Referral packet: DAVID SMITH

Draft for reviewer. Prepared September 6, 2026. Every statement below cites the numbered public record it came from.

Subject	Findings	Public records cited	Regulations
NPI 1780780031	13	14	4

> This packet describes public records and dates. It does not assert fraud, intent or guilt. Each finding cites the numbered records at the end, and the section Rule out first lists the ordinary explanations a reviewer must eliminate before any action.

Summary

DAVID SMITH (NPI **1780780031**) is an individual in Winston Salem, NC. The registry taxonomy is 2084P0802X. It is enrolled in Medicaid in NC. Medicare revoked billing privileges on **August 30, 2021** under **42 CFR 424.535(a)(1)** noncompliance (not professionally licensed) and 424.535(a)(9) failure to report. The bar on re-enrolling runs to **October 21, 2027**.

Description

Evidence tier 1: documented action, then payment. Dollars at stake are **$1,063,751,** taken from the detector that set the tier. Listed on the Medicare revocation list and the SC Medicaid exclusion list since **August 30, 2021**. Medicaid still paid claims in 7 later months, **$1,063,751** in total. Medicaid dollars per patient on code 80307 (**$557** per patient-month) sit in the top **5%** of every provider billing that code. Medicare revoked billing privileges on **August 30, 2021** under **42 CFR 424.535(a)(1)** noncompliance (not professionally licensed) and 424.535(a)(9) failure to report.

What the records show

01 Evidence tier 1: documented action, then payment. Dollars at stake are **$1,063,751,** taken from the detector that set the tier.
Records 2 (Verity risk tier)

02 Listed on the Medicare revocation list and the SC Medicaid exclusion list since **August 30, 2021**.
Records 3 (Verity risk tier)

03 Medicaid still paid claims in 7 later months, **$1,063,751** in total.
Records 4 (Verity risk tier)

04 Medicaid dollars per patient on code 80307 (**$557** per patient-month) sit in the top **5%** of every provider billing that code.

Records 5 (Verity risk tier)

05 Medicare revoked billing privileges on **August 30, 2021** under **42 CFR 424.535(a)(1)** noncompliance (not professionally licensed) and 424.535(a)(9) failure to report. The bar on re-enrolling runs to **October 21, 2027**.

Records 6 (Medicare revocation list)

06 The Medicare revocation list action is dated **August 30, 2021**. Medicaid then paid **$1,063,751** across 7 later months, from **September 2021** to **December 2022**. The screening window closes on **October 21, 2027**. In the 12 months before the action Medicaid paid **$2,674,933**.

Records 7 (paid after a list action)

07 The SC Medicaid exclusion list action is dated **November 16, 2022**. Medicaid then paid **$23,337** across 1 later month, from **December 2022** to **December 2022**. In the 12 months before the action Medicaid paid **$246,274**.

Records 8 (paid after a list action)

08 Code G0483, Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms, was paid **$2,912,337** over 24 months. That is **68%** of this provider's Medicaid dollars. It runs at **$557** per patient-month. That ranks at the 99th percentile of all providers billing this code, where the typical figure is **$146**.

Records 9 (procedures billed, Medicaid)

09 Code 80307, Testing for presence of drug, by chemistry analyzers, was paid **$1,079,222** over 24 months. That is **25%** of this provider's Medicaid dollars. It runs at **$206** per patient-month. That ranks at the 99th percentile of all providers billing this code, where the typical figure is **$45**.

Records 10 (procedures billed, Medicaid)

10 Code 99213, Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more, was paid **$70,293** over 14 months. That is **2%** of this provider's Medicaid dollars. It runs at **$115** per patient-month. That ranks at the 96th percentile of all providers billing this code, where the typical figure is **$44**.

Records 11 (procedures billed, Medicaid)

11 Code 99214, Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more, was paid **$57,525** over 26 months. That is **1%** of this provider's Medicaid dollars. It runs at **$71** per patient-month. That ranks at the 62nd percentile of all providers billing this code, where the typical figure is **$60**.

Records 12 (procedures billed, Medicaid)

12 Code 99215, Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more, was paid **$46,306** over 5 months. That is **1%** of this provider's Medicaid dollars. It runs at **$186** per patient-month. This code family has a history of abuse.

Records 13 (procedures billed, Medicaid)

13 Code U0003, Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), amplified probe technique, making use of high throughput technologies as described by cms-2020-01-r, was paid **$42,000** over 6 months. That is **1%** of this provider's Medicaid dollars. It runs at **$128** per patient-month. That ranks at the 89th percentile of all providers billing this code, where the typical figure is **$75**.

Records 14 (procedures billed, Medicaid)

Regulations this relates to

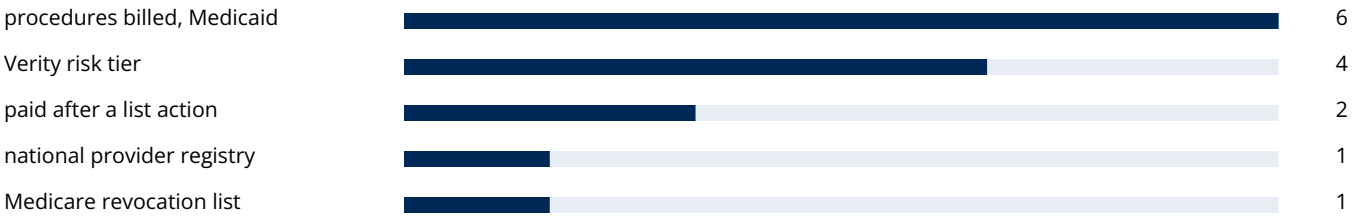
42 CFR 455.416(c) the State Medicaid agency must deny or terminate the enrollment of any provider that is terminated on or after January 1, 2011 under Medicare or under the Medicaid program or CHIP of any other State and is included in the termination database under 455.417.

42 CFR 455.436 states must confirm identity and determine exclusion status through routine checks of the Social Security Death Master File, NPPES, the LEIE and the EPLS (now SAM), upon enrollment and reenrollment and, for the LEIE and EPLS, no less frequently than monthly.

42 CFR 455.23 the State Medicaid agency must suspend all Medicaid payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending, unless there is good cause not to suspend or to suspend only in part; 455.23(d) requires referral to the Medicaid Fraud Control Unit.

42 CFR 424.535(a) Medicare revocation grounds; the basis of the Medicare action cited in the evidence (for example (a)(2) exclusion, (a)(3) felony, (a)(4) false or misleading information, (a)(5) not operational at the practice location, (a)(8) abuse of billing privileges).

Where the records come from



Recommended next step

Route to the health plan special investigations unit, and to the state Medicaid program integrity unit where the payer is a Medicaid managed care plan, for a records request and a screening check under **42 CFR 455.436.** Consider a pre-payment review pending that check; a payment suspension under **42 CFR 455.23** requires the state's own credible-allegation determination. Verify every fact against the cited rows before any action. This packet is a screening product, not a finding.

Procedures behind the dollars

G0483 Medicaid: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to gc/ms (any type, single or tandem) and lc/ms

99th percentile of providers on this code, $557 per patient-month against a typical $146

80307	Medicaid: Testing for presence of drug, by chemistry analyzers 99th percentile of providers on this code, $206 per patient-month against a typical $45	$1.1M 25%
99213	Medicaid: Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more 96th percentile of providers on this code, $115 per patient-month against a typical $44	$70K 2%
99214	Medicaid: Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more 62nd percentile of providers on this code, $71 per patient-month against a typical $60	$58K 1%
99215	Medicaid: Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more	$46K 1%
U0003	Medicaid: Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), amplified probe technique, making use of high throughput technologies as described by cms-2020-01-r 89th percentile of providers on this code, $128 per patient-month against a typical $75	$42K 1%

Rule out first

- A revocation can be reversed on appeal or through a corrective action plan; confirm the current enrollment status with the state and in PECOS before acting.
- State lists carry reinstatements and administrative terminations; confirm the action type with the listing agency.

Public records cited

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national provider registry

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