

§ 1001.1501 Default of health education loan or scholarship obligations.

(a) *Circumstance for exclusion.* (1) Except as provided in paragraph (a)(4) of this section, the OIG may exclude any individual that the administrator of the health education loan, scholarship, or loan repayment program determines is in default on repayments of scholarship obligations or loans, or the obligations of any loan repayment program, in connection with health professions education made or secured in whole or in part by the Secretary.

(2) Before imposing an exclusion in accordance with paragraph (a)(1) of this section, the OIG must determine that the administrator of the health education loan, scholarship, or loan repayment program has taken all reasonable administrative steps to secure repayment of the loans or obligations. When an individual has been offered a Medicare offset arrangement as required by section 1892 of the Act, the OIG will find that all reasonable steps have been taken.

(3) The OIG will take into account access of beneficiaries to physicians' services for which payment may be made under Medicare, Medicaid or other Federal health care programs in determining whether to impose an exclusion.

(4) The OIG will not exclude a physician who is the sole community physician or the sole source of essential specialized services in a community if a State requests that the physician not be excluded.

(b) *Length of exclusion.* The individual will be excluded until the administrator of the health education loan, scholarship, or loan repayment program notifies the OIG that the default has been cured or that there is no longer an outstanding debt. Upon such notice, the OIG will inform the individual of his or her right to apply for reinstatement.

[57 FR 3330, Jan. 29, 1992, as amended at 64 FR 39427, July 22, 1999; 67 FR 11935, Mar. 18, 2002; 82 FR 4115, Jan. 12, 2017]

§ 1001.1551 Exclusion of individuals with ownership or control interest in sanctioned entities.

(a) *Circumstance for exclusion.* The OIG may exclude any individual who—

(1) Has a direct or indirect ownership or control interest in a sanctioned entity, and who knows or should know (as defined in section 1128A(i)(6) of the Act) of the action constituting the basis for the conviction or exclusion set forth in paragraph (b) of this section; or

(2) Is an officer or managing employee (as defined in section 1126(b) of the Act) of such an entity.

(b) For purposes of paragraph (a) of this section, the term “sanctioned entity” means an entity that—

(1) Has been convicted of any offense described in §§ 1001.101 through 1001.401 of this part; or

(2) Has been terminated or excluded from participation in Medicare, Medicaid and all other Federal health care programs.

(c) *Length of exclusion.* (1) If the entity has been excluded, the length of the individual's exclusion will be for the same period as that of the sanctioned entity.

(2) If the entity was not excluded, the length of the individual's exclusion will be determined by considering the factors that would have been considered if the entity had been excluded.

(3) An individual excluded under this section may apply for reinstatement in accordance with the procedures set forth in § 1001.3001.

[63 FR 46689, Sept. 2, 1998. Redesignated and amended at 82 FR 4115, Jan. 12, 2017]

§ 1001.1552 Making false statements or misrepresentation of material facts.

(a) *Circumstance for exclusion.* The OIG may exclude any individual or entity that it determines has knowingly made or caused to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including Medicare Advantage organizations under Part C of Medicare, prescription drug plan sponsors under Part D of Medicare, Medicaid managed care organizations, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.

(b) *Definition of “Material”*. For purposes of this section, the term “material” means having a natural tendency to influence or be capable of influencing the decision to approve or deny the request to participate or enroll as a provider of services or supplier under a Federal health care program.

(c) *Sources*. The OIG’s determination under paragraph (a) of this section will be made on the basis of information from the following sources:

- (1) CMS;
- (2) Medicaid State agencies;
- (3) Fiscal agents or contractors or private insurance companies;
- (4) Law enforcement agencies;
- (5) State or local licensing or certification authorities;
- (6) State or local professional societies; or
- (7) Any other sources deemed appropriate by the OIG.

(d) *Length of exclusion*. In determining the length of an exclusion imposed in accordance with this section, the OIG will consider the following factors:

- (1) The nature and circumstances surrounding the false statement;
- (2) Whether and to what extent payments were requested or received from the Federal health care program under the application, agreement, bid, or contract on which the false statement, omission, or misrepresentation was made; and
- (3) Whether the individual or entity has a documented history of criminal, civil, or administrative wrongdoing.

[82 FR 4115, Jan. 12, 2017]

§ 1001.1601 Violations of the limitations on physician charges.

(a) *Circumstance for exclusion*. (1) The OIG may exclude a physician whom it determines—

- (i) Is a non-participating physician under section 1842(j) of the Act;
- (ii) Furnished services to a beneficiary;
- (iii) Knowingly and willfully billed—
 - (A) On a repeated basis for such services actual charges in excess of the maximum allowable actual charge determined in accordance with section 1842(j)(1)(C) of the Act for the period January 1, 1987 through December 31, 1990, or

(B) Individuals enrolled under part B of title XVIII of the Act during the statutory freeze for actual charges in excess of such physician’s actual charges determined in accordance with section 1842(j)(1)(A) of the Act for the period July 1, 1984 to December 31, 1986; and”

(iv) Is not the sole community physician or sole source of essential specialized services in the community.

(2) The OIG will take into account access of beneficiaries to physicians’ services for which Medicare payment may be made in determining whether to impose an exclusion.

(b) *Length of exclusion*. (1) In determining the length of an exclusion in accordance with this section, the OIG will consider the following factors—

- (i) The number of services for which the physician billed in excess of the maximum allowable charges;
 - (ii) The number of beneficiaries for whom services were billed in excess of the maximum allowable charges;
 - (iii) The amount of the charges that were in excess of the maximum allowable charges; and
 - (iv) Whether the physician has a documented history of criminal, civil, or administrative wrongdoing (the lack of any prior record is to be considered neutral).
- (2) The period of exclusion may not exceed 5 years.

[57 FR 3329, Jan. 29, 1992; 57 FR 9669, Mar. 20, 1992, as amended at 63 FR 46689, Sept. 2, 1998; 82 FR 4116, Jan. 12, 2017]

§ 1001.1701 Billing for services of assistant at surgery during cataract operations.

(a) *Circumstance for exclusion*. The OIG may exclude a physician whom it determines—

- (1) Has knowingly and willfully presented or caused to be presented a claim, or billed an individual enrolled under Part B of the Medicare program (or his or her representative) for:
 - (i) Services of an assistant at surgery during a cataract operation, or
 - (ii) Charges that include a charge for an assistant at surgery during a cataract operation;
- (2) Has not obtained prior approval for the use of such assistant from the appropriate Utilization and Quality