
**UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY**

UNITED STATES OF AMERICA : CRIMINAL COMPLAINT
 :
 v. : Mag. No. 10-6047
 :
 ROLAND ASEMOTA : HON. MICHAEL A. SHIPP

I, Eric Rubenstein, the undersigned complainant, being duly sworn, state the following is true and correct to the best of my knowledge and belief. From in or about January 2006 through in or about November 2009, in Essex County, in the District of New Jersey, and elsewhere, defendant

ROLAND ASEMOTA

did knowingly and willfully (1) falsify, conceal, and cover up by trick, scheme, and device a material fact, and (2) make materially false, fictitious, and fraudulent statements and representations, and make and use materially false writings and documents knowing the same to contain materially false, fictitious, and fraudulent statements and entries, in connection with the delivery of and payment for health care benefits, items, and services in a matter involving a health care benefit program, in violation of Title 18, United States Code, Sections 1035 and 2.

I further state that I am a Special Agent with the Department of Health and Human Services, Office of the Inspector General, and that this Complaint is based on the following facts:

SEE ATTACHMENT A

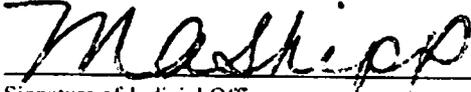
continued on the attached pages and made a part hereof.

Special Agent Eric Rubenstein
Department of Health and Human Services
Office of the Inspector General

Sworn to before me and subscribed in my presence,

_____, 2010, at Newark, in the District of New Jersey

HONORABLE MICHAEL A. SHIPP
UNITED STATES MAGISTRATE JUDGE



Signature of Judicial Officer

ATTACHMENT A

I, Eric Rubenstein, a Special Agent with the Department of Health and Human Services, Office of the Inspector General, having conducted an investigation, having spoken with other individuals, and having reviewed reports, am aware of the following facts:

The Medicare Program and Billing Procedures

1. The Medicare Program ("Medicare") is a federal program that provides free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled. Medicare is a "health care benefit program" as defined by Title 18, United States Code, Section 24(b). Individuals who receive benefits under Medicare are commonly referred to as "beneficiaries."
2. The Medicare Part B program is a federally funded supplemental insurance program that provides supplementary Medicare insurance benefits for individuals aged sixty-five or older and certain individuals who are disabled. The Medicare Part B program pays for medical services, including durable medical equipment ("DME"), for beneficiaries. Power mobility devices ("PMDs"), such as motorized wheelchairs, are a form of DME. The Medicare Part B program carrier for DME in New Jersey at all times relevant to this complaint was NHIC Corporation ("NHIC").
3. Approved providers of services and equipment to Medicare beneficiaries are required to submit claims for payment on a form CMS-1500. Medicare requires that the provider of services or supplier of items certify that the services rendered or items delivered were medically necessary and were furnished by that provider or supplier. Providers participating in the Medicare program must certify in writing that they will be responsible for the accuracy of all claims submitted by themselves, their employees or their agents, and that all claims submitted under their provider numbers will be accurate, complete and truthful. The bottom of the CMS-1500 form explicitly states that it is a crime to submit any false claims, statements or the concealment of a material fact in relation to the submission of a claim.
4. Medicare does not reimburse providers for providing PMD in the absence of meeting the requirements outlined in what are known as Local Coverage Decisions (herein "LCD"). An LCD is Medicare's method of advising providers of the requirements for billing. Should the documentation outlined in the LCD not be on file with the supplier of the PMD, any claims for reimbursement for the provision of said PMD would be denied.
5. Under Medicare LCD, reimbursement is provided for those beneficiaries who have been appropriately evaluated by their physician as being in medical need of a PMD. As part of that evaluation, the referring physician completes what is known as a "face-to-face" evaluation that provides salient information relative to the beneficiary's medical need for a PMD. When a physician refers a Medicare beneficiary to a supplier of PMD, the supplier is obligated to obtain two documents before supplying the PMD to the beneficiary and submitting a claim to Medicare: (a) a copy of a "face-to-face" physician evaluation; and (b) a Valid Order for the PMD (hereinafter

“Valid Order”). These documents do not need to be submitted to Medicare, but are required to be kept on file with the supplier of the PMD.

6. When submitting a CMS-1500 to Medicare for reimbursement, a supplier of PMD certifies that it has the “face-to-face” evaluation and the Valid Order by supplying a code on the form called the “KX modifier.” By supplying the KX modifier to the CMS-1500, the PMD supplier certifies to Medicare that the required documentation is on file.

Roland Asemota’s Scheme to Defraud Medicare

7. For all times relevant to this complaint, defendant ROLAND ASEMOTA (hereinafter “ASEMOTA”) was the manager of Rose’s Medical Supply (“RMS”), a Medicare-approved provider of PMD, and was responsible for RMS’s Medicare billings. RMS is located at 359 Main Street, East Orange, New Jersey.

8. As a Medicare-approved provider of PMDs, RMS was required by Medicare to obtain and retain a copy of the “face-to-face” evaluation and Valid Order for each PMD for which it sought reimbursement from Medicare.

9. In or about August 2006, a newsletter was disseminated to all members of the NHIC electronic listserve, including RMS. In that newsletter, it was stated that a new LCD was being promulgated for the provision of PMD, with an effective date of October 1, 2006. As part of the new LCD, the KX modifier (which was already in use for other billing applications) was to be used for claims for PMD reimbursement. The newsletter further stated that claims for PMD that did not contain the KX modifier would be denied by Medicare.

10. The KX modifier is applicable to many LCD, but has always meant that the required documentation is on file. In fact, a review of RMS’s billing records reflects that RMS has been using the KX modifier since at least March 2005. Furthermore, our investigation has revealed that since May 2006, RMS has received electronic newsletters with regard to LCD, policies, rules, regulations, and coding and billing issues.

11. During an interview of ASEMOTA on or about January 20, 2010, ASEMOTA admitted that he was RMS’s manager and that he was familiar with Medicare billing and coding, and that his wife, Rosaline Okrakpo, owned RMS. ASEMOTA further stated that he was aware that RMS needed a face-to-face evaluation and a Valid Order in order to submit a claim for reimbursement for PMD, and that the KX modifier indicated that RMS had these documents on file. ASEMOTA stated that he and his wife attended a September 2008 seminar on billing and coding, and that is where he learned about the use of the KX modifier.

12. In or about June 2009, Tri-Centurian (“Tri-C”), an agency that has contracted with the Centers for Medicare and Medicaid Services to identify and deter Medicare fraud and abuse, conducted an on-site audit and random sampling of RMS’s Medicare billings. Tri-C conducted a random sampling of 20 PMD billings RMS sent to Medicare between on or about January 18, 2006 and in or about April 1, 2009, all of which used the KX modifier. As a result of this

sampling, Tri-C discovered that for 19 of the 20 billings where RMS had used the KX modifier to indicate that it had both the "face-to-face" evaluation as well as the Valid Order, RMS did not in fact have this documentation. Although RMS did not have these documents, it used the KX modifier and thereby certified to Medicare that it had the documents on file. Medicare therefore paid the claims. As a result of these fraudulent billings submitted to Medicare, Medicare paid RMS \$70,105 for 19 PMD orders.

13. As a result of the on-site audit, in June 2009, Medicare placed RMS on "pre-pay" review, meaning that for every PMD that RMS sought reimbursement for, the accompanying "face-to-face" evaluation and Valid Order had to be submitted.

14. Between June 2009 and November 2009, RMS submitted eight additional claims seeking reimbursement for providing PMD to Medicare beneficiaries. In each of these eight instances, RMS utilized the "KX" modifier, and thereby indicated that RMS had both the "face-to-face" evaluation and the Valid Order. In submitting documentation to support the claim for reimbursement, six of the claims were rejected due to the fact that RMS failed to provide either a copy of the "face-to-face" evaluation, a Valid Order for the PMD, or both. In one of the six denials, it was determined through our investigation that the Medicare beneficiary who received the PMD only needed to have a wheel on a walker repaired, and did not want or need a PMD.