Referral packet: HISHAM SADEK

Draft for reviewer. Prepared September 5, 2026. Every statement below cites the numbered public record it came from.

Subject	Findings	Public records cited	Regulations
NPI 1619941614	11	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

Public records show NPI **1619941614**, HISHAM SADEK, an individual psychiatry provider in Chicago, IL, has been on the Indiana Medicaid termination list since **July 15, 2015**, and that Medicaid paid **$2,029,469** across 54 service months from **May 2020** through **November 2024**, with **$0** paid in the 12 months before the action. Medicare revoked billing privileges on **August 6, 2025** under 424.535(a)(9) and 424.535(a)(12) with a re-enrollment bar to **January 14, 2031**, and the provider's Medicaid evaluation and management billing sits at the 93rd and 94th percentiles for codes 99215, 99213 and 99214, which together warrant a records request and an enrollment status review.

Description

HISHAM SADEK is an individual provider in Chicago, Illinois, with a psychiatry taxonomy and Illinois as the Medicaid home state. Indiana Medicaid placed this provider on its termination list on **July 15, 2015**. Records show Medicaid paid **$2,029,469** to this provider across 54 service months between **May 2020** and **November 2024**, while nothing was paid in the 12 months before the Indiana action. Medicare separately revoked the provider on **August 6, 2025** for failure to report and for another program termination, with a bar on re-enrollment until **January 14, 2031**. Within Medicaid, the largest paid codes are office visits at high, low and moderate levels of decision making, and the per patient per month amounts for those codes rank at the 93rd, 94th and 94th percentiles compared with other providers billing the same codes.

What the records show

01 NPI **1619941614** is listed in NPPES as HISHAM SADEK, an individual in Chicago, IL, with taxonomy 2084P0800X and Illinois as the Medicaid home state.

Records 1 (providers/NPPES)

02 The provider has been listed on the Indiana Medicaid exclusion list since **July 15, 2015**, and Medicaid still paid claims in 54 later months totaling **$2,029,469**.

Records 12 (provider risk)

03 After the Indiana state exclusion action of **July 15, 2015**, taken from the Indiana Family and Social Services Administration terminations file, Medicaid paid **$2,029,469** across 54 service months from **May 2020** through **November 2024**, and **$0** in the 12 months before.

Records 14 (flags/D3 + T-MSIS spending)

04 Medicare revoked the provider on **August 6, 2025** under 424.535(A)(9) Failure To Report and 424.535(A)(12) Other Program Termination (Medicaid), with a re-enrollment bar to **January 14, 2031**.

Records 13 (Revocation Extract)

05 Code 99215 accounts for **$666,791** paid over 32 months, 33 percent of this provider's Medicaid dollars, at **$186** per patient-month, the 93rd percentile among providers billing this code, where typical is **$88,** and this code family has a history of abuse.

Records 2 (procedures billed, Medicaid)

06 Code 99213 accounts for **$572,204** paid over 46 months, 28 percent of this provider's Medicaid dollars, at **$101** per patient-month, the 94th percentile among providers billing this code, where typical is **$44**.

Records 3 (procedures billed, Medicaid)

07 Code 99214 accounts for **$151,844** paid over 16 months, 7 percent of this provider's Medicaid dollars, at **$127** per patient-month, the 94th percentile among providers billing this code, where typical is **$60**.

Records 6 (procedures billed, Medicaid)

08 Code 90792 accounts for **$202,708** paid over 45 months, 10 percent of Medicaid dollars, at **$159** per patient-month, the 75th percentile, where typical is **$112**; code 90836 accounts for **$176,186** over 34 months, 9 percent of Medicaid dollars, at **$114** per patient-month, the 81st percentile, where typical is **$72**.

Records 4 (procedures billed, Medicaid), 5 (procedures billed, Medicaid)

09 Code T1016 case management accounts for **$97,730** paid over 7 months, 5 percent of this provider's Medicaid dollars, at **$229** per patient-month, the 78th percentile, where typical is **$98**.

Records 7 (procedures billed, Medicaid)

10 In Medicare 2024 the provider billed 433 services of code 99213 for 75 beneficiaries with **$26,494** paid, 33 services of code 99443 for 24 beneficiaries with **$3,119** paid, 18 services of code 90792 for 18 beneficiaries with **$2,395** paid, and 19 services of code 99214 for 14 beneficiaries with **$1,783** paid.

Records 8 (procedures billed, Medicare 2024), 9 (procedures billed, Medicare 2024), 10 (procedures billed, Medicare 2024), 11 (procedures billed, Medicare 2024)

11 The risk record is evidence tier 1 (documented action, then payment) with detectors D3 and D2 and dollars at risk of **$2,029,469,** described as the figure of the detector that set the tier and not a sum.

Records 12 (provider risk)

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.

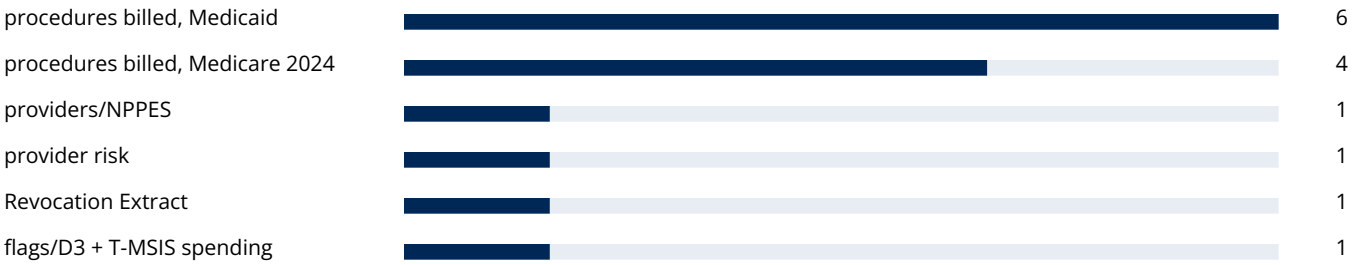
42 CFR 455.436

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

Request from the Illinois Medicaid agency and any contracted managed care plans the full enrollment file, revalidation history and screening logs for NPI **1619941614**, plus the claim level detail for the 54 service months from **May 2020** through **November 2024** that total **$2,029,469**. Confirm whether the Indiana Medicaid termination of **July 15, 2015** appears in the termination database and whether denial or termination of enrollment was required under **42 CFR 455.416(c)**. Document the monthly exclusion and identity screening required by **42 CFR 455.436**, including NPPES, the Social Security Death Master File, the List of Excluded Individuals and Entities and SAM, and identify the months in which the Indiana action should have surfaced. Obtain the Medicare revocation record dated **August 6, 2025** citing 424.535(a)(9) and 424.535(a)(12) with the bar to **January 14, 2031**, and reconcile it against the grounds in **42 CFR 424.535(a)**. Pull medical records and time documentation for a sample of 99215, 99213 and 99214 claims, given the 93rd and 94th percentile per patient-month figures, to test level of service support. If the review establishes a credible allegation of fraud, apply the payment suspension analysis under **42 CFR 455.23(a)** and make the referral to the Medicaid Fraud Control Unit required by **42 CFR 455.23(d)**.

Procedures behind the dollars

99215 Medicaid: Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more — $667K 33%

93rd percentile of providers on this code, $186 per patient-month against a typical $88; code family with a history of abuse

99213 Medicaid: Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more — $572K 28%

94th percentile of providers on this code, $101 per patient-month against a typical $44

90792	Medicaid: Psychiatric diagnostic evaluation with medical services 75th percentile of providers on this code, $159 per patient-month against a typical $112	$203K 10%
90836	Medicaid: Psychotherapy with evaluation and management visit, 45 minutes 81st percentile of providers on this code, $114 per patient-month against a typical $72	$176K 9%
99214	Medicaid: Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more 94th percentile of providers on this code, $127 per patient-month against a typical $60	$152K 7%
T1016	Medicaid: Case management each 15 min 78th percentile of providers on this code, $229 per patient-month against a typical $98	$98K 5%
99213	Medicare 2024: Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more Submitted charge 1.8 times the allowed amount, usual 2.2 times	$26K 78%
99443	Medicare 2024: Telephone medical discussion with physician, 21-30 minutes Submitted charge 1.6 times the allowed amount, usual 2.2 times	$3K 9%
90792	Medicare 2024: Psychiatric diagnostic evaluation with medical services Submitted charge 1.8 times the allowed amount, usual 2.2 times	$2K 7%
99214	Medicare 2024: Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more Submitted charge 1.8 times the allowed amount, usual 2.3 times	$2K 5%

Rule out first

- The Indiana Medicaid termination may have been appealed, reversed or reinstated after July 15, 2015, and the state file extracted from the Indiana Family and Social Services Administration terminations spreadsheet may not reflect a later change in status.
- A termination in Indiana Medicaid does not by itself bar enrollment or payment in Illinois Medicaid; the Illinois agency may have made an independent enrollment determination that must be reviewed before any conclusion.
- Identity matching is based on name and NPI; the exclusion list entry should be confirmed against date of birth, Social Security number or other identifiers to rule out a similar name match.
- Payments in the 54 service months may include claims billed under a group or supervising arrangement, or claims with dates of service or adjudication dates that differ from the service months shown, so payment attribution needs verification.
- Data lag and retroactive adjustments in T-MSIS and Medicare files can shift both service months and paid amounts, and the $0 paid in the 12 months before the action may reflect absence of data rather than absence of activity.
- High percentile per patient-month amounts for office visit codes can reflect a severely ill psychiatric caseload, long visit times or a narrow patient panel, and are not by themselves evidence of incorrect coding.
- The Medicare revocation dated August 6, 2025 under failure to report and other program termination may be under appeal or subject to a corrective action plan, and the re-enrollment bar to January 14, 2031 could change as a result.
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Medicare submitted to allowed ratios for this provider are below the usual ratios for the same codes, which cuts against an inflated charge pattern.

Public records cited

1 NPI 1619941614 HISHAM SADEK (individual), CHICAGO, IL; taxonomy 2084P0800X; Medicaid home state IL.
providers/NPPES

2 Code 99215 (Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more): $666,791 paid over 32 months, 33% of this provider's Medicaid dollars, $186 per patient-month, which ranks at the 93th percentile of all providers billing this code (typical $88); this code family has a history of abuse.
procedures billed, Medicaid

3 Code 99213 (Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more): $572,204 paid over 46 months, 28% of this provider's Medicaid dollars, $101 per patient-month, which ranks at the 94th percentile of all providers billing this code (typical $44).
procedures billed, Medicaid

4 Code 90792 (Psychiatric diagnostic evaluation with medical services): $202,708 paid over 45 months, 10% of this provider's Medicaid dollars, $159 per patient-month, which ranks at the 75th percentile of all providers billing this code (typical $112).
procedures billed, Medicaid

5 Code 90836 (Psychotherapy with evaluation and management visit, 45 minutes): $176,186 paid over 34 months, 9% of this provider's Medicaid dollars, $114 per patient-month, which ranks at the 81th percentile of all providers billing this code (typical $72).
procedures billed, Medicaid

6 Code 99214 (Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more): $151,844 paid over 16 months, 7% of this provider's Medicaid dollars, $127 per patient-month, which ranks at the 94th percentile of all providers billing this code (typical $60).
procedures billed, Medicaid

7 Code T1016 (Case management each 15 min): $97,730 paid over 7 months, 5% of this provider's Medicaid dollars, $229 per patient-month, which ranks at the 78th percentile of all providers billing this code (typical $98).
procedures billed, Medicaid

8 Code 99213 (Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more): 433 services for 75 beneficiaries, $26,494 paid; submitted $155 per service against $86 allowed, a ratio of 1.8x where the usual ratio for this code is 2.2x.
procedures billed, Medicare 2024

9 Code 99443 (Telephone medical discussion with physician, 21-30 minutes): 33 services for 24 beneficiaries, $3,119 paid; submitted $190 per service against $122 allowed, a ratio of 1.6x where the usual ratio for this code is 2.2x.
procedures billed, Medicare 2024

10 Code 90792 (Psychiatric diagnostic evaluation with medical services): 18 services for 18 beneficiaries, $2,395 paid; submitted $330 per service against $188 allowed, a ratio of 1.8x where the usual ratio for this code is 2.2x.
procedures billed, Medicare 2024

11 Code 99214 (Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more): 19 services for 14 beneficiaries, $1,783 paid; submitted $225 per service against $126 allowed, a ratio of 1.8x where the usual ratio for this code is 2.3x.

procedures billed, Medicare 2024

12 Evidence tier 1 (documented action, then payment); detectors D3, D2; dollars at risk $2,029,469 (figure of the detector that set the tier, not a sum); reasons: Listed on the IN Medicaid exclusion list since July 15, 2015; Medicaid still paid claims in 54 later months, $2,029,469 in total.

provider risk

13 Revoked 2025-08-06 under 424.535(A)(9) Failure To Report;424.535(A)(12) Other Program Termination (Medicaid); re-enrollment bar to 2031-01-14.

Revocation Extract

14 After the STATE EXCL IN action of 2015-07-15 (State list extracted from https://www.in.gov/fssa/ompp/files/OMPP Terminations.xlsx (pandas claude colmap)), Medicaid paid $2,029,469 across 54 service months (2020-05 to 2024-11); $0 in the 12 months before.

flags/D3 + T-MSIS spending