

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

STATE OF CONNECTICUT : **FILED UNDER SEAL**
 : October 23, 2023
COUNTY OF HARTFORD :

AFFIDAVIT IN SUPPORT OF AN APPLICATION FOR A SEARCH WARRANT

I, Ryan P. Driscoll, being first duly sworn, state the following:

INTRODUCTION AND AGENT BACKGROUND

1. I am a Special Agent with the United States Department of Health and Human Services, Office of Inspector General (HHS-OIG), where I have been employed since January 2019. I am a graduate of the Criminal Investigator Training Program at the Federal Law Enforcement Training Center in Glynco, Georgia. I received a Bachelor of Science in National Security Studies and Criminal Justice from the Henry C. Lee College of Criminal Justice and Forensic Sciences, University of New Haven in 2018. Before becoming a Special Agent, I was employed as an Anti-Money Laundering Analyst with a major financial institution for approximately six months.

2. As an HHS-OIG Special Agent, I am responsible for investigating allegations of fraud against the various programs under HHS's jurisdiction, including the Medicare and Medicaid programs. I have participated in numerous investigations involving those programs and have interviewed witnesses, conducted surveillance, and reviewed claims data, medical records and other business records. I have also assisted with the execution of search and arrest warrants.

3. I am an investigative or law enforcement officer of the United States within the meaning of Section 2510(7) of Title 18 of the United States Code, in that I am empowered by law to conduct investigations and to make arrests for federal felony offenses.

4. Pursuant to Rule 41, Fed. R. Crim. P., I submit this affidavit in support of an application for a search warrant for 41C NEW LONDON TURNPIKE, GLASTONBURY, CT 06033 (“TARGET PREMISES”), the business address of the psychology practice for MICHAEL B. PINES (“INDIVIDUAL 1”) and Michael B. Pines, Ph.D., P.C. (“Entity 1”), which are more particularly described in Attachment A, to obtain evidence, fruits, and instrumentalities of violations of Title 18, United States Code, Sections 1347 (health care fraud) and 1035 (false statements relating to health care matters). Such evidence, fruits, and instrumentalities consist of items set forth in Attachment B.

5. Along with the Federal Bureau of Investigation (“FBI”), HHS-OIG is investigating INDIVIDUAL 1, who has been licensed by the State of Connecticut as a psychologist since January 25, 1978, and Entity 1, which was registered in the State of Connecticut on November 18, 1981. The government is investigating allegations that, beginning no later than January 1, 2017 and continuing through at least September 15, 2023, INDIVIDUAL 1 has been defrauding the Connecticut Medicaid Program by submitting fraudulent claims for psychotherapy counseling sessions that in fact were never provided to Medicaid patients. More specifically and as discussed further below, INDIVIDUAL 1 is: (1) repeatedly billing Medicaid for providing 12 or more hours of services on a single day; (2) repeatedly billing Medicaid for services rendered while INDIVIDUAL 1 is traveling; and (3) billing Medicaid for services purportedly rendered to patients, sometimes for months or years, after the patients stopped seeing INDIVIDUAL 1.

6. This affidavit sets forth facts and evidence that are relevant to the requested search warrant but does not set forth all of the facts and evidence that have been gathered during the

course of the investigation of this matter. More specifically, I have set forth only facts that I believe are necessary to establish probable cause for the issuance of the requested search warrant. I base this affidavit upon my personal knowledge, upon information and documents provided to me by other investigators assigned to this investigation, and upon information and documents provided by third parties.

THE INVESTIGATION TO DATE

A. The Medicaid Program in Connecticut

7. The Connecticut Department of Social Services (“DSS”) provides medical assistance to low-income persons and people who could otherwise support themselves if not for the fact that they have excessive health care costs. DSS provides this assistance through the Connecticut Medical Assistance Program (CTMAP). CTMAP offers a comprehensive health care benefit package that includes the following:

- a. HUSKY A - Family Medicaid;
- b. HUSKY B - State Children’s Health Insurance Program (“SCHIP”);
- c. HUSKY C - previously referred to as Medicaid, Title XIX, fee-for-service, or Adult Medicaid; and
- d. HUSKY D - previously referred to as Medicaid for Low Income Adults (“MLIA”).

8. The HUSKY programs identified above are joint federal-state government programs designed primarily to finance the provision of the medical services to the indigent. This affidavit refers to the various HUSKY programs above collectively as “Medicaid.” DSS administers these Medicaid programs in Connecticut. The Medicaid program is administered at the federal level by the Centers for Medicare and Medicaid Services and is funded approximately 50 percent by the federal government. The remaining approximately 50 percent is funded by the State of Connecticut.

9. Medicaid is a public plan or contract that pays claims submitted by participating health care providers for medically necessary benefits, items, and services rendered to Medicaid members. As such, Medicaid is a “health care benefit program” under 18 U.S.C. § 24(b).

B. Medicaid’s Coverage of Behavioral Health Services

10. The Connecticut DSS Provider Manual, which sets forth the rules of the Medicaid program, defines “behavioral health clinician services” as “preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed behavioral health clinician within the licensed behavioral health clinician’s scope of practice under state law.” The services INDIVIDUAL 1 allegedly provides are considered behavioral health clinician services.

11. Per the Provider Manual, Medicaid pays providers “only for behavioral health clinician services that are (1) [w]ithin the licensed behavioral health clinician’s scope of practice as defined by chapters 376b, 383a, 383b, or 383c of the Connecticut General Statutes, as applicable to the behavioral health clinician; and (2) medically necessary to treat the client’s condition.” The Provider Manual also states that Medicaid does not pay for “services provided by anyone other than” the licensed provider, or for “cancelled office visits or appointments not kept.”

12. Thus, Medicaid covers only behavioral health services that are provided by licensed health care providers, with a very narrow exception for license-eligible individuals in a behavioral health clinic. Under Connecticut law, these licensed providers include psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, licensed family and marriage therapists, and licensed alcohol and drug counselors.

13. DSS defines medically necessary services as “those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual’s medical condition, including mental illness, or its effect, in order to attain or maintain the individual’s achievable health and independent functioning.”

14. In order to participate in the Medicaid program, health care providers complete enrollment forms and must provide proof of licensure. As part of their enrollment, providers certify that they will abide by all applicable federal and state statutes and regulations and will keep

accurate and current records regarding the nature, scope, and extent of services furnished to Medicaid recipients. They also acknowledge prohibitions against the following:

- a. false statements, misrepresentation, concealment, failure to disclose, and conversion of benefits;
- b. any giving or seeking of kickbacks, rebates, or similar remuneration;
- c. charging or receiving reimbursement in excess of that provided by the State; and
- d. false statements or misrepresentation in order to qualify as a provider.

15. Furthermore, participating providers in the Medicaid program are required to maintain: (1) a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, and a current treatment plan signed by the licensed behavioral health clinician; and (2) documentation of services provided, including, types of service or modalities, date of service, location of the service and the start and stop time of the service. Providers must maintain these records for at least five years from the date of service.

16. When Medicaid sends payments to providers for services, Medicaid also sends a document called a remittance advice/notice to the provider. The remittance advice/notice details the amount Medicaid paid or denied for each claim. Unlike many other health benefit plans, Medicaid does not send Explanation of Benefits forms to its members for claims submitted to Medicaid. As a result, Medicaid members generally do not know if a provider has billed Medicaid for services that the member did not in fact receive.

C. How Providers Bill Medicaid: CPT Codes

17. In order to bill health care benefit programs such as Medicaid, Medicare, or private health insurance programs, providers use a five-digit number, known as a Current Procedural Terminology (“CPT”) code, which identifies the nature and complexity of the service provided. The CPT codes are listed in a manual that is published annually by the American Medical Association. CPT codes are universally used by health care providers to bill government and

private health insurance programs for services rendered. Virtually every medical procedure has its own CPT code and Medicaid and private insurance companies pay a specified amount of money for each CPT code billed.

18. The CPT codes that INDIVIDUAL 1 uses to bill Medicaid are those commonly used by behavioral health clinicians who provide psychotherapy services. According to the CPT manual, psychotherapy is defined as “the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.”

19. The CPT manual describes the codes for psychotherapy sessions and defines the various levels of psychotherapy sessions according to the “times for face-to-face services with [a] patient, and may include informant(s).” The CPT manual also provides that “[t]he patient must be present for a majority of the service.”

20. Since 2013, the CPT manual listed several codes of psychotherapy sessions. Generally speaking, the longer the psychotherapy session, the more that Medicaid or any other health plan pays for the service.

21. The code most commonly used by INDIVIDUAL 1 to bill Medicaid is described as follows in the CPT manual:

90837 Psychotherapy, 60 minutes with patient and/or family

22. For a small minority of the submitted claims (almost all in early 2017), INDIVIDUAL 1 also billed Medicaid for services using the following CPT Code:

90834 Psychotherapy, 45 minutes with patient

23. According to the American Psychological Association (“APA”), although the times for CPT psychotherapy codes are specific, the coding manual allows for some flexibility.

According to the APA, in general, if the total duration of the psychotherapy session is 38-52 minutes, a provider should choose CPT Code 90834 (the 45-minute code), and if the total duration of the psychotherapy session is 53 or more minutes, the provider should choose CPT Code 90837 (the 60-minute code).

24. Beginning June 8, 2020, INDIVIDUAL 1 billed Medicaid for services using the following CPT Code:

90847 Family psychotherapy (with patient present), 50 minutes

25. According to the APA, “with the 30-, 45- and 60-minute psychotherapy codes, the focus of the service delivered is on the individual patient. The codes can be used with the occasional involvement of family members. With the family psychotherapy codes, the focus of the service delivery is on family dynamics or interactions – or a subset of the family such as parents or children – though the treatment is still intended for the benefit of the patient.” DSS regulations require a minimum session time of 45 minutes for CPT code 90847.

26. If a Medicaid provider sees more than one family member for a group psychotherapy session, Medicaid only reimburses for one identified family member client per session, regardless of the number of family members in attendance. Thus, for example, if a child and two parents attend a group psychotherapy session, the provider may not bill Medicaid and be paid for three separate claims.

27. In addition to billing for 60-minute face-to-face psychotherapy counseling sessions, the first time INDIVIDUAL 1 bills Medicaid for a patient, INDIVIDUAL 1 bills the following CPT code:

90791 Psychiatric diagnostic evaluation

This code is discussed in the section of the CPT manual describing Psychiatric Diagnostic Procedures, which provides in relevant part as follows:

Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

* * *

In certain circumstances, one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Code[] 90791 . . . may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other information. Report services as being provided to the patient and not the informant or other party in such circumstances. . .

. . . Code[] 90791 [is] used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.

28. According to the Centers for Medicare and Medicaid Services, for Medicare patients, a psychiatric diagnostic interview examination under CPT Code 90791 requires (a) elicitation of a complete medical and psychiatric history (including past, family, and social); (b) a mental status examination; (c) establishment of an initial diagnosis; (d) evaluation of the patient's ability and capacity to respond to treatment; and (e) an initial plan of treatment. Although this Medicare guidance is not binding upon Medicaid programs, public and private health plans often look to Medicare guidance as establishing the proper billing requirements, and it is therefore a useful description of the components of a psychiatric diagnostic evaluation.

INDIVIDUAL 1

29. INDIVIDUAL 1 is licensed by the State of Connecticut as a psychologist and obtained that license on or about January 25, 1978. His license is active.

30. On or about September 30, 2014, INDIVIDUAL 1 enrolled individually as a Behavioral Health Clinician provider in the Connecticut Medicaid Program with a provider specialty in psychology. According to a publicly viewable LinkedIn profile, INDIVIDUAL 1 received a Ph.D. in psychology from the University of Connecticut in or around 1977.

31. According to a profile of INDIVIDUAL 1 available at Psychology Today's website:

I am a psychologist with over 35 years in practice. I work primarily with children and adolescents and their families experiencing a variety of problems--anxiety, depression, mood disorders, ADHD, autism spectrum disorders, behavioral disorders and notably issues related to trauma, loss and attachment. I also treat a variety of adjustment disorders related to childhood and adolescence. In addition, I see adults and couples as well.

I specialize in treating children and adolescents experiencing problems related to trauma, loss and attachment stemming from a variety of disruptive sources. Many of my clients have histories of foster care and adoption which have had a profound impact on their lives.

I bring a pragmatic solution based approach to my work focused on symptom relief as well as exploring underlying issues which may be driving behavior. I am committed to forming reciprocal relationships in treatment and the importance of the relationship overtime.

32. INDIVIDUAL 1 has been associated with the TARGET PREMISES as INDIVIDUAL 1's business address since at least September 30, 2014, when he listed the TARGET PREMISES as his service location, mailing address, home office address, and enrollment address in a re-enrollment application for Medicaid providers. INDIVIDUAL 1 reaffirmed those representations in another re-enrollment application on or about April 23, 2019. INDIVIDUAL 1 is enrolled in Medicaid as an individual practitioner. He is the sole owner of his practice.

33. According to the Connecticut Secretary of State, Entity 1 is an active business with the TARGET PREMISES listed as its business and mailing address. INDIVIDUAL 1 is listed as the Entity 1's president, while INDIVIDUAL 1's spouse is listed as its secretary. Entity 1's NAICS code is listed as "offices of mental health practitioners (except physicians)." On INDIVIDUAL 1's re-enrollment application to Medicaid in September 2014, he listed Entity 1 as the contact for check and remittance advice. Payments from Medicaid to INDIVIDUAL 1 are remitted to a business bank account in the name of Entity 1.

34. As discussed further below, the TARGET PREMISES is an office suite within a commercial office building.

35. In both his 2014 and 2019 re-enrollment applications, INDIVIDUAL 1 answered “No” when asked: “Do you store your health records electronically?” Because, as noted above, the applicable Medicaid regulations require record retention for a period of at least five years, INDIVIDUAL 1 is required to store any health records in hard copy form in his office (*i.e.*, the TARGET PREMISES).

INDIVIDUAL 1’S CLAIMS TO MEDICAID

36. Investigators have reviewed the claims INDIVIDUAL 1 submitted or caused to be submitted to Medicaid for dates of service from January 1, 2017 through September 15, 2023. During that time period, there were over 22,000 claims totaling over \$2,300,000 paid to INDIVIDUAL 1.

37. By way of one comparison, for the time period of dates of service from January 1, 2020 through May 12, 2023, INDIVIDUAL 1 was the second-highest paid behavioral health clinician in Connecticut enrolled in Medicaid. Medicaid paid INDIVIDUAL 1 over \$1.1 million on over 10,000 purported services. Another peer comparison during the same timeframe identified INDIVIDUAL 1 as the highest paid psychologist enrolled in Connecticut Medicaid for CPT Code 90837 Psychotherapy, 60 minutes with patient and/or family. Medicaid paid INDIVIDUAL 1 over \$1.1 million while the second-highest paid psychologist received over \$405,000.

A. INDIVIDUAL 1 Repeatedly Billed Medicaid For Providing 12 or More Hours of Service on a Single Day.

38. For dates of service from January 1, 2017 through May 12, 2023, INDIVIDUAL 1 routinely billed Medicaid for purportedly providing psychotherapy services that met or exceeded 12 hours in a day. An ongoing review of these claims reveals that INDIVIDUAL 1 regularly claimed on average of 12 hours of psychotherapy services every weekday, except major holidays.

39. For example, the time period of March 20, 2022 through May 12, 2023, consists of 60 weeks. Of the 300 weekdays in that period, the only days that INDIVIDUAL 1 did not claim any hours were Memorial Day, July 4th, Labor Day, Thanksgiving, the day after Christmas, the day after New Year's, and March 13-14, 2023. Besides that, INDIVIDUAL 1 claimed and was paid for the following hours of psychotherapy services:

No. of hours billed per day	No. of days billed (out of 300)
9 hrs./day	2
10 hrs./day	3
11 hrs./day	15
12 hrs./day	270
13 hrs./day	2

40. A similar paid claims pattern is evident for the time period of January 1, 2017 through March 19, 2022.

41. There appear to be other billing anomalies. For example, INDIVIDUAL 1 never submitted claims for purported dates of service on a weekend, except for one Saturday—March 17, 2018—in which claims to have billed 11 hours, and one Sunday, in September 2020 in which INDIVIDUAL 1 submitted one claim. Moreover, in the very beginning of the COVID-19 pandemic, INDIVIDUAL 1's claims reveal that he allegedly treated the approximate same number of patients, i.e., an average of 12 patients per day.

42. INDIVIDUAL 1's practice is not limited solely to Medicaid beneficiaries. Financial records indicate that, during the time period under investigation, INDIVIDUAL 1 saw patients who have private insurance and patients who appear to pay out of pocket. Moreover, INDIVIDUAL 1 has also received payments from both public school districts and private schools in Connecticut, which suggests that he provided services to those schools. These services to non-Medicaid beneficiaries further increases the likelihood that INDIVIDUAL 1 did not provide the claimed

services to the Medicaid recipients, since it would not be likely that INDIVIDUAL 1 provided the volume of psychological services at the consistent pace that he purports for nearly a six-and-a-half year period.

B. INDIVIDUAL 1's Claims Appear Implausible In Part Because Most of His Patients are School-Aged Children.

43. Most of INDIVIDUAL 1's patients were minors, with some five years old or younger at the time of service. Yet, the majority of INDIVIDUAL 1's claims were for individual psychotherapy sessions of 60 minutes. Moreover, most of INDIVIDUAL 1's patients were school-aged children, which makes it unlikely that INDIVIDUAL 1 provided the services he claimed at the rate and frequency reported, particularly during the school year. Unless the vast majority of these minor patients were being taken out of school for regular psychotherapy sessions with INDIVIDUAL 1, it does not appear plausible that INDIVIDUAL 1 could actually provide the claimed services starting when school ended and still bill an average of 12 hours a day, every weekday, for years.

44. For dates of service from January 1, 2017 through May 12, 2023, INDIVIDUAL 1 claimed to have provided psychotherapy to 15 children while they were under the age of five. Some of the patients were as young as three years old. For this group of age five and under patients, INDIVIDUAL 1 billed Medicaid for 283 services, the vast majority of which were for 60 minutes of psychotherapy.

45. For dates of service from January 1, 2017 through May 12, 2023, INDIVIDUAL 1 also provided treatment to Medicaid beneficiaries with ages between 5 and 18. INDIVIDUAL 1 claimed to have provided eight or more hours of services to children in this age group (excluding the summer months of June, July, and August, when children are generally not in school) on 960 weekdays (out of a possible 1,225 non-summer weekdays). For example, on Monday, October 18,

2021, INDIVIDUAL 1 claimed to have provided 15 hours total of psychotherapy services (billed using CPT code 90837 (psychotherapy, 60 minutes with patient and/or family) to 15 patients between 7 and 15 years old.

46. In another, more recent example, for the date of service of Wednesday, May 3, 2023, INDIVIDUAL 1 was paid for 12 claims by Medicaid, all of which were under CPT code 90837. Eleven of the twelve patients INDIVIDUAL 1 purported to treat that day were ages 6 to 14, i.e., school-aged children. Each of these patients had been purportedly seeing INDIVIDUAL 1 for at least a few months and thus were not new patients. Assuming that none of these patients were pulled out of school that day for their appointment with INDIVIDUAL 1 and the earliest likely appointment at INDIVIDUAL 1's office was 2:30 p.m., it is highly unlikely that INDIVIDUAL 1 saw 11 minor patients back to back from 2:30 p.m. until 1:30 a.m. the next day.¹ Even if a few of these minor patients were pulled out of school for an appointment to see INDIVIDUAL 1, it remains highly unlikely that INDIVIDUAL 1 provided services to children in this age group into the late evening.

47. This billing pattern was common in INDIVIDUAL 1's claims that occurred over the course of the period under investigation, i.e., January 1, 2017 through September 15, 2023.

C. INDIVIDUAL 1 Repeatedly Billed Medicaid When INDIVIDUAL 1 was Traveling.

48. The investigation has revealed that INDIVIDUAL 1 traveled internationally in 2017 (St. Martin), 2018 (Ireland), 2019 (Ireland), and 2022 (South Africa). An ongoing analysis of his claims indicates that, despite this foreign travel and potential time zone differences, he submitted and was paid for over 400 claimed services over approximately 37 days that totaled over \$50,000

¹ Even if INDIVIDUAL 1 saw each patient for the minimum time period permitted by Medicaid for CTP code 90837 (i.e., 53 minutes), INDIVIDUAL 1 would have been seeing these young patients continuously until past midnight.

during those trips. During INDIVIDUAL 1's trip to South Africa from October 30 to November 16, 2022, for example, he billed Medicaid 12 hours every weekday, except for one 11 hour day.

D. Multiple Interviews Confirm that INDIVIDUAL 1 Billed Medicaid for Services That INDIVIDUAL 1 did not Provide.

49. Investigating agents have interviewed several parents of INDIVIDUAL 1's minor patients, some of whom were adopted or in foster care. Each of the parents have more than one child who are or were treated by INDIVIDUAL 1. Thus far, these interviews revealed that: (1) INDIVIDUAL 1 billed Medicaid for alleged services for at least one child he did not treat; (2) INDIVIDUAL 1 billed Medicaid for alleged services to patients at a greater frequency than their actual appointments; (3) INDIVIDUAL 1 billed Medicaid for alleged services to patients who had stopped seeing him; and (4) INDIVIDUAL 1 billed for alleged services to at least one parent when no such services were provided.

Parent 1

50. In connection with the investigation, agents interviewed Parent 1 in July 2023. Parent 1 has children, including J.L. and A.L. While J.L. has seen INDIVIDUAL 1, neither A.L. nor Parent 1 were ever a patient. Parent 1 said that J.L. generally saw INDIVIDUAL 1 without Parent 1 present, although a few times Parent 1 would go in with J.L. for a few minutes before leaving J.L. and INDIVIDUAL 1 alone. Parent 1 perhaps saw INDIVIDUAL 1 once alone for a few minutes to discuss J.L.

51. Furthermore, Parent 1 told investigators that J.L.'s last appointment scheduled with INDIVIDUAL 1 was October 17, 2022, which they canceled because [REDACTED]. Parent 1 confirmed that date after consulting her planner. J.L. did not see INDIVIDUAL 1 after that date.

52. During the interview, Parent 1 reviewed a print out of the claims INDIVIDUAL 1 submitted to Medicaid for J.L., A.L., and Parent 1 and compared them to the calendar Parent 1 kept for 2022. Parent 1 confirmed that she did not receive services from INDIVIDUAL 1 at all, even though Medicaid claims data shows that INDIVIDUAL 1 was paid over \$29,000 for 260 purported dates of service to Parent 1.

53. Parent 1 confirmed that A.L. never saw INDIVIDUAL 1 for services, despite the 101 dates of service for A.L. reflected in Medicaid claims data for which INDIVIDUAL 1 was paid over \$11,000.

54. For the time period of January 5, 2022 through October 17, 2022, Parent 1 compared her calendar to the Medicaid claims data showing 40 purported dates of service for J.L. Of those 40 dates, 27 of them were not reflected as appointments J.L. kept with INDIVIDUAL 1. Parent 1 said that it was very unlikely that a visit occurred that was not in her planner.

55. Medicaid claims data indicate that, from January 1, 2017 through February 6, 2023, J.L. had 258 dates of service with INDIVIDUAL 1, who was paid a total of nearly \$30,000. When asked if J.L. could have seen INDIVIDUAL 1 over 200 times, Parent 1 said that sounded “way too high.”

56. Parent 1 further stated that, during J.L.’s visits with INDIVIDUAL 1, INDIVIDUAL 1 took handwritten notes. Parent 1 also thought there were filing cabinets in INDIVIDUAL 1’s office.

Parent 2

57. In connection with the investigation, agents interviewed Parent 2 in July 2023. Parent 2 has two adopted children, K.F. and J.F., who saw INDIVIDUAL 1.

58. Parent 2 stated that K.F. and J.F. only saw INDIVIDUAL 1 in person and not via telehealth. INDIVIDUAL 1's offices at the TARGET PREMISES was about a [REDACTED]-minute drive from Parent 2's home.

59. Parent 2 described the appointments with INDIVIDUAL 1 as "more of a family session" and recalled them occurring every other week, typically on Wednesday, for one hour. If INDIVIDUAL 1 was on vacation, J.F. and K.F. did not have any appointments with him. J.F. and K.F. would never see INDIVIDUAL 1 on Fridays. Parent 2 said that J.F. and K.F. did not see INDIVIDUAL 1 individually for one hour each, but only together for one hour total.

60. Parent 2 maintains a comprehensive iCalendar listing various appointments and events related to K.F. and J.F. The iCalendar has appointments dating back to at least 2016 and Parent 2 felt very confident in its accuracy. The only instances that may be inaccurate were if any appointment were cancelled and Parent 2 did not remove it from the calendar.

61. Parent 2 reviewed a spreadsheet of Medicaid claims data reflecting purported services INDIVIDUAL 1 provided to K.F. and J.F. For the vast majority of the time period between January 4, 2017 through April 7, 2020, INDIVIDUAL 1 billed Medicaid for separate 60-minute individual psychotherapy sessions for K.F. and J.F., even though Parent 2 said that INDIVIDUAL 1 saw K.F. and J.F. together.² Furthermore, in that same time period, Medicaid paid INDIVIDUAL 1 over \$35,000 for approximately 308 dates of service. Of those dates, Parent 2 indicated that approximately 145 of them were not in her iCalendar at all.

62. Parent 2 stated that she saw INDIVIDUAL 1 retrieve paper patient files from filing cabinets at the TARGET PREMISES within a filing room behind a vacant secretarial area. Parent 2 never saw anyone but INDIVIDUAL 1 go into the filing room. INDIVIDUAL 1 sometimes took

² As discussed above, a provider is not permitted to bill for separate individual claims if in fact the services are for group services.

handwritten notes during sessions with K.F. and J.F. and also might have had a laptop at his desk in his office.

Parent 3

63. In connection with the investigation, agents interviewed Parent 3 telephonically in August 2023. Parent 3 [REDACTED].

64. Parent 3 has six children, all of whom saw INDIVIDUAL 1 for services at one point, but only two of whom were seeing INDIVIDUAL 1 at the time of the interview. When the agent informed Parent 3 that five of her children were being billed by INDIVIDUAL 1 in 2023, Parent 3 indicated that was not true.

Parent 4

65. In connection with the investigation, agents interviewed Parent 4 in August 2023. [REDACTED], Parent 4 is the parent of four adopted children, three of whom saw INDIVIDUAL 1: A.S., S.S., and R.S. Parent 4 explained that his children initially saw INDIVIDUAL 1 at their school and later at the TARGET PREMISES. After the COVID-19 pandemic began, his children saw INDIVIDUAL 1 exclusively via telehealth.

66. Parent 4 said that his children did not have one set day of the week they would see INDIVIDUAL 1. INDIVIDUAL 1 never saw Parent 4's children back-to-back or even on the same day as each other. Parent 4 reiterated that he never drove the children to INDIVIDUAL 1's office for a session with multiple children. There were also no telehealth visits with more than one child on the same day. Moreover, Parent 4 said that none of his children ever saw INDIVIDUAL 1 more than twice per month, except perhaps right at the beginning when INDIVIDUAL 1 was getting to know the children. Later in the interview, Parent 4 said even in the beginning, his children did not see INDIVIDUAL 1 more than twice per month. For instance, Parent 4 said that A.S. likely saw

INDIVIDUAL 1 more than his other two children, but never saw INDIVIDUAL 1 as frequently as weekly and likely never saw INDIVIDUAL 1 more than twice per month.

67. A review of INDIVIDUAL 1's Medicaid claims data indicates that, as a general matter, he purportedly provided services to A.S. and R.S. at least four to five times a month.

68. When asked if INDIVIDUAL 1 could have seen S.S. 173 times and R.S. 175 times,³ Parent 4 said those numbers seemed very high and later said the legitimate number of visits was “nowhere near that number.” When asked if 47 total visits for A.S. sounded right, Parent 4 said that he “could believe” that number. Parent 4 believes all the sessions with INDIVIDUAL 1 were 45 minute sessions.

69. Parent 4 said that he believed S.S. stopped seeing INDIVIDUAL 1 sometime in 2020 and that R.S. stopped seeing INDIVIDUAL 1 around September 2020. Yet Medicaid claims data shows that INDIVIDUAL 1 claimed to have provided services to S.S. and RS on 108 dates of service after 2020 (from January 1, 2021 through May 26, 2022) and was paid \$12,516.

70. Medicaid claims data also reveals that, on at least some occasions, INDIVIDUAL 1 billed for services purportedly given to more than one of Parent 4's children on the same day, which Parent 4 said did not occur. Claims data also indicates that, beginning in or around March 26, 2020, INDIVIDUAL 1 billed primarily for services under various CPT codes for telehealth.

71. Parent 4 said that INDIVIDUAL 1's office (the TARGET PREMISES) has no receptionist but does have a space for a receptionist. In that space is where the filing cabinets are located. When one walks into the office the reception/records space is straight ahead and INDIVIDUAL 1's office is down the hall on the left. Parent 4 observed INDIVIDUAL 1 in that

³ In fact, Medicaid claims data shows that Medicaid *paid* INDIVIDUAL 1 over \$17,000 for services purportedly provided to S.S. from April 2, 2019 through December 29, 2021. Medicaid *paid* INDIVIDUAL 1 over \$18,000 for purported services to R.S. from through February 6, 2019 through May 26, 2022.

reception/records area frequently. INDIVIDUAL 1 would take handwritten notes during the sessions. INDIVIDUAL 1 also had a desktop computer on his desk in his office.

E. INDIVIDUAL 1's Medicaid Billing Trends

72. For dates of service from January 1, 2017, through September 15, 2023, Medicaid claim records show that both the number of appointments and the money paid to INDIVIDUAL 1 has generally remained consistent year over year, notwithstanding the COVID-19 pandemic:

YEAR	NUMBER OF PATIENTS	NUMBER OF SERVICES/APPOINTMENTS	AMOUNT PAID
2017	110	3,041	\$343,281
2018	121	2,950	\$335,083
2019	121	2,951	\$334,818
2020	110	3,411	\$348,090
2021	132	3,214	\$350,245
2022	125	3,021	\$351,244
2023 ⁴	111	2,254	\$246,737
Total	378 (Unique Patients)	20,842	\$2,309,498

73. I have reviewed INDIVIDUAL 1's claims through September 15, 2023. While the review of those claims is preliminary, the general patterns of billing described above continue through that date.

PROBABLE CAUSE FOR THE TARGET PREMISES

74. The TARGET PREMISES is 41C NEW LONDON TURNPIKE, GLASTONBURY, CT 06033. The building at that location is a two-story wooden structure and a basement containing

⁴ Through September 15, 2023.

various business suites. The premises is more particularly described as a 1812 square foot condominium office on the main floor. On the exterior, there are two glass doors with the door on the right providing a visual of an interior glass door displaying a sign of “Psychologists” and the names MICHAEL B. PINES, Ph.D. and [REDACTED] in red lettering.

75. As discussed above, INDIVIDUAL 1 represented to DSS in April 2019 that he maintained patient records at the TARGET PREMISES. Parent 3 also told investigating agents that INDIVIDUAL 1 was treating patients at the TARGET PREMISES as recently as late August 2023. Moreover, INDIVIDUAL 1’s Medicaid claims show office visits through at least September 15, 2023. In late September 2023, October 18, and October 20, 2023, investigators surveilled INDIVIDUAL 1’s registered vehicle at the parking lot of the office building where the TARGET PREMISES is located, as well as an individual who appeared to be INDIVIDUAL 1 entering and leaving the office building in which the TARGET PREMISES is located. The signage for the office building lists INDIVIDUAL 1 as having offices therein. Moreover, on October 20, 2023, the door to INDIVIDUAL’s office had handwritten post it on it that read: “Fed Ex Delivery Please leave package in office Thank you,” followed by the names of INDIVIDUAL 1 and INDIVIDUAL 1’s spouse.

76. The investigation has also revealed that the TARGET PREMISES may also be used or had been used as the offices of other providers who are not under investigation, including [REDACTED] (“S.D.”), [REDACTED] (“M.F.”), and [REDACTED] (“Y.C.”). Therefore, the proposed search warrant does not include any private office space or containers under the exclusive control of S.D., M.F., Y.C., or their practices, or any other providers who utilized the TARGET PREMISES, but does include any common spaces or containers that INDIVIDUAL 1 could access within the TARGET PREMISES.

77. Therefore, probable cause exists that the patient, financial, and business records of INDIVIDUAL 1 would likely be located at the TARGET PREMISES. As discussed above, as a Medicaid-enrolled provider, INDIVIDUAL 1 would be required to maintain any such records for a period of at least five years from the date of service. Thus, the existence (or absence) of any patient, financial, and business records for INDIVIDUAL 1's patients at the TARGET PREMISES would be evidence of the crimes under investigation. If such records are found, investigators can determine whether they were accurate and legitimate. If no such records are found, it would be consistent with a provider submitting materially false claims to Medicaid. Moreover, to the extent that INDIVIDUAL 1 communicated with others, including third-party billing services, about the services rendered that should be billed to Medicaid, evidence of such communications at the TARGET PREMISES may be evidence of the Target Offenses.

78. In addition, in my training and experience, I know that a provider typically maintains these types of records in order to provide support for patient services and billing transactions if later questioned by insurers, vendors, the Internal Revenue Service, and federal or state regulatory agencies.

CONCLUSION

79. Based upon the information contained within this affidavit, I submit that this affidavit supports probable cause for a warrant to search the property at the TARGET PREMISES, which is more particularly described in Attachment A for the items identified in Attachment B.

RYAN DRISCOLL

Digitally signed by RYAN
DRISCOLL
Date: 2023.10.23 13:34:18 -04'00'

RYAN P. DRISCOLL, SPECIAL AGENT
OFFICE OF THE INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subscribed and sworn to before me this 23 day of October 2023, in Hartford, Connecticut.

Robert A. Richardson

Digitally signed by Robert A.
Richardson
Date: 2023.10.23 14:40:19 -04'00'

HONORABLE ROBERT A. RICHARDSON
UNITED STATES MAGISTRATE JUDGE

ATTACHMENT A

Property to be searched

The premises to be searched is 41C NEW LONDON TURNPIKE, GLASTONBURY, CT 06033. The building at that location is a two-story wooden structure and a basement containing various business suites. The premises is more particularly described as a 1812 square foot condominium office on the main floor. On the exterior, there are two glass doors with the door on the right providing a visual of an interior glass door displaying a sign of “Psychologists” and the names MICHAEL B. PINES, Ph.D. and [REDACTED] in red lettering.

The scope of the search is to encompass the entire premises of 41C NEW LONDON TURNPIKE, GLASTONBURY, CT 06033, including but not limited to desks, drawers, file cabinets, safes, boxes, briefcases, garages, sheds, and any other storage containers and facilities, but excludes any office space or containers under the exclusive control of any another provider, including but not limited to [REDACTED], and [REDACTED].

Exterior of Target Premises





Entry Door to Target Premises



ATTACHMENT B

Property to be seized

All records relating to violations of Title 18, United States Code, Sections 1347 (health care fraud), and Title 18, United States Code, Section 1035 (false statements relating to health care matters), that have been committed by MICHAEL B. PINES and/or Michael B. Pines, Ph.D., P.C., all occurring for the time period of January 1, 2017 to the present, including:

1. Patient or client treatment files, and other patient/client records, including demographic information, patient progress notes, referrals for behavioral health services, diagnoses, certificates of medical necessity, correspondence with patient/clients and patient/client appointment schedules or other records of patient/client encounters, and correspondence with the patient or patient's family;
2. Provider applications, enrollment forms, and agreements with public or private health care benefit programs;
3. Billing and payment records for services, including claim forms or instructions, remittance advices, records of claims submitted, and records of payments received from any source;
4. Instructions on insurance or other source of reimbursement for services, CPT codes, or claims to any private or public health care benefit plan, including interpretations or guidance concerning CPT codes;
5. Private and public insurance carrier billing records, claims, documents and manuals;
6. General journals, subsidiary ledgers, cash receipts and disbursements journals, invoices, billing statements, contracts, accounts payable or receivable ledgers;
7. Business correspondence documents including letters, notes, emails, memorandums internal and external, and records of phone communications, including communications with any third party to submit claims to Medicaid;
8. Remittance advices from Medicaid or any other health care benefit program, or similar correspondence regarding payments for medical services;
9. Banking, credit card and investment account documents such as statements, signature cards, deposit tickets, canceled checks, and check registers, money orders, wire transfer documents, withdrawal slips, margin accounts, security receipts, confirmation slips;
10. Employee and contractor or subcontractor records, including personnel files, employee schedules and time cards, invoices for work, forms W-2, 1099-MISC, W-4 and labor contracts, training records, and documents related to oversight or quality assurance of such employees, contractors, or subcontractors;

11. Calendars, diaries, appointment books, address and phone number registries;
12. Federal and state income tax returns, including amended federal and state tax returns, as well as records used in or resulting from the preparation of federal and state income tax returns;
13. Records of income and expenses, such as profit and loss statements, financial statements, balance sheets and income and expense journals;
14. Evidence of expenditures, by cash or other means, including but not limited to invoices, receipts, deeds, cashier's checks, money orders, stocks, bonds, other securities, wire transfers and purchase contracts; and
15. Safe deposit box keys.