Referral packet: SIGRID ELSTON

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 1003839317	12	17	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 data for an individual provider enrolled in Indiana with an Atlanta, Georgia address shows nine months in which billed hands-on service time exceeds the hours available in a calendar day, peaking at 31.4 implied hours per day across three billing organizations, with **$14,148,685** identified by the detector that set the risk tier. The same records show **$11,177,970** paid on code 97153 at **$11,668** per patient-month against a typical **$1,554,** placing the provider at the 99th percentile, which supports a request for records to confirm who rendered the services and on what days.

Description

Sigrid Elston is listed in the national provider file as an individual provider with an Atlanta, Georgia address and a Medicaid home state of Indiana. Medicaid paid more than eleven million dollars on the applied behavior analysis technician code 97153 over thirty months, plus about two and a half million dollars on the related professional code 97155. In nine separate months, the claims tied to this provider add up to more hands-on service time than a calendar day contains, with one month reaching 31.4 implied hours in a day, and the claims in those months come from three different billing organizations. About 97 percent of the Medicaid dollars sit on code families that have a history of billing abuse. These are patterns in paid claims records only, and there is no finding here about intent or wrongdoing.

What the records show

01 The national provider file lists NPI **1003839317** for Sigrid Elston as an individual provider in Atlanta, Georgia, with taxonomy 103TC1900X and a Medicaid home state of Indiana.

Records 1 (providers/NPPES)

02 Code 97153, adaptive behavior treatment by protocol delivered by a technician, was paid **$11,177,970** over 30 months, representing 74 percent of this provider's Medicaid dollars, at **$11,668** per patient-month against a typical **$1,554,** ranking at the 99th percentile of all providers billing that code.
Records 2 (procedures billed, Medicaid)

03 Code 97155, adaptive behavior treatment with protocol modification by a qualified health professional, was paid **$2,467,114** over 26 months at **$2,892** per patient-month against a typical **$512,** ranking at the 99th percentile.
Records 3 (procedures billed, Medicaid)

04 Code 90837, one hour of psychotherapy, was paid **$1,083,772** over 57 months at **$286** per patient-month against a typical **$191,** ranking at the 81st percentile.
Records 4 (procedures billed, Medicaid)

05 Code 97151, behavior identification assessment by a professional in 15 minute units, was paid **$100,391** over 7 months at **$930** per patient-month against a typical **$389,** ranking at the 91st percentile.
Records 6 (procedures billed, Medicaid)

06 The risk record places the provider at evidence tier 2 for impossible volume with concurrency, cites detector D2, and lists dollars at risk of **$14,148,685,** described as the figure of the detector that set the tier and not a sum.
Records 8 (provider risk)

07 The stated reasons include billing more hands-on hours than a day holds in nine months, peaking at 31.4 hours per day across three billing organizations, and that 97 percent of Medicaid dollars fall on codes with a history of abuse.
Records 8 (provider risk)

08 For the month beginning **March 1, 2022**, the flag records implied hours per clinician calendar day of 31.4 with a lower bound of 24.3 and a point estimate of 81.8, **$1,029,378** in spending, three billing organizations, and codes 90837, 90846, 97151, 97153, 97155 and 97156.
Records 11 (flags/D2 + T-MSIS spending)

09 For the month beginning **February 1, 2022**, the flag records implied hours per clinician calendar day of 30.5 with a lower bound of 23.5 and a point estimate of 77.5, **$867,138** in spending, and three billing organizations.
Records 17 (flags/D2 + T-MSIS spending)

10 For the month beginning **March 1, 2021**, the flag records implied hours per clinician calendar day of 27.6 with a lower bound of 27.1, **$620,290** in spending, three billing organizations, and nine distinct procedure codes including 90791, 90832, 90834, 90837, 90846, 97151, 97153, 97155 and 97156.
Records 9 (flags/D2 + T-MSIS spending)

11 For the month beginning **April 1, 2021**, a flag based on line counts rather than a conservative rate records implied hours per clinician calendar day of 25.1 with a lower bound of 31.5, **$636,309** in spending, and three billing organizations.
Records 15 (flags/D2 + T-MSIS spending)

12 Additional months carrying the same impossible conservative rate flag include **November 2021** at 24.3 implied hours and **$657,225, December 2021** at 25.7 implied hours and **$583,226, October 2021** at 26.9 implied hours and **$789,811, May 2021** at 24.1 implied hours and **$656,037** across two billing organizations, and **April 2022** at 24.8 implied hours and **$797,258**.

Records 10 (flags/D2 + T-MSIS spending), 12 (flags/D2 + T-MSIS spending), 16 (flags/D2 + T-MSIS spending), 13 (flags/D2 + T-MSIS spending), 14 (flags/D2 + T-MSIS spending)

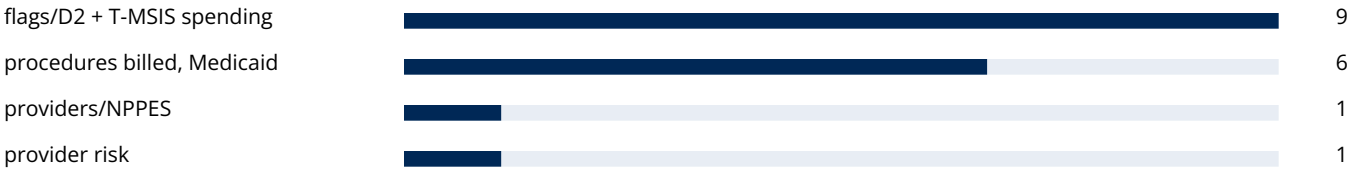
Regulations this relates to

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 state Medicaid agency and the three billing organizations the full claim detail for the nine flagged months, including rendering and billing provider identifiers on every line, service start and stop times, session notes, and technician supervision logs for codes 97153, 97155 and 97151. Obtain payroll and scheduling records for the technicians whose services were billed under this provider, along with the treatment plans and authorizations supporting the per patient-month amounts on code 97153. Verify enrollment, screening and revalidation status in Indiana and any other state of enrollment under **42 CFR 455.410**, which requires screening under subpart E as a condition of enrollment and revalidation at least every five years, and confirm no excluded person furnished the services, which is relevant under **42 CFR 1003.200** covering claims for items or services not provided as claimed or furnished by an excluded person. If the records review supports a credible allegation of fraud, the state must refer the matter to the Medicaid Fraud Control Unit and address payment suspension under **42 CFR 455.23(a)** and (d), including any good cause determination not to suspend or to suspend only in part.

Procedures behind the dollars

97153 Medicaid: Adaptive behavior treatment by protocol by technician — $11.2M 74%

99th percentile of providers on this code, $12K per patient-month against a typical $2K; code family with a history of abuse

97155 Medicaid: Adaptive behavior treatment with protocol modification by QHP — $2.5M 16%

99th percentile of providers on this code, $3K per patient-month against a typical $512; code family with a history of abuse

90837	Medicaid: Psychotherapy, 1 hour 81st percentile of providers on this code, $286 per patient-month against a typical $191; code family with a history of abuse	$1.1M	7%
90846	Medicaid: Family psychotherapy without patient, 50 minutes 82nd percentile of providers on this code, $177 per patient-month against a typical $113	$136K	1%
97151	Medicaid: Behavior identification assessment by professional, each 15 minutes 91st percentile of providers on this code, $930 per patient-month against a typical $389	$100K	1%
97156	Medicaid: Family adaptive behavior treatment guidance 45th percentile of providers on this code, $185 per patient-month against a typical $210	$66K	0%

Rule out first

- Applied behavior analysis is commonly delivered by technicians and billed under a supervising professional, so hours attributed to one individual identifier may represent the combined work of many staff; the rendering versus billing identifier on each line must be checked before any conclusion is drawn.
- The provider appears across three billing organizations, and group or agency billing conventions can concentrate an entire team's service time under a single individual identifier.
- The implied hours figures are derived from per line rate assumptions using median and trimmed fifth percentile per line rates, and in several months the stated lower bound and the reported implied hours diverge, so unit to minute conversions should be recomputed from actual claim units.
- Percentile comparisons on codes 97153 and 97155 can be distorted by a small or high intensity caseload, by authorized high hour treatment plans, or by patients receiving full day programming.
- Paid claims data can lag, and adjustments, voids, recoupments, appeals and reinstatements may change the paid amounts and the months in which services are counted.
- An Atlanta, Georgia practice address with an Indiana Medicaid home state may reflect a corporate or mailing address rather than the service location, and the national provider file may not be current.
- The note that certain code families have a history of abuse is a general statement about the codes and not an observation about this provider's claims.

Public records cited

1 NPI 1003839317 SIGRID ELSTON (individual), ATLANTA, GA; taxonomy 103TC1900X; Medicaid home state IN.
providers/NPPES

2 Code 97153 (Adaptive behavior treatment by protocol by technician): $11,177,970 paid over 30 months, 74% of this provider's Medicaid dollars, $11,668 per patient-month, which ranks at the 99th percentile of all providers billing this code (typical $1,554); this code family has a history of abuse.
procedures billed, Medicaid

3 Code 97155 (Adaptive behavior treatment with protocol modification by QHP): $2,467,114 paid over 26 months, 16% of this provider's Medicaid dollars, $2,892 per patient-month, which ranks at the 99th percentile of all providers billing this code (typical $512); this code family has a history of abuse.
procedures billed, Medicaid

4 Code 90837 (Psychotherapy, 1 hour): $1,083,772 paid over 57 months, 7% of this provider's Medicaid dollars, $286 per patient-month, which ranks at the 81th percentile of all providers billing this code (typical $191); this code family has a history of abuse.
procedures billed, Medicaid

5 Code 90846 (Family psychotherapy without patient, 50 minutes): $136,294 paid over 42 months, 1% of this provider's Medicaid dollars, $177 per patient-month, which ranks at the 82th percentile of all providers billing this code (typical $113).
procedures billed, Medicaid

6 Code 97151 (Behavior identification assessment by professional, each 15 minutes): $100,391 paid over 7 months, 1% of this provider's Medicaid dollars, $930 per patient-month, which ranks at the 91th percentile of all providers billing this code (typical $389).
procedures billed, Medicaid

7 Code 97156 (Family adaptive behavior treatment guidance): $65,572 paid over 17 months, 0% of this provider's Medicaid dollars, $185 per patient-month, which ranks at the 45th percentile of all providers billing this code (typical $210).
procedures billed, Medicaid

8 Evidence tier 2 (impossible volume with concurrency); detectors D2; dollars at risk $14,148,685 (figure of the detector that set the tier, not a sum); reasons: Billed more hands-on hours than a day holds in 9 month(s), peaking at 31.4 hours per day across 3 billing organizations; Medicaid dollars per patient on code 97153 ($11668 per patient-month) sit in the top 5% of every provider billing that code; 97% of Medicaid dollars are on codes with a history of abuse.
provider risk

9 2021-03-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 27.6 (lower bound 27.1, point 61.7); $620,290; codes ['90791', '90832', '90834', '90837', '90846', '97151', '97153', '97155', '97156']; 3 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

10 2021-11-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 24.3 (lower bound 23.0, point 60.0); $657,225; codes ['90837', '90846', '97153', '97155', '97156']; 3 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

11 2022-03-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 31.4 (lower bound 24.3, point 81.8); $1,029,378; codes ['90837', '90846', '97151', '97153', '97155', '97156']; 3 billing organizations; rate source p05 per line trimmed,p50 per line.

flags/D2 + T-MSIS spending

12 2021-12-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 25.7 (lower bound 19.3, point 57.2); $583,226; codes ['90837', '90846', '97151', '97153', '97155', '97156']; 3 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

13 2021-05-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 24.1 (lower bound 26.0, point 58.9); $656,037; codes ['90791', '90834', '90837', '90846', '97151', '97153', '97155', '97156']; 2 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

14 2022-04-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 24.8 (lower bound 20.3, point 65.2); $797,258; codes ['90837', '90846', '97153', '97155', '97156']; 3 billing organizations; rate source p05 per line trimmed,p50 per line.
flags/D2 + T-MSIS spending

15 2021-04-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 25.1 (lower bound 31.5, point 60.7); $636,309; codes ['90791', '90832', '90834', '90837', '90846', '90847', '97153', '97155', '97156']; 3 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

16 2021-10-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 26.9 (lower bound 21.7, point 67.4); $789,811; codes ['90837', '90846', '97153', '97155', '97156']; 3 billing organizations; rate source p50 per line,p05 per line trimmed.
flags/D2 + T-MSIS spending

17 2022-02-01: IMPOSSIBLE CONSERVATIVE RATE; implied hours per per clinician calendar day personal services 30.5 (lower bound 23.5, point 77.5); $867,138; codes ['90837', '90846', '97151', '97153', '97155', '97156']; 3 billing organizations; rate source p05 per line trimmed,p50 per line.
flags/D2 + T-MSIS spending