AO 91 Criminal Complaint - Revised 4/20

UNITED STATES DISTRICT COURT

for the

District of Connecticut

United States of America
v.
Marisol Rodriguez, also known as Marisol Colon

Case No. 3:26MJ586 (TOF)

Defendant(s)

CRIMINAL COMPLAINT

I, the complainant in this case, state that the following is true to the best of my knowledge and belief.

On or about the date(s) of 1/11/2022 to 8/23/2025 in the county of Hartford in the District of Connecticut, the defendant(s) violated:

Code Section	*Offense Description*
18 U.S.C. § 1347	Health Care Fraud
18 U.S.C. § 1035	False Statements Relating to Health Care Matters

This criminal complaint is based on these facts:

See attached affidavit of FBI Special Agent Catherine M. Tota, which is expressly incorporated herein by reference.

☑ Continued on the attached sheet.

CATHERINE TOTA Digitally signed by CATHERINE TOTA Date: 2026.05.19 11:30:13 -04'00'

Complainant's signature

Catherine M. Tota, FBI Special Agent

Printed name and title

Attested to by the applicant in accordance with the requirements of Fed. R. Crim. P. 4.1 by telephone.

Date: 05/19/2026

Thomas O. Farrish Date: 2026.05.19 15:08:35 -04'00'

Judge's signature

City and state: Hartford, Connecticut

Hon. Thomas O. Farrish, U.S. Magistrate Judge

Printed name and title

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UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

IN RE APPLICATION FOR ARREST WARRANT	Case No. 3:26MJ~~386~~ 586 (TOF) May 19, 2026 **Filed Under Seal**

AFFIDAVIT IN SUPPORT OF CRIMINAL COMPLAINT AND ARREST WARRANT

I, Catherine M. Tota, being first duly sworn, hereby depose and state as follows:

INTRODUCTION AND AGENT BACKGROUND

1. I am a Special Agent with the Federal Bureau of Investigation ("FBI") and have been since July 2024. I am currently assigned to the New Haven FBI Field Office, where I investigate violations of federal law, specifically health care fraud and other financial crimes committed against federal government programs, such as the Medicare and Medicaid Programs. In my capacity as a Special Agent, I have participated in numerous investigations of criminal activity involving, among other things, health care fraud.

2. During my tenure with the FBI, I have executed and participated in multiple federal arrest and search warrants, conducted surveillance, interviewed subjects, witnesses and victims, analyzed financial and telephone records, and have reviewed claims data, medical records, and other business records. With my previous work experience in health care and my training and work experience as a Special Agent, I am familiar with the behaviors and methods used by individuals who commit health care fraud and other types of fraud. Additionally, I have received specialized training in the field of financial crimes and the investigative methods used by law enforcement to disrupt and dismantle criminal activity.

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. I make this affidavit in support of a criminal complaint against, and the arrest warrant for, **Marisol Rodriguez, also known as Marisol Colon ("Individual 1")**, for violations of 18 U.S.C. § 1347 (Health Care Fraud) and 18 U.S.C. § 1035 (False Statements Relating to Health Care Matters).

5. **Individual 1** currently resides in Florida. On or about February 27, 2026, **Individual 1** booked a flight scheduled for May 21, 2026 from Southwest Florida International Airport in Fort Myers, Florida to Bradley International Airport in Hartford, Connecticut.

6. This affidavit sets forth facts and evidence that are relevant to the requested arrest warrant but does not set forth all of the facts and evidence that have been gathered during the course of the investigation to date. More specifically, I have set forth only facts that I believe are necessary to establish probable cause for the issuance of the requested arrest 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.

PROBABLE CAUSE

7. Along with the Department of Health and Human Services – Office of Inspector General ("HHS-OIG") and the Medicaid Fraud Control Unit ("MFCU") of the Connecticut Office of the Chief State's Attorney, the Federal Bureau of Investigation ("FBI") has been investigating **Individual 1**. The government has been investigating allegations that, beginning no later than January 11, 2022, and continuing through at least August 23, 2025, **Individual 1** has defrauded the Connecticut Medicaid Program by submitting fraudulent claims for what appear to

be medication management services that, in fact, were not provided to Medicaid patients. Based on the facts set forth in this affidavit, there is probable cause to believe that **Individual 1** has committed violations of 18 U.S.C. § 1347 (Health Care Fraud) and 18 U.S.C. § 1035 (False Statements Relating to Health Care Matters) (the "**Target Offenses**").

8. As discussed further below, **Individual 1** is a licensed Advanced Practice Registered Nurse ("APRN") who during the relevant time period was licensed to prescribe, and did prescribe, controlled substances to Medicaid recipients. **Individual 1** billed Medicaid for what appear to be medication management services to these patients.

9. There is probable cause to believe that **Individual 1** was repeatedly billing Medicaid for services not rendered, including but not limited to: (1) billing Medicaid for services purportedly rendered to patients, sometimes for months or years, after the patients stopped seeing **Individual 1**; (2) billing Medicaid for services while working full-time at a different employer, (3) billing Medicaid for purported services while **Individual 1** collected unemployment benefits from the State of Connecticut; and (4) billing Medicaid for services purportedly rendered to patients that were inpatient, incarcerated, or deceased.

10. The investigation has also revealed that **Individual 1** did not adequately review—if at all—a patient's medical history (including other prescriptions) prior to prescribing controlled substances and did not consider or address how **Individual 1**'s prescriptions were necessary or safe in light of the patient's other prescriptions. Moreover, investigators have learned from witnesses that it was very difficult to get in touch with **Individual 1** when they had questions about **Individual 1**'s prescriptions, which caused delays or non-fulfillment of prescriptions for patients who—according to **Individual 1**—had been diagnosed with anxiety,

depression, attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), panic disorder, bipolar disorder, insomnia, suicidal ideations, and other conditions.

A. The Medicaid Program in Connecticut

11. 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").

12. 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.

13. 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).

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 patient including, but not limited to: name, address, birth date, Medicaid identification number, and pertinent diagnostic information; 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 recipients for claims submitted to Medicaid. As a result, Medicaid recipients generally do not know if a provider has billed Medicaid for services that the member did not in fact receive.

B. 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 medical providers for routine office visits, specifically CPT codes 99214, 99215, 99204, and 99205. Approximately 95 percent of **Individual 1**'s paid claims are under CPT code 99214.

19. CPT codes 99214 and 99215 are evaluation and management codes (office visits) for *established* patients.[1] In contrast, CPT codes 99204 and 99205 are evaluation and management codes (office visits) for *new* patients.[2]

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[1] According to the CPT manual, CPT codes 99214 and 99215 are described as follows:

CPT code 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

CPT code 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40 minutes or more of total time is spent on the date of the encounter.

[2] According to the CPT manual, CPT codes 99204 and 99205 are described as follows:

CPT code 99204: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

20. According to the Centers for Medicare & Medicaid Services, three key components of an evaluation and management visit are history, examination, and medical decision making. Documentation should include an assessment, clinical impression, or diagnosis for each encounter; the initiation of or changes in the treatment plan, which may include patient instruction, nursing instruction, therapies, and medication management; any referrals made, or consultations requested.

21. In 2021, changes were made to the CPT manual which allowed providers to choose CPT code level based on either the complexity of medical decision making *or* the total time spent with the patient. According to the CPT manual, medical decisionmaking includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. In summary, the CPT manual considers medical decisionmaking in the office or other outpatient based on (1) the number and complexity of problem(s) that are addressed during the encounter; (2) the amount and/or complexity of data to be reviewed and analyzed; and (3) the risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s).

The Controlled Substances Act

22. The Controlled Substance Act ("CSA"), 21 U.S.C. § 801 *et seq.* and its implementing regulations, govern the possession, manufacture, distribution, dispensing, administering, and prescribing of controlled substances within the United States. The CSA

CPT code 99205: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

provides that a prescription for a controlled substance must be issued for a legitimate medical purpose by a practitioner acting in the usual course of her professional practice.

23. Under the CSA, there are five schedules of controlled substances—Schedules I, II, III, IV, and V. Controlled substances are scheduled into these levels based upon their potential for abuse, among other things. **Individual 1** prescribed a number of Schedule II and Schedule IV controlled substances, including but not limited to: (1) dextroamphetamine-amphetamine—which is sold and marketed under the name Adderall—is prescribed to treat Attention Deficit Hyperactivity Disorder (ADHD) and narcolepsy and is classified under the CSA as a Schedule II controlled substance; (2) clonazepam—which is sold and marketed under the name Klonopin—is a sedative used to treat seizure disorders and panic disorder and is classified under the CSA as a Schedule IV controlled substance, (3) alprazolam—which is sold and marketed under the trade name Xanax—is prescribed to treat anxiety disorders and is classified under the CSA as a Schedule IV controlled substance, and (4) zolpidem tartrate—which is sold and marketed under the trade name Ambien—is a sedative prescribed to treat insomnia and is classified under the CSA as a Schedule IV controlled substance.

24. From my training and experience, I know that controlled substances such as the ones that **Individual 1** prescribed have the potential for abuse by their users if not properly prescribed and monitored. I also know that such controlled substances can be sold or diverted into the illicit market to be resold to others for nonprescribed use and abuse.

25. Under Connecticut law, information about all transactions for Schedule II through V controlled substances dispensed in Connecticut must be reported to the Connecticut Prescription Monitoring and Reporting System (CPMRS), which is a part of the Connecticut Prescription Monitoring Program (PMP). Dispensing practitioners must submit data daily.

26. According to the Connecticut Department of Consumer Protection, the PMP collects prescription data for Schedule II through Schedule V drugs into a centralized database, the CPMRS, which can then be used by healthcare providers and pharmacists in the active treatment of their patients. The purpose of the CPMRS is to present a complete picture of a patient's controlled substance use, including prescriptions by other providers. As a healthcare tool, the CPMRS is used to improve quality of patient care and to reduce prescription abuse, opioid use disorder, and overdose. This allows providers the opportunity to properly manage the patient's treatment, including referral of a patient to services offering treatment for substance use disorders when appropriate.

27. APRNs such as **Individual 1** must comply with certain Connecticut laws regarding the prescribing of scheduled controlled substances. Under Conn. Gen. L. § 21a-254(j)(9), a prescribing practitioner who is prescribing more than a 72-hour supply of any controlled substance must review in advance the patient's CPMRS. Moreover, whenever a prescribing practitioner prescribes a controlled substance (other than a schedule V nonnarcotic controlled substance) for the continuous or prolonged treatment of any patient, the prescriber must review the patient's records in the CPMRS not less than once every ninety days.

Individual 1

28. **Individual 1** is licensed by the State of Connecticut as an APRN and obtained that license on or about November 25, 2020. Her license is active. Also, on or about November 25, 2020, **Individual 1** obtained a controlled substance certificate of registration, which permitted **Individual 1** to prescribe scheduled controlled substances in Connecticut. As discussed further below, **Individual 1** voluntarily surrendered that registration effective January 29, 2025.

29. On or about April 6, 2021, **Individual 1** enrolled individually as an Advanced Practice Nurse provider in the Connecticut Medicaid Program with a provider specialty as a Nurse Practitioner. According to a previous webpage on one of **Individual 1's** former employers, SMPsychotherapy & Counseling Services ("Former Employer 1"), **Individual 1** began her medical career over 22 years ago as a medical assistant, and later a registered nurse. **Individual 1** studied at Southern Connecticut State University and later became a Psychiatric Nurse Practitioner.

30. **Individual 1** billed Medicaid as an individual provider through her private practice for dates of service beginning on or about January 11, 2022. In addition to her private practice, **Individual 1** was employed in various roles by Hartford HealthCare ("Former Employer 2"), from on or about December 4, 2001, to March 26, 2025, when she was terminated from her position as a Data Integrity Specialist, as discussed further below.

31. According to the Connecticut Secretary of State website, **Individual 1** was listed as the principal of a business named Professional Nurse Practitioner LLC ("Company 1"), which was formed on May 9, 2023, and dissolved on August 7, 2025. This business had a listed address of 81 Market Sq, 7, Newington, CT 06111. Although Company 1 was enrolled as a Connecticut Medicaid provider as an Advance Practice Nurse Group, Company 1 did not bill Medicaid. Rather, **Individual 1** billed and was paid using **Individual 1's** individual CT Medicaid provider number.

32. According to property records, on November 7, 2024, **Individual 1** and another individual purchased a single-family residence located at 3206 42nd Street SW, Lehigh Acres, Florida. The investigation has revealed that **Individual 1** permanently relocated to Florida on or around this date.

33. Payments from Medicaid to **Individual 1** were remitted to a personal checking account in the name of **Individual 1**.

Individual 1 Billed Medicaid For Services Not Rendered

34. Investigators have reviewed the claims **Individual 1** submitted or caused to be submitted to Medicaid for dates of service from January 11, 2022, through at least August 17, 2025. During that time period, there were over 15,000 claims totaling over $1,350,000 paid to **Individual 1**. Virtually all of **Individual 1**'s paid claims during that period lists the "Facility Type Code Description" as "Telehealth," meaning they were purportedly rendered virtually and not in person. In addition, all of **Individual 1's** claims to Medicaid list **Individual 1** as the "Performing Provider." This means that **Individual 1** represented to Medicaid that she was the individual that provided each service billed to Medicaid. Based on the ongoing investigation, probable cause exists that **Individual 1** has committed the **Target Offenses**.

35. By way of one analysis conducted by the DSS, for the time period of dates of service from February 4, 2022, through August 17, 2025, **Individual 1** was ranked number one among a peer group of 116 APRNs for total amount paid as well as the total number of alleged services provided:

Billing Provider (by rank)	Service Count	Total Amount Paid
Individual 1	13,432	$1,358,403.51
APRN B	8,475	$841,908.72
APRN C	7,219	$606,053.64
APRN D	5,472	$574,839.41
APRN E	5,340	$394,204.33

36. **Individual 1** also ranked number one for the average paid amount per Medicaid recipient amongst the same group of providers. Between dates of service February 4, 2022, through August 17, 2025, the average paid amount per recipient for **Individual 1** was $5,660.01,

or 37% more than the average paid amount per recipient for the second ranked Medicaid provider in Connecticut.

37. The investigation has revealed that, beginning no later than January 11, 2022 and continuing through at least August 23, 2025, **Individual 1** engaged in a scheme to defraud Medicaid by billing for purported medical services that were not likely rendered. As discussed further below, such billing occurred even when **Individual 1** patients confirmed that **Individual 1** did not provide services as she represented to Medicaid, when **Individual 1** was purportedly working a full-time job at another employer (Former Employer 2), when **Individual 1** was claiming unemployment benefits, and when patients were receiving in-patient care, incarcerated, or had died.

38. Further, based on my training and experience, I know that an APRN such as **Individual 1**, who had a number of Medicaid patients, would and should have been documenting any patient encounters to document the medical necessity of any prescriptions, particularly those for controlled substances. In order for a prescription to be issued in the course of legitimate medical practice, it must be (1) issued in the context of a valid patient-provider relationship; (2) be based on a valid patient encounter, including (a) a subjective complaint; (b) objective examination of a patient; (c) an assessment and diagnosis of a patient, including a determination that the medication prescribed is indicated for the patient's condition and is not contraindicated; and (d) includes a plan of care for the patient, including a follow-up assessment of the medication's effectiveness and to rule out any adverse reaction. Not only is this standard medical practice, but it ensures the continuity of care and protects both the practitioner and the patient if Medicaid, or any employer, regulator, or law enforcement agency investigates any particular patient or prescription.

39. As discussed further below, multiple patients confirm that, to the extent **Individual 1** performed the services at all, they were usually brief and perfunctory. Thus, there is probable cause to believe that, even when an appointment with a patient took place, **Individual 1** was not permitted to bill for CPT code 99214 under either the complexity of medical decision making *or* the total time spent with the patient.

A. Interviews with Patients Confirm that Individual 1 Billed Medicaid for Services That Individual 1 did not Provide.

40. Investigating agents have conducted interviews regarding **Individual 1** and services she billed to Medicaid. Thus far, these interviews revealed that: (1) **Individual 1** billed Medicaid for alleged services to patients at a greater frequency than their actual appointments; and (2) **Individual 1** billed Medicaid for alleged services to patients who had stopped seeing her.

i. *Patient 1 and Patient 2*

41. As part of the investigation, agents interviewed Patient 1 and Patient 2. Patient 1 positively identified a photo of **Individual 1** shown to her by investigators. Patient 1 and Patient 2 began seeing **Individual 1** for medication management services after **Individual 1** left Former Employer 1 to begin her own private practice. Patient 1 and Patient 2 were patients of Former Employer 1 and received telehealth counseling services and medication management from another APRN ("APRN 1"). In or around June 2022, APRN 1 and **Individual 1** left Former Employer 1 and APRN 1 agreed to work with **Individual 1** at her new practice, Company 1.

42. Patient 1 and Patient 2 continued to see APRN 1 for monthly counseling and medication management appointments. In or around the end of June 2024, APRN 1 left **Individual 1's** practice. Beginning in August 2024, Patient 1 and Patient 2 began meeting with **Individual 1** "exclusively" for medication management services only. During this time, Patient 1 continued to meet with a clinician for counseling services at Former Employer 1. Patient 1 met

with **Individual 1** via telehealth in the evenings, usually after 5:00 PM and did not meet with **Individual 1** on the weekend.

43. Patient 1 described **Individual 1** as, "inconsistent," "difficult to get a hold of," and "not getting back to [Patient 1] or [Patient 2]." Patient 1 wondered if there were other providers at **Individual 1's** practice that Patient 1 could meet with. **Individual 1** also refilled Patient 1's prescriptions without meeting with Patient 1. Patient 1 was prescribed anxiety, depression, and sleep medication. Patient 1 told **Individual 1** she wanted to taper off her medications. However, Patient 1 felt **Individual 1** tapered Patient 1 off her medications too quickly, unlike APRN 1, who Patient 1 felt had a more careful process.

44. Patient 2 also received prescriptions from **Individual 1**. Patient 2 was supposed to have a scheduled telehealth appointment with **Individual 1** on or about November 20, 2024. Patient 2 waited for over an hour to meet with **Individual 1** and **Individual 1** never showed up. Patient 2 sent **Individual 1** a message and received an automated reply that **Individual 1**'s email address could not be found. Patient 2 currently sees a different provider for medication management and that provider expressed concern regarding the medications **Individual 1** prescribed Patient 2 and subsequently modified Patient 2's prescriptions.

45. Patient 1 and Patient 2 were shown Medicaid claims data for dates of service purportedly provided to Patient 1 and Patient 2 by **Individual 1**. Patient 1 reiterated that she and Patient 2 did not meet with **Individual 1** on the weekend and not on Sundays, as their family attends church.

46. Following the interview, Patient 1 voluntarily provided agents with iMessage communications with **Individual 1**. Patient 1 last communicated with **Individual 1** on or about December 19, 2024. Patient 1 and Patient 2 did not meet with **Individual 1** for the rest of 2024

and not at all in 2025. Despite this, **Individual 1** billed Medicaid and was paid approximately $3,406 for 35 purported dates of service between December 23, 2024, and August 16, 2025 to Patient 1.

ii. *Patient 3*

47. As part of the investigation, agents interviewed Patient 3. Patient 3 positively identified a photo of **Individual 1** shown to her by investigators. Patient 3 described **Individual 1** as her previous prescriber of psychotropic medication. Patient 3 was a patient of **Individual 1** from approximately July 2022 through approximately December 2024. Patient 3 saw **Individual 1** for appointments at **Individual 1**'s Former Employer 1 for less than a year before **Individual 1** "branched off" to start her own independent practice. Patient 3 continued to see **Individual 1** after **Individual 1** started her own practice, Company 1.

48. Patient 3 described the scheduling of her appointments with **Individual 1** as "not regular" and "all over the place." The appointments were all conducted as telehealth visits through a medical platform or by text or phone call. Patient 3 had appointments with **Individual 1** once a month. At first, Patient 3 felt the appointments were initially longer, similar to an intake visit, but later were typically 10 minutes "at most." These visits typically involved **Individual 1** asking Patient 3 how she was doing, how Patient 3's medications were going, and ordering medication refills. Patient 3 said she definitely did not have more than one or two visits a month and they were never as long as 30 to 39 minutes. Patient 3 had different mental health therapists throughout the time she received prescriptions from **Individual 1**.

49. Patient 3 noted her appointments were at various times during the day and reiterated that she saw **Individual 1** once a month "from the beginning."

50. Towards the end of her time seeing **Individual 1**, Patient 3 said she tried to call **Individual 1** and **Individual 1's** phone number was busy, and her voicemail was always full.

51. During the interview, Patient 3 reviewed iMessage communications with **Individual 1**. Patient 3's last iMessage to **Individual 1** was on December 10, 2024, requesting **Individual 1** to refill her medication. **Individual 1** responded, "Ok." Patient 3 confirmed she did not have any additional appointments with **Individual 1** after December 10, 2024.

52. Despite this, **Individual 1** billed Medicaid and was paid approximately $3,688 for 37 purported dates of service between December 11, 2024, and August 17, 2025 for Patient 3.

53. In addition, agents identified three separate inpatient hospital stays for Patient 3 from April 11, 2023 to April 25, 2023; July 3, 2023 to July 14, 2023; and February 24, 2024 to February 29, 2024. Patient 3 confirmed she would not have received services from **Individual 1** while inpatient. Medicaid claims data shows that **Individual 1** billed and was paid approximately $299 for three dates of service on April 13, 2023, July 10, 2023, and February 25, 2024.

iii. *Patient 4*

54. As part of the investigation, agents interviewed Patient 4. Patient 4 positively identified a photo of **Individual 1** shown to her by investigators. Patient 4 began seeing **Individual 1** for medication management at **Individual 1's** Former Employer 1. During this time, Patient 4 also saw another clinician for counseling services at Former Employer 1. Patient 4 estimated she saw **Individual 1** for medication management from 2021 to 2024. Around 2022, **Individual 1** informed Patient 4 that she was leaving to start her own independent practice, Company 1. Patient 4 continued to receive prescriptions from **Individual 1** after **Individual 1** left Former Employer 1 and Patient 4 continued to receive counseling services from the other clinician.

55. Patient 4 received prescriptions for Zoloft, Adderall, and Klonopin (clonazepam). Patient 4 described her interactions with **Individual 1** as "very quick," consisting of three-to-five-minute check-in phone calls. These interactions occurred once per month. Patient 4 said her first visit with **Individual 1** might have been over video, but the remaining visits were just phone calls. Patient 4 recalled only seeing **Individual 1's** face once or twice.

56. Patient 4 located iMessage communications with **Individual 1** and identified a first message dated August 31, 2021, and a lasted message dated March 26, 2024. During this review, Patient 4 noted that her messages to **Individual 1** often indicated that the telehealth video links were not working. On May 28, 2024, **Individual 1** left a voicemail for Patient 4 asking Patient 4 how things were going. Patient 4 did not call **Individual 1** back.

57. Patient 4 used CVS Pharmacy to fill her prescriptions from **Individual 1**. On occasion, there were issues with CVS not having her prescription filled or ready, so Patient 4 sent messages to **Individual 1** to rectify. While reviewing these messages, Patient 4 and agents observed that **Individual 1** repeatedly replied with "Name," which suggests that **Individual 1** did not know whom she was corresponding with. Patient 4 had to reply with her own name and **Individual 1** sent the prescription to the pharmacy.

58. Patient 4 described **Individual 1** as lax, and that **Individual 1** asked Patient 4 if she was still doing therapy and how her medications were. Patient 4 had two prescriptions for 10mg and 30mg Adderall and told **Individual 1** she did not want to be dependent on the medication. **Individual 1** told Patient 4 it was better to have the medication and not need it. Patient 4 could tell **Individual 1** did not want to taper Patient 4 off the medication. Patient 4 asked **Individual 1** when she should take medication and **Individual 1** said, "Whatever you feel you need." Patient 4 took the medication on an as-needed basis.

59. **Individual 1** also prescribed Patient 4 Klonopin (clonazepam) after Patient 4 informed **Individual 1** she was no longer taking it. Patient 4 noted she had so many pills of Klonopin that she ended up flushing them down the toilet. Patient 4 felt she probably could have asked **Individual 1** for any medication she wanted, reiterating that **Individual 1** was "pretty lax." Patient 4 also felt she could have asked **Individual 1** to increase the dosage of her medications. Patient 4 described **Individual 1** as "pleasant" and that **Individual 1** did not give Patient 4 a hard time, but again reiterated her interactions with **Individual 1** were "quick check-ins."

60. Despite Patient 4's last communication with **Individual 1** on March 26, 2024, **Individual 1** billed Medicaid and was paid approximately $5,782 for 58 dates of service between April 2, 2024, and August 17, 2025 purportedly provided to Patient 4.

B. Individual 1 Billed for Improbable Services to Medicaid When She Worked Full Time for a Former Employer.

61. As mentioned above, **Individual 1** worked at Former Employer 2 from on or about December 4, 2001 to March 26, 2025. **Individual 1**'s personnel file with Former Employer 2 reflected that from November 6, 2022, through November 2, 2024, **Individual 1's** job title was "System Manager, Release of Information (ROI) & Data Integrity (DI)." According to the job summary, this position "oversees system-wide centralized Release of Information (ROI) operations, ensuring adherence to HIPAA, State, Federal laws, regulations and statutes." From November 3, 2024 through the termination of her employment on March 26, 2025, **Individual 1**'s job title was "Data Integrity Specialist." According to the job summary, "this position reports to the Data Integrity Coordinator and is responsible for maintaining the accuracy and consistency of information across all entities of the Health System."

62. **Individual 1** began billing Medicaid for her private practice services for dates of service starting January 11, 2022. At the time, **Individual 1** was employed at a full-time, exempt, and salaried job at Former Employer 2 and expected to work 40 hours a week.

63. In reviewing **Individual 1**'s claims to Medicaid, however, it would be highly improbable that **Individual 1** treated the number of Medicaid patients for the services allegedly provided while working 40 hours a week at her job for Former Employer 2. As an example, between June 13, 2022 to November 30, 2024 (i.e., shortly after she relocated to Florida), **Individual 1**'s timekeeping records with Former Employer 2 do not indicate she took any time off. Yet, during this time period, **Individual 1**'s claims data indicate that she purportedly provided an average of 70 services per week to Medicaid recipients.

64. Most of the claims paid during this time period were for CPT code 99214, which are based on either the complexity of medical decision making *or* 30-39 minutes total time spent with the patient. As discussed above, however, to the extent **Individual 1** was seeing patients at all, her interactions were brief and perfunctory. Yet even using a 30-minute-per-service guide for each claim, it is exceedingly unlikely that **Individual 1** spent an average of 35 hours per week seeing patients on top of her 40-hour-a-week job at Former Employer 2 over a nearly three-year period, with no alleged time off.

65. **Individual 1** became a non-exempt, hourly employee at Former Employer 2 on November 3, 2024 and remained so until she was terminated on March 26, 2025. For that approximate time period, **Individual 1** reported working an average of over 39 hours per week, although in some cases she claimed to have worked more than 40 hours per week with overtime. Nevertheless, **Individual 1** billed Medicaid for an average of 118 dates of services per week. It is

not likely that **Individual 1** worked approximately 39 hours per week for Former Employer 2 during this time period and provided over 100 services to Medicaid recipients on top of that.

66. Moreover, the investigation has revealed that, in addition to her full-time job at Former Employer 2 and providing services to Medicaid recipients through Company 1, **Individual 1** worked briefly at a third job with Former Employer 3, a medical spa that provides beauty-related treatments. In an unemployment insurance benefits claim that **Individual 1** submitted to the Connecticut Department of Labor in or around April 2025 (after her termination from Former Employer 2), **Individual 1** claimed to have worked at Former Employer 3 from August 4, 2024 to September 27, 2024 for 15 hours a week. While it appears that **Individual 1** may have been out sick from this job for much of September 2024, this additional employment further shows the improbability of **Individual 1** performing the Medicaid services she claims to have rendered.

C. Individual 1 Claimed Unemployment Benefits While Purportedly Providing Services to Medicaid Recipients.

67. On or about March 30, 2025, **Individual 1** filed a claim for unemployment insurance benefits from the State of Connecticut. In **Individual 1**'s initial application, she represented that she resided in Plainville, Connecticut. By that point, however, and as discussed above, **Individual 1** had moved permanently to Florida. **Individual 1** further claimed that she was not currently self-employed and that she had a medical condition/disability that prevented her from accepting full-time work immediately.

68. According to the Connecticut Department of Labor's Guide to Unemployment Insurance, UI is "designed to provide temporary income to workers who lost their job or whose hours were reduced through no fault of their own—for example, due to layoff, plant closure, or lack of available work." Beneficiaries are required to submit weekly claim certifications under

the penalties of perjury. The certifications include an advisement that: "If you worked last week, Sunday through Saturday you must report any earnings even if you do not get paid until later. Failure to report work and earnings may result in fraud disqualification that will stop your benefits and result in an overpayment to the state of Connecticut."

69. In weekly certifications ending the weeks of April 5 through October 4, 2025, **Individual 1** represented to the Connecticut Department of Labor that she did not work in any self-employment and did not perform any work. In many of the weekly certifications, **Individual 1** claimed to have attempted to seek work from employers in person in Connecticut, even though she had already moved to Florida.

70. Financial records reveal that from April 21, 2025, to September 25, 2025, **Individual 1** was paid $18,400 in unemployment benefits compensation. From the time period of March 30, 2025 (when **Individual 1** claimed unemployment) to August 17, 2025, however, **Individual 1** represented to Medicaid that she performed over 2,100 services, for which the CT Medicaid program paid **Individual 1** over $217,000.

71. Based on the investigation, I believe that, during the time period **Individual 1** was claiming unemployment benefits from Connecticut, **Individual 1** was not providing any services to Medicaid recipients. Notwithstanding that she was receiving unemployment benefits, however, **Individual 1** continued to collect significant Medicaid payments from DSS.

D. Individual 1 Billed Medicaid for Services Purportedly Rendered to Patients on Dates When the Patient were Inpatient, were Incarcerated, or are Deceased.

72. As part of the investigation, investigating agents reviewed Medicaid claims data to determine whether **Individual 1** billed Medicaid for purportedly providing services to any Medicaid patient while the patient was admitted as an inpatient at a hospital, since it is unlikely that **Individual 1** provided services while patients were hospitalized. The claims data revealed

that between January 10, 2023, and August 10, 2025, **Individual 1** was paid $3,788.22 for purportedly providing 38 services to 17 patients who were admitted as inpatients at a hospital on the purported date of service. **Individual 1** was listed as the sole performing provider for these services.

73. As part of the investigation, investigating agents reviewed Medicaid claims data to determine whether **Individual 1** billed Medicaid for purportedly providing services to any patient while the patient was incarcerated at a State of Connecticut Correctional Facility. The claims data revealed that between February 8, 2023, and August 16, 2025, **Individual 1** was paid $1,096.59 for purportedly providing 11 services to 7 patients who were incarcerated at a State of Connecticut Correctional Facility on the purported date of service. Again, **Individual 1** was listed as the sole performing provider for these services.

74. As part of the investigation, investigating agents reviewed Medicaid claims data to determine whether **Individual 1** billed Medicaid for purportedly providing services to any patient that was deceased. The claims data revealed that **Individual 1** billed Medicaid for purportedly providing services to a patient who had died on March 8, 2023. **Individual 1** billed for services for dates of service of March 17, 2023 and March 31, 2023. **Individual 1** was not paid for these services.

E. DSS Unsuccessfully Attempted to Obtain Patient Records from Individual 1 During an Audit.

75. On or about September 10, 2025, DSS emailed a letter to **Individual 1** requesting records for certain patients, including treatment notes and billing records. By letter of October 8, 2025, **Individual 1**'s counsel responded to DSS indicating that his office represented **Individual 1** in connection with DSS's request and requested to speak with DSS. DSS did not appear to

make contact with **Individual 1**'s counsel thereafter. The requested records were not produced to DSS.

76. By that time, as discussed above, **Individual 1** had stopped submitting claims to Medicaid. The last claim **Individual 1** submitted to Medicaid was on August 21, 2025 for an alleged date of service of August 17, 2025. Notably, on this last billed date, **Individual 1** submitted 476 claims for CPT code 99214, for which she was paid more than $47,000. **Individual 1** claimed to have provided almost half of these billed services more than three months earlier and as far back as February 3, 2025.

77. For the time period of June 8, 2022 through August 27, 2025, in addition to approximately $100,000 **Individual 1** received from Former Employer 2 and approximately $18,000 in unemployment benefits discussed above, **Individual 1** received over $1.3 million from Medicaid. During that time period, **Individual 1** spent over $83,000 at Amazon, over $40,000 at Instacart, over $30,000 at American Airlines, over $19,000 at DoorDash, over $13,000 at Etsy, and over $12,000 at That Bombshell Beauty (a hair salon in Wethersfield), among other expenses. **Individual 1** also appears to have purchased or leased a Porsche, as evidenced by over $13,000 in payments to Porsche Fort Myers in April 2025.

F. Individual 1 Continued to Bill for Medicaid After She Surrendered Her Registration to Prescribe Controlled Substances.

78. As discussed above, **Individual 1** had limited interactions with patients before prescribing scheduled controlled substances.

79. In 2023-2024, the Connecticut Department of Consumer Protection's Drug Control Division (DCP) investigated allegations that **Individual 1** did not respond to a dispensing pharmacist's repeated inquiries about a prescription **Individual 1** issued for a

controlled substance. The prescription was not filled and the patient did not receive the prescribed medications.

80. On or about October 26, 2023, the DCP learned that, in the previous year, **Individual 1** did not check the PMP for her patients before issuing prescriptions to them. Between October 26, 2022 to October 26, 2023, **Individual 1** issued 1,959 prescriptions for scheduled controlled substances.

81. Based on my training and experience, I know that prescribing practitioners who do not review a patient's PMP before issuing a prescription for controlled substance is highly unlikely to know or be able to verify the other medications that patient is prescribed, thereby increasing the risk that the patient will be taking concomitant medications that would increase the risk of dangerous conditions, aggravated conditions, overmedication, or result in medically unwarranted or needless prescriptions.

82. In fact, on or about April 23, 2024, the Connecticut Medical Assistance Drug Utilization Review Program ("DURP") sent **Individual 1** a letter concerning patient M.S., who **Individual 1** had prescribed eszopiclone and hydromorphone HCL. According to the letter, "[t]he concomitant use of opioids with sedative-hypnotics can increase the risk of hypotension, respiratory depression, profound sedation, coma, and death. Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate." The letter also reminded **Individual 1** of her obligation to review a patient's records in CPMRS before prescribing any controlled substances for more than a 3-day supply of medication.

83. M.S. was not the only patient for which DURP notified **Individual 1** about potentially concerning prescriptions. Between August 2, 2021 and October 29, 2024, DURP notified **Individual 1** of 49 instances (including the one pertaining to patient M.S. discussed

above) where DURP identified potential issues regarding **Individual 1**'s prescriptions. There is no evidence that **Individual 1** responded to any of these notices.

84. On or about January 22, 2024, investigators from DCP contacted **Individual 1** to request a meeting to review some prescriptions that she wrote. After exchanging emails with **Individual 1** discussing scheduling such a meeting, an attorney representing **Individual 1** then responded on her behalf to DCP's inquiries.

85. On or about March 28, 2024, DCP representatives met with **Individual 1's** attorney. At the meeting, DCP presented evidence to the attorney that **Individual 1** had not reviewed the PMP before issuing prescriptions. DCP requested a meeting with **Individual 1** during which her medical records were available. Although DCP attempted to schedule such a meeting through her attorney, no such meeting occurred.

86. After March 28, 2024, **Individual 1** checked PMP more frequently, but not consistently. Beginning on March 29, 2024, she wrote approximately 1,064 prescriptions but only checked the PMP approximately half the time.

87. On or around November 1, 2024, DCP's legal division sent a settlement agreement to **Individual 1's** attorney. DCP then scheduled a compliance meeting with **Individual 1** and her attorney. On or around January 23, 2025, **Individual 1**'s attorney informed DCP's legal division that **Individual 1** would voluntarily surrender her controlled substances certificate of registration. It appears a settlement agreement was never entered into.

88. On or about January 29, 2025, **Individual 1** voluntarily surrendered her Connecticut controlled substances certificate of registration. By doing so, **Individual 1** agreed to immediately stop prescribing any controlled substances in Schedules II through V.

89. Notwithstanding the voluntary surrender, however, **Individual 1**'s PMP shows that she wrote five prescriptions for controlled substances *after* January 29, 2025 for two different patients on February 9 and 10, 2025.

90. In addition, **Individual 1** continued to bill Medicaid for alleged services provided after January 29, 2025. For purported dates of service from January 30, 2025 to August 17, 2025, **Individual 1** billed Medicaid for over 3,200 alleged services to Medicaid patients. DSS paid **Individual 1** over $318,000 for these services.

91. Of the over 3,200 claims **Individual 1** made after January 29, 2025, all but one were billed as CPT code 99214 (visit for the evaluation and management of an established patient). The investigation thus far has revealed, however, that **Individual 1** did not provide therapy to patients, but rather medication management services related to prescriptions. If **Individual 1** could not and (except for the five unauthorized prescriptions discussed above) did not prescribe any controlled substances, it is highly unlikely that **Individual 1** provided any legitimate services to patients that would qualify under CPT code 99214.

CONCLUSION

92. For the reasons set forth herein, I submit that there is probable cause to believe, and I do believe, that **Individual 1** has engaged in violations of 18 U.S.C. § 1347 (Health Care Fraud) and 18 U.S.C. § 1035 (False Statements Relating to Health Care Matters). Accordingly, I respectfully request that the Court issue a warrant for the arrest of **Individual 1**.

Respectfully submitted,

CATHERINE TOTA Digitally signed by CATHERINE TOTA Date: 2026.05.19 13:58:38 -04'00'

CATHERINE M. TOTA, SPECIAL AGENT
FEDERAL BUREAU OF INVESTIGATION

Subscribed and sworn to before me via Teams this 19th day of May 2026, in Hartford, Connecticut.

Thomas O. Farrish Date: 2026.05.19 15:09:36 -04'00'

HONORABLE THOMAS O. FARRISH
UNITED STATES MAGISTRATE JUDGE