Department of Justice

FOR IMMEDIATE RELEASE
TUESDAY, OCTOBER 29, 2019
WWW.JUSTICE.GOV

CRM
(202) 514-2007
TTY (866) 544-5309

FORMER MISSOURI HOSPITAL EXECUTIVE PLEADS GUILTY TO PASS-THROUGH BILLING SCHEME THAT CAUSED OVER $100 MILLION IN LOSSES

WASHINGTON – The former CEO of a Missouri hospital pleaded guilty today for his role in a pass-through billing scheme in which the hospital was used to submit fraudulent claims for toxicology and blood testing, resulting in multiple insurance companies and the Missouri Medicaid program paying over $100 million in claims.

Assistant Attorney General Brian A. Benczkowski of the Justice Department's Criminal Division, U.S. Attorney Maria Chapa Lopez of the Middle District of Florida, U.S. Attorney Timothy A. Garrison of the Western District of Missouri, Special Agent in Charge Rachel Rojas of the FBI's Jacksonville Field Office, Special Agent in Charge Timothy R. Langan Jr., of the FBI's Kansas City Field Office, Deputy Assistant Inspector General Thomas W. South of the U.S. Office of Personnel Management-Office of Inspector General (OPM-OIG), Special Agent in Charge Rafiq Ahmad of the U.S. Department of Labor-Office of Inspector General (DOL-OIG) and Special Agent in Charge Basil P. Demczak of the Amtrak Office of Inspector General (Amtrak-OIG) made the announcement.

David Lane Byrns, 62, of Lighthouse Point, Florida, the former CEO of Putnam County Memorial Hospital (Putnam), of Unionville, Missouri, pleaded guilty before U.S. Magistrate Judge James R. Klindt of the Middle District of Florida to a one-count information charging him with conspiracy to commit health care fraud. The information was filed in the Western District of Missouri and the case was transferred to the Middle District of Florida by consent for the entry of Byrns' plea. As part of his guilty plea, Byrns agreed to a forfeiture judgment of $5,100,000. Sentencing before U.S. District Judge Timothy Corrigan of the Middle District of Florida has not yet been scheduled.

According to admissions made as part of his guilty plea, in 2016, Byrns and another individual took control of Putnam, a rural hospital in Missouri, through a management agreement with the hospital's board, and Byrns was installed as the hospital's CEO. Byrns and others, including a laboratory owner, then arranged for urine drug tests (UDTs) and blood tests to be performed on a massive scale at diagnostic testing laboratories outside Missouri, on behalf of individuals who were not Putnam patients and who otherwise had no connection to Putnam. To obtain samples for testing, Byrns and his co-conspirators entered into arrangements with marketers, who solicited samples from substance abuse treatment centers, sober living homes,

physicians' offices and other sources throughout the United States, in exchange for a portion of the insurance reimbursements. Many of the tests conducted were medically unnecessary. Byrns and his co-conspirators billed the tests to private insurers and to the Missouri Medicaid program using Putnam's billing credentials, in order to take advantage of Putnam's favorable reimbursement rates under its in-network contracts with the insurers, while failing to identify the fact that most testing had not taken place at Putnam, Byrns admitted.

During a 15-month period, Byrns and his co-conspirators caused private insurers and the Missouri Medicaid Program to reimburse Putnam approximately $114 million for the laboratory tests, most of which was shared among Byrns and his co-conspirators, including the laboratories, marketers and billing companies involved in the scheme, Byrns admitted.

The case was investigated by the FBI's Jacksonville Field Office, the Jefferson City, Missouri Resident Agency of the FBI's Kansas City Field Office, OPM-OIG, DOL-OIG and Amtrak OIG. Trial Attorneys Gary A. Winters and James V. Hayes of the Criminal Division's Fraud Section, Assistant U.S. Attorney Tysen Duva of the Middle District of Florida and Assistant U.S. Attorney Lucinda Woolery of the Western District of Missouri are prosecuting the case.

The Department wishes to acknowledge the assistance of the Missouri State Auditor's Office and the Missouri Attorney General's Medicaid Fraud Control Unit.

The Fraud Section leads the Medicare Fraud Strike Force. Since its inception in March 2007, the Medicare Fraud Strike Force, which maintains 15 strike forces operating in 24 districts, has charged more than 4,200 defendants who have collectively billed the Medicare program for nearly $19 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

# # #

19-XXX