

(e) The procedures in part 1005 of this chapter will apply to the appeal.

[57 FR 3330, Jan. 29, 1992, as amended at 67 FR 11935, Mar. 18, 2002]

### Subpart F—Reinstatement into the Programs

#### § 1001.3001 Timing and method of request for reinstatement.

(a)(1) Except as provided in paragraphs (a)(2) and (a)(3) of this section or in § 1001.501(b)(4) of this part, an excluded individual or entity (other than those excluded in accordance with §§ 1001.1001 and 1001.1501) may submit a written request for reinstatement to the OIG only after the date specified in the notice of exclusion. Obtaining a program provider number or equivalent does not reinstate eligibility.

(2) An entity under § 1001.1001 may apply for reinstatement prior to the date specified in the notice of exclusion by submitting a written request for reinstatement that includes documentation demonstrating that the standards set forth in § 1001.3002(c) have been met.

(3) Upon receipt of a written request, the OIG will require the requestor to furnish specific information and authorization to obtain information from private health insurers, peer review bodies, probation officers, professional associates, investigative agencies and such others as may be necessary to determine whether reinstatement should be granted.

(4) Failure to furnish the required information or authorization will result in the continuation of the exclusion.

(b) If a period of exclusion is reduced on appeal (regardless of whether further appeal is pending), the individual or entity may request reinstatement once the reduced exclusion period expires.

[57 FR 3330, Jan. 29, 1992, as amended at 63 FR 46691, Sept. 2, 1998]

#### § 1001.3002 Basis for reinstatement.

(a)(1) The OIG will authorize reinstatement if it determines that—

(i) The period of exclusion has expired;

(ii) There are reasonable assurances that the types of actions that formed the basis for the original exclusion

have not recurred and will not recur; and

(iii) There is no additional basis under sections 1128(a) or (b) or 1128A of the Act for continuation of the exclusion.

(2) Submitting claims or causing claims to be submitted or payments to be made by the programs for items or services furnished, ordered or prescribed, including administrative and management services or salary, may serve as the basis for denying reinstatement. This section applies regardless of whether an individual or entity has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated.

(b) In making the reinstatement determination, the OIG will consider—

(1) Conduct of the individual or entity occurring prior to the date of the notice of exclusion, if not known to the OIG at the time of the exclusion;

(2) Conduct of the individual or entity after the date of the notice of exclusion;

(3) Whether all fines, and all debts due and owing (including overpayments) to any Federal, State or local government that relate to Medicare, Medicaid and all other Federal health care programs, have been paid or satisfactory arrangements have been made to fulfill obligations;

(4) Whether CMS has determined that the individual or entity complies with, or has made satisfactory arrangements to fulfill, all of the applicable conditions of participation or supplier conditions for coverage under the statutes and regulations; and

(5) [Reserved]

(6) Whether the individual or entity has, during the period of exclusion, submitted claims, or caused claims to be submitted or payment to be made by any Federal health care program, for items or services the excluded party furnished, ordered or prescribed, including health care administrative services.

(c) If the OIG determines that the criteria in paragraphs (a)(1)(ii) and (iii) of this section have been met, an entity excluded in accordance with