ORDER OF THE
DEPARTMENT OF HEALTH SERVICES
TO ADOPT RULES

The Wisconsin Department of Health Services proposes an order **to renumber** DHS 124.24 (3) to DHS 124.08; **to repeal** DHS 124.02 (1), (7), (8), (15) to (18), (20) and (21), DHS 124 Subchapter III, DHS 124.13 to 124.24 (2), and DHS 124.25 to DHS 124.28, DHS 124.32 (1), (3) (c) and (5), DHS 124.33, and DHS 124.34 (1) and (2), DHS 124.34 (4) to (7), DHS 124.35 (1) and (3) to (7), and DHS 124.36 (1) to (10), and DHS 124.40 and to **repeal and recreate** DHS 124.02 (10) and (14), DHS 124.04 (2), DHS 124 Subchapter II and (title), DHS 124.29 and (title), DHS 124.30 and (title), and DHS 124.131 are repealed and recreated and **to create** DHS 124.34 (3) (c) and DHS 124.36 (11) (Note), relating to Hospitals.

RULE SUMMARY

Statute interpreted
Sections 50.33 (2) (c), 50.34, 50.36 (2) (a), 50.36 (3), 50.36 (4), 50.36 (6m), 50.377 (1), and 51.61(1), Stats.

Statutory authority
Sections 50.36 (1), 50.36(1m), 50.36 (2) (b), 51.61(9), and 227.11 (2) (a) Stats.

Explanation of agency authority
"Pursuant to s. 50.36 (1), Stats., the Department may promulgate additional rules if they are necessary to provide safe and adequate care and treatment of hospital patients and to protect the health and safety of the patients and employees. The proposed rules are necessary to effectuate the purposes of the statutes listed in the "statute interpreted" section, and also necessary to comply with s. 227.11 (2) (a), Stats."

Related statute or rule
See the "statutes interpreted" and "statutory authority" sections.

Plain language analysis
Beginning July 1, 2016, pursuant to s. 50.36 (1m) (a), (b), and (c), Stats., the department may not, except for s. DHS 124.24 (3), enforce any of the rules contained in s. DHS 124.40 or subch. II, III, or IV of ch. DHS 124. Also effective July 1, 2016, s. 50.36 (1), Stats., requires the department to use and enforce Medicare conditions of participation for hospitals as the minimum standards that apply to hospitals and interpret the conditions for Medicare participation for hospitals using guidelines adopted by the federal Centers for Medicare and Medicaid Services unless the department determines that a different interpretation is reasonably necessary to protect public health and safety. The department may promulgate additional rules if they are necessary to provide safe and adequate care and treatment of hospital patients and to protect the health and safety of the patients and employees, per s. 50.36 (1), Stats.

The department has determined that the following rule changes are necessary to ensure a safe and adequate environment for hospital patients and employees and to protect the health and welfare of the patients and employees. The rule would affect hospitals licensed by the State of Wisconsin.

<u>Plans of correction</u>
Section 50.36 (4), Stats., states that if the department takes enforcement action against a hospital for a violation of the requirements for hospitals, and the department subsequently conducts an on-site inspection of the hospital to review the hospital's action to correct the violation, the department may, unless the hospital is operated by the state, impose a $200 inspection fee on the hospital. The proposed rules establish the manner in which violations of requirements stated in ch. DHS 124 and ss. 50.32 to 50.39, Stats., must be

communicated to hospitals and the manner in which the hospital communicates its plan to correct the violation to the department.

Waivers and variances

Section 50.36 (6m), Stats., authorizes the department to grant a variance or a waiver of a requirement for hospitals. The proposed rule interprets the circumstances under which a waiver or variance would be seen to support the efficient and economic operation of the hospital.

Maternity and neonatal care

Section 50.36 (1), Stats., provides that the department must use and enforce the conditions for Medicare participation for hospitals as quality control measures, but may promulgate such additional rules as it deems necessary for safe and adequate care of hospital patients and to protect the health and safety of the patients and employees. The department has determined that additional rules are necessary to address the care and treatment of maternity patients and newborns regarding personnel, admission, patient placement and transfer, delivery, security, labor inducing medication and nursery.

Patient rights and responsibilities in critical assess hospitals

Section 50.36 (1), Stats., provides that the department must use and enforce the conditions for Medicare participation for hospitals as quality control measures, but may promulgate such additional rules as it deems necessary for safe and adequate care of hospital patients and to protect the health and safety of the patients and employees. The conditions of participation for Medicare do not address patient rights in the critical access hospital setting. Proposed rules establish patient rights similar to the rights in the previous provisions contained in s. DHS 124.05 (3) (a).

Freestanding emergency departments

Section 50.36(1), Stats., provides that the department must use and enforce the conditions for Medicare participation for hospitals as quality control measures, but may promulgate such additional rules as it deems necessary for safe and adequate care of hospital patients and to protect the health and safety of the patients and employees. It was determined that additional rules were necessary to address physical environment, personnel, laboratory, and pharmacy and ambulance delivery in these settings.

Physical environment

Existing rules under ch. DHS 124, subch. V, relating to the hospital's physical environment, require hospitals to design, construct, and operate their facilities in accordance with the Life Safety Code, national standards on construction and fire safety established by the National Fire Protection Association. The rules also require that patient rooms be of sufficient size, supported by sanitary support spaces and afford the patient privacy and the means to contact staff, fire safe finishes, emergency procedures, and fire incident reporting to the department. Proposed rules require hospitals to meet the provisions of the Life Safety Code (LSC) adopted into the federal Conditions of Participation.

Fee schedule for plan review

Section 50.36 (2) (a), Stats., requires the department to conduct plan reviews of all capital construction and remodeling projects of hospitals to ensure that the plans comply with applicable building code requirements under ch. 101, Stats., and with the physical plant requirements under ch. 50, Stats., or department rules. Section 50.36 (2) (b), Stats., requires the department to promulgate rules that establish a fee schedule for its services in conducting plan reviews. Proposed rules establish standards for plan reviews and prescribe a fee schedule for providing plan review services.

Summary of, and comparison with, existing or proposed federal regulations

There appears to be no existing or proposed federal regulations that address the activities regulated by the proposed rule.

Comparison with rules in adjacent states

Illinois:
Plans of correction/waivers/variances: Illinois has no administrative code regarding plans of correction, waivers and variances.

Maternity and neonatal care: Illinois has extensive regulations regarding obstetric departments including standards related to accommodations and facilities for obstetric patients, personnel requirements medical personnel, procedures for care of mother and infants, identification of infants, pharmacy services, caesarean birth, labor, delivery, recovery and postpartum care, records and infant feeding.

Patient rights in critical access hospitals: Illinois has no administrative code regarding patient rights in critical access hospitals.

Freestanding emergency departments: Illinois has extensive regulations for freestanding emergency centers and a Certificate of Need program that reviews all applications for freestanding emergency centers. Illinois law allows a maximum of 10 freestanding emergency centers in the state.

Physical Environment: Illinois has extensive rules regarding hospital physical environment that address orientation and follow-up training for staff in the principles of asepsis, cross-infection and safe practices, adequacy of space and the structure and equipment kept in good repair and maintained in operating condition at all times. Emergency eclectic service and weekly inspections and testing of emergency generator are mandated. Standards also address the adequacy of water supply regulated by thermostatic or other control devices, ventilation, heating air condition and air exchange systems provide and maintained in good repaint and operating in a manner which will prevent the spread of infection and provide patient comfort. All sewage and liquid wastes are to be disposed of in a municipal sewage system where such facilities are available.

Plan review and fee schedule: The Illinois Department of Public Health, Design and Construction Section, is responsible for plan review for licensed hospitals. A certificate of need review board approval is required prior to plan review of any new construction involving additional bed capacity. Local municipalities individually enforce the state's commercial building code. Plan review fees are based on a total of estimated fixed equipment value and the cost of construction.

Iowa:
Plans of correction/waivers/variances: Iowa has no administrative code regarding plans of correction, waivers and variances.

Maternity and neonatal care: Iowa has no administrative code regarding maternity and neonatal care.

Patient rights in critical access hospitals: Iowa has no administrative code regarding patient rights in critical access hospitals.

Freestanding emergency departments: Iowa has no administrative code regarding freestanding emergency departments.

Physical Environment: Iowa has no administrative code regarding physical environment.
Plan review and fee schedule: The Iowa State Fire Marshall Division, State Building Code Bureau requires all hospital projects involving federal regulations for new buildings, additions to existing buildings, remodeling or renovation of existing buildings and change of occupancy to undergo a plan review and inspection. Plan review fees are based on a total of estimated material, labor, and construction costs.

Michigan:

Plans of correction/waivers/variances: Michigan has no administrative code regarding plans of correction, waivers and variances.

Maternity and neonatal care: Michigan has rules for maternity hospitals and departments that require hospitals to meet physical plant standards, establish minimum policies regarding the use and administration of mediations, and provide required equipment and supplies, post-delivery and nursery procedures, care provided to the mother and the maintenance of medicals records.

Patient rights in critical access hospitals: Michigan has no administrative code regarding patient rights in critical access hospitals.

Freestanding emergency departments: Michigan has no administrative code regarding freestanding emergency departments.

Physical Environment: Michigan has no administrative code regarding physical environment.

Plan review and fee schedule: The Michigan Department of Licensing and Regulatory Affairs, Health Facility Engineering Section, provides plan review and inspection services for the design and construction of hospitals to ensure the safe, efficient, and effective delivery of healthcare. Plan review fees are based on a total of estimated fixed equipment value, professional fees, and the cost of construction.

Minnesota:
Plans of correction/waivers/variances: Minnesota has no administrative code regarding plans of correction, waivers and variances.

Maternity and neonatal care: Minnesota has rules for obstetrical department that establish minimum delivery room size, illumination, beds, equipment and obstetrical isolation facilities. Additional rules establish criteria for newborn nursery, bassinets, observation window, incubators and formula preparation.

Patient rights in critical access hospitals: Minnesota has no administrative code regarding critical access hospitals.

Freestanding emergency departments: Minnesota has no administrative code regarding freestanding emergency departments.

Physical Environment: Minnesota has general rules that require the hospital structure and equipment to be kept in good repair and operational all times with regarding for the health, treatment and comfort and safety of the patient and personnel. The rule provides standards that address heating, laundry, lighting, emergency lighting, stairways and ramps, storage, ventilation, walls, floors and ceilings. The rule also established standards for water facilities regarding adequacy of supply, sewage disposal, plumbing and the number and location of toilets, handwashing and bathing facilities.

Plan review and fee schedule: The Minnesota Department of Industry and Department of Health provide plan review and inspection services for hospital physical plant state licensure and federal certification requirements. The scope of these responsibilities encompasses both construction of new spaces and modifications to existing spaces. Plan review fees are based on a total of estimated material, labor, and construction costs.

Summary of factual data and analytical methodologies
The department relied on all of the following sources to draft the proposed rule and to determine the impact on small businesses.

- The department solicited comments from representatives of the Wisconsin Hospital Association, Wisconsin Public Psychiatric Hospital, and Wisconsin Healthcare Engineering Association. Representatives from these organizations reviewed the initial draft of the rule.

- DHS databases including the ASPEN Information System which contains demographic, licensing, program, and compliance history of hospitals in Wisconsin.

Analysis and supporting documents used to determine effect on small business
TBD, pending an economic impact analysis.

Effect on small business
The rules are anticipated to have little to no economic impact on small businesses.

Agency contact person
Pat Benesh, Division of Quality Assurance, 608-264-9896

Statement on quality of agency data
The data sources used to draft the rules and analyses are accurate, reliable and objective and are listed in the Summary of Factual Data and Analytical Methodologies section of this rule order.

Place where comments are to be submitted and deadline for submission
Comments may be submitted to the agency contact person that is listed above until the deadline given in the upcoming notice of public hearing. The deadline for submitting comments and the notice of public hearing will be posted on the Wisconsin Administrative Rules Website at http://adminrules.wisconsin.gov after the hearing is scheduled.

RULE TEXT

SECTION 1. DHS 124.02 (1), (7), (8), are repealed.

SECTION 2. DHS 124.02 (10) and (14) are repealed and recreated to read:

DHS 124.02 (10) "Hospital staff" means the hospital's organized component of practitioners that was recommended to be on the hospital staff by the hospital staff, and is comprised of individuals appointed by the governing body of the hospital.

DHS 124.02 (14) "Practitioners" means physicians, dentists, podiatrists or other professions permitted by Wisconsin law to distribute, dispense and administer medications in the course of professional practice, admit patients to a hospital, or provide any other health care service that is within that professions' scope of practice and for which the governing body grants clinical privileges.

SECTION 3. DHS 124.02 (15) to (18), (20), and (21) are repealed.

SECTION 4. DHS 124.04 (2) is repealed and recreated to read:

DHS 124.04 (2) REQUIREMENTS FOR WAIVERS AND VARIANCES. A hospital may submit a request in writing to the department to grant a waiver or variance. The department may grant the waiver or variance if the department determines:

(a) The waiver or variance is necessary to protect the public health, safety, or welfare.

(b) The waiver or variance will support the efficient and economic operation of the hospital, such as when any of the following apply:

1. Strict enforcement of a requirement would result in unreasonable hardship on the hospital or on a patient.

2. An alternative to a rule, which may involve a new concept, method, procedure or technique, new equipment, new personnel qualifications or the conduct of a pilot project, is in the interests of better care or management.

SECTION 5. DHS 124 Subchapter II and (title) are repealed and recreated to read:

Subchapter II -- Requirements

DHS 124.05 Statements of deficiency and plans of correction.

(1) Based upon an inspection and investigation by the department under s. 50.36 (4), Stats., the department may issue a statement of deficiency notifying the hospital of noncompliance with a requirement of ch. 50, Stats., or department rules.

(2) The hospital shall submit a plan of correction to the department within 10 calendar days, including holidays and weekends, after receiving a statement of deficiency. The plan of correction shall include a reasonable fixed time period within which deficiencies are to be corrected.

(3) After the plan of correction is submitted, the department shall determine whether the corrections proposed by the hospital would result in compliance with the requirements of ch. 50, Stats., and department rules, and notify the hospital of the department's determination. If the department determines the corrections proposed by the hospital would not result in compliance, the department's notice shall describe the deficiency of the plan of correction.

DHS 124.06 Patient rights and responsibilities in critical access hospitals.

(1) Every critical access hospital shall have written policies on patient rights and responsibilities, established by the governing body, which shall provide all of the following:

(a) The patient may not be denied appropriate care because of the patient's race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment.

(b) The patient shall be treated with consideration, respect and recognition of the patient's individuality and personal needs, including the need for privacy in treatment.

(c) The patient's medical record, including all computerized medical information, shall be kept confidential as required by law.

(d) The patient, or a person authorized to act on behalf of the patient in making health care related decisions, shall have access to the patient's medical record as permitted by law.

(e) The patient shall be entitled to know who has overall responsibility for the patient's care.

(f) The patient, or any person authorized to act on behalf of the patient in making health care related decisions, shall receive information about the patient's illness, course of treatment and prognosis for recovery.

(g) The patient shall have the opportunity to participate to the fullest extent possible in planning for the patient's care and treatment.

(h) The patient or his or her designated representative shall be given, at the time of admission, a copy of the critical access hospital's policies on patient rights and responsibilities.

(i) Except in emergencies, the consent of the patient or a person authorized to act on behalf of the patient in making health care related decisions shall be obtained before treatment is administered.

(j) The patient may refuse treatment to the extent permitted by law and shall be informed of the medical consequences of the refusal.

(k) The informed consent of the patient or a person authorized to act on behalf of the patient in making health care related decisions shall be obtained before the patient participates in any form of research.

(L) Except in emergencies, the patient may not be transferred to another facility without being given a full explanation for the transfer, without provision being made for continuing care and without acceptance by the receiving institution.

(m) The patient shall be permitted to examine, and to receive an explanation of, any bill that the patient receives from the critical access hospital, and the patient shall receive, upon request, information relating to financial assistance available through the critical access hospital.

(n) The patient shall be informed of the patient's responsibility to comply with the rules of the critical access hospital, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information concerning payment of charges.

(o) The patient shall be informed in writing about the critical access hospital's policies and procedures for initiation, review and resolution of patient complaints, including the address where complaints may be filed with the department.

(p) The patient may designate persons who are permitted to visit the patient during the patient's stay at the critical access hospital.

(2) A patient who receives treatment at a critical access hospital for mental illness, a developmental disability, alcohol abuse or drug abuse shall have, in addition, the rights listed under s. 51.61, Stats., and ch. DHS 94.

(3) Critical access hospital staff assigned to direct patient care shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and appropriate in-service training activities.

(Note) Access to the records of a patient receiving treatment for mental illness, a developmental disability, alcohol abuse or drug abuse is governed by s. 51.30 (4), Stats.

DHS 124.07 Maternity and neonatal care.

(1) DEFINITIONS. In this section:

(a) "Neonatal" means pertaining to the first 28 days following birth.

(b) "Perinatal" means pertaining to the mother, fetus or infant, in anticipation of and during pregnancy and through the first 28 days following birth.

(c) "Nurse-midwife" means an individual licensed under s. 441.15, Stats., and ch. N 4.

(2) PERSONNEL.

(a) A registered nurse shall be responsible for the admission assessment of the maternity patient in labor and continuing assessment and support of the mother and fetus during labor, delivery and the early postpartum period.

(b) A registered nurse shall be responsible for the admission assessment of the newborn infant and continuing assessment until the newborn infant is stabilized as defined by current, accepted standards of practice.

(c) Hospitals with maternity units shall have a qualified anesthesia provider available at all times to provide emergency care to maternity patients.

(3) ADMISSION AND PATIENT PLACEMENT.

(a) The hospital shall establish and implement written policies for maternity and non-maternity patients who may be admitted to the maternity unit, including a policy that delineates medical staff responsibility for the admission of maternity patients in non-emergency situations.

(b) The hospital's infection prevention policies shall address patient placement and visitation in the maternity unit.

(c) The hospital shall establish and implement written policies for admission of newborn infants, including newborn infants born outside the hospital, and criteria for identifying conditions for directly admitting or readmitting newborn infants to the newborn nursery or neonatal intensive care unit for further treatment and follow-up care. For an infant delivered outside the hospital, admission may be made directly to the newborn nursery or neonatal intensive care unit if the admission complies with infection control policies adopted by the hospital to protect patients from communicable disease or infection.

(4) TRANSFER. A maternity service shall do all of the following:

(a) Provide adequate facilities, personnel, and equipment and support services for the care of high-risk infants, including premature infants, or a plan for transfer of these infants to a neonatal or pediatric intensive care unit.

(b) Establish and implement written policies and procedures for inter-hospital transfer of perinatal and neonatal patients.

(c) Establish and implement written policies for the transfer of infants from one hospital to another hospital.

(d) Personnel and equipment for the transfer of infants from one hospital to another hospital shall be available to each hospital's maternity service. The execution of transfer is a joint responsibility of the sending and receiving hospitals.

(5) DELIVERY.

(a) If cesarean deliveries are not performed in the maternity unit, equipment for neonatal stabilization and resuscitation shall be available during delivery.

(b) Delivery rooms shall be used only for delivery and operating procedures related to deliveries unless permitted by a written safety risk assessment that facilitates safe delivery of care.

(6) TESTS FOR CONGENITAL DISORDERS. The hospital shall establish and implement written policies that address the screening and testing of newborns for congenital and metabolic disorders consistent with s. 253.13, Stats., and ch. DHS 115.

(7) SECURITY.

(a) The hospital shall establish and implement written policies that address infant identification and security.

(b) An infant may be discharged only to a parent who has lawful custody of the infant or to an individual who is legally authorized to receive the infant. If the infant is discharged to a legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents. The hospital shall record the identity of the legally authorized individual to whom the infant is discharged.

(8) LABOR-INDUCING MEDICATIONS.

(a) Only a physician or a nurse-midwife may order the administration of a labor-inducing medication.

(b) Only a physician or a nurse-midwife or a registered nurse who has adequate training and experience may administer a labor-inducing medication.

(c) A registered nurse shall be present when administration of a labor-inducing medication is initiated and shall remain immediately available to monitor maternal and fetal well-being. Hospitals shall develop and implement policies allowing the registered nurse to discontinue the labor-inducing medication if circumstances warrant discontinuation and no standing orders by a physician or a nurse-midwife are in place authorizing their discontinuation.

(d) A registered nurse shall closely monitor and document the administration of a labor-inducing medication. Monitoring shall include monitoring of the fetus and monitoring of uterine contraction during administration of a labor-inducing medication.

(e) The physician or nurse-midwife, who prescribed the labor-inducing medication, or another physician or nurse-midwife, shall be readily available during its administration so that, if needed, he or she will arrive at the patient's bedside within 30 minutes after being notified.

(9) RELIGIOUS CIRCUMCISIONS. A separate room apart from the newborn nursery shall be provided when circumcisions are performed according to religious rites. A physician, physician's assistant or registered nurse shall be present during the performance of the religious rite. Aseptic techniques shall be used when an infant is circumcised.

DHS 124.09 Freestanding emergency departments.

(1) DEFINITIONS. In this subchapter: "Freestanding emergency department" means a dedicated location that is physically separate from a hospital's primary campus, with services and staff organized primarily for the purpose of delivering emergency medical services without requiring a previously scheduled appointment.

(2) FREESTANDING EMERGENCY DEPARTMENTS.

(a) A freestanding emergency department must have provider-based status under 42 CFR 413.65 and comply with the conditions for Medicare participation for hospitals and comply with subs. (3), (4), and (5).

(b) A freestanding emergency department shall be under the direction of the emergency services department of a Wisconsin licensed hospital.

(c) A freestanding emergency department shall provide emergency services 24 hours a day, seven days a week, 365 days a year, on an outpatient basis.

(3) PHYSICAL ENVIRONMENT.

(a) Freestanding emergency department shall be identifiable to a patient.

(b) The exterior entrance of a freestanding emergency department shall be at grade level, well-marked, and illuminated, with a covered ambulance bay.

(c) The freestanding emergency department equipment shall be readily available, serviced, maintained and adequate to provide comprehensive emergency care.

(4) PERSONNEL.

(a) There shall be sufficient qualified medical, nursing, and ancillary personnel available to the freestanding emergency departments at all times to manage the number and severity of emergency department cases anticipated by the location. At all times, freestanding emergency departments shall have on-site the following minimum staffing, equipment and services necessary to evaluate and treat patients:

1. One physician, who through education, training, and experience specializes in emergency medicine.

2. One registered nurse, who through education, training, and experience specializes in emergency nursing.

3. A laboratory technician to provide laboratory services.

(b) A person authorized to perform radiological services pursuant to ch. 462, Stats. shall be available at the freestanding emergency department, as follows:

1. At all times for plain films.

2. On-call to perform CT scanning within thirty minutes.

3. On-call to perform ultrasound within one hour.

(5) ANCILLARY SERVICES.

(a) Radiology.

1. Plain film, CT scanner and ultrasound equipment shall be available.

2. Radiologist interpretation of CT scans and ultrasounds shall be available within one hour.

3. The freestanding emergency department shall develop and implement a written policy for timely interpretation of plain film studies.

(b) Laboratory.

1. Blood or blood replacement shall be available within thirty minutes.

2. Services available within the freestanding emergency department shall be appropriate for the care of emergency medical cases anticipated by the location.

(c) Pharmacy, respiratory and social services.

1. The freestanding emergency department shall provide pharmacy and respiratory services appropriate for the care of emergency medical cases anticipated by the location.

2. Services and supplies available within the freestanding emergency department shall be appropriate for the care of emergency medical cases anticipated by the freestanding emergency department.

3. Written policies regarding the availability and utilization of social services shall be established.

(6) AMBULANCE DELIVERY. A freestanding emergency department shall:

(a) Establish written policies and procedures governing ambulance delivery of patients that are consistent with the local emergency medical service system.

(b) Communicate these policies to the local emergency medical services system to ensure appropriate routing of emergency cases by emergency medical technicians.

(c) Establish written policies regarding patient transfers to other medical facilities. The policies shall address transfers by ambulance and, if the freestanding emergency department determines it is appropriate for that location, by helicopter.

SECTION 6. DHS 124 Subchapter III and DHS 124.13 to 124.24 (2) are repealed.

SECTION 7. DHS 124.24 (3) is renumbered to DHS 124.08.

SECTION 8. DHS 124.25 to DHS 124.28 are repealed.

SECTION 9. DHS 124.29 and (title), DHS 124.30 and (title), and DHS 124.131 are repealed and recreated to read:

DHS 124.29 Plans for new construction and alterations.

(1) DEFINITIONS. In this section:

(a) "Alteration" has the meaning provided in SPS 361.05 International Building Code Sec. 202.

(b) "Existing construction" means a building which is in place or is being constructed with plans approved by the department prior to the effective date of this chapter.

(Note) The International Building Code is located at www.iccsafe.org

(2) SIGNING AND SEALING.

Construction documents submitted to the department for review shall be prepared, signed and sealed in accordance with ch. 443, Stats., and s. A−E 2.02.

(3) CONTENTS AND INFORMATION.

(a) Construction documents submitted to the department for review shall be dimensioned and drawn to scale. The scale used for the construction documents shall be indicated on the documents.

(b) Except as provided in sub. (2), at least 4 sets of construction documents shall be submitted to the department for review. At least one set of construction specifications shall be submitted to the department for review.

One complete set of plans may be submitted, provided it is accompanied with 3 copies of the cover sheet for the complete set, and provided all 4 cover sheets comply with sub. (2). A capital construction and scope of work application form shall be included with the construction documents and information submitted to the department for examination and approval.

(c) Fees shall be remitted to the department at the time the plans are submitted. No plan examinations, approvals, or onsite reviews shall be made until fees are received.

(4) APPLICATION APPROVAL.

(a) The department shall review and make a determination on an application for capital construction and scope of work review under this chapter within 30 business days.

(b) An application for conditional approval will not be granted if, upon examination, the department determines that the construction documents or application for approval require additional information.

(c) If, upon examination, the department determines that the construction documents and the application for approval comply substantially with this chapter, a conditional approval, in writing, may be granted and the plans will be stamped "conditionally approved." The applicant, before and during construction, shall comply with all conditions as stated in the construction approval before or during construction.

(d) If, upon examination, the department determines that the construction documents or application for approval do not substantially comply with this chapter, the application for conditional approval will be denied, in writing.

(5) EXPIRATION OF APPROVAL.

(a) *Building shell.* Plan approval by the department for new buildings and building additions shall expire 2 years after the approval date indicated on the approved building plans if the building shell is not closed-in within those 2 years.

(b) *Occupancy*. Plan approval by the department for new buildings and building additions shall expire 3 years after the approval date indicated on the approved building plans if the building is not ready for occupancy within those 3 years.

(c) *Alterations.* Plan approval by the department for interior building alterations shall expire one year after the approval date indicated on the approved building plans if the alteration work is not completed within that year.

(d) *HVAC construction only.* Plan approval by the department for heating, ventilating, or air conditioning construction that does not include any associated building construction shall expire one year after the approval date indicated on the approved plans if the building or building area affected by the plans is not ready for occupancy within that year.

(e) *Fire protection systems only*. Plan approval by the department for a fire protection system that does not include any associated building construction shall expire 2 years after the approval date indicated on the approved plans if the building or building area affected by the plans is not ready for occupancy within those 2 years.

(6) EXTENSION OF PLAN APPROVAL. Upon request and payment of the fee specified in s. DHS 124.31 (4) (d), the expiration dates in subs. (5) (a) to (e) may be extended, provided the request is submitted prior to expiration of the original approval.

(7) CHANGES TO APPROVED FINAL PLANS. Any changes in the approved final plans affecting the application of the requirements of this subchapter shall be shown on the approved final plans and shall be submitted to the department for approval before construction is undertaken. The department shall notify the hospital in writing of any conflict with this subchapter found in its review of modified plans and specifications.

(8) PERMISSION TO START CONSTRUCTION.

(a) A building owner may request and the department may grant permission to start construction for the footings and foundations upon submission of construction documents under s. DHS 124.29.

(b) The department shall review and make a determination on an application for permission to start construction of the footings and foundations within 3 business days of receipt of the application and all forms, fees, construction documents and information required to complete the review.

(c) A building owner who has been granted permission to start construction of the footings and foundations may proceed at the owner's own risk without assurance that a conditional approval for the building will be granted.

(9) ONSITE REVIEWS. At the request of the owner, the department may conduct onsite reviews during the construction phase of the project including but not limited to framing reviews, above ceiling reviews, and finish reviews.

DHS 124.30 Plan review.

(1) DEFINITIONS. In this section:

(a) "Life Safety Code" means the National Fire Protection Association's (NFPA) Standard 101.

(b) "New construction" means construction for the first time of any building or addition to an existing building, the plans for which are approved after July 1, 2016.

(Note) Copies of the Life Safety Code and related codes can be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts, USA 02169-7471.

(2) Before the start of any new construction or alteration project for a hospital, the plans for the construction or alteration shall be submitted to the department, pursuant to s. DHS 124.29, for review and approval by the department.

(3) The department shall review hospital construction and alteration plans for compliance with:

(a) Ch. DHS 124.

(b) Chapters SPS 361 to 366, except s. SPS 361.31 (3). Where chs. SPS 361 to 366 refer to the department of safety and professional services, those rules shall be deemed for purposes of review under this chapter to refer to the department of health services.

(c) Life Safety Code as identified in the Conditions of Participation per s. 50.36, Stats.

DHS 124.31 Fees for plan reviews.

(1) GENERAL. The fees established in this section shall be paid to the department for providing plan review services under this subchapter. The department may withhold providing services to parties who have past due accounts with the department for plan review services. The fee for review of plans shall be based on the total gross floor area of s. SPS Table 302.31-1 and on the dollar value of the project to the table under sub. (3).

(2) DEFINITION. In this section:

(a) **"**Miscellaneous plans" means plans that have no building or heating, ventilation and air conditioning plan submissions, including all of the following:

1. Footing and foundation plans submitted prior to the submission of the building plans.

2. Structural plans submitted as independent projects, such as docks or, antennae.

3. Plans for any building component.

(2) FEE TABLE. Fee part based on project dollar value.

Project Dollar Value	Fee
Less Than $4,999	$125
$5,000 - $12,249	$175
$12,500 - $24,999	$375
$25,000 - $49,999	$475
$50,000 - $99,999	$625
$100,000 - $249,999	$775
$250,000 - $499,999	$925
$500,000 - $749,999	$1,175
$750,000 - $999,999	$1,550
$1,000,000 - $2,499,999	$2,350
$2,500,000 - $4,999,999	$4,675
$5,000,000 - $9,999,999	$6,250
$10,000,000 - $19,999,999	$12,500
$20,000,000 And Over	$20,000

(3) ADDITIONAL FEES.

(a) *Fee for plan entry*. Each submission of plans for the project shall be accompanied by a $100.00 plan entry fee. When plans for multiple projects are submitted together, each project shall constitute a separate submission and requires a $100.00 plan entry fee.

(b) *Fee for miscellaneous plans*. The fee for a miscellaneous plan shall be $250. This fee is for plan review and inspection.

(c) *Fee for permission to start construction*. The fee for permission to start construction shall be $75. This fee shall apply only to applicants proposing to start construction prior to approval of their plans by the department.

(d) *Fee for plan revision*. The fee for revision of previously approved plans shall be $75. This paragraph applies when plans are revised for reasons other than those that were requested by the department. The department may not charge a fee for revisions requested by the department as a condition of original plan approval.

(e) *Fee for extension of plan approval*. The examination fee for a plan approved for extension beyond the time limit specified in this chapter shall be $125 per plan.

(f) *Fee for petitions for variance*. The fee for reviewing commercial building code petitions for variance shall be in accordance with ch. SPS 302. The fee for reviewing a petition on a priority basis shall be in accordance with ch. SPS 302.

SECTION 10. DHS 124.32 (1), (3) (c) and (5), DHS 124.33, and DHS 124.34 (1) and (2) are repealed.

SECTION 11. DHS 124.34 (3) (c) is created to read:

DHS 124.34 (3) (c) Individual patient toilet room bed pan washers are permitted in lieu of the clinical fixture requirement stated in s. DHS 124.34 (3) (b) 1.

SECTION 12. DHS 124.34 (4) to (7), DHS 124.35 (1) and (3) to (7), and DHS 124.36 (1) to (10), and DHS 124.40 are repealed.

SECTION 13. DHS 124.36 (11) (Note) is created to read:

DHS 124.36 (11) (Note) Information about online fire reporting is available at:
http://www.dhs.wisconsin.gov/publications/p01729.pdf

SECTION 14. EFFECTIVE DATE: This rule shall take effect on the first day of the month following publication in the Wisconsin administrative register, as provided in § 227.22 (2) (intro.), Wis. Stats.