

(2) The circumstances under which the failure occurred;

(3) The nature of the failure to comply;

(4) The impact of the exclusion on Medicare, Medicaid or any of the other Federal health care programs, beneficiaries or the public; and

(5) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral).

[57 FR 3330, Jan. 29, 1992, as amended at 63 FR 46689, Sept. 2, 1998; 64 FR 39427, July 22, 1999]

§ 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 Public Health Service (PHS) determines is in default on repayments of scholarship obligations or loans 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 PHS has taken all reasonable administrative steps to secure repayment of the loans or obligations. If PHS has 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 such time as PHS 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 indi-

vidual 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]

§ 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;

(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); and

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(v) The availability of alternative sources of the type of health care items or services furnished by the physician.

(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]

§ 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 Control Quality Improvement Organization (QIO) or Medicare carrier; and

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

(b) 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.

(c) 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 instances for which claims were submitted or beneficiaries were billed for unapproved use of assistants during cataract operations;

(ii) The amount of the claims or bills presented;

(iii) The circumstances under which the claims or bills were made, including whether the services were medically necessary;

(iv) Whether approval for the use of an assistant was requested from the QIO or carrier;

(v) Whether the physician has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral); and

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(vi) The availability of alternative sources of the type of health care items or services furnished by the physician.

(2) The period of exclusion may not exceed 5 years.

[57 FR 3330, Jan. 29, 1992, as amended at 63 FR 46690, Sept. 2, 1998]

APPENDIX A TO SUBPART C OF PART 1001

The following is a sample written disclosure for purposes of satisfying the requirements of § 1001.952(v)(3)(i)(B)(I)(i) of this part. This form is for illustrative purposes only; parties may, but are not required to, adapt this sample written disclosure form.

NOTICE OF AMBULANCE RESTOCKING PROGRAM

Hospital X offers the following ambulance restocking program:

1. We will restock all ambulance providers (other than ambulance providers that do not provide emergency services) that bring patients to Hospital X [or to a subpart of Hospital X, such as the emergency room] in the following category or categories: [insert description of category of ambulances to be restocked, i.e., all ambulance providers, all ambulance providers that do not charge patients or insurers for their services, or all nonprofit and Government ambulance providers]. [Optional: We only offer restocking of emergency transports.]

2. The restocking will include the following drugs and medical supplies, and linens, used for patient prior to delivery of the patient to Hospital X: [insert description of drugs and medical supplies, and linens to be restocked].

3. The ambulance providers [will/will not] be required to pay for the restocked drugs and medical supplies, and linens.

4. The restocked drugs and medical supplies, and linens, must be documented as follows: [insert description consistent with the documentation requirements described in § 1001.952(v). By way of example only, documentation may be by a patient care report filed with the receiving facility within 24 hours of delivery of the patient that records the name of the patient, the date of the transport, and the relevant drugs and medical supplies.]

5. This restocking program does not apply to the restocking of ambulances that only provide non-emergency services or to the general stocking of an ambulance provider's inventory.

6. To ensure that Hospital X does not bill any Federal health care program for restocked drugs or supplies for which a participating ambulance provider bills or is eligible to bill, all participating ambulance providers must notify Hospital X if they intend to submit claims for restocked drugs or supplies to any Federal health care program. Participating ambulance providers must agree to