

UNITED STATES DISTRICT COURT  
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA : Hon.  
 :  
 v. : Criminal No. 10-  
 :  
 ROLAND ASEMOTA : 18 U.S.C. § 1347  
 : 18 U.S.C. § 1035  
 : 18 U.S.C. § 2

I N D I C T M E N T

The Grand Jury, in and for the District of New Jersey,  
sitting at Newark, charges:

COUNTS ONE THROUGH TWENTY-THREE  
(18 U.S.C. § 1347)

The Defendant and Rose's Medical Supply

1. At all times relevant to this Indictment, the Defendant, Roland Asemota, was the manager of Rose's Medical Supply ("RMS"), a Medicare-approved provider of durable medical equipment ("DME"). In that role, the defendant was responsible for RMS's Medicare billings. RMS supplied a type of DME known as power mobility devices ("PMD"), such as motorized wheelchairs.

The Medicare Program and Billing Procedures

2. 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."

3. 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 DME, for beneficiaries. The Medicare Part B program carrier for DME in New Jersey at all times relevant to this ~~complaint~~<sup>INDICTMENT</sup> was NHIC Corporation ("NHIC").

4. Medicare-approved providers of services and equipment to Medicare beneficiaries, such as RMS, 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 are medically necessary and are 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 or statements, or to conceal a material fact, in relation to the submission of a claim.

5. 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.

Using the "KX" Modifier for PMD Billing to Medicare

6. Under Medicare LCD, reimbursement is provided for those beneficiaries who have been evaluated by their physician as being in medical need of a PMD. As part of that evaluation, the referring physician must complete 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, such as RMS, 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 the "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 the supplier of the PMD is required to keep these documents on file.

7. 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 known as 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.

8. Therefore, as a Medicare-approved provider of PMDs, if RMS supplied the KX modifier on the CMS-1500, 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. If a CMS-1500 form billed for a PMD but did not contain the KX modifier, Medicare would not reimburse the provider.

#### The Scheme to Defraud

9. From at least in or about January 2007 through at least in or about November 2009, in Essex County, in the District of New Jersey, and elsewhere, defendant

ROLAND ASEMOTA

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute and attempt to execute a scheme and artifice to defraud Medicare, a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, Medicare, that is, the defendant, as set forth below, submitted and aided and abetted in

submitting false and fraudulent claims to Medicare, seeking reimbursement for the cost of PMD.

The Object of the Scheme to Defraud

10. The object of the scheme and artifice to defraud was for Asemota to cause RMS to falsely code CMS-1500 forms in order to induce Medicare to make payments to RMS for PMD that it otherwise would not have made.

The Manner and Means of the Scheme to Defraud

11. From in or about January 2007 through on or about April 1, 2009, RMS supplied PMD to Medicare beneficiaries and submitted CMS-1500 forms to Medicare for reimbursement.

12. On at least 19 separate occasions during this relevant time period, Asemota caused RMS to submit CMS-1500 forms for PMD reimbursement that contained the KX modifier, thereby certifying that Asemota and RMS had obtained and retained a copy of the "face-to-face" evaluation and Valid Order for each of the PMDs billed. In fact, however, RMS had neither obtained nor retained these documents for each of these 18 claims.

13. Although RMS did not have these documents, Asemota caused each of the 19 PMD billings submitted to Medicare on the CMS-1500 forms to include the KX modifier, and Medicare therefore paid the claims.

14. 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. As a result of the audit, Tri-C discovered that on 19 separate occasions during the period from January 2007 through April 2009, RMS did not in fact have the documentation to support its use of the KX modifier on its PMD billings, and as a result, Medicare should not have paid those 19 claims.

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

16. Nevertheless, on at least 5 more occasions between June 2009 and November 2009, Asemota caused RMS to submit PMD billings with the KX modifier, but did not submit the appropriate documentation with the claim. These claims were denied by Medicare.

17. On or about the dates listed below, in Essex County, in the District of New Jersey, and elsewhere, the defendant

ROLAND ASEMOTA

in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully

execute, and attempt to execute, and aid and abet in executing, the above-described scheme and artifice to defraud a health care benefit program affecting commerce, that is Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody of said health care benefit program, as set forth below, each constituting a separate count of this Indictment:

COUNT	DATE OF SERVICE	TOTAL PAID BY MEDICARE	OVERPAYMENT
1	February 7, 2007	\$3,537.63	\$3,537.63
2	May 18, 2007	\$3,537.63	\$3,537.63
3	June 18, 2007	\$3,537.63	\$3,537.63
4	June 27, 2007	\$3,697.34	\$3,697.34
5	June 29, 2007	\$3,537.63	\$3,537.63
6	July 6, 2007	\$3,537.63	\$3,537.63
7	August 1, 2007	\$3,527.02	\$3,527.02
8	September 4, 2007	\$3,537.63	\$3,537.63
9	September 29, 2007	\$3,537.63	\$3,537.63
10	November 17, 2007	\$3,697.34	\$3,697.34
11	January 18, 2008	\$5,460.27	\$5,460.27
12	February 5, 2008	\$3,537.63	\$3,537.63
13	March 14, 2008	\$3,510.67	\$3,510.67
14	July 3, 2008	\$3,427.60	\$3,427.60
15	December 3, 2008	\$3,330.54	\$3,330.54

16	December 23, 2008	\$3,427.60	\$3,427.60
17	March 14, 2009	\$3,259.60	\$3,259.60
18	April 1, 2009	\$5,039.26	\$5,039.26
19	May 4, 2009	\$5,003.69	\$0 (claim denied)
20	June 9, 2009	\$6,053.44	\$0 (claim denied)
21	July 1, 2009	\$4,978.26	\$0 (claim denied)
22	September 22, 2009	\$6,782.91	\$0 (claim denied)
23	November 12, 2009	\$6,993.68	\$0 (claim denied)

In violation of Title 18, United States Code, Sections  
1347 and 2.

COUNTS TWENTY-FOUR THROUGH FORTY-SIX  
(18 U.S.C. § 1035)

1. Paragraphs 1 through 8 and 10 through 17 of Counts One through Twenty-Four of this Superseding Indictment are alleged as if set forth fully herein.

2. On or about the dates listed below, in Essex County, in the District of New Jersey, and elsewhere, defendant

ROLAND ASEMOTA

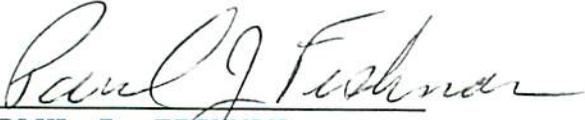
did knowingly and willfully (1) falsify, conceal, and cover up by trick, scheme, and device a material fact, and (2) make materially false, fictitious, and fraudulent statements and representations, and make and use materially false writings and documents knowing the same to contain materially false, 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 as set forth below, each constituting a separate count of this Indictment:

COUNT	DATE OF SERVICE	TOTAL PAID BY MEDICARE	OVERPAYMENT
24	February 7, 2007	\$3,537.63	\$3,537.63
25	May 18, 2007	\$3,537.63	\$3,537.63
26	June 18, 2007	\$3,537.63	\$3,537.63
27	June 27, 2007	\$3,697.34	\$3,697.34
28	June 29, 2007	\$3,537.63	\$3,537.63
29	July 6, 2007	\$3,537.63	\$3,537.63

30	August 1, 2007	\$3,527.02	\$3,527.02
31	September 4, 2007	\$3,537.63	\$3,537.63
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37	July 3, 2008	\$3,427.60	\$3,427.60
38	December 3, 2008	\$3,330.54	\$3,330.54
39	December 23, 2008	\$3,427.60	\$3,427.60
40	March 14, 2009	\$3,259.60	\$3,259.60
41	April 1, 2009	\$5,039.26	\$5,039.26
42	May 4, 2009	\$5,003.69	\$0 (claim denied)
43	June 9, 2009	\$6,053.44	\$0 (claim denied)
44	July 1, 2009	\$4,978.26	\$0 (claim denied)
45	September 22, 2009	\$6,782.91	\$0 (claim denied)
46	November 12, 2009	\$6,993.68	\$0 (claim denied)

In violation of Title 18, United States Code, Sections 1035 and 2.

A TRUE BILL

  
 PAUL J. FISHMAN  
 United States Attorney

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 FOREPERSON