UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

INDICTMENT FOR CONSPIRACY TO COMMIT HEALTH CARE FRAUD

UNITED STATES OF AMERICA	*	**CRIMINAL NO.** 26-153
v.	*	**SECTION** SECT. CMAG.5
HOLLY BROUSSARD	*	**VIOLATION: 18 U.S.C. § 1349**
	*	

* * *

The Grand Jury charges that:

COUNT 1
(Conspiracy to Commit Health Care Fraud)

A. AT ALL TIMES RELEVANT HEREIN:

Health Care Benefit Programs

1. The Medicare program ("Medicare") was a federal health insurance program, affecting commerce, that provided benefits to persons who were 65 years of age and older or disabled. The benefits available under Medicare were governed by federal statutes and regulations. The United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"), oversaw and administered Medicare.

2. The Louisiana Medicaid Program ("Medicaid") was a federal and state funded health insurance program designed to provide medical assistance to persons whose income and resources were insufficient to meet the costs of necessary care and services. Medicaid was administered by HHS through CMS. CMS contracted with the Louisiana Department of Health to manage the Medicaid program in Louisiana.

3. The TRICARE program ("TRICARE") was a comprehensive health care program that provided benefits to United States military personnel, retirees, and their families. TRICARE was administered by the United States Department of Defense, through the Defense Health Agency.

4. The Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA") was a federal health care benefit program within the Department of Veterans Affairs ("VA"). CHAMPVA was a comprehensive health care program in which the VA shared the cost of covered health care services and supplies with eligible beneficiaries. The eligible categories for CHAMPVA beneficiaries were the spouses and children of veterans who had been rated permanently and totally disabled for a service-connected disability and the surviving spouses and children of veterans who died from a VA-rated service-connected disability.

5. In addition, various private insurance companies, including Blue Cross & Blue Shield of Louisiana, A Mutual Insurance Company ("BCBSLA") and the Federal Employee Health Benefits Program ("FEHBP") (collectively with Medicare, Medicaid, TRICARE, and CHAMPVA, "the health care benefit programs"), provided health care benefits for individuals enrolled with their plans.

6. The health care benefit programs were each a "health care benefit program" within the meaning of Title 18, United States Code, Section 24(b).

7. Individuals who qualified for benefits under the health care benefit programs were commonly referred to as "beneficiaries," "recipients," or "members" (collectively herein, "beneficiaries"). Each beneficiary was given a unique identification number. These beneficiary identification numbers were used to determine a beneficiary's eligibility for health care benefits and to submit claims to the health care benefit programs seeking reimbursement for covered benefits, items, and services.

8. Health care providers ("providers") could enroll with a health care benefit program and provide services to individuals enrolled with their plans. For example, as part of the Medicare enrollment process, providers submitted enrollment applications to Medicare. The Medicare provider enrollment application required a provider, or an authorized representative of the provider, to certify that the provider would comply with all Medicare-related laws, rules, and regulations, and that the provider "w[ould] not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare" and "w[ould] not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

9. A "provider number" was assigned to a provider upon approval of the provider enrollment application, after which, a provider could submit claims to obtain reimbursement for medically necessary items and services.

10. When submitting claims to health care benefit programs, or to their fiscal intermediaries, providers generally certified that the contents of the forms were true, correct, and complete; the forms were prepared in compliance with laws, regulations, and program rules applicable to the health care benefit program; and the services purportedly provided, as set forth in the claims, were medically reasonable and necessary.

11. The health care benefit programs reimbursed providers for services only if they

were medically reasonable and necessary.

Diagnostic Testing

12. Except for limited statutory exceptions, Medicare reimbursed clinical laboratories for diagnostic tests only if the tests were "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). Further, to be reimbursable by Medicare, "[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem." 42 C.F.R. § 410.32(a).

13. Diagnostic laboratory tests were available to detect bacterial and viral pathogens that could cause respiratory diseases.

14. "COVID-19 tests" assessed whether an individual had the novel coronavirus disease 2019, commonly referred to as COVID-19.

15. Tests for respiratory pathogens were sometimes performed in panels that targeted multiple pathogens, known as respiratory pathogen panel tests ("respiratory panel tests"). In submitting claims to health care benefit programs for respiratory panel tests, providers used a variety of billing codes to indicate such tests had been performed. For example, Current Procedural Terminology code 87633 indicated tests for 12-25 pathogens. Generally, reimbursement rates for respiratory panel tests were several times higher than reimbursement rates for COVID-19 tests and other standalone respiratory pathogen tests.

16. Generally, in order to have a COVID-19 test or a test for another respiratory pathogen (including respiratory panel tests), an individual completed a buccal or nasopharyngeal swab to collect a specimen, which was then transmitted to a laboratory for testing.

17. The health care benefit programs did not cover diagnostic testing, including respiratory panel testing, that was not reasonable and necessary for the diagnosis or treatment of illness or injury. Each pathogen tested in a panel had to be medically reasonable and necessary to be reimbursed by a health care benefit program. Respiratory pathogen tests were not intended to be used on asymptomatic patients.

18. In or around May 2020, in response to the public health emergency resulting from the COVID-19 pandemic, Medicare removed the requirement that COVID-19 tests and certain, defined respiratory pathogen tests be ordered by a treating physician. Under the interim policy, Medicare covered COVID-19 tests and certain, defined respiratory pathogen tests when ordered by any health care professional authorized to do so under state law. Under the interim policy, COVID-19 tests and respiratory pathogen tests still had to be reasonable and necessary for the treatment of illness or injury, eligible for reimbursement, and provided as documented in order to be covered by Medicare.

The Defendant and Related Individuals and Entities

19. The defendant, **HOLLY BROUSSARD** ("**BROUSSARD**"), was a sales representative and account manager for Company 1. **BROUSSARD** was a resident of Shreveport, Louisiana.

20. Company 1 was a Louisiana limited liability company formed in or around 2013. Company 1 operated a diagnostic testing laboratory in Houma, Louisiana, in the Eastern District of Louisiana.

21. Company 2 was a Texas limited liability company formed in or around 2020. Company 2 operated a diagnostic testing laboratory in Houston, Texas.

22. Person 1 was a resident of New Orleans, Louisiana. Person 1 was the Chief Executive Officer of Company 1 until in or around 2022 and was the co-owner of Company 1 and Company 2.

23. Person 2 was a resident of New Orleans, Louisiana. Person 2 was the Director of Laboratory Operations of Company 1 until in or around 2023 and was the co-owner of Company 1 and Company 2.

B. THE CONSPIRACY:

Beginning in or around March 2020, and continuing through in or around March 2022, in the Eastern District of Louisiana, and elsewhere, the defendant, **HOLLY BROUSSARD**, did knowingly and willfully conspire with Person 1, Person 2, and others known and unknown to the Grand Jury, to execute, and attempt to execute, a scheme and artifice to defraud health care benefit programs affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, the health care benefit programs, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money owned by, and under the custody and control of, the health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

C. THE PURPOSE OF THE CONSPIRACY:

It was a purpose of the conspiracy for **BROUSSARD** and her co-conspirators to unlawfully enrich themselves by, among other things:

1. Submitting and causing the submission of false and fraudulent claims to the health care benefit programs for respiratory panel testing, including through Company 1, located in the Eastern District of Louisiana, for testing rendered to beneficiaries located in the Eastern District

of Louisiana and elsewhere;

2. Receiving and obtaining the reimbursements paid by the health care benefit programs based on the false and fraudulent claims submitted;

3. Concealing the lack of medical reasonableness and necessity for the respiratory panel testing and the submission of false and fraudulent claims to the health care benefit programs; and

4. Diverting proceeds of the fraud for the personal use and benefit of **BROUSSARD** and her co-conspirators, and to further the fraud.

D. THE MANNER AND MEANS OF THE CONSPIRACY:

The manner and means by which **BROUSSARD** and her co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among others, the following:

1. Beginning at least in or around 2017, Person 1 and Person 2 enrolled Company 1 in Medicare and other health care benefit programs. In doing so, they received education on health care benefit program rules and regulations, as well as prohibitions on fraud, waste, and abuse, which Person 1 and Person 2 shared with **BROUSSARD**. For example, in or around 2019, Person 1 sent **BROUSSARD** an article from CMS highlighting concern over "excessive or improper use of clinical laboratory services for reasons not related to the medical needs of the patient," as well the "use of excessively large panels" and "standing orders for laboratory tests" used as a "scheme" to "maximize reimbursement in the absence of medical necessity."

2. Despite knowledge of applicable rules and regulations, beginning at least in early 2020, **BROUSSARD** began soliciting providers to issue orders for excessive and unnecessary respiratory panel tests, to be bundled with COVID-19 tests, in order to maximize reimbursement from the health care benefit programs.

3. **BROUSSARD** capitalized on COVID-19 testing shortages across the State of Louisiana by offering providers short turnarounds on COVID-19 tests through Company 1, but only if the COVID-19 tests were ordered in combination with medically unnecessary, and far more expensive, respiratory panel tests. **BROUSSARD** and others specifically targeted providers in rural areas who had limited or no other options for treatment, including nursing homes and assisted living facilities that needed only COVID-19 testing.

4. **BROUSSARD** gave providers Company 1-branded requisition forms that contained a template respiratory panel listing over 30 pathogens—including Enterovirus, Candida Albicans, Legionella pneumophilia, MRSA, and Bordetella pertussis—that could not be modified or individualized based upon the medical condition and need of the individual patient. The requisition form was designed to maximize reimbursement from the health care benefit programs. Providers were told by **BROUSSARD**, for the purpose of increasing reimbursement and capitalizing on providers' need to obtain timely COVID-19 test results in the midst of the pandemic, that they could only receive timely COVID-19 test results from Company 1 if they ordered the full respiratory panel test. **BROUSSARD** concealed from providers that Company 1's respiratory panel tests could not appropriately be used for exposure, screening, or drive-through COVID-19 testing, rendering it medically unnecessary for situations that required the delivery of rapid results regarding a patient's COVID-19 status.

5. In order to conceal the fraud, **BROUSSARD** and others instructed providers to use false diagnosis codes, such as cough or fever, to ensure reimbursement by the health care benefit programs for testing of asymptomatic patients whose testing was not otherwise properly reimbursable. **BROUSSARD** also concealed the billing codes from medical providers to hide Company 1's bundling of the expensive and medically unnecessary respiratory panel testing when,

as **BROUSSARD** knew, the providers intended to order only a COVID-19 test. In or around May 2020, when another sales representative texted **BROUSSARD** that a provider was "pretty much using [the respiratory panel testing] for COVID-19 I'm guessing," **BROUSSARD** responded, "Yes and trying to figure out how much we are billing sounds like  ."

6. **BROUSSARD** communicated with other sales representatives about the respiratory panel testing and lack of medical necessity for the testing. For example, in or around November 2021, another sales representative texted **BROUSSARD** that **BROUSSARD** "has her Bumpkin town clinics swabbing livestock again," to which **BROUSSARD** responded, "Haha! Gotta do what we gotta do!"

7. Despite providers only ordering COVID-19 testing, **BROUSSARD** caused Company 1 to bill the health care benefit programs for respiratory tests not ordered by the providers. For example, when one provider expressly ordered "Covid-19 pre op testing prior to procedure. No other viral tests to be done," **BROUSSARD** caused Company 1 to perform and bill for the full respiratory panel.

8. Beginning in or around April 2020, Company 1 was audited by multiple health care benefit programs. As a part of the audits, Company 1 received numerous education letters from the health care benefit programs, which contained specific guidance on medical necessity requirements for respiratory panel testing, including that respiratory panel tests were inappropriate for asymptomatic patients or to determine if a person had COVID-19. **BROUSSARD** was aware of such correspondence and forwarded certain findings by the health care benefit programs to Person 1 and Person 2.

9. In or around the same time period as the audits and education letters, **BROUSSARD** received complaints that patients were being charged approximately $600 to

$1,000 for unnecessary testing for respiratory pathogens that had been bundled with the provider's order for a COVID-19 test run by Company 1. Despite these complaints, the scheme continued.

10. To further conceal the fraud, **BROUSSARD** pressured providers to sign back-dated provider attestations of medical necessity for the respiratory panel testing, despite providers only needing COVID-19 testing.

11. In early 2021, after scrutiny of Company 1's respiratory panel testing claims by health care benefit programs intensified, Person 1 and Person 2 shifted the billing to Company 2, located in Texas, and began using different billing codes to conceal the scheme, as **BROUSSARD** knew.

12. **BROUSSARD** was incentivized by Person 1, Person 2, and others to arrange for the ordering of as many respiratory panel tests as possible through Company 1. **BROUSSARD** received over $1.2 million in commission payments from Company 1, mostly on a per-referral basis. **BROUSSARD** spent the proceeds on, among other things, luxury goods, home renovations, and vacations. In or around March 2020, in response to a message from Person 1 that **BROUSSARD** had the top sales territory and that **BROUSSARD** would be "getting a new Gucci," **BROUSSARD** responded, "Or two! 😂 😂."

13. In total, **BROUSSARD** caused the submission of over $51.7 million in claims to the health care benefit programs for respiratory panel testing, of which the health care benefit programs reimbursed over $28.4 million.

All in violation of Title 18, United States Code, Section 1349.

NOTICE OF FORFEITURE

1. The allegations of Count 1 of this Indictment are incorporated by reference as though set forth fully herein for the purpose of alleging forfeiture to the United States.

2. As a result of the offense alleged in Count 1, the defendant, **HOLLY BROUSSARD**, shall forfeit to the United States pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses.

3. If any of the above-described property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty,

the United States shall seek a money judgment and, pursuant to Title 21, United States Code, Section 853(p), forfeiture of any other property of the defendant up to the value of said property.

[redacted]

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June 22, 2026

FORM OBD-34

No. _____

UNITED STATES DISTRICT COURT

Eastern *District of* Louisiana

Criminal *Division*

THE UNITED STATES OF AMERICA

vs.

HOLLY BROUSSARD

INDICTMENT

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VIOLATION: Title 18, U.S.C., Section 1349

[redacted]

Filed in open court this _____ *day of* _____ *A.D.* *2026.*

_____
Clerk

Bail, $ _____

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