Referral packet: ELENA WAGNER

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 1023351970	18	28	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

Medicaid claims filed under NPI **1023351970** for Elena Wagner, an individual provider in Seattle, Washington, carry a detector flag for implied clinician hours beyond a single day in 16 separate months between **March 2018** and **July 2020**, with monthly Medicaid spending on office visit codes ranging from about **$61,628** to **$180,067** and claims submitted through as many as seven billing organizations in a single month. The same provider sits at the 99th percentile on Medicaid dollars per patient-month for code 99214 and shows a Medicare 2024 submitted-to-allowed charge ratio of 17.5 times on code 58558 against a usual ratio of 4.7 times, which together warrant a records request to identify who actually performed the services and to review documentation supporting the visit levels.

Description

Elena Wagner is an individual provider in Seattle, Washington, enrolled with Washington Medicaid under taxonomy 207V00000X. In 16 different months her Medicaid claims add up to more clinical hours in a day than one person can work, with one month, **July 2018**, implying about 52.7 hours in a calendar day of personal services and **$180,067** in office visit payments. During those months the claims came in through several different billing organizations at once, as many as seven, and the volume reached up to 1,133 patients in a month, so the pattern may reflect a supervising clinician listed on work done by others rather than one person's own hours. Separately, her Medicaid payments per patient-month on the moderate level established patient visit code 99214 are **$210** against a typical **$60,** placing her in the top one percent of providers billing that code. In Medicare 2024 she submitted **$4,250** per service for a uterine lining biopsy code against **$243** allowed, a ratio of 17.5 times where the usual ratio is 4.7 times. None of this shows wrongdoing on its own, and records are needed to explain it.

What the records show

01 NPI **1023351970** is registered to Elena Wagner, an individual provider in Seattle, Washington, with taxonomy 207V00000X and Medicaid home state Washington.

Records 1 (providers/NPPES)

02 The provider risk record places this subject at evidence tier 4 for structure or single-organization volume, with detector D2 and dollars at risk of **$1,879,895,** described as the figure of the detector that set the tier rather than a sum.

Records 12 (provider risk)

03 The stated reason for the flag is hours beyond a day in 16 months, but with up to 1,133 patients a month across 7 billing organizations, which the record says points to a supervising clinician on the claims rather than one person's hours, and records are needed.

Records 12 (provider risk)

04 For the month beginning **July 1, 2018**, the impossible conservative rate flag shows implied hours per clinician calendar day of personal services of 52.7, with a lower bound of 12.7 and a point estimate of 79.1, covering **$180,067** across office visit codes 99201, 99202, 99203, 99211, 99212, 99213 and 99214 and 6 billing organizations.

Records 13 (flags/D2 + T-MSIS spending)

05 For the month beginning **October 1, 2018**, the same flag shows implied hours of 44.4, with a lower bound of 10.1 and a point estimate of 66.6, covering **$140,070** across the same office visit codes and 7 billing organizations.

Records 17 (flags/D2 + T-MSIS spending)

06 For the month beginning **June 1, 2018**, the flag shows implied hours of 40.9, with a lower bound of 9.1 and a point estimate of 61.3, covering **$127,445** and 5 billing organizations.

Records 19 (flags/D2 + T-MSIS spending)

07 For the month beginning **April 1, 2018**, the flag shows implied hours of 38.4, with a lower bound of 10.4 and a point estimate of 57.6, covering **$122,096** and 5 billing organizations.

Records 23 (flags/D2 + T-MSIS spending)

08 For the month beginning **June 1, 2019**, the flag shows implied hours of 36.3, with a lower bound of 7.2 and a point estimate of 54.5, covering **$95,812** and 7 billing organizations.

Records 24 (flags/D2 + T-MSIS spending)

09 Additional flagged months include **March 2018** at 26.8 implied hours and **$93,511, May 2018** at 33.8 implied hours and **$110,691, August 2018** at 26.4 implied hours and **$88,108, September 2018** at 29.0 implied hours and **$88,126, November 2018** at 29.9 implied hours and **$91,786,** and **December 2018** at 31.0 implied hours and **$100,981**.

Records 28 (flags/D2 + T-MSIS spending), 26 (flags/D2 + T-MSIS spending), 21 (flags/D2 + T-MSIS spending), 20 (flags/D2 + T-MSIS spending), 16 (flags/D2 + T-MSIS spending), 18 (flags/D2 + T-MSIS spending)

10 Flagged months continue into 2019 and 2020, with **January 2019** at 32.1 implied hours and **$92,505, February 2019** at 31.8 implied hours and **$81,418, March 2019** at 32.2 implied hours and **$90,597, April 2019** at 28.5 implied hours and **$74,702,** and **July 2020** at 25.9 implied hours and **$61,628**.

Records 27 (flags/D2 + T-MSIS spending), 22 (flags/D2 + T-MSIS spending), 15 (flags/D2 + T-MSIS spending), 25 (flags/D2 + T-MSIS spending), 14 (flags/D2 + T-MSIS spending)

11 In every flagged month the rate source is listed as the median per line, described in the records as p50 per line.

Records 13 (flags/D2 + T-MSIS spending), 17 (flags/D2 + T-MSIS spending), 19 (flags/D2 + T-MSIS spending), 23 (flags/D2 + T-MSIS spending), 24 (flags/D2 + T-MSIS spending)

12 Medicaid paid **$840,525** over 29 months on code 99214, established patient office or other outpatient visit with moderate level of decision making, which is 30 percent of this provider's Medicaid dollars and **$210** per patient-month against a typical **$60,** ranking at the 99th percentile of all providers billing that code.
Records 2 (procedures billed, Medicaid), 12 (provider risk)

13 Medicaid paid **$481,248** over 28 months on code 99213 at **$132** per patient-month against a typical **$44,** ranking at the 97th percentile.
Records 3 (procedures billed, Medicaid)

14 Medicaid paid **$211,290** over 21 months on code 99202, a new patient visit with straightforward medical decision making, at **$203** per patient-month against a typical **$45,** ranking at the 98th percentile.
Records 5 (procedures billed, Medicaid)

15 Medicaid paid **$173,346** over 25 months on code 99212 at **$101** per patient-month against a typical **$28,** ranking at the 91st percentile, and **$168,514** over 26 months on code 87806, an HIV detection test by immunoassay, at **$33** per patient-month against a typical **$25,** ranking at the 92nd percentile.
Records 6 (procedures billed, Medicaid), 7 (procedures billed, Medicaid)

16 Medicaid paid **$308,157** over 22 months on code S4993 at **$129** per patient-month against a typical **$77,** ranking at the 77th percentile.
Records 4 (procedures billed, Medicaid)

17 In Medicare 2024, code 58558, biopsy of the lining of the uterus and or removal of a polyp using an endoscope, shows 14 services for 14 beneficiaries and **$2,713** paid, with **$4,250** submitted per service against **$243** allowed, a ratio of 17.5 times where the usual ratio for that code is 4.7 times.
Records 9 (procedures billed, Medicare 2024)

18 In Medicare 2024, code 99214 shows 32 services for 22 beneficiaries and **$2,936** paid at a submitted to allowed ratio of 2.5 times against a usual 2.3 times, code 99204 shows 15 services for 15 beneficiaries and **$1,857** paid at 2.6 times against a usual 2.4 times, and code 99213 shows 21 services for 17 beneficiaries and **$1,309** paid at 2.6 times against a usual 2.2 times.
Records 8 (procedures billed, Medicare 2024), 10 (procedures billed, Medicare 2024), 11 (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

procedures billed, Medicaid	6
procedures billed, Medicare 2024	4
providers/NPPES	1
provider risk	1

Recommended next step

Open a records request before any payment action. First, obtain from the Washington Medicaid agency the full claim detail for the 16 flagged months from **March 2018** through **July 2020**, including the rendering and billing provider identifiers on each line, so the seven billing organizations that submitted under this NPI can be identified and the rendering clinician on each claim confirmed. Second, request appointment schedules, sign-in logs, time records and the treatment notes for a sample of dates in the highest exposure months, **July 2018**, **October 2018**, **June 2018** and **April 2018**, to test whether the services attributed to this provider were personally performed or performed by supervised staff. Third, request the documentation supporting the level of service on codes 99214, 99213, 99202 and 99212 for a sampled set of dates, given the top 5 percent standing on dollars per patient for code 99214. Fourth, obtain the chargemaster or fee schedule basis for the Medicare 2024 submitted amount of **$4,250** per service on code 58558. Fifth, verify current enrollment, ownership and screening status for this provider and for each of the seven billing organizations, and confirm that revalidation is current, under **42 CFR 455.410**, which requires all providers to be screened under subpart E as a condition of enrollment and requires states to revalidate enrollment at least every 5 years. If the records review establishes a credible allegation of fraud for which an investigation is pending, refer to the Medicaid Fraud Control Unit and evaluate payment suspension under **42 CFR 455.23(a)** and (d), including whether good cause exists not to suspend or to suspend only in part. If the review shows claims were presented for items or services not provided as claimed, refer for consideration of civil monetary penalties under **42 CFR 1003.200.** Do not take payment action on the detector output alone.

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 99th percentile of providers on this code, $210 per patient-month against a typical $60	$841K 30%
99213	Medicaid: Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more 97th percentile of providers on this code, $132 per patient-month against a typical $44	$481K 17%
S4993	Medicaid: Medicaid service code 77th percentile of providers on this code, $129 per patient-month against a typical $77	$308K 11%
99202	Medicaid: New patient office or other outpatient visit with straightforward medical decision making, if using time, 15 minutes or more 98th percentile of providers on this code, $203 per patient-month against a typical $45	$211K 8%
99212	Medicaid: Established patient office or other outpatient visit with straightforward medical decision making, if using time, 10 minutes or more 91st percentile of providers on this code, $101 per patient-month against a typical $28	$173K 6%
87806	Medicaid: Detection test by immunoassay with direct visual observation for hiv-1 antigen, with hiv-1 and hiv-2 antibodies 92nd percentile of providers on this code, $33 per patient-month against a typical $25	$169K 6%

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 2.5 times the allowed amount, usual 2.3 times	$3K 33%
58558	Medicare 2024: Biopsy of lining of uterus and/or removal of polyp using an endoscope Submitted charge 17.5 times the allowed amount, usual 4.7 times	$3K 31%
99204	Medicare 2024: New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more Submitted charge 2.6 times the allowed amount, usual 2.4 times	$2K 21%
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 2.6 times the allowed amount, usual 2.2 times	$1K 15%

Rule out first

- The risk record itself states that with up to 1,133 patients a month across 7 billing organizations the pattern points to a supervising clinician on the claims rather than one person's own hours, so supervisory and incident to billing conventions must be ruled out first.
- The implied hours figures are model estimates built on a median time per line, and in every flagged month the stated lower bound is well below the point estimate, for example 12.7 hours against a point estimate of 79.1 in July 2018, so the conservative reading may not by itself be impossible for a staffed practice.
- Claims submitted through multiple billing organizations may reflect employment at several clinics, locum or coverage arrangements, or a group that reassigned benefits, rather than any single practice location.
- Submitted charge amounts, including the $4,250 per service on Medicare code 58558, do not determine payment; the Medicare allowed amount was $243 and total paid was $2,713, and high list prices can reflect a chargemaster convention.
- High dollars per patient-month on office visit codes can reflect a genuinely complex or high acuity panel, and the percentile comparison does not adjust for patient mix or specialty.
- Claims data is subject to lag, adjustments, voids and reprocessing, so month level totals and service counts should be refreshed before any action.
- Any prior enrollment action, appeal, reinstatement or settlement involving this provider or the associated billing organizations should be checked, since resolved matters may already explain part of the pattern.

Public records cited

1 NPI 1023351970 ELENA WAGNER (individual), SEATTLE, WA; taxonomy 207V00000X; Medicaid home state WA.
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): $840,525 paid over 29 months, 30% of this provider's Medicaid dollars, $210 per patient-month, which ranks at the 99th 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): $481,248 paid over 28 months, 17% of this provider's Medicaid dollars, $132 per patient-month, which ranks at the 97th percentile of all providers billing this code (typical $44).
procedures billed, Medicaid

4 Code S4993: $308,157 paid over 22 months, 11% of this provider's Medicaid dollars, $129 per patient-month, which ranks at the 77th percentile of all providers billing this code (typical $77).
procedures billed, Medicaid

5 Code 99202 (New patient office or other outpatient visit with straightforward medical decision making, if using time, 15 minutes or more): $211,290 paid over 21 months, 8% of this provider's Medicaid dollars, $203 per patient-month, which ranks at the 98th percentile of all providers billing this code (typical $45).
procedures billed, Medicaid

6 Code 99212 (Established patient office or other outpatient visit with straightforward medical decision making, if using time, 10 minutes or more): $173,346 paid over 25 months, 6% of this provider's Medicaid dollars, $101 per patient-month, which ranks at the 91th percentile of all providers billing this code (typical $28).
procedures billed, Medicaid

7 Code 87806 (Detection test by immunoassay with direct visual observation for hiv-1 antigen, with hiv-1 and hiv-2 antibodies): $168,514 paid over 26 months, 6% of this provider's Medicaid dollars, $33 per patient-month, which ranks at the 92th percentile of all providers billing this code (typical $25).
procedures billed, Medicaid

8 Code 99214 (Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more): 32 services for 22 beneficiaries, $2,936 paid; submitted $330 per service against $131 allowed, a ratio of 2.5x where the usual ratio for this code is 2.3x.
procedures billed, Medicare 2024

9 Code 58558 (Biopsy of lining of uterus and/or removal of polyp using an endoscope): 14 services for 14 beneficiaries, $2,713 paid; submitted $4,250 per service against $243 allowed, a ratio of 17.5x where the usual ratio for this code is 4.7x.
procedures billed, Medicare 2024

10 Code 99204 (New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more): 15 services for 15 beneficiaries, $1,857 paid; submitted $428 per service against $167 allowed, a ratio of 2.6x where the usual ratio for this code is 2.4x.
procedures billed, Medicare 2024

11 Code 99213 (Established patient office or other outpatient visit with low level od decision making, if using time, 20 minutes or more): 21 services for 17 beneficiaries, $1,309 paid; submitted $235 per service against $92 allowed, a ratio of 2.6x where the usual ratio for this code is 2.2x.
procedures billed, Medicare 2024

12 Evidence tier 4 (structure or single-organization volume); detectors D2; dollars at risk $1,879,895 (figure of the detector that set the tier, not a sum); reasons: Hours beyond a day in 16 month(s), but with up to 1133 patients a month across 7 billing organizations, which points to a supervising clinician on the claims rather than one person's hours; records needed; Medicaid dollars per patient on code 99214 ($210 per patient-month) sit in the top 5% of every provider billing that code.
provider risk

13 2018-07-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 52.7 (lower bound 12.7, point 79.1); $180,067; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 6 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

14 2020-07-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 25.9 (lower bound 4.7, point 38.9); $61,628; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 4 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

15 2019-03-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 32.2 (lower bound 6.3, point 48.3); $90,597; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 3 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

16 2018-11-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 29.9 (lower bound 6.6, point 44.8); $91,786; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 3 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

17 2018-10-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 44.4 (lower bound 10.1, point 66.6); $140,070; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 7 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

18 2018-12-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 31.0 (lower bound 6.9, point 46.4); $100,981; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 5 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

19 2018-06-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 40.9 (lower bound 9.1, point 61.3); $127,445; codes ['99202', '99203', '99211', '99212', '99213', '99214']; 5 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

20 2018-09-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 29.0 (lower bound 6.4, point 43.4); $88,126; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 5 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

21

2018-08-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 26.4 (lower bound 5.9, point 39.5); $88,108; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 4 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

22 2019-02-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 31.8 (lower bound 6.4, point 47.7); $81,418; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 4 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

23 2018-04-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 38.4 (lower bound 10.4, point 57.6); $122,096; codes ['99201', '99202', '99211', '99212', '99213', '99214']; 5 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

24 2019-06-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 36.3 (lower bound 7.2, point 54.5); $95,812; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 7 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

25 2019-04-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 28.5 (lower bound 5.7, point 42.8); $74,702; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 5 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

26 2018-05-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 33.8 (lower bound 7.8, point 50.7); $110,691; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 3 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

27 2019-01-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 32.1 (lower bound 6.5, point 48.2); $92,505; codes ['99201', '99202', '99203', '99211', '99212', '99213', '99214']; 4 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

28 2018-03-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 26.8 (lower bound 8.0, point 40.2); $93,511; codes ['99201', '99202', '99211', '99212', '99213', '99214']; 4 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending