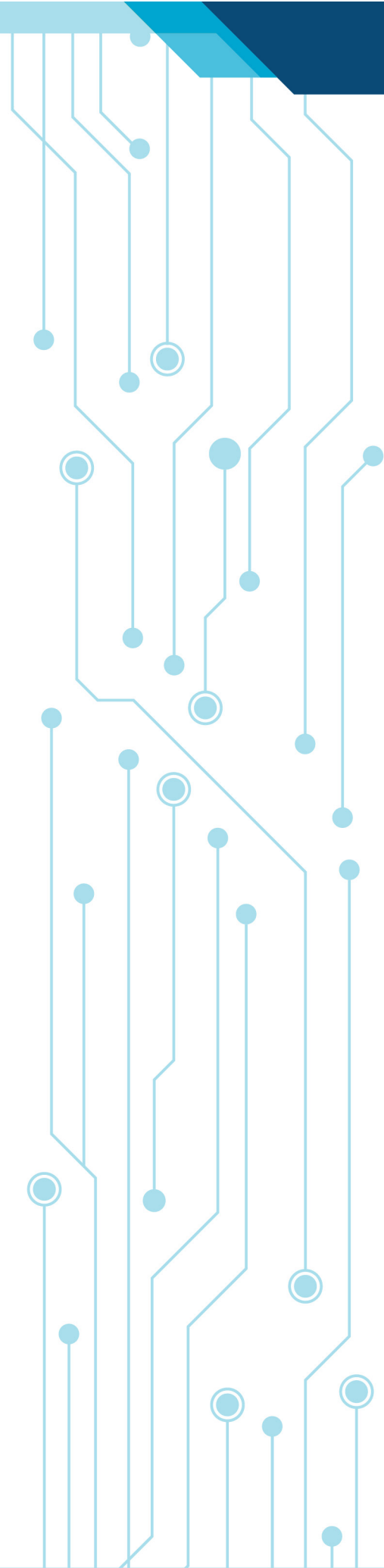
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U.S. Department of Health and Human Services

Office of Inspector General

Public Affairs

330 Independence Ave., SW

Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov