Department of Health and Human Services
Office of Inspector General
Office of Audit Services

July 2026 | OAS-25-01-084

Georgia Claimed at Least $26.1 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements

REPORT HIGHLIGHTS

July 2026 | OAS-25-01-084

Georgia Claimed at Least $26.1 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 data analysis that indicated certain States, including Georgia, are at risk for noncompliance with Federal and State requirements.
- This audit examined Georgia's fee-for-service Medicaid payments for clinical diagnostic laboratory services provided during calendar years 2019 through 2023.

What OIG Found

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

- For 648,412 of 13,603,258 services, Georgia paid providers more than they would have been paid under the Medicare program or more than the amounts allowed by State requirements.
- Additionally, for 1,910,462 professional and 618,412 hospital outpatient lines of service, Georgia potentially paid providers more than they would have paid under the Medicare program or the amounts allowed by State requirements.

As a result, the Federal reimbursement that Georgia claimed exceeded the rates allowed by the Federal and State requirements by $26.1 million ($18.5 million Federal share) and potentially exceeded the rates allowed by Federal and State requirements by an additional $4.4 million ($3.1 million Federal share).

What OIG Recommends

We made five recommendations to Georgia, including that it refund $18.5 million to the Federal Government related to professional and hospital outpatient services, conduct a self-review of the 2,528,874 lines of service to determine whether potential overpayments of $3.1 million complied with Federal and State requirements, and review payments made after our audit period to identify additional overpayments to refund to the Federal Government. The full recommendations are in the report.

Georgia concurred with all five 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 a data analysis that indicated certain States, including Georgia, are still at risk for noncompliance with Federal and State requirements. Therefore, we conducted this audit of the Georgia Department of Community Health's (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 was 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, the Centers for Medicare & Medicaid Services (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 Georgia, the State agency administers the Medicaid program. The State agency uses the Georgia Medicaid Management Information System (the System) to process Medicaid claims.

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, Georgia's FMAP ranged between 65.89 and 73.5 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 tests 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's *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 contractor 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 schedule (CLFS) that is published regularly and available to the public on the CMS web site.[4]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $363,650,993 ($257,767,428 Federal share and $105,883,565 State share) in FFS Medicaid payments for 13,603,258 clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency on the Form CMS-64 for services provided during the audit period.[5]

We calculated the amount that should have been paid according to Federal requirements and compared it to the amount that was actually paid based on a data extract from the Transformed Medicaid Statistical Information System (T-MISIS). Our analysis identified 3,177,286 claim line services for which the State agency claimed $30,509,781 ($21,655,888 Federal share and $8,853,893 State share) in Medicaid reimbursements for clinical diagnostic laboratory services

[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, "HCPCS Quarterly Update." Accessed on Feb. 26, 2026.

[4] CMS's official update of the Medicare CLFS is available at "CLFS Files | CMS." Accessed on Feb. 26, 2026.

[5] We limited our audit to professional and hospital outpatient claim types. Professional services generally cover services provided by an individual licensed under State law to practice medicine or osteopathy. Hospital outpatient services generally cover diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

that exceeded Medicare CLFS rates. We separated claim lines of service with potential overpayments of Federal share into two groups: (1) potential overpayments that were $3 or less that we did not validate with the State agency and (2) potential overpayments that were greater than $3 that we validated with the State agency. For claim lines of service with potential overpayments that were $3 or less, there were 2,528,874 lines of service with potential overpayments of $4,378,379 ($3,114,849 Federal share and $1,263,530 State share). For claim lines of service with potential overpayments that were greater than $3, there were 648,412 lines of service with potential overpayments of $26,131,402 ($18,541,039 Federal share and $7,590,363 State share).[6]

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, and Appendix B shows overpayment totals by claim type and calendar year.

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 13,603,258 services that were covered by this audit, Medicaid payments that the State agency made for 10,425,972 services did not exceed the amounts allowed by Federal and State requirements. However, for 648,412 services, the State agency paid providers more than they would have been paid under the Medicare program or more than the amounts allowed by State requirements. Specifically, the State agency paid providers for 501,021 professional services and 147,391 hospital outpatient services that exceeded the Medicare CLFS rate that we validated with the State.

Additionally, for 1,910,462 professional and 618,412 hospital outpatient lines of service, the State agency potentially paid providers more than they would have paid under the Medicare program or allowed by State requirements.[7]

As a result, the reimbursement that the State agency claimed exceeded the rates allowed by Federal and State requirements by $26,131,402 ($18,541,039 Federal share and $7,590,363 State share). In addition, State agency claimed reimbursement for an additional $4,378,379

[6] Potential overpayments greater than $3 per service accounted for approximately 20 percent of the claim line services and 86 percent of the potential overpayments.

[7] There were 2,528,874 lines of service with Federal share of potential overpayments that were $3 or less per service.

($3,114,849 Federal share and $1,263,530 State share) in clinical diagnostic laboratory services that we did not validate with the State.

Medicaid overpayments occurred because the State agency did not follow its State plan to ensure that the amounts claimed for professional and hospital outpatient clinical diagnostic laboratory services did not exceed the amount that would have been paid under the Medicare program or the amount allowed by State requirements. Specifically, the State agency did not update certain Medicaid fee schedules used to pay professional and hospital outpatient clinical diagnostic laboratory services with the applicable Medicare CLFS rates. In addition, the State agency applied reimbursement methodologies that calculated clinical diagnostic laboratory rates that exceeded the Medicare CLFS rates. Finally, the State agency had policies and procedures to conduct testing and monitoring of laboratory claims reimbursement; however, the testing did not verify that the updated, correct Medicare CLFS rates were applied to professional and hospital outpatient clinical diagnostic laboratory services.

FEDERAL AND STATE REQUIREMENTS

No Federal financial participation is available for any amounts expended for clinical diagnostic laboratory tests that exceed the amount that would be recognized under the Medicare program (the Act § 1903(i)(7) and CMS's *State Medicaid Manual* § 6300).

Medicare clinical diagnostic laboratory tests are generally reimbursed based on the Medicare fee schedule published annually by CMS (the Act § 1833(h) and 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.

The Georgia State Plan for independent laboratory and X-ray services states that payments are made for specific authorized procedures on a statewide basis and are limited to the lower of the actual charge for the procedure or the statewide rate in effect on the date of service. Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical diagnostic laboratory test (Georgia State Plan Transmittal Number: 15-006, attachment 4.19-B, page 3g, effective date July 1, 2015).

The Georgia State Plan for outpatient hospital services states that clinical diagnostic laboratory services performed for outpatient and nonhospital patients are reimbursed at the lesser of the submitted charge or at the State agency's fee schedule rates used for the laboratory services program. Clinical diagnostic laboratory services are subject to an upper payment limit described in section 1903(i)(7) of the Act, which is that amount Medicare would pay on a per test basis (or per billing code basis for a bundled/panel of tests) from Medicare's CLFS. Federal matching funds are available to the extent a State pays at or below the per test rate paid by Medicare for these services (Georgia State Plan Transmittal Number: 18-0010, attachment 4.19-B, page 8.1, effective date July 1, 2018).

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. Of the 13,603,258 services that we audited, the Medicaid payments that the State agency made for 10,425,972 services did not exceed the amounts allowed by Federal and State requirements. However, for 648,412 services, the State agency paid providers more than they would have been paid under the Medicare program or more than the amounts allowed by State requirements. Furthermore, we identified an additional 2,528,874 lines of service that the State agency paid providers that potentially exceeded the amount they would have paid under the Medicare program or allowed by State requirements.[8]

The State Agency Paid More for Professional Laboratory Services Than Allowed Under the Medicare Program

The State agency did not claim Federal Medicaid reimbursements for professional clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, the State agency paid providers more than the Medicare program and the State requirements allowed for all 501,021 professional services for HCPCS code rates we reviewed and validated with the State agency. Furthermore, we identified an additional 1,910,462 lines of service that the State agency paid providers an amount that may have exceeded what they would have paid under the Medicare program or allowed by State requirements.

Example of Overpayment for Professional Laboratory Service

During March 2020, a provider billed $4,000 to the State agency for one unit of service for HCPCS code 81162.* The State agency paid $1,988.69 to the provider. On the Medicare fee schedule for year 2020, the national limit was $1,824.88 per unit for HCPCS code 81162. The Federal and State requirements limit Medicaid reimbursement to providers to the limit in the current Medicare CLFS. Accordingly, we identified a Medicaid overpayment of $163.81 for this service ($1,988.69 minus $1,824.88). The Federal share of the overpayment is $120.40 ($163.81 multiplied by the 73.5 percent of FMAP).

* HCPCS code 81162 is used for genetic testing of the BRCA1 and BRCA2 genes, which are critical in assessing risk for breast, ovarian, and other related cancers.

The State agency sets up a statewide default rate for a HCPCS code when it is originally configured in the System. The default rate is not updated as part of the CMS annual HCPCS code rate refresh process; it is only updated when there is legislative action taken or through a

[8] There were 2,528,874 lines of service with Federal share of potential overpayments that were $3 or less per service.

high-level request process.[9] The State agency reimburses professional services at the default rate in the System on that date of service.

As a result, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $22,901,704 ($16,224,285 Federal share and $6,677,419 State share) for clinical diagnostic laboratory services that we validated with the State. In addition, State agency claimed reimbursement for an additional $3,385,813 ($2,402,136 Federal share and $983,677 State share) in clinical diagnostic laboratory services that we did not validate with the State.

The State Agency Paid More for Hospital Outpatient Laboratory Services Than Allowed Under the Medicare Program

The State agency did not claim Federal Medicaid reimbursements for hospital outpatient clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, the State agency paid providers more than the Medicare program and the State requirements allowed for all 147,391 hospital outpatient services for HCPCS code rates we reviewed and validated with the State. Furthermore, we identified an additional 618,412 lines of service that the State agency paid providers that potentially exceeded the amount they would have paid under the Medicare program or allowed by State requirements.

Example of Overpayment for Hospital Outpatient Laboratory Service for Out-of-State Provider

During February 2023, a provider billed $1,617 to the State agency for one unit of service for HCPCS code 0202U.* The State agency paid $727.65 to the provider. On the Medicare fee schedule for year 2023, the national limit was $416.78 per unit for HCPCS code 0202U. Accordingly, we identified a Medicaid overpayment of $310.67 for this service ($727.65 minus $416.78). The Federal share of the overpayment is $204.83 ($310.67 multiplied by the 65.89 percent of FMAP).

* HCPCS code 0202U is used to bill for tests to identify the cause of respiratory symptoms by detecting 22 different viruses and bacteria, including SARS-CoV-2.

In April 2014, the State agency implemented a reimbursement methodology change to the System that decreased hospital outpatient rates for clinical diagnostic laboratory services so that the rates would be at or below the Medicare CLFS. Although the System was updated annually with current rates under the Medicare CLFS, the System continued to price and pay claims based on the old rates set in April 2014. The State agency was not able to explain this error. This error caused hospital outpatient clinical diagnostic laboratory reimbursements to exceed the amounts allowed under Medicare.

[9] The high-level request process is a System Maintenance Request (SMR). As part of an SMR, the reimbursement rate, effective date, and additional coverage fields can be changed for a professional services HCPCS code.

In addition, the State agency applied reimbursement methodologies that calculated clinical diagnostic laboratory rates that exceed the rates allowed under the Medicare program or the amount allowed by the State requirements. The State agency indicated that it conducted extensive review and research and does not have documentation on why these methodologies were applied to reimburse hospital outpatient clinical diagnostic laboratory services. Specifically:

- The State plan states that outpatient services provided by out-of-State nonparticipating hospitals are reimbursed at 45 percent of covered charges. However, the Federal statutory provision limits Medicaid reimbursement to the amount recognized under the Medicare program, and there is no exception for services provided by out-of-State nonparticipating hospitals. When this 45 percent methodology was applied, it caused some hospital outpatient clinical diagnostic laboratory reimbursements to exceed the amount allowed under Medicare.

- The State agency applied a hospital tax and inpatient cap add-on rate to hospital outpatient clinical diagnostic laboratory services that resulted in an additional payment to laboratory service rates and caused some reimbursements to exceed the amount allowed under Medicare. The hospital tax add-on is based on a 1.45 percent fee on hospitals passed by the Georgia House Bill 1055 of 2010. The inpatient cap add-on is based on the comparison of the hospital outpatient claim priced through the System against the amount the claim would have been priced at if the claim had been an inpatient claim. The State pays the lesser of the two prices. However, the Federal and State requirements limit Medicaid reimbursement for clinical diagnostic laboratory services to the current Medicare CLFS.

As a result, the reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $3,229,698 ($2,316,754 Federal share and $912,944 State share) for clinical diagnostic laboratory services that we validated with the State. In addition, the State agency claimed reimbursement for an additional $992,566 ($712,713 Federal share and $279,853 State share) in clinical diagnostic laboratory services that we did not validate with the State.

RECOMMENDATIONS

- We recommend that the State agency refund $18,541,039 to the Federal Government.

- We recommend that the State agency conduct a self-review of the 2,528,874 lines of service with potential overpayments of $3,114,849 to determine whether it received any overpayments 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 follow its State plan and Federal requirements when claiming professional and hospital outpatient clinical diagnostic laboratory services so that they do not exceed the amount that would be paid under the Medicare program or the amounts allowed by State requirements.

- We recommend that the State agency update its policies and procedures for testing and monitoring clinical diagnostic laboratory services to require verification that the CMS annual updates are correctly applied to the professional fee-for-service default rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all five recommendations and described the actions that it has taken and plans to take to address them. For example, the State agency said that it submitted a State Plan Amendment to change the methodology so that claims for professional and hospital outpatient clinical diagnostic laboratory services would not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $363,650,993 ($257,767,428 Federal share and $105,883,565 State share) in FFS Medicaid payments for 13,603,258 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.[10] We calculated the amount that should have been paid according to Federal requirements and compared it to the amount that was actually paid. Our analysis identified 3,177,286 claim line services for which the State agency claimed $30,509,781 ($21,655,888 Federal share and $8,853,893 State share) in Medicaid reimbursements for clinical diagnostic laboratory services exceeding Medicare CLFS rates. We separated claim lines of service with potential overpayments of Federal share into two groups: (1) potential overpayments that were $3 or less that we did not validate with the State and (2) potential overpayments that were greater than $3 dollars that we validated with the State. For lines of service with potential overpayments that were $3 or less, there were 2,528,874 lines of service with a potential overpayment of $4,378,379 ($3,114,849 Federal share and $1,263,530 State share). For lines of service with potential overpayments that were greater than $3, there were 648,412 lines of service with a potential overpayment of $26,131,402 ($18,541,039 Federal share and $7,590,363 State share).[11]

We submitted the HCPCS codes and the corresponding rates for all 648,412 lines of service with potential overpayment greater than $3 for the State to validate the potential overpayments. In total, we submitted 1,086 professional and 1,448 hospital outpatient HCPCS code rates from the CLFS that we used in our calculations. The State agency compared the HCPCS code rates we submitted with the rates configured in the System and confirmed our calculations.

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. We assessed whether the State agency had adequate controls in place to ensure Medicaid reimbursement for clinical diagnostic laboratory services did not exceed Medicare CLFS rates. This included how the State agency processes updates to the Medicare CLFS and reimbursement methodologies for how the System prices and pays clinical diagnostic laboratory services.

[10] We limited our audit to professional and hospital outpatient claim types.

[11] Potential overpayments greater than $3 accounted for approximately 20 percent of the claim line services and 86 percent of the potential overpayments.

We established reasonable assurance of the authenticity and accuracy of the data extracted from the T-MISIS 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.

We conducted our audit from March 2025 through May 2026.

METHODOLOGY

To accomplish our audit objective, we:

- Reviewed applicable Federal and State laws, regulations, and guidance and the CMS-approved State plan

- Corresponded with officials from CMS and the State agency to gain an understanding of the State plan and amendments

- Interviewed officials from the State agency to gain an understanding of how clinical diagnostic laboratory services are reimbursed

- 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

- Evaluated the claims data to identify 13,603,258 Medicaid FFS and hospital outpatient clinical diagnostic laboratory services totaling $363,650,993 ($257,767,428 Federal share and $105,883,565 State share)

- 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 in excess of the amounts allowed by State regulations and the amounts that would be paid under the Medicare program by:

    - Computing what the Medicare payment limit should be for each service by multiplying the Medicare clinical laboratory fee schedule rate by the number of units billed, per HCPCS code

    - Calculating 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 for each service

- Submitting to the State, for validation with the rates in the System, the HCPCS codes and the corresponding rates from the CLFS we used in our calculations for lines of service Federal share of potential overpayment greater than $3

- Totaling the differences

- 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.

APPENDIX B: FEDERAL MEDICAID REIMBURSEMENT FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES EXCEEDED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

Table 1: Medicaid Overpayments by Calendar Year Validated With The State

Year	Category	Number of Services	Share of Overpayment	Total State Share of Overpayment	Total
2019	Hospital	16,569	$287,779	$124,712	$412,491
	Professional	63,917	5,508,120	2,600,778	8,108,898
2020	Hospital	26,092	390,447	141,900	532,346
	Professional	110,764	4,889,022	1,771,423	6,660,445
2021	Hospital	28,049	537,466	197,858	735,325
	Professional	118,832	1,881,351	691,424	2,572,774
2022	Hospital	52,340	739,760	281,279	1,021,039
	Professional	121,713	2,223,964	841,134	3,065,099
2023	Hospital	24,341	361,303	167,194	528,497
	Professional	85,795	1,721,828	772,660	2,494,488
Total		**648,412**	**$18,541,039**	**$7,590,363**	**$26,131,402**

Table 2: Medicaid Overpayments by Calendar Year Not Validated With The State

Year	Category	Number of Services	Total Fed Share of Overpayment	Total State Share of Overpayment	Total
2019	Hospital	85,623	$85,419	$39,741	$125,160
	Professional	602,562	599,592	285,243	884,835
2020	Hospital	288,576	262,378	94,883	357,261
	Professional	328,890	463,939	168,271	632,210
2021	Hospital	82,984	125,083	46,031	171,114
	Professional	332,151	464,361	171,030	635,391
2022	Hospital	79,547	118,698	44,750	163,448
	Professional	317,156	435,360	164,777	600,137
2023	Hospital	81,682	121,136	54,448	175,584
	Professional	329,703	438,883	194,357	633,240
Total		**2,528,874**	**$3,114,849**	**$1,263,530**	**$4,378,379**

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Dean Burke, MD, Commissioner**

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July 7, 2026

Regional Inspector General for Audit Services
Office of the Inspector General
15 New Sudbury Street
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Re: Report Number: **OAS-25-01-084**

OIG Aduit Services Department:

The Department of Community Health (DCH) has reviewed the draft report titled **Georgia *Claimed at Least $26.1 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements*.** Georgia works diligently to assure that claims for Federal Medicaid reimbursement for clinical diagnostic laboratory services are in accordance with Federal and State requirements. Georgia welcomes the opportunity to correct any processes that have led to claims that exceeded the amounts that would have been paid under the Medicare program or the amounts allowed by State requirements.

Attachment A outlines the actions DCH will take to resolve each finding. DCH appreciates the work performed by HHS OIG and the opportunity to respond to the draft audit report.

If you have any other questions, please contact Stuart Portman, Georgia Medicaid Executive Director at Stuart.portmant@dch.ga.gov.

Sincerely,
Stuart Portman

Stuart Portman
Executive Director

CC: Dean Burke, Commissioner
Lisa Davies, Chief Operating Officer
Sybil Henderson, Policy Administration Director
Sonja Allen-Smith, Inspector General

ATTACHMENT A

OIG Recommendation No. 1:
We recommend that the State agency refund $18,541,039 to the Federal Government.

DCH Response to Recommendation No. 1:
The Department concurs with the recommendation and will refund the $18,541,039 to the Federal Government as a return of funds on June CMS64.

OIG Recommendation No. 2:
We recommend that the State agency conduct a self-review of the 2,528,874 lines of service with potential overpayments of $3,114,849 to determine whether it received any overpayments and refund the Federal share of any overpayments to the Federal Government.

DCH Response to Recommendation No. 2:
The Department concurs with this recommendation and will work with our vendor to conduct a self-review of the **2,528,874 lines of service** with potential overpayments of $3,114,849 to determine whether any overpayments were received and refund the Federal share of any overpayments to the Federal Government. The audit will be conducted over the audit period covering clinical diagnostic laboratory services provided during calendar years 2019-2023 and any identified overpayments will be refunded as a return of funds.

Recommendation No. 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.

DCH Response to Recommendation No. 3:
The Department concurs with this recommendation. The State agency will review payments made **after** the Lab audit period to identify any additional overpayments and refund the Federal share to the Federal Government.

Additionally, the State agency will **identify** any additional overpayments refunded as having been made in accordance with the recommendations.

Recommendation No. 4:
We recommend that the State agency follow its State plan and Federal requirements when claiming professional and hospital outpatient clinical diagnostic laboratory services so that they do not exceed the amount that would be paid under the Medicare program or the amounts allowed by State requirements.

DCH Response to Recommendation No. 4:

The Department concurs with this recommendation. The State agency submitted the State Plan Amendment (SPA) on June 30, 2026 to change the methodology, so not to exceed the amount that would be paid under the Medicare program or the amounts allowed by State requirements. The effective date of the SPA will be June 12, 2026.

Recommendation No. 5:

We recommend that the State agency update its policies and procedures for testing and monitoring clinical diagnostic laboratory services to require verification that the CMS annual updates are correctly applied to the professional fee-for-service default rate.

DCH Response to Recommendation No. 5:

The Department concurs with this recommendation, and the State Agency has already completed the update to its laboratory services policies and procedures. Additionally, the State has implemented monitoring of clinical diagnostic laboratory services and applied reimbursement methodology through a contracted vendor to perform specific **Agreed Upon Procedures** (AUP) for the Georgia Department of Community Health (DCH).

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Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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