L656

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§418.100(f) Standard: Hospice multiple locations

If a hospice operates multiple locations, it must meet the following requirements:

(1) Medicare approval.

(i) **All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.**

Interpretive Guidelines §418.100(f)(1)(i)

It is inherent in the provider certification process for a hospice to notify CMS of its proposal to add a location from which it provides services. Absent such notification, CMS has no way of carrying out the statutorily mandated obligation of determining whether the hospice is complying with all applicable participation requirements at the new location. It is a longstanding CMS policy that there is no basis for a provider to bill Medicare for services provided from a location that has not been determined to meet applicable requirements of participation.

When an existing hospice intends to add a multiple location, it must notify CMS, the State Survey Agency (SA), and, if deemed, it should notify its approved national accreditation organization (AO), in writing of the proposed location if it expects this location to participate in Medicare or Medicaid. The hospice must also submit a Form CMS-855A change of information request (including all supporting documentation) to its Medicare Administrative Contractor (MAC) before CMS approval can be granted. The provider must also obtain CMS' approval of the new multiple location before it is permitted to bill Medicare for services provided from the new location.

NOTE: CMS will not approve a hospice's inpatient facility or a change of location for a hospice's own inpatient facility without a survey to assure that the facility meets all requirements specified at 42 CFR 418.110.

A hospice may not bill Medicare for services provided from a multiple location until the new site or location has been approved by CMS. The fact that a national accreditation organization with deeming authority has approved a new site or location will not affect CMS' decision. CMS' determination will be based on its independent application of its regulations to the facts in the case. Services provided before the effective date of approval should not be billed to Medicare.

If the hospice does operate at multiple locations, a deficiency found at any location will result in a compliance issue for the entire hospice.