

§ 401.722

and its contractors must immediately upon receipt of notification of the termination commence returning or destroying any and all CMS data (and any derivative files). In no instance can this process exceed 30 days.

(2) If a qualified entity voluntarily terminates participation under this subpart, it and its contractors must return to CMS, or destroy, any and all CMS data in its possession within 30 days of notifying CMS of its intent to end its participation.

[76 FR 76567, Dec. 7, 2011, as amended at 81 FR 44482, July 7, 2016]

§ 401.722 Qualified clinical data registries.

(a) A qualified clinical data registry that agrees to meet all the requirements in this subpart, with the exception of § 401.707(d), may request access to Medicare data as a quasi qualified entity in accordance with such qualified entity program requirements.

(b) Notwithstanding § 401.703(q) (generally defining combined data), for purposes of qualified clinical data registries acting as quasi qualified entities under the qualified entity program requirements, combined data means, at a minimum, a set of CMS claims data provided under this subpart combined with clinical data or a subset of clinical data.

[81 FR 44482, July 7, 2016]

PART 402—CIVIL MONEY PENALTIES, ASSESSMENTS, AND EXCLUSIONS

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AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 63 FR 68690, Dec. 14, 1998, unless otherwise noted.

Subpart A—General Provisions

§ 402.1 Basis and scope.

(a) *Basis.* This part is based on the sections of the Act that are specified in paragraph (c) of this section.

(b) *Scope.* This part—

(1) Provides for the imposition of civil money penalties, assessments, and exclusions against persons that violate the provisions of the Act specified in paragraph (c), (d), or (e) of this section; and

(2) Sets forth the appeal rights of persons subject to penalties, assessments, or exclusion and the procedures for reinstatement following exclusion.

(c) *Civil money penalties.* CMS or OIG may impose civil money penalties against any person or other entity specified in paragraphs (c)(1) through (c)(35) of this section under the identified section of the Act. (The authorities that also permit imposition of an assessment or exclusion are noted in the applicable paragraphs.)

(1) Sections 1833(h)(5)(D) and 1842(j)(2)—Any person that knowingly and willfully, and on a repeated basis, bills for a clinical diagnostic laboratory test, other than on an assignment-related basis. This provision includes tests performed in a physician's office but excludes tests performed in a rural health clinic. (This violation may also include an assessment and cause exclusion.)

(2) Section 1833(i)(6)—Any person that knowingly and willfully presents, or causes to be presented, a bill or request for payment for an intraocular lens inserted during or after cataract surgery for which the Medicare payment rate includes the cost of acquiring the class of lens involved.

(3) Section 1833(q)(2)(B)—Any entity that knowingly and willfully fails to provide information about a referring physician, including the physician's name and unique physician identification number for the referring physician, when seeking payment on an unassigned basis. (This violation, if it occurs in repeated cases, may also cause an exclusion.)

(4) Sections 1834(a)(11)(A) and 1842(j)(2)—Any durable medical equipment supplier that knowingly and willfully charges 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). (This violation may also include an assessment and cause exclusion.)

(5) Sections 1834(a)(18)(B) and 1842(j)(2)—Any nonparticipating durable medical equipment supplier that knowingly and willfully, in violation of section 1834(a)(18)(A), fails 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. (This violation may also include an assessment and cause exclusion.)

(6) Sections 1834(b)(5)(C) and 1842(j)(2)—Any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge, as specified in section 1834(b)(5)(B), for radiologist services. (This violation

may also include an assessment and cause exclusion.)

(7) Sections 1834(c)(4)(C) and 1842(j)(2)—Any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge, as specified in section 1834(c)(4)(B), for mammography screening. (This violation may also include an assessment and cause exclusion.)

(8) Sections 1834(h)(3) and 1842(j)(2)—Any supplier of prosthetic devices, orthotics, and prosthetics that knowingly and willfully charges 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). (This violation may also include an assessment and cause exclusion.)

(9) Section 1834(j)(2)(A)(iii)—Any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies, that knowingly and willfully distributes a certificate of medical necessity in violation of section 1834(j)(2)(A)(i) or fails to provide the information required under section 1834(j)(2)(A)(ii).

(10) Sections 1834(j)(4) and 1842(j)(2)—

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

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

(B) The service is denied in advance under section 1834(a)(15); or

(C) The service is determined not to be medically necessary or reasonable.

(ii) These violations may also include an assessment and cause exclusion.

(11) Sections 1842(b)(18)(B) and 1842(j)(2)—Any practitioner specified in section 1842(b)(18)(C) (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, and clinical psychologists) or other person that

knowingly and willfully bills or collects for any services by the practitioners on other than an assignment-related basis. (This violation may also include an assessment and cause exclusion.)

(12) Sections 1842(k) and 1842(j)(2)—Any physician who knowingly and willfully presents, or causes 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). (This violation may also include an assessment and cause exclusion.)

(13) Sections 1842(l)(3) and 1842(j)(2)—Any nonparticipating physician who does not accept payment on an assignment-related basis and who knowingly and willfully fails 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). (This violation may also include an assessment and cause exclusion.)

(14) Sections 1842(m)(3) and 1842(j)(2)—(i) 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, who knowingly and willfully fails to—

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

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

(ii) This violation may also include an assessment and cause exclusion.

(15) Sections 1842(n)(3) and 1842(j)(2)—Any physician who knowingly and willfully, in repeated cases, bills 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). (This violation may also include an assessment and cause exclusion.)

(16) Section 1842(p)(3)(A)—Any physician or practitioner who knowingly and willfully fails promptly to provide the appropriate diagnosis code or codes upon request by CMS or a carrier on any request for payment or bill not

submitted on an assignment-related basis for any service furnished by the physician. (This violation, if it occurs in repeated cases, may also cause exclusion.)

(17) Sections 1848(g)(1)(B) and 1842(j)(2)—

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

(A) Knowingly and willfully bills or collects in excess of the limiting charge (as defined in section 1848(g)(2)) on a repeated basis; or

(B) Fails to make an adjustment or refund on a timely basis as required by section 1848(g)(1)(A)(iii) or (iv).

(ii) These violations may also include an assessment and cause exclusion.

(18) Section 1848(g)(3)(B) and 1842(j)(2)—Any person that knowingly and willfully bills for State plan approved physicians' services, as defined in section 1848(j)(3), on other than an assignment-related basis for a Medicare beneficiary who is also eligible for Medicaid (these individuals include qualified Medicare beneficiaries). This provision applies to services furnished on or after April 1, 1990. (This violation may also include an assessment and cause exclusion.)

(19) Section 1848(g)(4)(B)(ii), 1842(p)(3), and 1842(j)(2)(A)—

(i) Any physician, supplier, or other person (except any person that has been excluded from the Medicare program) that, for services furnished after September 1, 1990, knowingly and willfully—

(A) Fails to submit a claim on a standard claim form for services provided for which payment is made under Part B on a reasonable charge or fee schedule basis; or

(B) Imposes a charge for completing and submitting the standard claims form.

(ii) These violations, if they occur in repeated cases, may also cause exclusion.

(20) Section 1862(b)(6)(B)—Any entity that knowingly, willfully, and repeatedly—

(i) Fails to complete a claim form relating to the availability of other

health benefit plans in accordance with section 1862(b)(6)(A); or

(ii) Provides inaccurate information relating to the availability of other health benefit plans on the claim form.

(21) Section 1862(b)(7)(B)—Except for the situation described in paragraphs (c)(21)(ii)(A) and (B) of this section, any entity that has a reporting obligation under section 1862(b)(7) of the Act (“reporting entity”) that—

(i) Fails to report any beneficiary record within 1 year of the last acceptable reporting date, defined as 365 days from the GHP coverage effective date or the Medicare beneficiary’s entitlement date, whichever is later.

(ii) A civil money penalty (CMP) is not imposed if—

(A) The incident of noncompliance is associated with a specific reporting policy or procedural change on the part of CMS that has been effective for less than 6 months following the implementation of that policy or procedural change (or for 1 year, should CMS be unable to provide a minimum of 6 months’ notice prior to implementing such changes).

(B) The entity complies with any reporting thresholds or any other reporting exclusions.

(22) Section 1862(b)(8)(E)—Except for the situations described in paragraph (c)(22)(ii)(A), (B) and (C) of this section, any applicable plan that has a reporting obligation under section 1862(b)(8) of the Act (“applicable plan”), that—

(i) Fails to report any beneficiary record within 1 year from the date of the settlement, judgment, award, or other payment, or the effective date where ongoing payment responsibility for medical care has been assumed by the entity.

(ii) A CMP is not imposed in the following situations:

(A) An NGHP applicable plan fails to report required information as a result of the applicable plan’s inability to obtain an individual’s last name, first name, date of birth, gender, Medicare Beneficiary Identifier (MBI), Social Security Number (SSN), or the last 5 digits of the SSN, and the applicable plan has made a good faith effort to obtain this information by meeting the following:

(1) Has communicated the need for this information to the individual and his or her attorney, or other representative, if applicable, or both.

(2) Has requested the information from the individual and his or her attorney, or other representative (if applicable), at least three times—

(i) Once in writing (including electronic mail);

(ii) Then at least once more by mail; and

(iii) At least once more by phone or other means of contact in the absence of a response to the mailings.

(3) Has not received a response or has received a written response clearly indicating that the individual refuses to provide the needed information. Should the applicable plan receive a written response from the individual or their attorney or representative that clearly and unambiguously declines or refuses to provide any portion of the information specified herein, no additional communications with the individual or their attorney or other representative are required.

(4) Has documented its efforts to obtain the MBI or SSN (or the last 5 digits of the SSN). This documentation, including any written rejection correspondence, must be retained for a minimum of 5 years.

(B) An NGHP applicable plan complies with any reporting thresholds or any other reporting exclusions.

(C) The incident of noncompliance is associated with a specific reporting policy or procedural change on the part of CMS that has been effective for less than 6 months following the implementation of that policy or procedural change (or for 12 months, should CMS be unable to provide a minimum of 6 months’ notice prior to implementing such changes).

(23) Section 1877(g)(5)—Any person that fails to report information required by HHS under section 1877(f) concerning ownership, investment, and compensation arrangements. (This violation may also include an assessment and cause exclusion.)

(24) Sections 1879(h), 1834(a)(18), and 1842(j)(2)—

(i) Any durable medical equipment supplier, including a supplier of prosthetic devices, prosthetics, orthotics,

or supplies, that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries for services billed on an assignment-related basis if—

(A) The supplier did not possess a Medicare supplier number;

(B) The service is denied in advance under section 1834(a)(15) of the Act; or

(C) The service is determined not to be payable under section 1834(a)(17)(b) because of unsolicited telephone contacts.

(ii) These violations may also include an assessment and cause exclusion.

(25) Section 1882(a)(2)—Any person that issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards on and after the effective date in section 1882(p)(1)(C). (This violation may also include an assessment and cause exclusion.)

(26) Section 1882(p)(8)—Any person that sells or issues Medicare supplemental policies, on or after July 30, 1992, that fail to conform to the NAIC or Federal standards established under section 1882(p). (This violation may also include an assessment and cause exclusion.)

(27) Section 1882(p)(9)(C)—

(i) Any person that sells a Medicare supplemental policy and—

(A) Fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits; or

(B) Fails to provide the individual, before the sale of the policy, an outline of coverage describing the benefits provided by the policy.

(ii) These violations may also include an assessment and cause exclusion.

(28) Section 1882(q)(5)(C)—

(i) Any person that fails to—

(A) Suspend a Medicare supplemental policy at the policyholder's request, if the policyholder applies for and is determined eligible for medical assistance, and the policyholder provides notice within 90 days of the eligibility determination; or

(B) Automatically reinstate the policy as of the date of termination of medical assistance if the policyholder loses eligibility for medical assistance

and the policyholder provides notice within 90 days of loss of eligibility.

(ii) These violations may also include an assessment and cause exclusion.

(29) Section 1882(r)(6)(A)—Any person that fails to provide refunds or credits as required by section 1882(r)(1)(B). (This violation may also include an assessment and cause exclusion.)

(30) Section 1882(s)(4)—

(i) Any issuer of a Medicare supplemental policy that—

(A) Does not waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods if the time periods were already satisfied under a preceding Medicare supplemental policy; or

(B) Denies a policy, conditions the issuance or effectiveness of the policy, or discriminates in the pricing of the policy based on health status or other criteria as specified in section 1882(s)(2)(A).

(ii) These violations may also include an assessment and cause exclusion.

(31) Section 1882(t)(2)—

(i) Any issuer of a Medicare supplemental policy that—

(A) Fails substantially to provide medically necessary services to enrollees seeking the services through the issuer's network of entities;

(B) Imposes premiums on enrollees in excess of the premiums approved by the State;

(C) Acts to expel an enrollee for reasons other than nonpayment of premiums; or

(D) Does not provide each enrollee at the time of enrollment with the specific information provided in section 1882(t)(1)(E)(i) or fails to obtain a written acknowledgment from the enrollee of receipt of the information (as required by section 1882(t)(1)(E)(ii)).

(ii) These violations may also include an assessment and cause exclusion.

(32) Sections 1834(k)(6) and 1842(j)(2)—Any person or entity who knowingly and willfully bills or collects for any outpatient therapy services or comprehensive outpatient rehabilitation services on other than an assignment-related basis. (This violation may also include an assessment and cause exclusion.)

(33) Sections 1834(l)(6) and 1842(j)(2)—Any supplier of ambulance services who knowingly and willfully bills or collects for any services on other than an assignment-related basis. (This violation may also include an assessment and cause exclusion.)

(34) Section 1806(b)(2)(B)—Any person who knowingly and willfully fails to furnish a beneficiary with an itemized statement of items or services within 30 days of the beneficiary's request.

(35) Section 1128G (b) (1) and (2)—Any applicable manufacturer or applicable group purchasing organization that fails to timely, accurately, or completely report a payment or other transfer of value or an ownership or investment interest to CMS, as required under part 403, subpart I, of this chapter.

(d) *Assessments.* CMS or OIG may impose assessments in addition to civil money penalties for violations of the following statutory sections:

(1) Section 1833: Paragraph (h)(5)(D).

(2) Section 1834: Paragraphs (a)(11)(A), (a)(18)(B), (b)(5)(C), (c)(4)(C), (h)(3), (j)(4), (k)(6), and (l)(6).

(3) Section 1842: Paragraphs (k), (l)(3), (m)(3), and (n)(3).

(4) Section 1848: Paragraph (g)(1)(B).

(5) Section 1877: Paragraph (g)(5).

(6) Section 1879: Paragraph (h).

(7) Section 1882: Paragraphs (a)(2), (p)(8), (p)(9)(C), (q)(5)(C), (r)(6)(A), (s)(3), and (t)(2).

(e) *Exclusions.* (1) CMS or OIG may exclude any person from participation in the Medicare program on the basis of any of the following violations of the statute:

(i) Section 1833: Paragraphs (h)(5)(D) and, in repeated cases, (q)(2)(B).

(ii) Section 1834: Paragraphs (a)(11)(A), (a)(18)(B), (b)(5)(C), (c)(4)(C), (h)(3), (j)(4), (k)(6), and (l)(6).

(iii) Section 1842: Paragraphs (b)(18)(B), (k), (l)(3), (m)(3), (n)(3), and, in repeated cases, (p)(3)(B).

(iv) Section 1848: Paragraphs (g)(1)(B), (g)(3)(B), and, in repeated cases, (g)(4)(B)(ii).

(v) Section 1877: Paragraph (g)(5).

(vi) Section 1879: Paragraph (h).

(vii) Section 1882: Paragraphs (a)(2), (p)(8), (p)(9)(C), (q)(5)(C), (r)(6)(A), (s)(4), and (t)(2).

(2) CMS or OIG must exclude from participation in the Medicare program any of the following, under the identified section of the Act:

(i) Section 1834(a)(17)(C)—Any supplier of durable medical equipment and supplies that are covered under section 1834(a)(13) that knowingly contacts Medicare beneficiaries by telephone regarding the furnishing of covered services in violation of section 1834(a)(17)(A) and whose conduct establishes a pattern of prohibited contacts as described under section 1834(a)(17)(A).

(ii) Section 1834(h)(3)—Any supplier of prosthetic devices, orthotics, and prosthetics that knowingly contacts Medicare beneficiaries by telephone regarding the furnishing of prosthetic devices, orthotics, or prosthetics in the same manner as in the violation under section 1834(a)(17)(A) and whose conduct establishes a pattern of prohibited contacts in the same manner as described in section 1834(a)(17)(C).

(f) *Responsible persons.* (1) If CMS or OIG determines that more than one person is responsible for any of the violations described in paragraph (c) or paragraph (d) of this section, it may impose a civil money penalty or a civil money penalty and assessment against any one of those persons or jointly and severally against two or more of those persons. However, the aggregate amount of the assessments collected may not exceed the amount that could be assessed if only one person were responsible.

(2) A principal is liable for penalties and assessments for the actions of his or her agent acting within the scope of the agency.

(g) *Time limits.* Neither CMS nor OIG initiates an action to impose a civil money penalty, assessment, or proceeding to exclude a person from participation in the Medicare program unless it begins the action within 6 years from the date on which the claim was presented, the request for payment was made, or the incident occurred.

[63 FR 68690, Dec. 14, 1998, as amended at 66 FR 49546, Sept. 28, 2001; 78 FR 9520, Feb. 8, 2013; 88 FR 70372, Oct. 11, 2023]

§ 402.3 Definitions.

For purposes of this part:

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Assessment means the amount described in § 402.107 and includes the plural of that term.

Assignment-related basis means that the claim submitted by a physician, supplier or other person is paid on the basis of an assignment, whereby the physician, supplier or other person agrees to accept the Medicare payment as payment in full for the services furnished to the beneficiary and is precluded from charging the beneficiary more than the deductible and coinsurance based upon the approved Medicare fee amount. Additional obligations, including obligations to make refunds in certain circumstances, are established at section 1842(b)(3) of the Act.

Claim means an application for payment for a service for which the Medicare or Medicaid program may pay.

Covered means that a service is described as reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A service is not covered if it is specifically identified as excluded from Medicare Part B coverage or is not a defined Medicare Part B benefit.

Exclusion means the temporary or permanent barring of a person or other entity from participation in the Medicare or State health care program and that services furnished or ordered by that person are not paid for under either program.

General Counsel means the General Counsel of HHS or his or her designees.

Initiating agency means whichever agency (CMS or the OIG) initiates the interaction with the person.

Knowingly or knowingly and willfully means that a person, with respect to information—

- (1) Has actual knowledge of the information;
- (2) Acts in deliberate ignorance of the truth or falsity of the information; or
- (3) Acts in reckless disregard of the truth or falsity of the information; and
- (4) No proof of specific intent is required.

Medicare supplemental policy means a policy guaranteeing that a health plan will pay a policyholder's coinsurance and deductible and will cover other limitations on payment imposed under title XVIII of the Act and will provide

additional health plan or non-Medicare coverage for services up to a predefined benefit limit.

NAIC stands for the National Association of Insurance Commissioners.

Nonparticipating describes a physician, supplier, or other person (excluding any provider of services) that, at the time of furnishing the services to Medicare Part B beneficiaries, is not a participating physician or supplier.

Participating describes a physician or supplier (excluding any provider of services) that, before the beginning of any given year, enters into an agreement with HHS that provides that the physician or supplier will accept payment under the Medicare program on an assignment-related basis for all services furnished to Medicare Part B beneficiaries.

Penalty means the amount described in § 402.105 and includes the plural of that term.

Person means an individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

Physicians' services means the following Medicare covered professional services:

- (1) Surgery, consultation, home, office and institutional calls, and other professional services performed by physicians.
- (2) Services and supplies furnished "incident to" a physician's professional services.
- (3) Outpatient physical and occupational therapy services.
- (4) Diagnostic x-ray tests and other diagnostic tests (excluding clinical diagnostic laboratory tests).
- (5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.
- (6) Antigens prepared by a physician.

Radiologist service means radiology services performed only by, or under the direction of, a physician who is certified, or eligible to be certified, by the American Board of Radiology or for whom radiology services account for at least 50 percent of the total amount of charges made under part B of title XVIII of the Act.

Request for payment means an application submitted by a person to any person for payment for a service.

Respondent means the person upon which CMS or OIG has imposed, or proposes to impose, a civil money penalty, assessment, or exclusion.

Service includes—

(1) Any item, device, medical supply, or service claimed to have been furnished to a patient and listed in an itemized claim for program payment; or

(2) In the case of a claim based on costs, any entry or omission in a cost report, books of account or other documents supporting the claim.

State includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

Timely basis means that the adjustment to a bill or a refund is considered “on a timely basis” if the physician, supplier, or other person makes the adjustment or refund to the appropriate party no later than 30 days after the date the physician, supplier, or other person is notified by the Medicare Part B contractor of the violation and the requirement to refund any excess collections.

[63 FR 68690, Dec. 14, 1998, as amended at 72 FR 39752, July 20, 2007]

§ 402.5 Right to a hearing before the final determination.

CMS or OIG does not make a determination adverse to any person under this part until the person has been given a written notice and opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

§ 402.7 Notice of proposed determination.

(a) If CMS or OIG proposes a penalty and, as applicable, an assessment, or proposes to exclude a respondent from participation in Medicare in accordance with this part, it sends the respondent written notice of its intent by certified mail, return receipt requested. The notice includes the following information:

(1) Reference to the statutory basis or bases for the penalty, assessment,

exclusion, or any combination, as applicable.

(2)(i) A description of the claims, requests for payment, or incidents with respect to which the penalty, assessment, and exclusion are proposed; or

(ii) If CMS or OIG is relying upon statistical sampling to project the number and types of claims or requests for payment and the dollar amount, a description of the claims and requests for payment comprising the sample and a brief description of the statistical sampling technique CMS or OIG used.

(3) The reason why the claims, requests for payment, or incidents are subject to a penalty and assessment.

(4) The amount of the proposed penalty and of any proposed assessment.

(5) Any mitigating or aggravating circumstances that CMS or OIG considered when it determined the amount of the proposed penalty and any applicable assessment.

(6) Information concerning response to the notice, including—

(i) A specific statement of the respondent's right to a hearing; and

(ii) A statement that failure to request a hearing within 60 days renders the proposed determination final and permits the imposition of the proposed penalty and any assessment.

(iii) A statement that the debt may be collected through an administrative offset.

(7) In the case of a respondent that has an agreement under section 1866 of the Act, notice that imposition of an exclusion may result in termination of the provider's agreement in accordance with section 1866(b)(2)(C) of the Act.

§ 402.9 Failure to request a hearing.

(a) If the respondent does not request a hearing within 60 days of receipt of the notice of proposed determination specified in § 402.7, any civil money penalty, assessment, or exclusion becomes final and CMS or OIG may impose the proposed penalty, assessment, or exclusion, or any less severe penalty, assessment, or suspension.

(b) CMS or OIG notifies the respondent by certified mail, return receipt requested, of any penalty, assessment, or exclusion that has been imposed and of the means by which the respondent may satisfy the judgment.

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(c) The respondent has no right to appeal a penalty, assessment, or exclusion for which he or she has not requested a hearing.

§ 402.11 Notice to other agencies and other entities.

(a) Whenever a penalty, assessment, or exclusion becomes final, CMS or OIG notifies the following organizations and entities about the action and the reasons for it:

(1) The appropriate State or local medical or professional association.

(2) The appropriate quality improvement organization.

(3) As appropriate, the State agency responsible for the administration of each State health care program (Medicaid, the Maternal and Child Health Services Block Grant Program, and the Social Services Block Grant Program).

(4) The appropriate Medicare carrier or fiscal intermediary.

(5) The appropriate State or local licensing agency or organization (including the Medicare and Medicaid State survey agencies).

(6) The long-term care ombudsman.

(b) For exclusions, CMS or OIG also notifies the public and specifies the effective date.

§ 402.13 Penalty, assessment, and exclusion not exclusive.

Penalties, assessments, and exclusions imposed under this part are in addition to any other penalties prescribed by law.

§ 402.15 Collateral estoppel.

(a) When a final determination that the respondent presented or caused to be presented a claim or request for payment falling within the scope of § 402.1 has been rendered in any proceeding in which the respondent was a party and had an opportunity to be heard, the respondent is bound by that determination in any proceeding under this part.

(b) A person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements is barred from denying the essential elements of the criminal offense if the proceedings under this part involve the same transactions.

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§ 402.17 Settlement.

CMS or OIG has exclusive authority to settle any issues or case, without the consent of the ALJ or the Secretary, at any time before a final decision by the Secretary. Thereafter, the General Counsel has the exclusive authority.

§ 402.19 Hearings and appeals.

The hearings and appeals procedures set forth in part 1005 of chapter V of this title are available to any person that receives an adverse determination under this part. For an appeal of a civil money penalty, assessment, or exclusion imposed under this part, either CMS or OIG may represent the government in the hearing and appeals process.

§ 402.21 Judicial review.

After exhausting all available administrative remedies, a respondent may seek judicial review of a penalty, assessment, or exclusion that has become final. The respondent may seek review only with respect to a penalty, assessment, or exclusion with respect to which the respondent filed an exception under § 1005.21(c) of this title unless the court excuses the failure or neglect to urge the exception in accordance with section 1128A(e) of the Act because of extraordinary circumstances.

Subpart B—Civil Money Penalties and Assessments

§ 402.105 Amount of penalty.

(a) \$2,000. Except as provided in paragraphs (b) through (h) of this section, CMS or OIG may impose a penalty of not more than \$2,000 as adjusted annually under 45 CFR part 102 for each service, bill, or refusal to issue a timely refund that is subject to a determination under this part and for each incident involving the knowing, willful, and repeated failure of an entity furnishing a service to submit a properly completed claim form or to include on the claim form accurate information regarding the availability of other health insurance benefit plans (§ 402.1(c)(21)).