Chapter HSS 123

CAPITAL EXPENDITURE REVIEW FOR HOSPITALS, OTHER ACUTE CARE FACILITIES AND HOME HEALTH AGENCIES

Note: Chapter HSS 123 was created as an emergency rule effective January 1, 1984.

HSS 123.01 Authority and purpose. This chapter is promulgated under the authority of s. 150.03, Stats., to implement subchs. I and III of ch. 150, Stats. Its purpose is to provide definitions, standards and procedures to be used by the department to implement the capital expenditure review program for hospitals, ambulatory surgery centers and other acute health care facilities, and for home health agencies, established by subch. III of ch. 150, Stats. That program is primarily directed at containment of health care costs, but also seeks to promote orderly and cost-effective development of efficient health facilities and services and to prevent unwarranted expansion or replacement in the health care industry. The department recognizes that the scaling down of hospital operations, development of alternatives for excess bed capacity, conversion of services from inpatient to outpatient and the enhancement of price competition both among hospitals and between hospitals and health care providers not regulated by the department are ways in which cost containment may be achieved.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 123.02 Applicability. (1) This chapter applies to any application declared complete by the department on or after the effective date of this chapter. Interim rules adopted under s. 2020 (11) (b) of 1983 Wisconsin Act 27 apply to projects declared complete prior to April 1, 1985.

(2) This chapter applies to any person who proposes to:

(a) Obligate for a capital expenditure, by or on behalf of a hospital, that exceeds $600,000, as adjusted by the department under s. 150.15, Stats., and s. HSS 123.04 (3);

(b) Undertake a substantial change in a health service;

(c) Obligate for an expenditure, by or on behalf of a hospital, independent practitioner, partnership, unincorporated medical group or service corporation for clinical medical equipment that exceeds $600,000, as adjusted by the department under s. 150.15, Stats., and s. HSS 123.04 (3);

(d) Purchase or otherwise acquire a hospital;

(e) Add to a hospital's approved bed capacity; or

(f) Construct or operate an ambulatory surgery center or a home health agency.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85; correction in (1) made under s. 13.93 (2m) (b) 14, Stats., Register, March, 1986, No. 363.

HSS 123.03 Definitions. In this chapter:

(1) "Acquire" means to gain ownership but does not include consolidation or merger of 2 or more corporations each of which owns a currently approved and operating hospital if the consolidation or merger is without consideration. In this subsection, "consideration" means something of value given or promised that has the effect of making an agreement a legally enforceable contract.

(2) "Affected party" means the applicant, a health systems agency or other local planning agency, a governmental agency, another person providing similar services in the applicant's service area, the public to be served by the proposed project, a 3rd-party payer or any other person who the department determines is affected by an application for approval of a project.

(3) "Annual survey of hospitals" means the survey conducted every year by the department of health and social services to collect information from all Wisconsin hospitals.

(4) "Application" means the document submitted by an applicant to the department for the purpose of obtaining approval of a project.

(5) "Approval" means a written statement from the department authorizing a person to commence implementing a project under review.

(6) "Approved bed capacity" means a hospital's bed count collected and verified by the department and by the hospital under s. HSS 123.30.

(7) "Branch office" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the home health agency.

(8) "Capital expenditure" means an expenditure by or on behalf of a hospital that under generally accepted accounting principles is not properly chargeable as an expense of operations or maintenance. "Capital expenditure" does not include an expenditure relating to maintenance, housekeeping or general administration if made on behalf of one or more hospitals by a person other than a hospital.

(9) "Chemical dependency service" means an organized service for the provision of medical care and rehabilitative treatment, usually of 21 to 28 days in duration, for patients dependent on alcohol or other drugs or both alcohol and other drugs.

(10) "Clinical medical equipment" means any equipment which performs functions or tests directly on a patient, including every piece, component or appurtenance which facilitates functioning of the equipment or sharing of the equipment among users.

(11) "Clinically efficacious" means that the technology has been demonstrated to have the effect it purports to have or is represented to have under the conditions of use prescribed on the basis of well-controlled investigations, including clinical investigations, by experts qualified by training and experience to evaluate the effectiveness of the device.

(12) "Cost-effective" means the solution that achieves the intended result at the lowest cost or a cost lower than any alternative solution.

(13) "Cost overrun" means an obligation exceeding the maximum capital expenditure authorized by an approval.

(14) "Department" means the department of health and social services.

(15) "Dollar threshold" means the minimum capital expenditure amount or minimum amount of operating revenue which is subject to review under this chapter.

(16) "Emergency situation that threatens patient safety" means a situation, physical condition, practice, method or operation that presents an imminent danger of death or of severe physical or mental harm to any patient in a hospital.

(17) "Expected length of stay" means the statewide average length of stay of a patient in a hospital adjusted for diagnostic related groups as established under PL 98-21, 601 to 607.

(18) "Functional program" means the evaluation of services and workloads to determine the methods of meeting institutional objectives, as defined by the committee on architecture for health of the American institute of architects.

(19) "Functional space program" means a functional program translated into facility space requirements to provide the basis for architectural design, including a tabulation of every room or area, with its designated function and the area needed to perform that function, as defined by the committee on architecture for health, American institute of architects.

(20) "General hospital" means a hospital that provides many types of medical and surgical care.

(21) "Generally accepted accounting principles" means uniform rules, procedures, methods and standards set by organizations such as the financial accounting standards board and which accountants employ in recording and reporting financial information.

(22) "Health planning area" means one of the areas of the state designated pursuant to 42 USC 300L for health planning purposes, with boundaries as specified in appendix A.

(23) "Health systems agency" or "HSA" means the agency responsible for local health planning under 42 USC 300L.

(24) "Hospital" has the meaning specified in s. 50.33 (1), Stats., but excludes facilities exempted under s. 50.39 (3), Stats., and includes all corporations and other persons who have been issued a certificate of approval under s. 50.35, Stats., to operate the hospital.

(25) "Hospital discharge survey" means the study conducted periodically by the department to collect information on patients discharged from Wisconsin hospitals.

(26) "Innovative medical technology" means equipment or procedures that are potentially useful for diagnostic or therapeutic purposes and that introduce new technology in the diagnosis and treatment of disease, illness or injury.

(27) "Inpatient psychiatric services" means services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional or behavioral disorders.

(28) "Life cycle cost" means all relevant costs associated with a project during the length of time over which alternatives are compared.

(29) "Long-term" means an average length of stay for the service of more than 30 days.

(30) "Market share population" means the ratio of the number of patients from a geographic area who are hospitalized in a particular hospital or group of hospitals to the total number of patients hospitalized from the area multiplied by the total population in the area, with the number representing the "market share population" for an area published in the state medical facilities plan (SMFP).

(31) "Material change in project scope" means the inclusion of services which were not in the application, or a significant change in the project which has a significant financial impact on the project.

(32) "Metropolitan statistical area" or "MSA" means a county or multi-county area which is designated as a large population area for statistical reporting purposes by the U.S. office of management and budget.

(33) "Natural disaster" means a flood, ice storm, tornado, severe windstorm, mudslide or other act of destruction resulting from weather or geologic conditions beyond the control of the applicant.

(34) "Obligation" means any enforceable contract that is entered into for the construction, leasing, acquisition or permanent financing of a capital asset.

(35) "Permanent financing" means that the interim or long-term mortgage has been executed by all parties and the proceeds are available to the borrower in an amount sufficient to complete the project, or the bonds have been sold, either publicly or privately, and the proceeds are available to the borrower in an amount sufficient to complete the project.

(3) RECOVERY OF EXPENSES. Recovery of capital expenses may occur only upon approval of an application under s. HSS 123.08, and recovery of operating expenses may occur only after the innovative medical technology has been approved by the U.S. food and drug administration for safety and efficacy and 3rd-party payers have agreed to pay for these expenses.

(4) RESCINDING OF EXEMPTION. An exemption granted under this section may be rescinded if:

(a) Based on information subsequently discovered, one or more of the conditions for granting an exemption under sub. (2) is not in fact met or is no longer met; or

(b) The studies and research described in sub. (2) (b), (c) and (e) have not been undertaken.

(5) APPROVAL OF ACQUISITION. When specific equipment or procedures are determined pursuant to sub. (6) no longer to constitute innovative medical technology, the department shall initiate concurrent review for acquisition of the technology under s. HSS 123.08 (10) (a) 3.

(6) TECHNOLOGY SUBJECT TO EXEMPTION. (a) The department finds that the following constitute innovative medical technologies and may be acquired only for research, development and evaluation and then only with an exemption granted under this section:

1. Brain electrical activity mapping; and

2. Positron emission tomography.

(b) Additions to or deletions from the list of innovative medical technologies in par. (a) may be made by means of a petition for rule-making under s. 227.015, Stats., or adoption of rules under ch. 227, Stats.

(c) Equipment or procedures may also be declared innovative medical technologies pursuant to a request for determination of reviewability under s. HSS 123.06, or after receiving a notice of intent under s. HSS 123.08 (2), if the equipment or procedures as proposed:

1. Have not been proven safe;

2. Have not been proven clinically efficacious;

3. Have not been proven cost-effective;

4. Have not been proven appropriate for a clinical setting;

5. Are being assessed by the federal office of technology assessment; or

6. Are the first generation of a technology or procedure which will be undergoing rapid change and improvement.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85; r. (6) (a) 1. and 2. and (d), Register, March, 1986, No. 363, eff. 4-1-86; renum. (6) (a) 3. and 4. to 1. and 2. under s. 13.93 (2m) (b) 1, Stats., Register, March, 1986, No. 363.

HSS 123.06 Determination of reviewability. (1) REQUEST FOR DETERMINATION. (a) Any potential applicant or an affected HSA may request that the department make a determination concerning the reviewability

of a project. The purpose of the request is to ascertain whether the project is reviewable under ch. 150, Stats.

Note: The request should be submitted to the Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701.

(b) The request shall be in writing and shall include a brief description of the project, the estimated capital expenditure, the estimated annual operating revenue to be generated by the proposed project, and the name of an authorized representative of the applicant.

(c) The department may ask for additional information of the person submitting the request before issuing a determination. A request is not complete until the additional information is received by the department.

(2) ISSUANCE OF DETERMINATION. (a) The department shall issue a written determination of reviewability which states whether the project is reviewable under ch. 150, Stats., within 30 days following receipt of a request for a determination unless the department has requested information within 30 days of receipt of the request for a determination or has asked the potential applicant or affected HSA for a 30-day extension. When additional information or an extension has been requested, the determination shall be issued within 30 days following the department's receipt of additional information or 30 days following the date on which the extension was granted. If the department fails to issue a written determination within 30 days, the project shall be considered nonreviewable.

(b) The department's determination of reviewability is neither a declaratory ruling within the meaning of s. 227.06, Stats., nor a final decision within the meaning of s. 227.10, Stats. The determination of reviewability is binding upon the department and the person submitting the request unless:

1. Section HSS 123.08 (8) is applicable; or

2. The affected HSA or potential applicant requests a declaratory ruling under sub. (3).

(3) APPEAL. The exclusive means of review of a determination under this section is by petition for declaratory ruling under s. 227.06, Stats. Notwithstanding s. 227.06 (1) and (4), Stats., the department shall issue a declaratory ruling in response to each petition under this section.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 123.08 Review process. (1) PROCEDURES AND CRITERIA. Projects shall be reviewed in accordance with the process established under ss. 150.65 to 150.71, Stats., and this section, the review criteria in s. 150.69, Stats., and s. HSS 123.13, the applicable service-specific criteria in ss. HSS 123.14 to 123.22 and the state medical facilities plan.

(2) NONACCEPTABILITY OF APPLICATIONS. The department may not accept any application under this chapter for the addition of hospital beds that would exceed the total number of beds authorized by the state medical facilities plan for the service area where the project would be located.

(3) NOTIFICATION OF INTENT. (a) Any person intending to submit an application for approval of a project shall submit a notice of intent to the

department and the HSA on a form prescribed by the department prior to the submission of the application.

(b) The form shall include the name and address of the applicant, the anticipated date for the obligation or initiation of the project, the estimated cost of the project and a brief narrative describing the scope and purpose of the project.

(c) Prior to sending out an application form, the department or the HSA may schedule a meeting with the potential applicant to discuss the project.

(d) There shall be a 30-day waiting period between the submission of the notice of intent and the submission of an application.

(e) A notice of intent is valid for one year after receipt by the department. If after one year a complete application has not been received, the applicant shall submit a new notice of intent before submitting an application.

Note: Notice of intent forms may be obtained from the local health systems agency or, if no HSA exists in the area, from the Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701. Completed applications should be sent to the same address.

(4) SUBMISSION OF AN APPLICATION. (a) *Forms and reviewers.* Applications shall be submitted to the department and HSA on forms provided by the department. Additional questions may be included as the department and HSA determine necessary for the review of an application. The forms shall be sent to the applicant by the HSA, or by the department if no HSA exists, within 10 working days after receipt of the notice of intent. Forms may also be sent to other health care providers for the purpose of concurrent review as specified in sub. (10). Applications from projects proposing to serve persons in more than one health planning area may be reviewed by all involved HSAs. The HSA in which a project will be serving most of the persons shall act as the lead agency with the other HSAs submitting comments to the lead agency. The applicant shall send materials to all involved HSAs.

Note: Application forms may be obtained from the local health systems agency or, if no HSA exists in the area, from the Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701. Completed applications should be sent to the same address.

Upon written request, the department will provide technical assistance to any small business, as defined in s. 227.16 (1) (a), Stats., or other small organization with fewer than 25 full-time employes or annual revenues of less than $2,500,000 regarding application materials and procedures. Requests should be sent to the same address.

(b) *Waiting period.* The department and the HSA shall not accept an application until the notice of intent waiting period under sub. (3) (d) has elapsed.

(c) *Review for completeness.* On receipt of an application, the department and all HSAs involved shall review the application for completeness. An application may not be considered complete unless:

1. The application form and any additional questions are completed to the satisfaction of the department. Additional questions may be asked or additional information sought of the applicant prior to a determination of completeness;

2. The application fee has been received. The fee shall be equal to .37% of the estimated project cost, but not less than $1,850 and not more than $37,000;

3. When the applicant is a hospital, the department has on file a current capital budget report which meets the reporting requirements of s. HSS 123.29; and

4. When the applicant is a hospital, the applicant has furnished the department with an affidavit of mailing as proof that it has submitted the application to the rate-setting authority.

(d) *Fee refund.* The department shall refund the application fee if requested within 10 working days after receipt of the application. The application fee shall not be refunded after the application is declared complete unless a determination of nonreviewability has been made under sub. (8). Fees may only be refunded as provided in this paragraph.

(e) *Notice of incompleteness.* If the department, upon conferring with the HSA and rate-setting authority, determines that any applicable item on the application form or additional question has not been adequately answered, the application is incomplete. Within 10 working days of receipt of all application materials, the department shall mail to the applicant a notice of incomplete application. The notice shall state which items were determined incomplete and the basis for that determination. If the department fails to give this notice, the application shall be deemed complete as of the date the department received the last application materials.

(5) COMPLETE APPLICATION NOTIFICATION. On or before the 20th day of the month following the receipt of a complete application, the department shall send a notice of receipt of a complete application to the applicant and publish the notice in a daily newspaper of general circulation that serves the area where the proposed project would be located.

(6) PUBLIC MEETING AND HSA RECOMMENDATION. (a) At the request of any affected party, the appropriate HSA, or the department if no HSA exists in the area, shall hold a public meeting at which all affected parties may present testimony regarding the review of projects seeking approval. A public meeting request shall be made to the local HSA or, in an area where no HSA exists, to the department no later than 10 days from the date of notification under sub. (5). An HSA, as an affected party, may hold a public meeting on a project seeking approval without the request of another affected party. If a request for a public meeting is made by an affected party in an area where no HSA exists, the department shall conduct the public meeting.

(b) Any affected party presenting testimony regarding the review of a project seeking approval shall state any organizational affiliation and shall register in support of the project, in opposition to the project, in support of the project with modifications, or as presenting information which is neither in support of or in opposition to the project.

(c) The record of the public meeting shall include:

1. A list of persons, their organizational affiliations, and how they registered under par. (b); and

2. An electronic transcription of the meeting.

(d) Within 60 days after the date of notification under sub. (5), the HSA shall recommend to the department approval or a denial of the project based upon the review criteria set forth in this chapter. An applicant and HSA may agree to an amendment to an application in order for an applicant to obtain a favorable HSA recommendation only if the amendment does not change the substance of a project. The amendment shall be submitted by the applicant to the department in writing. A change in the substance of a project requires resubmission of a new application.

(7) DEPARTMENT REVIEW. (a) A 75-day period for department review of an application shall begin on the date of notification of a complete application under sub. (5).

(b) The department shall issue an initial finding to the applicant and the HSA within the review period specified in par. (a). Unless the HSA or the applicant requests a hearing under s. HSS 123.09 within 10 days following the department's issuance of the initial finding, the department's initial finding is its final action. Upon request of an applicant for good cause shown, the department and HSA may agree to issue their recommendation and initial finding within a stated period of time less than the deadlines specified in par. (a) and sub. (6) (d).

(8) DETERMINATION OF NON-REVIEWABILITY. If, during the review process, the department finds that a project previously thought to be or determined to be reviewable is not in fact reviewable, the department shall return the application and the application fee to the applicant.

(9) CONDITION OF APPROVAL. The department and applicant may agree to any modification of the project as a condition of approval.

(10) CONCURRENT REVIEW. (a) Pursuant to s. 150.67 (2), Stats., the department may group for concurrent review applications for similar types of facilities or services that are proposed within the same health planning area or service area. Applications from an acute care service area which overlaps HSA boundaries or applications which will serve several health planning areas may be reviewed by boths HSAs. The review procedures set forth under subs. (1) to (9) and sub. (11) shall apply in reviewing all applications except as modified by this subsection in the review of applications for concurrent review. The department may initiate concurrent review as follows:

1. The department may initiate concurrent review upon receipt of any notice of intent under sub. (3), by sending to the person who submitted the notice of intent a notice of concurrent review and publishing and distributing that notice as the department deems fit. The notice of concurrent review shall include the name of the person who submitted the notice of intent, the type of facility or service being concurrently reviewed and the area of concurrent review. Upon receipt of the first completed application for the concurrent review, the department shall notify all other applicants and persons who have submitted notices of intent relevant to the concurrent review that complete applications must be received by the end of the current calendar month in order to be reviewed in the concurrent review. Complete applications received after the end of the current calendar month may be reviewed separately or concurrently with other applications for similar types of facilities or services or within the same planning area or service area which are completed during the same calendar month.

2. The department may concurrently review applications which are declared complete within the same calendar month, regardless of when the notices of intent were received. Concurrent review under this papagraph shall be initiated by including a notice to that effect in the notice under sub. (5).

3. The department may initiate concurrent review by publishing at the end of any calendar month a notice that all completed applications for a particular type of facility or service or within particular health planning areas or service areas which are received during the second calendar month following publication of the notice will be grouped for concurrent review. The notice shall state that notices of intent for the concurrent review will be accepted during the calendar month following publication of the notice. Completed applications received after the second calendar month following publication of the notice may be reviewed separately or reviewed concurrently with other completed applications for similar types of facilities or services or within the same health planning area or service area which are received during the same calendar month.

(b) The department shall base concurrent review on a comparative analysis of the applications under all applicable review criteria set forth in this chapter. If, after removing from consideration all applications which fail to meet one or more applicable review criteria, there remain more applications than can be approved under applicable need criteria, the department shall rank the remaining applications according to how each meets each applicable review criterion, assigning the lowest number to the application which best meets each criterion. Applications shall be approved in order beginning with the lowest total score, until all need is met. If there is a tie between applications for the last available approval, the department shall rank the applications according to their scores on review criteria under s. 150.69 (5), Stats.

(c) The department shall issue one initial finding for all projects reviewed concurrently under this subsection. A request for hearing under s. HSS 123.09 (2) precludes issuance of any approval under this subsection until a final decision is issued by the secretary or the secretary's designee.

(d) If another hospital has reported a proposal similar to the applicant's project in the hospital's current capital budget report, the department may advise that other hospital to submit a competing application for concurrent review.

(e) The department may extend the review period by up to 60 days for applications undergoing concurrent review if warranted by the volume of applications received. A determination of whether an extension is necessary and the length of the extension shall be made by the department no later than 31 days after the date of notification under sub. (5).

(f) The initial finding pursuant to concurrent review may take any of the following forms:

1. The approval of a single project;

2. The approval of more than one project;

3. The approval of parts of any project, if agreed to by the applicant;

4. The approval of any combination of projects or parts of projects if agreed upon by the applicants; or

5. The approval of no projects.

(g) A request for hearing prusuant to s. HSS 123.09 (2) shall preclude issuance of any approval until a final decision is issued by the secretary or the secretary's designee.

(11) EXPEDITED REVIEW PROCESS. The department shall expedite the review of projects involving a substantial change in a health service resulting in revenues of between $250,000 and $500,000. The review procedures set forth under this section shall apply except for the following:

(a) Projects undergoing an expedited review shall not be grouped for concurrent review; and

(b) The department shall issue its initial finding no later than 5 working days after receipt of the HSA recommendation or the rate-setting authority's analysis, whichever is received later.

(12) HOSPITAL MERGER PROJECTS. (a) This subsection governs review of certain projects resulting from merger or consolidation of 2 or more corporations each of which owns a currently approved and operating hospital. Projects subject to review under this subsection are limited to service consolidation at one or more sites, service closure at one or more sites and expansion at others, and service relocation from one or more sites to others. Service retention at one site and introduction of the service at the other site as part of merger or consolidation is also governed by this subsection if the merged hospitals agree as a condition of approval to consolidate the service at one site within 3 years following introduction of the service at the second site. In order to be reviewed under this subsection, reviewable projects resulting from a merger or consolidation must be submitted for review under this chapter and ch. 150, Stats., within 3 years following merger or consolidation.

(b) The department shall issue its initial finding under s. 150.71 (2), Stats., to approve or disapprove any project reviewed under this subsection within 5 working days after the department receives the recommendation of the HSA under s. 150.71 (1), Stats., or, if there is no HSA, within 60 days after the department publishes its notice under s. 150.67 (1), Stats.

(c) The department and the merging or consolidating hospitals, prior or subsequent to merger or consolidation, may enter into a memorandum of understanding which generally describes the project to be reviewed under this subsection, identifies which of the review criteria set forth in this chapter and ch. 150, Stats., are applicable to those projects, and specifies the approved bed capacity of the merged or consolidated hospital which may not be altered by either the department or applicant during review.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85; renum. (10) (b) 1. to be (10) (b) and am., r. (10) (b) 2., Register, March, 1986, No. 363, eff. 4-1-86.

HSS 123.09 Hearing process. (1) RIGHT TO A HEARING. An applicant whose project is rejected or any adversely affected HSA may request a public hearing to review the department's initial finding or may ask for a contested case hearing.

(2) REQUEST FOR A HEARING. (a) An applicant or HSA desiring either a public hearing or a contested case hearing shall submit a written request, no later than 10 days after the issuance of the initial finding, to both the

department's division of health and the department's office of administrative hearings. The request shall identify whether the hearing requested is a public hearing or a contested case hearing, and the writer as an applicant or an affected HSA.

Note: The request for a hearing should be submitted to the Director, Bureau of Planning and Development, P.O. Box 1808, Madison, Wisconsin 53701 and Office of Adminstrative Hearings, P.O. Box 7875, Madison, Wisconsin 53707.

(b) The applicant or HSA requesting the hearing shall identify the criteria at issue no later than 20 days after the issuance of the finding.

(c) An applicant or HSA may select only one type of hearing for the duration of the hearing process. Multiple hearing requests based on an initial finding resulting from a concurrent review shall be adjudicated within one hearing. If more than one party which has undergone concurrent review requests a hearing and the requests are not in agreement on the type of hearing, a contested case hearing shall be held.

(3) PUBLIC HEARING. (a) Within 30 days after the filing of the request or the last request in the event of a concurrent review, a public hearing shall be held in the health planning area where the project is to be located. The department shall publish a notice of the public hearing in a daily newspaper of general circulation in the area of the project at least 5 days before the hearing.

(b) An examiner appointed by the department shall conduct the hearing. The examiner need not be an attorney.

(c) The following shall be the order of business at the hearing except as modified by the examiner:

1. The hearing shall commence with the examiner introducing the following items into the record:

a. The application, supporting documents which were submitted with the application, and additional information submitted in response to the department's request;

(b) Whether the applicant has demonstrated it will more effectively use personnel as documented in s. HSS 123.13 (7);

(c) Whether the applicant will charge lower nonprofessional and professional fees for nursing and therapy services as documented in sub. (7) (e);

(d) Whether the applicant has a more extensive service area as documented in sub. (3) (b) and supported by written referral agreements in sub. (6) (a) through (d);

(e) Whether the applicant offers a broader range of services based in part on the documentation provided in sub. (5); and,

(f) Whether the applicant presents the stronger documentation of potential sources and number of referrals as documented in sub. (6) (a) through (d).

(9) INVALIDATION OF AN APPROVAL. (a) The department may declare an approval for a new home health agency invalid if the approval holder has not obtained a license under s. 141.15, Stats., and ch. HSS 133 within one year from the date of the approval, pursuant to s. 150.75, Stats. The approval holder has a right to a hearing under s. 227.064, Stats., to review an invalidation under this paragraph.

(b) Since the department is relying on the representations in the application to be accurate and truthful when granting an approval, the continuing validity of an approval depends on substantial compliance by the applicant with the rates it has represented it will charge. Therefore the approval of any home health agency is invalid under s. 150.75, Stats., if the agency charges rates substantially in excess of those authorized in the approval during the first 2 years of operation. As used in this paragraph, "substantial compliance" means the rates charged in the first 2 years of operation will not exceed the rates established in the approval by more than 5%.

(10) DATA REPORTING REQUIREMENTS. Home health agencies shall provide the department and the HSA with data relating to operating costs and to numbers, types, and origin of patients and other demographic information. The information shall be provided on request of the department, but not more often than twice a year unless current data are required for the review of a proposal for the addition of a new home health agency in the county.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85.

HSS 123.22 New medical technology criteria. (1) USE. The criteria set out in this section shall be used by the department to review applications for approval to acquire technology determined under s. HSS 123.05 (6) no longer to constitute innovative medical technology, unless technology-specific criteria have been adopted under sub. (4). The applicable criteria of s. HSS 123.13 shall also be used in the review of applications subject to this section.

(2) DEFINITION. In this section, "acquire technology" means to obtain technology by purchase, donation, on-site development, lease or comparable arrangement.

(3) REVIEW CRITERIA. The department shall not approve an application to acquire for general medical use any technology previously ex-

empted from review under s. 150.63 (2), Stats., and subsequently determined under s. HSS 123.05 (6) no longer to constitute innovative medical technology unless:

(a) The technology has been classified by the U.S. food and drug administration as a class I, class II, or class III device under 21 USC 360c to k;

(b) The applicant demonstrates that the technology has documented clinical applications;

(c) The applicant identifies the specific discharge diagnoses for which the technology's clinical application is efficacious;

(d) The applicant demonstrates that the expected patient utilization for each efficacious clinical application of the technology will be sufficient to justify its costs. The number of expected patients shall consist of the total of inpatients discharges, outpatients and referral patients, by diagnosis type, in the year preceding application;

(e) The applicant demonstrates that the capital costs, operating expenses and charges are reasonable and cost beneficial. Capital costs of the technology include any facilities necessary to house the technology, and the direct and indirect resource expense associated with the provision of the service rendered by the technology. In evaluating reasonableness, the department may consider:

1. The unit cost of the services provided; and

2. Savings realized by reduction in health care costs due to the technology's effectiveness in advancing diagnosis or therapy.

(f) The application meets the technology-specific criteria adopted pursuant to sub. (4).

(4) TECHNOLOGY-SPECIFIC CRITERIA. The department finds that the public health and welfare necessitates adopting rules governing acquisition of technology under this section pursuant to the emergency rulemaking procedures set forth in s. 227.027, Stats. The department may publish emergency rules pursuant to this subsection on or after the effective date of the rule adopted under s. HSS 123.05 (6) (b) determining the technology no longer to be innovative medical technology. Rules adopted under this subsection shall set forth technology-specific criteria to be used in the review of applications subject to this section and shall consider cost containment as the first priority.

(5) PARTICIPATION IN DATA BASE DEVELOPMENT. Notwithstanding HSS s. 123.08 (9), as a condition of approval, the applicant shall participate with the department in developing and maintaining a data base for departmental use in future reviews of other applications under this section.

(6) DEVELOPMENTAL PHASES. The applicant may include in a single application developmental phases of the technology which may require future capital expenditures.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85; am. (1) and (4), Register, March, 1986, No. 363, eff. 4-1-86.

HSS 123.23 Hospital merger projects criteria. (1) USE. The criteria set out in this section shall be used by the department to review applications under s. HSS 123.08 (12). If the criteria set out in this section are met, the criteria of ss. HSS 123.13 to 123.19 shall not be used in the review of applications subject to this section.

(2) DEFINITIONS. In this section:

(a) "Conditions beyond the control of the hospital" means a natural disaster or actual inflation rates which exceed those established using the hospital market projections of data resources, inc.

(b) "Weighted average" means each hospital's average rate prior to merger multiplied by the number of cases each rate is based on divided by the total number of cases for both hospitals.

(3) REVIEW CRITERIA. The department shall not approve an application under this section unless the applicant demonstrates that:

(a) The project will result in a net bed decrease for the proposed merged or consolidated hospital which meets the requirements of ss. HSS 123.13 (13) (e) and 123.27 (10) for the merging or consolidating hospital which has the greatest number of excess beds, as measured under those provisions;

(b) For service consolidation projects there will be an actual reduction in financial requirements in the third and subsequent years following completion of the project when compared to total financial requirements of the hospitals prior to merger or consolidation;

(c) The proposed rates exclusive of increases associated with conditions beyond the control of the merged or consolidated hospital to be establihsed in the approval under s. 150.75 (3), Stats., will be less than the weighted average of the rates of the hospitals prior to merger or consolidation;

(d) Resources will be more efficiently and economically used, when compared to the hospitals prior to merger or consolidation; and

(e) There will be a net reduction in the full-time equivalent employes by the third year after merger or consolidation.

History: Cr. Register, March, 1985, No. 351, eff. 4-1-85; reprinted to correct error in (3) (a), Register, May, 1985, No. 353.

HSS 123.24 Magnetic resonance imaging criteria. (1) USE. The criteria set out in this section shall be used by the department to review applications relating to magnetic resonance imaging. The applicable criteria of s. HSS 123.13 shall also be used in the review of applications subject to this section.

(2) DEFINITIONS. In this section:

(a) "Health service area" means a health planning area identified in appendix A, except that health planning areas 3 and 4 constitute one health service area for purposes of this section.

(b) "Magnetic resonance imaging" or "MRI" means a diagnostic technique that employs magnetic and radio frequency fields to produce images of body structures and organs.

(c) "Scan" means a series of images done at one patient visit.

(3) NEED FOR MAGNETIC RESONANCE IMAGING SERVICES. (a) The department shall not approve an application under this section if the approval of an additional MRI device would mean that the maximum number of MRI devices permitted in the health service area would be exceeded. The department shall establish this number for each service area by:

1. Ascertaining for each area the annual total number of inpatient clinically-applicable MRI discharges. This shall be accomplished by employing the methodology in appendix F and using the latest available statewide hospital discharge survey data adjusted by the overall percentage difference between the discharge survey data and admissions data from the most recent annual hospital survey;

2. Determining the estimated annual total number of MRI procedures for each area. This shall be accomplished by multiplying the number obtained under subd. 1. by 1.6666, to arrive at estimated total procedures, including outpatient procedures; and

3. Arriving at the maximum number of MRI devices in each area. This shall be accomplished by dividing the number obtained under subd. 2. by 3,400, and rounding each result to the nearest whole number.

(b) The department shall not approve an application under this section unless the applicant projects a minimum of 2,000 annual MRI procedures by:

1. Ascertaining its annual total number of hospital inpatient clinically-applicable MRI discharges by employing the methodology in appendix F and using the actual hospital inpatient discharge data for the 12-month period preceding the date of application. Any percentage of hospital inpatient discharges in designated major ICD-9-CM groupings shall be documented by the applicant. The combined documented percentage for all applicants shall not exceed 100 percent of these discharges for any hospital; and

2. Determining the estimated annual total number of MRI procedures by muliplying the number obtained under subd. 1. by 1.6666, to arrive at estimated total procedures, including outpatient procedures.

(c) The department shall not approve an application under this section unless the applicant provides referral agreements with appropriate physicians and clinics indicating a commitment to use the MRI service or refer patients to the MRI service. These agreements shall include estimates of the number of MRI scans for patients of each member of the applicant's medical staff and for patients referred by in-state and out-of-state physicians.

(4) REQUIRED RESOURCES. The department shall not approve an application under this section unless:

(a) The applicant proves that the proposed MRI device has been classified by the U.S. food and drug administration as a class I, class II or class III device under 21 USC 360c to k;

(b) The applicant provides written documentation that the area housing the MRI device, including necessary arrangements for mobile MRI

equipment, will be constructed in accordance with standards established by the U.S. food and drug administration, the manufacturer and the national electrical manufacturers association and in accordance with applicable federal and state standards;

(c) The applicant includes with the application a written plan for an ongoing quality assurance program for MRI which includes at least the following:

1. A safety manual governing the equipment and its location, providing coverage of security measures and hazards;

2. Procedures for managing emergencies within the MRI facility or with mobile equipment, in conformity with accepted medical practices; and

3. Protocols that ensure that all MRI scans performed are medically necessary and will not unnecessarily duplicate other services;

(d) The applicant documents that adequate numbers of at least the following personnel will be available, either through direct employment or through an agreement with the manufacturer or a serice contract, consistent with the applicant's projected utilization determined under sub. (3) (b), patient needs and the facility's operational needs:

1. A director of the MRI service who is a board-certified or board-eligible radiologist, whose primary responsibility over the last 3 years has been in the interpretation of cross-sectional imaging for all body areas and who has had at least 60 hours of instruction in the methods and principles of MRI at a facility with an operational MRI device;

2. One or more licensed physicians who have attained a thorough knowledge of the methods and principles of MRI through continuing medical education (CME) credits, experience or post-graduate education which qualifies them to interpret MRI scans in the specialty field appropriate to each physician;

3. A medical physicist who is certified by the American board of radiology and has a thorough knowledge of MRI techniques; and

4. Technologists who have been specially trained in MRI methods;

(e) The applicant demonstrates that MRI will function as an integrated component of a comprehensive diagnostic imaging inpatient or outpatient service, by documenting in writing that it has access, either on-site or through formal referral arrangements, to equipment and personnel for conventional radiology, computed tomography, ultrasound, angiography and nuclear medicine;

(f) The applicant demonstrates that the proposed MRI service will serve as a regional resource for physicians by providing the department with the following:

1. A written plan for a system of referrals, which shall include a feedback mechanism for providing patient information to the referring physician and facility;

2. A written plan for maintaining current listings of appropriate clinical applications of MRI for the guidance of on-site and referring physicians and facilities; and

3. A written plan for a continuing education and training program, which shall include education of all interested physicians in the specific indications and contraindications of MRI use; and

(g) The applicant provides a written plan for scheduling patients that ranks patients in order of priority according to standards of need and appropriateness rather than source of referral.

(5) FINANCIAL FEASIBILITY. The department shall not approve an application unless the applicant demonstrates that the project is financially feasible by:

(a) Documenting that the projected average total cost per MRI procedure, including but not limited to fixed and variable operating costs, is similar to costs for similar MRI services provided in similar settings. In projecting the average total cost per MRI procedure, the applicant shall base this calculation on the projected utilization determined under sub. (3) (b);

(b) Documenting that the projected average charge per MRI procedure, excluding the charges for professional fees, ancillary services and hospitalization, is similar to charges for similar MRI services provided in similar settings;

(c) Documenting the projected overall charge per MRI procedure, which includes at least the average charge per MRI procedure under par. (b) plus charges for professional fees; and

(d) Documenting the net financial impact on its hospital rates, if the applicant is hospital-based.

(6) MOBILE MRI EQUIPMENT. For an application relating to mobile MRI equipment, the applicant shall be the person acquiring the MRI equipment.

(7) CONCURRENT REVIEW. The provisions in s. HSS 123.08 (10) shall be used for concurrent review when there are 2 or more applications. The department shall approve the application or applications receiving the highest score based on a comparative analysis of the applications using all applicable review criteria in s. HSS 123.13, the review criteria in subs. (3) to (6) and the following special review criteria:

(a) Preference shall be given to the application proposing a multifacility or shared service arrangement and, if more than one application proposes a multifacility or shared service arrangement, the one that provides written documentation demonstrating the greatest number and diversity of patient referrals from referring specialists;

(b) Preference shall be given to the application providing the best geographical accessibility for the population being served in the health service area as determined by an analysis by the department of the geographical market areas that have been identified by each applicant as areas where the applicant intends to focus its resources and marketing strategies for the proposed MRI device. Each applicant shall provide the department with the number of anticipated patient referrals from each identified market area and the patient origin by county for all referrals; and

(c) Preference shall be given to the application providing the greatest number of MRI scan hours per week in relation to the number of qualified staff set forth in sub. (4) (d).

(8) DATA REPORTING REQUIREMENTS. All entities in the state having MRI shall provide the department and the appropriate HSA with data relating to the number of patients served, patient utilization, operating costs, patient origin and any other information deemed necessary by the department to determine compliance with this section. The information shall be provided, upon request, in a format prescribed by the department for purposes of evaluation and project review. The department may not request the information more often than twice a year.

(9) REVISION OF THE RULE. The department shall review this section within 2 years of its effective date.

History: Cr. Register, March, 1986, No. 363, eff. 4-1-86.

HSS 123.25 Extracorporeal shock wave lithotripsy criteria. (1) USE. The criteria set out in this section shall be used by the department to review applications relating to extracorporeal shock wave lithotripsy. The applicable criteria of s. HSS 123.13 shall also be used in the review of applications subject to this section.

(2) DEFINITIONS. In this section:

(a) "ESWL procedure" means one patient treatment which includes setup time, using a computerized fluoroscopic x-ray system to position the stone in the passage of the shock waves and to monitor stone destruction, coordinating the shock waves with the electrocardiogram, delivering the shock waves and cleanup time.

(b) "Extracorporeal shock wave lithotripsy" or "ESWL" means a noninvasive technique for disintegrating urinary stones by focusing shock waves on a urinary stone from outside the body.

(c) "Lithotriptor" means the device used to generate the shock waves which disintegrate the urinary stones.

(d) "Percutaneous stone surgery" means removal of urinary stones by means of an incision through the skin rather than by ESWL.

(e) "Urinary stones" mean renal or kidney and ureteral calculi.

(3) NEED FOR EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY SERVICES. The department shall not approve an application under this section unless:

(a) Approval would result in no more than one lithotriptor in the health planning area and no more than 2 lithotriptors statewide, not including any lithotriptor under an exemption granted pursuant to s. 150.63, Stats.; and

(b) The applicant demonstrates that the proposed lithotriptor will have sufficient resources, referrals and patient volume to support 800 procedures annually within 3 years following initiation of the service. Multifacility, free-standing, shared service and mobile ESWL applicants shall include patient volume from all participating hospitals, clinics and physician groups. A bilateral treatment of kidney stones shall count as two ESWL procedures. The department shall analyze the 3-year utiliza-

tion projection based on written documentation provided by the applicant which includes:

1. The proposed area from which the applicant will draw its patients, including other states;

2. A description of the assumptions and methodology used to project utilization; and

3. The projected utilization from the proposed area under subd. 1. substantiated by referral agreements with appropriate physicians indicating their intent to use the lithotriptor or refer their patients to the lithotriptor. These agreements shall include estimates of the number of ESWL procedures for patients of each member of the applicant's medical staff and for patients referred by in-state and out-of-state physicians.

(4) REQUIRED RESOURCES. The department shall not approve an application under this section unless:

(a) The applicant proves that the proposed lithotriptor has been classified by the U.S. food and drug administration as a class I, class II or class III device under 21 USC 360c to k;

(b) The applicant provides written documentation that the area housing the lithotriptor, including necessary arrangements for mobile ESWL equipment, will be constructed in accordance with standards established by the U.S. food and drug administration and the manufacturer and in accordance with applicable federal and state standards;

(c) The applicant includes with the application a written plan for an ongoing quality assurance program for ESWL which includes at least the following:

1. A safety manual governing the equipment and its location, providing coverage of security measures and hazards;

2. Procedures for managing emergencies within the ESWL facility or with mobile equipment, in conformity with accepted medical practices; and

3. Protocols that ensure that all ESWL procedures performed are medically necessary and will not unnecessarily duplicate other services;

(d) The applicant documents that at least the following personnel will be available when patients are undergoing treatment:

1. A urologist who has attained a thorough knowledge of extracorporeal shock wave lithotripsy either by documented specific training or postgraduate education and experience;

2. An anesthesiologist; and

3. A technician with documented education and experience in radiology and lithotriptor technology;

(e) The applicant demonstrates in writing that it is able to provide the following care as needed for the patient to sustain operation of the ESWL service:

1. Medical services, which include at least:

a. Anesthesiology;

b. Cardiology;

c. Radiology, including diagnostic x-ray, fluoroscopy, intravenous pyelogram tomography, ultrasound, and placement of percutaneous nephrostomy for percutaneous stone surgery; and

d. Urology, capable of performing percutaneous nephrostomy, ureteroscopy, medical management of calculi, transurethral ureteral manipulation of the calculi, and surgery to remove calculi from the urinary tract;

2. Nursing services;

3. Laboratory services, as follows:

a. Chemistry;

b. Hemotology;

c. Microbiology; and

d. Urinalysis; and

4. Ancillary services, which include at least:

a. Pharmacy; and

b. Recovery room;

(f) The applicant demonstrates that many physicians will have access to and use the lithotriptor by providing the department with the following:

1. A written plan for a system of referrals, which shall include a feedback mechanism for providing patient information to the referring physician and facility; and

2. A written plan for a continuing education and training program, which shall include education of all interested physicians in the specific indications and contraindications of ESWL use; and

(g) The applicant provides a written plan for scheduling patients that ranks patients in order of priority according to standards of need and appropriateness rather than source of referral.

(5) FINANCIAL FEASIBILITY. The department shall not approve an application unless the applicant demonstrates that the project is financially feasible by:

(a) Documenting that the projected average total cost per ESWL procedure, including but not limited to fixed and variable operating costs, is similar to costs for similar ESWL services provided in similar settings. In projecting the average total cost per ESWL procedure, the applicant shall base this calculation on the projected utilization determined under sub. (3) (b);

(b) Documenting that the projected average charge per ESWL procedure, excluding the charges for professional fees, ancillary services and hospitalization, is similar to charges for similar ESWL services provided in similar settings;

(c) Documenting the projected overall charge per ESWL procedure, which includes at least the average charge per ESWL procedure under par. (b) plus charges for professional fees, ancillary services and hospitalization; and

(d) Documenting the net financial impact on its hospital rates, if the applicant is hospital-based, including the net change in surgical revenues which results from substitution of the new technology.

(6) MOBILE ESWL EQUIPMENT. For an application relating to mobile ESWL equipment, the applicant shall be the person acquiring the ESWL equipment.

(7) CONCURRENT REVIEW. The provisions in s. HSS 123.08 (10) shall be used for concurrent review when there are 2 or more applications. The department shall approve the application or applications receiving the highest score based on a comparative analysis of the applications using all applicable review criteria in s. HSS 123.13, the review criteria in subs. (3) to (6) and the following special review criteria:

(a) Preference shall be given to the application proposing a multifacility or shared service arrangement and, if more than one application proposes a multifacility or shared service arrangement, the one that provides written documentation demonstrating the greatest number and diversity of patient referrals from referring specialists;

(b) Preferences shall be given to the applicant providing the best geographical accessiblity for the population being served in the health service area as determined by an analysis by the department of the geographical market areas that have been identified by each applicant as areas where the applicant intends to focus its resources and marketing strategies for the proposed lithotriptor. Each applicant shall provide the department with the number of anticipated patient referrals from each identified market area and the patient origin by county for all referrals; and

(c) Preferences shall be given to the application providing the greatest number of ESWL procedure hours per week in relation to the number of qualified staff set forth in sub. (4) (d).

(8) DATA REPORTING REQUIREMENTS. All entities in the state having lithotriptors shall provide the department and the appropriate HSA with data relating to the number of patients served, patient utilization, operating costs, patient origin and any other information deemed necessary by the department to determine compliance with this section. The information shall be provided, upon request, in a format prescribed by the department for purposes of evaluation and project review. The department may not request the information more often than twice a year.

(9) REVISION OF THE RULE. The department shall review this section within 2 years of its effective date.

History: Cr. Register, March, 1986, No. 363, eff. 4-1-86.

HSS 123.27 State medical facilities plan. (1) PLAN REQUIREMENT. The department shall prepare and adopt a state medical facilities plan (SMFP) at least once every 3 years, pursuant to s. 150.83, Stats., in order to determine the number and type of hospital beds needed in each acute care service area of the state. The plan shall designate acute care

service areas, describe the hospital system in the state, identify needed and surplus hospital beds, describe needed and surplus health services and include other components useful to the department in reviewing project applications. Applications submitted for review under s. HSS 123.08 (4) shall be consistent with the standards and findings set forth in the SMFP.

(2) ACUTE CARE SERVICE AREAS. The department shall designate acute care service areas in the SMFP. The department shall define those areas using the methodology provided in this subsection and the SMFP, and shall update the areas at least every 3 years. Acute care service areas shall not be construed to limit or inhibit the development of multihospital systems, hospital consolidations or mergers between hospitals in different service areas. Calculations used in determining acute care service areas shall be based on information contained in the hospital discharge survey conducted by the department. Hospitals seeking approval under this chapter shall participate in the discharge survey and the department's annual survey of hospitals.

(a) *Methodology.* 1. Definitions. In this paragraph:

a. "Market strength" means the number of patients from a zip code area that go to a hospital divided by the total number of patients from the zip code area that are hospitalized.

b. "Milwaukee area hospitals" means those hospitals located in the cities of Brookfield, Cudahy, Menomonee Falls, Milwaukee, New Berlin, Oconomowoc, Waukesha, Wauwatosa and West Allis.

c. "Zip code area" means the delivery boundaries used by the U.S. postal service and mapped by the department in a publication entitled, *Population Estimates and Maps for Five-Digit Zip Code Areas in Wisconsin.*

2. Criteria for defining areas. Acute care service areas shall be defined by means of a methodology which:

a. Identifies where persons from a given geographic area go for hospital care; and

b. Groups hospitals which, based on recorded use, draw patients from the same service population base. Groupings of hospitals sharing d service populations shall be generated by a computer analysis, using the methodology set forth in this paragraph and the SMFP.

3. Areas defined by population served. Acute care service areas shall be defined by the population served by the hospitals rather than by governmental or other common geographical boundaries. A specific geographic area may be included in more than one service area, depending upon the relevant portion of the population seeking care in 2 or more service areas.

4. Market strength. An acute care hospital's market strength in a zip code area shall be calculated for all zip codes from which the hospital draws patients. The hospital's market strength in a zip code area shall be equal to the number of patients from the zip code area that go to the hospital divided by the total number of patients from that zip code area that are hospitalized.

a. The hospital's overall average market strength shall be the weighted average of all of its individual market strength ratios. The overall mar-

ket strength shall be computed for every hospital. Hospitals shall be rank-ordered by their average market strength from lowest to highest.

b. The hospital with the lowest overall market strength shall be selected and the average market strength for all other hospitals in the state shall be calculated for those zip code areas served by the hospital with the lowest overall market strength.

c. The combined market strength of the hospital with the lowest market strength and the hospital with the highest market strength shall be compared to the average market strength of the hospital with the lowest market strength. If there is a significant improvement of at least 10% in the overall market strength, the hospitals shall be combined into one ser-

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APPENDIX E: NOTES

(1) Total patient days from the Wisconsin Annual Survey of Hospitals excluding patient days for psychiatric and chemical dependency (AODA) services and from neonatal intensive and intermediate care.

(2) Total approved beds excluding psychiatric, chemical dependency (AODA), neonatal intensive and intermediate care.

(3) [(1) + 365] + (2)

(4) Sum of (a) + (b) + (c) + (d):

(a)	Medical/surgical service bed complement (all other beds excluding psychiatric, chemical dependency and neonatal intensive/intermediate)	+	Total approved beds (excluding psychiatric, chemical dependency, and neonatal intensive/ intermediate)	+	Medical/surgical occupancy standard for the hospital's medical/ surgical bed complement from Appendix D.
(b)	Pediatric service bed complement	+	Total approved beds (excluding psychiatric, chemical dependency, and neonatal intensive/ intermediate)	+	Pediatric occupancy standard in Appendix D unless the unit is less than 10 beds for which the medical/surgical occupancy rate in (4a) is used.
(c)	Obstetrics service bed complement	+	Total approved beds (excluding psychiatric, chemical dependency, and neonatal intensive/ intermediate)	+	Obstetrics occupancy standard in Appendix D.
(d)	ICU/CCU bed complement	+	Total approved beds (excluding psychiatric, chemical dependency, and neonatal intensive/ intermediate)	+	ICU/CCU occupancy standard in Appendix D.

(5) $(2) - \left[\frac{(1)+(4)}{365}\right]$

(6) Sum of current hospital excess for all hospitals in ACSA [(5) + (5a) + (5b)]

(7) Total projected ACSA as stated in the SMFP and as calculated in Appendix C-1.

(8) (5) × (7) + (6)

(8a) (5a) × (7) + (6)

(8b) (5b) × (7) + (6)

If (5), (5a) or (5b) are negative, the numbers are excluded from the calculation to determine (6) and therefore in the calculation of 199X proportionate share of hospital excess.

Note: (5a) and (5b) represent current hospital excess for the other hospitals in the ACSA XX.

APPENDIX F

METHODOLOGY FOR DETERMINING THE NUMBER OF CLINICALLY-APPLICABLE MRI DISCHARGES

[s. HSS 123.24 (3) (a) and (b)]

Major ICD-9-CM Groupings		Inpatient MRI Utilization Weights
001-139	Infectious and parasitic diseases	6.25%
140-239	Neoplasms	20.93%
290-319	Mental disorders	.11%
320-389	Diseases of the nervous system and sense organs	11.46%
390-459	Diseases of the circulatory system and connective tissue	15.29%
710-739	Diseases of the musculoskeletal system and connective tissue	7.78%
740-759	Congenital anomalies	1.99%
800-999	Injury and poisoning	.56%

The methodology to determine the number of inpatient clinically-applicable MRI discharges is as follows:

1. Count the number of principal diagnosis inpatient discharges that correspond to each major grouping of ICD-9-CM codes listed above; and

2. Multiply the number for each major grouping by the corresponding inpatient MRI utilization weight and add the products together to produce the number of inpatient clinically-applicable MRI discharges.

Note: ICD-9-CM codes refer to the standard disease codes and nomenclature found in the *International Classification of Diseases – 9th Revision – Clinical Modification*, prepared by the Commission on Professional and Hospital Activities for the U.S. National Center for Health Statistics. The major ICD-9-CM groupings and inpatient MRI utilization weights are based on the work of a panel of experts and high correlation averages as reported in the American Hospital Association's publication, *NMR – Issues for 1985 and Beyond.*