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

July 2026 | OAS-25-01-004

Connecticut Generally Claimed Medicaid Reimbursement for Clinical Diagnostic Laboratory Services in Accordance With Federal and State Requirements

REPORT HIGHLIGHTS

July 2026 | OAS-25-01-004

Connecticut Generally Claimed Medicaid Reimbursement for Clinical Diagnostic Laboratory Services in Accordance With 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 regulations.
- We performed this audit because a recent OIG data analysis indicated that certain States, including Connecticut, are at risk for noncompliance with Federal and State requirements.
- This audit examined Connecticut's fee-for-service Medicaid payments for clinical diagnostic laboratory services provided during calendar years 2019 through 2023.

What OIG Found

Connecticut generally claimed Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, over 99 percent of the fee-for-service Medicaid payments that we audited complied with Federal and State requirements, and less than 1 percent did not or potentially did not comply.

However, for a small number of Medicaid payments the Federal reimbursement that Connecticut claimed exceeded the rates allowed by the Federal and State requirements by $273,485 ($152,728 Federal share) and potentially exceeded the rates allowed by Federal and State requirements by an additional $1,069,983 ($582,301 Federal share).

What OIG Recommends

We made two recommendations to Connecticut, including that it refund $152,728 to the Federal Government and work with CMS to determine whether the potential overpayments of $582,301 complied with Federal and State requirements and refund the Federal share of any overpayments to the Federal Government. The full recommendations are in the report.

Connecticut concurred with our first recommendation. It did not indicate concurrence or nonoccurrence with our second recommendation but stated that it appreciated the opportunity to discuss the recommendation further with CMS.

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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 certain States, including Connecticut, are at risk for noncompliance with Federal and State requirements. Therefore, we conducted this audit of the Connecticut Department of Social 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.[1]

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 Connecticut, 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, Connecticut'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).

[1] *California Made at Least $13.9 Million More in Medicaid Reimbursements for Clinical Diagnostic Laboratory Services Than Was Allowed by Federal and State Requirements*, (OAS-25-01-076), June 8, 2026.

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.[2] Annually, CMS furnishes to the Medicare contractors the proper amount to pay for each HCPCS code.[3] This information is available to the public on the CMS Web site.[4] CMS also maintains the Medicare clinical laboratory fee schedules (CLFS), which are published regularly and available to the public on the CMS web site.[5]

HOW WE CONDUCTED THIS AUDIT

The State agency made $543,089,603 ($297,384,471 Federal share) in FFS Medicaid payments for 45,080,580 clinical diagnostic laboratory services with claim type codes 8013 (outpatient hospital), 8014 (hospital laboratory services provided to nonpatients), 8700 (professional), and 8072 (end-stage renal disease dialysis).[6] These services were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period. We compared the amount that should have been paid according to Federal requirements to the amount that was actually paid. Initially, we identified $28,976,797 ($15,618,798 Federal share) in FFS Medicaid payments for 614,358 clinical diagnostic laboratory services with these claim type codes that potentially exceeded the amounts that would have been paid under the Medicare CLFS or the Connecticut fee schedule.

[2] 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.

[3] The *Medicare Claims Processing Manual*, chapter 16, § 20.

[4] CMS, "CMS HCPCS Quarterly Update." Accessed on Jan. 21, 2026.

[5] CMS's official update of the Medicare CLFS is available at "CLFS Files | CMS." Accessed on Jan. 21, 2026.

[6] Our audit did not include HCPCS codes without CMS-established payment limits.

After discussions with the State agency, we determined that the services associated with claim types 8013 (outpatient hospital) and 8072 (end-stage renal disease dialysis) were not subject to Medicare CLFS or Connecticut fee schedule payment limits. Therefore, we limited our audit to claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) with HCPCS codes listed on the Medicare fee schedules for each CY. The State agency made $365,825,551 ($199,971,886 Federal share) in FFS Medicaid payments for 36,806,922 clinical diagnostic laboratory services with claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) that were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period.

We identified $3,995,192 ($2,179,071 Federal share) in FFS Medicaid payments for 455,674 clinical diagnostic laboratory services with claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) that potentially exceeded the amounts that would have been paid under the Medicare CLFS or Connecticut fee schedule.[7] We did not review all services that potentially exceeded the rates allowed under the Medicare program because the financial impact of those services was de minimis. Specifically, we limited our review to services with potential overpayments greater than $2 (combined share), which totaled $2,786,714 ($1,523,516 Federal share) in FFS Medicaid payments for 120,497 clinical diagnostic laboratory services. 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.

The Appendix contains details of our audit scope and methodology.

FINDINGS

The State agency generally claimed Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the $365,825,551 ($199,971,886 Federal share) in FFS Medicaid payments for clinical diagnostic laboratory services with claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional), $364,482,083 ($199,236,856 Federal share), or 99.6 percent, complied with the payment limits set in Federal and State requirements. However, for a small number of Medicaid payments the Federal reimbursement that Connecticut claimed exceeded the rates

[7] The remaining $361,830,359 ($197,792,815 Federal share) did not exceed the payment limits set in Federal requirements ($365,825,551 minus $3,995,192 equals $361,830,359).

allowed by the Federal and State requirements by $273,485 ($152,728 Federal share) and potentially exceeded the rates allowed by Federal and State requirements by an additional $1,069,983 ($582,301 Federal share).

The Medicaid overpayments occurred because the State agency did not follow its policies and procedures for reviewing and updating payment limits set in Federal and State requirements for a small number of procedure codes. Specifically, the State agency did not update the payments limits for 19 of approximately 1,500 codes.

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) 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 State agency reviews Medicare rate changes annually to ensure compliance with Federal requirements and publishes State fee schedule rates (the Connecticut State Plan, addendum page 11 to attachment 4.19-B).

The State regulations state that payment made to independent clinical diagnostic laboratory service providers must be made at the lowest of: the provider's usual and customary charge to the general public, the lowest Medicare rate, the amount in the applicable fee schedule as published by the State agency, the amount billed by the provider, or the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity (Regulations of Connecticut State Agencies § 17b-262-649 (a)).

The State agency uses an Ambulatory Payment Classification (APC) system for all outpatient hospital services. The APC system is based on Medicare's system but modified for Connecticut's Medicaid program. The APC system uses national weights and a statewide conversion factor that is the same for every hospital, plus an adjustment for the geographic wage index based on the county in which the hospital is located.[8] Some services are paid outside the APC methodology using Medicaid fee schedules (Connecticut State Plan, addendum page 1a-1c to attachment 4.19-B, page 1). The State agency did not anticipate that this State Plan Amendment would change Federal Medicaid expenditures because reimbursement rates under

[8] The "APC relative weight" is the relative value assigned to each APC and is the same as Medicare's weight. The "APC conversion factor" is a set dollar amount determined by the department that is used as the basis for calculating the payment for outpatient hospital services based on the APC payment methodology.

the new payment methodology were calculated to be revenue neutral overall (Connecticut State Plan Transmittal Number: 16-0016-A, effective date July 1, 2016).

MOST MEDICAID PAYMENTS DID NOT EXCEED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

The State agency generally claimed Federal Medicaid reimbursement in accordance with the payment limits set in Federal and State requirements. For 3,204 of the 120,497 clinical diagnostic laboratory 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.

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	29,345	$507,638	$256,803	15	$9,171	$4,586
2020	20,450	413,750	232,519	6	2,331	1,310
2021	26,179	483,864	271,902	232	22,881	12,859
2022	24,481	948,929	532,987	2,904	224,936	126,409
2023	20,042	432,534	229,306	47	14,166	7,564
Total	**120,497**	**$2,786,714**	**$1,523,516**	**3,204**	**$273,485**	**$152,728**

In total, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $273,485 ($152,728 Federal share).

Example of an Overpayment

During February 2022, a provider billed the State agency for one unit of service for HCPCS code 87804.* The State agency paid $17.18 to the provider and claimed $9.66 for Federal Medicaid reimbursement. On the Medicare fee schedule for 2022 the national payment limit was $16.55 per unit for HCPCS code 87804. However, the State plan further limited Medicaid reimbursement for this HCPCS on the State fee schedule. For 2022, the State limit was $11.45 for one unit. As a result, we identified a Medicaid overpayment of $5.73 ($17.18 minus $11.45). The Federal share of the overpayment is $3.22 ($5.73 multiplied by the 56.2 percent of FMAP).

* HCPCS code 87804 (influenza test, which is a detection test by immunoassay with direct optical observation) is used to bill for tests to detect the presence of influenza antigens.

A SMALL NUMBER OF MEDICAID PAYMENTS POTENTIALLY EXCEEDED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

The State agency generally claimed Federal Medicaid reimbursement in accordance with the payment limits set in Federal and State requirements. However, for 9,197 of the 120,497 clinical diagnostic laboratory 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 services reimbursed under the State's outpatient hospital APC system. We were unable to calculate the amount of clinical diagnostic laboratory services provided to hospital nonpatients that exceeded the amounts allowed by Federal and State requirements because these services were paid based on the rate determined by the APC system instead of the Medicare fee schedule rate, and we do not have complete claim information for these services to make a determination.

Although the State agency bills for services provided to outpatient hospital nonpatients using procedure codes that appear on Medicare's CLFS, it maintains that these services are paid under the State's outpatient hospital APC system and, therefore, are not subject to Medicare's rate limitations for clinical laboratory services. However, based on the CMS-approved State plan, "[l]aboratory services provided to hospital non-patients are reimbursed in accordance with section 3 of Attachment 4.19-B." Section 3 states that laboratory services are paid based on the State agency's fee schedule (Connecticut State Plan, addendum page 1c to attachment 4.19-B, page 1, under the section "Services Reimbursed Separately from APC").

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	29,345	$507,638	$256,803	2,134	$243,197	$122,808
2020	20,450	413,750	232,519	2,070	239,244	134,455
2021	26,179	483,864	271,902	1,873	219,443	123,312
2022	24,481	948,929	532,987	1,573	187,455	105,313
2023	20,042	432,534	229,306	1,547	180,644	96,413
Total	**120,497**	**$2,786,714**	**$1,523,516**	**9,197**	**$1,069,983**	**$582,301**

In total, the Federal reimbursement claimed by the State agency potentially exceeded the rates allowed by Federal and State requirements by $1,069,983 ($582,301 Federal share).

Example of a Potential Overpayment

During July 2023, a provider billed the State agency for one unit of service for HCPCS code 86850 provided to a hospital nonpatient.* The State agency paid $51.69 to the provider and claimed $27.14 for Federal Medicaid reimbursement under the APC system. On the Medicare fee schedule for 2023, the national payment limit was $9.77 per unit for HCPCS code 86850. However, the State plan further limited Medicaid reimbursement for this HCPCS on the State fee schedule. For 2023, the State limit was $3.65 for one unit. As a result, we identified a potential Medicaid overpayment of $48.04 ($51.69 minus $3.65). The Federal share of the potential overpayment is $25.22 ($48.04 multiplied by the 52.5 percent of FMAP).

*HCPCS code 86850 (antibody screen, red blood cell antigen typing) is used to bill for tests to analyze specific red blood cell antibodies in blood. These antibodies in a person receiving a blood transfusion or mother's blood during pregnancy are reviewed to assess the risk of antibodies destroying red blood cells that are foreign.

THE STATE AGENCY DID NOT FOLLOW ITS STATE PLAN

The Medicaid overpayments occurred because the State agency did not follow its State plan for reviewing and updating payment limits set in Federal and State requirements for a small number of procedure codes. Specifically, the State agency did not update the payments limits for 19 of approximately 1,500 codes.

RECOMMENDATIONS

- We recommend that the State agency refund $152,728 to the Federal Government.

- We recommend that the State agency work with CMS to determine whether potential overpayments of $582,301 (Federal share) complied with Federal and State requirements and refund the Federal share of any overpayments to the Federal Government.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first recommendation and described the corrective actions that it has taken or plans to take to address it. For example, the State agency said that it is implementing a systematic review to identify other procedure codes for which the reimbursement rule will be updated to reimburse the service accurately. The State agency also said that it is developing a process to identify and reprocess claims when a reimbursement rule is updated retroactively.

The State agency did not indicate concurrence or nonoccurrence with our second recommendation but stated that it appreciated the opportunity to discuss the recommendation further with CMS.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

The State agency made $543,089,603 ($297,384,471 Federal share) in FFS Medicaid payments for 45,080,580 clinical diagnostic laboratory services with claim type codes 8013 (outpatient hospital), 8014 (hospital laboratory services provided to nonpatients), 8700 (professional), and 8072 (end-stage renal disease dialysis).[9] These services were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period. We compared the amount that should have been paid according to Federal requirements to the amount that was actually paid. Initially, we identified $28,976,797 ($15,618,798 Federal share) in FFS Medicaid payments for 614,358 clinical diagnostic laboratory services with these claim type codes that potentially exceeded the amounts that would have been paid under the Medicare CLFS or the Connecticut fee schedule.

After discussions with the State agency, we determined that the services associated with claim types 8013 (outpatient hospital) and 8072 (end-stage renal disease dialysis) were not subject to Medicare CLFS or Connecticut fee schedule payment limits. Therefore, we limited our audit to claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) with HCPCS codes listed on the Medicare fee schedules for each CY. The State agency made $365,825,551 ($199,971,886 Federal share) in FFS Medicaid payments for 36,806,922 clinical diagnostic laboratory services with claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) that were submitted by providers and claimed by the State agency on Form CMS-64 for services provided during the audit period.

We identified $3,995,192 ($2,179,071 Federal share) in FFS Medicaid payments for 455,674 clinical diagnostic laboratory services with claim type codes 8014 (hospital laboratory services provided to nonpatients) and 8700 (professional) that potentially exceeded the amounts that would have been paid under the Medicare CLFS or Connecticut fee schedule.[10] We did not review all services that potentially exceeded the rates allowed under the Medicare program because the financial impact of those services was de minimis. Specifically, we limited our review to services with potential overpayments greater than $2 (combined share), which totaled $2,786,714 ($1,523,516 Federal share) in FFS Medicaid payments for 120,497 clinical diagnostic laboratory services. 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.

[9] Our audit did not include HCPCS codes without CMS-established payment limits.

[10] The remaining $361,830,359 ($197,792,815 Federal share) did not exceed the payment limits set in Federal requirements ($365,825,551 minus $3,995,192 equals $361,830,359).

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.

We conducted our audit from October 2024 through May 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 in excess of 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 120,497 Medicaid FFS clinical diagnostic laboratory services totaling $2,786,714 ($1,523,516 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.

STATE OF CONNECTICUT

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Social Services

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July 13, 2026

Richard Miller
HHS Office of Inspector General
Office of Audit Services

The Connecticut Department of Social Services (DSS) appreciates the opportunity to review and comment on the Office of Inspector General's draft report titled, "*Connecticut Generally Claimed Medicaid Reimbursement for Clinical Diagnostic Laboratory Services in Accordance With Federal and State Requirements*" Report Number: (OAS-25-01-004).

As noted in the report, Connecticut generally claimed Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements, with more than 99.6 percent of reviewed payments found to be compliant. The audit identified a limited number of procedure codes for which reimbursement exceeded applicable payment limits. DSS reviewed the audit findings and recommendations; responses are detailed below.

Recommendation 1: Refund $152,728 to the Federal Government.

State Response:

The majority of the identified overpayments resulted from a reimbursement rule update that was implemented retrospectively within the claims processing system. This update did not account for claims already processed at the incorrect rate. Specifically, claims reprocessing associated with a small subset of procedure codes were not implemented following the revisions to the applicable reimbursement methodologies. The affected codes represented 19 of approximately 1,500 laboratory procedure codes maintained by the program.

DSS concurs with this recommendation. DSS confirms the identified overpayments and will work with CMS to ensure the appropriate Federal share is returned in accordance with established adjustment and reconciliation processes.

DSS Corrective actions:

- Implementing a systematic review to identify other procedure codes for which the reimbursement rule will be updated to reimburse the service accurately

- Developing a process to identify and reprocess claims when a reimbursement rule is updated retroactively

Recommendation 2: Work with CMS to determine whether potential overpayments of $582,301 (Federal share) complied with Federal and State requirements and refund the Federal share of any overpayments to the Federal Government.

State Response: While DSS maintains that current reimbursement for laboratory services in the outpatient hospital setting aligns with CT Medicaid regulations and State Plan Amendment, we appreciate the opportunity to discuss it further with CMS.

DSS appreciates OIG's recognition that the State generally complied with Federal and State requirements and remains committed to maintaining program integrity and ensuring accurate Medicaid reimbursement.

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