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\$150,000 as annually adjusted under 45 CFR part 102.

(e) *\$15,000.* CMS or OIG may impose a penalty of not more than \$15,000 as adjusted annually under 45 CFR part 102 for if the seller of a Medicare supplemental policy is not the issuer, for each violation described in paragraphs (f)(2) and (f)(3) of this section (§ 402.1(c)(25) and (c)(26)).

(f) *\$25,000.* CMS or OIG may impose a penalty of not more than \$25,000 as adjusted annually under 45 CFR part 102 for each of the following violations:

(1) Issuance of a Medicare supplemental policy that has not been approved by an approved State regulatory program or does not meet Federal standards on and after the effective date in section 1882(p)(1)(C) of the Act (§ 402.1(c)(23)).

(2) Sale or issuance after July 30, 1992, of a Medicare supplemental policy that fails to conform with the NAIC or Federal standards established under section 1882(p) of the Act (§ 402.1(c)(25)).

(3) Failure to make the core group of basic benefits available for sale when selling other Medicare supplemental plans with additional benefits (§ 402.1(c)(26)).

(4) Failure to provide, before sale of a Medicare supplemental policy, an outline of coverage describing the benefits provided by the policy (§ 402.1(c)(26)).

(5) Failure of an issuer of a policy to suspend or reinstate a policy, based on the policy holder's request, during entitlement to or upon loss of eligibility for medical assistance (§ 402.1(c)(27)).

(6) Failure to provide refunds or credits for Medicare supplemental policies as required by section 1882(r)(1)(B) (§ 402.1(c)(28)).

(7) By an issuer of a Medicare supplemental policy—

(i) Substantial failure to provide medically necessary services to enrollees seeking the services through the issuer's network of entities;

(ii) Imposition of premiums on enrollees in excess of the premiums approved by the State;

(iii) Action to expel an enrollee for reasons other than nonpayment of premiums; or

(iv) Failure to provide each enrollee, at the time of enrollment, with the specific information provided in sec-

tion 1882(t)(1)(E)(i) or failure to obtain a written acknowledgment from the enrollee of receipt of the information (as required by section 1882(t)(1)(E)(ii)) (section 1882(t)(2)).

(g) *\$100.* CMS or OIG may impose a penalty of not more than \$100 as adjusted annually under 45 CFR part 102 for each violation if the person or entity does not furnish an itemized statement to a Medicare beneficiary within 30 days of the beneficiary's request.

(h) *\$100,000.* CMS or OIG may impose a penalty of not more than \$10,000 as adjusted annually under 45 CFR part 102 for each knowing failure of an applicable manufacturer or an applicable group purchasing organization to report timely, accurately or completely a payment or other transfer of value or an ownership or investment interest (§ 402.1(c)(34)). The total penalty imposed with respect to knowing failures to report in an annual submission of information will not exceed \$1,000,000 as annually adjusted under 45 CFR part 102.

[63 FR 68690, Dec. 14, 1998, as amended at 66 FR 49546, Sept. 28, 2001; 72 FR 39752, July 20, 2007; 72 FR 46175, Aug. 17, 2007; 78 FR 9520, Feb. 8, 2013; 81 FR 61561, Sept. 6, 2016]

§ 402.107 Amount of assessment.

A person subject to civil money penalties specified in § 402.1(c) may be subject, in addition, to an assessment. An assessment is a monetary payment in lieu of damages sustained by HHS or a State agency.

(a) The assessment may not be more than twice the amount claimed for each service that was a basis for the civil money penalty, except for the violations specified in paragraph (b) of this section that occur before January 1, 1997.

(b) For the violations specified in this paragraph occurring after January 1, 1997, the assessment may not be more than three times the amount claimed for each service that was the basis for a civil money penalty. The violations are the following:

(1) Knowingly and willfully billing, and on a repeated basis, for a clinical diagnostic laboratory test, other than on an assignment-related basis (§ 402.1(c)(1)).

(2) By any durable medical equipment supplier, knowingly and willfully charging for a covered service that is furnished on a rental basis after the rental payments may no longer be made (except for maintenance and servicing) as provided in section 1834(a)(7)(A) (§ 402.1(c)(4)).

(3) By any durable medical equipment supplier, knowingly and willfully failing, in violation of section 1834(a)(18)(A), to make a refund to Medicare beneficiaries for a covered service for which payment is precluded due to an unsolicited telephone contact from the supplier (§ 402.1(c)(5)).

(4) By any nonparticipating physician or supplier, knowingly and willfully charging a Medicare beneficiary more than the limiting charge, as specified in section 1834(b)(5)(B), for radiologist services (§ 402.1(c)(6)).

(5) By any nonparticipating physician or supplier, knowingly and willfully charging a Medicare beneficiary more than the limiting charge as specified in section 1834(c)(3), for mammography screening (§ 402.1(c)(7)).

(6) By any supplier of prosthetic devices, orthotics, and prosthetics, knowingly and willfully charging for a covered prosthetic device, orthotic, or prosthetic that is furnished on a rental basis after the rental payment may no longer be made (except for maintenance and servicing) (§ 402.1(c)(8)).

(7) By any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies, knowingly and willfully failing to make refunds in a timely manner to Medicare beneficiaries for services billed other than on an assignment-related basis if—

(i) The supplier does not possess a Medicare supplier number;

(ii) The service is denied in advance; or

(iii) The service is determined not to be medically necessary or reasonable (§ 402.1(c)(10)).

(8) Knowingly and willfully billing or collecting for any services on other than an assignment-related basis for a person or entity specified in sections 1834(k)(6), 1834(l)(6), or 1842(b)(18)(B) (§ 402.1(c)(11), (c)(31), or (c)(32)).

(9) By any physician, knowingly and willfully presenting, or causing to be

presented, a claim or bill for an assistant at cataract surgery performed on or after March 1, 1987 for which payment may not be made because of section 1862(a)(15) (§ 402.1(c)(12)).

(10) By any nonparticipating physician who does not accept payment on an assignment-related basis, knowingly and willfully failing to refund on a timely basis any amounts collected for services that are not reasonable or medically necessary or are of poor quality, in accordance with section 1842(l)(1)(A) (§ 402.1(c)(13)).

(11) By any nonparticipating physician, who does not accept payment for an elective surgical procedure on an assignment-related basis and whose charge is at least \$500, knowingly and willfully failing to—

(i) Disclose the information required by section 1842(m)(1) concerning charges and coinsurance amounts; and

(ii) Refund on a timely basis any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program (§ 402.1(c)(14)).

(12) By any physician, in repeated cases, knowingly and willfully billing one or more beneficiaries, for purchased diagnostic tests, any amount other than the payment amount specified in section 1842(n)(1)(A) or section 1842(n)(1)(B) (§ 402.1(c)(15)).

(13) By any nonparticipating physician, supplier, or other person that furnishes physicians' services and does not accept payment on an assignment-related basis—

(i) Knowingly and willfully billing or collecting in excess of the limiting charge (as defined in section 1843(g)(2)) on a repeated basis; or

(ii) Failing to make an adjustment or refund on a timely basis as required by section 1848(g)(1)(A) (iii) or (iv) (§ 402.1(c)(17)).

(14) Knowingly and willfully billing for State plan approved physicians' services on other than an assignment-related basis for a Medicare beneficiary who is also eligible for Medicaid (§ 402.1(c)(18)).

(15) By any supplier of durable medical equipment, including suppliers of prosthetic devices, prosthetics, orthotics, or supplies, knowingly and willfully failing to make refunds in a

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timely manner to Medicare beneficiaries for services billed on an assignment-related basis if—

- (i) The supplier did not possess a Medicare supplier number;
- (ii) The service is denied in advance; or
- (iii) The service is determined not to be medically necessary or reasonable (§ 402.1(c)(23)).

[63 FR 68690, Dec. 14, 1998, as amended at 66 FR 49546, Sept. 28, 2001]

§ 402.109 Statistical sampling.

(a) *Purpose.* CMS or OIG may introduce the results of a statistical sampling study to show the number and amount of claims subject to sanction under this part that the respondent presented or caused to be presented.

(b) *Prima facie evidence.* The results of the statistical sampling study, if based upon an appropriate sampling and computed by valid statistical methods, constitute prima facie evidence of the number and amount of claims or requests for payment subject to sanction under § 402.1.

(c) *Burden of proof.* Once CMS or OIG has made a prima facie case, the burden is on the respondent to produce evidence reasonably calculated to rebut the findings of the statistical sampling study. CMS or OIG then has the opportunity to rebut this evidence.

§ 402.111 Factors considered in determinations regarding the amount of penalties and assessments.

(a) *Basic factors.* In determining the amount of any penalty or assessment, CMS or OIG takes into account the following:

- (1) The nature of the claim, request for payment, or information given and the circumstances under which it was presented or given.
- (2) The degree of culpability, history of prior offenses, and financial condition of the person submitting the claim or request for payment or giving the information.
- (3) The resources available to the person submitting the claim or request for payment or giving the information.
- (4) Such other matters as justice may require.

(b) *Criteria to be considered.* As guidelines for taking into account the fac-

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tors listed in paragraph (a) of this section, CMS or OIG considers the following circumstances:

(1) *Aggravating circumstances of the incident.* An aggravating circumstance is any of the following:

- (i) The services or incidents were of several types, occurring over a lengthy period of time.
- (ii) There were many of these services or incidents or the nature and circumstances indicate a pattern of claims or requests for payment for these services or a pattern of incidents.
- (iii) The amount claimed or requested for these services was substantial.

(iv) Before the incident or presentation of any claim or request for payment subject to imposition of a civil money penalty, the respondent was held liable for criminal, civil, or administrative sanctions in connection with a program covered by this part or any other public or private program of payment for medical services.

(v) There is proof that a respondent engaged in wrongful conduct, other than the specific conduct upon which liability is based, relating to government programs or in connection with the delivery of a health care service. (The statute of limitations governing civil money penalty proceedings does not apply to proof of other wrongful conduct as an aggravating circumstance.)

(2) *Mitigating circumstances.* The following circumstances are mitigating circumstances:

- (i) All the services or incidents subject to a civil money penalty were few in number and of the same type, occurred within a short period of time, and the total amount claimed or requested for the services was less than \$1,000.
- (ii) The claim or request for payment for the service was the result of an unintentional and unrecognized error in the process of presenting claims or requesting payment and the respondent took corrective steps promptly after discovering the error.
- (iii) Imposition of the penalty or assessment without reduction would jeopardize the ability of the respondent to continue as a health care provider.