

(c) After evaluating any additional evidence submitted by the excluded person (or at the end of the 30-day period described in paragraph (a) of this section, if no documentary evidence or written request is submitted), the initiating agency sends written notice to the excluded person either confirming the denial, or approving the reinstatement in the manner set forth in § 402.304. If the initiating agency elects to uphold its denial decision, the written notice also indicates that a subsequent request for reinstatement will not be considered until at least 1 year after the date of the written denial notice.

(d) The decision to deny reinstatement is not subject to administrative review.

§ 402.308 Waivers of exclusions.

(a) *Basis.* Section 1128(c)(3)(B) of the Act specifies that in the case of an exclusion from participation in the Medicare program based upon section 1128(a)(1), (a)(3), or (a)(4) of the Act, the individual may request that CMS present, on his or her behalf, a request to the OIG for a waiver of the exclusion.

(b) *Definitions.* For purposes of this section:

Excluded person has the same meaning as a “person” as defined in § 402.3 who meets for the purposes of this subpart, the definition of the term “exclusion” in § 402.3.

Hardship for purposes of this section means something that negatively affects Medicare beneficiaries and results from the imposition of an exclusion because the excluded person is the sole community physician or sole source of essential specialized services in the Medicare community.

Sole community physician has the same meaning as that term is defined § 1001.2 of this title.

Sole source of essential specialized services in the community has the same meaning as that term defined by the § 1001.2 of this title.

(c) *General rule.* If CMS determines that a hardship as defined in paragraph (b)(2) of this section results from exclusion of an affected person from the Medicare program, CMS may consider and may make a request to the Inspec-

tor General for waiver of the Medicare exclusion.

(d) *Submission and content of a waiver of exclusion request.* An excluded person must submit a request for waiver of exclusion in writing to CMS that includes the following:

(1) A copy of the exclusion notice from the OIG.

(2) A statement requesting that CMS present a waiver of exclusion request to the OIG on his or her behalf.

(3) A statement that he or she is the sole community physician or sole source of essential specialized services in the community.

(4) Documentation to support the statement in paragraph (d)(3) of this section.

(e) *Processing of waiver of exclusion requests.* CMS processes a request for a waiver of exclusion as follows:

(1) Notifies the submitter that the waiver of exclusion request has been received.

(2) Reviews and validates all submitted documents.

(3) During its analysis, CMS may require additional, specific information, and authorization to obtain information from private health insurers, peer review organizations (including, but not limited to, Quality Improvement Organizations), and others as necessary to determine validity.

(4) Makes a determination regarding whether or not to submit the waiver of exclusion request to the OIG based on review and validation of the submitted documents.

(5) If CMS elects to submit the waiver of exclusion request to the OIG, CMS copies the excluded person on the request.

(6) If CMS denies the request, then CMS notifies the excluded person of the decision and specifies the reason(s) for the decision.

(f) *Administrative or judicial review.* A determination rendered under paragraph (e)(4) of this section is not subject to administrative or judicial review.

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

Subpart A [Reserved]

Subpart B—Medicare Supplemental Policies

SOURCE: 47 FR 32400, July 26, 1982, unless otherwise noted.

§ 403.200 Basis and scope.

(a) *Provisions of the legislation.* This subpart implements, in part, section

1882 of the Social Security Act. The intent of that section is to enable Medicare beneficiaries to identify Medicare supplemental policies that do not duplicate Medicare, and that provide adequate, fairly priced protection against expenses not covered by Medicare. The legislation establishes certain standards for Medicare supplemental policies and provides two methods for informing Medicare beneficiaries which policies meet those standards:

(1) Through a State approved program, that is, a program that a Supplemental Health Insurance Panel determines to meet certain minimum requirements for the regulation of Medicare supplemental policies; and

(2) In a State without an approved program, through certification by the Secretary of policies voluntarily submitted by insuring organizations for review against the standards.

(b) *Scope of subpart.* This subpart sets forth the standards and procedures CMS will use to implement the voluntary certification program.

GENERAL PROVISIONS

§ 403.201 State regulation of insurance policies.

(a) The provisions of this subpart do not affect the right of a State to regulate policies marketed in that State.

(b) Approval of a policy under the voluntary certification program, as provided for in § 403.235(b), does not authorize the insuring organization to market a policy that does not conform to applicable State laws and regulations.

§ 403.205 Medicare supplemental policy.

(a) Except as specified in paragraph (e) of this section, Medicare supplemental (or Medigap) policy means a health insurance policy or other health benefit plan that—

(1) A private entity offers to a Medicare beneficiary; and

(2) Is primarily designed, or is advertised, marketed, or otherwise purported to provide payment for expenses incurred for services and items that are not reimbursed under the Medicare