

§ 1003.104

the contracting organization by Medicare beneficiaries and Medicaid recipients whose medical condition or history indicates a need for substantial future medical services.

(4) If enrollees are charged more than the allowable premium, the OIG will impose an additional penalty equal to double the amount of excess premium charged by the contracting organization. The excess premium amount will be deducted from the penalty and returned to the enrollee.

(5) The OIG will impose an additional \$15,000 penalty for each individual not enrolled when HCFA determines that a contracting organization has committed a violation described in paragraph (f)(3)(ii) of this section.

(6) For purposes of paragraph (f) of this section, a violation is each incident where a person has committed an act listed in §417.500(a) or §434.67(a) of this title, or failed to comply with a requirement set forth in §434.80(c) of this title.

(g) The OIG may impose a penalty of not more than \$25,000 against a health plan for failing to report information on an adverse action required to be reported to the Healthcare Integrity and Protection Data Bank in accordance with section 1128E of the Act and §1003.102(b)(5)(ii).

(h) For each violation of §1003.102(b)(11), the OIG may impose—

(1) A penalty of not more than \$50,000, and

(2) An assessment of up to three times the total amount of remuneration offered, paid, solicited or received, as specified in §1003.104(b).

[57 FR 3346, Jan. 29, 1992, as amended at 59 FR 32125, June 22, 1994; 59 FR 48566, Sept. 22, 1994; 60 FR 16584, Mar. 31, 1995; 60 FR 58241, Nov. 27, 1995; 61 FR 13449, Mar. 27, 1996; 61 FR 52301, Oct. 7, 1996; 64 FR 39429, July 22, 1999]

§ 1003.104 Amount of assessment.

(a) The OIG may impose an assessment, where authorized, in accordance with §1003.102 (except for §1003.102(b)(11)), of not more than three times the amount claimed for each item or service which was a basis for the penalty. The assessment is in lieu of damages sustained by the Department or a State because of that claim.

42 CFR Ch. V (10–1–99 Edition)

(b) In accordance with §1003.102(b)(11), the OIG may impose an assessment of not more than three times the total amount of remuneration offered, paid, solicited or received, without regard to whether a portion of such remuneration was offered, paid, solicited or received for a lawful purpose.

[64 FR 39429, July 22, 1999]

§1003.105 Exclusion from participation in Medicare, Medicaid and other Federal health care programs.

(a)(1) Except as set forth in paragraph (b) of this section, in lieu of or in addition to any penalty or assessment, the OIG may exclude from participation in Medicare, Medicaid and other Federal health care programs the following persons for a period of time determined under §1003.107—

(i) Any person who is subject to a penalty or assessment under §1003.102 (a) or (b)(1) through (b)(4).

(ii) Any responsible physician who—

(A) Knowingly violates section 1867 of the Act or §489.24 of this title on or after December 22, 1987, but before July 1, 1990;

(B) Knowingly and willfully, or negligently, violates section 1867 of the Act or §489.24 of this title on or after July 1, 1990 but before May 1, 1991; or

(C) Commits a gross and flagrant, or repeated, violation of section 1867 of the Act or §489.24 of this title on or after May 1, 1991. For purposes of this section, a gross and flagrant violation is one that presents an imminent danger to the health, safety or well-being of the individual who seeks emergency examination and treatment or places that individual unnecessarily in a high-risk situation.

(2) Nothing in this section will be construed to limit the Department's authority to impose an exclusion without imposing a penalty.

(b)(1)(i) With respect to determinations under §1003.102(b)(2) or (b)(3), a physician may not be excluded if the OIG determines that he or she is the sole community physician or the sole source of essential specialized services in a community.

(ii) With respect to determinations under §1003.102(b)(5)(ii), no exclusion shall be imposed.

(2)(i) With respect to any exclusion based on liability for a penalty or assessment under §1003.102 (a), (b)(1), or (b)(4), the OIG will consider an application from a State agency for a waiver if the person is the sole community physician or the sole source of essential specialized services in a community. With respect to any exclusion imposed under §1003.105(a)(1)(ii), the OIG will consider an application from a State agency for a waiver if the physician's exclusion from the State health care program would deny beneficiaries access to medical care or would otherwise cause hardship to beneficiaries.

(ii) If a waiver is granted, it is applicable only to the State health care program for which the State requested the waiver.

(iii) If the OIG subsequently obtains information that the basis for a waiver no longer exists, or the State agency submits evidence that the basis for the waiver no longer exists, the waiver will cease and the person will be excluded from the State health care program for the remainder of the period that the person is excluded from Medicare.

(iv) The OIG notifies the State agency whether its request for a waiver has been granted or denied.

(v) The decision to deny a waiver is not subject to administrative or judicial review.

(3) For purposes of this section, the definitions contained in §1001.2 of this chapter for "sole community physician" and "sole source of essential specialized services in a community" apply.

(c) When the Inspector General proposes to exclude a nursing facility from the Medicare and Medicaid programs, he or she will, at the same time he or she notifies the respondent, notify the appropriate State licensing authority, the State Office of Aging, the long-term care ombudsman, and the State Medicaid agency of the Inspector General's intention to exclude the facility.

[59 FR 32125, June 22, 1994, as amended at 64 FR 39429, July 22, 1999]

§1003.106 Determinations regarding the amount of the penalty and assessment.

(a) *Amount of penalty.* (1) In determining the amount of any penalty or assessment in accordance with §1003.102 (a), (b)(1), (b)(4), (b)(9), and (b)(10), the Department will take into account—

(i) The nature of the claim, request for payment or information given, and the circumstances under which it was presented or given;

(ii) The degree of culpability of the contracting provider, or the person submitting the claim or request for payment, or giving the information;

(iii) The history of prior offenses of the contracting provider (or principals of the contracting provider), or the person submitting the claim or request for payment, or giving the information;

(iv) The financial condition of the person presenting the claim or request for payment, or giving the information;

(v) The completeness and timeliness of the refund with respect to §1003.102(b)(9);

(vi) The amount of financial interest involved with respect to §1003.102(b)(10);

(vii) Whether the contracting provider actually knew of the exclusion when employing or otherwise contracting with an excluded individual or entity in accordance with §1003.102(a)(2);

(viii) The harm to patients or any Federal or State health care program which resulted or could have resulted from the provision of care by a person or entity with which the contracting provider is expressly prohibited from contracting under section 1128A(a)(6) of the Act; and

(ix) Such other matters as justice may require.

(2) In determining the amount of any penalty in accordance with §§1003.102 (b)(5) and (b)(6), the Department will take into account—

(i) The nature and circumstances of the failure to properly report information, or the improper disclosure of information, as required;

(ii) The degree of culpability of the person in failing to provide timely and