

§ 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 (g) of this section, CMS or OIG may impose a penalty of not more than \$2,000 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)).

(b) *\$1,000.* CMS or OIG may impose a penalty of not more than \$1,000 for the following:

(1) Per certificate of medical necessity knowingly and willfully distributed to physicians on or after December 31, 1994 that—

- (i) Contains information concerning the medical condition of the patient; or
- (ii) Fails to include cost information.

(2) Per individual about whom information is requested, for willful or repeated failure of an employer to respond to an intermediary or carrier about coverage of an employee or spouse under the employer's group health plan (§ 402.1(c)(20)).

(c) *\$5,000.* CMS or OIG may impose a penalty of not more than \$5,000 for each violation resulting from the following:

(1) The failure of a Medicare supplemental policy issuer, on a replacement policy, to waive any time periods appli-

cable to pre-existing conditions, waiting periods, elimination periods, or probationary periods that were satisfied under a preceding policy (§ 402.1(c)(29)); and

(2) Any issuer of any Medicare supplemental policy denying a policy, conditioning the issuance or effectiveness of the policy, or discriminating in the pricing of the policy based on health status or other criteria as specified in section 1882(s)(2)(A). (§ 402.1(c)(29)).

(d) *\$10,000.* (1) CMS or OIG may impose a penalty of not more than \$10,000 for each day that reporting entity ownership arrangements is late (§ 402.1(c)(22)).

(2) CMS or OIG may impose a penalty of not more than \$10,000 for the following violations that occur on or after January 1, 1997:

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

(ii) 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)).

(iii) By any durable medical equipment supplier, knowingly and willfully, in violation of section 1834(a)(18)(A), failing 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)).

(iv) 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)).

(v) 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)).

(vi) 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