Referral packet: CASEY STELTER

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 1073607222	11	13	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 for Casey Stelter, an individual provider in Layton, Utah, show a **November 2024** Medicaid month in which billed hands-on therapy time implies about 4.7 hours per clinician per calendar day across three billing organizations, tied to **$30,145** in payments for seven therapy and speech codes. The same records show concentrated Medicaid payment in office visit codes at the 80th and 82nd percentiles for dollars per patient-month, plus two short-duration codes that paid **$69,137** and **$18,968** in two months and one month respectively, which together warrant a records request and time verification.

Description

Casey Stelter is an individual provider registered in Layton, Utah, with a family medicine style taxonomy and Utah as the Medicaid home state. In one month, **November 2024**, the therapy and speech services billed under this provider add up to roughly 4.7 hours of hands-on time per clinician per calendar day, and those lines were submitted through three different billing organizations. That single month accounts for **$30,145** in payments. Separately, the Medicaid records show two office visit codes making up about two thirds of this provider's Medicaid dollars at rates per patient-month above the typical level for other providers billing the same codes, and two other codes that paid large amounts inside very short windows. None of this shows that anything improper happened, and the reviewer should first confirm who actually performed and supervised the services.

What the records show

01 National Provider Identifier **1073607222** belongs to Casey Stelter, an individual provider in Layton, Utah, with taxonomy 207Q00000X and Utah listed as the Medicaid home state.

Records 1 (providers/NPPES)

02 The risk record places this provider at evidence tier 2 for impossible volume with concurrency, names detector D2, lists dollars at risk of **$30,145,** and states that the provider billed more hands-on hours than a day holds in one month, peaking at 4.7 hours per day across three billing organizations.
Records 12 (provider risk)

03 The flag dated **November 1, 2024** is labeled impossible by line count, shows implied hours per clinician per calendar day for personal services of 4.7 with a lower bound of 36.6 and a point value of 8.5, **$30,145** in payment, three billing organizations, and codes 92507, 97110, 97112, 97116, 97140, 97530 and 97535, with rates taken from the median per line source.
Records 13 (flags/D2 + T-MSIS spending)

04 Medicaid code 99214, established patient office visit with moderate level of decision making, paid **$126,067** over 55 months, 33 percent of this provider's Medicaid dollars, at **$91** per patient-month, ranking at the 80th percentile of all providers billing this code where the typical figure is **$60**.
Records 2 (procedures billed, Medicaid)

05 Medicaid code 99213, established patient office visit with low level of decision making, paid **$118,480** over 57 months, 31 percent of this provider's Medicaid dollars, at **$71** per patient-month, ranking at the 82nd percentile of all providers billing this code where the typical figure is **$44**.
Records 3 (procedures billed, Medicaid)

06 Medicaid code T2046 paid **$69,137** over 2 months, 18 percent of this provider's Medicaid dollars, at **$2,765** per patient-month.
Records 4 (procedures billed, Medicaid)

07 Medicaid code 97530, therapy procedure using functional activities, paid **$18,968** over 1 month, 5 percent of this provider's Medicaid dollars, at **$164** per patient-month.
Records 5 (procedures billed, Medicaid)

08 Medicaid nursing facility codes 99309 and 99306 paid **$15,559** over 17 months and **$13,958** over 15 months, at the 51st and 53rd percentiles respectively, close to the typical dollars per patient-month for those codes.
Records 6 (procedures billed, Medicaid), 7 (procedures billed, Medicaid)

09 In Medicare 2024, code 99490 for chronic care management shows 1,815 services for 449 beneficiaries and **$81,374** paid, with a submitted to allowed ratio of 1.8 times against a usual ratio of 1.8 times.
Records 8 (procedures billed, Medicare 2024)

10 In Medicare 2024, code 99309 shows 998 services for 409 beneficiaries and **$79,759** paid, and code 99306 shows 259 services for 210 beneficiaries and **$35,526** paid, both with submitted to allowed ratios below the usual ratio for those codes.
Records 9 (procedures billed, Medicare 2024), 11 (procedures billed, Medicare 2024)

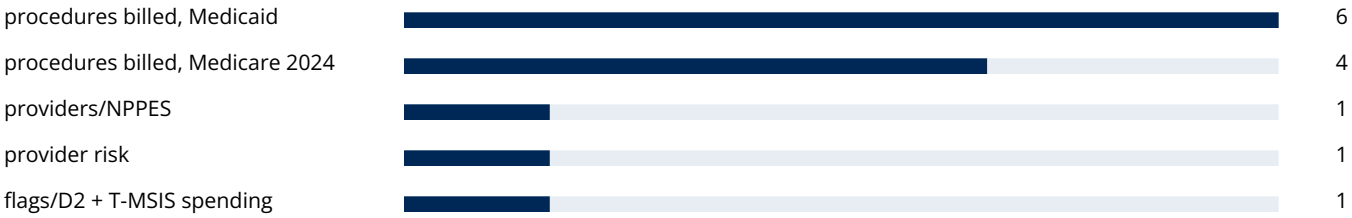
11 In Medicare 2024, code 99214 shows 493 services for 174 beneficiaries and **$38,485** paid, with a submitted to allowed ratio of 1.5 times against a usual ratio of 2.3 times.
Records 10 (procedures billed, Medicare 2024)

Regulations this relates to

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 1003.200	civil monetary penalties for presenting claims for items or services not provided as claimed, for services furnished by an excluded person, or that are false or fraudulent.
42 CFR 455.410	all providers must be screened under subpart E as a condition of enrollment, and states must revalidate enrollment at least every 5 years.

Where the records come from



Recommended next step

Request from the three billing organizations the complete claim detail, treatment notes, appointment schedules and staff time records for the **November 2024** dates covering codes 92507, 97110, 97112, 97116, 97140, 97530 and 97535, so the implied 4.7 hours per clinician per calendar day can be tested against actual rendering staff. Obtain rendering and supervising provider assignments and any locum or incident to arrangements to confirm whether services attributed to this National Provider Identifier were personally performed. Request the underlying documentation for Medicaid code T2046, which paid **$69,137** across two months, and for code 97530, which paid **$18,968** in one month, along with medical records supporting the level of decision making billed for codes 99213 and 99214. Verify enrollment and screening status under **42 CFR 455.410**, including whether revalidation has occurred within five years. If the time verification is not resolved by the records, refer to the Medicaid Fraud Control Unit under **42 CFR 455.23(d)** and evaluate payment suspension and good cause under **42 CFR 455.23(a)**; if a claims review shows services not provided as claimed, evaluate civil monetary penalty exposure under **42 CFR 1003.200.**

Procedures behind the dollars

99214	Medicaid: Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more 80th percentile of providers on this code, $91 per patient-month against a typical $60	$126K 33%
99213	Medicaid: Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more 82nd percentile of providers on this code, $71 per patient-month against a typical $44	$118K 31%
T2046	Medicaid: Medicaid service code	$69K 18%
97530	Medicaid: Therapy procedure using functional activities	$19K 5%
99309	Medicaid: Subsequent nursing facility care with moderate level of medical decision making, per day, if using time, at least 30 minutes 51st percentile of providers on this code, $21 per patient-month against a typical $21	$16K 4%

99306	Medicaid: Initial nursing facility care with high level of medical decision making, per day, if using time, 50 minutes or more 53rd percentile of providers on this code, $39 per patient-month against a typical $37	$14K	4%
99490	Medicare 2024: Chronic care management services, first 20 minutes of clinical staff time directed by health care professional, per calendar month Submitted charge 1.8 times the allowed amount, usual 1.8 times	$81K	22%
99309	Medicare 2024: Subsequent nursing facility care with moderate level of medical decision making, per day, if using time, at least 30 minutes Submitted charge 1.6 times the allowed amount, usual 2.0 times	$80K	22%
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 1.5 times the allowed amount, usual 2.3 times	$38K	11%
99306	Medicare 2024: Initial nursing facility care with high level of medical decision making, per day, if using time, 50 minutes or more Submitted charge 1.4 times the allowed amount, usual 1.9 times	$36K	10%

Rule out first

- The provider identifier may have been used as a supervising or billing identifier for services performed by therapists or clinical staff, which is a common convention and would explain hours that exceed one person's day.
- Three billing organizations appear on the same day, so a shared billing agent, a group practice arrangement or a shared address or landlord could cause claims from multiple clinicians to roll up to one identifier.
- The implied hours figure is derived from median per line rate assumptions and shows a wide range from a lower bound of 36.6 to a point value of 8.5, so the underlying time estimate may change once actual units and rendering staff are confirmed.
- Short duration codes such as T2046 and 97530 may reflect a limited program, a retroactive payment or a settlement rather than ongoing billing, and claims data lag can compress payments into a small number of months.
- The dollars at risk figure of $30,145 is the output of the detector that set the tier and is not a sum of overpayments.
- The percentile rankings for office visit codes reflect dollars per patient-month and may be explained by a sicker or more complex panel, and the Medicare submitted to allowed ratios for several codes are at or below the usual ratio.
- Prior appeals, reinstatements or corrected claims may already have adjusted some of the payments described here.

Public records cited

1 NPI 1073607222 CASEY STELTER (individual), LAYTON, UT; taxonomy 207Q00000X; Medicaid home state UT.
providers/NPPES

2 Code 99214 (Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more): $126,067 paid over 55 months, 33% of this provider's Medicaid dollars, $91 per patient-month, which ranks at the 80th percentile of all providers billing this code (typical $60).
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): $118,480 paid over 57 months, 31% of this provider's Medicaid dollars, $71 per patient-month, which ranks at the 82th percentile of all providers billing this code (typical $44).
procedures billed, Medicaid

4 Code T2046: $69,137 paid over 2 months, 18% of this provider's Medicaid dollars, $2,765 per patient-month.
procedures billed, Medicaid

5 Code 97530 (Therapy procedure using functional activities): $18,968 paid over 1 months, 5% of this provider's Medicaid dollars, $164 per patient-month.
procedures billed, Medicaid

6 Code 99309 (Subsequent nursing facility care with moderate level of medical decision making, per day, if using time, at least 30 minutes): $15,559 paid over 17 months, 4% of this provider's Medicaid dollars, $21 per patient-month, which ranks at the 51th percentile of all providers billing this code (typical $21).
procedures billed, Medicaid

7 Code 99306 (Initial nursing facility care with high level of medical decision making, per day, if using time, 50 minutes or more): $13,958 paid over 15 months, 4% of this provider's Medicaid dollars, $39 per patient-month, which ranks at the 53th percentile of all providers billing this code (typical $37).
procedures billed, Medicaid

8 Code 99490 (Chronic care management services, first 20 minutes of clinical staff time directed by health care professional, per calendar month): 1,815 services for 449 beneficiaries, $81,374 paid; submitted $100 per service against $57 allowed, a ratio of 1.8x where the usual ratio for this code is 1.8x.
procedures billed, Medicare 2024

9 Code 99309 (Subsequent nursing facility care with moderate level of medical decision making, per day, if using time, at least 30 minutes): 998 services for 409 beneficiaries, $79,759 paid; submitted $165 per service against $102 allowed, a ratio of 1.6x where the usual ratio for this code is 2.0x.
procedures billed, Medicare 2024

10 Code 99214 (Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more): 493 services for 174 beneficiaries, $38,485 paid; submitted $182 per service against $119 allowed, a ratio of 1.5x where the usual ratio for this code is 2.3x.
procedures billed, Medicare 2024

11 Code 99306 (Initial nursing facility care with high level of medical decision making, per day, if using time, 50 minutes or more): 259 services for 210 beneficiaries, $35,526 paid; submitted $250 per service against $173 allowed, a ratio of 1.4x where the usual ratio for this code is 1.9x.

procedures billed, Medicare 2024

12 Evidence tier 2 (impossible volume with concurrency); detectors D2; dollars at risk $30,145 (figure of the detector that set the tier, not a sum); reasons: Billed more hands-on hours than a day holds in 1 month(s), peaking at 4.7 hours per day across 3 billing organizations.

provider risk

13 2024-11-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 4.7 (lower bound 36.6, point 8.5); $30,145; codes ['92507', '97110', '97112', '97116', '97140', '97530', '97535']; 3 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending