42 USCS § 1320a-7a

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United States Code Service - Titles 1 through 51 > *TITLE 42. THE PUBLIC HEALTH AND WELFARE* > *CHAPTER 7. SOCIAL SECURITY ACT* > *TITLE XI. GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION* > *PART A. GENERAL PROVISIONS*

§ 1320a-7a. Civil monetary penalties

(a) Improperly filed claims. Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that--

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines--

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service--

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified,

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the Federal health care program (as defined in section 1128B(f) [*42 USCS § 1320a-7b(f)*]) under which the claim was made pursuant to Federal law. [, or]

(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

(2) knowingly presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii) [*42 USCS § 1395u(b)(3)(B)(ii)*], or (B) an agreement with a State agency (or other requirement of a State plan under title XIX [*42 USCS §§ 1396* et seq.]) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1)

[*42 USCS § 1395u(h)(1)*], or (D) an agreement pursuant to section 1866(a)(1)(G) [*42 USCS § 1395cc(a)(1)(G)*];

(3) knowingly gives or causes to be given to any person, with respect to coverage under title XVIII [*42 USCS §§ 1395* et seq.] of inpatient hospital services subject to the provisions of section 1886 [*42 USCS § 1395ww*], information that he knows or has reason to know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII [*42 USCS §§ 1395* et seq.] or a State health care program in accordance with this subsection or under section 1128 [*42 USCS § 1320a-7*] and who, at the time of a violation of this subsection--

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII [*42 USCS §§ 1395* et seq.] or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b) [*42 USCS § 1320a-5(b)*]) of such an entity;

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act [*42 USCS §§ 1395* et seq.], or under a State health care program (as defined in section 1128(h) [*42 USCS § 1320a-7(h)*]) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII [*42 USCS §§ 1395* et seq.], or a State health care program (as so defined);

(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f) [*42 USCS § 1320a-7b(f)*]), for the provision of items or services for which payment may be made under such a program;

(7) commits an act described in paragraph (1) or (2) of section 1128B(b) [*42 USCS § 1320a-7b(b)*];

(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; [or]

(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;

[(10)] (8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

[(11)] (9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to

participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII [*42 USCS §§ 1395w-21* et seq.], prescription drug plan sponsors under part D of title XVIII [*42 USCS §§ 1395w-101* et seq.], Medicaid managed care organizations under title XIX [*42 USCS §§ 1396* et seq.], and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

[(12)] (10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d) [*42 USCS § 1320a-7k(d)*]) and does not report and return the overpayment in accordance with such section;

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $ 10,000 for each item or service (or, in cases under paragraph (3), $ 15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), $ 10,000 for each day the prohibited relationship occurs; in cases under paragraph (7), $ 50,000 for each such act, in cases under paragraph (8), $ 50,000 for each false record or statement, or in cases under paragraph (9), $ 15,000 for each day of the failure described in such paragraph); or in cases under paragraph (9) [paragraph [(11)](9)], $ 50,000 for each false statement or misrepresentation of a material fact). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim (or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose; or in cases under paragraph (9) [paragraph [(11)](9)], an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact). In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1) [*42 USCS § 1320a-7b(f)(1)*]) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

(b) Payments to induce reduction or limitation of services.

(1) If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who--

(A) are entitled to benefits under part A or part B of title XVIII [*42 USCS §§ 1395c* et seq., *1395j* et seq] or to medical assistance under a State plan approved under title XIX [*42 USCS §§ 1396* et seq.], and

(B) are under the direct care of the physician, the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $ 2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph

[redacted]

(1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $ 2,000 for each individual described in such paragraph with respect to whom the payment is made.

(3) (A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of--

(i) $ 5,000, or

(ii) three times the amount of the payments under title XVIII [*42 USCS §§ 1395* et seq.] for home health services which are made pursuant to such certification.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII [*42 USCS §§ 1395* et seq.], that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) [*42 USCS § 1395f(a)(2)(C)* or *1395n(a)(2)(A)*] in the case of home health services furnished to the individual.

(c) Initiation of proceeding; authorization by Attorney General, notice, etc., estoppel, failure to comply with order or procedure.

(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by *Rule 4 of the Federal Rules of Civil Procedure.*

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which--

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include--

(A) in the case of refusal to provide or permit discovery, drawing negative factual

inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d) Amount or scope of penalty, assessment, or exclusion. In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b), the Secretary shall take into account--

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

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

(3) such other matters as justice may require.

(e) Review by courts of appeals. Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court [court] the record in the proceeding as provided in *section 2112 of title 28, United States Code*. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and

he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, expect that the same shall be subject to review by the Supreme Court of the United States, as provided in *section 1254 of title 28, United States Code*.

(f) Compromise of penalties and assessments; recovery; use of funds recovered. Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) (A) In the case of amounts recovered arising out of a claim under title XIX [*42 USCS §§ 1396* et seq.], there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V [*42 USCS §§ 701* et seq.], there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 [*42 USCS §§ 1395i*, *1395t*] shall be repaid to such trust funds.

(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f) [*42 USCS § 1320a-7b(f)*]), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) [*42 USCS § 1395i(k)(2)(C)*].

(4) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(g) Finality of determination respecting penalty, assessment, or exclusion. A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b) shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment assessed under this section.

(h) Notification of appropriate entities of finality of determination. Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b) becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h) [*42 USCS § 1320a-7(h)*]), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33) [*42 USCS §§ 1395aa(a)*, *1396a(a)(33)*]) that such a penalty or assessment has become final and the reasons therefor.

(i) Definitions. For the purposes of this section:

(1) The term ″State agency″ means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act [*42 USCS §§ 1396* et seq.] or designated to administer the State's program under title V or subtitle 1 of title XX of this Act [*42 USCS §§ 701* et seq. or *1397* et seq.].

(2) The term ″claim″ means an application for payments for items and services under a Federal health care program (as defined in section 1128B(f) [*42 USCS § 1320a-7b(f)*]).

(3) The term ″item or service″ includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term ″agency of the United States″ includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a Federal health care program (as so defined).

(5) The term ″beneficiary″ means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program (as so defined) but does not include a provider, supplier, or practitioner.

(6) The term ″remuneration″ includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term ″remuneration″ does not include--

(A) the waiver of coinsurance and deductible amounts by a person, if--

(i) the waiver is not offered as part of any advertisement or solicitation;

(ii) the person does not routinely waive coinsurance or deductible amounts; and

(iii) the person--

(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;

(B) subject to subsection (n), any permissible practice described in any subparagraph of section 1128B(b)(3) [*42 USCS § 1320a-7b(b)(3)*] or in regulations issued by the Secretary;

(C) differentials in coinsurance and deductible amounts as part of a benefit plan

design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996 [enacted Aug. 21, 1996];

(D) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated;

(E) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B); [or]

(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) [*42 USCS § 1320a-7b(f)*] and designated by the Secretary under regulations);

(G) the offer or transfer of items or services for free or less than fair market value by a person, if--

(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII [*42 USCS §§ 1395* et seq.] or a State health care program (as defined in section 1128(h) [*42 USCS § 1320a-7(h)*]);

(H) the offer or transfer of items or services for free or less than fair market value by a person, if--

(i) the items or services are not offered as part of any advertisement or solicitation;

(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII [*42 USCS §§ 1395* et seq.] or a State health care program (as so defined);

(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII [*42 USCS §§ 1395w-101* et seq.] or an MA organization offering an MA-PD plan under part C of such *title [42 USCS §§ 1395w-21* et seq.] of any copayment for the first fill of a covered part D drug (as defined in section 1860D-2(e) [*42 USCS § 1395w-102(e)*]) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.

(7) The term ″should know″ means that a person, with respect to information--

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(j) Subpoenas.

(1) The provisions of subsections (d) and (e) of section 205 [*42 USCS § 405(d)*, (e)] shall apply with respect to this section to the same extent as they are applicable with respect to title II [*42 USCS §§ 401* et seq.]. The Secretary may delegate the authority granted by section 205(d) [*42 USCS § 405(d)*] (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1128 [*42 USCS § 1320a-7*] to the Inspector General of the Department of Health and Human Services.

(k) Injunctions. Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) Liability of principal for acts of agent. A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

(m) Claims within jurisdiction of other departments or agencies.

(1) For purposes of this section, with respect to a Federal health care program not contained in this Act [*42 USCS §§ 301* et seq.], references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

(2) (A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or

agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.

(n) Safe harbor for payment of medigap premiums.

(1) Subparagraph (B) of subsection (i)(6) shall not apply to a practice described in paragraph (2) unless--

(A) the Secretary, through the Inspector General of the Department of Health and Human Services, promulgates a rule authorizing such a practice as an exception to remuneration; and

(B) the remuneration is offered or transferred by a person under such rule during the 2-year period beginning on the date the rule is first promulgated.

(2) A practice described in this paragraph [subsection] is a practice under which a health care provider or facility pays, in whole or in part, premiums for medicare supplemental policies for individuals entitled to benefits under part A of title XVIII [*42 USCS §§ 1395c* et seq.] pursuant to section 226A [*42 USCS § 426-1*].

History

(Aug. 14, 1935, ch 531, Title XI, Part A, § 1128A, as added Aug. 13, 1981,P.L. 97-35, Title XXI, Subtitle A, ch 2, § 2105(a), 95 Stat. 789; Sept. 3, 1982, P.L. 97-248, Title I, Subtitle B, § 137(b)(26), 96 Stat. 380; July 18, 1984, P.L. 98-369, Division B, Title III, Subtitle A, Part I, § 2306(f)(1), Part II, § 2354(a)(3), 98 Stat. 1073, 1100; Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle D, Part 2, §§ 9313(c)(1), 9317(a),(b), 100 Stat. 2003, 2008; Aug. 18, 1987, P.L. 100-93, § 3, 101 Stat. 686; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 2, Subpart C, § 4039(h)(1), Subtitle B, Part 2, § 4118(e)(1)(A), (B), (6)-(10), 101 Stat. 1330-81, 155; July 1, 1988, *P.L. 100-360, Title II, Subtitle A, § 202(c)(2), Title IV, Subtitle B, § 411(e) (3), (k)(10)(B)(I), (III), (D), 102 Stat. 715, 775, 795; Oct. 13, 1988, P.L. 100-485, Title VI, § 608(d)(26)(H)-(K), 102 Stat. 2422; Dec. 13, 1989, P.L. 101-234, Title II, § 201(a)(1), 103 Stat. 1981; Dec. 19, 1989, P.L. 101-239, Title VI, Subtitle A, Part 1, Subpart A, § 6003(g)(3)(D)(i), 103 Stat. 2153; Nov. 5, 1990, P.L. 101-508, Title IV, Subtitle A, Part 3, §§ 4204(a)(3), 4207(h), Subtitle B, Part 4, Subpart C, § 4731(b)(1), Subpart E, § 4753, 104 Stat. 1388-109, 1388-123, 1388-195, 1388-208; Oct. 31, 1994, P.L. 103-432, Title I, Subtitle C, § 160(d)(4), 108 Stat. 4444; Aug. 21, 1996, P.L. 104-191, Title II, Subtitle D, §§ 231(a)-(e), (h), 232(a), 110 Stat. 2012, 2014, 2015; Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle C, § 4201(c)(1), Subtitle D, § 4304(a), (b), Ch 3, § 4331(e), Subtitle F, Ch 2, § 4523(c), 111 Stat. 373, 383, 396, 449; Oct. 21, 1998, P.L. 105-277, Div J, Title V, Subtitle B, § 5201(a), (b)(1), 112 Stat. 2681-916.)*

(As amended March 23, 2010,P.L. 111-148, Title VI, Subtitle E, §§ 6402(d)(2), 6408(a), Subtitle H, § 6703(d)(3)(B), 124 Stat. 757, 770, 804.)

Annotations

Notes

References in text:

"Section 1833(t)(5)(B)", referred to in subsec. (i)(6)[(E)](D), is § 1833(t)(5)(B) of Act Aug. 14, 1935, ch 531, which was redesignated § 1833(t)(8)(B) of such Act by Act Nov. 29, 1999, *P.L. 106-113*, Div B, § 1000(a)(6) [Title II, §§ 201(a)(1), 202(a)(2)], 113 Stat. 1536, 1501A-336, 1501A-342, and appears as *42 USCS § 1395l(t)(8)(B)*.

The ″Health Insurance Portability and Accountability Act of 1996″, referred to in this section, is Act Aug. 21, 1996, P.L. 104-191, 110 Stat. 1936. For full classification of such Act, consult USCS Tables volumes.

Explanatory notes:

At the end of subsec. (a)(1)(D), ″, or″ has been inserted in brackets to indicate the probable intent of Congress so substitute such matter for the concluding period.

The word ″or″ has been enclosed in brackets in subsec. (a)(8) to indicate the probable intent of Congress to delete it.

The bracketed paragraph designators ″(10)″, ″(11)″, and ″(12)″ have been inserted in para. (a) in order to maintain numerical continuity.

In the concluding matter of subsec. (a), the bracketed words ″paragraph [(11)](9)″ have been inserted in brackets to indicate to which of the two paras. (9) Congress probably intended to refer.

The bracketed word ″court″ has been inserted in subsec. (e) to indicate the capitalization probably intended by Congress.

The word ″or″ has been enclosed in brackets in subsec. (i)(6)(E) to indicate the probable intent of Congress to delete it.

The bracketed word ″subsection″ has been inserted in subsec. (n)(2) to indicate the word probably intended by Congress.

Amendments:

1982 . Act Sept. 3, 1982 (effective as provided by § 137(d)(2) of such Act, which appears as *42 USCS § 1396a note), in subsec. (a), substituted the introductory matter and paras. (1) and (2) for matter which which read:*

″(a) Any person (including an organization, agency, or other entity) that presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines--

″(1) is for a medical or other item or service--

″(A) that the person knows or has reason to know was not provided as claimed, or

″(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), 1862(d), or 1866(b)(2), or

″(2) is submitted in violation of an agreement between the person and the United States or a State agency,″.

1984 . Act July 18, 1984 (effective 7/18/84, as provided in § 2354(e), which appears as *42 USCS § 1320a-1 note), in subsec. (a)(2), inserted ″, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1)″; and, in subsec. (g), substituted ″utilization and*

quality control peer review organization″ for ″Professional Standards Review Organization″.

1986 . Act Oct. 21, 1986, (effective as provided by § 9313(c)(2) of such Act, which appears as a note to this section), in subsec. (a)(1), substituted ″(i)″ for ″(h)″ wherever appearing; redesignated subsecs. (b) through (h) as (c) through (i) respectively; added a new subsec. (b); in subsecs. (c) and (d) as redesignated inserted ″or (b)″ wherever appearing; in subsec. (g) as redesignated inserted ″or (b)″ and substituted ″(e)″ for ″(d)″ wherever appearing; and, in subsec. (h) as redesignated inserted ″or (b)″.

Such Act further (effective as provided by § 9317(d) of such Act, which appears as a note to this section), in subsec. (c) as redesignated, added paras. (3) and (4).

1987 . Act Aug. 18, 1987 (effective as provided by § 15 of such Act, which appears as *42 USCS § 1320a-7 note), in subsec. (a), in para. (1), substituted ″the Secretary determines--″ and subparas. (A)-(D) for ″the Secretary determines is for a medical or other item or service--*

″(A) that the person knows or has reason to know was not provided as claimed, or

″(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or″.

Such Act further, in subsec. (a), in para. (2), in cl. (B), inserted ″(or other requirement of a State plan under title XIX)″, and inserted ″or (D) an agreement pursuant to section 1866(a)(1)(G), or″, added para. (3), in the concluding matter of subsec. (a), inserted ″(or, in cases under paragraph (3), $ 15,000 for each individual with respect to whom false or misleading information was given)″, and added the sentence beginning ″In addition the Secretary . . .″; in subsec. (c)(1), substituted ″penalty, assessment, or exclusion″ for ″penalty or assessment″ and added the two sentences beginning ″The Secretary may not initiate an action . . .″ and ″The Secretary may initiate an action . . .″; in subsec. (d), in the introductory matter, substituted ″penalty, assessment, or exclusion″ for ″penalty or assessment″; in subsec. (f)(1)(A), substituted ″bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid″ for ″equal to the State's share of the amount paid by the State agency″; in subsec. (g), substituted ″penalty, assessment, or exclusion″ for ″penalty or assessment″; in subsec. (h), substituted ″penalty, assessment, or exclusion″ for ″penalty or assessment″ and inserted ″the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),″; and added subsec. (k).

Such Act further (effective on enactment as provided by § 15(c)(2) of such Act, which appears as *42 USCS § 1320a-7* note) added subsec. (j).

Act Dec. 22, 1987 (applicable to activities occurring before, on, or after 12/22/87 as provided by § 4118(e)(14) of such Act, which appears as a note to this section), in subsec. (a)(1), in subparas. (A)-(C), substituted ″or should know″ for ″or has reason to know″ wherever appearing.

Section 4039(h)(1) of such Act, as added by Act July 1, 1988 (effective as if included in Act Dec. 22, 1987, P.L. 100-203 as provided by § 411(a)(2) of Act July 1, 1988, which appears as *1 USCS § 106* note), in subsec. (b), in para. (1)(A), substituted ″XVIII″ for ″XVII″, and in para. (2), inserted ″each″.

Section 4118(e)(1)(B), (6), (7) of such Act, as added Act July 1, 1988 (effective as if included

in Act Dec. 22, 1987, P.L. 100-203, as provided by § 411(a)(2) of Act July 1, 1988, which appears as *1 USCS § 106* note), in subsec. (a), in the introductory matter, inserted ″, but excluding a beneficiary, as defined in subsection (i)(5)″, in para. (1)(D), substituted ″from the program″ for ″under the program″, and inserted ″or as a result of the application of the provisions of section 1842(j)(2) or section 1867(d)(2)″; in subsec. (c)(1), inserted ″, request for payment, or other occurrence described in this section″ and ″, the request for payment was made, or the occurrence took place″; in subsec. (i), in the introductory matter, substituted ″section″ for ″subsection″, in para. (1), inserted ″or title XX″, and substituted para. (2) for one which read:

″(2) The term 'claim' means an application submitted by--

″(A) a provider or services or other person, agency, or organization that furnishes an item or service under title XVIII of this Act, or

″(B) a person, agency, or organization that furnishes an item or service for which medical assistance is provided under title XIX of this Act, or

″(C) a person, agency, or organization that provides an item or service for which payment is made under title V of this Act or from an allotment to a State under such title, to the United States or a State agency, or agent thereof, for payment for health care services under title XVIII or XIX of this Act or for any item or service under title V of this Act.″.

Such Act further, in subsec. (i), added para. (5); and added subsec. (l).

1988 . Act July 1, 1988 (applicable as provided by § 202(m) of such Act, which appears as *42 USCS § 1395u* note), *in subsec. (a), in para. (1)(D), deleted ″or″ following the concluding semicolon, in para. (2), in subpara. (C), inserted ″or to be a participating pharmacy under section 1842(o)″, and in subpara. (D), substituted a semicolon for ″, or″, in para. (3), inserted ″or″ following the concluding semicolon, and added para. (4).*

Such Act further, as amended by Act Oct. 13, 1988 (effective as if included in Act July 1, 1988, as provided by § 608(g) of the later 1988 Act, which appears as 42 USCS § 704 note), in subsec. (a)(1)(D), deleted ″or section 1867(d)(2)″ preceding the semicolon.

Act Oct. 13, 1988 (effective as provided by § 608(g) of such Act, which appears as 42 USCS § 704 note), in subsec. (l), inserted ″for penalties, assessments, and an exclusion″.

Such Act further (effective as if included in Act July 1, 1988, as provided by § 608(g) of the later 1988 Act, which appears as 42 USCS § 704 note) amended the directory language of Act July 1, 1988, P.L. 100-360, without affecting the text of this section.

1989 . Act Dec. 13, 1989 (effective 1/1/90 as provided by § 201(c) of such Act, which appears as a note to this section), pursuant to the repeal of §§ 201-208 of Act July 1, 1988, *P.L. 100-360, in subsec. (a), in para. (1)(D), inserted ″or″ following the concluding semicolon, in para. (2), in subpara. (C), deleted ″or to be a participating pharmacy under section 1842(o)″ preceding ″, or″, in subpara. (D), substituted ″, or″ for the concluding semicolon, in para. (3), deleted ″or″ following the semicolon, and deleted para. (4) which read:*

″(4) in the case of a participating or nonparticipating pharmacy (as defined for purposes of part B of title XVIII)--

″(A) presents or causes to be presented to any person a request for payment for covered outpatient drugs dispensed to an individual entitled to benefits under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary in regulations), or

″(B) fails to provide the information requested by the Secretary in a survey under section 1834(c)(3)(C)(ii);″.

Act Dec. 19, 1989, in subsec. (b)(1), in the introductory matter, and in subpara. (C), substituted ″hospital or a rural primary care hospital″ for ″hospital″.

1990 . Act Nov. 5, 1990 (effective on enactment as provided by § 4204(a)(4) of such Act, which appears as *42 USCS § 1395mm note), in subsec. (b)(1), in the introductory matter, deleted ″, an eligible organization with a risk-sharing contract under section 1876,″ following ″primary care hospital″, in subpara. (A), added ″and″ following the concluding comma, deleted subpara. (B) which read: ″in the case of an eligible organization or an entity, are enrolled with the organization or entity, and″, redesignated subpara. (C) as subpara. (B), and in such subparagraph, deleted ″or organization″ following ″primary care hospital″.*

Section 4207(h) of Act Nov. 5, 1990; as amended by Act Oct. 31, 1994, in subsec. (j), designated the existing provisions as para. (1), and added para. (2).

Section 4731(b)(1) of such Act further (effective on enactment as provided by § 4731(c) of such Act, which appears as *42 USCS § 1396b* note), in subsec. (b)(1), deleted ″or an entity with a contract under section 1903(m)″ preceding ″knowingly makes″.

Section 4753 of such Act made the same amendments to subsec. (j) as were made by § 4207, set forth above.

1994 . Act Oct. 31, 1994, amended the directory language of Act Nov. 5, 1990, *P.L. 101-508, without affecting the text of this section.*

1996 . Act Aug. 21, 1996 (applicable to certfications made on or after enactment, as provided by § 232(b) of such Act, which appears as a note to this section), in subsec. (b), added para. (3).

Such Act further (applicable to acts or omissions occurring on or after 1/1/97, as provided by § 231(i) of such Act, which appears as a note to this section), in subsec. (a), in para. (1), in the introductory matter, inserted ″knowingly″, in subpara. (A), substituted ″claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,″ for ″claimed,″ in subpara. (C)(iii), deleted ″or″ after the concluding comma, and, in subpara. (D), deleted ″or″ after the concluding semicolon and deleted the semicolon and inserted ″, or″, and added subpara. (E), in para. (2), inserted ″knowingly″ and substituted a semicolon for ″, or″, in para. (3), substituted ″knowingly gives or causes to be given″ for ″gives″, substituted ″; or″ for a concluding semicolon, and deleted ″or″ after the concluding semicolon, added para. (4) and, in subpara. (B) of such paragraph, substituted ″; or″ for a concluding semicolon, and added para. (5), and, in the concluding matter, substituted ″$ 10,000″ for ″$ 2,000″, inserted ″; in cases under paragraph (4), $ 10,000 for each day the prohibited relationship occurs″, substituted ″3 times the amount″ for ″twice the amount″, and substituted ″Federal health care programs (as defined in section 1128B(f)(1))″ for ″programs under title XVIII″; in subsec. (f), redesignated para. (3) as para. (4), and added new para. (3); in subsec. (i), in para. (2), substituted ″a Federal health care program (as defined in section 1128B(f))″ for ″title V, XVIII, XIX, or XX of this Act″, in para. (4), substituted ″a Federal health care program (as so defined)″ for ″a health insurance or medical services program under title XVIII or XIX of this Act″, in para. (5), substituted ″a Federal health care program (as so defined)″ for ″title V, XVIII, XIX, or XX″, and added paras. (6) and (7); and added subsec. (m).

1997 . Act Aug. 5, 1997 (applicable to services furnished on or after 10/1/97, as provided by §

4201(d) of such Act, which appears as *42 USCS § 1395f note), in subsec. (b)(1), in the introductory matter and in subpara. (B) substituted "critical access" for "rural primary care".*

Such Act further (applicable to arrangements and contracts entered into after enactment, as provided by § 4304(c)(1) of such Act, which appears as a note to this section), in subsec. (a), in para. (4), deleted "or" after the concluding semicolon, in para. (5), added "or" after the concluding semicolon, and added para. (6).

Such Act further (applicable to acts committed after enactment, as provided by § 4304(c)(2) of such Act, which appears as a note to this section), in subsec. (a), in para. (5), deleted "or" after the concluding semicolon, in para. (6), added "or" after the concluding semicolon, added para. (7) and, in the concluding matter, substituted "occurs; or in cases under paragraph (7), $ 50,000 for each such act)" for "occurs)", and inserted "(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)".

Such Act further (effective as if included in the enactment of Act Aug. 21, 1996, *P.L. 104-191*, as provided by § 4331(f)(1) of the 1997 Act, which appears as *42 USCS § 1320a-7e* note), in subsec. (i)(6), in subpara. (A)(iii), in subcl. (I), inserted "or" following the concluding semicolon, in subcl. (II), deleted "or" following the concluding semicolon, and, deleted subcl. (III) which read: "(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;", redesignated subparas. (B) and (C) as subparas. (C) and (D), respectively, and added a new subpara. (B).

Such Act further purported to amend subsec. (i)(6) by deleting "or" at the end of subpara (B) and substituting "; or" for a period at the end of subpara. (C); however, because of a prior amendment, these amendments could not be executed.

Such Act further, in subsec. (i)(6), added subpara. [(E)](D).

1998 . Act Oct. 21, 1998 (effective on enactment as provided by § 5201(d) of Division J of such Act, which appears as a note to this section), in subsec. (i)(6), substituted subpara. (B) for one which read: "(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;"; and added subsec. (n).

2010 . Act March 23, 2010, in subsec. (a), in para. (1)(D), substituted "was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law." for "was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or", in para. (6), deleted "or" following the concluding semicolon, added paras. (8)-(10), and in the concluding matter, deleted "or" after "prohibited relationship occurs;", and inserted "; or in cases under paragraph (9), $ 50,000 for each false statement or misrepresentation of a material fact" and "; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact"; and in subsec. (i), in para. (1), inserted "subtitle 1 of", and in para. (6), in subpara. (C), deleted "or" following the concluding semicolon, in subpara. (D), substituted the concluding semicolon for a period, redesignated subpara.

[(E)](D) as subpara. (E), and in such subparagraph as redesignated, substituted ″; or″ for a concluding period, and added subparas. (F)-(I).

Such Act further (applicable to acts committed on or after 1/1/2010, as provided by § 6408(d) of such Act, which appears as *42 USCS § 1320a-7 note), in subsec. (a), added paras. (8) and (9).*

Such Act further (applicable as above), purported to amend subsec. (a) by deleting ″or″ at the end of para. (6) and by deleting ″or″ before ″in cases under paragraph (7)″; however, because of previous amendments, these amendments could not be executed. The Act also directed that the concluding matter of subsec. (a) be amended by substituting ″act, in cases under paragraph (8), $ 50,000 for each false record or statement, or in cases under paragraph (9), $ 15,000 for each day of the failure described in such paragraph)″ for ″act)″; however, because of previous amendments, such substitution has been made for ″act″ in order to effectuate the probable intent of Congress.

Other provisions:

Effective date and application of amendments made by § 9313(c)(1) of Act Oct. 21, 1986. Act Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle D, Part 2, § 9313(c)(2), 100 Stat. 2003; Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle A, Part 2, Subpt. A, § 4016, 101 Stat. 1330-64; Dec. 19, 1989, *P.L. 101-239*, Title VI, Subtitle A, Part 3, Subpart A, § 6207(a), 103 Stat. 2245, provides:

″The amendments made by paragraph (1) [amending this section] shall apply to--

″(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act [enacted Oct. 21, 1986], and

″(B) payments by eligible organizations or entities occurring on or after April 1, 1991.″.

Study. Act Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle D, Part 2, § 9313(c)(3), 100 Stat. 2003, provides:

″The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall--

″(A) review the type of incentive arrangements in common use,

″(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

″(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act [subsec. (b) of this section], for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.″.

Effective date and application of amendments made by § 9317 of Act Oct. 21, 1986. Act Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle D, Part 2, § 9317(d)(1), (2), 100 Stat. 2009, provides:

″(1) The amendment made by subsection (a) [adding subsec. (c)(3)] shall take effect on the date of the enactment of this Act, without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of nolo contendere tendered after the date of the

enactment of this Act.

″(2) The amendment made by subsection (b) [adding subsec. (c)(4)] shall apply to failures or misconduct occurring on or after the date of the enactment of this Act.″.

Application of amendments made to subsec. (a)(1). Act Dec. 22, 1987, P.L. 100-203, Title IV, Subtitle B, Part 2, § 4118(e)(14), 101 Stat. 1330-155, as amended July 1, 1988, *P.L. 100-360*, Title IV, Subtitle B, § 411(k)(10)(B)(i), 102 Stat. 794, effective as if included in Act Dec. 22, 1987 amendment, as provided by § 411(a)(2) of the 1988 Act which appears as *1 USCS § 106* note, provides: ″The amendments made by paragraph (1) [amending subsec. (a)(1) of this section] shall apply to activities occurring before, on, or after the date of the enactment of this Act.″.

Repeal of expansion of Medicare Part B benefits. Act Dec. 13, 1989 (the Medicare Catastrophic Coverage Repeal Act of 1989), *P.L. 101-234*, Title II, § 201(a), 103 Stat. 1981, effective Jan. 1, 1990, as provided by § 201(c) of such Act, which appears as a note to this section, provides:

″(1) General rule. Except as provided in paragraph (2), sections 201 through 208 of MCCA [*P.L. 100-360* (the Medicare Catastrophic Coverage Act of 1988); for full classification, consult USCS Tables volumes] are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

″(2) Exception. Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA [adding *42 USCS § 1395u(p)* and *42 USCS § 1395u* note].″.

Repeal of § 205(f) of Act July 1, 1988 (the Medicare Catastrophic Coverage Act of 1988). Act July 1, 1988, *P.L. 101-360*, Title II, Subtitle A, § 205(g), 102 Stat. 731, was repealed by Act Dec. 13, 1989, *P.L. 101-234*, Title II, § 201(a)(1), 103 Stat. 1981, effective Jan. 1, 1990, as provided by § 201(c) of such Act, which appears as a note to this section. Such provisions related to the study of alternative out-of-home services.

Effective date of the repeal of §§ 201-208 of Act July 1, 1988. Act Dec. 13, 1989, *P.L. 101-234*, Title II, § 201(c), 103 Stat. 1981, provides: ″The provisions of this section [for full classification, consult USCS Tables volumes] shall take effect January 1, 1990.″.

Application of amendments made by § 231 of Act Aug. 21, 1996. Act Aug. 21, 1996, *P.L. 104-191*, Title II, Subtitle D, § 231(i), *110 Stat. 2105*, provides: ″The amendments made by this section [*42 USCS §§ 1320a-7a*, *1320c-5(b)(3)*, and *1395mm(i)(6)*] shall apply to acts or omissions occurring on or after January 1, 1997.″.

Application of subsec. (b)(3). Act Aug. 21, 1996, *P.L. 104-191*, Title II, Subtitle D, § 232(b), 110 Stat. 2015, provides: ″The amendment made by subsection (a) [adding subsec. (b)(3) of this section] shall apply to certifications made on or after the date of the enactment of this Act.″.

Application of amendments made by § 4304(a), (b) of Act Aug. 5, 1997. Act Aug. 5, 1997, *P.L. 105-33*, Title IV, Subtitle D, Ch 1, § 4304(c), 111 Stat. 384, provides:

″(1) Contracts with excluded persons. The amendments made by subsection (a) [adding subsec. (a)(6) of this section] shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

″(2) Kickbacks. The amendments made by subsection (b) [adding para. (7) and amending the concluding matter of subsec. (a) of this section] shall apply to acts committed after the date of the enactment of this Act.″.

Repeal of provisions relating to GAO study and report on impact of safe harbor on medigap policies. Act Oct. 21, 1998, *P.L. 105-277*, Div J, Title V, Subtitle B, § 5201(b)(2), *112 Stat. 2681*-917, which formerly appeared as a note to this section, was repealed by Act March 11,

2009, P.L. 111-8, Div G, Title I, § 1301(c), 123 Stat. 829. Such note provided for a GAO study and report on the impact of safe harbor on medigap policies.

Effective date of Oct. 21, 1998 amendments. Act Oct. 21, 1998, P.L. 105-277, Div J, Title V, Subtitle B, § 5201(d), 112 Stat. 2681-917, provides: "The amendments made by this section [amending 42 USCS §§ 1320a-7a and 1320a-7d(b)(2)(A)] shall take effect on the date of the enactment of this Act.".

Oct. 21, 1998 amendments; interim final rulemaking authority. Act Oct. 21, 1998, P.L. 105-277, Div J, Title V, Subtitle B, § 5201(e), 112 Stat. 2681-917, provides: "The Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, in order to implement the amendments made by this section [amending 42 USCS §§ 1320a-7a and 1320a-7d(b)(2)(A)] in a timely manner.".

Case Notes

1. Constitutional issues

Civil Monetary Penalties and Assessment Act is constitutional on its face and as applied to chiropractor who engaged in fraudulent scheme to disguise nonreimbursable chiropractic services as services rendered by physician; penalty was civil in nature, and judgment of 70 times amount actually collected from Medicare program was justified by aggravating circumstances of case. *Mayers v U.S. Dep't of Health & Human Services (1986, CA11) 806 F2d 995,* reh den, en banc (1987, CA11) 813 F2d 411 and cert den *(1987) 484 US 822, 98 L Ed 2d 44, 108 S Ct 82.*

Retroactive application of 6-year statute of limitations found in 1987 amendment to *42 USCS § 1320*-7a is not unconstitutional where it is applied to suit commenced after effective date of amendment. *Bernstein v Sullivan (1990, CA10) 914 F2d 1395.*

Psychiatrist's action seeking interim injunctive relief to stay suspension under *42 USCS § 1320a-7(a)* for "conviction" of Medicare- or Medicaid-related crimes is dismissed, despite psychiatrist's claim that municipal court's dismissal pursuant to "disposition agreement" of criminal complaint concerning psychiatrist's submission of false Medicaid claim did not constitute "conviction," where psychiatrist's due process claims do not overcome need for psychiatrist to exhaust administrative remedies through Department of Health and Human Services. *Doe v Bowen (1987, DC Mass) 682 F Supp 637.*

2. Application

42 USCS § 1320a-7a could not be applied retroactively to pharmacist convicted of submitting, before act's effective date, false Medicaid claims. *Griffon v United States Dep't of Health & Human Services (1986, CA5) 802 F2d 146.*

Civil Monetary Penalties Law proceedings are civil, not quasi-criminal. *Scott v Bowen (1988, CA9) 845 F2d 856.*

Pharmacist properly suffered mandatory 5-year exclusion from participation in Medicare and similar programs, where pharmacist pleaded guilty to one count of falsely billing state for brand-name prescription when he had actually dispensed generic drug of lesser value, because pharmacist's crime was clearly program-related fraud triggering mandatory exclusion. *Greene v Sullivan (1990, ED Tenn) 731 F Supp 835,* dismd (1990, ED Tenn) *731 F Supp 838.*

Pharmacist's 5-year exclusion from participation in Medicare and similar programs does not constitute second punishment, even though state court already sentenced pharmacist to 2 years' probation, community service, and restitution and fines plus court costs for falsely billing generic prescription at brand-name price, because sanction seeks no monetary recovery from pharmacist. *Greene v Sullivan (1990, ED Tenn) 731 F Supp 838.*

Pharmacist did not meet *Fed. R. Civ. P. 9(b)* specificity requirements with regard to allegations against pharmacy operators concerning several fraud categories, including cash and gift kickbacks to physicians, prescription recycling, and falsified customer copay records being issued to customers; as result, even though pharmacy operators could be subject to criminal penalties under *42 USCS § 1320a-7b* or civil monetary penalties under *42 USCS § 1320a-7a* if claims were proven, pharmacist did not plead fraud with particularity as required by *Fed. R. Civ. P. 9(b)* and dismissal of pharmacists claims under False Claims Act, *31 USCS §§ 3729* et seq., was mandated although pharmacist would be given chance to replead. *United States ex rel. Grenadyor v Ukranian Vill. Pharm., Inc. (2012, ND Ill) 895 F Supp 2d 872.*

Six-year statute of limitations and notice requirements provided in Civil Monetary Penalties Law (*42 USCS § 1320a-7a*) do not apply to exclusions imposed under *42 USCS § 1320a-7(a)(1)*. Ramon Antonio Pichardo M.D. (Dept. of Health and Human Services, Departmental Appeals Board, Feb. 10, 2011) 2011 HHSDAB LEXIS 6.

3. Monetary penalties

Under Civil Monetary Penalties Law, it was appropriate to measure penalty by twice amount falsely claimed, even though actual losses were substantially less and were recouped. *Chapman v United States, Dep't of Health & Human Services (1987, CA10) 821 F2d 523.*

Substantial evidence supported assessment of civil monetary penalties against former owner and former finance director of home health agency pursuant to *42 USCS § 1320a-7a(a)(1)(B)* and exclusion of owner and director from participation in federal health care programs under *42 USCS § 1320a-7(b)(7)* based on inclusion in Medicare and Medicaid cost reports of costs that were not related to patient care; costs included fees related to owner's divorce, costs for personal use of luxury vehicles, and club membership dues, and it was unnecessary for claims to have been concealed in order for them to have been false or fraudulent. *Horras v Leavitt (2007, CA8) 495 F3d 894.*

Substantial evidence did not support imposition of civil monetary penalty against skilled nursing facility for immediate jeopardy violation of *42 CFR § 483.13(c)*; record did not show that resident suffered extreme bruising prior to morning on which resident was hospitalized or that facility failed to properly investigate any allegation of abuse. *Grace Healthcare v United States HHS (2009, CA8) 589 F3d 926.*

Substantial evidence supported imposition of civil monetary penalties against nursing facility where (1) it failed to notify resident's family and doctor when there was significant change in his

condition, causing noncompliance with *42 CFR § 483.10(b)(11)*; (2) its noncompliance put residents in immediate jeopardy under *42 CFR § 488.301*; and (3) it failed to provide sufficient fluid intake to its residents in compliance with *42 CFR § 483.25(j)*. *Claiborne-Hughes Health Ctr. v Sebelius (2010, CA6) 609 F3d 839, 2010 FED App 184P.*

Nursing home's petition for review of decision of Departmental Appeals Board of United States Department of Health and Human Services imposing $ 5,000 per-instance civil monetary penalty against it for violating *42 CFR § 483.25(h)* regarding resident wandering from its facility was reviewed under deferential standards required to be applied under *5 USCS §§ 706(2)(A)*-(E) and dismissed; decision was supported by evidence in that facts showed that facility's actions toward resident were not reasonable in that it did not take all reasonable steps to prevent her from wandering, particularly based on resident's history of wandering, and facility's failure to implement care plan to prevent wandering. *Cedar Lake Nursing Home v United States HHS (2010, CA5) 619 F3d 453.*

Because Center for Medicare and Medicaid Services manual provided 2 possible requisites for cooking eggs: (1) time and temperature and (2) degree or extent of congealing, without evidence of petitioner nursing center's eggs' temperature, cooking time, or cooking method, evidence of noncompliance with time-and-temperature requirements was insufficient for imposed monetary penalties. *Elgin Nursing & Rehab. Ctr. v United States HHS (2013, CA5) 718 F3d 488.*

Civil monetary penalty of $ 60,660 will be enforced against physician for filing false claims with state Medicaid program, because civil penalty assessment by federal authorities following conviction and fine under state law cannot be disturbed on double jeopardy grounds due to dual sovereignty doctrine, and federal civil action against physician was timely filed within 6 years of his crimes pursuant to *42 USCS § 1320a-7a(c)(1)*. *United States v Anthony (1989, ED NY) 727 F Supp 792.*

Where plaintiff, successor to Medicare provider, challenged civil money penalty, and asserted it was entitled to hearing under *42 USCS § 1320a-7a(c)(2)*, motion to dismiss such claim by defendants, United States Department of Health and Human Services and its Secretary, was granted because predecessor had not sought administrative hearing and successor was not entitled to one years after-the-fact. *Delta Health Group, Inc. v United States HHS (2006, ND Fla) 459 F Supp 2d 1207, 20 FLW Fed D 185.*

Unpublished Opinions

Unpublished: Where surveyors found that nursing home facility was out of compliance with federal regulations, including failure to prevent development of pressure sores, in violation of *42 C.F.R. § 483.25(c)*, substantial evidence supported findings under *42 USCS § 1320a-7a(e)*; also, $ 33,600 penalty imposed on facility was reasonable. *Batavia Nursing & Convalescent Ctr. v Thompson (2005, CA6) 129 Fed Appx 181.*

Unpublished: Civil penalty was properly imposed on nursing home because substantial evidence existed under *42 USCS § 1320a-7a(e)* to show that pressure sores were not properly treated and prevented under *42 C.F.R. § 483.25(c)* where at least one patient stayed in wheelchair for long period of time and remained in urine-soaked underwear; moreover, accident prevention under § 483.25(h) was inadequate where at least one patient was improperly restrained. *Clermont Nursing & Convalescent Ctr. v Leavitt (2005, CA6) 142 Fed Appx 900, 2005 FED App 662N.*

Unpublished: Substantial evidence supported administrative law judge's decision to credit determination of nurse surveyor over facility doctor's conclusions that pressure sores found on patient were unavoidable and that civil monetary penalty was appropriate; doctor's opinion was submitted as letter rather than as affidavit affirmed under penalty of perjury and doctor first expressed opinion that patient's pressure sores could be unavoidable only after it became apparent that patient's condition would have serious negative impact on facility. *Sanctuary at Whispering Meadows v Thompson (2005, CA6) 151 Fed Appx 386, 2005 FED App 826N.*

Unpublished: Substantial evidence supported Secretary of Health and Human Services' determination that skilled nursing facility that participated in Medicare and Medicaid violated *42 C.F.R. § 483.13(c)* by failing to adequately investigate claims of sexual abuse of residents by members of facility's nursing staff; $ 3400 per instance civil monetary penalty assessed against facility pursuant to *42 USCS §§ 1320a-7a* and *1395i-3(h)(2)(B)(ii)* was neither arbitrary and capricious, nor abuse of discretion. *Park v Leavitt (2005, CA6) 157 Fed Appx 858, 2005 FED App 957N.*

Unpublished: Imposition of civil monetary penalties by Department of Health and Human Services (DHHS) against nursing home facility, Medicare participant, was affirmed where substantial evidence supported finding that nursing home's noncompliance with standards of care was so severe that it warranted application of immediate jeopardy level of severity; it was reasonable for DHHS to conclude that absence of adequate infection tracking procedures likely would result in serious harm to residents should outbreak occur, and nursing home's argument that any serious harm had to occur within 24 hours in order to warrant immediate jeopardy treatment was invalid. *Barbourville Nursing Home v United States HHS (2006, CA6) 174 Fed Appx 932, 2006 FED App 243N.*

Unpublished: Imposition of civil monetary penalty (CMP) against nursing care facility for violations of requirements as described in Social Security Act, *42 USCS § 1395i-3(a)*-(d), was upheld pursuant to *42 USCS § 1320*-7a, as supported by substantial evidence, because, inter alia, facility failed to provide adequate supervision and assistance to prevent accidents, improperly used restraints, provided care that was not consistent with many residents' plan of care, and allowed several residents to develop pressure sores without providing necessary treatment; further, ALJ adequately considered required factors in fashioning reasonable *CMP. Lakeridge Villa Health Care Ctr. v Leavitt (2006, CA6) 202 Fed Appx 903, 2006 FED App 809N.*

Unpublished: In Medicare case, imposition of $ 100 per day civil monetary penalty on nursing home for being in substantial noncompliance with *42 CFR § 483.25(j)* was affirmed because substantial evidence supported both finding of substantial noncompliance and reasonableness of monetary penalty. *Woodland Vill. Nursing Ctr. v United States HHS (2007, CA5) 239 Fed Appx 80.*

Unpublished: Substantial evidence supported Departmental Appeals Board's conclusion that nursing home's non-compliance placed residents in immediate jeopardy, warranting hefty fine; for example, nursing home nurses exposed two residents to very serious risks of harm when they failed to consult doctor about residents' dangerously low blood-sugar levels. Life Care Ctr. Tullahoma v Sec'y of United States HHS (2011, CA6) 2011 FED App 852N.

Unpublished: Substantial evidence supported Departmental Appeals Board's conclusion that nursing home's was ″culpable,″ meaning it was guilty of neglect, indifference, or disregard for

resident care, comfort, or safety, including hours-long delay in notifying one resident's doctor about her elevated potassium levels, failure to record another resident's diabetes prescription correctly, and "lack of diligence" in complying with doctors' orders. Life Care Ctr. Tullahoma v Sec'y of United States HHS (2011, CA6) 2011 FED App 852N.

Unpublished: Imposition of civil penalty for violation of *42 CFR § 483.70* was affirmed because skilled-nursing facility had to do more than merely install fire alarm system; it needed to see that system and protocols operated to achieve their intended purpose of insuring resident safety; such requirement was reasonable interpretation of § 483.80. *Sunset Manor, Inc. v United States HHS (2009, CA10) 2009 US App LEXIS 4360.*

Unpublished: On review governed by *5 USCS § 706* and *42 USCS § 1320a-7a(e)*, civil money penalty (CMP) of $ 3,300 for one day of immediate jeopardy due to noncompliance with Medicare regulations was proper because mandatory minimum CMP for immediate jeopardy situations was $ 3050, under *42 CFR § 488.438(a)(1)(i)*, and widespread potential for more than minimal harm was sufficient to support agency's finding of immediate jeopardy. *Cox Ret. Props. v Johnson (2009, CA10) 2009 US App LEXIS 8195.*

Unpublished: On review governed by *5 USCS § 706* and *42 USCS § 1320a-7a(e)*, imposition of $ 50 per day civil money penalty against skilled-nursing facility for deficiencies based on *42 CFR §§ 483.20(d)*, *483.20(k)(1)*, and *483.20(k)(3)(ii)* was proper as authorized in *42 CFR § 488.406* and supported by substantial evidence. *Cox Ret. Props. v Johnson (2009, CA10) 2009 US App LEXIS 8195.*

Unpublished: Substantial evidence under *42 USCS § 1320a-7a(e)* supported imposition of civil monetary penalties on skilled nursing facility for failing to comply with federal health and safety regulations because there were two incidents wherein facility residents were injured by falling out of wheelchairs while being transported in facility's van. *SunBridge Care & Rehab. for Pembroke v Leavitt (2009, CA4) 2009 US App LEXIS 16287.*

Unpublished: Under *42 USCS §§ 1320a-7a(e)* and *1395i-3(h)(2)(B)(ii)*, imposition of civil money penalties against skilled nursing facility was supported by substantial evidence because nurse's note indicated that nursing assistant handled elderly resident in manner nurse found excessive, nursing assistant's contact caused bruises on resident's wrist, facility failed to promptly investigate and report allegation of abuse, and facility's violations resulted in immediate jeopardy during period between incident and time nursing assistant was suspended. *Beverly Healthcare Lumberton v Leavitt (2009, CA4) 2009 US App LEXIS 16293.*

Unpublished: Where nursing home was found to be not in substantial compliance with physician consultation requirement in *42 CFR § 483.10(b)(11)* and requirement regarding pressure sores, part of quality of care standards in *42 CFR § 483.25*, imposition of civil monetary penalty of $ 800 per day, for total of $ 35,200, was not unreasonable because home was in its sixth noncompliance cycle and had previously failed to comply with physician consultation requirement *Senior Rehab. & Skilled Nursing Ctr. v HHS (2010, CA5) 2010 US App LEXIS 25885.*

Unpublished: Secretary of United States Department of Health and Human Services' imposition of per diem civil monetary penalty was supported by substantial evidence, under *42 USCS § 1320a-7a(e)*, because, while Medicare nursing facility presented some evidence to contrary, Secretary had before her substantial evidence that facility failed to satisfy requirements that were

condition of participation in Medicare program until on or about September 28, 2009, because Secretary had before her statements from experienced pharmacist and surveyor, as well as facility's own pharmacist consultant, that, at time of survey, facility still lacked adequate systems to ensure that residents taking Coumadin were monitored closely for possible subtle signs of Coumadin toxicity, and Secretary had before her substantial evidence that, despite April measures, facility continued to lack effective system for ensuring that labs were properly drawn and results reported. *Universal Healthcare/King v Sebelius (2012, CA4) 2012 US App LEXIS 25637.*

Unpublished: Secretary of United States Department of Health and Human Services' imposition of per diem civil monetary penalty was supported by substantial evidence, under *42 USCS § 1320a-7a(e)*, because, while Medicare nursing facility presented some evidence to contrary, Secretary had before her substantial evidence that facility failed to satisfy requirements that were condition of participation in Medicare program until on or about September 28, 2009, because Secretary had before her statements from experienced pharmacist and surveyor, as well as facility's own pharmacist consultant, that, at time of survey, facility still lacked adequate systems to ensure that residents taking Coumadin were monitored closely for possible subtle signs of Coumadin toxicity, and Secretary had before her substantial evidence that, despite April measures, facility continued to lack effective system for ensuring that labs were properly drawn and results reported. *Universal Healthcare/King v Sebelius (2012, CA4) 2012 US App LEXIS 25637.*

Unpublished: Civil monetary penalties were properly imposed on nursing home because (1) Centers for Medicare & Medicaid Services' (CMS) determination that nursing home violated *42 CFR §§ 483.13(c)* and *483.25(h)* was supported by substantial evidence because there was at least some confusion as to standard course of procedure for addressing elopement, and it was reasonable to conclude that resident did not receive adequate supervision or assistance devices to prevent him from eloping; (2) CMS's designation of immediate jeopardy was supported by substantial evidence because nursing home's failure to prevent or address resident's elopements had potential to result in serious harm to resident; and (3) CMS offered several persuasive reasons for determining that period of immediate jeopardy did not end until June 2, 2010. *Miss. Care Ctr. of Greenville v United States HHS (2013, CA5) 2013 US App LEXIS 2668.*

Unpublished: Duration of civil monetary penalties imposed were reasonable because resurvey occurred on December 29, 2009, and found that skilled nursing facility was in substantial compliance with participation requirements as of December 11, 2009, and facility failed to provide any acceptable documentation that it was in substantial compliance before that date. *Libertywood Nursing Ctr. v Sebelius (2013, CA4) 2013 US App LEXIS 4263.*

4. Miscellaneous

Notification by Medicare carrier that employment status of nurse anesthetists was pivotal element in completing requirement for reimbursement put doctor association on notice that it should have educated itself about their employment status and association had obligation to find out its relationship to nurses. *Anesthesiologists Affiliated v Sullivan (1991, CA8) 941 F2d 678.*

Decision of Departmental Appeals Board (DAB) for United States Department of Health and Human Services was not supported by substantial evidence *42 USCS § 1320a-7a(e)*, as program that skilled nursing facility had in place substantially complied with requirements of pest and rodent regulation, *42 CFR § 483.70(h)(4)*, at least insofar as facility would have reasonably understood them at time; Centers for Medicare and Medicaid Services had not previously cited facility for

any pest control-related penalties--though there had been past incidents involving ants on premises--nor had it suggested changes to facility's pest control program. *Emerald Shores Health Care Assocs. v United States HHS (2008, CA11) 545 F3d 1292, 21 FLW C 1192.*

Resident's care plan called for monthly testing, per physician, and physician also told state surveyor that patient taking stable dose of drug at issue should have had certain monitoring once month; it was reasonable for agency to conclude that standard of care did not allow staff to send facsimile to doctor and then wait indefinitely for response that might never come; Departmental Appeals Board's conclusion that nurses failed to comply with professional standard of care for nurses in case of resident was supported by substantial evidence, administrative record included ample evidence about serious risks associated with drug therapy and importance of monthly testing and monitoring, and it was not necessary to establish specifically that facility's noncompliance caused harm to resident. *Greenbrier Nursing & Rehab. Ctr. v United States HHS (2012, CA8) 686 F3d 521.*

Relator's allegations that drug manufacturers gave excess overfill of drug to providers for which providers did not pay, advocated that providers bill Medicare for free doses, and induced providers to purchase drug and make false certifications of compliance under anti-kickback statute, *42 USCS §§ 1320a-7b(b)(1)(B)* and *1320a-7a(i)(6)*, were sufficient to state claim for violation of *31 USCS § 3729* because excess overfill constituted free doses of drug and created potential for providers to profit from Medicare reimbursement; claim satisfied *Fed. R. Civ. P. 9(b)* because relator provided factual and statistical evidence supporting conclusion that since manufacturers began giving kickbacks, providers involved in kickback scheme had likely made knowingly false statements on Medicare reenrollment forms. *United States ex rel. Westmoreland v Amgen, Inc. (2010, DC Mass) 738 F Supp 2d 267.*

Unpublished Opinions

Unpublished: Substantial evidence supported ALJ's determination that nursing facility's noncompliance problem was systemic--that is, noncompliance consisted not merely of using latex on single resident believed to be allergic to latex, but also of failing to follow necessary plan and procedures to protect residents who had allergies; as ALJ found, weakness of facility's system for protecting its residents was demonstrated by series of errors that occurred in providing care to resident; for this reason, ALJ concluded that systemic failure to implement protective measures would jeopardize any resident who was dependent on staff to treat him or her subject to safety precautions; finding no error, appellate court affirmed determination that noncompliance met requirement of ″immediate jeopardy″ under *42 CFR § 488.301*. Liberty Commons Nursing & Rehab Ctr. - *Johnston v Leavitt (2007, CA4) 241 Fed Appx 76.*

Unpublished: Under *42 USCS § 1320a-7a(e)*, finding by Secretary of Health and Human Services that skilled nursing facility was not in compliance with *42 CFR §§ 483.25(h)(2)* and *483.75*, which required facilities to take reasonable steps to prevent accidents and to administer resources so as to maintain residents' physical, mental, and psychosocial well-being, was supported by substantial evidence because it was reasonably foreseeable that resident who suffered from mental impairment, who had history of unsafe smoking behaviors, and who became confused when he was not on his oxygen might have fire-related accident, facility did not adequately supervise smoking habits of its residents, facility did not adequately investigate violations of its smoking policy, and facility's deficient administration of its smoking policy was systemic problem that endangered all of its residents. *Century Care of Crystal Coast v Leavitt (2008, CA4) 2008 US App LEXIS 12538.*

Unpublished: Under *42 USCS § 1320a-7a(e)*, finding by Departmental Appeals Board of U.S. Department of Health and Human Services that nursing facility failed to adequately supervise resident and prevent accidents as required by *42 CFR § 483.25(h)(2)* was supported by substantial evidence because resident was able to elope several times after facility had notice that resident was eloping by flipping bypass switch and resident, who had severe Alzheimer's disease and osteoporosis and ambulated using walker, was at high risk for experiencing falls. Covering bypass switches with paper was not sufficient precaution because that measure did not prevent someone with resident's cognitive ability from operating switches and facility could have used proven measure of one-on-one supervision. *Liberty Commons Nursing & Rehab Ctr. v Leavitt (2008, CA4) 2008 US App LEXIS 15459.*

Unpublished: Substantial evidence supported finding that nursing facility was not in compliance with *42 CFR §§ 483.20(b)(2)(ii)* and *483.25(c)* based on resident's development of pressure sores; there was sufficient showing that sores had impact on more than one area of resident's heath and that development of sores was not unavoidable; also, evidence that call bells were not accessible to some residents supported finding of noncompliance with § 483.25(a)(3), and evidence that resident was found with glaucoma eye drops that resident could not safely self-administer supported finding of noncompliance with *42 CFR § 483.10(n)*. *Windsor Place v United States HHS (2011, CA5) 2011 US App LEXIS 12391.*

Unpublished: Secretary of United States Department of Health and Human Services' determination that skilled nursing facility was not in substantial compliance with *42 CFR § 483.25(h)* was supported by substantial evidence because risk that resident would continue his inappropriate behavior was foreseeable, yet facility's response was woefully inadequate under circumstances because after first inappropriate touching on September 6, 2009, incidents that followed were foreseeable, and it was not until October 17, 2009, incident that facility instituted any meaningful measures to control resident's inappropriate sexual behavior, when it commenced one-to-one supervision; but, even then, it failed to require one-to-one supervision at all times when resident was out of bed, although it was foreseeable that he might inappropriately touch female residents without such supervision. *Libertywood Nursing Ctr. v Sebelius (2013, CA4) 2013 US App LEXIS 4263.*

Unpublished: Secretary of United States Department of Health and Human Services' determination of immediate jeopardy, under *42 CFR § 488.301*, was not clearly erroneous because (1) it was skilled nursing facility's noncompliance with governing regulations that made resident's inappropriate behavior possible; (2) had facility instituted adequate measures to control resident's inappropriate sexual behavior, which was foreseeable, behavior would not have continued; and (3) although only one other resident made formal complaint about resident's inappropriate behavior, facility failed to conduct investigation as to degree of harm suffered by other female residents whom resident inappropriately touched. *Libertywood Nursing Ctr. v Sebelius (2013, CA4) 2013 US App LEXIS 4263.*

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