

(b) Notice of action on request for reinstatement. (1) If the State agency approves the request for reinstatement, it must give written notice to the excluded party, and to all others who were informed of the exclusion in accordance with §1002.212, specifying the date on which Medicaid program participation may resume.

(2) If the State agency does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with State procedures and need not be subject to administrative or judicial review, unless required by State law.

#### Subpart D—Notification to OIG of State or Local Convictions of Crimes Against Medicaid

##### § 1002.230 Notification of State or local convictions of crimes against Medicaid.

(a) The State agency must notify the OIG whenever a State or local court has convicted an individual who is receiving reimbursement under Medicaid of a criminal offense related to participation in the delivery of health care items or services under the Medicaid program, except where the State Medicaid Fraud Control Unit (MFCU) has so notified the OIG.

(b) If the State agency was involved in the investigation or prosecution of the case, it must send notice within 15 days after the conviction.

(c) If the State agency was not so involved, it must give notice within 15 days after it learns of the conviction.

#### PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

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SOURCE: 51 FR 34777, Sept. 30, 1986, unless otherwise noted.

##### § 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, 1128E, 1140, 1876(i)(6), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Public Law 99-660 (42 U.S.C. 1320a-7, 1320a-7a, 1320a-7e, 1320a-7(c), 1320b(10), 1395mm, 1395ss(d), 1396(m), 11131(c) and 11137(b)(2)).

(b) *Purpose.* This part—

(1) Provides for the imposition of civil money penalties and, as applicable, assessments against persons who—

(i) Have submitted certain prohibited claims under the Medicare, Medicaid, or the Maternal and Child Health Services or Social Services Block Grant programs;

(ii) Seek payment in violation of the terms of an assignment agreement or a limitation on charges or payments under the Medicare program, or a requirement not to charge in excess of the amount permitted under the Medicaid program;

(iii) Give false or misleading information that might affect the decision to discharge a Medicare patient from the hospital;

(iv)(A) Fail to report information concerning medical malpractice payments or who improperly disclose, use or permit access to information reported under part B of title IV of Public Law 99-660, and regulations specified in 45 CFR part 60, or

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(B) Are health plans and fail to report information concerning sanctions or other adverse actions imposed on providers as required to be reported to the Healthcare Integrity and Protection Data Bank (HIPDB) in accordance with section 1128E of the Act;

(v) Misuse certain Departmental and Medicare and Medicaid program words, letters, symbols or emblems;

(vi) Violate a requirement of section 1867 of the Act or §489.24 of this title;

(vii) Substantially fail to provide an enrollee with required medically necessary items and services, or who engage in certain marketing, enrollment, reporting, claims payment, employment or contracting abuses, or that do not meet the requirements for physician incentive plans for Medicare specified in §§417.479 (d) through (i) of this title;

(viii) Have submitted, or caused to be submitted, certain prohibited claims, including claims for services rendered by excluded individuals employed by or otherwise under contract with such person, under one or more Federal health care programs;

(ix) Present or cause to be presented a bill or claim for designated health service (as defined in §411.351 of this title) that they know, or should know, were furnished in accordance with a referral prohibited under §411.353 of this title;

(x) Have collected amounts that they know or should know were billed in violation of §411.353 of this title and have not refunded the amounts collected on a timely basis;

(xi) Are physicians or entities that enter into an arrangement or scheme that they know or should know has as a principal purpose the assuring of referrals by the physician to a particular entity which, if made directly, would violate the provisions of §411.353 of this title; or

(xii) Violate the Federal health care programs' anti-kickback statute as set forth in section 1128B of the Act.

[57 FR 3345, Jan. 29, 1992, as amended at 59 FR 32124, June 22, 1994; 59 FR 48566, Sept. 22, 1994; 60 FR 16583, Mar. 31, 1995; 60 FR 58241, Nov. 27, 1995; 61 FR 13449, Mar. 27, 1996; 64 FR 39428, July 22, 1999]

§ 1003.101 Definitions.

For purposes of this part:

*Act* means the Social Security Act.

*Adverse effect* means medical care has not been provided and the failure to provide such necessary medical care has presented an imminent danger to the health, safety, or well-being of the patient or has placed the patient unnecessarily in a high-risk situation.

*ALJ* means an Administrative Law Judge.

*Assessment* means the amount described in §1003.104, and includes the plural of that term.

*Claim* means an application for payment for an item or service for which payment may be made under the Medicare, Medicaid, Maternal and Child Health Services Block Grant, or Social Services Block Grant programs.

(a) An item or service for which payment may be made under Medicare, or

(b) An item or service for which medical assistance is provided under a State plan for medical assistance, or

(c) An item or service for which payment may be made under the Maternal and Child Health Services Block Grant program.

*Contracting organization* means a public or private entity, including of a health maintenance organization (HMO), competitive medical plan, or health insuring organization (HIO) which meets the requirements of section 1876(b) of the Act or is subject to the requirements in section 1903(m)(2)(A) of the Act and which has contracted with the Department or a State to furnish services to Medicare beneficiaries or Medicaid recipients.

*Department* means the Department of Health and Human Services.

*Enrollee* means an individual who is eligible for Medicare or Medicaid and who enters into an agreement to receive services from a contracting organization that contracts with the Department under title XVIII or title XIX of the Act.

*Exclusion* means the temporary or permanent barring of a person from participation in the Medicare program or in a State health care program, and that items or services furnished or ordered by such person are not reimbursed under such programs.