Referral packet: NARICIA FUTRELL

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 1033425483	11	19	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 records for NPI **1033425483**, Naricia Futrell, an individual behavioral health provider in Millington, Tennessee, show eleven separate months in 2018 flagged as impossible by line count, with implied hands on time reaching 33.0 hours per clinician calendar day for personal services in **August 2018** and claims submitted through as many as three billing organizations in the same month. The provider was paid **$1,275,680** on code 90837 over 49 months, which is 91 percent of the provider's Medicaid dollars, and the detector that set the evidence tier places **$893,393** at risk, which supports a request for time and attendance records, appointment schedules and treatment notes.

Description

Naricia Futrell is an individual behavioral health provider enrolled in Tennessee Medicaid under NPI **1033425483**. Almost all of the Medicaid money paid to this provider, 91 percent, is for one code, 90837, which is a one hour psychotherapy session, totaling **$1,275,680** over 49 months. In eleven months during 2018, the number of service lines billed under this one provider adds up to more hours of face to face care than a calendar day contains, with the highest month implying 33.0 hours in a day. In several of those months the claims came in through two or three different billing organizations at the same time. The amounts paid per patient per month are close to or below what other providers bill for the same codes, so the question raised by the records is about the hours and the number of lines, not the price of each service.

What the records show

01 The subject is listed in national provider records as NPI **1033425483**, Naricia Futrell, an individual provider in Millington, Tennessee, with taxonomy 104100000X and Tennessee as the Medicaid home state.
Records 1 (providers/NPPES)

02 Code 90837, psychotherapy for one hour, accounts for **$1,275,680** paid over 49 months and 91 percent of this provider's Medicaid dollars, at **$203** per patient month, ranking at the 55th percentile of all providers billing this code against a typical **$191**.

Records 2 (procedures billed, Medicaid)

03 The provider risk record places the file at evidence tier 2 for impossible volume with concurrency, cites detector D2, lists dollars at risk of **$893,393** as the figure of the detector that set the tier rather than a sum, and states that the provider billed more hands on hours than a day holds in 11 months, peaking at 33.0 hours per day across 3 billing organizations, with 91 percent of Medicaid dollars on codes with a history of abuse.
Records 8 (provider risk)

04 On **August 1, 2018** the claims were flagged as impossible by line count with implied hours per clinician calendar day for personal services of 33.0, a lower bound of 71.1 and a point estimate of 49.5, on **$97,850** for codes 90791, 90834, 90837 and 90847 across 3 billing organizations, using the median per line rate source.
Records 19 (flags/D2 + T-MSIS spending)

05 On **October 1, 2018** the claims were flagged as impossible by line count with implied hours per clinician calendar day for personal services of 30.2 on **$89,388** for codes 90791, 90834, 90837, 90846 and 90847 across 2 billing organizations.
Records 16 (flags/D2 + T-MSIS spending)

06 On **September 1, 2018** the claims were flagged as impossible by line count with implied hours per clinician calendar day for personal services of 29.3 on **$84,024** for codes 90791, 90834, 90837, 90846 and 90847 across 3 billing organizations.
Records 13 (flags/D2 + T-MSIS spending)

07 On **November 1, 2018** the claims were flagged as impossible by line count with implied hours per clinician calendar day for personal services of 25.1 on **$72,136** for codes 90791, 90837 and 90847 across 3 billing organizations.
Records 12 (flags/D2 + T-MSIS spending)

08 Additional impossible by line count flags were recorded for **January 2018** at 18.9 implied hours and **$55,984, February 2018** at 21.9 implied hours and **$58,525, March 2018** at 24.3 implied hours and **$72,158, April 2018** at 27.0 implied hours and **$77,485, May 2018** at 27.7 implied hours and **$81,756, June 2018** at 27.5 implied hours and **$78,786,** and **July 2018** at 28.3 implied hours and **$83,610**.
Records 14 (flags/D2 + T-MSIS spending), 11 (flags/D2 + T-MSIS spending), 10 (flags/D2 + T-MSIS spending), 15 (flags/D2 + T-MSIS spending), 9 (flags/D2 + T-MSIS spending), 17 (flags/D2 + T-MSIS spending), 18 (flags/D2 + T-MSIS spending)

09 Code 90847, family psychotherapy with the patient for 50 minutes, accounts for **$62,188** paid over 13 months and 4 percent of Medicaid dollars, at **$111** per patient month, ranking at the 39th percentile against a typical **$130**.
Records 3 (procedures billed, Medicaid)

10 Code 90791, psychiatric diagnostic evaluation, accounts for **$45,039** paid over 27 months and 3 percent of Medicaid dollars, at **$70** per patient month, ranking at the 25th percentile against a typical **$105**.
Records 4 (procedures billed, Medicaid)

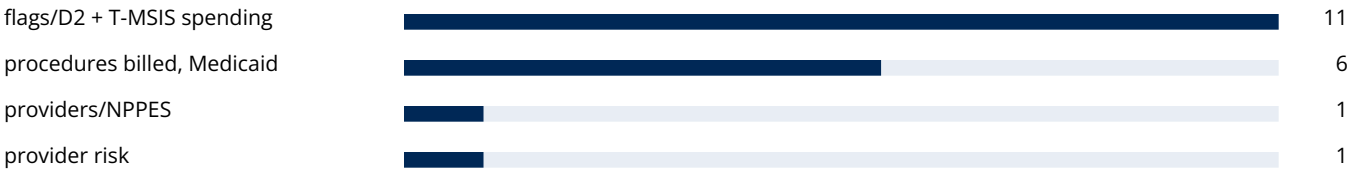
11 Code 90846, family psychotherapy without the patient for 50 minutes, accounts for **$8,511** over 6 months at the 30th percentile, code 90834, psychotherapy for 45 minutes, accounts for **$7,845** over 17 months at the 15th percentile, and code 90853, group psychotherapy, accounts for **$1,417** over 2 months.
Records 5 (procedures billed, Medicaid), 6 (procedures billed, Medicaid), 7 (procedures billed, Medicaid)

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 provider and from each of the three billing organizations the daily appointment schedules, sign in sheets, session start and stop times, and signed treatment notes for the eleven flagged months in calendar year 2018, together with payroll and time records for the rendering clinician and any employed or contracted clinicians whose services were billed under NPI **1033425483**. Reconcile the paid line counts for codes 90837, 90847, 90791, 90846, 90834 and 90853 against those records to determine how many distinct clinicians actually furnished the services and whether the rendering provider field reflects the person who performed them. Confirm the enrollment, screening and revalidation status of the provider and of each billing organization under **42 CFR 455.410**, which requires screening under subpart E as a condition of enrollment and revalidation at least every 5 years. If the records review supports a credible allegation of fraud, the state agency should apply **42 CFR 455.23(a)** on payment suspension, including the good cause and partial suspension options, and make the referral to the Medicaid Fraud Control Unit required by **42 CFR 455.23(d)**; potential exposure for claims for services not provided as claimed may be evaluated under **42 CFR 1003.200.**

Procedures behind the dollars

90837	Medicaid: Psychotherapy, 1 hour 55th percentile of providers on this code, $203 per patient-month against a typical $191; code family with a history of abuse	$1.3M 91%
90847	Medicaid: Family psychotherapy with patient, 50 minutes 39th percentile of providers on this code, $111 per patient-month against a typical $130	$62K 4%
90791	Medicaid: Psychiatric diagnostic evaluation 25th percentile of providers on this code, $70 per patient-month against a typical $105	$45K 3%
90846	Medicaid: Family psychotherapy without patient, 50 minutes 30th percentile of providers on this code, $90 per patient-month against a typical $113	$9K 1%

90834	Medicaid: Psychotherapy, 45 minutes 15th percentile of providers on this code, $33 per patient-month against a typical $101	$8K	1%
90853	Medicaid: Group psychotherapy	$1K	0%

Rule out first

- The implied hours are estimated from a median per line rate source rather than from documented session start and stop times, so actual session lengths could differ from the modeled durations.
- Claims billed through two or three billing organizations under one individual NPI may reflect supervisory or group practice billing conventions in which services furnished by employed or supervised clinicians are submitted under the supervising provider's number.
- The provider may work across multiple agencies or sites, and duplicate or overlapping submissions from separate billing entities can inflate line counts before adjustments, voids and recoupments are applied.
- Amounts per patient month are at or below peer norms for most codes, at the 55th percentile for 90837, the 39th percentile for 90847, the 25th percentile for 90791, the 30th percentile for 90846 and the 15th percentile for 90834, which is consistent with ordinary pricing.
- Paid claims data can lag, and pending appeals, adjustments or reinstatements may change the paid amounts and line counts shown for the flagged months.
- All flags fall within calendar year 2018, so current billing patterns may differ and should be verified before any payment action.

Public records cited

1 NPI 1033425483 NARICIA FUTRELL (individual), MILLINGTON, TN; taxonomy 104100000X; Medicaid home state TN.
providers/NPPES

2 Code 90837 (Psychotherapy, 1 hour): $1,275,680 paid over 49 months, 91% of this provider's Medicaid dollars, $203 per patient-month, which ranks at the 55th percentile of all providers billing this code (typical $191); this code family has a history of abuse.
procedures billed, Medicaid

3 Code 90847 (Family psychotherapy with patient, 50 minutes): $62,188 paid over 13 months, 4% of this provider's Medicaid dollars, $111 per patient-month, which ranks at the 39th percentile of all providers billing this code (typical $130).
procedures billed, Medicaid

4 Code 90791 (Psychiatric diagnostic evaluation): $45,039 paid over 27 months, 3% of this provider's Medicaid dollars, $70 per patient-month, which ranks at the 25th percentile of all providers billing this code (typical $105).
procedures billed, Medicaid

5 Code 90846 (Family psychotherapy without patient, 50 minutes): $8,511 paid over 6 months, 1% of this provider's Medicaid dollars, $90 per patient-month, which ranks at the 30th percentile of all providers billing this code (typical $113).
procedures billed, Medicaid

6 Code 90834 (Psychotherapy, 45 minutes): $7,845 paid over 17 months, 1% of this provider's Medicaid dollars, $33 per patient-month, which ranks at the 15th percentile of all providers billing this code (typical $101).
procedures billed, Medicaid

7 Code 90853 (Group psychotherapy): $1,417 paid over 2 months, 0% of this provider's Medicaid dollars, $38 per patient-month; this code family has a history of abuse.
procedures billed, Medicaid

8 Evidence tier 2 (impossible volume with concurrency); detectors D2; dollars at risk $893,393 (figure of the detector that set the tier, not a sum); reasons: Billed more hands-on hours than a day holds in 11 month(s), peaking at 33.0 hours per day across 3 billing organizations; 91% of Medicaid dollars are on codes with a history of abuse.
provider risk

9 2018-05-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 27.7 (lower bound 45.0, point 41.5); $81,756; codes ['90791', '90834', '90837', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

10 2018-03-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 24.3 (lower bound 40.0, point 36.5); $72,158; codes ['90791', '90834', '90837', '90846', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

11 2018-02-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 21.9 (lower bound 36.3, point 32.8); $58,525; codes ['90791', '90834', '90837', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

12 2018-11-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 25.1 (lower bound 47.0, point 37.6); $72,136; codes ['90791', '90837', '90847']; 3 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

13 2018-09-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 29.3 (lower bound 51.1, point 44.0); $84,024; codes ['90791', '90834', '90837', '90846', '90847']; 3 billing organizations; rate source p50 per line.

flags/D2 + T-MSIS spending

14 2018-01-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 18.9 (lower bound 31.1, point 28.3); $55,984; codes ['90791', '90834', '90837', '90846', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

15 2018-04-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 27.0 (lower bound 43.7, point 40.5); $77,485; codes ['90791', '90834', '90837', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

16 2018-10-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 30.2 (lower bound 45.3, point 45.2); $89,388; codes ['90791', '90834', '90837', '90846', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

17 2018-06-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 27.5 (lower bound 44.1, point 41.2); $78,786; codes ['90791', '90834', '90837', '90846', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

18 2018-07-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 28.3 (lower bound 46.7, point 42.4); $83,610; codes ['90834', '90837', '90847']; 2 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending

19 2018-08-01: IMPOSSIBLE BY LINE COUNT; implied hours per per clinician calendar day personal services 33.0 (lower bound 71.1, point 49.5); $97,850; codes ['90791', '90834', '90837', '90847']; 3 billing organizations; rate source p50 per line.
flags/D2 + T-MSIS spending