Referral packet: KIUP KIM

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 1225242985	11	10	3

> 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 and claims records show that this provider was placed on the California Medi-Cal Suspended and Ineligible Provider List on **December 10, 2018**, and that Medicaid nonetheless paid **$2,046,769** across 52 service months from **January 2019** through **August 2023**. The paid-after-action pattern, combined with high percentile ranking on two vascular ultrasound codes, warrants a records request to confirm identity, enrollment status and exclusion screening history.

Description

Kiup Kim is an individual provider in Phoenix, Arizona, with National Provider Identifier **1225242985** and a vascular surgery taxonomy, whose Medicaid home state is Arizona. California listed this provider on its Medi-Cal Suspended and Ineligible Provider List on **December 10, 2018**. Medicaid records show payments continuing after that date, totaling **$2,046,769** over 52 service months between **January 2019** and **August 2023**, compared with **$205,683** in the twelve months before the listing. More than half of this provider's Medicaid dollars came from one vein laser destruction code, and two vein ultrasound codes rank at the 77th and 90th percentile of all providers billing them, with per patient-month amounts several times the typical figure. These are records observations only, and the reviewer should confirm whether the California listing applies to the paying state program and whether the listing was ever appealed or lifted.

What the records show

01 The subject is an individual provider, National Provider Identifier **1225242985**, Kiup Kim, of Phoenix, Arizona, with taxonomy 208600000X and Medicaid home state Arizona.

Records 1 (providers/NPPES)

02 Records show the provider listed on the California Medicaid exclusion list since **December 10, 2018**, with Medicaid still paying claims in 52 later months totaling **$2,046,769**.
Records 9 (provider risk)

03 After the California state exclusion action dated **December 10, 2018**, recorded on the California Medi-Cal Suspended and Ineligible Provider List dated **July 2026**, Medicaid paid **$2,046,769** across 52 service months from **January 2019** to **August 2023**, compared with **$205,683** in the 12 months before.
Records 10 (flags/D3 + T-MSIS spending)

04 Procedure code 36478, laser destruction of an incompetent vein of the arm or leg using imaging guidance, accounts for **$1,220,774** paid over 44 months, 54 percent of this provider's Medicaid dollars, at **$983** per patient-month, which ranks at the 28th percentile of all providers billing this code against a typical **$1,305**.
Records 2 (procedures billed, Medicaid)

05 Procedure code 93970, ultrasound study of arm or leg veins with compression and maneuvers, accounts for **$274,714** paid over 57 months, 12 percent of this provider's Medicaid dollars, at **$106** per patient-month, which ranks at the 77th percentile against a typical **$36**.
Records 3 (procedures billed, Medicaid)

06 Procedure code 93971, ultrasound study of one arm or leg veins with compression and maneuvers, accounts for **$148,432** paid over 39 months, 7 percent of this provider's Medicaid dollars, at **$103** per patient-month, which ranks at the 90th percentile against a typical **$18**.
Records 5 (procedures billed, Medicaid)

07 Procedure code 36471, injection of a chemical agent into multiple incompetent veins of the leg, accounts for **$138,283** paid over 27 months, 6 percent of this provider's Medicaid dollars, at **$247** per patient-month, which ranks at the 92nd percentile against a typical **$147**.
Records 6 (procedures billed, Medicaid)

08 Procedure code 36465, injection of a chemical agent into a single incompetent vein of the leg using ultrasound guidance, accounts for **$227,187** paid over 13 months, 10 percent of this provider's Medicaid dollars, at **$1,023** per patient-month, which ranks at the 36th percentile against a typical **$1,215**.
Records 4 (procedures billed, Medicaid)

09 Procedure code 36482, chemical destruction of the first incompetent vein of the arm or leg using imaging guidance, accounts for **$62,052** paid over 2 months, 3 percent of this provider's Medicaid dollars, at **$2,068** per patient-month.
Records 7 (procedures billed, Medicaid)

10 In Medicare 2024 data, procedure code 93971 shows 15 services for 14 beneficiaries and **$1,336** paid, with **$342** submitted per service against **$112** allowed, a ratio of 3.1 times where the usual ratio for this code is 4.2 times.
Records 8 (procedures billed, Medicare 2024)

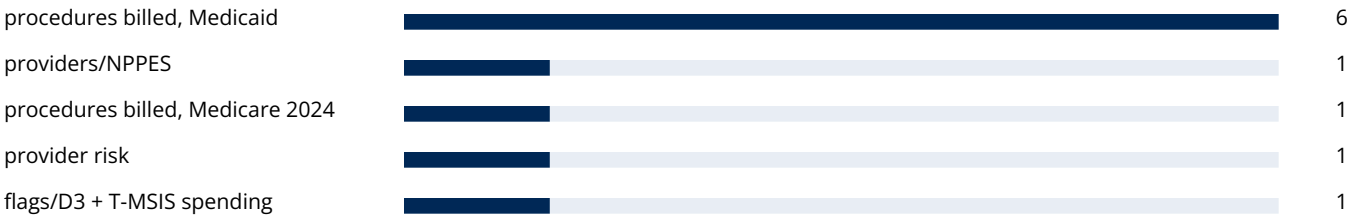
11 The risk record assigns evidence tier 1, documented action followed by payment, detector D3, with dollars at risk of **$2,046,769,** described as the figure of the detector that set the tier rather than a sum.
Records 9 (provider risk)

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.

Where the records come from



Recommended next step

Request the Arizona Medicaid enrollment and revalidation file for National Provider Identifier **1225242985**, including all screening results, and confirm identity and exclusion status through routine checks of the Social Security Death Master File, the National Plan and Provider Enumeration System, the List of Excluded Individuals and Entities and the System for Award Management, as required by **42 CFR 455.436**, which also requires those last two checks no less frequently than monthly. Verify against the termination database whether this provider appears as terminated under Medicare or under the Medicaid program or CHIP of another state, since **42 CFR 455.416(c)** requires the state agency to deny or terminate enrollment of a provider terminated on or after **January 1, 2011** and included in that database. Obtain from California the full listing record, the effective date, the basis for the listing and any appeal, reinstatement or removal history, and confirm whether the listing is a termination for cause or another status. Pull the paid claims detail for the 52 service months from **January 2019** through **August 2023**, including rendering and billing identifiers, to establish whether payments were made to this individual or through a group arrangement. Request medical records and vascular testing documentation for a sample of claims under procedure codes 93970 and 93971, given the 77th and 90th percentile rankings, and for procedure code 36478, which represents 54 percent of Medicaid dollars. If the review supports a credible allegation of fraud for which an investigation is pending, **42 CFR 455.23(a)** requires the state agency to suspend all Medicaid payments unless good cause exists not to suspend or to suspend only in part, and **42 CFR 455.23(d)** requires referral to the Medicaid Fraud Control Unit.

Procedures behind the dollars

36478	Medicaid: Laser destruction of incompetent vein of arm or leg using imaging guidance 28th percentile of providers on this code, $983 per patient-month against a typical $1K	$1.2M 54%
93970	Medicaid: Ultrasound study of arm or leg veins with compression and maneuvers 77th percentile of providers on this code, $106 per patient-month against a typical $36	$275K 12%

36465	Medicaid: Injection of chemical agent into single incompetent vein of leg using ultrasound guidance 36th percentile of providers on this code, $1K per patient-month against a typical $1K	$227K 10%
93971	Medicaid: Ultrasound study of one arm or leg veins with compression and maneuvers 90th percentile of providers on this code, $103 per patient-month against a typical $18	$148K 7%
36471	Medicaid: Injection of chemical agent into multiple incompetent veins of leg 92nd percentile of providers on this code, $247 per patient-month against a typical $147	$138K 6%
36482	Medicaid: Chemical destruction of first incompetent vein of arm or leg using imaging guidance	$62K 3%
93971	Medicare 2024: Ultrasound study of one arm or leg veins with compression and maneuvers Submitted charge 3.1 times the allowed amount, usual 4.2 times	$1K 100%

Rule out first

- The California listing is a California program action and the payments identified were made by the Arizona Medicaid program, so the reviewer must confirm whether the listing carried a reciprocal effect on the paying state before drawing any conclusion.
- The listing may have been appealed, stayed, lifted or reinstated, and the record cited is a Suspended and Ineligible Provider List dated July 2026, so effective dates and current status must be confirmed against the source agency.
- Identity matching by name and National Provider Identifier may be imperfect and the listed party may be a different individual, so identity should be verified per 42 CFR 455.436 before any action.
- Claims may have been submitted under a group or supervising arrangement, so the rendering and billing identifiers on the paid claims need to be examined before attributing payments to this individual.
- Data lag and retroactive adjustments in T-MSIS and in state paid claims extracts can shift service months and dollar totals, and the dollars at risk figure is described as the figure of the detector that set the tier rather than a sum.
- High percentile rankings on the two vein ultrasound codes may reflect a vascular practice with a concentrated case mix rather than an aberrant billing pattern, and two of the codes rank at the 28th and 36th percentile, below the typical amount.

Public records cited

1 NPI 1225242985 KIUP KIM (individual), PHOENIX, AZ; taxonomy 208600000X; Medicaid home state AZ.
providers/NPPES

2 Code 36478 (Laser destruction of incompetent vein of arm or leg using imaging guidance): $1,220,774 paid over 44 months, 54% of this provider's Medicaid dollars, $983 per patient-month, which ranks at the 28th percentile of all providers billing this code (typical $1,305).
procedures billed, Medicaid

3 Code 93970 (Ultrasound study of arm or leg veins with compression and maneuvers): $274,714 paid over 57 months, 12% of this provider's Medicaid dollars, $106 per patient-month, which ranks at the 77th percentile of all providers billing this code (typical $36).
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6 Code 36471 (Injection of chemical agent into multiple incompetent veins of leg): $138,283 paid over 27 months, 6% of this provider's Medicaid dollars, $247 per patient-month, which ranks at the 92th percentile of all providers billing this code (typical $147).
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7 Code 36482 (Chemical destruction of first incompetent vein of arm or leg using imaging guidance): $62,052 paid over 2 months, 3% of this provider's Medicaid dollars, $2,068 per patient-month.
procedures billed, Medicaid

8 Code 93971 (Ultrasound study of one arm or leg veins with compression and maneuvers): 15 services for 14 beneficiaries, $1,336 paid; submitted $342 per service against $112 allowed, a ratio of 3.1x where the usual ratio for this code is 4.2x.
procedures billed, Medicare 2024

9 Evidence tier 1 (documented action, then payment); detectors D3; dollars at risk $2,046,769 (figure of the detector that set the tier, not a sum); reasons: Listed on the CA Medicaid exclusion list since December 10, 2018; Medicaid still paid claims in 52 later months, $2,046,769 in total.
provider risk

10 After the STATE EXCL CA action of 2018-12-10 (CA Medi-Cal Suspended & Ineligible Provider List (July 2026)), Medicaid paid $2,046,769 across 52 service months (2019-01 to 2023-08); $205,683 in the 12 months before.
flags/D3 + T-MSIS spending