

§ 402.115

respondent has not requested a hearing before an ALJ.

(b) Immediately after the respondent abandons or waives his or her appeal right at any administrative level.

(c) Thirty days after the respondent receives the ALJ's decision imposing a civil money penalty or assessment under § 1005.20(d) of this title, if the respondent has not requested a review before the DAB.

(d) If the DAB grants an extension of the period for requesting the DAB's review, the day after the extension expires if the respondent has not requested the review.

(e) Immediately after the ALJ's decision denying a request for a stay of the effective date under § 1005.22(b) of this title.

(f) If the ALJ grants a stay under § 1005.22(b) of this title, immediately after the judicial ruling is completed.

(g) Sixty days after the respondent receives the DAB's decision imposing a civil money penalty if the respondent has not requested a stay of the decision under § 1005.22(b) of this title.

§ 402.115 Collection of penalty or assessment.

(a) Once a determination by HHS has become final, CMS is responsible for the collection of any penalty or assessment.

(b) The General Counsel may compromise a penalty or assessment imposed under this part, after consultation with CMS or OIG, and the Federal government may recover the penalty or assessment in a civil action brought in the United States district court for the district where the claim was presented or where the respondent resides.

(c) The United States or a State agency may deduct the amount of a penalty and assessment when finally determined, or the amount agreed upon in compromise, from any sum then or later owing to the respondent.

(d) Matters that were raised or that could have been raised in a hearing before an ALJ or in an appeal under section 1128A(e) of the Act may not be raised as a defense in a civil action by the United States to collect a penalty under this part.

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Subpart C—Exclusions

SOURCE: 72 FR 39752, July 20, 2007, unless otherwise noted.

§ 402.200 Basis and purpose.

(a) *Basis.* This subpart is based on the sections of the Act that are specified in § 402.1(e).

(b) *Purpose.* This subpart—

(1) Provides for the imposition of an exclusion from the Medicare and Medicaid programs (and, where applicable, other Federal health care programs) against persons that violate the provisions of the Act provided in § 402.1(e) (and further described in § 402.1(c)); and

(2) Sets forth the appeal rights of persons subject to exclusion and the procedures for reinstatement following exclusion.

§ 402.205 Length of exclusion.

The length of exclusion from participation in Medicare, Medicaid, and, where applicable, other Federal health care programs, is contingent upon the specific violation of the Medicare statute. A full description of the specific violations identified in the sections of the Act are cross-referenced in the regulatory sections listed in the table in paragraph (a) of this section.

(a) In no event will the period of exclusion exceed 5 years for violation of the following sections of the Act:

Social Security Act paragraph	Code of Federal Regulations section
1833(h)(5)(D) in repeated cases	§ 402.1(c)(1)
1833(q)(2)(B) in repeated cases	§ 402.1(c)(3)
1834(a)(11)(A)	§ 402.1(c)(4)
1834(a)(18)(B)	§ 402.1(c)(5)
1834(b)(5)(C)	§ 402.1(c)(6)
1834(c)(4)(C)	§ 402.1(c)(7)
1834(h)(3)	§ 402.1(c)(8)
1834(j)(4)	§ 402.1(c)(10)
1834(k)(6)	§ 402.1(c)(31)
1834(l)(6)	§ 402.1(c)(32)
1842(b)(18)(B)	§ 402.1(c)(11)
1842(k)	§ 402.1(c)(12)
1842(l)(3)	§ 402.1(c)(13)
1842(m)(3)	§ 402.1(c)(14)
1842(n)(3)	§ 402.1(c)(15)
1842(p)(3)(B) in repeated cases	§ 402.1(c)(16)
1848(g)(1)(B) in repeated cases	§ 402.1(c)(17)
1848(g)(3)(B)	§ 402.1(c)(18)
1848(g)(4)(B)(ii) in repeated cases	§ 402.1(c)(19)
1879(h)	§ 402.1(c)(23)

(b) For violation of the following sections, there is no maximum time limit for the period of exclusion.

Social Security Act paragraph	Code of Federal Regulations section
1834(a)(17)(c) for a pattern of contacts.	§ 402.1(e)(2)(i)
1834(h)(3) for a pattern of contacts	§ 402.1(e)(2)(ii)
1877(g)(5)	§ 402.1(c)(22)
1882(a)(2)	§ 402.1(c)(24)
1882(p)(8)	§ 402.1(c)(25)
1882(p)(9)(C)	§ 402.1(c)(26)
1882(q)(5)(C)	§ 402.1(c)(27)
1882(r)(6)(A)	§ 402.1(c)(28)
1882(s)(4)	§ 402.1(c)(29)
1882(t)(2)	§ 402.1(c)(30)

of this section, the initiating agency may consider any one or more of the circumstances listed in paragraphs (b)(1) and (b)(2) of this section, as applicable. The respondent, in his or her written response to the notice of intent to exclude (that is, the proposed exclusion), may provide information concerning potential mitigating circumstances.

(1) *Aggravating circumstances.* An aggravating circumstance may be any of the following:

(i) The services or incidents were of several types and occurred over an extended period of time.

(ii) There were numerous services or incidents, or the nature and circumstances indicate a pattern of claims or requests for payment or a pattern of incidents, or whether a specific segment of the population was targeted.

(iii) Whether the person was held liable for criminal, civil, or administrative sanctions in connection with a program covered by this part or any other public or private program of payment for health care items or services at any time before the incident or whether the person presented any claim or made any request for payment that included an item or service subject to a determination under § 402.1.

(iv) There is proof that the person engaged in wrongful conduct, other than the specific conduct upon which liability is based, relating to government programs and in connection with the delivery of a health care item or service. The statute of limitations governing civil money penalty proceedings at section 1128A(c)(1) of the Act does not apply to proof of other wrongful conducts as an aggravating circumstance.

(v) The wrongful conduct had an adverse impact on the financial integrity of the Medicare program or its beneficiaries.

(vi) The person was the subject of an adverse action by any other Federal, State, or local government agency or board, and the adverse action is based on the same set of circumstances that serves as a basis for the imposition of the exclusion.

(c) For a person excluded under any of the grounds specified in paragraph (a) of this section, notwithstanding any other requirements in this section, reinstatement occurs—

(1) At the expiration of the period of exclusion, if the exclusion was imposed for a period of 5 years; or

(2) At the expiration of 5 years from the effective date of the exclusion, if the exclusion was imposed for a period of less than 5 years and the initiating agency did not receive the appropriate written request for reinstatement as specified in § 402.300.

§ 402.208 Factors considered in determining whether to exclude, and the length of exclusion.

(a) *General factors.* In determining whether to exclude a person and the length of exclusion, the initiating agency considers the following:

(1) The nature of the claims and the circumstances under which they were presented.

(2) The degree of culpability, the history of prior offenses, and the financial condition of the person presenting the claims.

(3) The total number of acts in which the violation occurred.

(4) The dollar amount at issue (Medicare Trust Fund dollars or beneficiary out-of-pocket expenses).

(5) The prior history of the person insofar as its willingness or refusal to comply with requests to correct said violations.

(6) Any other facts bearing on the nature and seriousness of the person's misconduct.

(7) Any other matters that justice may require.

(b) *Criteria to be considered.* As a guideline for taking into account the general factors listed in paragraph (a)