

PREPARED TESTIMONY OF AGHAEBUNA ODELUGO
BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON OVERSIGHT

Mr. Chairman and Members of the Committee:

It is with profound humility, and deep gratitude for this opportunity, that I come before the Members of the Committee today to provide testimony on the pressing issue of Medicare fraud in the durable medical equipment (DME) sector of the healthcare services industry. My name is Aghaegbuna “Ike” Odelugo. I am from Nigeria and came to the United States in 1998 with the sincerest of intentions to eventually acquire my master’s degree. Instead, beginning in 2005 and extending to 2008, I engaged in a business that presents unique opportunities for fraud and abuse. I am speaking of the DME sector of the healthcare services industry. I engaged in fraud and abuse in this industry. I participated with others in fourteen different companies reaching eleven different states.

DME fraud is incredibly easy to commit. The primary skill required to do it successfully is knowledge of basic data entry on a computer. Additionally required is the presence of so-called “marketers” who recruit patients and often falsify patient data and prescription data. With these two essential ingredients, one possesses a recipe for fraud and abuse. The oven in which this recipe is prepared is the Medicare system. This system has a number of weaknesses which are easily exploitable and of which I shall speak more. This is a non-violent crime and is often committed by very educated people, including business people, hospitals, doctors and administrators. It reaches across all ethnic and racial lines. It relies on an often unsuspecting victim base of Medicare recipients, elderly citizens who long for attention and care, who simply want someone to talk to. It also, at times, involves patients who willingly participate in the fraud.

DME providers who engage in this type of fraud either do their own billing or outsource the billing to persons such as myself. In my own experience, I dealt with fourteen DME companies and did their billing. I often dealt directly with marketers who provided patient referrals, most of them fraudulent. I also dealt with physicians who knowingly participated in this fraud by knowingly writing prescriptions when they knew they were not medically necessary or, at times, writing prescriptions for patients they never saw. I have cooperated for over two years with federal law enforcement authorities and my cooperation has resulted in the arrest and prosecution of numerous individuals in many states as well as ongoing investigations in other states. I am not here today to appear proud of what I have done, yet I want the Members of the Committee to understand that I have done everything humanly possible to correct my past

wrongs. The opportunity to testify today before this Subcommittee is something I am very grateful to be able to do.

DME providers often maintain an appearance of legitimacy by billing for a percentage of legitimate claims. These legitimate billings, in my own experience, constituted approximately 40% of all billings. The appearance of legitimacy, however, is maintained to allow the furtherance of the fraudulent activity. This further complicates the ability of law enforcement to uncover this type of fraud. It also permits the offender to rationalize his or her fraudulent activities.

I humbly submit that Congress can, and should, implement certain changes to the Medicare reimbursement system that will, in my opinion, eliminate up to 70% of certain types of DME fraud. I shall now elaborate on what I perceive to be some of the more easily exploitable areas of the Medicare reimbursement process.

FORGED PRESCRIPTIONS

Much DME fraud is perpetrated by marketers and providers who submit claims for reimbursement based on forged prescriptions by doctors. A person engaging in this fraud will typically purchase a forged prescription from a marketer for a price determined by the amount the person anticipates earning. Usually this would be an amount of 15% to 20% of the anticipated profit. The claim is submitted to Medicare electronically. Medicare then reimburses the claim and the illegitimate profit is earned. What is missing, however, is a bill from the “physician” who rendered the medical services which resulted in the writing of the prescription. Medicare should implement a system that cross-references electronically each claim for equipment reimbursement with the parallel claim from the physician for reimbursement for the medical services provided. In this manner, forged prescriptions will be more readily detected. Doctors bill for their services. This is how they get paid. It will be rare for a doctor to not bill for his or her services. Once the bill from the doctor is received, it can be electronically cross-referenced with the claim submitted by the DME provider. If Medicare does not receive a bill from the physician for the service, then the claim from the DME provider should be denied.

MULTIPLE BILLING CODES

Medicare maintains a system of multiple billing codes for essentially the same piece of medical equipment. As an example, a wheelchair may have four or five different codes with only minor differences underlying each code. A fraudulent DME biller may submit a claim for a particular wheelchair and that claim will be denied because Medicare already has a flag on the particular code due to excessive usage in a geographic region. The biller can then simply resubmit the claim using another code that in reality reflects only a minor difference in the equipment, for example a safety strap rather than a seat belt. Medicare should move toward a more standardized billing code system that would eliminate the ability to do multiple billings for

the same item. Alternatively, Medicare should put into place a method of detecting multiple billings for rejected claims.

Both the example of forged prescriptions and multiple billing codes are exploitable defects in the system that can be corrected with software programming. Because the system is interfaced by the biller electronically, a change in the program at Medicare to automatically cross-reference physician and DME provider billing, as well as cross-referencing multiple code entries for the same equipment should be implemented.

PHYSICIAN UPIN

Physicians are given a “unique physician identifier number” (UPIN) to prove that the physician is who he/she claims to be. These numbers are readily available to the public online. The UPIN can be a useful tool for a fraudulent DME provider to exploit. The UPIN is necessary to facilitate the electronic transmission of the claim to Medicare. Astonishingly, UPIN’s are accessible to anyone who knows where to look for them on the internet. These critical identifiers should be kept secure by Medicare. As this statement is being written, I have looked up the UPIN’s of several doctors simply to illustrate to the Members of the Committee how easily accessible this critical information is. Again, this information should be secure by law. Doing so would frustrate the efforts of many healthcare providers who engage in fraud.

MEDICARE PROVIDER NUMBERS

One of the easier things to acquire in the DME fraud arena is a Medicare provider number. There are a number of persons engaged in DME fraud that have criminal backgrounds or who are under indictment yet they still get Medicare provider numbers. I have personally witnessed persons with criminal backgrounds receive approval for a Medicare provider number. This entire process should be more strictly enforced and background investigations should be conducted on all applicants.

BONDED DME

There should a probationary period for any DME provider for one to two years during which they would be required to be bonded by an independent bonding company. Such bond requirements are not unusual in the context of government contracting. In the DME business, because of the high volume of Medicare claims, the DME provider is, in essence, a modified government contractor. Imposing the requirement of a bond would weed out those who wished to enter the market for a “quick hit” and then close shop after a year or so. It would also share some of the burden currently on the shoulders of Medicare to investigate DME start-ups. Finally, it would provide a safety net to Medicare and the American taxpayer in the event fraud was detected in the early stages of the operation of the business. The legitimate DME provider should have little difficulty in complying with Medicare’s regulations and, following a reasonable period of time, would become “certified” and no longer need to be bonded.

QUARTERLY SUBMISSIONS

A practical tool which Congress could implement in the Medicare system and which would both discourage fraud and lead to its early detection is a requirement that DME providers submit, on a quarterly basis, their paperwork for review. These documents could be scanned and submitted electronically and then randomly audited. This, of course, would be a substantial expense. However, given the magnitude of healthcare fraud in the United States, this cost of such random auditing would be minimal in relation to the overall savings to the American taxpayer. No DME provider engaging in fraud believes that he or she will ever have to have the actual paperwork they maintain reviewed by the government. They all believe that a physical inspection of their business will never happen to them. Requiring the submission of paperwork, even with the knowledge that it may not be randomly selected, is a powerful disincentive to engage in fraud. At this time, there is no requirement that paperwork be submitted.

RATES OF REIMBURSEMENT

I would like to finally talk about what I perceive to be the most significant flaw in Medicare: the rates of reimbursement. I do not know who decides, or how the decision is made, but the rate of reimbursement for certain pieces of durable medical equipment is beyond exorbitant. An example is the case of the knee braces. These items are available on the market to a DME provider for less than \$100.00. Medicare, however, reimburse, if I remember correctly, approximately 1,000% of this cost. Back braces that cost approximately \$100.00 are reimbursed at a rate of almost 900%. Wheelchairs that cost less than \$1,000.00 are reimbursed at almost 500% of cost. For anyone engaging in fraud, these numbers are too good to be true. It defies logic to believe that a system like Medicare can reimburse at these rates and not attract a great deal of fraud.

I have not mentioned the issue of corrupt physicians, of whom there are many. I have personally worked with physicians who have taken kickbacks in the form of payment for prescriptions. I know that some of these physicians have been arrested and prosecuted and others have not. It is difficult for me to make recommendations regarding physicians because, frankly, if a doctor is going to be corrupt, there is, in my opinion, little that can be done to stop them. However, if the doctors are checked for their billings and spikes in certain types of equipment are found to exist, this should raise a flag for investigators. Additionally, I have encountered doctors who have written fifty prescriptions on the back of a car in a parking lot simply to make some quick cash. When confronted, they have stated that their signature was forged. Implementing the recommendation above regarding cross-referencing of physician billing to DME billing would contribute to eliminating this practice.

Mr. Chairman and Members of the Committee, I want to again thank you for allowing me the opportunity to address the Subcommittee on Oversight. I sincerely regret my actions over the past years and today's testimony, I hope, will be understood as part of a continuing effort on my

part to help in any way I can to correct my wrongs and prevent future wrongs. I also wish to take this opportunity to publicly thank Assistant United States Attorney Al Balboni and Special Agent Joseph Martin of Health and Human Services for the confidence they have placed in me during the course of my continuing cooperation. Finally, I wish to publicly apologize to this body and, most of all, to the American taxpayers.

Thank you.

Embargoed until 3/2/11 2:00pm