As Introduced

131st General Assembly

Regular Session **H. B. No. 157**

2015-2016

Representatives Butler, Johnson, T.
Cosponsors: Representatives Becker, Boose, Brenner, Brinkman, Conditt, DeVitis, Henne, Hood, Huffman, Maag, McColley, Perales, Retherford, Rezabek, Roegner, Romanchuk, Sprague, Terhar, Thompson, Vitale, Young, Zeltwanger

A BILL

To amend section 1751.67, 2117.06, 2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.171, 3923.63, 3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.28, 3937.29, 3955.05, 4715.30, 4723.28, 4723.341, 4725.19, 4729.16, 4730.25, 4730.32, 4731.22, 4731.224, 4731.281, 4734.31, 4734.32, 4755.47, 4765.11, 5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 5167.01, 5167.03, 5167.10, and 5167.30 and to enact sections 195.01, 195.02, 195.03, 195.04, 195.05, 195.06, 1739.30, 1739.31, 1739.32, 1739.33, 3727.61, 3937.24, 3965.01, 3965.02, 3965.03, 3965.04, 3965.05, 3965.06, 3965.07, 3965.10, 3965.11, 3965.12, 3965.15, 3965.16, 3965.17, 3965.18, 3965.19, 3965.20, 3965.21, 3965.22, 3965.23, 3965.24, 3965.25, 3965.30, 3965.31, 3965.32, 3965.33, 3965.34, 3965.35, 3965.36, 3965.37, 3965.40, 3965.41, 3965.42,

3965.43, 3965.44, 3965.45, 3965.46, 3965.47, 3965.50, 3965.51, 3965.52, 3965.54, 3965.59, 3965.60, 3965.70, 3965.71, 3965.75, 3965.76, 3965.77, 3965.78, 3965.80, 3967.01, 3967.02, 3967.03, 3967.05, 3967.06, 3967.07, 3967.10, 3967.11, 3967.12, 3967.13, 3967.14, 3967.15, 3967.20, 3967.23, 3967.24, 3967.27, 3967.32, 3967.40, 3967.42, 3967.99, 4731.74, 4743.08, 4743.09, 4746.01, 4746.02, 4746.03, 4746.04, 4746.05, 4746.06, 5162.63, 5164.78, 5164.83, 5165.24, 5165.98, 5166.50, 5166.52, 5166.521, 5166.522, 5166.523, 5166.524, 5166.525, 5166.526, 5166.527, 5166.528, 5166.529, 5166.5210, 5166.53, 5167.04, 5167.16, 5167.32, and 5167.33, and to repeal section 4731.143 of the Revised Code to revise the laws governing health insurance coverage, medical malpractice claims, the Medicaid program, health care provider discipline, and required and permitted health care provider disclosures; and to create the Nonstandard Multiple Employer Welfare Arrangement Program and to terminate that program after five years.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.67, 2117.06, 2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21,

2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.171, 3923.63, 3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.28, 3937.29, 3955.05, 4715.30, 4723.28, 4723.341, 4725.19, 4729.16, 4730.25, 4730.32, 4731.22, 4731.224, 4731.281, 4734.31, 4734.32, 4755.47, 4765.11, 5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 5167.01, 5167.03, 5167.10, and 5167.30 be amended and sections 195.01, 195.02, 195.03, 195.04, 195.05, 195.06, 1739.30, 1739.31, 1739.32, 1739.33, 3727.61, 3728.04, 3728.99, 3937.24, 3965.01, 3965.02, 3965.03, 3965.04, 3965.05, 3965.06, 3965.07, 3965.10, 3965.11, 3965.12, 3965.15, 3965.16, 3965.17, 3965.18, 3965.19, 3965.20, 3965.21, 3965.22, 3965.23, 3965.24, 3965.25, 3965.30, 3965.31, 3965.32, 3965.33, 3965.34, 3965.35, 3965.36, 3965.37, 3965.40, 3965.41, 3965.42, 3965.43, 3965.44, 3965.45, 3965.46, 3965.47, 3965.50, 3965.51, 3965.52, 3965.54, 3965.59, 3965.60, 3965.70, 3965.71, 3965.75, 3965.76, 3965.77, 3965.78, 3965.80, 3967.01, 3967.02, 3967.03, 3967.05, 3967.06, 3967.07, 3967.10, 3967.11, 3967.12, 3967.13, 3967.14, 3967.15, 3967.20, 3967.23, 3967.24, 3967.27, 3967.32, 3967.40, 3967.42, 3967.99, 4731.74, 4743.08, 4743.09, 4746.01, 4746.02, 4746.03, 4746.04, 4746.05, 4746.06, 5162.63, 5164.78, 5164.83, 5165.24, 5165.98, 5166.50, 5166.52, 5166.521, 5166.522, 5166.523, 5166.524, 5166.525, 5166.526, 5166.527, 5166.528, 5166.529, 5166.5210, 5166.53, 5167.04, 5167.16, 5167.32, and 5167.33 of the Revised Code be enacted to read as follows:

Sec. 195.01. As used in this chapter:

(A) "Administrator" means an administrator subject to Chapter 3959. of the Revised Code.

(B) "Insurer" means any of the following:

(1) A person authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident

insurance in this state;

(2) A health insuring corporation;

(3) A multiple employer welfare arrangement;

(4) A legal entity that is self-insured and provides benefits to its employees or members;

(5) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such a contract.

(C) "Participant" means a person or government entity that accepts money from the state or a county for any of the following reasons:

(1) The person or government entity purchases drugs eligible for partial or full reimbursement from the state or a county or purchases, leases, or uses medical equipment eligible for partial or full reimbursement from the state or a county.

(2) The person or government entity reimburses another person or government entity for the expenses described in division (C)(1) of this section.

(3) The person or government entity uses the money to pay for the expenses described in division (C)(1) of this section.

Sec. 195.02. Sections 195.03 to 195.06 of the Revised Code are subject to section 5166.50 of the Revised Code.

Sec. 195.03. There is hereby created the office of medical purchasing in the department of administrative services. The office shall be under the supervision of a manager, who shall be appointed by the director of administrative services. The director, in consultation with the manager, shall hire or assign

employees. The director shall furnish equipment and supplies, as necessary, for the fulfillment of the office's purpose as stated in section 195.04 of the Revised Code. Administrative costs associated with the operation of the office shall be paid from amounts appropriated to the department for such purposes.

Sec. 195.04. The purpose of the office of medical purchasing is to maximize the purchasing power of participants, insurers, and administrators so that expenses for drugs and medical equipment are minimized. In furtherance of this purpose, the office shall seek to enter into a pact with other states and Canadian provinces to negotiate discounted prices for drugs and medical equipment with the suppliers of those items.

Sec. 195.05. If the office of medical purchasing enters into a pact described in section 195.04 of the Revised Code, the office shall collaborate with the other pact members to ensure that the prices that are negotiated are the lowest prices that can be attained. The office shall seek to negotiate prices that do not exceed those negotiated by Canadian provinces that are not pact members.

Sec. 195.06. (A) A participant described in division (C)(1) or (3) of section 195.01 of the Revised Code shall purchase drugs or purchase, lease, or use medical equipment from suppliers that have agreed to provide those items at the discounted prices negotiated by members of a pact described in section 193.04 of the Revised Code.

(B) A participant described in division (C)(2) of section 195.01 of the Revised Code shall reimburse a person or government entity for the expenses described in division (C)(1) of this section only if those expenses are incurred as a result of a relationship with a supplier that has agreed to provide

those items at the discounted prices negotiated by pact members.

(C) An insurer or administrator may purchase drugs or purchase, lease, or use medical equipment from suppliers that have agreed to provide those items at the discounted prices negotiated by pact members.

Sec. 1739.30. As used in sections 1739.30 to 1739.33 of the Revised Code:

(A) "Medicare physician fee schedule" means the medicare physician fee schedule produced by the centers for medicare and medicaid services.

(B) "Program" means the nonstandard multiple employer welfare arrangement program prescribed in sections 1739.30 to 1739.33 of the Revised Code.

(C) "Program participant" means a multiple employer welfare arrangement formed under sections 1739.30 to 1739.33 of the Revised Code.

(D) "Program participant insurer" means any insurer that provides stop-loss insurance to a multiple employer welfare arrangement under section 1739.12 of the Revised Code that is a program participant.

(E) "Reference-based pricing" means an insurance model through which the insurer provides benefits according to a predetermined reference cost for each covered service.

(F) "Stop-loss insurance" has the same meaning as in section 1739.01 of the Revised Code.

Sec. 1739.31. (A) Notwithstanding any provision of sections 1739.01 to 1739.27 of the Revised Code, the department of insurance shall operate a nonstandard multiple employer

welfare arrangement program for the purpose of enabling a group of employers that is a bona fide association, as defined in 45 C.F.R. 144.103, to form a self-insured multiple employer welfare arrangement that does not meet the criteria or standards necessary for certification prescribed in sections 1739.01 to 1739.27 of the Revised Code.

(B) Program participants shall have a projected enrollment of at least two individuals and not more than five hundred individuals.

(C) The department of insurance shall provide reinsurance coverage for program participants as prescribed in section 1739.32 of the Revised Code.

(D) The department of insurance shall guarantee the liabilities of program participants as prescribed in section 1739.33 of the Revised Code.

(E) A multiple employer welfare arrangement shall not participate in the program for a period greater than five years.

(F) While participating in the program, a multiple employer welfare arrangement shall adhere to both of the following:

(1) A program participant shall have appointed to its board of trustees a representative of the department of insurance and at least one representative of the participating members of the arrangement.

(2)(a) A program participant shall reimburse health care providers using reference-based pricing.

(b) The reference cost for such reimbursements shall be set at an amount not to exceed the rate prescribed for a

specific service in the medicare physician fee schedule multiplied by one and two-tenths.

(G) The superintendent of insurance shall adopt rules for the implementation of sections 1739.30 to 1739.33 of the Revised Code. The rules shall address all of the following:

(1) Eligibility for the program;

(2) Enabling a group of employers to participate in the program with relative ease and simplicity;

(3)(a)(i) Fees to be paid to the department of insurance by program participants;

(ii) Fees to be paid by program participant insurers receiving reinsurance coverage under section 1739.32 of the Revised Code.

(b) Such fees shall be set at an amount necessary to ensure the continued operation of the program.

(4) When payment is to be made under sections 1739.32 and 1739.33 of the Revised Code;

(5) Any other topic the superintendent considers relevant to the operation of the program.

Sec. 1739.32. (A) There is hereby created in the state treasury the nonstandard multiple employer welfare arrangement reinsurance fund. Revenues to the fund shall consist of fees collected by the department of insurance from insurers providing stop-loss insurance coverage to program participants, as required under section 1739.12 of the Revised Code, and any other transfers made to the fund. The fund shall be used to reduce the cost of purchasing stop-loss insurance coverage for program participants and pay any related expenses.

(B) The department of insurance shall provide reinsurance coverage to those insurers that provide stop-loss insurance coverage to program participants, as required under section 1739.12 of the Revised Code, with the intent of reducing the cost of such coverage.

Sec. 1739.33. (A) There is hereby created in the state treasury the nonstandard multiple employer welfare arrangement guarantee fund. Revenue to the fund shall consist of fees collected by the department of insurance from program participants and any other transfers made to the fund. The fund shall be used to guarantee the liabilities of program participants as prescribed in this section and pay any related expenses.

(B)(1) The department of insurance, upon default by a program participant on liabilities assumed under this chapter, shall guarantee a program participant's liabilities, with the total amount being paid out on such liabilities being not more than the surplus amount required pursuant to section 1739.13 of the Revised Code.

(2)(a) The guarantee amount that a program participant qualifies for, as prescribed in division (C) of this section, shall be counted toward meeting the minimum surplus requirement prescribed in section 1739.13 of the Revised Code.

(b) To meet the requirement prescribed in section 1739.13 of the Revised Code, a program participant shall maintain surplus in an amount equal to one hundred fifty thousand dollars less the guarantee amount.

(3) Any amount paid out by the department of insurance under this section shall be repaid to the department of

insurance by the respective program participant, if the program participant is still in existence, according to a timetable and terms set by the department of insurance in rule.

(C) A program participant's guarantee amount shall be set according to the following:

(1) One hundred per cent of the surplus amount required pursuant to section 1739.31 of the Revised Code for the first year of participation;

(2) Eighty per cent of the surplus amount required pursuant to section 1739.13 of the Revised Code for the second year of participation;

(3) Sixty per cent of the surplus amount required pursuant to section 1739.13 of the Revised Code for the third year of participation;

(4) Forty per cent of the surplus amount required pursuant to section 1739.13 of the Revised Code for the fourth year of participation;

(5) Twenty per cent of the surplus amount required pursuant to section 1739.13 of the Revised Code for the fifth year of participation.

(D) Guarantees provided under this section do not preclude a multiple employer welfare arrangement from obtaining stop-loss insurance coverage as required by section 1739.12 of the Revised Code.

Sec. 1751.67. (A) Each individual or group health insuring corporation policy, contract, or agreement delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up

care for a mother and her newborn as follows:

(1) The policy, contract, or agreement shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The policy, contract, or agreement shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at

least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the provider responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C)(1) No health insuring corporation may do either of the following:

(a) Terminate the participation of a provider or health care facility in an individual or group health care plan solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26

of the Revised Code.

(D) This section does not do any of the following:

(1) Require a policy, contract, or agreement to cover inpatient or follow-up care that is not received in accordance with the policy's, contract's, or agreement's terms pertaining to the providers and facilities from which an individual is authorized to receive health care services;

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or to derivative claims for relief, as those terms are defined in section 2305.113 or 3965.01 of the Revised Code.

Sec. 2117.06. (A) All creditors having claims against an estate, including claims arising out of contract, out of tort, on cognovit notes, or on judgments, whether due or not due, secured or unsecured, liquidated or unliquidated, shall present their claims in one of the following manners:

(1) After the appointment of an executor or administrator

and prior to the filing of a final account or a certificate of termination, in one of the following manners:

(a) To the executor or administrator in a writing;

(b) To the executor or administrator in a writing, and to the probate court by filing a copy of the writing with it;

(c) In a writing that is sent by ordinary mail addressed to the decedent and that is actually received by the executor or administrator within the appropriate time specified in division (B) of this section. For purposes of this division, if an executor or administrator is not a natural person, the writing shall be considered as being actually received by the executor or administrator only if the person charged with the primary responsibility of administering the estate of the decedent actually receives the writing within the appropriate time specified in division (B) of this section.

(2) If the final account or certificate of termination has been filed, in a writing to those distributees of the decedent's estate who may share liability for the payment of the claim.

(B) Except as provided in section 2117.061 of the Revised Code, all claims shall be presented within six months after the death of the decedent, whether or not the estate is released from administration or an executor or administrator is appointed during that six-month period. Every claim presented shall set forth the claimant's address.

(C) Except as provided in section 2117.061 of the Revised Code, a claim that is not presented within six months after the death of the decedent shall be forever barred as to all parties, including, but not limited to, devisees, legatees, and distributees. No payment shall be made on the claim and no

action shall be maintained on the claim, except as otherwise provided in sections 2117.37 to 2117.42 of the Revised Code with reference to contingent claims.

(D) In the absence of any prior demand for allowance, the executor or administrator shall allow or reject all claims, except tax assessment claims, within thirty days after their presentation, provided that failure of the executor or administrator to allow or reject within that time shall not prevent the executor or administrator from doing so after that time and shall not prejudice the rights of any claimant. Upon the allowance of a claim, the executor or the administrator, on demand of the creditor, shall furnish the creditor with a written statement or memorandum of the fact and date of the allowance.

(E) If the executor or administrator has actual knowledge of a pending action commenced against the decedent prior to the decedent's death in a court of record in this state, the executor or administrator shall file a notice of the appointment of the executor or administrator in the pending action within ten days after acquiring that knowledge. If the administrator or executor is not a natural person, actual knowledge of a pending suit against the decedent shall be limited to the actual knowledge of the person charged with the primary responsibility of administering the estate of the decedent. Failure to file the notice within the ten-day period does not extend the claim period established by this section.

(F) This section applies to any person who is required to give written notice to the executor or administrator of a motion or application to revive an action pending against the decedent at the date of the death of the decedent.

(G) Nothing in this section or in section 2117.07 of the Revised Code shall be construed to reduce the periods of limitation or periods prior to repose in section 2125.02 or Chapter 2305. or 3965. of the Revised Code, provided that no portion of any recovery on a claim brought pursuant to that section or any section in that chapter shall come from the assets of an estate unless the claim has been presented against the estate in accordance with Chapter 2117. of the Revised Code.

(H) Any person whose claim has been presented and has not been rejected after presentment is a creditor as that term is used in Chapters 2113. to 2125. of the Revised Code. Claims that are contingent need not be presented except as provided in sections 2117.37 to 2117.42 of the Revised Code, but, whether presented pursuant to those sections or this section, contingent claims may be presented in any of the manners described in division (A) of this section.

(I) If a creditor presents a claim against an estate in accordance with division (A)(1)(b) of this section, the probate court shall not close the administration of the estate until that claim is allowed or rejected.

(J) The probate court shall not require an executor or administrator to make and return into the court a schedule of claims against the estate.

(K) If the executor or administrator makes a distribution of the assets of the estate pursuant to section 2113.53 of the Revised Code and prior to the expiration of the time for the presentation of claims as set forth in this section, the executor or administrator shall provide notice on the account delivered to each distributee that the distributee may be liable to the estate if a claim is presented prior to the filing of the

final account and may be liable to the claimant if the claim is presented after the filing of the final account up to the value of the distribution and may be required to return all or any part of the value of the distribution if a valid claim is subsequently made against the estate within the time permitted under this section.

Sec. 2125.01. (A)(1) When the death of a person is caused by wrongful act, neglect, or default which would have entitled the party injured to maintain an action and recover damages if death had not ensued, the person who would have been liable if death had not ensued, or the administrator or executor of the estate of such person, as such administrator or executor, shall be liable to an action for damages, notwithstanding the death of the person injured and although the death was caused under circumstances which make it aggravated murder, murder, or manslaughter. When the action is against such administrator or executor, the damages recovered shall be a valid claim against the estate of such deceased person. No action for the wrongful death of a person may be maintained against the owner or lessee of the real property upon which the death occurred if the cause of the death was the violent unprovoked act of a party other than the owner, lessee, or a person under the control of the owner or lessee, unless the acts or omissions of the owner, lessee, or person under the control of the owner or lessee constitute gross negligence. This section does not apply to a claim filed under Chapters 3965. and 3967. of the Revised Code. With respect to a chiropractic claim, dental claim, medical claim, or optometric claim, this section shall apply only in either of the following circumstances:

(a) The claim alleges that the health care provider against whom the claim is brought intentionally caused the

injury, as defined in section 3965.02 of the Revised Code, that resulted in the death of the person.

(b) The health care provider against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(2) As used in division (A) of this section, "chiropractic claim," "dental claim," "health care provider," "medical claim," and "optometric claim" have the same meanings as in section 2305.113 of the Revised Code.

(B) When death is caused by a wrongful act, neglect, or default in another state or foreign country, for which a right to maintain an action and recover damages is given by a statute of such other state or foreign country, such right of action may be enforced in this state. Every such action shall be commenced within the time prescribed for the commencement of such actions by the statute of such other state or foreign country.

(C) The same remedy shall apply to any such cause of action now existing and to any such action commenced before January 1, 1932, or attempted to be commenced in proper time and now appearing on the files of any court within this state, and no prior law of this state shall prevent the maintenance of such cause of action.

Sec. 2125.02. (A)(1) Except as provided in this division, a civil action for wrongful death shall be brought in the name of the personal representative of the decedent for the exclusive benefit of the surviving spouse, the children, and the parents of the decedent, all of whom are rebuttably presumed to have suffered damages by reason of the wrongful death, and for the exclusive benefit of the other next of kin of the decedent. A

parent who abandoned a minor child who is the decedent shall not receive a benefit in a civil action for wrongful death brought under this division.

(2) The jury, or the court if the civil action for wrongful death is not tried to a jury, may award damages authorized by division (B) of this section, as it determines are proportioned to the injury and loss resulting to the beneficiaries described in division (A)(1) of this section by reason of the wrongful death and may award the reasonable funeral and burial expenses incurred as a result of the wrongful death. In its verdict, the jury or court shall set forth separately the amount, if any, awarded for the reasonable funeral and burial expenses incurred as a result of the wrongful death.

(3)(a) The date of the decedent's death fixes, subject to division (A)(3)(b)(iii) of this section, the status of all beneficiaries of the civil action for wrongful death for purposes of determining the damages suffered by them and the amount of damages to be awarded. A person who is conceived prior to the decedent's death and who is born alive after the decedent's death is a beneficiary of the action.

(b)(i) In determining the amount of damages to be awarded, the jury or court may consider all factors existing at the time of the decedent's death that are relevant to a determination of the damages suffered by reason of the wrongful death.

(ii) Consistent with the Rules of Evidence, a party to a civil action for wrongful death may present evidence of the cost of an annuity in connection with an issue of recoverable future damages. If that evidence is presented, then, in addition to the factors described in division (A)(3)(b)(i) of this section and,

if applicable, division (A)(3)(b)(iii) of this section, the jury or court may consider that evidence in determining the future damages suffered by reason of the wrongful death. If that evidence is presented, the present value in dollars of an annuity is its cost.

(iii) Consistent with the Rules of Evidence, a party to a civil action for wrongful death may present evidence that the surviving spouse of the decedent is remarried. If that evidence is presented, then, in addition to the factors described in divisions (A)(3)(b)(i) and (ii) of this section, the jury or court may consider that evidence in determining the damages suffered by the surviving spouse by reason of the wrongful death.

(B) Compensatory damages may be awarded in a civil action for wrongful death and may include damages for the following:

(1) Loss of support from the reasonably expected earning capacity of the decedent;

(2) Loss of services of the decedent;

(3) Loss of the society of the decedent, including loss of companionship, consortium, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, and education, suffered by the surviving spouse, dependent children, parents, or next of kin of the decedent;

(4) Loss of prospective inheritance to the decedent's heirs at law at the time of the decedent's death;

(5) The mental anguish incurred by the surviving spouse, dependent children, parents, or next of kin of the decedent.

(C) A personal representative appointed in this state,

with the consent of the court making the appointment and at any time before or after the commencement of a civil action for wrongful death, may settle with the defendant the amount to be paid.

(D)(1) Except as provided in division (D)(2) of this section, a civil action for wrongful death shall be commenced within two years after the decedent's death.

(2)(a) Except as otherwise provided in divisions (D)(2)(b), (c), (d), (e), (f), and (g) of this section or in section 2125.04 of the Revised Code, no cause of action for wrongful death involving a product liability claim shall accrue against the manufacturer or supplier of a product later than ten years from the date that the product was delivered to its first purchaser or first lessee who was not engaged in a business in which the product was used as a component in the production, construction, creation, assembly, or rebuilding of another product.

(b) Division (D)(2)(a) of this section does not apply if the manufacturer or supplier of a product engaged in fraud in regard to information about the product and the fraud contributed to the harm that is alleged in a product liability claim involving that product.

(c) Division (D)(2)(a) of this section does not bar a civil action for wrongful death involving a product liability claim against a manufacturer or supplier of a product who made an express, written warranty as to the safety of the product that was for a period longer than ten years and that, at the time of the decedent's death, has not expired in accordance with the terms of that warranty.

(d) If the decedent's death occurs during the ten-year period described in division (D)(2)(a) of this section but less than two years prior to the expiration of that period, a civil action for wrongful death involving a product liability claim may be commenced within two years after the decedent's death.

(e) If the decedent's death occurs during the ten-year period described in division (D)(2)(a) of this section and the claimant cannot commence an action during that period due to a disability described in section 2305.16 of the Revised Code, a civil action for wrongful death involving a product liability claim may be commenced within two years after the disability is removed.

(f)(i) Division (D)(2)(a) of this section does not bar a civil action for wrongful death based on a product liability claim against a manufacturer or supplier of a product if the product involved is a substance or device described in division (B)(1), (2), (3), or (4) of section 2305.10 of the Revised Code and the decedent's death resulted from exposure to the product during the ten-year period described in division (D)(2)(a) of this section.

(ii) If division (D)(2)(f)(i) of this section applies regarding a civil action for wrongful death, the cause of action that is the basis of the action accrues upon the date on which the claimant is informed by competent medical authority that the decedent's death was related to the exposure to the product or upon the date on which by the exercise of reasonable diligence the claimant should have known that the decedent's death was related to the exposure to the product, whichever date occurs first. A civil action for wrongful death based on a cause of action described in division (D)(2)(f)(i) of this section shall

be commenced within two years after the cause of action accrues and shall not be commenced more than two years after the cause of action accrues.

(g) Division (D)(2)(a) of this section does not bar a civil action for wrongful death based on a product liability claim against a manufacturer or supplier of a product if the product involved is a substance or device described in division (B)(5) of section 2315.10 of the Revised Code. If division (D)(2)(g) of this section applies regarding a civil action for wrongful death, the cause of action that is the basis of the action accrues upon the date on which the claimant is informed by competent medical authority that the decedent's death was related to the exposure to the product or upon the date on which by the exercise of reasonable diligence the claimant should have known that the decedent's death was related to the exposure to the product, whichever date occurs first. A civil action for wrongful death based on a cause of action described in division (D)(2)(g) of this section shall be commenced within two years after the cause of action accrues and shall not be commenced more than two years after the cause of action accrues.

(E)(1) If the personal representative of a deceased minor has actual knowledge or reasonable cause to believe that the minor was abandoned by a parent seeking to benefit from a civil action for wrongful death or if any person listed in division (A)(1) of this section who is permitted to benefit from a civil action for wrongful death commenced in relation to a deceased minor has actual knowledge or reasonable cause to believe that the minor was abandoned by a parent seeking to benefit from the action, the personal representative or the person may file a motion in the court in which the action is commenced requesting the court to issue an order finding that the parent abandoned

the minor and is not entitled to recover damages in the action based on the death of the minor.

(2) The movant who files a motion described in division (E)(1) of this section shall name the parent who abandoned the deceased minor and, whether or not that parent is a resident of this state, the parent shall be served with a summons and a copy of the motion in accordance with the Rules of Civil Procedure. Upon the filing of the motion, the court shall conduct a hearing. In the hearing on the motion, the movant has the burden of proving, by a preponderance of the evidence, that the parent abandoned the minor. If, at the hearing, the court finds that the movant has sustained that burden of proof, the court shall issue an order that includes its findings that the parent abandoned the minor and that, because of the prohibition set forth in division (A)(1) of this section, the parent is not entitled to recover damages in the action based on the death of the minor.

(3) A motion requesting a court to issue an order finding that a specified parent abandoned a minor child and is not entitled to recover damages in a civil action for wrongful death based on the death of the minor may be filed at any time during the pendency of the action.

(F) This section does not create a new cause of action or substantive legal right against any person involving a product liability claim.

(G) As used in this section:

(1) "Annuity" means an annuity that would be purchased from either of the following types of insurance companies:

(a) An insurance company that the A. M. Best Company, in

its most recently published rating guide of life insurance companies, has rated A or better and has rated XII or higher as to financial size or strength;

(b)(i) An insurance company that the superintendent of insurance, under rules adopted pursuant to Chapter 119. of the Revised Code for purposes of implementing this division, determines is licensed to do business in this state and, considering the factors described in division (G)(1)(b)(ii) of this section, is a stable insurance company that issues annuities that are safe and desirable.

(ii) In making determinations as described in division (G)(1)(b)(i) of this section, the superintendent shall be guided by the principle that the jury or court in a civil action for wrongful death should be presented only with evidence as to the cost of annuities that are safe and desirable for the beneficiaries of the action who are awarded compensatory damages under this section. In making the determinations, the superintendent shall consider the financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and the management of a particular insurance company involved and also may consider ratings, grades, and classifications of any nationally recognized rating services of insurance companies and any other factors relevant to the making of the determinations.

(2) "Civil action for wrongful death" means an action described in section 2125.01 of the Revised Code.

(3) "Future damages" means damages that result from the wrongful death and that will accrue after the verdict or determination of liability by the jury or court is rendered in the civil action for wrongful death.

~~(3)~~ (4) "Abandoned" means that a parent of a minor failed without justifiable cause to communicate with the minor, care for the minor, and provide for the maintenance or support of the minor as required by law or judicial decree for a period of at least one year immediately prior to the date of the death of the minor.

~~(4)~~ (5) "Minor" means a person who is less than eighteen years of age.

~~(5)~~ (6) "Harm" means death.

~~(6)~~ (7) "Manufacturer," "product," "product liability claim," and "supplier" have the same meanings as in section 2307.71 of the Revised Code.

(H) Divisions (D), (G)(5), and (G)~~(6)~~ (7) of this section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action commenced on or after ~~the effective date of this amendment~~ April 7, 2005, in which those divisions are relevant, regardless of when the cause of action accrued and notwithstanding any other section of the Revised Code or prior rule of law of this state, but shall not be construed to apply to any civil action pending prior to ~~the effective date of this amendment~~ April 7, 2005.

Sec. 2305.11. (A) An action for libel, slander, malicious prosecution, or false imprisonment, an action for malpractice other than an action upon a medical, dental, optometric, or chiropractic claim, or an action upon a statute for a penalty or forfeiture shall be commenced within one year after the cause of action accrued, provided that an action by an employee for the payment of unpaid minimum wages, unpaid overtime compensation, or liquidated damages by reason of the nonpayment of minimum

wages or overtime compensation shall be commenced within two years after the cause of action accrued.

(B) A civil action for unlawful abortion pursuant to section 2919.12 of the Revised Code, a civil action authorized by division (H) of section 2317.56 of the Revised Code, a civil action pursuant to division (B)(1) or (2) of section 2307.51 of the Revised Code for performing a dilation and extraction procedure or attempting to perform a dilation and extraction procedure in violation of section 2919.15 of the Revised Code, and a civil action pursuant to division (B) of section 2307.52 of the Revised Code for terminating or attempting to terminate a human pregnancy after viability in violation of division (A) of section 2919.17 of the Revised Code shall be commenced within one year after the performance or inducement of the abortion, within one year after the attempt to perform or induce the abortion in violation of division (A) of section 2919.17 of the Revised Code, within one year after the performance of the dilation and extraction procedure, or, in the case of a civil action pursuant to division (B)(2) of section 2307.51 of the Revised Code, within one year after the attempt to perform the dilation and extraction procedure.

(C) This section does not apply to a claim brought pursuant to Chapter 3965. of the Revised Code.

(D) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Sec. 2305.113. (A) This section shall apply only to a medical, dental, optometric, or chiropractic claim in which either of the following applies:

(1) A claimant alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the action accrued.

(B) Except as otherwise provided in this section, an action upon a medical, dental, optometric, or chiropractic claim shall be commenced within one year after the cause of action accrued.

~~(B)~~ (C)(1) If prior to the expiration of the one-year period specified in division ~~(A)~~ (B) of this section, a claimant who allegedly possesses a medical, dental, optometric, or chiropractic claim gives to the person who is the subject of that claim written notice that the claimant is considering bringing an action upon that claim, that action may be commenced against the person notified at any time within one hundred eighty days after the notice is so given.

(2) An insurance company shall not consider the existence or nonexistence of a written notice described in division ~~(B)~~ (C)(1) of this section in setting the liability insurance premium rates that the company may charge the company's insured person who is notified by that written notice.

~~(C)~~ (D) Except as to persons within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division ~~(D)~~ (E) of this section, both of the following apply:

(1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

~~(D)~~ (E)(1) If a person making a medical claim, dental claim, optometric claim, or chiropractic claim, in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division ~~(C)~~ (D)(1) of this section, the person may commence an action upon the claim not later than one year after the person discovers the injury resulting from that act or omission.

(2) If the alleged basis of a medical claim, dental claim, optometric claim, or chiropractic claim is the occurrence of an act or omission that involves a foreign object that is left in the body of the person making the claim, the person may commence an action upon the claim not later than one year after the person discovered the foreign object or not later than one year after the person, with reasonable care and diligence, should have discovered the foreign object.

(3) A person who commences an action upon a medical claim,

dental claim, optometric claim, or chiropractic claim under the circumstances described in division ~~(D)~~ (E)(1) or (2) of this section has the affirmative burden of proving, by clear and convincing evidence, that the person, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three-year period described in division ~~(D)~~ (E)(1) of this section or within the one-year period described in division ~~(D)~~ (E)(2) of this section, whichever is applicable.

~~(E)~~ (F) As used in this section:

(1) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including, but not limited to, those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(2) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(3) "Medical claim" means any claim that is asserted in

any civil action against a physician, podiatrist, hospital, home, or residential facility, against any employee or agent of a physician, podiatrist, hospital, home, or residential facility, or against a licensed practical nurse, registered nurse, advanced practice registered nurse, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes the following:

(a) Derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person;

(b) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

(i) The claim results from acts or omissions in providing medical care.

(ii) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

(c) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

(4) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(5) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(6) "Dental claim" means any claim that is asserted in any civil action against a dentist, or against any employee or agent of a dentist, and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person. "Dental claim" includes derivative claims for relief that arise from a dental operation or the dental diagnosis, care, or treatment of a person.

(7) "Derivative claims for relief" include, but are not limited to, claims of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arise from that diagnosis, care, treatment, or operation, and that seek the recovery of damages for any of the following:

(a) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;

(b) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(8) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the board of nursing.

(9) "Chiropractic claim" means any claim that is asserted in any civil action against a chiropractor, or against any employee or agent of a chiropractor, and that arises out of the chiropractic diagnosis, care, or treatment of any person. "Chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(10) "Chiropractor" means any person who is licensed to practice chiropractic by the state chiropractic board.

(11) "Optometric claim" means any claim that is asserted in any civil action against an optometrist, or against any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person. "Optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(12) "Optometrist" means any person licensed to practice optometry by the state board of optometry.

(13) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code.

(14) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(15) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code.

(16) "Advanced practice registered nurse" means any certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who holds a certificate of authority issued by the board

of nursing under Chapter 4723. of the Revised Code.

(17) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(18) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code.

(19) "Emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic" means any person who is certified under Chapter 4765. of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

Sec. 2305.15. (A) When a cause of action accrues against a person, if the person is out of the state, has absconded, or conceals self, the period of limitation for the commencement of the action as provided in sections 2305.04 to 2305.14, 1302.98, and 1304.35 of the Revised Code does not begin to run until the person comes into the state or while the person is so absconded or concealed. After the cause of action accrues if the person departs from the state, absconds, or conceals self, the time of the person's absence or concealment shall not be computed as any part of a period within which the action must be brought.

(B) When a person is imprisoned for the commission of any offense, the time of the person's imprisonment shall not be computed as any part of any period of limitation, as provided in section 2305.09, 2305.10, 2305.11, 2305.113, ~~or~~ 2305.14<u>, or 3965.30</u> of the Revised Code, within which any person must bring

any action against the imprisoned person.

Sec. 2305.23. No person shall be liable in civil damages or under Chapter 3965. or 3967. of the Revised Code for administering emergency care or treatment at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, for acts performed at the scene of such emergency, unless such acts constitute willful or wanton misconduct.

Nothing in this section applies to the administering of such care or treatment where the same is rendered for remuneration, or with the expectation of remuneration, from the recipient of such care or treatment or someone on ~~his~~ the recipient's behalf. The administering of such care or treatment by one as a part of ~~his~~ a person's duties as a paid member of any organization of law enforcement officers or fire fighters does not cause such to be a rendering for remuneration or expectation of remuneration.

Sec. 2305.231. (A) As used in this section:

(1) "Dentist" means a person who is licensed under Chapter 4715. of the Revised Code to practice dentistry.

(2) "Physician" means a person who holds a certificate issued by the state medical board to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(3) "Registered nurse" means a nurse who is licensed as a registered nurse under Chapter 4723. of the Revised Code.

(B) No physician who volunteers the physician's services as a team physician or team podiatrist to a school's athletics program, no dentist who volunteers the dentist's services as a

team dentist to a school's athletics program, and no registered nurse who volunteers the registered nurse's services as a team nurse to a school's athletics program is liable in damages in a civil action or in a claim filed under Chapters 3965. and 3967. of the Revised Code for administering emergency medical care, emergency dental care, other emergency professional care, or first aid treatment to a participant in an athletic event involving the school, at the scene of the event or while the participant is being transported to a hospital, physician's or dentist's office, or other medical or dental facility, or for acts performed in administering the care or treatment, unless the acts of the physician, dentist, or registered nurse constitute willful or wanton misconduct.

(C) This section does not apply if the administration of emergency medical care, emergency dental care, other emergency professional care, or first aid treatment is rendered for remuneration, or with the expectation of remuneration, from the recipient of the care or treatment or from someone on the recipient's behalf.

Sec. 2305.234. (A) As used in this section:

(1) "Chiropractic claim," "medical claim," and "optometric claim" have the same meanings as in section 2305.113 or 3965.01 of the Revised Code.

(2) "Dental claim" has the same meaning as in section 2305.113 or 3965.01 of the Revised Code, except that it does not include any claim arising out of a dental operation or any derivative claim for relief that arises out of a dental operation.

(3) "Governmental health care program" has the same

meaning as in section 4731.65 of the Revised Code.

(4) "Health care facility or location" means a hospital, clinic, ambulatory surgical facility, office of a health care professional or associated group of health care professionals, training institution for health care professionals, or any other place where medical, dental, or other health-related diagnosis, care, or treatment is provided to a person.

(5) "Health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

(a) Physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(b) Registered nurses and licensed practical nurses licensed under Chapter 4723. of the Revised Code and individuals who hold a certificate of authority issued under that chapter that authorizes the practice of nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner;

(c) Physician assistants authorized to practice under Chapter 4730. of the Revised Code;

(d) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;

(e) Physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, and athletic trainers licensed under Chapter 4755. of the Revised Code;

(f) Chiropractors licensed under Chapter 4734. of the

Revised Code;

(g) Optometrists licensed under Chapter 4725. of the Revised Code;

(h) Podiatrists authorized under Chapter 4731. of the Revised Code to practice podiatry;

(i) Dietitians licensed under Chapter 4759. of the Revised Code;

(j) Pharmacists licensed under Chapter 4729. of the Revised Code;

(k) Emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic, certified under Chapter 4765. of the Revised Code;

(l) Respiratory care professionals licensed under Chapter 4761. of the Revised Code;

(m) Speech-language pathologists and audiologists licensed under Chapter 4753. of the Revised Code;

(n) Licensed professional clinical counselors, licensed professional counselors, independent social workers, social workers, independent marriage and family therapists, and marriage and family therapists, licensed under Chapter 4757. of the Revised Code;

(o) Psychologists licensed under Chapter 4732. of the Revised Code;

(p) Individuals licensed or certified under Chapter 4758. of the Revised Code who are acting within the scope of their license or certificate as members of the profession of chemical dependency counseling or alcohol and other drug prevention

services.

(6) "Health care worker" means a person other than a health care professional who provides medical, dental, or other health-related care or treatment under the direction of a health care professional with the authority to direct that individual's activities, including medical technicians, medical assistants, dental assistants, orderlies, aides, and individuals acting in similar capacities.

(7) "Indigent and uninsured person" means a person who meets all of the following requirements:

(a) The person's income is not greater than two hundred per cent of the current poverty line as defined by the United States office of management and budget and revised in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended.

(b) The person is not eligible for the medicaid program or any other governmental health care program.

(c) Either of the following applies:

(i) The person is not a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan.

(ii) The person is a policyholder, certificate holder, insured, contract holder, subscriber, enrollee, member, beneficiary, or other covered individual under a health insurance or health care policy, contract, or plan, but the insurer, policy, contract, or plan denies coverage or is the subject of insolvency or bankruptcy proceedings in any jurisdiction.

(8) "Nonprofit health care referral organization" means an entity that is not operated for profit and refers patients to, or arranges for the provision of, health-related diagnosis, care, or treatment by a health care professional or health care worker.

(9) "Operation" means any procedure that involves cutting or otherwise infiltrating human tissue by mechanical means, including surgery, laser surgery, ionizing radiation, therapeutic ultrasound, or the removal of intraocular foreign bodies. "Operation" does not include the administration of medication by injection, unless the injection is administered in conjunction with a procedure infiltrating human tissue by mechanical means other than the administration of medicine by injection. "Operation" does not include routine dental restorative procedures, the scaling of teeth, or extractions of teeth that are not impacted.

(10) "Tort action" means a civil action for damages for injury, death, or loss to person or property other than a civil action for damages for a breach of contract or another agreement between persons or government entities.

(11) "Volunteer" means an individual who provides any medical, dental, or other health-care related diagnosis, care, or treatment without the expectation of receiving and without receipt of any compensation or other form of remuneration from an indigent and uninsured person, another person on behalf of an indigent and uninsured person, any health care facility or location, any nonprofit health care referral organization, or any other person or government entity.

(12) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(13) "Deep sedation" means a drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation, a patient's ability to independently maintain ventilatory function may be impaired, a patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate, and cardiovascular function is usually maintained.

(14) "General anesthesia" means a drug-induced loss of consciousness during which a patient is not arousable, even by painful stimulation, the ability to independently maintain ventilatory function is often impaired, a patient often requires assistance in maintaining a patent airway, positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function, and cardiovascular function may be impaired.

(B)(1) Subject to divisions (F) and (G)(3) of this section, a health care professional who is a volunteer and complies with division (B)(2) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, or for a claim filed under Chapters 3965. and 3967. of the Revised Code for injury, death, or loss to person or property that allegedly arises from an action or omission of the volunteer in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, including the provision of samples of medicine and other medical products, unless the action or omission constitutes willful or wanton misconduct.

(2) To qualify for the immunity described in division (B)(1) of this section, a health care professional shall do all of the following prior to providing diagnosis, care, or treatment:

(a) Determine, in good faith, that the indigent and uninsured person is mentally capable of giving informed consent to the provision of the diagnosis, care, or treatment and is not subject to duress or under undue influence;

(b) Inform the person of the provisions of this section, including notifying the person that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot hold the health care professional liable for damages in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, unless the action or omission of the health care professional constitutes willful or wanton misconduct or under a claim filed under Chapter 3965. or 3967. of the Revised Code unless the act or omission of the health care professional was intentional as described in section 3965.02 of the Revised Code or the health care professional was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued;

(c) Obtain the informed consent of the person and a written waiver, signed by the person or by another individual on behalf of and in the presence of the person, that states that the person is mentally competent to give informed consent and, without being subject to duress or under undue influence, gives informed consent to the provision of the diagnosis, care, or treatment subject to the provisions of this section. A written waiver under division (B)(2)(c) of this section shall state clearly and in conspicuous type that the person or other

individual who signs the waiver is signing it with full knowledge that, by giving informed consent to the provision of the diagnosis, care, or treatment, the person cannot bring a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the health care professional unless the action or omission of the health care professional constitutes willful or wanton misconduct or file a claim under Chapter 3965. or 3967. of the Revised Code against the health care professional unless the act or omission of the health care professional was intentional as described in section 3965.02 of the Revised Code or the health care professional was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

~~(3) A physician or podiatrist who is not covered by medical malpractice insurance, but complies with division (B)(2) of this section, is not required to comply with division (A) of section 4731.143 of the Revised Code.~~

(C) Subject to divisions (F) and (G)(3) of this section, health care workers who are volunteers are not liable in damages to any person or government entity in a tort or other civil action, including an action upon a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care worker in the provision to an indigent and uninsured person of medical, dental, or other health-related diagnosis, care, or treatment, unless the action or omission constitutes willful or wanton misconduct or in a claim filed under Chapter 3965. or 3967. of the Revised Code against the health care worker unless the act or omission of the health care worker was intentional as

described in section 3965.02 of the Revised Code or the health care worker was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(D) Subject to divisions (F) and (G)(3) of this section, a nonprofit health care referral organization is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the nonprofit health care referral organization in referring indigent and uninsured persons to, or arranging for the provision of, medical, dental, or other health-related diagnosis, care, or treatment by a health care professional described in division (B)(1) of this section or a health care worker described in division (C) of this section, unless the action or omission constitutes willful or wanton misconduct.

(E) Subject to divisions (F) and (G)(3) of this section and to the extent that the registration requirements of section 3701.071 of the Revised Code apply, a health care facility or location associated with a health care professional described in division (B)(1) of this section, a health care worker described in division (C) of this section, or a nonprofit health care referral organization described in division (D) of this section is not liable in damages to any person or government entity in a tort or other civil action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, for injury, death, or loss to person or property that allegedly arises from an action or omission of the health care professional or worker or nonprofit health care referral organization relative to the medical, dental, or other health-

related diagnosis, care, or treatment provided to an indigent and uninsured person on behalf of or at the health care facility or location, unless the action or omission constitutes willful or wanton misconduct.

(F)(1) Except as provided in division (F)(2) of this section, the immunities provided by divisions (B), (C), (D), and (E) of this section are not available to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location if, at the time of an alleged injury, death, or loss to person or property, the health care professionals or health care workers involved are providing one of the following:

(a) Any medical, dental, or other health-related diagnosis, care, or treatment pursuant to a community service work order entered by a court under division (B) of section 2951.02 of the Revised Code or imposed by a court as a community control sanction;

(b) Performance of an operation to which any one of the following applies:

(i) The operation requires the administration of deep sedation or general anesthesia.

(ii) The operation is a procedure that is not typically performed in an office.

(iii) The individual involved is a health care professional, and the operation is beyond the scope of practice or the education, training, and competence, as applicable, of the health care professional.

(c) Delivery of a baby or any other purposeful termination of a human pregnancy.

(2) Division (F)(1) of this section does not apply when a health care professional or health care worker provides medical, dental, or other health-related diagnosis, care, or treatment that is necessary to preserve the life of a person in a medical emergency.

(G)(1) This section does not create a new cause of action or substantive legal right against a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location.

(2) This section does not affect any immunities from civil liability or defenses established by another section of the Revised Code or available at common law to which a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location may be entitled in connection with the provision of emergency or other medical, dental, or other health-related diagnosis, care, or treatment.

(3) This section does not grant an immunity from tort or other civil liability to a health care professional, health care worker, nonprofit health care referral organization, or health care facility or location for actions that are outside the scope of authority of health care professionals or health care workers.

(4) This section does not affect any legal responsibility of a health care professional, health care worker, or nonprofit health care referral organization to comply with any applicable law of this state or rule of an agency of this state.

(5) This section does not affect any legal responsibility of a health care facility or location to comply with any

applicable law of this state, rule of an agency of this state, or local code, ordinance, or regulation that pertains to or regulates building, housing, air pollution, water pollution, sanitation, health, fire, zoning, or safety.

Sec. 2305.25. As used in this section and sections 2305.251 to 2305.253 of the Revised Code:

(A)(1) "Health care entity" means an entity, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts as part of its regular business activities professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by health care providers, including both individuals who provide health care and entities that provide health care.

(2) "Health care entity" includes any entity described in division (A)(1) of this section, regardless of whether it is a government entity; for-profit or nonprofit corporation; limited liability company; partnership; professional corporation; state or local society composed of physicians, dentists, optometrists, psychologists, or pharmacists; accountable care organization; other health care organization; or combination of any of the foregoing entities.

(B) "Health insuring corporation" means an entity that holds a certificate of authority under Chapter 1751. of the Revised Code. "Health insuring corporation" includes wholly owned subsidiaries of a health insuring corporation.

(C) "Hospital" means any of the following:

(1) An institution that has been registered or licensed by the department of health as a hospital;

(2) An entity, other than an insurance company authorized to do business in this state, that owns, controls, or is affiliated with an institution that has been registered or licensed by the department of health as a hospital;

(3) A group of hospitals that are owned, sponsored, or managed by a single entity.

(D) "Incident report or risk management report" means a report of an incident involving injury or potential injury to a patient as a result of patient care provided by health care providers, including both individuals who provide health care and entities that provide health care, that is prepared by or for the use of a peer review committee of a health care entity and is within the scope of the functions of that committee.

(E)(1) "Peer review committee" means a utilization review committee, quality assessment committee, performance improvement committee, tissue committee, credentialing committee, or other committee that does either of the following:

(a) Conducts professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by health care providers, including both individuals who provide health care and entities that provide health care;

(b) Conducts any other attendant hearing process initiated as a result of a peer review committee's recommendations or actions.

(2) "Peer review committee" includes all of the following:

(a) A peer review committee of a hospital or long-term care facility or a peer review committee of a nonprofit health care corporation that is a member of the hospital or long-term

care facility or of which the hospital or facility is a member;

(b) A peer review committee of a community mental health center;

(c) A board or committee of a hospital, a long-term care facility, or other health care entity when reviewing professional qualifications or activities of health care providers, including both individuals who provide health care and entities that provide health care;

(d) A peer review committee, professional standards review committee, or arbitration committee of a state or local society composed of members who are in active practice as physicians, dentists, optometrists, psychologists, or pharmacists;

(e) A peer review committee of a health insuring corporation that has at least a two-thirds majority of member physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers that adversely affects or could adversely affect the health or welfare of any patient;

(f) A peer review committee of a health insuring corporation that has at least a two-thirds majority of member physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the health insuring corporation to provide health care services to enrollees, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;

(g) A peer review committee of a sickness and accident

insurer that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers that adversely affects or could adversely affect the health or welfare of any patient;

(h) A peer review committee of a sickness and accident insurer that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the insurer to provide health care services to insureds, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;

(i) A peer review committee of any insurer authorized under Title XXXIX of the Revised Code to do the business of medical professional liability insurance in this state that conducts professional quality review activities involving the competence or professional conduct of health care providers that adversely affects or could affect the health or welfare of any patient;

(j) A peer review committee of the bureau of workers' compensation or the industrial commission that is responsible for reviewing the professional qualifications and the performance of providers certified by the bureau to participate in the health partnership program or of providers conducting medical examinations or file reviews for the bureau or the commission;

(k) Any other peer review committee of a health care entity.

(F) "Physician" means an individual authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(G) "Sickness and accident insurer" means an entity authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state.

(H) "Tort action" means a civil action for damages or a claim filed under Chapters 3965. and 3967. of the Revised Code for injury, death, or loss to a patient of a health care entity. "Tort action" includes a product liability claim, as defined in section 2307.71 of the Revised Code, and an asbestos claim, as defined in section 2307.91 of the Revised Code, but does not include a civil action for a breach of contract or another agreement between persons.

(I) "Accountable care organization" means such an organization as defined in 42 C.F.R. 425.20.

Sec. 2307.24. (A) Sections 2307.22 and 2307.23 of the Revised Code do not affect joint and several liability that is not based in tort.

(B) Sections 2307.22 and 2307.23 of the Revised Code do not affect any other section of the Revised Code or the common law of this state to the extent that the other section or common law makes a principal, master, or other person vicariously liable for the tortious conduct of an agent, servant, or other person. For purposes of section 2307.22 of the Revised Code, a principal and agent, a master and servant, or other persons having a vicarious liability relationship shall constitute a single party when determining percentages of tortious conduct in a tort action in which vicarious liability is asserted.

(C) Sections 2307.22 and 2307.23 of the Revised Code do not apply to claims filed under Chapters 3965. and 3967. of the Revised Code.

Sec. 2307.26. (A) If a judgment that imposes joint and several liability has been entered in an action against one or more tortfeasors for the same injury or loss to person or property or for the same wrongful death, contribution may be enforced in that action by judgment in favor of one against other judgment debtors, by motion, upon notice to all parties to the action. If there is a judgment for the injury or loss to person or property or the wrongful death against the tortfeasor seeking contribution, that tortfeasor shall commence any separate action to enforce contribution within one year after the judgment has become final by lapse of time for appeal or after appellate review.

If there is no judgment for the injury or loss to person or property or the wrongful death against the tortfeasor seeking contribution, that tortfeasor's right of contribution is barred unless either of the following applies:

~~(A)~~ (1) That tortfeasor has discharged by payment the common liability within the statute of limitations period applicable to the claimant's right of action against that tortfeasor and has commenced that tortfeasor's action for contribution within one year after the payment.

~~(B)~~ (2) That tortfeasor has agreed while an action is pending against that tortfeasor to discharge the common liability and has paid within one year after the agreement the common liability and commenced that tortfeasor's action for contribution.

(B) Sections 2307.222 and 2307.23 of the Revised Code do not apply to claims filed under Chapters 3965. and 3967. of the Revised Code.

Sec. 2315.21. (A) As used in this section:

(1) "Tort action" means a civil action for damages for injury or loss to person or property. "Tort action" includes a product liability claim for damages for injury or loss to person or property that is subject to sections 2307.71 to 2307.80 of the Revised Code, but does not include ~~a~~ either of the following:

(a) A civil action for damages for a breach of contract or another agreement between persons;

(b) A claim filed under Chapters 3965. and 3967. of the Revised Code.

(2) "Trier of fact" means the jury or, in a nonjury action, the court.

(3) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(4) "Employer" includes, but is not limited to, a parent, subsidiary, affiliate, division, or department of the employer. If the employer is an individual, the individual shall be considered an employer under this section only if the subject of the tort action is related to the individual's capacity as an employer.

(5) "Small employer" means an employer who employs not more than one hundred persons on a full-time permanent basis, or, if the employer is classified as being in the manufacturing sector by the North American industrial classification system,

"small employer" means an employer who employs not more than five hundred persons on a full-time permanent basis.

(B)(1) In a tort action that is tried to a jury and in which a plaintiff makes a claim for compensatory damages and a claim for punitive or exemplary damages, upon the motion of any party, the trial of the tort action shall be bifurcated as follows:

(a) The initial stage of the trial shall relate only to the presentation of evidence, and a determination by the jury, with respect to whether the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant. During this stage, no party to the tort action shall present, and the court shall not permit a party to present, evidence that relates solely to the issue of whether the plaintiff is entitled to recover punitive or exemplary damages for the injury or loss to person or property from the defendant.

(b) If the jury determines in the initial stage of the trial that the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant, evidence may be presented in the second stage of the trial, and a determination by that jury shall be made, with respect to whether the plaintiff additionally is entitled to recover punitive or exemplary damages for the injury or loss to person or property from the defendant.

(2) In a tort action that is tried to a jury and in which a plaintiff makes a claim for both compensatory damages and punitive or exemplary damages, the court shall instruct the jury to return, and the jury shall return, a general verdict and, if that verdict is in favor of the plaintiff, answers to an

interrogatory that specifies the total compensatory damages recoverable by the plaintiff from each defendant.

(3) In a tort action that is tried to a court and in which a plaintiff makes a claim for both compensatory damages and punitive or exemplary damages, the court shall make its determination with respect to whether the plaintiff is entitled to recover compensatory damages for the injury or loss to person or property from the defendant and, if that determination is in favor of the plaintiff, shall make findings of fact that specify the total compensatory damages recoverable by the plaintiff from the defendant.

(C) Subject to division (E) of this section, punitive or exemplary damages are not recoverable from a defendant in question in a tort action unless both of the following apply:

(1) The actions or omissions of that defendant demonstrate malice or aggravated or egregious fraud, or that defendant as principal or master knowingly authorized, participated in, or ratified actions or omissions of an agent or servant that so demonstrate.

(2) The trier of fact has returned a verdict or has made a determination pursuant to division (B)(2) or (3) of this section of the total compensatory damages recoverable by the plaintiff from that defendant.

(D)(1) In a tort action, the trier of fact shall determine the liability of any defendant for punitive or exemplary damages and the amount of those damages.

(2) Except as provided in division (D)(6) of this section, all of the following apply regarding any award of punitive or exemplary damages in a tort action:

(a) The court shall not enter judgment for punitive or exemplary damages in excess of two times the amount of the compensatory damages awarded to the plaintiff from that defendant, as determined pursuant to division (B)(2) or (3) of this section.

(b) If the defendant is a small employer or individual, the court shall not enter judgment for punitive or exemplary damages in excess of the lesser of two times the amount of the compensatory damages awarded to the plaintiff from the defendant or ten ~~percent~~ per cent of the employer's or individual's net worth when the tort was committed up to a maximum of three hundred fifty thousand dollars, as determined pursuant to division (B)(2) or (3) of this section.

(c) Any ~~attorneys~~ attorney's fees awarded as a result of a claim for punitive or exemplary damages shall not be considered for purposes of determining the cap on punitive damages.

(3) No award of prejudgment interest under division (C)(1) of section 1343.03 of the Revised Code shall include any prejudgment interest on punitive or exemplary damages found by the trier of fact.

(4) In a tort action, the burden of proof shall be upon a plaintiff in question, by clear and convincing evidence, to establish that the plaintiff is entitled to recover punitive or exemplary damages.

(5)(a) In any tort action, except as provided in division (D)(5)(b) or (6) of this section, punitive or exemplary damages shall not be awarded against a defendant if that defendant files with the court a certified judgment, judgment entries, or other evidence showing that punitive or exemplary damages have already

been awarded and have been collected, in any state or federal court, against that defendant based on the same act or course of conduct that is alleged to have caused the injury or loss to person or property for which the plaintiff seeks compensatory damages and that the aggregate of those previous punitive or exemplary damage awards exceeds the maximum amount of punitive or exemplary damages that may be awarded under division (D)(2) of this section against that defendant in the tort action.

(b) Notwithstanding division (D)(5)(a) of this section and except as provided in division (D)(6) of this section, punitive or exemplary damages may be awarded against a defendant in either of the following types of tort actions:

(i) In subsequent tort actions involving the same act or course of conduct for which punitive or exemplary damages have already been awarded, if the court determines by clear and convincing evidence that the plaintiff will offer new and substantial evidence of previously undiscovered, additional behavior of a type described in division (C) of this section on the part of that defendant, other than the injury or loss for which the plaintiff seeks compensatory damages. In that case, the court shall make specific findings of fact in the record to support its conclusion. The court shall reduce the amount of any punitive or exemplary damages otherwise awardable pursuant to this section by the sum of the punitive or exemplary damages awards previously rendered against that defendant in any state or federal court. The court shall not inform the jury about the court's determination and action under division (D)(5)(b)(i) of this section.

(ii) In subsequent tort actions involving the same act or course of conduct for which punitive or exemplary damages have

already been awarded, if the court determines by clear and convincing evidence that the total amount of prior punitive or exemplary damages awards was totally insufficient to punish that defendant's behavior of a type described in division (C) of this section and to deter that defendant and others from similar behavior in the future. In that case, the court shall make specific findings of fact in the record to support its conclusion. The court shall reduce the amount of any punitive or exemplary damages otherwise awardable pursuant to this section by the sum of the punitive or exemplary damages awards previously rendered against that defendant in any state or federal court. The court shall not inform the jury about the court's determination and action under division (D)(5)(b)(ii) of this section.

(6) Division (D)(2) of this section does not apply to a tort action where the alleged injury, death, or loss to person or property resulted from the defendant acting with one or more of the culpable mental states of purposely and knowingly as described in section 2901.22 of the Revised Code and when the defendant has been convicted of or pleaded guilty to a criminal offense that is a felony, that had as an element of the offense one or more of the culpable mental states of purposely and knowingly as described in that section, and that is the basis of the tort action.

(E) This section does not apply to tort actions against the state in the court of claims, including, but not limited to, tort actions against a state university or college that are subject to division (B)(1) of section 3345.40 of the Revised Code, to tort actions against political subdivisions of this state that are commenced under or are subject to Chapter 2744. of the Revised Code, or to the extent that another section of

the Revised Code expressly provides any of the following:

(1) Punitive or exemplary damages are recoverable from a defendant in question in a tort action on a basis other than that the actions or omissions of that defendant demonstrate malice or aggravated or egregious fraud or on a basis other than that the defendant in question as principal or master knowingly authorized, participated in, or ratified actions or omissions of an agent or servant that so demonstrate.

(2) Punitive or exemplary damages are recoverable from a defendant in question in a tort action irrespective of whether the plaintiff in question has adduced proof of actual damages.

(3) The burden of proof upon a plaintiff in question to recover punitive or exemplary damages from a defendant in question in a tort action is one other than clear and convincing evidence.

(4) Punitive or exemplary damages are not recoverable from a defendant in question in a tort action.

(F) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limits on punitive or exemplary damages pursuant to division (D) of this section, and neither counsel for any party or a witness shall inform the jury or potential jurors of those limits.

(G) When determining the amount of an award of punitive or exemplary damages against either a home or a residential facility licensed under section 5123.19 of the Revised Code, the trier of fact shall consider all of the following:

(1) The ability of the home or residential facility to pay the award of punitive or exemplary damages based on the home's or residential facility's assets, income, and net worth;

(2) Whether the amount of punitive or exemplary damages is sufficient to deter future tortious conduct;

(3) The financial ability of the home or residential facility, both currently and in the future, to provide accommodations, personal care services, and skilled nursing care.

Sec. 2315.32. (A) Sections 2315.32 to 2315.36 of the Revised Code do not apply to actions described in section 4113.03 of the Revised Code or to claims filed under Chapters 3965. and 3967. of the Revised Code.

(B) The contributory fault of the plaintiff may be asserted as an affirmative defense to a tort claim, except that the contributory fault of the plaintiff may not be asserted as an affirmative defense to an intentional tort claim.

Sec. 2317.02. The following persons shall not testify in certain respects:

(A)(1) An attorney, concerning a communication made to the attorney by a client in that relation or concerning the attorney's advice to a client, except that the attorney may testify by express consent of the client or, if the client is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased client. However, if the client voluntarily reveals the substance of attorney-client communications in a nonprivileged context or is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the attorney may be compelled to testify on the same subject.

The testimonial privilege established under this division does not apply concerning a communication between a client who

has since died and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased client when the deceased client executed a document that is the basis of the dispute or whether the deceased client was a victim of fraud, undue influence, or duress when the deceased client executed a document that is the basis of the dispute.

(2) An attorney, concerning a communication made to the attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima-facie showing of bad faith, fraud, or criminal misconduct by the client.

(B)(1) A physician or a dentist concerning a communication made to the physician or dentist by a patient in that relation or the physician's or dentist's advice to a patient, except as otherwise provided in this division, division (B)(2), and division (B)(3) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician may be compelled to testify on the same subject.

The testimonial privilege established under this division

does not apply, and a physician or dentist may testify or may be compelled to testify, in any of the following circumstances:

(a) In any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. of the Revised Code, under any of the following circumstances:

(i) If the patient or the guardian or other legal representative of the patient gives express consent;

(ii) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent;

(iii) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 or 3965.01 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(b) In any civil action concerning court-ordered treatment or services received by a patient, if the court-ordered treatment or services were ordered as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code.

(c) In any criminal action concerning any test or the results of any test that determines the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled

substance in the patient's whole blood, blood serum or plasma, breath, urine, or other bodily substance at any time relevant to the criminal offense in question.

(d) In any criminal action against a physician or dentist. In such an action, the testimonial privilege established under this division does not prohibit the admission into evidence, in accordance with the Rules of Evidence, of a patient's medical or dental records or other communications between a patient and the physician or dentist that are related to the action and obtained by subpoena, search warrant, or other lawful means. A court that permits or compels a physician or dentist to testify in such an action or permits the introduction into evidence of patient records or other communications in such an action shall require that appropriate measures be taken to ensure that the confidentiality of any patient named or otherwise identified in the records is maintained. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

(e)(i) If the communication was between a patient who has since died and the deceased patient's physician or dentist, the communication is relevant to a dispute between parties who claim through that deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased patient when the deceased patient executed a document that is the basis of the dispute or whether the deceased patient was a victim of fraud, undue influence, or duress when the deceased patient executed a document that is the basis of the dispute.

(ii) If neither the spouse of a patient nor the executor

or administrator of that patient's estate gives consent under division (B)(1)(a)(ii) of this section, testimony or the disclosure of the patient's medical records by a physician, dentist, or other health care provider under division (B)(1)(e)(i) of this section is a permitted use or disclosure of protected health information, as defined in 45 C.F.R. 160.103, and an authorization or opportunity to be heard shall not be required.

(iii) Division (B)(1)(e)(i) of this section does not require a mental health professional to disclose psychotherapy notes, as defined in 45 C.F.R. 164.501.

(iv) An interested person who objects to testimony or disclosure under division (B)(1)(e)(i) of this section may seek a protective order pursuant to Civil Rule 26.

(v) A person to whom protected health information is disclosed under division (B)(1)(e)(i) of this section shall not use or disclose the protected health information for any purpose other than the litigation or proceeding for which the information was requested and shall return the protected health information to the covered entity or destroy the protected health information, including all copies made, at the conclusion of the litigation or proceeding.

(2)(a) If any law enforcement officer submits a written statement to a health care provider that states that an official criminal investigation has begun regarding a specified person or that a criminal action or proceeding has been commenced against a specified person, that requests the provider to supply to the officer copies of any records the provider possesses that pertain to any test or the results of any test administered to the specified person to determine the presence or concentration

of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in the person's whole blood, blood serum or plasma, breath, or urine at any time relevant to the criminal offense in question, and that conforms to section 2317.022 of the Revised Code, the provider, except to the extent specifically prohibited by any law of this state or of the United States, shall supply to the officer a copy of any of the requested records the provider possesses. If the health care provider does not possess any of the requested records, the provider shall give the officer a written statement that indicates that the provider does not possess any of the requested records.

(b) If a health care provider possesses any records of the type described in division (B)(2)(a) of this section regarding the person in question at any time relevant to the criminal offense in question, in lieu of personally testifying as to the results of the test in question, the custodian of the records may submit a certified copy of the records, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of records submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test to which the records pertain, the person under whose supervision the test was administered, the custodian of the records, the person who made the records, or the person under whose supervision the records were made.

(3)(a) If the testimonial privilege described in division (B)(1) of this section does not apply as provided in division

(B)(1)(a)(iii) of this section, a physician or dentist may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the physician or dentist by the patient in question in that relation, or the physician's or dentist's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. of the Revised Code.

(b) If the testimonial privilege described in division (B)(1) of this section does not apply to a physician or dentist as provided in division (B)(1)(c) of this section, the physician or dentist, in lieu of personally testifying as to the results of the test in question, may submit a certified copy of those results, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of results submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test in question, the person under whose supervision the test was administered, the custodian of the results of the test, the person who compiled the results, or the person under whose supervision the results were compiled.

(4) The testimonial privilege described in division (B)(1) of this section is not waived when a communication is made by a physician to a pharmacist or when there is communication between a patient and a pharmacist in furtherance of the physician-patient relation.

(5)(a) As used in divisions (B)(1) to (4) of this section, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a physician or dentist to diagnose, treat, prescribe, or act for a patient. A "communication" may include, but is not limited to, any medical or dental, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(b) As used in division (B)(2) of this section, "health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(c) As used in division (B)(5)(b) of this section:

(i) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory health care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.

(ii) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.

(iii) "Health care practitioner" has the same meaning as in section 4769.01 of the Revised Code.

(iv) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(v) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.

(vi) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(d) As used in divisions (B)(1) and (2) of this section, "drug of abuse" has the same meaning as in section 4506.01 of the Revised Code.

(6) Divisions (B)(1), (2), (3), (4), and (5) of this section apply to doctors of medicine, doctors of osteopathic medicine, doctors of podiatry, and dentists.

(7) Nothing in divisions (B)(1) to (6) of this section affects, or shall be construed as affecting, the immunity from civil liability conferred by section 307.628 of the Revised Code or the immunity from civil liability conferred by section 2305.33 of the Revised Code upon physicians who report an employee's use of a drug of abuse, or a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee in accordance with division (B) of that

section. As used in division (B)(7) of this section, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code.

(C)(1) A cleric, when the cleric remains accountable to the authority of that cleric's church, denomination, or sect, concerning a confession made, or any information confidentially communicated, to the cleric for a religious counseling purpose in the cleric's professional character. The cleric may testify by express consent of the person making the communication, except when the disclosure of the information is in violation of a sacred trust and except that, if the person voluntarily testifies or is deemed by division (A)(4)(c) of section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the cleric may be compelled to testify on the same subject except when disclosure of the information is in violation of a sacred trust.

(2) As used in division (C) of this section:

(a) "Cleric" means a member of the clergy, rabbi, priest, Christian Science practitioner, or regularly ordained, accredited, or licensed minister of an established and legally cognizable church, denomination, or sect.

(b) "Sacred trust" means a confession or confidential communication made to a cleric in the cleric's ecclesiastical capacity in the course of discipline enjoined by the church to which the cleric belongs, including, but not limited to, the Catholic Church, if both of the following apply:

(i) The confession or confidential communication was made directly to the cleric.

(ii) The confession or confidential communication was made

in the manner and context that places the cleric specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine.

(D) Husband or wife, concerning any communication made by one to the other, or an act done by either in the presence of the other, during coverture, unless the communication was made, or act done, in the known presence or hearing of a third person competent to be a witness; and such rule is the same if the marital relation has ceased to exist;

(E) A person who assigns a claim or interest, concerning any matter in respect to which the person would not, if a party, be permitted to testify;

(F) A person who, if a party, would be restricted under section 2317.03 of the Revised Code, when the property or thing is sold or transferred by an executor, administrator, guardian, trustee, heir, devisee, or legatee, shall be restricted in the same manner in any action or proceeding concerning the property or thing.

(G)(1) A school guidance counselor who holds a valid educator license from the state board of education as provided for in section 3319.22 of the Revised Code, a person licensed under Chapter 4757. of the Revised Code as a licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, marriage and family therapist or independent marriage and family therapist, or registered under Chapter 4757. of the Revised Code as a social work assistant concerning a confidential communication received from a client in that relation or the person's advice to a client unless any of the following applies:

(a) The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger.

(b) The client gives express consent to the testimony.

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent.

(d) The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757. of the Revised Code may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the client is not germane to the counselor-client, marriage and family therapist-client, or social worker-client relationship.

(f) A court, in an action brought against a school, its administration, or any of its personnel by the client, rules after an in-camera inspection that the testimony of the school guidance counselor is relevant to that action.

(g) The testimony is sought in a civil action and concerns court-ordered treatment or services received by a patient as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code.

(2) Nothing in division (G)(1) of this section shall

relieve a school guidance counselor or a person licensed or registered under Chapter 4757. of the Revised Code from the requirement to report information concerning child abuse or neglect under section 2151.421 of the Revised Code.

(H) A mediator acting under a mediation order issued under division (A) of section 3109.052 of the Revised Code or otherwise issued in any proceeding for divorce, dissolution, legal separation, annulment, or the allocation of parental rights and responsibilities for the care of children, in any action or proceeding, other than a criminal, delinquency, child abuse, child neglect, or dependent child action or proceeding, that is brought by or against either parent who takes part in mediation in accordance with the order and that pertains to the mediation process, to any information discussed or presented in the mediation process, to the allocation of parental rights and responsibilities for the care of the parents' children, or to the awarding of parenting time rights in relation to their children;

(I) A communications assistant, acting within the scope of the communication assistant's authority, when providing telecommunications relay service pursuant to section 4931.06 of the Revised Code or Title II of the "Communications Act of 1934," 104 Stat. 366 (1990), 47 U.S.C. 225, concerning a communication made through a telecommunications relay service. Nothing in this section shall limit the obligation of a communications assistant to divulge information or testify when mandated by federal law or regulation or pursuant to subpoena in a criminal proceeding.

Nothing in this section shall limit any immunity or privilege granted under federal law or regulation.

(J)(1) A chiropractor in a civil proceeding concerning a communication made to the chiropractor by a patient in that relation or the chiropractor's advice to a patient, except as otherwise provided in this division. The testimonial privilege established under this division does not apply, and a chiropractor may testify or may be compelled to testify, in any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. of the Revised Code, under any of the following circumstances:

(a) If the patient or the guardian or other legal representative of the patient gives express consent.

(b) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent.

(c) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(2) If the testimonial privilege described in division (J)(1) of this section does not apply as provided in division (J)(1)(c) of this section, a chiropractor may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the chiropractor by the patient in question in that relation, or the chiropractor's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to

issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. of the Revised Code.

(3) The testimonial privilege established under this division does not apply, and a chiropractor may testify or be compelled to testify, in any criminal action or administrative proceeding.

(4) As used in this division, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a chiropractor to diagnose, treat, or act for a patient. A communication may include, but is not limited to, any chiropractic, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(K)(1) Except as provided under division (K)(2) of this section, a critical incident stress management team member concerning a communication received from an individual who receives crisis response services from the team member, or the team member's advice to the individual, during a debriefing session.

(2) The testimonial privilege established under division (K)(1) of this section does not apply if any of the following are true:

(a) The communication or advice indicates clear and present danger to the individual who receives crisis response services or to other persons. For purposes of this division, cases in which there are indications of present or past child abuse or neglect of the individual constitute a clear and

present danger.

(b) The individual who received crisis response services gives express consent to the testimony.

(c) If the individual who received crisis response services is deceased, the surviving spouse or the executor or administrator of the estate of the deceased individual gives express consent.

(d) The individual who received crisis response services voluntarily testifies, in which case the team member may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the individual who received crisis response services is not germane to the relationship between the individual and the team member.

(f) The communication or advice pertains or is related to any criminal act.

(3) As used in division (K) of this section:

(a) "Crisis response services" means consultation, risk assessment, referral, and on-site crisis intervention services provided by a critical incident stress management team to individuals affected by crisis or disaster.

(b) "Critical incident stress management team member" or "team member" means an individual specially trained to provide crisis response services as a member of an organized community or local crisis response team that holds membership in the Ohio critical incident stress management network.

(c) "Debriefing session" means a session at which crisis response services are rendered by a critical incident stress

management team member during or after a crisis or disaster.

(L)(1) Subject to division (L)(2) of this section and except as provided in division (L)(3) of this section, an employee assistance professional, concerning a communication made to the employee assistance professional by a client in the employee assistance professional's official capacity as an employee assistance professional.

(2) Division (L)(1) of this section applies to an employee assistance professional who meets either or both of the following requirements:

(a) Is certified by the employee assistance certification commission to engage in the employee assistance profession;

(b) Has education, training, and experience in all of the following:

(i) Providing workplace-based services designed to address employer and employee productivity issues;

(ii) Providing assistance to employees and employees' dependents in identifying and finding the means to resolve personal problems that affect the employees or the employees' performance;

(iii) Identifying and resolving productivity problems associated with an employee's concerns about any of the following matters: health, marriage, family, finances, substance abuse or other addiction, workplace, law, and emotional issues;

(iv) Selecting and evaluating available community resources;

(v) Making appropriate referrals;

(vi) Local and national employee assistance agreements;

(vii) Client confidentiality.

(3) Division (L)(1) of this section does not apply to any of the following:

(a) A criminal action or proceeding involving an offense under sections 2903.01 to 2903.06 of the Revised Code if the employee assistance professional's disclosure or testimony relates directly to the facts or immediate circumstances of the offense;

(b) A communication made by a client to an employee assistance professional that reveals the contemplation or commission of a crime or serious, harmful act;

(c) A communication that is made by a client who is an unemancipated minor or an adult adjudicated to be incompetent and indicates that the client was the victim of a crime or abuse;

(d) A civil proceeding to determine an individual's mental competency or a criminal action in which a plea of not guilty by reason of insanity is entered;

(e) A civil or criminal malpractice action brought against the employee assistance professional;

(f) When the employee assistance professional has the express consent of the client or, if the client is deceased or disabled, the client's legal representative;

(g) When the testimonial privilege otherwise provided by division (L)(1) of this section is abrogated under law.

Sec. 2323.41. (A) In any civil action upon a medical,

dental, optometric, or chiropractic claim, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation.

(B) If the defendant elects to introduce evidence described in division (A) of this section, the plaintiff may introduce evidence of any amount that the plaintiff has paid or contributed to secure the plaintiff's right to receive the benefits of which the defendant has introduced evidence.

(C) A source of collateral benefits of which evidence is introduced pursuant to division (A) of this section shall not recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(D) This section shall apply only to a medical, dental, optometric, or chiropractic claim in which either of the following applies:

(1) A claimant alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(E) As used in this section, "medical claim," "dental

claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Sec. 2323.42. (A) Upon the motion of any defendant in a civil action based upon a medical claim, dental claim, optometric claim, or chiropractic claim, the court shall conduct a hearing regarding the existence or nonexistence of a reasonable good faith basis upon which the particular claim is asserted against the moving defendant. The defendant shall file the motion not earlier than the close of discovery in the action and not later than thirty days after the court or jury renders any verdict or award in the action. After the motion is filed, the plaintiff shall have not less than fourteen days to respond to the motion. Upon good cause shown by the plaintiff, the court shall grant an extension of the time for the plaintiff to respond as necessary to obtain evidence demonstrating the existence of a reasonable good faith basis for the claim.

(B) At the request of any party to the good faith motion described in division (A) of this section, the court shall order the motion to be heard at an oral hearing and shall consider all evidence and arguments submitted by the parties. In determining whether a plaintiff has a reasonable good faith basis upon which to assert the claim in question against the moving defendant, the court shall take into consideration, in addition to the facts of the underlying claim, whether the plaintiff did any of the following:

(1) Obtained a reasonably timely review of the merits of the particular claim by a qualified medical, dental, optometric, or chiropractic expert, as appropriate;

(2) Reasonably relied upon the results of that review in supporting the assertion of the particular claim;

(3) Had an opportunity to conduct a pre-suit investigation or was afforded by the defendant full and timely discovery during litigation;

(4) Reasonably relied upon evidence discovered during the course of litigation in support of the assertion of the claim in question;

(5) Took appropriate and reasonable steps to timely dismiss any defendant on behalf of whom it was alleged or determined that no reasonable good faith basis existed for continued assertion of the claim in question.

(C) If the court determines that there was no reasonable good faith basis upon which the plaintiff asserted the claim in question against the moving defendant or that, at some point during the litigation, the plaintiff lacked a good faith basis for continuing to assert that claim, the court shall award all of the following in favor of the moving defendant:

(1) All court costs incurred by the moving defendant;

(2) Reasonable attorneys' fees incurred by the moving defendant in defense of the claim after the time that the court determines that no reasonable good faith basis existed upon which to assert or continue to assert the claim;

(3) Reasonable attorneys' fees incurred in support of the good faith motion.

(D) Prior to filing a good faith motion as described in division (A) of this section, any defendant that intends to file that type of motion shall serve a "notice of demand for dismissal and intention to file a good faith motion." If, within fourteen days of service of that notice, the plaintiff dismisses the defendant from the action, the defendant after the dismissal

shall be precluded from filing a good faith motion as to any attorneys' fees and other costs subsequent to the dismissal.

(E) This section shall apply only to a medical, dental, optometric, or chiropractic claim in which either of the following applies:

(1) A claimant alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(F) As used in this section, "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Sec. 2323.421. A person licensed in another state to practice medicine, who testifies as an expert witness on behalf of any party in this state in any action against a physician for injury or death, whether in contract or tort or under Chapter 3965. or 3967. of the Revised Code, arising out of the provision of or failure to provide health care services, shall be deemed to have a temporary license to practice medicine in this state solely for the purpose of providing such testimony and is subject to the authority of the state medical board and the provisions of Chapter 4731. of the Revised Code. The conclusion of an action against a physician shall not be construed to have any effect on the board's authority to take action against a physician who testifies as an expert witness under this section.

Sec. 2323.43. (A) In a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property, all of the following apply:

(1) There shall not be any limitation on compensatory damages that represent the economic loss of the person who is awarded the damages in the civil action.

(2) Except as otherwise provided in division (A)(3) of this section, the amount of compensatory damages that represents damages for noneconomic loss that is recoverable in a civil action under this section to recover damages for injury, death, or loss to person or property shall not exceed the greater of two hundred fifty thousand dollars or an amount that is equal to three times the plaintiff's economic loss, as determined by the trier of fact, to a maximum of three hundred fifty thousand dollars for each plaintiff or a maximum of five hundred thousand dollars for each occurrence.

(3) The amount recoverable for noneconomic loss in a civil action under this section may exceed the amount described in division (A)(2) of this section but shall not exceed five hundred thousand dollars for each plaintiff or one million dollars for each occurrence if the noneconomic losses of the plaintiff are for either of the following:

(a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system;

(b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities.

(B) If a trial is conducted in a civil action upon a

medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property and a plaintiff prevails with respect to that claim, the court in a nonjury trial shall make findings of fact, and the jury in a jury trial shall return a general verdict accompanied by answers to interrogatories, that shall specify all of the following:

(1) The total compensatory damages recoverable by the plaintiff;

(2) The portion of the total compensatory damages that represents damages for economic loss;

(3) The portion of the total compensatory damages that represents damages for noneconomic loss.

(C)(1) After the trier of fact in a civil action upon a medical, dental, optometric, or chiropractic claim to recover damages for injury, death, or loss to person or property complies with division (B) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for economic loss in the amount determined pursuant to division (B)(2) of this section, and, subject to division (D)(1) of this section, the court shall enter a judgment in favor of the plaintiff for compensatory damages for noneconomic loss. In no event shall a judgment for compensatory damages for noneconomic loss exceed the maximum recoverable amount that represents damages for noneconomic loss as provided in divisions (A)(2) and (3) of this section. Division (A) of this section shall be applied in a jury trial only after the jury has made its factual findings and determination as to the damages.

(2) Prior to the trial in the civil action, any party may seek summary judgment with respect to the nature of the alleged

injury or loss to person or property, seeking a determination of the damages as described in division (A)(2) or (3) of this section.

(D)(1) A court of common pleas has no jurisdiction to enter judgment on an award of compensatory damages for noneconomic loss in excess of the limits set forth in this section.

(2) If the trier of fact is a jury, the court shall not instruct the jury with respect to the limit on compensatory damages for noneconomic loss described in divisions (A)(2) and (3) of this section, and neither counsel for any party nor a witness shall inform the jury or potential jurors of that limit.

(E) Any excess amount of compensatory damages for noneconomic loss that is greater than the applicable amount specified in division (A)(2) or (3) of this section shall not be reallocated to any other tortfeasor beyond the amount of compensatory damages that that tortfeasor would otherwise be responsible for under the laws of this state.

(F)(1) If pursuant to a contingency fee agreement between an attorney and a plaintiff in a civil action upon a medical claim, dental claim, optometric claim, or chiropractic claim, the amount of the attorney's fees exceed the applicable amount of the limits on compensatory damages for noneconomic loss as provided in division (A)(2) or (3) of this section, the attorney shall make an application in the probate court of the county in which the civil action was commenced or in which the settlement was entered. The application shall contain a statement of facts, including the amount to be allocated to the settlement of the claim, the amount of the settlement or judgment that represents the compensatory damages for economic loss and noneconomic loss,

the relevant provision in the contingency fee agreement, and the dollar amount of the attorney's fees under the contingency fee agreement. The application shall include the proposed distribution of the amount of the judgment or settlement.

(2) The attorney shall give written notice of the hearing and a copy of the application to all interested persons who have not waived notice of the hearing. Notwithstanding the waivers and consents of the interested persons, the probate court shall retain jurisdiction over the settlement, allocation, and distribution of the claim.

(3) The application shall state the arrangements, if any, that have been made with respect to the attorney's fees. The attorney's fees shall be subject to the approval of the probate court.

(G) This section does not apply to any of the following:

(1) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against the state in the court of claims, including, but not limited to, those actions in which a state university or college is a defendant and to which division (B)(3) of section 3345.40 of the Revised Code applies;

(2) Civil actions upon a medical, dental, optometric, or chiropractic claim that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744. of the Revised Code. Division (C) of section 2744.05 of the Revised Code applies to recoverable damages in those actions;

(3) Wrongful death actions brought pursuant to Chapter 2125. of the Revised Code.

(H) <u>This section shall apply only to a medical, dental,</u>

optometric, or chiropractic claim in which either of the following applies:

(1) A claimant alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(I) As used in this section:

(1) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action.

(2) "Medical claim," "dental claim," "optometric claim,"

and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(3) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.

(4) "Trier of fact" means the jury or, in a nonjury action, the court.

Sec. 2323.45. (A)(1) A health care provider named as a defendant in a civil action based upon a medical claim is permitted to file a motion with the court for dismissal of the claim accompanied by an affidavit of noninvolvement. The defendant shall notify all parties in writing of the filing of the motion. Prior to ruling on the motion, the court shall allow the parties not less than thirty days from the date that the parties were served with the notice to respond to the motion.

(2) An affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the defendant was misidentified or otherwise not involved individually or through the action of the defendant's agents or employees in the care and treatment of the plaintiff, was not obligated individually or through the defendant's agents or employees to provide for the care and treatment of the plaintiff, and could not have caused the alleged malpractice individually or through the defendant's agents or employees in any way.

(B)(1) The parties shall have the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the court that contradicts the assertions of noninvolvement made in the defendant's affidavit of noninvolvement.

(2) If the affidavit of noninvolvement is challenged, any party may request an oral hearing on the motion for dismissal. If requested, the court shall hold a hearing to determine if the defendant was involved, directly or indirectly, in the care and treatment of the plaintiff, or was obligated, directly or indirectly, for the care and treatment of the plaintiff.

(3) The court shall consider all evidence submitted by the parties and the parties' arguments and may dismiss the civil action based upon the defendant's lack of involvement in the elements of the plaintiff's medical claim. The court shall rule on all challenges to the affidavit of noninvolvement within seventy-five days after the filing of the affidavit of noninvolvement.

(4) A court's dismissal of a claim against a defendant pursuant to this section shall be deemed otherwise than upon the merits and without prejudice pursuant to Civil Rule 41.

(C) If the court determines that a health care provider named as a defendant has falsely filed or made false or inaccurate statements in an affidavit of noninvolvement, the court, upon a motion or upon its own initiative, shall immediately reinstate the claim against that defendant, if previously dismissed. Reinstatement of a party pursuant to this division shall not be barred by any statute of limitations defense that was not valid at the time the original affidavit was filed.

(D) In any action in which the defendant is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the defendant, or both, an appropriate sanction, including, but not limited to, an order to pay to other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorney's fees.

(E) In any action in which the court determines that a party falsely objected to a defendant's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a defendant's affidavit, the court shall impose upon the party or the party's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorney's fees.

(F) This section shall apply only to a medical claim in which either of the following applies:

(1) A claimant alleges that the health care provider against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The health care provider against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(G) As used in this section:

(1) "Health care provider" has the same meaning as in division (B)(5) of section 2317.02 of the Revised Code.

(2) "Medical claim" means any claim that is asserted in any civil action against a health care provider and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes derivative claims for relief.

Sec. 2323.55. (A) As used in this section:

(1) "Economic loss" means any of the following types of pecuniary harm:

(a) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(b) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim;

(c) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action.

(2) "Future damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim and that will accrue after the verdict or

determination of liability is rendered in that action by the trier of fact. "Future damages" includes both economic and noneconomic loss.

(3) "Medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

(4) "Noneconomic loss" means nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.

(5) "Past damages" means any damages that result from an injury, death, or loss to person or property that is a subject of a civil action upon a medical, dental, optometric, or chiropractic claim and that have accrued by the time that the verdict or determination of liability is rendered in that action by the trier of fact. "Past damages" include both economic loss and noneconomic loss.

(6) "Trier of fact" means the jury or, in a nonjury action, the court.

(B) In any civil action upon a medical, dental, optometric, or chiropractic claim in which a plaintiff makes a good faith claim against the defendant for future damages that exceed fifty thousand dollars, upon motion of that plaintiff or the defendant, the trier of fact shall return a general verdict and, if that verdict is in favor of that plaintiff, answers to

interrogatories or findings of fact that specify both of the following:

(1) The past damages recoverable by that plaintiff;

(2) The future damages recoverable by that plaintiff.

(C) If answers to interrogatories are returned or findings of fact are made pursuant to division (B) of this section and if the future damages recoverable by that plaintiff exceeds fifty thousand dollars, the plaintiff or defendant may file a motion with the court that seeks a determination under division (D) of this section. The plaintiff or defendant shall file the motion at any time after the verdict or determination in favor of the plaintiff is rendered by the trier of fact but prior to the entry of judgment in accordance with Civil Rule 58.

(D)(1) Upon the filing of a motion pursuant to division (C) of this section and prior to the entry of judgment in accordance with Civil Rule 58, the court shall do all of the following:

(a) Set a date for a hearing to address whether all or any part of the future damages recoverable by the plaintiff shall be received by the plaintiff in a series of periodic payments rather than in a lump sum;

(b) Give notice of the date of the hearing described in division (D)(1)(a) of this section to the parties involved and their counsel of record;

(c) Conduct the hearing described in division (D)(1)(a) of this section, allow the parties involved to present any relevant evidence at the hearing, consider the factors described in division (D)(2) of this section in making its determination, and make its determination in accordance with division (D)(3) of

this section.

(2) In determining whether all or any part of the future damages recoverable by the plaintiff shall be received by the plaintiff in a series of periodic payments rather than in a lump sum, the court shall consider all of the following factors:

(a) The purposes for which those portions of the future damages were awarded to that plaintiff;

(b) The business or occupational experience of that plaintiff;

(c) The age of that plaintiff;

(d) The physical and mental condition of that plaintiff;

(e) Whether that plaintiff or the parent, guardian, or custodian of that plaintiff is able to competently manage the future damages;

(f) Any other circumstance that relates to whether the injury sustained by that plaintiff would be better compensated by the payment of the future damages in a lump sum or by their receipt in a series of periodic payments.

(3) After the hearing described in division (D)(1) of this section and prior to the entry of judgment in accordance with Civil Rule 58, the court shall determine, in its discretion, whether all or any part of the future damages recoverable by the plaintiff shall be received by the plaintiff in a series of periodic payments rather than in a lump sum. If the court determines that a plaintiff shall receive the future damages recoverable by the plaintiff in a series of periodic payments, it may order the payments only as to the amount of the future damages recoverable by the plaintiff that exceeds fifty thousand

dollars. If the court determines that the plaintiff shall receive the future damages recoverable by the plaintiff in a lump sum, the future damages shall be paid in a lump sum.

(E) If the court determines pursuant to division (D) of this section that a plaintiff shall receive the future damages recoverable by the plaintiff in a series of periodic payments, both of the following apply:

(1) Within twenty days after the court makes that determination, the plaintiff shall submit a periodic payments plan to the court. The plan may include, but is not limited to, a provision for a trust or an annuity and may be submitted by that plaintiff alone or by that plaintiff and the defendant.

(2) Within twenty days after the court makes that determination, the defendant may submit to the court, alone or jointly with the plaintiff, a periodic payments plan. If the defendant submits a periodic payments plan, the plan may include, but is not limited to, a provision for a trust or an annuity.

(F)(1) If the defendant and plaintiff do not jointly submit a periodic payments plan and if the defendant does not separately submit a periodic payments plan, then, within ten days after that plaintiff submits a plan, the defendant may submit to the court written comments relative to the periodic payments plan of the plaintiff.

(2) If the defendant and plaintiff do not jointly submit a periodic payments plan and if the defendant separately submits a periodic payments plan, then, within ten days after the defendant submits the plan, the plaintiff may submit to the court written comments relative to the periodic payments plan of

the defendant.

(G)(1) The court, in its discretion, may modify, approve, or reject any submitted periodic payments plan. In approving any periodic payments plan, the court shall require interest on the judgment in question in accordance with section 1343.03 of the Revised Code. Additionally, in approving any periodic payments plan, the court is not required to ensure that payments under the periodic payments plan are equal in amount or that the total amount paid each year under the periodic payments plan is equal in amount to the total amount paid in other years under the plan; rather, a periodic payments plan may provide for payments to be made in irregular or varied amounts, or to be graduated upward or downward in amount over the duration of the periodic payments plan.

(2) The court shall include in any approved periodic payments plan adequate security to insure that the plaintiff will receive all of the periodic payments under that plan. If the approved periodic payments plan includes a provision for an annuity as the adequate security or otherwise, the defendant shall purchase the annuity from either of the following types of insurance companies:

(a) An insurance company that the A.M. Best Company, in its most recently published rating guide of life insurance companies, has rated A or better and has rated XII or higher as to financial size or strength;

(b) An insurance company that the superintendent of insurance, under rules adopted pursuant to Chapter 119. of the Revised Code for purposes of implementing this division, determines is licensed to do business in this state and, considering the factors described in this division, is a stable

insurance company that issues annuities that are safe and desirable. In making determinations as described in this division, the superintendent shall be guided by the principle that annuities should be safe and desirable for plaintiffs who are awarded damages. In making those determinations, the superintendent shall consider the financial condition, general standing, operating results, profitability, leverage, liquidity, amount and soundness of reinsurance, adequacy of reserves, and the management of any insurance company in question and also may consider ratings, grades, and classifications of any nationally recognized rating services of insurance companies and any other factors relevant to the making of such determinations.

(3) If a periodic payments plan provides for periodic payments over a period of five years or more to the plaintiff, the court, in its discretion, may include in the approved periodic payments plan a provision in which it reserves to itself continuing jurisdiction over that plan, including jurisdiction to review and modify that plan.

(4) The court shall specify in the entry of judgment in the tort action the determination made pursuant to division (D) of this section and, if applicable, the terms of any approved periodic payments plan.

(H) After a periodic payments plan is approved, the future damages that are to be received in periodic payments shall be paid in accordance with the plan, including, if applicable, payment over to a trust or annuity provided for in the plan.

(I) If a court orders a series of periodic payments of future damages in accordance with this section and the plaintiff dies prior to the receipt of all of the future damages, the liability for the unpaid portion of those damages that is not

yet due at the time of the death of that plaintiff shall continue, but the payments shall be paid to the heirs of that plaintiff as scheduled in and otherwise in accordance with the approved periodic payments plan or, if the plan does not contain a relevant provision, as the court shall order.

(J)(1) Nothing in this section precludes a plaintiff and a defendant from mutually agreeing to a settlement of the action.

(2) Except as otherwise provided in this section, nothing in this section increases the time for filing any motion or notice of appeal or taking any other action relative to a civil action upon a medical, dental, optometric, or chiropractic claim, alters the amount of any verdict or determination of damages by the trier of fact in a civil action upon a medical, dental, optometric, or chiropractic claim, or alters the liability of any party to pay or satisfy the verdict or determination.

(K) This section does not apply to tort actions that are brought against political subdivisions of this state and that are commenced under or are subject to Chapter 2744. of the Revised Code or to tort actions brought against the state in the court of claims. This section shall apply only to a medical, dental, optometric, or chiropractic claim in which either of the following applies:

(1) A claimant alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the claimant or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is

brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

Sec. 2711.21. (A) This section shall apply only to a medical, dental, optometric, or chiropractic claim in which either of the following applies:

(1) A plaintiff alleges that the individual or entity against whom the claim is brought intentionally caused, as defined in section 3965.02 of the Revised Code, the injury to or death of the plaintiff or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

(B) Upon the filing of any medical, dental, optometric, or chiropractic claim as defined in section 2305.113 of the Revised Code, if all of the parties to the medical, dental, optometric, or chiropractic claim agree to submit it to nonbinding arbitration, the controversy shall be submitted to an arbitration board consisting of three arbitrators to be named by the court. The arbitration board shall consist of one person designated by the plaintiff or plaintiffs, one person designated by the defendant or defendants, and a person designated by the court. The person designated by the court shall serve as the chairperson of the board. Each member of the board shall receive a reasonable compensation based on the extent and duration of actual service rendered, and shall be paid in equal proportions by the parties in interest. In a claim accompanied by a poverty affidavit, the cost of the arbitration shall be borne by the court.

~~(B)~~ (C) The arbitration proceedings shall be conducted in accordance with sections 2711.06 to 2711.16 of the Revised Code insofar as they are applicable. Such proceedings shall be conducted in the county in which the trial is to be held.

~~(C)~~ (D) If the decision of the arbitration board is not accepted by all parties to the medical, dental, optometric, or chiropractic claim, the claim shall proceed as if it had not been submitted to nonbinding arbitration pursuant to this section. The decision of the arbitration board and any dissenting opinion written by any board member are not admissible into evidence at the trial.

~~(D)~~ (E) Nothing in this section shall be construed to limit the right of any person to enter into an agreement to submit a controversy underlying a medical, dental, optometric, or chiropractic claim to binding arbitration.

Sec. 2711.22. (A) Except as otherwise provided in this section, a written contract between a patient and a hospital or healthcare provider to settle by binding arbitration any dispute or controversy arising out of the diagnosis, treatment, or care of the patient rendered by a hospital or healthcare provider, that is entered into prior to the diagnosis, treatment, or care of the patient is valid, irrevocable, and enforceable ~~once~~ if the contract is signed by all parties and specifically references the patient's ability to file a claim under Chapters 3965. and 3967. of the Revised Code. The contract remains valid, irrevocable, and enforceable until or unless the patient or the patient's legal representative rescinds the contract by written notice within thirty days of the signing of the contract. A guardian or other legal representative of the patient may give written notice of the rescission of the contract if the patient

is incapacitated or a minor. No contract described in this division shall limit a patient's ability to file a claim under Chapters 3965. and 3967. of the Revised Code.

(B) As used in this section and in sections 2711.23 and 2711.24 of the Revised Code:

(1) "Healthcare provider" means a physician, podiatrist, dentist, licensed practical nurse, registered nurse, advanced practice registered nurse, chiropractor, optometrist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, or physical therapist.

(2) "Hospital," "physician," "podiatrist," "dentist," "licensed practical nurse," "registered nurse," "advanced practice registered nurse," "chiropractor," "optometrist," "physician assistant," "emergency medical technician-basic," "emergency medical technician-intermediate," "emergency medical technician-paramedic," "physical therapist," "medical claim," "dental claim," "optometric claim," and "chiropractic claim" have the same meanings as in section 2305.113 of the Revised Code.

Sec. 2711.23. To be valid and enforceable any arbitration agreements pursuant to sections 2711.01 and 2711.22 of the Revised Code for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving any care, diagnosis, or treatment shall include or be subject to the following conditions:

(A) The agreement shall provide that the care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;

(B) The agreement shall provide that the patient, or the patient's spouse, or the personal representative of the patient's estate in the event of the patient's death or incapacity, shall have a right to withdraw the patient's consent to arbitrate the patient's claim by notifying the healthcare provider or hospital in writing within thirty days after the patient's signing of the agreement. Nothing in this division shall be construed to mean that the spouse of a competent patient can withdraw over the objection of the patient the consent of the patient to arbitrate;

(C) The agreement shall provide that the decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;

(D) The agreement shall, if appropriate, provide that its terms constitute a waiver of any right to a trial in court, or a waiver of any right to a trial by jury;

(E) The agreement shall provide that the arbitration expenses shall be divided equally between the parties to the agreement;

(F) Any arbitration panel shall consist of three persons, no more than one of whom shall be a physician or the representative of a hospital;

(G) The arbitration agreement shall be separate from any other agreement, consent, or document;

(H) The agreement shall not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

(I) Filing of a medical, dental, chiropractic, or optometric claim within the thirty days provided for withdrawal

of a patient from the arbitration agreement shall be deemed a withdrawal from the agreement;

(J) The agreement shall contain a separately stated notice that clearly informs the patient of the patient's rights under division (B) of this section;

(K) The agreement shall specify that the patient has a right to bring a claim under Chapters 3965. and 3967. of the Revised Code.

Sec. 2711.24. To the extent it is in ten-point type and is executed in the following form, an arbitration agreement of the type stated in section 2711.23 of the Revised Code shall be presumed valid and enforceable in the absence of proof by a preponderance of the evidence that the execution of the agreement was induced by fraud, that the patient executed the agreement as a direct result of the willful or negligent disregard by the healthcare provider of the patient's right not to so execute, or that the patient executing the agreement was not able to communicate effectively in spoken and written English or any other language in which the agreement is written:

"AGREEMENT TO RESOLVE FUTURE MALPRACTICE

CLAIM BY BINDING ARBITRATION

In the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the healthcare provider, the dispute or controversy shall be submitted to binding arbitration.

Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of

such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement.

The patient, by signing this agreement, also acknowledges that the patient has been informed that:

(1) Care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;

(2) The agreement may not even be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

(3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;

(4) The agreement waives the patient's right to a trial in court for any future malpractice claim the patient may have against the healthcare provider;

(5) The patient must be furnished with two copies of this agreement.

PATIENT'S RIGHT TO CANCEL

AGREEMENT TO ARBITRATE

The patient, or the patient's spouse or the personal representative of the patient's estate in the event of the

patient's death or incapacity, has the right to cancel this agreement to arbitrate by notifying the healthcare provider in writing within thirty days after the patient's signing of the agreement. The patient, or the patient's spouse or representative, as appropriate, may cancel this agreement by merely writing "cancelled" on the face of one of the patient's copies of the agreement, signing the patient's name under such word, and mailing, by certified mail, return receipt requested, the copy to the healthcare provider within the thirty-day period.

Filing of a medical claim in a court within the thirty days provided for cancellation of the arbitration agreement by the patient will cancel the agreement without any further action by the patient. However, a patient retains the right to file a claim with the Medical Injury Compensation Center.

Date:

.....

Signature of Provider of Medical Services

.....

Signature of Patient"

Sec. 2743.02. (A)(1) The state hereby waives its immunity from liability, except as provided for the office of the state fire marshal in division (G)(1) of section 9.60 and division (B) of section 3737.221 of the Revised Code and subject to division (H) of this section, and consents to be sued, and have its liability determined, in the court of claims created in this chapter in accordance with the same rules of law applicable to suits between private parties, except that the determination of liability is subject to the limitations set forth in this

chapter and, in the case of state universities or colleges, in section 3345.40 of the Revised Code, and except as provided in division (A)(2) or (3) of this section. To the extent that the state has previously consented to be sued, this chapter has no applicability.

Except in the case of a civil action filed by the state, filing a civil action in the court of claims results in a complete waiver of any cause of action, based on the same act or omission, that the filing party has against any officer or employee, as defined in section 109.36 of the Revised Code. The waiver shall be void if the court determines that the act or omission was manifestly outside the scope of the officer's or employee's office or employment or that the officer or employee acted with malicious purpose, in bad faith, or in a wanton or reckless manner.

(2) If a claimant proves in the court of claims that an officer or employee, as defined in section 109.36 of the Revised Code, would have personal liability for the officer's or employee's acts or omissions but for the fact that the officer or employee has personal immunity under section 9.86 of the Revised Code, the state shall be held liable in the court of claims in any action that is timely filed pursuant to section 2743.16 of the Revised Code and that is based upon the acts or omissions.

(3)(a) Except as provided in division (A)(3)(b) of this section, the state is immune from liability in any civil action or proceeding involving the performance or nonperformance of a public duty, including the performance or nonperformance of a public duty that is owed by the state in relation to any action of an individual who is committed to the custody of the state.

(b) The state immunity provided in division (A)(3)(a) of this section does not apply to any action of the state under circumstances in which a special relationship can be established between the state and an injured party. A special relationship under this division is demonstrated if all of the following elements exist:

(i) An assumption by the state, by means of promises or actions, of an affirmative duty to act on behalf of the party who was allegedly injured;

(ii) Knowledge on the part of the state's agents that inaction of the state could lead to harm;

(iii) Some form of direct contact between the state's agents and the injured party;

(iv) The injured party's justifiable reliance on the state's affirmative undertaking.

(B) The state hereby waives the immunity from liability of all hospitals owned or operated by one or more political subdivisions and consents for them to be sued, and to have their liability determined, in the court of common pleas, in accordance with the same rules of law applicable to suits between private parties, subject to the limitations set forth in this chapter. This division is also applicable to hospitals owned or operated by political subdivisions that have been determined by the supreme court to be subject to suit prior to July 28, 1975.

(C) Any hospital, as defined in section 2305.113 of the Revised Code, may purchase liability insurance covering its operations and activities and its agents, employees, nurses, interns, residents, staff, and members of the governing board

and committees, and, whether or not such insurance is purchased, may, to the extent that its governing board considers appropriate, indemnify or agree to indemnify and hold harmless any such person against expense, including attorney's fees, damage, loss, or other liability arising out of, or claimed to have arisen out of, the death, disease, or injury of any person as a result of the negligence, malpractice, or other action or inaction of the indemnified person while acting within the scope of the indemnified person's duties or engaged in activities at the request or direction, or for the benefit, of the hospital. A hospital may obtain this insurance to cover claims filed under Chapters 3965. and 3967. of the Revised Code. Any hospital electing to indemnify those persons, or to agree to so indemnify, shall reserve any funds that are necessary, in the exercise of sound and prudent actuarial judgment, to cover the potential expense, fees, damage, loss, or other liability. The superintendent of insurance may recommend, or, if the hospital requests the superintendent to do so, the superintendent shall recommend, a specific amount for any period that, in the superintendent's opinion, represents such a judgment. This authority is in addition to any authorization otherwise provided or permitted by law.

(D) Recoveries against the state shall be reduced by the aggregate of insurance proceeds, disability award, or other collateral recovery received by the claimant. This division does not apply to civil actions in the court of claims against a state university or college under the circumstances described in section 3345.40 of the Revised Code. The collateral benefits provisions of division (B)(2) of that section apply under those circumstances.

(E) The only defendant in original actions in the court of

claims is the state. The state may file a third-party complaint or counterclaim in any civil action, except a civil action for ten thousand dollars or less, that is filed in the court of claims.

(F) A civil action against an officer or employee, as defined in section 109.36 of the Revised Code, that alleges that the officer's or employee's conduct was manifestly outside the scope of the officer's or employee's employment or official responsibilities, or that the officer or employee acted with malicious purpose, in bad faith, or in a wanton or reckless manner shall first be filed against the state in the court of claims that has exclusive, original jurisdiction to determine, initially, whether the officer or employee is entitled to personal immunity under section 9.86 of the Revised Code and whether the courts of common pleas have jurisdiction over the civil action. The officer or employee may participate in the immunity determination proceeding before the court of claims to determine whether the officer or employee is entitled to personal immunity under section 9.86 of the Revised Code.

The filing of a claim against an officer or employee under this division tolls the running of the applicable statute of limitations until the court of claims determines whether the officer or employee is entitled to personal immunity under section 9.86 of the Revised Code.

(G) If a claim lies against an officer or employee who is a member of the Ohio national guard, and the officer or employee was, at the time of the act or omission complained of, subject to the "Federal Tort Claims Act," 60 Stat. 842 (1946), 28 U.S.C. 2671, et seq., the Federal Tort Claims Act is the exclusive remedy of the claimant and the state has no liability under this

section.

(H) If an inmate of a state correctional institution has a claim against the state for the loss of or damage to property and the amount claimed does not exceed three hundred dollars, before commencing an action against the state in the court of claims, the inmate shall file a claim for the loss or damage under the rules adopted by the director of rehabilitation and correction pursuant to this division. The inmate shall file the claim within the time allowed for commencement of a civil action under section 2743.16 of the Revised Code. If the state admits or compromises the claim, the director shall make payment from a fund designated by the director for that purpose. If the state denies the claim or does not compromise the claim at least sixty days prior to expiration of the time allowed for commencement of a civil action based upon the loss or damage under section 2743.16 of the Revised Code, the inmate may commence an action in the court of claims under this chapter to recover damages for the loss or damage.

The director of rehabilitation and correction shall adopt rules pursuant to Chapter 119. of the Revised Code to implement this division.

Sec. 2743.43. (A) No person shall be deemed competent to give expert testimony on the liability issues in a medical claim, as defined in section 2305.113 of the Revised Code, unless:

(1) Such person is licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery by the state medical board or by the licensing authority of any state;

(2) Such person devotes three-fourths of the person's professional time to the active clinical practice of medicine or surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, or to its instruction in an accredited university;

(3) The person practices in the same or a substantially similar specialty as the defendant. The court shall not permit an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties.

(4) If the person is certified in a specialty, the person must be certified by a board recognized by the American board of medical specialties or the American board of osteopathic specialties in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

(B) Nothing in division (A) of this section shall be construed to limit the power of the trial court to adjudge the testimony of any expert witness incompetent on any other ground.

(C) Nothing in division (A) of this section shall be construed to limit the power of the trial court to allow the testimony of any other witness, on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim involved.

(D) This section shall apply only to a medical claim in which either of the following applies:

(1) A plaintiff alleges that the individual or entity against whom the claim is brought intentionally caused, as

defined in section 3965.02 of the Revised Code, the injury to or death of the plaintiff or the individual upon whose behalf the claimant brought the claim.

(2) The individual or entity against whom the claim is brought was not in compliance with division (A) of section 3965.02 of the Revised Code at the time the claim accrued.

Sec. 2919.171. (A) A physician who performs or induces or attempts to perform or induce an abortion on a pregnant woman shall submit a report to the department of health in accordance with the forms, rules, and regulations adopted by the department that includes all of the information the physician is required to certify in writing or determine under sections 2919.17 and 2919.18 of the Revised Code:

(B) By September 30 of each year, the department of health shall issue a public report that provides statistics for the previous calendar year compiled from all of the reports covering that calendar year submitted to the department in accordance with this section for each of the items listed in division (A) of this section. The report shall also provide the statistics for each previous calendar year in which a report was filed with the department pursuant to this section, adjusted to reflect any additional information that a physician provides to the department in a late or corrected report. The department shall ensure that none of the information included in the report could reasonably lead to the identification of any pregnant woman upon whom an abortion is performed.

(C)(1) The physician shall submit the report described in division (A) of this section to the department of health within fifteen days after the woman is discharged. If the physician fails to submit the report more than thirty days after that

fifteen-day deadline, the physician shall be subject to a late fee of five hundred dollars for each additional thirty-day period or portion of a thirty-day period the report is overdue. A physician who is required to submit to the department of health a report under division (A) of this section and who has not submitted a report or has submitted an incomplete report more than one year following the fifteen-day deadline may, in an action brought by the department of health, be directed by a court of competent jurisdiction to submit a complete report to the department of health within a period of time stated in a court order or be subject to contempt of court.

(2) If a physician fails to comply with the requirements of this section, other than filing a late report with the department of health, or fails to submit a complete report to the department of health in accordance with a court order, the physician is subject to division (B)~~(41)~~(43) of section 4731.22 of the Revised Code.

(3) No person shall falsify any report required under this section. Whoever violates this division is guilty of abortion report falsification, a misdemeanor of the first degree.

(D) Within ninety days of~~ the effective date of this section~~ October 20, 2011, the department of health shall adopt rules pursuant to section 111.15 of the Revised Code to assist in compliance with this section.

Sec. 3727.61. (A) As used in this section:

(1) "Emergency department" means either of the following:

(a) The area operated as an emergency department by a hospital subject to section 1867 of the "Social Security Act," 42 U.S.C. 1985dd, also known as the "Emergency Medical Treatment

and Labor Act," and the corresponding federal regulations, including the requirements of 42 C.F.R. 489.24;

(b) A facility operated as a freestanding emergency department.

(2) "Federally-qualified health center" has the same meaning as in section 1905(l)(2)(B) of the "Social Security Act," 42 U.S.C. 1396d(l)(2)(B).

(3) "Nonemergency medical condition" means a condition on the list established by the state medical board under section 4731.74 of the Revised Code.

(4) "Qualified staff member" means an individual who is determined by the operator of an emergency department through the operator's bylaws or rules and regulations to be qualified to conduct a medical screening examination, as described in 42 C.F.R. 489.24(a)(1)(i).

(B) Implementation of this section is subject to section 5166.50 of the Revised Code.

(C) Each operator of an emergency department shall do either of the following:

(1) Designate a space within the operator's facility that is separate from the area operated as an emergency department, or that is adjacent to the operator's facility, where services may be provided twenty-four hours a day, seven days a week, to patients who have nonemergency medical conditions;

(2) Authorize a federally-qualified health center to operate twenty-four hours a day, seven days a week, in a space within or adjacent to the operator's facility.

(D)(1) Except as provided in division (D)(2) of this

section, if medical treatment is sought for an individual at an emergency department, a qualified staff member shall request a description of the individual's symptoms before any treatment is provided to the individual. The description shall be requested from the individual, the individual's representative, or if the individual is a minor, the minor's parent, guardian, or other person responsible for the individual's care.

If the individual, representative, or other person responsible for the individual's care reports that the individual has symptoms that are associated with a nonemergency medical condition, as specified by the state medical board under section 4731.73 of the Revised Code, the qualified staff member may refer the individual to receive services at the space within or adjacent to the facility that is described in division (C)(1) or (2) of this section. The decision to make the referral shall be based only on the description of the individual's symptoms given by the individual, representative, or other person responsible for the individual's care. The qualified staff member may assign another employee of the facility or a volunteer to escort the individual to the space and ensure that the individual is registered to be seen by a health care professional.

(2) The request for a description of the individual's symptoms is not required if a qualified staff member determines either of the following:

(a) That the individual is unable to respond and no other person responsible for the individual's care is present to provide the description;

(b) That the individual's medical condition requires immediate emergency care.

(E) There is a rebuttable presumption that a referral made under division (D)(1) of this section was not negligent.

(F) Each operator of an emergency department shall implement this section in such a manner that an individual is not required to duplicate any application or other administrative procedures relative to the receipt of services when a referral is made under division (D)(1) of this section or when, subsequent to the referral, it is determined that the individual requires emergency medical care and must return to the area operated as an emergency department.

(G) In addition to the provisions of section 5164.83 of the Revised Code relative to hospitals participating in the medicaid program, any health care services that are provided to an individual in an emergency department shall not be charged to any person or government entity as emergency services if, at the time the services are provided, the individual has a nonemergency medical condition. If health care services are provided in an emergency department for a nonemergency medical condition, the amount that is charged for the services shall not exceed the usual and customary charge that would have been charged if the services were provided at a space within or adjacent to the facility, as described in division (C)(1) or (2) of this section.

Sec. 3923.63. (A) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The policy shall cover a minimum of forty-eight hours

of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The policy shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or

newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C)(1) No sickness and accident insurer may do either of the following:

(a) Terminate the participation of a health care professional or health care facility as a provider under a sickness and accident insurance policy solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(D) This section does not do any of the following:

(1) Require a policy to cover inpatient or follow-up care that is not received in accordance with the policy's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services;

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.113 or 3965.01 of the Revised Code.

Sec. 3923.64. (A) Notwithstanding section 3901.71 of the Revised Code, each public employee benefit plan established or modified in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The plan shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include

medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The plan shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay

to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C)(1) No public employer who offers an employee benefit plan may do either of the following:

(a) Terminate the participation of a health care professional or health care facility as a provider under the plan solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(D) This section does not do any of the following:

(1) Require a plan to cover inpatient or follow-up care that is not received in accordance with the plan's terms pertaining to the health care professionals and facilities from

which an individual is authorized to receive health care services;

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.113 or 3965.01 of the Revised Code.

Sec. 3929.302. (A) The superintendent of insurance, by rule adopted in accordance with Chapter 119. of the Revised Code, shall require the medical injury compensation center and each authorized insurer, surplus lines insurer, risk retention group, self-insurer, captive insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, and any other entity that provides medical malpractice insurance to risks located in this state, to report information to the department of insurance at least annually regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in any of the following results:

(1) A final judgment in any amount;

(2) A settlement in any amount;

(3) A final disposition of the claim resulting in no indemnity payment on behalf of the insured.

(B)(1) The report required by division (A) of this section shall contain such information as the superintendent prescribes by rule adopted in accordance with Chapter 119. of the Revised Code, including, but not limited to, the following information:

~~(1)~~ (a) The name, address, and specialty coverage of the insured;

~~(2)~~ (b) The insured's policy number;

~~(3)~~ (c) The date of the occurrence that created the claim;

~~(4)~~ (d) The name and address of the injured person;

~~(5)~~ (e) The date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic loss, noneconomic loss and, if applicable, punitive damages;

~~(6)~~ (f) In the case of a settlement, the date and amount of the settlement;

~~(7)~~ (g) Any allocated loss adjustment expenses;

~~(8)~~ (h) Any other information required by the superintendent pursuant to rules adopted in accordance with Chapter 119. of the Revised Code.

(2) Notwithstanding division (B)(1) of this section, the center shall include the following information in the center's report:

(a) The name of the insured;

(b) The amount of compensation awarded in a claim filed under Chapters 3965. and 3967. of the Revised Code;

(c) The information required under divisions (B)(1)(c), (d), (f), and (h) of this section.

(C) The superintendent may prescribe the format and the manner in which the information described in division (B) of this section is reported. The superintendent may, by rule adopted in accordance with Chapter 119. of the Revised Code, prescribe the frequency that the information described in division (B) of this section is reported.

(D) The superintendent may designate one or more rating organizations licensed pursuant to section 3937.05 of the Revised Code or other agencies to assist the superintendent in gathering the information, and making compilations thereof, required by this section.

(E) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting under this section or its agents or employees, or the department of insurance or its employees, for any action taken that is authorized under this section.

(F) ~~The~~ Except with respect to the center, the superintendent may impose a fine not to exceed five hundred dollars against any person designated in division (A) of this section that fails to timely submit the report required under this section. Fines imposed under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created under section 3901.021 of the Revised Code.

(G) Except as specifically provided in division (H) of this section, the information required by this section shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person.

(H) The department of insurance shall prepare an annual report that summarizes the closed claims reported under this section. The annual report shall summarize the closed claim reports on a statewide basis, and also by specialty and geographic region. Individual claims data shall not be released in the annual report. Copies of the report shall be provided to the members of the general assembly.

(I)(1) Except as specifically provided in division (I)(2) of this section, any information submitted to the department of insurance by an attorney, law firm, or legal professional association pursuant to rules promulgated by the Ohio supreme court shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information submitted is not subject to discovery or subpoena and shall not be made public by the department of insurance or any other person.

(2) The department of insurance shall summarize the information submitted by attorneys, law firms, and legal professional associations and include the information in the annual report required by division (H) of this section. Individual claims data shall not be released in the annual report.

(J) As used in this section, medical, dental, optometric,

and chiropractic claims include those claims asserted against a risk located in this state that either:

(1) Meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 or 3965.01 of the Revised Code;

(2) Have not been asserted in any civil action, but that otherwise meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 or 3965.01 of the Revised Code.

Sec. 3929.62. As used in sections 3929.62 to 3929.70 of the Revised Code and any rules adopted pursuant to those sections:

(A) "Applicant" means any licensed physician, podiatrist, or hospital as those terms are defined in section 2305.113 of the Revised Code.

(B) "Medical liability underwriting association" means a nonprofit unincorporated underwriting association for medical liability insurance established under section 3929.63 of the Revised Code.

(C) "Medical liability insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service or related to the credentialing or accreditation of any medical professional or hospital by any licensed physician, podiatrist, or hospital, as those terms are defined in section 2305.113 of the Revised Code, or any employee or agent acting within the scope of their duties for a physician, podiatrist, or hospital or by any provider as

defined in section 3965.01 of the Revised Code.

Sec. 3929.67. (A) A medical liability insurance policy that insures a provider as defined in section 3965.01 of the Revised Code or a physician or podiatrist, written by or on behalf of the medical liability underwriting association pursuant to sections 3929.62 to 3929.70 of the Revised Code, may only be cancelled during the term of the policy for one of the following reasons:

(1) Nonpayment of premiums;

(2) The license of the insured to practice the provider's profession or to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery has been suspended or revoked;

(3) The insured's failure to meet minimum eligibility and underwriting standards;

(4) The occurrence of a change in the individual risk that substantially increases any hazard insured against after the coverage has been issued or renewed, except to the extent that the medical liability underwriting association reasonably should have foreseen the change or contemplated the risk in writing the policy;

(5) Discovery of fraud or material misrepresentation in the procurement of insurance or with respect to any claim submitted thereunder.

(B) A medical liability insurance policy that insures a hospital, written by or on behalf of the medical liability underwriting association pursuant to sections 3929.62 to 3929.70 of the Revised Code, may only be cancelled during the term of the policy for one of the following reasons:

(1) Nonpayment of premiums;

(2) The hospital is not certified or accredited in accordance with Chapter 3727. of the Revised Code;

(3) An injunction against the hospital has been granted under section 3727.05 of the Revised Code;

(4) The insured's failure to meet minimum eligibility and underwriting standards;

(5) The occurrence of a change in the individual risk that substantially increases any hazard insured against after the coverage has been issued or renewed, except to the extent that the medical liability underwriting association reasonably should have foreseen the change or contemplated the risk in writing the policy;

(6) Discovery of fraud or material misrepresentation in the procurement of insurance or with respect to any claim submitted thereunder.

Sec. 3931.01. Individuals, partnerships, and corporations of this state, designated in sections 3931.01 to 3931.12 of the Revised Code, as "subscribers," may exchange reciprocal or interinsurance contracts with each other, and with individuals, partnerships, and corporations of other states, districts, provinces, and countries, providing indemnity among themselves from any loss which may be legally insured against by any fire or casualty insurance company or association provided that contracts of indemnity against property damage and bodily injury arising out of the ownership, maintenance or use of a singly owned private passenger automobile principally used for nonbusiness purposes may not be exchanged through a reciprocal insurer which maintains a surplus over all liabilities of less

than two and one-half million dollars and provided that this exception shall not prohibit the exchanging of contracts of indemnity against any form of liability otherwise authorized and arising out of any business or commercial enterprise. Such contracts and the exchange thereof and such subscribers, their attorneys, and representatives shall be regulated by such sections, and no law enacted after July 4, 1917, shall apply to them, unless they are expressly designated therein.

Such a contract may be executed by an attorney or other representative designated "attorney," in sections 3931.01 to 3931.12 of the Revised Code, authorized by and acting for such subscribers under powers of attorney. Such attorney may be a corporation. The principal office of such attorney shall be maintained at the place designated by the subscribers in the powers of attorney.

Except for such limitations on assessability as are approved by the superintendent of insurance, every reciprocal or interinsurance contract written pursuant to this chapter for medical malpractice insurance shall be fully assessable and shall contain a statement, in boldface capital letters and in type more prominent than that of the balance of the contract, setting forth such terms of assessability. As used in this section, "medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, podiatrist, or hospital, as those terms are defined in section 2305.113 of the Revised Code or a provider as defined in section 3965.01 of the Revised Code.

Sec. 3937.24. No insurer shall cancel, refuse to write or renew, or increase the premium rate of a policy of medical malpractice insurance, as defined in section 3937.25 of the Revised Code, based on a claim under Chapter 3965. or 3967. of the Revised Code that lists the insured as a provider.

Sec. 3937.25. (A) As used in sections 3937.25 to 3937.29 of the Revised Code, "medical malpractice insurance" means insurance coverage against the legal liability of the insured for loss, damage, or expense arising from a medical, optometric, or chiropractic claim, as those claims are defined in section 2305.113 or 3965.01 of the Revised Code.

(B) After a policy of commercial property insurance, commercial fire insurance, or commercial casualty insurance other than fidelity or surety bonds, medical malpractice insurance, and automobile insurance as defined in section 3937.30 of the Revised Code, has been in effect for more than ninety days, a notice of cancellation for such policy shall not be issued by any licensed insurer unless it is based on one of the following grounds:

(1) Nonpayment of premium;

(2) Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;

(3) Discovery of a moral hazard or willful or reckless acts or omissions on the part of the named insured that increase any hazard insured against;

(4) The occurrence of a change in the individual risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed, except to the

extent the insurer reasonably should have foreseen the change or contemplated the risk in writing the contract;

(5) Loss of applicable reinsurance or a substantial decrease in applicable reinsurance, if the superintendent has determined that reasonable efforts have been made to prevent the loss of, or substantial decrease in, the applicable reinsurance, or to obtain replacement coverage;

(6) Failure of an insured to correct material violations of safety codes or to comply with reasonable written loss control recommendations;

(7) A determination by the superintendent of insurance that the continuation of the policy would create a condition that would be hazardous to the policyholders or the public.

(C) The notice of cancellation required by this section must be in writing, be mailed to the insured at the insured's last known address, and contain all of the following:

(1) The policy number;

(2) The date of the notice;

(3) The effective date of the cancellation;

(4) An explanation of the reason for cancellation.

Such notice of cancellation also shall be mailed to the insured's agent.

(D) Except for nonpayment of premium, the effective date of cancellation must be no less than thirty days from the date of mailing the notice. When cancellation is for nonpayment of premium, the effective date of cancellation must be no less than ten days from the date of mailing the notice.

(E) Nothing in division (B) of this section shall be construed to prevent an insurer from writing a policy of commercial property insurance, commercial fire insurance, or commercial casualty insurance other than medical malpractice insurance and automobile insurance as defined in section 3937.30 of the Revised Code for a period greater than one year and providing in such policy that the insurer may issue a notice of cancellation of such policy at least thirty days prior to an anniversary of such policy, with the effective date of cancellation being that anniversary.

The superintendent may prescribe that adequate disclosure be made to the insured when a policy is issued for a term of more than one year.

(F) There is no liability on the part of, and no cause of action of any nature arises against, the superintendent of insurance, any insurer, or any person furnishing information requested by the superintendent, an insurer, the agent, employee, attorney, or other authorized representative of any such persons, for any oral or written statement made to supply information relevant to a determination on cancellation of any policy of commercial property insurance, commercial fire insurance, or commercial casualty insurance other than fidelity or surety bonds, medical malpractice insurance, and automobile insurance as defined in section 3937.30 of the Revised Code, or in connection with advising an insured or an insured's attorney of the reasons for a cancellation of such insurance, or in connection with any administrative or judicial proceeding arising out of or related to such cancellation.

Sec. 3937.28. (A) A notice of cancellation of a policy of medical malpractice insurance shall not be issued by any

licensed insurer unless it is based on one of the following grounds:

(1) Nonpayment of premium;

(2) Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;

(3) Discovery of a moral hazard or willful or reckless acts or omissions on the part of the named insured that increase any hazard insured against;

(4) The occurrence of a change in the individual risk that substantially increases any hazard insured against after insurance coverage has been issued or renewed, except to the extent the insurer reasonably should have foreseen the change or contemplated the risk in writing the contract and except, as provided under section 3937.24 of the Revised Code, for a change based on a claim filed with the medical injury compensation center;

(5) Loss of applicable reinsurance or a substantial decrease in applicable reinsurance, if the superintendent of insurance has determined that reasonable efforts have been made to prevent the loss of, or substantial decrease in, the applicable reinsurance, or to obtain replacement coverage;

(6) Failure of an insured to correct material violations of safety codes or to comply with reasonable written loss control recommendations;

(7) A determination by the superintendent that the continuation of the policy would create a condition that would be hazardous to the policyholders or the public.

(B) The notice of cancellation required by this section shall be in writing, be mailed both to the insured at the insured's last known address and to the insured's agent, and contain all of the following:

(1) The policy number;

(2) The date of the notice;

(3) The effective date of the cancellation;

(4) An explanation of the grounds for cancellation.

(C) Except when cancellation is for nonpayment of premium, the effective date of cancellation shall be not less than sixty days from the date of mailing the notice. When cancellation is for nonpayment of premium, the effective date of cancellation shall be not less than ten days from the date of mailing the notice.

(D) Nothing in division (A) of this section shall be construed to prevent an insurer from writing a policy of medical malpractice insurance for a period greater than one year and providing in such policy that the insurer may issue a notice of cancellation of such policy at least sixty days prior to an anniversary of such policy, with the effective date of cancellation being that anniversary.

The superintendent may prescribe that adequate disclosure be made to the insured when a policy is issued for a term of more than one year.

(E) There is no liability on the part of, and no cause of action of any nature arises against, the superintendent, any insurer, or any person furnishing information requested by the superintendent or an insurer, or the agent, employee, attorney

or other authorized representative of any such persons, for any oral or written statement made to supply information relevant to a determination on cancellation of any policy of medical malpractice insurance, or in connection with advising an insured or the insured's attorney of the grounds for a cancellation of such insurance, or in connection with any administrative or judicial proceeding arising out of or related to such cancellation.

Sec. 3937.29. (A) An insurer that intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance that it has issued to any class, type, or specialty of practitioner, or that intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance in a specific geographic area, which may include the state as a whole, shall file written notice of its intended action with the superintendent of insurance. These actions by an insurer are not effective unless the written notice is filed with the superintendent within the following time frames:

(1) At least one hundred eighty days prior to the insurer acting to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance that the insurer has issued in this state;

(2) At least one hundred twenty days prior to the insurer acting to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance for a specific class, type, or specialty of practitioner or in a specific geographic area other than this state as a whole.

Written notice also shall be filed with the superintendent at least one hundred twenty days prior to the insurer making changes in its underwriting guidelines, if the effect of the

changes will be to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance for a specific class, type, or specialty of practitioner or in a specific geographic area other than this state as a whole.

(B) The written notice filed with the superintendent under division (A) of this section shall contain all of the following information:

(1) The date of the notice;

(2) The number of insureds with policies that will be cancelled, terminated, or not renewed;

(3) The date that the insurer intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance that the insurer has issued to any class, type, or specialty of practitioner, or that the insurer intends to cancel, terminate, or otherwise not renew all policies of medical malpractice insurance in a specific geographic area, including the state as a whole;

(4) The specific geographic area, if any;

(5) Any other information required by the superintendent.

(C) An insurer who files a notice with the superintendent under division (A) of this section shall file a copy of that notice with the administrator of medical injury compensation within thirty days after filing the notice with the superintendent.

(D) An insurer that intends to condition renewal of a policy of medical malpractice insurance upon an increase in premium shall mail a notice of the insurer's intention to the agent of record and to the insured at the insured's last known

address at least sixty days prior to the expiration date of the policy.

~~(D)~~ (E) An insurer may refuse to renew a policy of medical malpractice insurance by mailing a notice of the insurer's intention to the agent of record and to the insured at the insured's last known address at least sixty days prior to the expiration date of the policy. The notice mailed under this division shall contain all of the following information:

(1) The policy number;

(2) The date of the notice;

(3) The expiration date of the policy;

(4) An explanation of the grounds for nonrenewal.

~~(E)~~ (F) If the notice required by divisions ~~(C) and~~ (D) and (E) of this section is mailed less than sixty days before the expiration date of the policy, the insured's coverage then in effect remains in effect until sixty days after the date of mailing the notice unless either of the following is true:

(1) In the case of a premium increase, the insured accepts the increased premium. The change is then effective immediately following the expiration of the insured's coverage then in effect.

(2) In the case of nonrenewal, the insured notifies the insurer in writing that the insured accepts the nonrenewal as stated.

~~(F)~~ (G) If the insured's coverage is extended beyond the original expiration date of the policy as provided by division ~~(E)~~ (F) of this section, the premium for the time after the original expiration date must be calculated using the rates

originally applicable to the insured's coverage then in effect. The insurer shall notify the insured of the amount of the premium for the time after the expiration of the insured's coverage then in effect. The insured shall pay the premium unless either of the following is true:

(1) In the case of a premium increase, the insured notifies the insurer in writing that the insured does not want the coverage then in effect to be extended past the expiration date.

(2) In the case of nonrenewal, the insured notifies the insurer in writing that the insured accepts the nonrenewal as stated.

Sec. 3955.05. Sections 3955.01 to 3955.19 of the Revised Code apply to all kinds of direct insurance, except:

(A) Title insurance;

(B) Fidelity or surety bonds, or any other bonding obligations;

(C) Credit insurance, vendors' single interest insurance, collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(D) Mortgage guaranty, financial guaranty, residual value, or other forms of insurance offering protection against investment risks;

(E) Ocean marine insurance;

(F) Any insurance provided by or guaranteed by government, including, but not limited to, any department, board, office, commission, agency, institution, or other instrumentality or

entity of any branch of state government, any political subdivision of this state, the United States or any agency of the United States, or any separate or joint governmental self-insurance or risk-pooling program, plan, or pool;

(G) Contracts of any corporation by which health services are to be provided to its subscribers;

(H) Life, annuity, health, or disability insurance, including sickness and accident insurance written pursuant to Chapter 3923. of the Revised Code;

(I) Fraternal benefit insurance;

(J) Mutual protective insurance of persons or property;

(K) Reciprocal or interinsurance contracts written pursuant to Chapter 3931. of the Revised Code for medical malpractice insurance if the reciprocal exchange or interinsurance exchange is not subject to the risk-based capital requirements in effect in the state of domicile of the reciprocal exchange or interinsurance exchange. As used in this division, "medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, podiatrist, or hospital, as those terms are defined in section 2305.113 of the Revised Code<u> or a provider as defined in section 3965.01 of the Revised Code</u>.

(L) Any political subdivision self-insurance program or joint political subdivision self-insurance pool established under Chapter 2744. of the Revised Code;

(M) Warranty or service contracts, or the insurance of

those contracts;

(N) Any state university or college self-insurance program established under section 3345.202 of the Revised Code;

(O) Any transaction, or combination of transactions, between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, that involves the transfer of investment or credit risk unaccompanied by a transfer of insurance risk;

(P) Credit union share guaranty insurance issued pursuant to Chapter 1761. of the Revised Code;

(Q) Insurance issued by risk retention groups as defined in Chapter 3960. of the Revised Code;

(R) Workers' compensation insurance, including any contract indemnifying an employer who pays compensation directly to employees.

Sec. 3965.01. As used in this chapter and Chapter 3967. of the Revised Code:

(A) "Advanced practice registered nurse" means any certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who holds a certificate of authority issued by the board of nursing under Chapter 4723. of the Revised Code.

(B) "Chiropractic claim" means any claim under this chapter that lists a chiropractor or any employee or agent of a chiropractor and that arises out of the chiropractic diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, 3929.302, and 3937.35 of the Revised Code, "chiropractic claim" includes

derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

(C) "Chiropractor" means any person who is licensed to practice chiropractic by the state chiropractic board.

(D) "Claimant" means any individual who brings a claim under this chapter or who, if deceased, is the subject of a claim brought under this chapter.

(E) "Dental claim" means any claim under this chapter that lists a dentist or any employee or agent of a dentist and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, and 3929.302 of the Revised Code, "dental claim" includes derivative claims for relief that arise from the dental diagnosis, care, or treatment of a person.

(F) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(G) "Derivative claim" includes a claim of a parent, guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arises from that diagnosis, care, treatment, or operation, and that seeks the recovery of damages for any of the following:

(1) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or

spouse;

(2) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(H) "Emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic" mean any person who is certified under Chapter 4765. of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

(I) "Health care professional standards board" means the health care professional standards board created in section 4746.02 of the Revised Code.

(J) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(K) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of

physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(L) "Insurer" and "liability insurer" include the medical liability underwriting association, unless the context clearly indicates otherwise.

(M) "Liability insurance" means coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service or related to the credentialing or accreditation of any medical professional or hospital by any provider or any employee or agent acting within the scope of their duties for a provider.

(N) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(O) "Medical claim" means any claim under this chapter that lists a physician, podiatrist, hospital, home, or residential facility; any employee or agent of a physician, podiatrist, hospital, home, or residential facility; or a licensed practical nurse, registered nurse, advanced practice registered nurse, pharmacist, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic; and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes both of the

following:

(1) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

(a) The claim results from acts or omissions in providing medical care.

(b) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

(2) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

For purposes of sections 2305.234, 2317.02, 3929.302, and 3937.35 of the Revised Code, "medical claim" includes derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person.

(P) "Medical injury compensation panel" means a panel established pursuant to section 3967.02 of the Revised Code.

(Q) "Medical liability underwriting association" has the same meaning as in section 3929.62 of the Revised Code.

(R) "Optometric claim" means any claim under this chapter that lists an optometrist, or any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, 3929.302, and 3937.35 of the Revised Code, "optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(S) "Optometrist" means any person licensed to practice optometry by the state board of optometry.

(T) "Pharmacist" means a person who is licensed to practice pharmacy under Chapter 4729. of the Revised Code.

(U) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(V) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code.

(W) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code.

(X) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(Y) "Provider" means a dentist, chiropractor, emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, home, hospital, licensed practical nurse, optometrist, pharmacist, physician, physician assistant, physical therapist, podiatrist, registered nurse, or registered facility.

(Z) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(AA) "Residential facility" means a facility licensed

under section 5123.19 of the Revised Code.

Sec. 3965.02. (A) No provider shall fail to obtain liability insurance.

(B)(1) Except as otherwise provided in division (D) of this section, a provider who complies with division (A) of this section shall not be liable to respond in damages at common law or by statute for any of the following occurring during the period covered by the premiums paid by the provider to the insurer:

(a) An injury received by an individual that arises out of the chiropractic diagnosis, care, or treatment of the individual;

(b) An injury received by an individual that arises from a dental operation or the dental diagnosis, care, or treatment of the individual;

(c) An injury received by an individual that arises out of the medical diagnosis, care, or treatment of the individual;

(d) An injury received by an individual that arises out of the optometric diagnosis, care, or treatment of the individual;

(e) For the death of an individual resulting from an injury described in division (B)(1)(a), (b), (c), or (d) of this section;

(f) For a derivative claim that results from an injury described in division (B)(1)(a), (b), (c), or (d) of this section from the death of an individual resulting from such an injury.

(2) Division (B)(1) of this section applies to a common law or statutory claim as described in that division regardless

of whether an injury or death is compensable under this chapter.

(C) No employee of any provider shall be liable to respond in damages at common law or by statute for any injury, death, or derivative claim, as described in division (B) of this section on the condition that the injury, death, or derivative claim is found to be compensable under this chapter or Chapter 3967. of the Revised Code.

(D) The immunity provided under division (B) or (C) of this section is not applicable in either of the following claims:

(1) A claim that a provider or an employee of a provider intentionally caused an injury to or the death of an individual that arises out of any of the following:

(a) The chiropractic diagnosis, care, or treatment of the individual;

(b) A dental operation or the dental diagnosis, care, or treatment of the individual;

(c) The medical diagnosis, care, or treatment of the individual;

(d) The optometric diagnosis, care, or treatment of the individual.

(2) A claim that lists a provider who violates division (A) of this section for an injury or death arising out of any of the following:

(a) The chiropractic diagnosis, care, or treatment of the individual;

(b) A dental operation or the dental diagnosis, care, or

treatment of the individual;

(c) The medical diagnosis, care, or treatment of the individual;

(d) The optometric diagnosis, care, or treatment of the individual.

(E) As used in division (D) of this section, "intentionally caused" means that a provider acted with deliberate intent to cause another individual to suffer an injury or death.

(F) Except as provided in division (D) of this section, a claim brought under this chapter and Chapter 3967. of the Revised Code shall be the exclusive remedy against a provider or the provider's liability insurer for any injury, death, or derivative claim, as described in division (B) of this section, including any action by the health insurer or employer of the individual who is the subject of the claim.

Sec. 3965.03. A provider who fails to comply with division (A) of section 3965.02 of the Revised Code is not entitled to the benefits of this chapter in relation to chiropractic, dental, medical, optometric, or derivative claims that arise during the period of that noncompliance and is liable to an individual, and the individual's personal representatives, for damages suffered by reason of injury or death arising out of the circumstances described in division (B) of section 3965.02 of the Revised Code. In such a civil action, the defendant shall not avail the defendant's self of either of the following common law defenses:

(A) The defense of the assumption of risk;

(B) The defense of contributory negligence.

Sec. 3965.04. (A) If an individual files a chiropractic, dental, medical, optometric, or derivative claim for compensation under this chapter that lists a provider who was violating division (A) of section 3965.02 of the Revised Code at the time the claim arose, and it is determined under this chapter or Chapter 3967. of the Revised Code that the individual is entitled to compensation under this chapter, the administrator of medical injury compensation shall make and file for record in the office of the county recorder in the counties where the provider's real or tangible personal property is located, an affidavit that includes all of the following information:

(1) The date on which the application was filed with the administrator;

(2) The name and address of the provider listed in the claim;

(3) The fact that the provider had not complied with section 3965.02 of the Revised Code.

(B) The recorder shall accept and file the affidavit and record the same as a mortgage on real estate and shall file the same as a chattel mortgage, and the recorder shall index the same as a mortgage on real estate and as a chattel mortgage. A copy of the application or other record documenting the claim shall be filed with the affidavit. A copy of the affidavit shall be served upon the provider by the administrator.

(C) The affidavit constitutes a valid lien from the time of filing, in favor of the administrator, upon the real property and tangible personal property of the provider located within the county.

(D) The administrator shall have the lien canceled of record under the following circumstances:

(1) After the provider has paid to the claimant the compensation owed to the claimant;

(2) When the application has finally been denied after the claimant has exhausted the remedies provided by law;

(3) When the provider has filed a bond in the amount and with surety as the administrator approves conditioned on the payment of all sums ordered paid to the claimant.

(E) The recorder shall make no charge for the services provided by this section to be performed by the recorder.

Sec. 3965.05. Any interested party may enjoin the further operation of a provider subject to this chapter who has violated division (A) of section 3965.02 of the Revised Code. The procedure to obtain an injunction is governed by Chapter 2727. of the Revised Code, and the right to such relief is in addition to the rights described in section 2727.02 of the Revised Code.

Sec. 3965.06. No agreement by an individual to waive an individual's rights to compensation under this chapter is valid.

No agreement by an individual to directly pay any portion of the premium paid by the individual's provider for liability insurance is valid.

No provider shall directly charge an individual for any portion of the premium paid by the individual's provider for liability insurance.

Sec. 3965.07. (A) Each provider who obtains liability insurance shall post conspicuously in the provider's place of business a notice provided by the provider's liability insurer

that states all of the following information:

(1) The fact that the provider has paid the premium due;

(2) The date the premium was paid;

(3) The time period to which the premium payment applies.

(B) The liability insurer shall furnish an adequate number of copies of the notice to the provider at the time of the payment of the premium. The notice, when posted, constitutes sufficient notice to the provider's patients of the fact that the provider has made payment.

Sec. 3965.10. A provider may obtain liability insurance necessary to comply with section 3965.02 of the Revised Code through an insurer authorized under Title XXXIX of the Revised Code to conduct the business of insurance in this state or through the medical liability underwriting association.

Sec. 3965.11. An insurer providing liability insurance for purposes of this chapter and Chapter 3967. of the Revised Code shall pay compensation in any claim determined to be compensable under this chapter or Chapter 3967. of the Revised Code in accordance with the amount calculated pursuant to section 3965.60 of the Revised Code. The insurer shall pay the claims in accordance with the schedule provided under section 3965.52 of the Revised Code.

Sec. 3965.12. Beginning one hundred eighty days after the effective date of this section, and each year thereafter, each insurer providing liability insurance for purposes of this chapter and Chapter 3967. of the Revised Code shall submit a list to the administrator of medical injury compensation of the providers for whom the insurer provides coverage for purposes of this chapter and Chapter 3967. of the Revised Code.

Beginning one hundred eighty days after the effective date of this section, and each year thereafter, the state medical board, state dental board, state nursing board, state board of optometry, state chiropractic board, state board of pharmacy, Ohio occupational therapy, physical therapy, and athletic trainers board, and the state board of emergency medical, fire, and transportation services shall submit a list to the administrator of the providers who are subject to the board's jurisdiction and who are subject to this chapter and Chapter 3967. of the Revised Code.

The administrator shall adopt rules to establish procedures to allow the reports required under this section to be submitted electronically.

Sec. 3965.15. There is hereby created the medical injury compensation center, which shall be administered by the administrator of medical injury compensation. A person appointed to the position of administrator shall possess significant management experience in effectively managing an organization or organizations of substantial size and complexity. A person appointed to the position of administrator also shall possess a minimum of five years of experience in the field of insurance, particularly in the area of liability insurance, if possible. The governor shall appoint the administrator with the advice and consent of the senate, and the administrator shall serve at the pleasure of the governor. The governor shall fix the administrator's salary on the basis of the administrator's experience and the administrator's responsibilities and duties under this chapter and Chapter 3967. of the Revised Code. The governor shall not appoint to the position of administrator any person who has, or whose spouse has, given a contribution to the campaign committee of the governor in an amount greater than one

thousand dollars during the two-year period immediately preceding the date of the appointment of the administrator.

The administrator shall hold no other public office and shall devote full time to the duties of administrator. Before entering upon the duties of the office, the administrator shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code, and shall file in the office of the secretary of state a bond, signed by the administrator and by surety approved by the governor, for the sum of fifty thousand dollars payable to the state, conditioned upon the faithful performance of the administrator's duties.

Sec. 3965.16. The administrator of medical injury compensation shall do all of the following:

(A) Perform all acts and exercise all authorities and powers, discretionary and otherwise that are required of or vested in the medical injury compensation center or any of its employees in this chapter and Chapter 3967. of the Revised Code, except the acts and the exercise of authority and power that is required of and vested in a medical injury compensation panel pursuant to those chapters;

(B) Employ, direct, and supervise all employees required in connection with the performance of the duties assigned to the center by this chapter and Chapter 3967. of the Revised Code, including actuaries appointed to make determinations with respect to compensation under division (D) of section 3965.41 of the Revised Code;

(C) Provide offices, equipment, supplies, and other facilities for the center;

(D) Purchase supplies, materials, equipment, and services;

make contracts for, operate, and superintend the telephone, other telecommunication, and computer services for the use of the center and make contracts in connection with office reproduction, forms management, printing, and other services;

(E) Prepare an annual budget for internal operating purposes;

(F) Set standards for the reasonable and maximum handling time of claim processing and ensure, by rules, the impartial and prompt treatment of all claims, and establish a secure, accurate method of time stamping all incoming mail and documents hand delivered to center employees;

(G) Manage and operate a data processing system and develop a claims tracking system that is sufficient to monitor the status of a claim at any time and that lists appeals that have been filed and orders or determinations that have been issued pursuant to section 3965.41, 3967.15, or 3967.20 of the Revised Code, including the dates of the filings and issuances;

(H) Pursuant to section 3965.70 of the Revised Code, approve applications for the final settlement of claims for compensation under this chapter and Chapter 3967. of the Revised Code as the administrator determines appropriate;

(I) Adopt rules for the operation of the center and adopt other rules as the administrator considers necessary to administer this chapter and Chapter 3967. of the Revised Code;

(J) Review and process all claim applications;

(K) Establish a program for quality control, systems design, and internal auditing and ensure that audits are performed at least annually to determine whether the center meets the performance goals the administrator establishes;

(L) Operate a program designed to inform individuals, providers, and the liability insurers of providers of their rights and responsibilities under this chapter and Chapter 3967. of the Revised Code and as part of that program prepare and distribute pamphlets that clearly and simply explain at least all of the following:

(1) The rights and responsibilities of claimants, providers, and insurers;

(2) The procedures for processing claims;

(3) The procedure for fulfilling provider and insurer responsibility;

(4) All applicable statutes of limitation;

(5) The availability of services and benefits;

(6) The claimant's right to representation in the processing of a claim or to elect no representation.

(M) Establish and maintain a program to identify providers subject to this chapter and Chapter 3967. of the Revised Code;

(N) Create an operating manual setting forth procedural steps in detail for performing each of the assigned tasks of the center, set forth in the manual procedures for assigning and transferring claims, and require a center employee to obtain approval prior to deviating from the manual procedures;

(O) Create an online gateway that attorneys may use to file claims, provide documents, and otherwise communicate with the medical injury compensation center and service offices on behalf of claimants;

(P) Study the feasibility of creating an online gateway

similar to the one created in division (O) of this section, for pro se claimants;

(Q) Create a gateway for a claimant to use if the claimant is representing the claimant's self if, pursuant to the study conducted under division (P) of this section, the administrator determines that a gateway for pro se litigants is feasible.

Sec. 3965.17. No member of a medical injury compensation panel created under Chapter 3967. of the Revised Code or employee of the medical injury compensation center shall have any direct or indirect interest in the gains or profits of any insurer providing coverage for claims under this chapter and Chapter 3967. of the Revised Code.

Sec. 3965.18. The attorney general shall be the legal adviser of the administrator of medical injury compensation and the medical injury compensation center.

Sec. 3965.19. The administrator of medical injury compensation, for employees of the medical injury compensation center, may discipline, suspend, demote, or discharge any employee for misfeasance, malfeasance, or nonfeasance in accordance with Chapter 124. of the Revised Code. In the case of any employee assigned to the investigation or determination of claims, if the administrator determines that the employee is not efficient, impartial, or judicious, and if supported by evidence and not promoted by discrimination, the determination shall be accepted as a fact justifying the action taken by the administrator.

The administrator shall adopt rules establishing a code of ethics for all employees of the center and post copies of the rules in a conspicuous place in each center office.

The administrator shall adopt rules setting forth procedures designed to eliminate outside influence on center employees, produce an impartial claims handling process, and avoid favoritism in the claims handling process. Failure to adopt and enforce these rules constitutes grounds for removal of the administrator.

Sec. 3965.20. (A) The administrator of medical injury compensation shall establish service offices around the state as needed, based on the anticipated utilization of each office by claimants and liability insurers.

(B) The administrator shall appoint a service director for each service office. A service director shall do all of the following:

(1) Provide each claimant and liability insurer fair, impartial, and equal treatment;

(2) Recommend any needed improvements for changes in staff size and accessibility to service offices;

(3) Recommend to the administrator appropriate action concerning any allegations of misconduct, abuse of authority, or fraud committed in the service office;

(4) Ensure that all current center rules and operating procedures are carried out by all employees under the service director's direction;

(5) Assist claimants and providers who contact the service office for information or assistance with respect to claims processing and coverage.

(C) The administrator shall assign to each service office an adequate number of investigators and field auditors. A

service director shall make investigators available to a medical injury compensation panel and reviewing health care providers as needed.

Sec. 3965.21. (A) There is hereby created in the state treasury the medical injury compensation center operating fund, which shall consist of the assessments described in division (B) of this section. Any investment earnings of the fund shall be credited to the fund. The administrator shall use the fund to pay the costs attributable to the activities of the administrator, the medical injury compensation center, and any medical injury compensation panel.

(B)(1) The administrator annually shall assess each provider an administrative assessment for the costs attributable to the activities of the administrator and center. Except as provided in division (B)(2) of this section, the administrator shall allocate the administrative assessment in a fair and equitable manner, as specified in rules adopted by the administrator, among the providers subject to this chapter and Chapter 3967. of the Revised Code based upon the number of patients seen by each of those providers during the preceding year.

(2) For a provider who is an employee of a hospital, any patient seen in the hospital by that provider shall be attributable to the hospital for purposes of the administrator's annual assessment, and not to the employee provider.

Sec. 3965.22. In addition to any other rules the administrator of medical injury compensation is required to adopt under this chapter, the administrator shall adopt the following rules:

(A) Rules to regulate and provide for the kind and character of notices, and the services thereof, in cases of injury or death that result in a chiropractic, dental, medical, optometric, or derivative claim, to individuals that explain all of the following:

(1) The nature and extent of the proof and evidence, and the method of taking and furnishing the proof and evidence, necessary to establish the right to compensation under this chapter;

(2) The forms of application for those claiming to be entitled to compensation under this chapter;

(3) The method of making investigations, physical examinations, and inspections.

(B) Rules concerning the payment of attorney's fees and to resolve fee disputes;

(C) Rules designed to prevent the solicitation of employment in the prosecution or defense of claims and make and adopt reasonable rules designed to promote the orderly and expeditious submission, hearing, and determination of claims;

(D) Rules barring any employee of the medical injury compensation center from having a claim file in the employee's possession unless the file is necessary to the performance of the employee's duties.

Sec. 3965.23. No injunction shall issue suspending or restraining any order adopted by the administrator of medical injury compensation, the medical injury compensation center, a reviewing health care provider, or a medical injury compensation panel, or any action of the auditor of state, treasurer of state, attorney general, or the county auditor or county

treasurer of any county, required to be taken by this chapter. This section does not affect any right or defense in any action brought by the administrator, the center, or the state in pursuance of authority contained in this chapter.

Sec. 3965.24. (A) No person shall, orally or in writing, directly or indirectly, or through any agent or other person fraudulently hold the person's self out or represent the person's self or any of the person's partners or associates as authorized by a claimant to take charge of, or represent the claimant in respect of, any claim or matter in connection therewith before the medical injury compensation center, a reviewing health care provider, or any medical injury compensation panel. No person shall, without prior authority from the administrator, a reviewing health care provider, a member of a panel, the claimant, or the liability insurer of a provider, examine or directly or indirectly cause or employ another person to examine any claim file or any other file pertaining thereto. No person shall forge an authorization for the purpose of examining or causing another person to examine a claim file. No employee of the center shall divulge any information in respect of any claim or appeal that is or may be filed with a reviewing health care provider, the center, or panel member to any person other than members of the panel or to the superior of the employee except upon authorization of the administrator or a panel member or upon authorization of the claimant or the liability insurer of a provider.

(B)(1) All of the following records are not public records as defined in section 149.43 of the Revised Code:

(a) The records described or referred to in division (A) of this section;

(b) Any information directly or indirectly identifying the address or telephone number of a claimant, regardless of whether the claimant's claim is active or closed;

(c) The identity of any provider who is named in a claim.

(2) No person shall solicit or obtain any information referenced in division (B)(1) of this section from any employee without first having obtained an authorization as provided in this section.

(C) Except as otherwise specified in division (D) of this section, information kept by the center pursuant to this section is for the exclusive use and information of the center in the discharge of the center's official duties, and shall not be open to the public nor be used in any court in any action or proceeding pending therein, unless the center is a party to the action or proceeding. The information, however, may be tabulated and published by the center in statistical form that does not identify providers for the use and information of other state agencies and the public.

(D)(1) Upon receiving a written request made and signed by an individual whose primary occupation is as a journalist, the administrator of medical injury compensation or the center shall disclose to the individual the address or addresses and telephone number or numbers of claimants, regardless of whether their claims are active or closed, and the dependents of those claimants.

(2) An individual described in division (D)(1) of this section is permitted to request the information described in that division for multiple claimants or dependents in one written request.

(3) An individual described in division (D)(1) of this section shall include all of the following in the written request:

(a) The individual's name, title, and signature;

(b) The name and title of the individual's employer;

(c) A statement that the disclosure of the information sought is in the public interest.

(4) No center employee may inquire as to the specific public interest served by the disclosure of information requested by an individual under division (D) of this section.

(E) As used in this section, "journalist" has the same meaning as in section 149.43 of the Revised Code.

Sec. 3965.25. Upon the request of any medical injury compensation panel or the administrator of medical injury compensation, the attorney general, or under the attorney general's direction, the prosecuting attorney of any county in cases arising within the county, shall institute and prosecute the necessary actions or proceedings for the enforcement of this chapter or any penalty, and shall defend in like manner all suits, actions, or proceedings brought against the administrator, medical injury compensation center, a medical injury compensation panel, or a reviewing health care provider, in their official capacity under this chapter and Chapter 3967. of the Revised Code.

Sec. 3965.30. (A) An individual shall file with the medical injury compensation center a chiropractic, dental, medical, optometric, or derivative claim for compensation under this chapter within six months after the date of the injury or death or the discovery of an injury.

(B) Except as to an individual within the age of minority or of unsound mind as provided by section 2305.16 of the Revised Code, and except as provided in division (C) of this section, both of the following apply:

(1) No action upon a chiropractic, dental, medical, optometric, or derivative claim under this chapter shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the claim;

(2) If an action upon a chiropractic, dental, medical, optometric, or derivative claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the claim, then, any action upon that claim is barred.

(C)(1) If an individual making a chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim in the exercise of reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within three years and six months after the occurrence of the act or omission, but, in the exercise of reasonable care and diligence, discovers the injury resulting from that act or omission before the expiration of the four-year period specified in division (B)(1) of this section, the individual may file a claim under this chapter not later than six months after the individual discovers the injury resulting from that act or omission.

(2) If the alleged basis of a chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim is the occurrence of an act or omission that involves a foreign object that is left in the body of an individual, the individual making the claim may file a claim under this chapter not later

than the later of six months after the individual discovered the foreign object or six months after the individual, with reasonable care and diligence, should have discovered the foreign object.

(3) An individual who files a chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim under the circumstances described in division (C)(1) or (2) of this section has the affirmative burden of proving, by clear and convincing evidence, that the individual, with reasonable care and diligence, could not have discovered the injury resulting from the act or omission constituting the alleged basis of the claim within the three-year and six-month period described in division (C)(1) of this section or prior to the six-month period described in division (C)(2) of this section, whichever is applicable.

Sec. 3965.31. (A) The administrator of medical injury compensation shall prepare and furnish all of the following blank forms:

(1) Applications for compensation for a chiropractic, dental, medical, optometric, or derivative claim made under this chapter;

(2) Notices to liability insurers of providers and individuals;

(3) For proofs of injury or death and of medical attendance and hospital and nursing care;

(4) Any other necessary applications.

(B) The administrator, in the rules the administrator adopts under this chapter, shall provide for the preparation and distribution of the forms described in division (A) of this

section. The rules shall require the forms to be readily available and prepared so that the furnishing of information required of any individual or liability insurer with respect to any aspect of a claim is not delayed by a requirement that information with respect to another aspect of the claim shall be furnished on the form by the same or another person. Service offices shall keep on hand a sufficient supply of these forms.

Sec. 3965.32. The administrator of medical injury compensation, by published notices and other appropriate means, shall endeavor to cause claims to be filed in the service office of the medical injury compensation center from which the investigation and determination of the claim may be made most expeditiously. An individual may file a claim or appeal under this chapter or Chapter 3967. of the Revised Code with any office of the center within the required statutory period, and that claim or appeal is considered received for the purpose of processing claims or appeals.

Sec. 3965.33. (A) Within seven days after receipt of any claim under this chapter, the medical injury compensation center shall notify the claimant, the health care professional standards board, and the liability insurer of the provider named in the claim of the receipt of the claim and of the facts alleged in the claim. Upon receipt of a claim, the center shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. No center employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the center's responsibility to aid and assist a claimant in the filing of a claim and to advise the claimant of the claimant's rights under the law.

(B)(1) The administrator of medical injury compensation shall assign all claims and investigations to the center service office from which investigation and determination may be made most expeditiously.

(2) The administrator shall assign each claim, in accordance with section 3965.40 of the Revised Code, to a reviewing health care provider who is engaged in the type of practice that is the primary subject of the claim.

(3) The reviewing health care provider, with assistance from center employees, shall investigate the facts concerning an injury or death and ascertain those facts in whatever manner is most appropriate and may obtain statements of the claimant, provider, other attending physicians or providers, and witnesses in whatever manner is most appropriate.

(4) A reviewing health care provider may refer a claim to the administrator for reassignment if either of the following occur:

(a) If, on reviewing the records submitted in a claim pursuant to section 3965.41 of the Revised Code, the reviewing health care provider determines that the primary issue of a claim involves an area of practice in which the reviewing provider is not engaged.

(b) The reviewing health care provider is unable to make a determination as required under division (D) of section 3965.41 of the Revised Code with respect to the liability of a provider in a claim involved in an issue that is not the primary issue of the claim.

If the administrator receives a claim for reassignment under division (B)(4) of this section, the administrator

expeditiously shall reassign the claim in accordance with section 3965.40 of the Revised Code.

Sec. 3965.34. (A) A reviewing health care provider appointed pursuant to section 3965.40 of the Revised Code or a medical injury compensation panel may require any individual claiming the right to receive compensation under this chapter to submit to a medical examination at any time, and from time to time, at a place reasonably convenient for the individual, and as provided by the rules of the administrator of medical injury compensation. A claimant required by a panel or a reviewing health care provider to submit to a medical examination, at a point outside of the place of permanent or temporary residence of the claimant, as provided in this section, is entitled to have paid to the claimant by the medical injury compensation center the necessary and actual expenses on account of the attendance for the medical examination after approval of the expense statement by the center. Under extraordinary circumstances and with the unanimous approval of the panel, if the panel requires the medical examination, or with the approval of the reviewing health care provider, if the reviewing health care provider requires the medical examination, the center shall pay an injured individual the necessary, actual, and authorized expenses of treatment at a point outside the place of permanent or temporary residence of the claimant.

(B) If an individual refuses to submit to any medical examination scheduled pursuant to this section or obstructs the examination, the individual's right to have the individual's claim for compensation considered, if the claim is pending before a reviewing health care provider or a medical injury compensation panel, or to receive any payment for compensation previously granted, is suspended during the period of the

refusal or obstruction. A reviewing health care provider or panel shall dismiss an individual's claim if the individual fails to submit to an examination for a period of six months or longer.

(C) Examinations scheduled under this section do not limit examinations provided for in other provisions of this chapter.

Sec. 3965.35. (A) The liability insurer of a provider listed in a claim filed under this chapter may require, without the approval of a reviewing health care provider or a medical injury compensation panel, that the claimant be examined by a physician of the liability insurer's choice one time. Any further requests for medical examinations shall be made to the administrator of medical injury compensation, who shall consider and rule on the request. The liability insurer shall pay the cost of any examinations initiated by the liability insurer.

A provider selected by a liability insurer to conduct an examination under this division shall satisfy the requirements of division (A) of section 3965.43 of the Revised Code. With respect to a claim before a reviewing health care provider, a liability insurer may require a claimant to undergo an examination at the time permitted under division (D) of section 3965.41 of the Revised Code. With respect to a claim before a medical injury compensation panel, the liability insurer may require a claim to undergo both an examination as the panel is determining whether the claim is compensable and, if a claim is compensable, prior to the award of compensation.

(B) The medical injury compensation center shall prepare a form for the release of medical information, records, and reports relative to the issues necessary for the administration of a claim under this chapter. The claimant promptly shall

provide a current signed release of the information, records, and reports when requested by the liability insurer of a provider listed in a claim. The liability insurer promptly shall provide copies of all information, records, and reports that relate to the claim to the center and to the claimant or the claimant's representative upon request.

(C) If, without good cause, a claimant refuses to submit to any examination scheduled under this section or refuses to release or execute a release for any information, record, or report that is required to be released under this section and involves an issue pertinent to the condition alleged in the claim, the claimant's right to have the claimant's claim considered, if the claim is pending before a reviewing health care provider or a medical injury compensation panel, or to receive any payment for compensation previously granted, is suspended during the period of refusal. A reviewing health care provider or panel shall dismiss an individual's claim if the individual fails to submit to an examination for a period of six months or longer.

(D) No center employee shall alter any medical report obtained from a health care provider the liability insurer, reviewing health care provider, or a panel has selected or cause or request the health care provider to alter or change a report. The reviewing health care provider and panel shall make any request for clarification of a health care provider's report in writing and shall provide a copy of the request to the affected parties and their representatives at the time of making the request.

Sec. 3965.36. For the purpose of this chapter, a minor is sui juris, and no other person shall have any cause of action or

right to compensation for an injury to the minor, but in the event of the award of a lump sum of compensation to the minor, the sum shall be paid to the legally appointed guardian of the minor or in accordance with section 2111.05 of the Revised Code.

Sec. 3965.37. This chapter and Chapter 3967. of the Revised Code shall be liberally construed in favor of claimants.

Sec. 3965.40. (A) The medical injury compensation center shall employ a pool of reviewing health care providers, who shall determine claims filed under this chapter. A provider who participates in the pool shall practice at least fifty per cent of the time in a clinical setting. Any type of provider may serve as a reviewing health care provider. The administrator of medical injury compensation shall set the compensation of a reviewing health care provider during the time the provider performs services for the medical injury compensation center under this chapter and Chapter 3967. of the Revised Code.

(B) A reviewing health care provider who is appointed to determine a claim under this chapter shall serve for as long as is necessary to resolve the claim. A reviewing health care provider shall be assigned a claim based upon all of the following:

(1) Whether the claim is a chiropractic, dental, medical, optometric, or derivative claim;

(2) The type of practice in which the reviewing health care provider is engaged;

(3) Where the injury or death occurred.

(C)(1) The administrator shall periodically review the performance of each reviewing health care provider to ensure accuracy and impartiality in decisions made by the reviewing

health care provider.

(2) If the administrator, in conducting a review under division (C)(1) of this section, determines that the decisions of a reviewing health care provider are not accurate or impartial, the administrator may remove the reviewing health care provider from the pool described in division (A) of this section and from any claim being heard by the provider at the time of the determination.

Sec. 3965.41. (A) A reviewing health care provider appointed under section 3965.40 of the Revised Code shall review the medical or applicable records submitted in the chiropractic, dental, medical, optometric, or derivative claim over which the reviewing health care provider is presiding pursuant to this chapter. No reviewing health care provider shall review or consider as evidence in a claim under this chapter a determination made by the health care professional standards board under section 4746.04 of the Revised Code that the provider's acts or omissions constitute gross negligence or that the provider engaged in a pattern of negligent behavior over a short period of time.

(B) The reviewing health care provider shall review all chiropractic, dental, medical, or optometric records relevant to the claim. The reviewing health care provider may commission an expert witness in accordance with section 3965.43 of the Revised Code to present evidence regarding the claim.

(C) A reviewing health care provider shall determine whether clear and convincing evidence exists that the provider did not breach the chiropractic, dental, medical, or optometric standard of care applicable to the claim. If the reviewing health care provider determines that such evidence exists, the

claimant shall not be compensated under this chapter. If the reviewing health care provider determines that this evidence does not exist, the claimant shall be awarded compensation under this chapter. If the reviewing health care provider determines that such evidence exists with respect to the type of practice that is the primary issue of the claim, but is unable to determine whether such evidence exists with respect to other aspects of the claim, the reviewing health care provider may refer the portions of the claim for which the reviewing health care provider is unable to make a determination to the administrator for reassignment pursuant to section 3965.33 of the Revised Code.

(D) If a reviewing health care provider determines that a claim is compensable under this chapter, the reviewing health care provider shall request the administrator to assign an actuary to the claim. The administrator shall randomly assign an actuary employed by the medical injury compensation center to determine the amount of compensation to be awarded in accordance with section 3965.60 of the Revised Code using the same evidence the reviewing health care provider used to determine that the claim is compensable. However, prior to awarding compensation, the reviewing health care provider shall allow the liability insurer of a provider identified in the claim to have a medical examination of the claimant conducted by an independent health care provider at the insurer's expense in accordance with section 3965.35 of the Revised Code. If the liability insurer elects to have an independent medical examination conducted, the claimant, at the claimant's expense, also may elect to have an independent medical examination conducted. The results of any independent medical examination conducted pursuant to this division shall be submitted to the actuary assigned to the

claim, who shall use those results to determine the amount of compensation to award.

(E) The insurer of a provider listed in a claim or a claimant may appeal the decision of the reviewing health care provider in accordance with the procedures prescribed in Chapter 3967. of the Revised Code.

Sec. 3965.42. (A)(1) The liability insurer of a provider listed in a claim filed under this chapter may file a motion with the reviewing health care provider assigned to the claim under section 3965.40 of the Revised Code for dismissal of the claim accompanied by an affidavit of noninvolvement. The liability insurer shall notify all parties to the claim in writing of the filing of the motion. Prior to ruling on the motion, the reviewing health care provider shall allow the parties not less than thirty days from the date that the parties were served with the notice to respond to the motion.

(2) An affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate all of the following:

(a) That the provider listed in the claim was misidentified or otherwise not involved individually or through the action of the provider's agents or employees in the care and treatment of the individual who is the subject of the claim;

(b) That the provider was not obligated individually or through the provider's agents or employees to provide for the care and treatment of the individual who is the subject of the claim;

(c) That the provider could not have caused the alleged malpractice individually or through the provider's agents or employees in any way.

(B)(1) The parties shall have the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the reviewing health care provider that contradicts the assertions of noninvolvement made in the liability insurer's affidavit of noninvolvement.

(2) If the affidavit of noninvolvement is challenged, any party may request an oral hearing on the motion for dismissal. If requested, the reviewing health care provider shall hold a hearing to determine if the provider at question was involved, directly or indirectly, in the care and treatment of the individual who is the subject of the claim, or was obligated, directly or indirectly, for the care and treatment of that individual.

(3) The reviewing health care provider shall consider all evidence submitted by the parties and the parties' arguments. The reviewing health care provider may dismiss the claim based upon the lack of involvement of the provider in question in the elements of the chiropractic, dental, medical, optometric, or derivative claim. The reviewing health care provider shall determine all challenges to the affidavit of noninvolvement within seventy-five days after the filing of the affidavit of noninvolvement.

(4) The dismissal of a claim against a liability insurer of a provider pursuant to this section shall be deemed otherwise than upon the merits and without prejudice pursuant to Civil Rule 41.

(C) If the reviewing health care provider determines that a liability insurer has falsely filed or made false or inaccurate statements in an affidavit of noninvolvement, the reviewing health care provider, upon a motion or upon the

reviewing health care provider's own initiative, shall immediately reinstate the claim against that liability insurer, if previously dismissed. If a party is reinstated pursuant to this division, any period of limitations shall be considered to be tolled for the period beginning when the original affidavit was filed and ending upon reinstatement.

(D) In any claim in which the liability insurer of the provider in question is found by the reviewing health care provider to have knowingly filed a false or inaccurate affidavit of noninvolvement, the reviewing health care provider shall request that the health care professional standards board or other appropriate disciplinary board impose upon the person who signed the affidavit or represented the provider, or both, an appropriate sanction. An appropriate sanction may include an order to pay to other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorney's fees.

(E) In any claim in which the reviewing health care provider determines that a party falsely objected to a liability insurer's affidavit of noninvolvement or knowingly provided an inaccurate statement regarding such an affidavit, the reviewing health care provider shall request the appropriate authority to impose upon the party or the party's counsel, or both, an appropriate sanction. An appropriate sanction may include an order to pay to the other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorney's fees.

Sec. 3965.43. (A) No individual shall be considered

competent to give expert testimony on the liability or compensation issues in a chiropractic, dental, medical, or optometric claim filed under this chapter, unless all of the following apply to the individual:

(1) The individual is licensed to practice the applicable profession by the appropriate agency in this state or any other state.

(2) The individual devotes three-fourths of the individual's professional time to the active clinical practice or to instruction in an accredited university in the applicable subject area.

(3) The individual practices in the same or a substantially similar specialty as the provider listed in the claim filed under this chapter.

(4) If the person is certified in a specialty, the person must be certified by a nationally recognized board, as determined by the administrator of medical injury compensation, in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

(B) For purposes of division (A)(3) of this section, a reviewing health care provider or medical injury compensation panel shall not permit an expert in one medical specialty to testify against a provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties.

(C) Nothing in division (A) of this section shall be construed to limit the power of the reviewing health care provider or panel to adjudge the testimony of any expert witness

incompetent on any other ground.

(D) Nothing in division (A) of this section shall be construed to limit the power of the reviewing health care provider or a panel to allow the testimony of any other witness, on a matter unrelated to the liability or compensation issues in the chiropractic, dental, medical, or optometric claim, when that testimony is relevant to the claim involved.

Sec. 3965.44. Each member of a medical injury compensation panel and employees of the medical injury compensation center designated by the administrator of medical injury compensation, for the purposes of this chapter and Chapter 3967. of the Revised Code, may administer oaths, certify to official acts, take testimony or depositions, conduct hearings, inquiries, and investigations, issue subpoenas, and compel the attendance of witnesses and the production of books, accounts, papers, records, documents, evidence, and testimony.

In claims filed before a medical injury compensation panel or the medical injury compensation center by an individual and the dependents of a deceased individual on account of injury or death sustained by the individual in the course of the diagnosis, care, or treatment of the individual, a panel, a reviewing health care provider or the center may cause depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for the taking of depositions in civil actions in the court of common pleas.

Sec. 3965.45. A transcribed copy of the evidence and proceedings, or any specific part thereof, or any investigation, by a stenographer appointed by the medical injury compensation center, that is certified by that stenographer to be a true and correct transcript of the testimony on the investigation or of a

particular witness, or of a specific part of that testimony, carefully compared by the stenographer with the stenographer's original notes, and to be a correct statement of the evidence and proceedings had on that investigation so purporting to be taken and subscribed, may be received in evidence by a medical injury compensation panel with the same effect as if the stenographer were present and testified to the facts so certified. A copy of the transcript shall be furnished on demand to any party upon the payment of the fee therefor as provided for transcript in courts of common pleas.

Sec. 3965.46. If any person fails to comply with a subpoena issued by or an order of a medical injury compensation panel or the administrator of medical injury compensation, or on the refusal of a witness to testify to any matter regarding which the witness may be lawfully interrogated, the probate judge of the county in which the person resides, on application of any member of the panel, the reviewing health care provider, or the administrator, shall compel obedience by attachment proceedings as for contempt, as in the case of disobedience of the requirements of subpoena issued from that court on a refusal to testify therein.

Sec. 3965.47. Each officer who serves a subpoena issued under section 3965.44 of the Revised Code shall receive the same fees as a sheriff. Each witness who appears, in obedience to a subpoena, before a medical injury compensation panel, the administrator of medical injury compensation, or any inspector or examiner of the commission or administrator, shall receive the fees and mileage provided for under section 119.094 of the Revised Code. The fees shall be paid from the medical injury compensation center operating fund on the approval of the administrator. No witness subpoenaed at the instance of a party

other than the persons listed in this section is entitled to compensation under this section unless the administrator certifies that the witness's testimony was material to the matter investigated.

Sec. 3965.50. (A) Except as otherwise provided in section 3965.54 of the Revised Code, each individual who suffers an injury arising out of the following events is entitled to compensation under this chapter and Chapter 3967. of the Revised Code, if it is determined that clear and convincing evidence does not exist that the provider did not breach the medical standard of care applicable to the claim:

(1) The chiropractic diagnosis, care, or treatment of the individual;

(2) The dental diagnosis, care, or treatment of the individual;

(3) The medical diagnosis, care, or treatment of the individual;

(4) The optometric diagnosis, care, or treatment of the individual.

(B) A dependent of an individual whose death arises out of the services described under division (A)(1), (2), (3), or (4) of this section is entitled to compensation under this chapter and Chapter 3967. of the Revised Code if it is determined that clear and convincing evidence does not exist that the provider did not breach the medical standard of care applicable to the claim.

Sec. 3965.51. (A) The right of an individual or the individual's dependents to compensation under this chapter is the exclusive remedy against a provider or the provider's

liability insurer for any injury or death arising from any of the following:

(1) The chiropractic diagnosis, care, or treatment of the individual;

(2) The dental diagnosis, care, or treatment of the individual;

(3) The medical diagnosis, care, or treatment of the individual;

(4) The optometric diagnosis, care, or treatment of the individual.

(B) Payment to an injured individual, or to the individual's dependents in case death has ensued, is in lieu of any and all rights of action against the provider who rendered the services described in division (A) of this section.

(C) This section shall apply to any action brought against a provider by the health insurer of an individual, the employer of the individual, or any other person related to the injury that is the subject of the claim.

Sec. 3965.52. Payments of compensation to a claimant or on behalf of a claimant as a result of any order issued under this chapter or Chapter 3967. of the Revised Code shall commence thirty days after the earlier of the following:

(A) Fourteen days after the date the reviewing health care provider issues an order under section 3965.41 of the Revised Code, unless that order is appealed;

(B) The date when the liability insurer of the provider listed in the claim has waived the right to appeal a decision issued under section 3965.41 of the Revised Code;

(C) If no appeal of an order has been filed under Chapter 3967. of the Revised Code, the expiration of the time limitations for the filing of an appeal of an order;

(D) The date of receipt by the liability insurer of the provider listed in the claim of an order of a medical injury compensation panel issued under section 3967.15 of the Revised Code, unless a stay is ordered by a court of appropriate jurisdiction.

Sec. 3965.54. Compensation awarded under this chapter and Chapter 3967. of the Revised Code that is awarded prior to the confinement of a claimant in any state or federal correctional institution, or in any county jail in lieu of incarceration in a state or federal correctional institution, whether in this or any other state for conviction of violation of any state or federal criminal law is not payable to a claimant during the period of confinement.

Any compensation awarded to a claimant during a period of such confinement shall be subject to sections 2969.21 to 2969.27 of the Revised Code. A claim filed under this chapter shall be considered a civil action for purposes of those sections.

Sec. 3965.59. (A) The administrator of medical injury compensation shall do all of the following:

(1) Implement a program of impairment evaluation training for chiropractors, dentists, physicians, optometrists, and related professionals employed by the medical injury compensation center;

(2) Issue a policy manual covering impairment evaluation so as to increase consistency of medical reports;

(3) Develop a method of peer review of reports prepared by

center referral chiropractors, dentists, physicians, optometrists, and related professionals;

(4) Issue a policy manual as to the basis upon which referrals to other than center specialists will be made;

(5) Designate two hearing examiners and two staff members who shall be specially trained in medical-legal analysis;

(6) Require that prior to any examination a physician to whom a claimant is referred for examination receives all necessary medical information in the claim file about the claimant and a complete statement as to the purpose of the examination.

(B) The policy manual created under division (A)(2) of this section shall be available to the public at cost but shall be provided free to all chiropractors, dentists, physicians, optometrists, and related professionals who treat claimants or to whom claimants are referred for evaluation. The administrator shall take steps to ensure that the manual receives the widest possible distribution to chiropractors, dentists, physicians, optometrists, and related professionals.

(C) With respect to division (A)(5) of this section, the specialists shall write evaluations of medical-legal problems upon assignment by a reviewing health care provider or a medical injury compensation panel. The director of administrative services upon the advice of the administrator shall assign such employees to a salary schedule commensurate with expertise required of them.

(D) The administrator may establish a medical section within the center to perform the duties assigned to the administrator under this section.

Sec. 3965.60. (A) An actuary appointed by the administrator of medical injury compensation pursuant to section 3965.41 of the Revised Code shall take the following factors into account when determining the amount of compensation awarded under this chapter or Chapter 3967. of the Revised Code:

(1) All wages, salaries, or other compensation lost as a result of an injury, death, or loss to person or property that is a subject of a medical, dental, optometric, or chiropractic claim;

(2) All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury, death, or loss to person or property that is a subject of a medical, dental, optometric, or chiropractic claim;

(3) Any other expenditures incurred as a result of an injury, death, or loss to person or property that is a subject of a medical, dental, optometric, or chiropractic claim, other than attorney's fees incurred in connection with that action;

(4) With respect to a derivative claim, any nonpecuniary harm that results from an injury, death, or loss to person or property that is a subject of a medical, dental, optometric, or chiropractic claim, including pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, education, disfigurement, mental anguish, and any other intangible loss.

(B) Except as provided in division (F) of section 3967.20 of the Revised Code, compensation awarded under this chapter or Chapter 3967. of the Revised Code shall be reduced pursuant to

division (C) of this section.

(C)(1) The administrator shall have an actuary calculate the compensation modifier used in this section. To calculate the compensation modifier, the actuary shall do all of the following:

(a) Not later than one year after the effective date of this section:

(i) Determine the total cost of medical malpractice claims and services related to those claims during the two years immediately preceding the date on which the actuary makes the determination;

(ii) Determine the projected total cost of medical malpractice claims and services related to those claims, during the two years immediately following the date on which the actuary makes the determination, and adjust those amounts to eliminate any increased cost due solely to inflation, in accordance with rules adopted by the administrator;

(iii) If the amount determined in division (C)(1)(a)(ii) of this section is greater than the amount determined in division (C)(1)(a)(i) of this section, divide the lesser amount by the greater amount and report the quotient to the administrator. If the amount determined in division (C)(1)(a)(ii) of this section is less than the amount determined in division (C)(1)(a)(i) of this section, report the number one to the administrator.

(b) Not earlier than two years or later than three years after the effective date of this section:

(i) Determine the projected total costs of medical malpractice claims and services related to those claims during

the three calendar years immediately preceding the date on which the actuary makes the determination;

(ii) Determine the projected total costs of medical malpractice claims and services related to those claims during the three calendar years immediately following the date on which the actuary makes this determination and adjust those amounts to eliminate any increased cost due solely to inflation, in accordance with rules adopted by the administrator;

(iii) If the amount determined in division (C)(1)(b)(ii) of this section is greater than the amount determined in division (C)(1)(b)(i) of this section, divide the lesser amount by the greater amount and report the quotient to the administrator. If the amount determined in division (C)(1)(b)(ii) of this section is less than the amount determined in division (C)(1)(b)(i) of this section, report the number one to the administrator.

(c) Not earlier than four years or later than five years after the effective date of this section, and every five years thereafter:

(i) Determine the total cost of medical malpractice claims and services related to those claims during the five years immediately preceding the date on which the actuary makes the determination;

(ii) Determine the projected total costs of medical malpractice claims and services related to those claims during the five calendar years immediately following the date the administrator requests the determination and adjust those amounts to eliminate any increased cost due solely to inflation, in accordance with rules adopted by the administrator;

(iii) If the amount determined in division (C)(1)(c)(ii) of this section is greater than the amount determined in division (C)(1)(c)(i) of this section, divide the lesser amount by the greater amount and report the quotient to the administrator. If the amount determined in division (C)(1)(c)(ii) of this section is less than the amount determined in division (C)(1)(c)(i) of this section, report the number one to the administrator.

(2) An amount reported to the administrator under division (C)(1) of this section shall be the compensation modifier in effect for the period beginning on the first day of July immediately following the date the actuary reports the amount to the administrator and ending immediately after another compensation modifier takes effect pursuant to this section.

(3) A reviewing health care provider or panel shall multiply the compensation awarded by the compensation modifier. The result shall be the amount of compensation to be paid for that claim.

Sec. 3965.70. (A) The liability insurer of a provider listed in a claim filed under this chapter or the individual who filed the claim may file an application with the administrator of medical injury compensation for approval of a final settlement of a claim under this chapter. The application shall include the settlement agreement, and except as otherwise specified in this division, be signed by the claimant and the liability insurer, and clearly set forth the circumstances by reason of which the proposed settlement is considered desirable and that the parties agree to the terms of the settlement agreement.

A claimant may file an application without a liability

insurer's signature if the insurer is no longer doing business in this state. If a claimant files an application without a liability insurer's signature, and the insurer still is doing business in this state, the administrator shall send written notice of the application to the insurer immediately upon receipt of the application. If the liability insurer fails to respond to the notice within thirty days after the notice is sent, the application need not contain the liability insurer's signature.

If a liability insurer or an individual has not filed an application for a final settlement under this division, the administrator may file an application on behalf of the liability insurer or the individual, provided that the administrator gives notice of the filing to the insurer and the individual and to the representative of record of the insurer and of the individual immediately upon the filing. An application filed by the administrator shall contain all of the information and signatures required of a liability insurer or an individual who files an application under this division.

(B) Except as provided in divisions (C) and (D) of this section, a settlement agreed to under this section is binding upon all parties to it and as to items and injuries to which the settlement applies.

(C)(1) No settlement agreed to under division (A) of this section shall take effect until thirty days after the administrator approves the settlement. During the thirty-day period, the liability insurer, individual, or administrator may withdraw consent to the settlement by:

(a) A liability insurer providing written notice to the individual and the administrator;

(b) An individual providing written notice to the liability insurer and the administrator;

(c) The administrator providing written notice to the liability insurer and individual.

(2) If an individual dies during the thirty-day waiting period following the approval of a settlement, the settlement can be voided by any party for good cause shown.

(D) At the time of agreement to any final settlement agreement under division (A) of this section, the administrator immediately shall send a copy of the agreement to the reviewing health care provider who determined that the claim is compensable under this chapter. The reviewing health care provider shall determine, within the time limitations specified in division (C) of this section, whether the settlement agreement is or is not a gross miscarriage of justice. If the reviewing health care provider determines within that time period that the settlement agreement is clearly unfair, the reviewing health care provider shall issue an order disapproving the settlement agreement. If the reviewing health care provider determines that the settlement agreement is not clearly unfair or fails to act within those time limits, the settlement agreement is approved.

(E) A settlement entered into under this section may pertain to one or more claims of a claimant, or one or more parts of a claim, or the compensation pertaining to either, or any combination thereof. Nothing in this section shall be interpreted to require a claimant to enter into a settlement agreement for each claim that has been filed with the medical injury compensation center by that claimant under this chapter.

(F) A settlement entered into under this section is not appealable under sections 3967.10 to 3967.15 or 3967.20 of the Revised Code.

Sec. 3965.71. Notwithstanding section 2315.21 of Revised Code, no punitive damages shall be awarded for any claim filed under this chapter or any appeal filed under Chapter 3967. of the Revised Code.

Sec. 3965.75. (A) In determining the percentage of compensatory conduct attributable to a party in a claim filed under this chapter, the reviewing health care provider who determined that a claim is compensable under this chapter shall hold a hearing, make findings of fact, and issue an order that shall specify all of the following:

(1) The percentage of compensatory conduct that proximately caused the injury or death that is attributable to each provider listed in a claim filed under this chapter for the same injury or death;

(2) The percentage of compensatory conduct that proximately caused the injury or death that is attributable to each provider the claimant did not list in a claim filed under this chapter for the same injury or death.

(B) The sum of the percentages of compensatory conduct as determined pursuant to division (A) of this section shall equal one hundred per cent.

(C) For purposes of division (A)(2) of this section, it is an affirmative defense for the liability insurer of each provider listed in a claim filed under this chapter that a specific, positive percentage of the compensatory conduct that proximately caused the injury or death is attributable to one or

more persons the claimant did not list in a claim filed under this chapter for the same injury or death. Any liability insurer of a provider listed in a claim may raise an affirmative defense under this division at any time before the hearing regarding the compensability of the claim.

Sec. 3965.76. (A) Except as otherwise provided in sections 2307.25 to 2307.28 of the Revised Code, if one or more persons are jointly and severally liable in a claim filed under this chapter for the same injury or death, a right of contribution may exist even though judgment has not been recovered against all or any of them. The right of contribution exists only in favor of a liability insurer of a provider who has paid more than that liability insurer's proportionate share of the common liability, and that liability insurer's total recovery is limited to the amount paid by that liability insurer in excess of that liability insurer's proportionate share. No liability insurer may be compelled to make contribution beyond that provider's own proportionate share of the common liability.

(B) A liability insurer who enters into a settlement with a claimant under section 3965.70 of the Revised Code is not entitled to contribution from another liability insurer whose liability for the injury or death is not extinguished by the settlement, or in respect to any amount paid in a settlement that is in excess of what is reasonable.

(C) If a liability insurer by payment has discharged in full or in part the liability of a provider and has discharged in full by the payment its obligation as insurer, that insurer is subrogated to the provider's right of contribution to the extent of the amount it has paid in excess of the provider's proportionate share of the common liability. This division does

not limit or impair any right of subrogation arising from any other relationship.

(D) This section does not impair any right of indemnity under existing law. If one liability insurer of a provider listed in a claim is entitled to indemnity from another, the right of the indemnity obligee is for indemnity and not contribution, and the indemnity obligor is not entitled to contribution from the obligee for any portion of the indemnity obligation.

(E) The proportionate shares of providers in the common liability shall be based upon their relative degrees of legal responsibility. If equity requires the collective liability of some as a group, the group shall constitute a single share, and principles of equity applicable to contribution generally shall apply.

(F) Regardless of whether an order has been issued in a claim filed under this chapter that lists two or more providers for the same injury or death, contribution may be enforced by separate action filed in a court of appropriate jurisdiction.

Sec. 3965.77. If an order that imposes joint and several liability has been issued in a claim filed under this chapter against one or more liability insurers for the same injury or death, contribution may be enforced in that claim by an order in favor of one against other liability insurers, by a court of appropriate jurisdiction. If there is a determination for the injury or death against the liability insurer seeking contribution, that liability insurer shall file a claim for contribution in a court of appropriate jurisdiction to enforce contribution within one year after the order has become final by lapse of time for appeal or after appellate review.

If no determination is made for the injury or death against the liability insurer seeking contribution, that liability insurer's right of contribution is barred unless either of the following applies:

(A) That liability insurer has discharged by payment the common liability within the statute of limitations period applicable to the claimant's right of action against the provider listed in the claim and has commenced that liability insurer's claim for contribution within one year after the payment.

(B) That liability insurer has agreed while a claim is pending against that liability insurer to discharge the common liability and has paid within one year after the agreement the common liability and commenced that liability insurer's claim for contribution.

Sec. 3965.78. The recovery of an order for an injury or death in a claim filed under this chapter against the liability insurer of one provider does not of itself discharge the liability insurers of other providers from liability for the injury or death unless the order is satisfied. The satisfaction of the order does not impair any right of contribution.

Sec. 3965.80. (A) Sections 2305.23, 2305.231, 2305.234, and 2305.235 of the Revised Code apply to claims filed under this chapter.

(B) Section 2317.54 of the Revised Code applies to a claim filed under this chapter.

Sec. 3967.01. (A) The definitions located in section 3965.01 of the Revised Code apply to this chapter.

(B) As used in the Revised Code, "medical injury

compensation panel" means a panel established pursuant to section 3967.02 of the Revised Code.

Sec. 3967.02. For the purpose of hearing an appeal of a claim filed under Chapter 3965. of the Revised Code, the administrator of medical injury compensation shall appoint a medical injury compensation panel consisting of providers. The administrator shall select the panel membership in the same manner as a reviewing health care provider is appointed under section 3965.40 of the Revised Code, except that the administrator may select a provider with a specialty based upon the nature of the claim. The reviewing health care provider who determined the compensability of a claim under Chapter 3965. of the Revised Code shall not serve as a member of a panel that is hearing the appeal of that claim. A provider selected to serve on the panel shall serve a term in accordance with section 3965.40 of the Revised Code. The administrator, at the time a panel membership is selected, shall select one panel member to serve as chairperson of that panel. The chairperson, in consultation with the administrator, shall establish all hearing dates and times necessary for an appeal. The administrator shall provide administrative support and facilities for a panel to conduct its business. A majority of a panel constitutes a quorum to conduct business.

Sec. 3967.03. The attorney general shall be the legal advisor for a medical injury compensation panel.

Sec. 3967.05. A medical injury compensation panel shall have original jurisdiction over all appeals from a decision of a reviewing health care provider under section 3965.41 of the Revised Code and the determination of the amount of compensation, if any, awarded pursuant to that section. Members

of a panel shall not engage in any other activity that interferes with their service on the panel during normal working hours.

Sec. 3967.06. (A) The administrator of medical injury compensation shall adopt rules as to the conduct of all hearings before a medical injury compensation panel and the rendering of a decision. The administrator shall focus these rules on managing, directing, and otherwise ensuring a fair, equitable, and uniform hearing process. These rules shall provide for at least the following steps and procedures:

(1) Adequate notice to all parties and their representatives to ensure that no hearing is conducted unless all parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties;

(2) A public hearing;

(3) Written decisions;

(4) Impartial assignment of members of a panel and assignment of appeals from a decision of a reviewing health care provider to a panel;

(5) Publication of a docket;

(6) The securing of the attendance or testimony of witnesses;

(7) Prehearing rules, including rules relative to discovery, the taking of depositions, and exchange of information relevant to a claim prior to the conduct of a hearing;

(8) The issuance of orders by the panel that renders the

decision.

(B) Each decision by a panel shall be in writing and contain all of the following elements:

(1) A concise statement of the order or award;

(2) A notation as to notice provided and as to appearance of parties;

(3) Signatures of each panel member on the original copy of the decision only, verifying the member's vote;

(4) Description of the part of the body and nature of the disability recognized in the claim.

(C) The administrator shall adopt rules that ensure that no panel hears a claim unless all interested and affected parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties.

(D) All matters that, at the request of one of the parties or on the initiative of the administrator and any panel member, are to be expedited shall be given at least forty-eight hours' notice and a public hearing and shall include a statement in any order issued of the circumstances that justified an expeditious hearing.

(E) All hearings held by a panel shall be public with adequate notice, including, if necessary, notice to the claimant, the provider's liability insurer, their representatives, and the administrator. Confidentiality of medical evidence presented at a hearing does not constitute a sufficient ground to relieve the requirement of a public hearing, but the presentation of privileged or confidential

evidence shall not create any greater right of public inspection of evidence than presently exists.

(F) The administrator shall compile all of each panel's original memoranda, orders, and decisions in a journal and make the journal available to the public with sufficient indexing to allow orderly review of documents. The journal shall indicate the vote of each panel member.

(G)(1) All original orders, rules, memoranda, and decisions of a panel shall contain the signatures of two of the three panel members and state whether the order, rule, memorandum, or decision was adopted at a meeting of the panel or by circulation to individual panel members. Any facsimile or secretarial signature, initials of panel members, and any printed record of the "yes" and "no" vote of a panel member on that original is invalid.

(2) Written copies of final decisions of reviewing health care providers or panel members that are mailed to the administrator, claimant, provider, the provider's liability insurer, and their respective representatives need not contain the signatures of the panel members if the panel members have complied with divisions (B)(3) and (G)(1) of this section.

(H) The administrator shall appoint an individual as a hearing officer trainer who is in the unclassified civil service of the state and who serves at the pleasure of the administrator. The trainer shall be an attorney admitted to the practice of law in this state and have experience in training or education, and the ability to furnish the necessary training for reviewing health care providers and panel members. The hearing officer trainer shall develop and periodically update a training manual and any other training materials and courses as will

adequately prepare reviewing health care providers and panel members for their duties under this chapter and Chapter 3965. of the Revised Code. All reviewing health care providers and panel members shall undergo the training courses developed by the hearing officer trainer, the cost of which the administrator shall pay. The administrator shall make the hearing manual and all revisions thereto available to the public at cost. The administrator shall have the final right of approval over all training manuals, courses, and other materials the hearing officer trainer develops and updates.

(I) The administrator shall appoint a hearing administrator, who shall be in the classified civil service of the state, and sufficient support personnel for each hearing administrator. The support personnel shall be under the direct supervision of the hearing administrator. The hearing administrator shall do all of the following:

(1) Provide information to requesting parties or their representatives on the status of their claim;

(2) Issue compliance letters, upon a finding of good cause and without a formal hearing in all of the following areas:

(a) Requests for the taking of depositions of medical injury compensation center physicians;

(b) The issuance of subpoenas;

(c) The granting or denying of requests for continuances;

(d) Matters involving section 3967.24 of the Revised Code;

(e) Requests for conducting telephone prehearing conferences;

(f) Any other matter that will cause a free exchange of

information prior to the formal hearing.

(3) Take the necessary steps to prepare a claim to proceed to a hearing where the parties agree and advise the hearing administrator that the claim is not ready for a hearing.

(J) The administrator shall permit any person direct access to information contained in electronic data processing equipment regarding the status of a claim in the hearing process. The information shall indicate the number of days that the claim has been in process, the number of days the claim has been in its current location, and the number of days in the current point of the process within that location.

(K)(1) The administrator may establish an alternative dispute resolution process for claims that are within a panel's jurisdiction under this chapter when the administrator determines that such a process is necessary. The administrator may enter into personal service contracts with individuals who are qualified because of their education and experience to act as facilitators in the panel's alternative dispute resolution process.

(2) The parties' use of the alternative dispute resolution process is voluntary, and requires the agreement of all necessary parties. The use of the alternative dispute resolution process does not alter the rights or obligations of the parties, nor does it delay the timelines set forth in sections 3967.10 and 3967.15 of the Revised Code.

(3) The administrator shall prepare reports every six months and submit those reports to the governor, the president of the senate, and the speaker of the house of representatives describing all of the following:

(a) The names of each facilitator employed under a personal service contract;

(b) The hourly amount of money and the total amount of money paid to each facilitator;

(c) The number of disputed issues resolved during that month by each facilitator;

(d) The number of decisions of each facilitator that were appealed by a party;

(e) A certification by the administrator that the alternative dispute resolution process did not delay any hearing timelines as set forth in sections 3967.10 and 3967.15 of the Revised Code for any disputed issue.

(4) The administrator may adopt rules in accordance with Chapter 119. of the Revised Code for the administration of any alternative dispute resolution process that the administrator establishes.

Sec. 3967.07. A reviewing health care provider or a medical injury compensation panel is not bound by the usual common law or statutory rules of evidence or by any technical or formal rules of procedure, other than as provided in this chapter and Chapter 3965. of the Revised Code. The provider or panel may make an investigation in such manner as in the provider's or panel's judgment is best calculated to ascertain the substantial rights of the parties and to carry out justly the spirit of those chapters.

Sec. 3967.10. A liability insurer of a provider listed in a claim filed under Chapter 3965. of the Revised Code or a claimant may appeal an order issued pursuant to section 3965.41 of the Revised Code within fourteen days after the date of the

receipt of the order. The liability insurer of the provider and the claimant may waive, in writing, their rights to an appeal under this section. The administrator of medical injury compensation shall select a medical injury compensation panel in accordance with section 3967.02 of the Revised Code within twenty-eight days after receiving the appeal request. Each notice of an appeal from an order issued under section 3965.41 of the Revised Code shall state the names of the claimant and the liability insurer of the provider listed in the claim, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals the order. Except as otherwise provided in section 3967.24 of the Revised Code, an appeal is timely filed under this section only if the appeal is filed within the time limits set forth in this section.

Sec. 3967.11. A medical injury compensation panel shall hold a hearing within forty-five days after the last member of the panel is selected in accordance with section 3967.02 of the Revised Code. The administrator of medical injury compensation, on behalf of the panel, shall notify the parties and their representatives of the time and place of the hearing. All of the following apply to a hearing before a medical injury compensation panel:

(A) The parties shall proceed promptly and without continuances except for good cause.

(B) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the administrator adopts under section 3967.06 of the Revised Code.

(C) A panel shall hear an appeal de novo and shall make a decision using the standard described in section 3965.41 of the

Revised Code.

Sec. 3967.12. The sessions of a medical injury compensation panel shall be open to the public and shall stand and be adjourned without further notice thereof on its record. All of the proceedings of a panel shall be shown on its record, which shall be a public record except as provided in section 3965.24 of the Revised Code. All voting shall be had by calling the name of each member of the panel by the administrator of medical injury compensation, and each member's vote shall be recorded on the record of proceedings as cast. The administrator shall keep a separate record of each panel's proceedings relative to claims coming before it for compensation for injured individuals and the dependents of deceased individuals. That record shall contain the panel's findings and the award in each such claim for compensation considered by the panel, and in all such claims the panel shall state in the record the reasons for the allowance or rejection of the claim.

Sec. 3967.13. A medical injury compensation panel appointed to hear an appeal filed under this chapter may commission independent medical experts as the panel determines necessary to determine the compensability of the claim that is appealed. The panel shall comply with section 3965.43 of the Revised Code with respect to any expert witness commissioned by the panel.

Sec. 3967.14. A claimant or the liability insurer of a provider listed in a claim filed under Chapter 3965. of the Revised Code, at a hearing before a medical injury compensation panel selected pursuant to this chapter, may each submit the following to the panel:

(A) A statement regarding the claim;

(B) An expert witness report.

Sec. 3967.15. A medical injury compensation panel shall issue an order containing a decision within seven days after the conclusion of the hearing held pursuant to sections 3967.10 to 3967.14 of the Revised Code. The panel shall notify the parties and their respective representatives in writing of the order. Except as otherwise provided in this chapter and Chapter 3965. of the Revised Code, any party may appeal an order issued under this section to the court pursuant to section 3967.20 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section.

No panel shall review or consider as evidence in a claim under this chapter or Chapter 3965. of the Revised Code a determination made by the health care professional standards board under section 4746.04 of the Revised Code that a provider's acts or omissions constitute gross negligence or that a provider engaged in a pattern of negligent behavior over a short period of time.

Sec. 3967.20. (A) A claimant or the liability insurer of a provider listed in a claim under Chapter 3965. of the Revised Code may appeal an order of the medical injury compensation panel made under section 3967.15 of the Revised Code in any injury case, other than a decision as to the extent of disability, to the court of common pleas of the county in which the injury was inflicted or in which the contract for services was made if the injury occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. The

appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order that the appellant is appealing. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

If an action has been commenced in a court of a county other than a court of a county having jurisdiction over the action, the court, upon notice by any party or upon its own motion, shall transfer the action to a court of a county having jurisdiction. Notwithstanding anything to the contrary in this section, if the panel determines under section 3967.24 of the Revised Code that a claimant, liability insurer, or their respective representatives have not received written notice of an order or decision that is appealable to a court under this section and if the panel determines under section 3967.24 of the Revised Code that the party is entitled to appeal, the party has sixty days from receipt of the order under section 3967.24 of the Revised Code to file a notice of appeal under this section.

(B) The notice of appeal shall state the names of the claimant and the liability insurer of the provider listed in the claim, the number of the claim, the date of the order appealed from, and the fact that the appellant appeals therefrom. The liability insurer of the provider listed in the claim and the claimant shall be parties to the appeal and the court, upon the application of the panel, shall make the panel a party. The party filing the appeal shall serve a copy of the notice of appeal on the administrator of medical injury compensation at the central office of the medical injury compensation center in Columbus.

(C) The attorney general or one or more of the attorney

general's assistants or special counsel designated by the attorney general shall represent the panel. In the event the attorney general or the attorney general's designated assistants or special counsel are absent, the administrator shall select one or more of the attorneys in the employ of the administrator as the panel's attorney in the appeal. Any attorney so employed shall continue the representation during the entire period of the appeal and in all hearings thereof except where the continued representation becomes impractical.

(D) Upon receipt of a notice of appeal, the clerk of courts shall provide notice to all parties who are appellees and to the panel. The appellant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language explaining why the claim is or is not a compensable claim and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician taken in accordance with the provisions of the Revised Code. That deposition may be read in the trial of the action even though the physician is a resident of or subject to service in the county in which the trial is held. The administrator shall pay the cost of the stenographic deposition filed in court and of copies of the stenographic deposition for each party and charge the costs thereof against the unsuccessful party if the claimant's right to having a compensable claim is finally sustained or established in the appeal. In the event the deposition is taken and filed, the

physician whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the compensability of the claim upon the evidence adduced at the hearing of the action.

(E) The court shall certify its decision to the panel and the certificate shall be entered in the records of the court. Appeals from the judgment are governed by the law applicable to the appeal of civil actions.

(F) If a liability insurer appeals an order of the panel and the claimant's claim is determined to be compensable upon the final determination of the appeal, the award shall not be reduced by the compensation modifier under division (C) of section 3965.60 of the Revised Code.

(G) If the finding of the court or the verdict of the jury is that the claim is compensable, the panel and the administrator shall thereafter proceed in the matter of the claim as if the judgment were the decision of the panel.

(H) An appeal from an order issued under section 3967.15 of the Revised Code or any action filed in court in a case in which an award of compensation has been made shall stay the payment of compensation under the award during the pendency of the appeal.

(I) All actions and proceedings under this section that are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, regardless of position on the calendar.

Sec. 3967.23. In the case of an appeal by a liability insurer of a provider listed in a claim filed under Chapter

3965. of the Revised Code to a medical injury compensation panel selected under section 3965.40 of the Revised Code or to a court of common pleas, if upon deciding the appeal the panel or the court finds that the liability insurer appealed for the purpose of delay or other vexatious reason and without reasonable ground, the panel or the court may assess against the liability insurer attorney's fees and a sum not exceeding ten per cent of the total amount of the award in question as may be reasonable in the circumstances.

Sec. 3967.24. A claimant, the liability insurer of a provider listed in a claim filed under Chapter 3965. of the Revised Code, and their respective representatives are entitled to written notice of any hearing, determination, order, award, or decision under this chapter. A claimant or insurer is considered not to have received notice until the notice is received from the panel or the administrator by both the claimant and the claimant's representative of record and by the insurer.

If any person to whom a notice is mailed fails to receive the notice and if the panel, upon hearing, determines that the failure was due to cause beyond the control and without the fault or neglect of the person or the person's representative and that the person or representative did not have actual knowledge of the import of the information contained in the notice, the person may take the action afforded to the person within twenty-one days after the receipt of the notice of the determination of the panel. Delivery of the notice to the address of the person or the person's representative is prima facie evidence of receipt of the notice by the person.

Sec. 3967.27. (A) The administrator of medical injury

compensation may adopt rules in accordance with Chapter 119. of the Revised Code to do both of the following:

(1) Provide for the destruction of files of cases in which no further action may be taken;

(2) Provide for the retention and destruction of all other records in the administrator's possession or under the administrator's control pursuant to section 121.211 and sections 149.34 to 149.36 of the Revised Code.

(B) The medical injury compensation center may purchase or rent required equipment for the document retention media, as determined necessary to preserve the records. Photographs, microphotographs, microfilm, films, or other direct document retention media, when properly identified, have the same effect as the original record and may be offered in like manner and may be received as evidence in proceedings before a medical injury compensation panel and in any court where the original record could have been introduced.

Sec. 3967.32. (A) In any claim regarding a medical, dental, optometric, chiropractic, or derivative claim, the liability insurer of a provider listed in the claim may introduce evidence of any amount payable as a benefit to the claimant as a result of the damages that result from an injury, death, or loss to person or property that is the subject of the claim, except if the source of collateral benefits has a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation.

(B) If the liability insurer elects to introduce evidence described in division (A) of this section, the claimant may

introduce evidence of any amount that the claimant has paid or contributed to secure the claimant's right to receive the benefits of which the liability insurer has introduced evidence.

(C) A source of collateral benefits of which evidence is introduced pursuant to division (A) of this section shall not recover any amount against the claimant nor shall it be subrogated to the rights of the claimant against the liability insurer of a provider.

Sec. 3967.40. No person, other than an attorney admitted to the practice of law in this state, who solicits claims or who causes claims to be solicited shall be allowed to practice, or represent parties, before a medical injury compensation panel. An attorney admitted to the practice of law in this state shall comply with the rules of professional conduct adopted by the supreme court.

Sec. 3967.42. (A) As used in this section:

(1) "False" means wholly or partially untrue or deceptive.

(2) "Goods" includes medical supplies, appliances, rehabilitative equipment, and any other apparatus or furnishing provided or used in the care, treatment, or rehabilitation of a claimant.

(3) "Services" includes any service provided by any health care provider to a claimant and any and all services provided by the center or a liability insurer as part of liability insurance coverage.

(4) "Remuneration" includes wages, commissions, rebates, and any other reward or consideration.

(5) "Statement" includes any oral, written, electronic,

electronic impulse, or magnetic communication notice, letter, memorandum, receipt for payment, invoice, account, financial statement, or bill for services; a diagnosis, prognosis, prescription, hospital, medical, or dental chart or other record; and a computer-generated document.

(6) "Records" means any medical, professional, financial, or business record relating to the treatment or care of any person, to goods or services provided to any person, or to rates paid for goods or services provided to any person, or any record that the administrator of medical injury compensation requires pursuant to rule.

(B) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do any of the following:

(1) Receive compensation under this chapter or Chapter 3965. of the Revised Code to which the person is not entitled;

(2) Make or present or cause to be made or presented a false or misleading statement with the purpose to secure payment for goods or services rendered under this chapter or Chapter 3965. of the Revised Code or to secure compensation under those chapters;

(3) Alter, falsify, destroy, conceal, or remove any record or document that is necessary to fully establish the validity of any claim filed with, or necessary to establish the nature and validity of all goods and services for which reimbursement or payment was received or is requested from, the medical injury compensation center or a liability insurer under this chapter or Chapter 3965. of the Revised Code;

(4) Enter into an agreement or conspiracy to defraud the center or insurer by making or presenting or causing to be made

or presented a false claim for compensation.

(C) Whoever violates this section is guilty of medical injury compensation fraud.

(D) Upon application of the governmental body that conducted the investigation and prosecution of a violation of this section, the court shall order the person who is convicted of the violation to pay the governmental body its costs of investigating and prosecuting the case. These costs are in addition to any other costs or penalty provided in the Revised Code or any other section of law.

(E) The remedies and penalties provided in this section are not exclusive remedies and penalties and do not preclude the use of any other criminal or civil remedy or penalty for any act that is in violation of this section.

Sec. 3967.99. Except as otherwise provided in this section, a violation of division (B) of section 3967.42 of the Revised Code is a misdemeanor of the first degree. If the value of the goods, services, property, or money stolen is one thousand dollars or more and is less than seven thousand five hundred dollars, the violation is a felony of the fifth degree. If the value of the goods, services, property, or money stolen is seven thousand five hundred dollars or more and is less than one hundred fifty thousand dollars, the violation is a felony of the fourth degree. If the value of the goods, services, property, or money stolen is one hundred fifty thousand dollars or more, the violation of that section is a felony of the third degree.

Sec. 4715.30. (A) An applicant for or holder of a certificate or license issued under this chapter is subject to

disciplinary action by the state dental board for any of the following reasons:

(1) Employing or cooperating in fraud or material deception in applying for or obtaining a license or certificate;

(2) Obtaining or attempting to obtain money or anything of value by intentional misrepresentation or material deception in the course of practice;

(3) Advertising services in a false or misleading manner or violating the state dental board's rules governing time, place, and manner of advertising;

(4) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(5) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(6) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for, any felony or of a misdemeanor committed in the course of practice;

(7) Engaging in lewd or immoral conduct in connection with the provision of dental services;

(8) Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes, or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for

intervention in lieu of conviction for, a violation of any federal or state law regulating the possession, distribution, or use of any drug;

(9) Providing or allowing dental hygienists, expanded function dental auxiliaries, or other practitioners of auxiliary dental occupations working under the certificate or license holder's supervision, or a dentist holding a temporary limited continuing education license under division (C) of section 4715.16 of the Revised Code working under the certificate or license holder's direct supervision, to provide dental care that departs from or fails to conform to accepted standards for the profession, whether or not injury to a patient results;

(10) Inability to practice under accepted standards of the profession because of physical or mental disability, dependence on alcohol or other drugs, or excessive use of alcohol or other drugs;

(11) Violation of any provision of this chapter or any rule adopted thereunder;

(12) Failure to use universal blood and body fluid precautions established by rules adopted under section 4715.03 of the Revised Code;

(13) Except as provided in division (H) of this section, either of the following:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers dental services, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that certificate or license

holder;

(b) Advertising that the certificate or license holder will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers dental services, would otherwise be required to pay.

(14) Failure to comply with section 4715.302 or 4729.79 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

(15) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

(16) Failure to cooperate in an investigation conducted by the state dental board under division (D) of section 4715.03 of the Revised Code or by the health care professional standards board under section 4746.04 of the Revised Code, including failure to comply with a subpoena or order issued by ~~the~~ either board or failure to answer truthfully a question presented by ~~the~~ either board at a deposition or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either

quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;

(17) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing to a minor a prescription for a controlled substance containing an opioid.

(B) A manager, proprietor, operator, or conductor of a dental facility shall be subject to disciplinary action if any dentist, dental hygienist, expanded function dental auxiliary, or qualified personnel providing services in the facility is found to have committed a violation listed in division (A) of this section and the manager, proprietor, operator, or conductor knew of the violation and permitted it to occur on a recurring basis.

(C) Subject to Chapter 119. of the Revised Code, the state dental board may take one or more of the following disciplinary actions if one or more of the grounds for discipline listed in divisions (A) and (B) of this section exist:

(1) Censure the license or certificate holder;

(2) Place the license or certificate on probationary status for such period of time the state dental board determines necessary and require the holder to:

(a) Report regularly to the state dental board upon the matters which are the basis of probation;

(b) Limit practice to those areas specified by the state dental board;

(c) Continue or renew professional education until a satisfactory degree of knowledge or clinical competency has been attained in specified areas.

(3) Suspend the certificate or license;

(4) Revoke the certificate or license.

Where the state dental board places a holder of a license or certificate on probationary status pursuant to division (C)(2) of this section, the board may subsequently suspend or revoke the license or certificate if it determines that the holder has not met the requirements of the probation or continues to engage in activities that constitute grounds for discipline pursuant to division (A) or (B) of this section.

Any order suspending a license or certificate shall state the conditions under which the license or certificate will be restored, which may include a conditional restoration during which time the holder is in a probationary status pursuant to division (C)(2) of this section. The state dental board shall restore the license or certificate unconditionally when such conditions are met.

(D) If the physical or mental condition of an applicant or a license or certificate holder is at issue in a disciplinary proceeding, the state dental board may order the license or certificate holder to submit to reasonable examinations by an individual designated or approved by the board and at the board's expense. The physical examination may be conducted by any individual authorized by the Revised Code to do so, including a physician assistant, a clinical nurse specialist, a certified nurse practitioner, or a certified nurse-midwife. Any written documentation of the physical examination shall be completed by the individual who conducted the examination.

Failure to comply with an order for an examination shall be grounds for refusal of a license or certificate or summary

suspension of a license or certificate under division (E) of this section.

(E) If a license or certificate holder has failed to comply with an order under division (D) of this section, the state dental board may apply to the court of common pleas of the county in which the holder resides for an order temporarily suspending the holder's license or certificate, without a prior hearing being afforded by the board, until the board conducts an adjudication hearing pursuant to Chapter 119. of the Revised Code. If the court temporarily suspends a holder's license or certificate, the board shall give written notice of the suspension personally or by certified mail to the license or certificate holder. Such notice shall inform the license or certificate holder of the right to a hearing pursuant to Chapter 119. of the Revised Code.

(F) Any holder of a certificate or license issued under this chapter who has pleaded guilty to, has been convicted of, or has had a judicial finding of eligibility for intervention in lieu of conviction entered against the holder in this state for aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary, or who has pleaded guilty to, has been convicted of, or has had a judicial finding of eligibility for treatment or intervention in lieu of conviction entered against the holder in another jurisdiction for any substantially equivalent criminal offense, is automatically suspended from practice under this chapter in this state and any certificate or license issued to the holder under this chapter is automatically suspended, as of the date of the guilty plea, conviction, or judicial finding, whether the proceedings are brought in this state or another

jurisdiction. Continued practice by an individual after the suspension of the individual's certificate or license under this division shall be considered practicing without a certificate or license. The state dental board shall notify the suspended individual of the suspension of the individual's certificate or license under this division by certified mail or in person in accordance with section 119.07 of the Revised Code. If an individual whose certificate or license is suspended under this division fails to make a timely request for an adjudicatory hearing, the board shall enter a final order revoking the individual's certificate or license.

(G) If the supervisory investigative panel determines both of the following, the panel may recommend that the state dental board suspend an individual's certificate or license without a prior hearing:

(1) That there is clear and convincing evidence that an individual has violated division (A) of this section;

(2) That the individual's continued practice presents a danger of immediate and serious harm to the public.

Written allegations shall be prepared for consideration by the state dental board. The board, upon review of those allegations and by an affirmative vote of not fewer than four dentist members of the board and seven of its members in total, excluding any member on the supervisory investigative panel, may suspend a certificate or license without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension.

The state dental board shall issue a written order of suspension by certified mail or in person in accordance with

section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during pendency or any appeal filed under section 119.12 of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual.

Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The state dental board shall issue its final adjudicative order within seventy-five days after completion of its hearing. A failure to issue the order within seventy-five days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order.

(H) Sanctions shall not be imposed under division (A)(13) of this section against any certificate or license holder who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the state dental board upon request.

(2) For professional services rendered to any other person who holds a certificate or license issued pursuant to this chapter to the extent allowed by this chapter and the rules of the board.

(I) In no event shall the board consider or raise during a hearing required by Chapter 119. of the Revised Code the circumstances of, or the fact that the state dental board has received, one or more complaints about a person unless the one or more complaints are the subject of the hearing or resulted in the board taking an action authorized by this section against the person on a prior occasion.

(J) The state dental board may share any information it receives pursuant to an investigation under division (D) of section 4715.03 of the Revised Code, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state dental board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state dental board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

(K) If an individual who holds a certificate or license

issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state dental board shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state dental board shall take any disciplinary action required by the health care professional standards board against a certificate or license holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate or license holder, the state dental board shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state dental board may account for that disciplinary action in any future disciplinary action taken against the certificate or license holder.

Sec. 4723.28. (A) The board of nursing, by a vote of a quorum, may impose one or more of the following sanctions if it finds that a person committed fraud in passing an examination required to obtain a license, certificate of authority, or dialysis technician certificate issued by the board or to have committed fraud, misrepresentation, or deception in applying for or securing any nursing license, certificate of authority, or dialysis technician certificate issued by the board: deny, revoke, suspend, or place restrictions on any nursing license, certificate of authority, or dialysis technician certificate issued by the board; reprimand or otherwise discipline a holder of a nursing license, certificate of authority, or dialysis

technician certificate; or impose a fine of not more than five hundred dollars per violation.

(B) The board of nursing, by a vote of a quorum, may impose one or more of the following sanctions: deny, revoke, suspend, or place restrictions on any nursing license, certificate of authority, or dialysis technician certificate issued by the board; reprimand or otherwise discipline a holder of a nursing license, certificate of authority, or dialysis technician certificate; or impose a fine of not more than five hundred dollars per violation. The sanctions may be imposed for any of the following:

(1) Denial, revocation, suspension, or restriction of authority to engage in a licensed profession or practice a health care occupation, including nursing or practice as a dialysis technician, for any reason other than a failure to renew, in Ohio or another state or jurisdiction;

(2) Engaging in the practice of nursing or engaging in practice as a dialysis technician, having failed to renew a nursing license or dialysis technician certificate issued under this chapter, or while a nursing license or dialysis technician certificate is under suspension;

(3) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(4) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea

of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, any felony or of any crime involving gross immorality or moral turpitude;

(5) Selling, giving away, or administering drugs or therapeutic devices for other than legal and legitimate therapeutic purposes; or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, violating any municipal, state, county, or federal drug law;

(6) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in another jurisdiction that would constitute a felony or a crime of moral turpitude in Ohio;

(7) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in the course of practice in another jurisdiction that would constitute a misdemeanor in Ohio;

(8) Self-administering or otherwise taking into the body any dangerous drug, as defined in section 4729.01 of the Revised Code, in any way that is not in accordance with a legal, valid prescription issued for that individual, or self-administering or otherwise taking into the body any drug that is a schedule I

controlled substance;

(9) Habitual or excessive use of controlled substances, other habit-forming drugs, or alcohol or other chemical substances to an extent that impairs the individual's ability to provide safe nursing care or safe dialysis care;

(10) Impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care or safe dialysis care because of the use of drugs, alcohol, or other chemical substances;

(11) Impairment of the ability to practice according to acceptable and prevailing standards of safe nursing care or safe dialysis care because of a physical or mental disability;

(12) Assaulting or causing harm to a patient or depriving a patient of the means to summon assistance;

(13) Misappropriation or attempted misappropriation of money or anything of value in the course of practice;

(14) Adjudication by a probate court of being mentally ill or mentally incompetent. The board may reinstate the person's nursing license or dialysis technician certificate upon adjudication by a probate court of the person's restoration to competency or upon submission to the board of other proof of competency.

(15) The suspension or termination of employment by the department of defense or the veterans administration of the United States for any act that violates or would violate this chapter;

(16) Violation of this chapter or any rules adopted under it;

(17) Violation of any restrictions placed by the board on a nursing license or dialysis technician certificate;

(18) Failure to use universal and standard precautions established by rules adopted under section 4723.07 of the Revised Code;

(19) Failure to practice in accordance with acceptable and prevailing standards of safe nursing care or safe dialysis care;

(20) In the case of a registered nurse, engaging in activities that exceed the practice of nursing as a registered nurse;

(21) In the case of a licensed practical nurse, engaging in activities that exceed the practice of nursing as a licensed practical nurse;

(22) In the case of a dialysis technician, engaging in activities that exceed those permitted under section 4723.72 of the Revised Code;

(23) Aiding and abetting a person in that person's practice of nursing without a license or practice as a dialysis technician without a certificate issued under this chapter;

(24) In the case of a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, except as provided in division (M) of this section, either of the following:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers such nursing services, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to

receive health care services from that provider;

(b) Advertising that the nurse will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers such nursing services, would otherwise be required to pay.

(25) Failure to comply with the terms and conditions of participation in the chemical dependency monitoring program established under section 4723.35 of the Revised Code;

(26) Failure to comply with the terms and conditions required under the practice intervention and improvement program established under section 4723.282 of the Revised Code;

(27) In the case of a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner:

(a) Engaging in activities that exceed those permitted for the nurse's nursing specialty under section 4723.43 of the Revised Code;

(b) Failure to meet the quality assurance standards established under section 4723.07 of the Revised Code.

(28) In the case of a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, failure to maintain a standard care arrangement in accordance with section 4723.431 of the Revised Code or to practice in accordance with the standard care arrangement;

(29) In the case of a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner who holds a certificate to prescribe issued under section 4723.48 of the

Revised Code, failure to prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code;

(30) Prescribing any drug or device to perform or induce an abortion, or otherwise performing or inducing an abortion;

(31) Failure to establish and maintain professional boundaries with a patient, as specified in rules adopted under section 4723.07 of the Revised Code;

(32) Regardless of whether the contact or verbal behavior is consensual, engaging with a patient other than the spouse of the registered nurse, licensed practical nurse, or dialysis technician in any of the following:

(a) Sexual contact, as defined in section 2907.01 of the Revised Code;

(b) Verbal behavior that is sexually demeaning to the patient or may be reasonably interpreted by the patient as sexually demeaning.

(33) Assisting suicide as defined in section 3795.01 of the Revised Code;

(34) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing to a minor a prescription for a controlled substance containing an opioid~~.~~;

~~(34)~~ (35) Failure to comply with section 4723.487 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code.

(C) Disciplinary actions taken by the board of nursing under divisions (A) and (B) of this section shall be taken pursuant to an adjudication conducted under Chapter 119. of the

Revised Code, except that in lieu of a hearing, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by a vote of a quorum, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the agreement shall be of no effect.

(D) The hearings of the board of nursing shall be conducted in accordance with Chapter 119. of the Revised Code, the board may appoint a hearing examiner, as provided in section 119.09 of the Revised Code, to conduct any hearing the board is authorized to hold under Chapter 119. of the Revised Code.

In any instance in which the board of nursing is required under Chapter 119. of the Revised Code to give notice of an opportunity for a hearing and the applicant, licensee, or certificate holder does not make a timely request for a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by a vote of a quorum, a final order that contains the board's findings. In the final order, the board may order any of the sanctions listed in division (A) or (B) of this section.

(E) If a criminal action is brought against a registered nurse, licensed practical nurse, or dialysis technician for an act or crime described in divisions (B)(3) to (7) of this section and the action is dismissed by the trial court other than on the merits, the board of nursing shall conduct an adjudication to determine whether the registered nurse, licensed practical nurse, or dialysis technician committed the act on which the action was based. If the board determines on the basis

of the adjudication that the registered nurse, licensed practical nurse, or dialysis technician committed the act, or if the registered nurse, licensed practical nurse, or dialysis technician fails to participate in the adjudication, the board may take action as though the registered nurse, licensed practical nurse, or dialysis technician had been convicted of the act.

If the board of nursing takes action on the basis of a conviction, plea, or a judicial finding as described in divisions (B)(3) to (7) of this section that is overturned on appeal, the registered nurse, licensed practical nurse, or dialysis technician may, on exhaustion of the appeal process, petition the board for reconsideration of its action. On receipt of the petition and supporting court documents, the board shall temporarily rescind its action. If the board determines that the decision on appeal was a decision on the merits, it shall permanently rescind its action. If the board determines that the decision on appeal was not a decision on the merits, it shall conduct an adjudication to determine whether the registered nurse, licensed practical nurse, or dialysis technician committed the act on which the original conviction, plea, or judicial finding was based. If the board determines on the basis of the adjudication that the registered nurse, licensed practical nurse, or dialysis technician committed such act, or if the registered nurse, licensed practical nurse, or dialysis technician does not request an adjudication, the board shall reinstate its action; otherwise, the board shall permanently rescind its action.

Notwithstanding the provision of division (C)(2) of section 2953.32 of the Revised Code specifying that if records pertaining to a criminal case are sealed under that section the

proceedings in the case shall be deemed not to have occurred, sealing of the following records on which the board of nursing has based an action under this section shall have no effect on the board's action or any sanction imposed by the board under this section: records of any conviction, guilty plea, judicial finding of guilt resulting from a plea of no contest, or a judicial finding of eligibility for a pretrial diversion program or intervention in lieu of conviction.

The board of nursing shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F) The board of nursing may investigate an individual's criminal background in performing its duties under this section. As part of such investigation, the board may order the individual to submit, at the individual's expense, a request to the bureau of criminal identification and investigation for a criminal records check and check of federal bureau of investigation records in accordance with the procedure described in section 4723.091 of the Revised Code.

(G) During the course of an investigation conducted under this section, the board of nursing may compel any registered nurse, licensed practical nurse, or dialysis technician or applicant under this chapter to submit to a mental or physical examination, or both, as required by the board and at the expense of the individual, if the board finds reason to believe that the individual under investigation may have a physical or mental impairment that may affect the individual's ability to provide safe nursing care. Failure of any individual to submit to a mental or physical examination when directed constitutes an admission of the allegations, unless the failure is due to

circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence.

If the board of nursing finds that an individual is impaired, the board shall require the individual to submit to care, counseling, or treatment approved or designated by the board, as a condition for initial, continued, reinstated, or renewed authority to practice. The individual shall be afforded an opportunity to demonstrate to the board that the individual can begin or resume the individual's occupation in compliance with acceptable and prevailing standards of care under the provisions of the individual's authority to practice.

For purposes of this division, any registered nurse, licensed practical nurse, or dialysis technician or applicant under this chapter shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board of nursing, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(H) The board of nursing shall investigate evidence that appears to show that any person has violated any provision of this chapter or any rule of the board. Any person may report to the board any information the person may have that appears to show a violation of any provision of this chapter or rule of the board. In the absence of bad faith, any person who reports such information or who testifies before the board in any adjudication conducted under Chapter 119. of the Revised Code shall not be liable for civil damages as a result of the report or testimony.

(I) All of the following apply under this chapter with

respect to the confidentiality of information:

(1) Information received by the board of nursing pursuant to a complaint or an investigation is confidential and not subject to discovery in any civil action, except that the board may disclose information to law enforcement officers and government entities for purposes of an investigation of either a licensed health care professional, including a registered nurse, licensed practical nurse, or dialysis technician, or a person who may have engaged in the unauthorized practice of nursing or dialysis care. No law enforcement officer or government entity with knowledge of any information disclosed by the board pursuant to this division shall divulge the information to any other person or government entity except for the purpose of a government investigation, a prosecution, or an adjudication by a court or government entity.

(2) If an investigation requires a review of patient records, the investigation and proceeding shall be conducted in such a manner as to protect patient confidentiality.

(3) All adjudications and investigations of the board of nursing shall be considered civil actions for the purposes of section 2305.252 of the Revised Code.

(4) Any board activity that involves continued monitoring of an individual as part of or following any disciplinary action taken under this section shall be conducted in a manner that maintains the individual's confidentiality. Information received or maintained by the board of nursing with respect to the board's monitoring activities is not subject to discovery in any civil action and is confidential, except that the board may disclose information to law enforcement officers and government entities for purposes of an investigation of a licensee or

certificate holder.

(J) Any action taken by the board of nursing under this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the person may be reinstated to practice.

(K) When the board of nursing refuses to grant a license or certificate to an applicant, revokes a license or certificate, or refuses to reinstate a license or certificate, the board may specify that its action is permanent. An individual subject to permanent action taken by the board is forever ineligible to hold a license or certificate of the type that was refused or revoked and the board shall not accept from the individual an application for reinstatement of the license or certificate or for a new license or certificate.

(L) No unilateral surrender of a nursing license, certificate of authority, or dialysis technician certificate issued under this chapter shall be effective unless accepted by majority vote of the board of nursing. No application for a nursing license, certificate of authority, or dialysis technician certificate issued under this chapter may be withdrawn without a majority vote of the board. The board's jurisdiction to take disciplinary action under this section is not removed or limited when an individual has a license or certificate classified as inactive or fails to renew a license or certificate.

(M) Sanctions shall not be imposed under division (B)(24) of this section against any licensee who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that

expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request.

(2) For professional services rendered to any other person licensed pursuant to this chapter to the extent allowed by this chapter and the rules of the board of nursing.

(N) If an individual who is registered or holds a certificate or license issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the board of nursing shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The board of nursing shall take any disciplinary action required by the health care professional standards board against a registrant or certificate or license holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a registrant or certificate or license holder, the board of nursing shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the board of nursing may account for that disciplinary action in any future disciplinary action taken against the registrant or certificate or license holder.

Sec. 4723.341. (A) As used in this section, "person" has

the same meaning as in section 1.59 of the Revised Code and also includes the board of nursing and its members and employees; health care facilities, associations, and societies; insurers; and individuals.

(B) In the absence of fraud or bad faith, no person reporting to the board of nursing or the health care professional standards board or testifying in an adjudication conducted under Chapter 119. of the Revised Code with regard to alleged incidents of negligence or malpractice or matters subject to this chapter or sections 3123.41 to 3123.50 of the Revised Code and any applicable rules adopted under section 3123.63 of the Revised Code shall be subject to either of the following based on making the report or testifying:

(1) Liability in damages in a civil action for injury, death, or loss to person or property;

(2) Discipline or dismissal by an employer.

(C) An individual who is disciplined or dismissed in violation of division (B)(2) of this section has the same rights and duties accorded an employee under sections 4113.52 and 4113.53 of the Revised Code.

(D) In the absence of fraud or bad faith, no professional association of registered nurses, licensed practical nurses, dialysis technicians, community health workers, or medication aides that sponsors a committee or program to provide peer assistance to individuals with substance abuse problems, no representative or agent of such a committee or program, and no member of the board of nursing shall be liable to any person for damages in a civil action by reason of actions taken to refer a nurse, dialysis technician, community health worker, or

medication aide to a treatment provider or actions or omissions of the provider in treating a nurse, dialysis technician, community health worker, or medication aide.

Sec. 4725.19. (A) In accordance with Chapter 119. of the Revised Code and by an affirmative vote of a majority of its members, the state board of optometry, for any of the reasons specified in division (B) of this section, shall refuse to grant a certificate of licensure to an applicant and may, with respect to a licensed optometrist, do one or more of the following:

(1) Suspend the operation of any certificate of licensure, topical ocular pharmaceutical agents certificate, or therapeutic pharmaceutical agents certificate, or all certificates granted by it to the optometrist;

(2) Permanently revoke any or all of the certificates;

(3) Limit or otherwise place restrictions on any or all of the certificates;

(4) Reprimand the optometrist;

(5) Impose a monetary penalty. If the reason for which the state board of optometry is imposing the penalty involves a criminal offense that carries a fine under the Revised Code, the penalty shall not exceed the maximum fine that may be imposed for the criminal offense. In any other case, the penalty imposed by the board shall not exceed five hundred dollars.

(6) Require the optometrist to take corrective action courses.

The amount and content of corrective action courses shall be established by the state board of optometry in rules adopted under section 4725.09 of the Revised Code.

(B) The sanctions specified in division (A) of this section may be taken by the state board of optometry for any of the following reasons:

(1) Committing fraud in passing the licensing examination or making false or purposely misleading statements in an application for a certificate of licensure;

(2) Being at any time guilty of immorality, regardless of the jurisdiction in which the act was committed;

(3) Being guilty of dishonesty or unprofessional conduct in the practice of optometry;

(4) Being at any time guilty of a felony, regardless of the jurisdiction in which the act was committed;

(5) Being at any time guilty of a misdemeanor committed in the course of practice, regardless of the jurisdiction in which the act was committed;

(6) Violating the conditions of any limitation or other restriction placed by the state board of optometry on any certificate issued by the board;

(7) Engaging in the practice of optometry as provided in division (A)(1), (2), or (3) of section 4725.01 of the Revised Code when the certificate authorizing that practice is under suspension, in which case the state board of optometry shall permanently revoke the certificate;

(8) Being denied a license to practice optometry in another state or country or being subject to any other sanction by the optometric licensing authority of another state or country, other than sanctions imposed for the nonpayment of fees;

(9) Departing from or failing to conform to acceptable and prevailing standards of care in the practice of optometry as followed by similar practitioners under the same or similar circumstances, regardless of whether actual injury to a patient is established;

(10) Failing to maintain comprehensive patient records;

(11) Advertising a price of optical accessories, eye examinations, or other products or services by any means that would deceive or mislead the public;

(12) Being addicted to the use of alcohol, stimulants, narcotics, or any other substance which impairs the intellect and judgment to such an extent as to hinder or diminish the performance of the duties included in the person's practice of optometry;

(13) Engaging in the practice of optometry as provided in division (A)(2) or (3) of section 4725.01 of the Revised Code without authority to do so or, if authorized, in a manner inconsistent with the authority granted;

(14) Failing to make a report to the state board of optometry as required by division (A) of section 4725.21 or section 4725.31 of the Revised Code;

(15) Soliciting patients from door to door or establishing temporary offices, in which case the state board of optometry shall suspend all certificates held by the optometrist;

(16) Failing to comply with section 4725.092 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

(17) Except as provided in division (D) of this section:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers optometric services, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that optometrist.

(b) Advertising that the optometrist will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers optometric services, would otherwise be required to pay.

~~(17)~~ (18) Failing to comply with the requirements in section 3719.061 of the Revised Code before issuing to a minor a prescription for a controlled substance containing an opioid.

(C) Any person who is the holder of a certificate of licensure, or who is an applicant for a certificate of licensure against whom is preferred any charges, shall be furnished by the state board of optometry with a copy of the complaint and shall have a hearing before the board in accordance with Chapter 119. of the Revised Code.

(D) Sanctions shall not be imposed under division (B)(17) of this section against any optometrist who waives deductibles and copayments:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made

available to the board upon request.

(2) For professional services rendered to any other optometrist licensed by the board, to the extent allowed by sections 4725.01 to 4725.34 of the Revised Code and the rules of the state board of optometry.

(E) If an individual who holds a certificate of licensure issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state board of optometry shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state board of optometry shall take any disciplinary action required by the health care professional standards board against a certificate holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate holder, the state board of optometry shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state board of optometry may account for that disciplinary action in any future disciplinary action taken against the certificate holder.

Sec. 4729.16. (A) The state board of pharmacy, after notice and hearing in accordance with Chapter 119. of the Revised Code, may revoke, suspend, limit, place on probation, or refuse to grant or renew an identification card, or may impose a monetary penalty or forfeiture not to exceed in severity any

fine designated under the Revised Code for a similar offense, or in the case of a violation of a section of the Revised Code that does not bear a penalty, a monetary penalty or forfeiture of not more than five hundred dollars, if the board finds a pharmacist or pharmacy intern:

(1) Guilty of a felony or gross immorality;

(2) Guilty of dishonesty or unprofessional conduct in the practice of pharmacy;

(3) Addicted to or abusing liquor or drugs or impaired physically or mentally to such a degree as to render the pharmacist or pharmacy intern unfit to practice pharmacy;

(4) Has been convicted of a misdemeanor related to, or committed in, the practice of pharmacy;

(5) Guilty of willfully violating, conspiring to violate, attempting to violate, or aiding and abetting the violation of any of the provisions of this chapter, sections 3715.52 to 3715.72 of the Revised Code, Chapter 2925. or 3719. of the Revised Code, or any rule adopted by the state board of pharmacy under those provisions;

(6) Guilty of permitting anyone other than a pharmacist or pharmacy intern to practice pharmacy;

(7) Guilty of knowingly lending the pharmacist's or pharmacy intern's name to an illegal practitioner of pharmacy or having professional connection with an illegal practitioner of pharmacy;

(8) Guilty of dividing or agreeing to divide remuneration made in the practice of pharmacy with any other individual, including, but not limited to, any licensed health professional

authorized to prescribe drugs or any owner, manager, or employee of a health care facility, residential care facility, or nursing home;

(9) Has violated the terms of a consult agreement entered into pursuant to section 4729.39 of the Revised Code;

(10) Has committed fraud, misrepresentation, or deception in applying for or securing a license or identification card issued by the board under this chapter or under Chapter 3715. or 3719. of the Revised Code.

(B) Any individual whose identification card is revoked, suspended, or refused, shall return the identification card and license to the offices of the state board of pharmacy within ten days after receipt of notice of such action.

(C) As used in this section:

"Unprofessional conduct in the practice of pharmacy" includes any of the following:

(1) Advertising or displaying signs that promote dangerous drugs to the public in a manner that is false or misleading;

(2) Except as provided in section 4729.281 of the Revised Code, the sale of any drug for which a prescription is required, without having received a prescription for the drug;

(3) Knowingly dispensing medication pursuant to false or forged prescriptions;

(4) Knowingly failing to maintain complete and accurate records of all dangerous drugs received or dispensed in compliance with federal laws and regulations and state laws and rules;

(5) Obtaining any remuneration by fraud, misrepresentation, or deception.

(D) The state board of pharmacy may suspend a license or identification card under division (B) of section 3719.121 of the Revised Code by utilizing a telephone conference call to review the allegations and take a vote.

(E) If, pursuant to an adjudication under Chapter 119. of the Revised Code, the state board of pharmacy has reasonable cause to believe that a pharmacist or pharmacy intern is physically or mentally impaired, the board may require the pharmacist or pharmacy intern to submit to a physical or mental examination, or both.

(F) If an individual who is licensed under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state board of pharmacy shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state board of pharmacy shall take any disciplinary action required by the health care professional standards board against a license holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a license holder, the state board of pharmacy shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state board of pharmacy may account for that

disciplinary action in any future disciplinary action taken against the license holder.

Sec. 4730.25. (A) The state medical board, by an affirmative vote of not fewer than six members, may revoke or may refuse to grant a certificate to practice as a physician assistant or a certificate to prescribe to a person found by the board to have committed fraud, misrepresentation, or deception in applying for or securing the certificate.

(B) The state medical board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice as a physician assistant or certificate to prescribe, refuse to issue a certificate to an applicant, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate for any of the following reasons:

(1) Failure to practice in accordance with the conditions under which the supervising physician's supervision agreement with the physician assistant was approved, including the requirement that when practicing under a particular supervising physician, the physician assistant must practice only according to the physician supervisory plan the board approved for that physician or the policies of the health care facility in which the supervising physician and physician assistant are practicing;

(2) Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the state medical board;

(3) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or

conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the state medical board;

(4) Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including physical deterioration that adversely affects cognitive, motor, or perceptive skills;

(5) Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice;

(6) Administering drugs for purposes other than those authorized under this chapter;

(7) Willfully betraying a professional confidence;

(8) Making a false, fraudulent, deceptive, or misleading statement in soliciting or advertising for employment as a physician assistant; in connection with any solicitation or advertisement for patients; in relation to the practice of medicine as it pertains to physician assistants; or in securing or attempting to secure a certificate to practice as a physician assistant, a certificate to prescribe, or approval of a supervision agreement.

As used in this division, "false, fraudulent, deceptive, or misleading statement" means a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent

person to misunderstand or be deceived.

(9) Representing, with the purpose of obtaining compensation or other advantage personally or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured;

(10) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(11) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony;

(12) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(13) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(14) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude;

(15) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(16) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(17) A plea of guilty to, a judicial finding of guilt of,

or a judicial finding of eligibility for intervention in lieu of conviction for violating any state or federal law regulating the possession, distribution, or use of any drug, including trafficking in drugs;

(18) Any of the following actions taken by the state agency responsible for regulating the practice of physician assistants in another state, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

(19) A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established;

(20) Violation of the conditions placed by the state medical board on a certificate to practice as a physician assistant, a certificate to prescribe, a physician supervisory plan, or supervision agreement;

(21) Failure to use universal blood and body fluid precautions established by rules adopted under section 4731.051 of the Revised Code;

(22) Failure to cooperate in an investigation conducted by the board under section 4730.26 of the Revised Code, including failure to comply with a subpoena or order issued by the state medical board or the health care professional standards board or failure to answer truthfully a question presented by ~~the~~ either board at a deposition or in written interrogatories, except that

failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;

(23) Assisting suicide as defined in section 3795.01 of the Revised Code;

(24) Prescribing any drug or device to perform or induce an abortion, or otherwise performing or inducing an abortion;

(25) Failure to comply with section 4730.53 of the Revised Code, unless the board no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

~~(25)~~(26) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing to a minor a prescription for a controlled substance containing an opioid.

(C) Disciplinary actions taken by the state medical board under divisions (A) and (B) of this section shall be taken pursuant to an adjudication under Chapter 119. of the Revised Code, except that in lieu of an adjudication, the board may enter into a consent agreement with a physician assistant or applicant to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by an affirmative vote of not fewer than six members of the board, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the consent agreement shall be of no force or effect.

(D) For purposes of divisions (B)(12), (15), and (16) of

this section, the commission of the act may be established by a finding by the state medical board, pursuant to an adjudication under Chapter 119. of the Revised Code, that the applicant or certificate holder committed the act in question. The board shall have no jurisdiction under these divisions in cases where the trial court renders a final judgment in the certificate holder's favor and that judgment is based upon an adjudication on the merits. The board shall have jurisdiction under these divisions in cases where the trial court issues an order of dismissal upon technical or procedural grounds.

(E) The sealing of conviction records by any court shall have no effect upon a prior state medical board order entered under the provisions of this section or upon the board's jurisdiction to take action under the provisions of this section if, based upon a plea of guilty, a judicial finding of guilt, or a judicial finding of eligibility for intervention in lieu of conviction, the board issued a notice of opportunity for a hearing prior to the court's order to seal the records. The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F) For purposes of this division, any individual who holds a certificate issued under this chapter, or applies for a certificate issued under this chapter, shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the state medical board and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(1) In enforcing division (B)(4) of this section, the state medical board, upon a showing of a possible violation, may

compel any individual who holds a certificate issued under this chapter or who has applied for a certificate pursuant to this chapter to submit to a mental examination, physical examination, including an HIV test, or both a mental and physical examination. The expense of the examination is the responsibility of the individual compelled to be examined. Failure to submit to a mental or physical examination or consent to an HIV test ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board finds a physician assistant unable to practice because of the reasons set forth in division (B)(4) of this section, the board shall require the physician assistant to submit to care, counseling, or treatment by physicians approved or designated by the board, as a condition for an initial, continued, reinstated, or renewed certificate. An individual affected under this division shall be afforded an opportunity to demonstrate to the board the ability to resume practicing in compliance with acceptable and prevailing standards of care.

(2) For purposes of division (B)(5) of this section, if the state medical board has reason to believe that any individual who holds a certificate issued under this chapter or any applicant for a certificate suffers such impairment, the board may compel the individual to submit to a mental or physical examination, or both. The expense of the examination is the responsibility of the individual compelled to be examined. Any mental or physical examination required under this division shall be undertaken by a treatment provider or physician qualified to conduct such examination and chosen by the board.

Failure to submit to a mental or physical examination ordered by the state medical board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board determines that the individual's ability to practice is impaired, the board shall suspend the individual's certificate or deny the individual's application and shall require the individual, as a condition for initial, continued, reinstated, or renewed certification to practice or prescribe, to submit to treatment.

Before being eligible to apply for reinstatement of a certificate suspended under this division, the physician assistant shall demonstrate to the state medical board the ability to resume practice or prescribing in compliance with acceptable and prevailing standards of care. The demonstration shall include the following:

(a) Certification from a treatment provider approved under section 4731.25 of the Revised Code that the individual has successfully completed any required inpatient treatment;

(b) Evidence of continuing full compliance with an aftercare contract or consent agreement;

(c) Two written reports indicating that the individual's ability to practice has been assessed and that the individual has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by individuals or providers approved by the board for making such assessments and shall describe the basis for their determination.

The state medical board may reinstate a certificate suspended under this division after such demonstration and after the individual has entered into a written consent agreement.

When the impaired physician assistant resumes practice or prescribing, the state medical board shall require continued monitoring of the physician assistant. The monitoring shall include compliance with the written consent agreement entered into before reinstatement or with conditions imposed by board order after a hearing, and, upon termination of the consent agreement, submission to the board for at least two years of annual written progress reports made under penalty of falsification stating whether the physician assistant has maintained sobriety.

(G) If the secretary and supervising member determine that there is clear and convincing evidence that a physician assistant has violated division (B) of this section and that the individual's continued practice or prescribing presents a danger of immediate and serious harm to the public, they may recommend that the state medical board suspend the individual's certificate to practice or prescribe without a prior hearing. Written allegations shall be prepared for consideration by the board.

The state medical board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a certificate without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension.

The state medical board shall issue a written order of suspension by certified mail or in person in accordance with

section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during pendency of any appeal filed under section 119.12 of the Revised Code. If the physician assistant requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the physician assistant requests the hearing, unless otherwise agreed to by both the board and the certificate holder.

A summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the state medical board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudicative order within sixty days after completion of its hearing. Failure to issue the order within sixty days shall result in dissolution of the summary suspension order, but shall not invalidate any subsequent, final adjudicative order.

(H) If the state medical board takes action under division (B)(11), (13), or (14) of this section, and the judicial finding of guilt, guilty plea, or judicial finding of eligibility for intervention in lieu of conviction is overturned on appeal, upon exhaustion of the criminal appeal, a petition for reconsideration of the order may be filed with the board along with appropriate court documents. Upon receipt of a petition and supporting court documents, the board shall reinstate the certificate to practice or prescribe. The board may then hold an adjudication under Chapter 119. of the Revised Code to determine whether the individual committed the act in question. Notice of opportunity for hearing shall be given in accordance with Chapter 119. of the Revised Code. If the board finds, pursuant to an adjudication held under this division, that the individual

committed the act, or if no hearing is requested, it may order any of the sanctions identified under division (B) of this section.

(I) The certificate to practice issued to a physician assistant and the physician assistant's practice in this state are automatically suspended as of the date the physician assistant pleads guilty to, is found by a judge or jury to be guilty of, or is subject to a judicial finding of eligibility for intervention in lieu of conviction in this state or treatment or intervention in lieu of conviction in another state for any of the following criminal offenses in this state or a substantially equivalent criminal offense in another jurisdiction: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary. Continued practice after the suspension shall be considered practicing without a certificate.

The state medical board shall notify the individual subject to the suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. If an individual whose certificate is suspended under this division fails to make a timely request for an adjudication under Chapter 119. of the Revised Code, the board shall enter a final order permanently revoking the individual's certificate to practice.

(J) In any instance in which the state medical board is required by Chapter 119. of the Revised Code to give notice of opportunity for hearing and the individual subject to the notice does not timely request a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by an affirmative vote of not fewer than

six of its members, a final order that contains the board's findings. In that final order, the board may order any of the sanctions identified under division (A) or (B) of this section.

(K) Any action taken by the state medical board under division (B) of this section resulting in a suspension shall be accompanied by a written statement of the conditions under which the physician assistant's certificate may be reinstated. The board shall adopt rules in accordance with Chapter 119. of the Revised Code governing conditions to be imposed for reinstatement. Reinstatement of a certificate suspended pursuant to division (B) of this section requires an affirmative vote of not fewer than six members of the board.

(L) When the state medical board refuses to grant to an applicant a certificate to practice as a physician assistant or a certificate to prescribe, revokes an individual's certificate, refuses to issue a certificate, or refuses to reinstate an individual's certificate, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold the certificate and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.

(M) Notwithstanding any other provision of the Revised Code, all of the following apply:

(1) The surrender of a certificate issued under this chapter is not effective unless or until accepted by the state medical board. Reinstatement of a certificate surrendered to the board requires an affirmative vote of not fewer than six members of the board.

(2) An application made under this chapter for a certificate, approval of a physician supervisory plan, or approval of a supervision agreement may not be withdrawn without approval of the state medical board.

(3) Failure by an individual to renew a certificate in accordance with section 4730.14 or section 4730.48 of the Revised Code shall not remove or limit the state medical board's jurisdiction to take disciplinary action under this section against the individual.

(N) If an individual who holds a certificate issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state medical board shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state medical board shall take any disciplinary action required by the health care professional standards board against a certificate holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate holder, the state medical board shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state medical board may account for that disciplinary action in any future disciplinary action taken against the certificate holder.

Sec. 4730.32. (A) Within sixty days after the imposition

of any formal disciplinary action taken by a health care facility against any individual holding a valid certificate to practice as a physician assistant, the chief administrator or executive officer of the facility shall report to the state medical board and the health care professional standards board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, ~~the~~ either board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility.

The filing of a report with ~~the~~ each board or decision not to file a report, investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, does not preclude a health care facility from taking disciplinary action against a physician assistant.

In the absence of fraud or bad faith, no individual or entity that provides patient records to ~~the~~ either board shall be liable in damages to any person as a result of providing the records.

(B) A physician assistant, professional association or society of physician assistants, physician, or professional association or society of physicians that believes a violation of any provision of this chapter, Chapter 4731. of the Revised Code, or rule of the state medical board has occurred shall report to the board and the health care professional standards board the information upon which the belief is based. This division does not require any treatment provider approved by the state medical board under section 4731.25 of the Revised Code or

any employee, agent, or representative of such a provider to make reports with respect to a physician assistant participating in treatment or aftercare for substance abuse as long as the physician assistant maintains participation in accordance with the requirements of section 4731.25 of the Revised Code and the treatment provider or employee, agent, or representative of the provider has no reason to believe that the physician assistant has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of physician assistants to provide peer assistance to physician assistants with substance abuse problems with respect to a physician assistant who has been referred for examination to a treatment program approved by the board under section 4731.25 of the Revised Code if the physician assistant cooperates with the referral for examination and with any determination that the physician assistant should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the physician assistant has ceased to participate in the treatment program in accordance with section 4731.25 of the Revised Code or has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances.

(C) Any professional association or society composed primarily of physician assistants that suspends or revokes an individual's membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision, shall

report to the state medical board and the health care professional standards board, on forms prescribed and provided by the state medical board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing or nonfiling of a report with ~~the~~ each board, investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, shall not preclude a professional organization from taking disciplinary action against a physician assistant.

(D) Any insurer providing professional liability insurance to any person holding a valid certificate to practice as a physician assistant or any other entity that seeks to indemnify the professional liability of a physician assistant shall notify the state medical board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;

(2) The name and address of the insured who is the subject of the claim;

(3) The name of the person filing the written claim;

(4) The date of final disposition;

(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) ~~The~~ Either board may investigate possible violations of this chapter or the rules adopted under it that are brought

to its attention as a result of the reporting requirements of this section, except that the state medical board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, "repeated malpractice" means three or more claims for malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the physician assistant.

(F) All summaries, reports, and records received and maintained by the state medical board or the health care professional standards board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a physician assistant, supervising physician, or health care facility arising out of matters that are the subject of the reporting required by this section. The appropriate board may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against a physician assistant or supervising physician, or in any subsequent trial or appeal of a board action or order.

The appropriate board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing a physician assistant or supervising physician or reviewing their privilege to practice within a particular facility. The board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.

(G) Except for reports filed by an individual pursuant to

division (B) of this section, the state medical board shall send a copy of any reports or summaries it receives pursuant to this section to the physician assistant. The physician assistant shall have the right to file a statement with the state medical board and the health care professional standards board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that reports to the state medical board or the health care professional standards board or refers an impaired physician assistant to a treatment provider approved by the board under section 4731.25 of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, a professional association or society of physician assistants that sponsors a committee or program to provide peer assistance to a physician assistant with substance abuse problems, a representative or agent of such a committee or program, and a member of the state medical board shall not be held liable in damages to any person by reason of actions taken to refer a physician assistant to a treatment provider approved under section 4731.25 of the Revised Code for examination or treatment.

Sec. 4731.22. (A) The state medical board, by an affirmative vote of not fewer than six of its members, may limit, revoke, or suspend an individual's certificate to practice, refuse to grant a certificate to an individual, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate if the individual or certificate holder is found by the board to

have committed fraud during the administration of the examination for a certificate to practice or to have committed fraud, misrepresentation, or deception in applying for or securing any certificate to practice or certificate of registration issued by the board.

(B) The state medical board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate for one or more of the following reasons:

(1) Permitting one's name or one's certificate to practice or certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given;

(2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;

(3) Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug;

(4) Willfully betraying a professional confidence.

For purposes of this division, "willfully betraying a professional confidence" does not include providing any

information, documents, or reports to a child fatality review board under sections 307.621 to 307.629 of the Revised Code and does not include the making of a report of an employee's use of a drug of abuse, or a report of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code.

(5) Making a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board.

As used in this division, "false, fraudulent, deceptive, or misleading statement" means a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a

patient is established;

(7) Representing, with the purpose of obtaining compensation or other advantage as personal gain or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured;

(8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(9) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony;

(10) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(11) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(12) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(13) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude;

(14) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(15) Violation of the conditions of limitation placed by

the board upon a certificate to practice;

(16) Failure to pay license renewal fees specified in this chapter;

(17) Except as authorized in section 4731.31 of the Revised Code, engaging in the division of fees for referral of patients, or the receiving of a thing of value in return for a specific referral of a patient to utilize a particular service or business;

(18) Subject to section 4731.226 of the Revised Code, violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the state medical board specifies by rule. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The individual whose certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to the individual's profession.

For purposes of this division, a "provision of a code of ethics of a national professional organization" does not include any provision that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, "employee," "employer," and "physician"

have the same meanings as in section 2305.33 of the Revised Code.

(19) Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills.

In enforcing this division, the state medical board, upon a showing of a possible violation, may compel any individual authorized to practice by this chapter or who has submitted an application pursuant to this chapter to submit to a mental examination, physical examination, including an HIV test, or both a mental and a physical examination. The expense of the examination is the responsibility of the individual compelled to be examined. Failure to submit to a mental or physical examination or consent to an HIV test ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board finds an individual unable to practice because of the reasons set forth in this division, the board shall require the individual to submit to care, counseling, or treatment by physicians approved or designated by the board, as a condition for initial, continued, reinstated, or renewed authority to practice. An individual affected under this division shall be afforded an opportunity to demonstrate to the board the ability to resume practice in compliance with acceptable and prevailing standards under the provisions of the individual's certificate. For the purpose of this division, any individual who applies for or receives a certificate to practice

under this chapter accepts the privilege of practicing in this state and, by so doing, shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(20) Except when civil penalties are imposed under section 4731.225 or 4731.281 of the Revised Code, and subject to section 4731.226 of the Revised Code, violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board.

This division does not apply to a violation or attempted violation of, assisting in or abetting the violation of, or a conspiracy to violate, any provision of this chapter or any rule adopted by the state medical board that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code.

(21) The violation of section 3701.79 of the Revised Code or of any abortion rule adopted by the ~~public health council~~ director of health pursuant to section 3701.341 of the Revised Code;

(22) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

(23) The violation of section 2919.12 of the Revised Code or the performance or inducement of an abortion upon a pregnant woman with actual knowledge that the conditions specified in division (B) of section 2317.56 of the Revised Code have not been satisfied or with a heedless indifference as to whether those conditions have been satisfied, unless an affirmative defense as specified in division (H)(2) of that section would apply in a civil action authorized by division (H)(1) of that section;

(24) The revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice;

(25) Termination or suspension from participation in the medicare or medicaid programs by the department of health and human services or other responsible agency for any act or acts that also would constitute a violation of division (B)(2), (3), (6), (8), or (19) of this section;

(26) Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice.

For the purposes of this division, any individual authorized to practice by this chapter accepts the privilege of practicing in this state subject to supervision by the state medical board. By filing an application for or holding a certificate to practice under this chapter, an individual shall be deemed to have given consent to submit to a mental or physical examination when ordered to do so by the board in writing, and to have waived all objections to the admissibility of testimony or examination reports that constitute privileged communications.

If it has reason to believe that any individual authorized to practice by this chapter or any applicant for certification to practice suffers such impairment, the state medical board may compel the individual to submit to a mental or physical examination, or both. The expense of the examination is the responsibility of the individual compelled to be examined. Any mental or physical examination required under this division shall be undertaken by a treatment provider or physician who is qualified to conduct the examination and who is chosen by the board.

Failure to submit to a mental or physical examination ordered by the state medical board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board determines that the

individual's ability to practice is impaired, the board shall suspend the individual's certificate or deny the individual's application and shall require the individual, as a condition for initial, continued, reinstated, or renewed certification to practice, to submit to treatment.

Before being eligible to apply for reinstatement of a certificate suspended under this division, the impaired practitioner shall demonstrate to the state medical board the ability to resume practice in compliance with acceptable and prevailing standards of care under the provisions of the practitioner's certificate. The demonstration shall include, but shall not be limited to, the following:

(a) Certification from a treatment provider approved under section 4731.25 of the Revised Code that the individual has successfully completed any required inpatient treatment;

(b) Evidence of continuing full compliance with an aftercare contract or consent agreement;

(c) Two written reports indicating that the individual's ability to practice has been assessed and that the individual has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by individuals or providers approved by the board for making the assessments and shall describe the basis for their determination.

The state medical board may reinstate a certificate suspended under this division after that demonstration and after the individual has entered into a written consent agreement.

When the impaired practitioner resumes practice, the state medical board shall require continued monitoring of the

individual. The monitoring shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by board order after a hearing, and, upon termination of the consent agreement, submission to the board for at least two years of annual written progress reports made under penalty of perjury stating whether the individual has maintained sobriety.

(27) A second or subsequent violation of section 4731.66 or 4731.69 of the Revised Code;

(28) Except as provided in division (N) of this section:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual's services, otherwise would be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that individual;

(b) Advertising that the individual will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual's services, otherwise would be required to pay.

(29) Failure to use universal blood and body fluid precautions established by rules adopted under section 4731.051 of the Revised Code;

(30) ~~Failure to provide notice to, and receive acknowledgment of the notice from, a patient when required by section 4731.143 of the Revised Code prior to providing nonemergency professional services, or failure to maintain that notice in the patient's file;~~

~~(31)~~ Failure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730. of the Revised Code and the rules adopted under that chapter;

~~(32)~~(31) Failure of a physician or podiatrist to enter into a standard care arrangement with a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner with whom the physician or podiatrist is in collaboration pursuant to section 4731.27 of the Revised Code or failure to fulfill the responsibilities of collaboration after entering into a standard care arrangement;

~~(33)~~(32) Failure to comply with the terms of a consult agreement entered into with a pharmacist pursuant to section 4729.39 of the Revised Code;

~~(34)~~(33) Failure to cooperate in an investigation conducted by the state medical board under division (F) of this section or the health care professional standards board pursuant to section 4746.04 of the Revised Code, including failure to comply with a subpoena or order issued by ~~the~~ either board or failure to answer truthfully a question presented by ~~the~~ either board in an investigative interview, an investigative office conference, at a deposition, or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;

~~(35)~~(34) Failure to supervise an oriental medicine practitioner or acupuncturist in accordance with Chapter 4762. of the Revised Code and the state medical board's rules for

providing that supervision;

~~(36)~~(35) Failure to supervise an anesthesiologist assistant in accordance with Chapter 4760. of the Revised Code and the state medical board's rules for supervision of an anesthesiologist assistant;

~~(37)~~(36) Assisting suicide as defined in section 3795.01 of the Revised Code;

~~(38)~~(37) Failure to comply with the requirements of section 2317.561 of the Revised Code;

~~(39)~~(38) Failure to supervise a radiologist assistant in accordance with Chapter 4774. of the Revised Code and the state medical board's rules for supervision of radiologist assistants;

~~(40)~~(39) Performing or inducing an abortion at an office or facility with knowledge that the office or facility fails to post the notice required under section 3701.791 of the Revised Code;

~~(41)~~(40) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code for the operation of or the provision of care at a pain management clinic;

~~(42)~~(41) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code for providing supervision, direction, and control of individuals at a pain management clinic;

~~(43)~~(42) Failure to comply with the requirements of section 4729.79 or 4731.055 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code;

~~(44)~~(43) Failure to comply with the requirements of section 2919.171 of the Revised Code or failure to submit to the department of health in accordance with a court order a complete report as described in section 2919.171 of the Revised Code;

~~(45)~~(44) Practicing at a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the person operating the facility has obtained and maintains the license with the classification;

~~(46)~~(45) Owning a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the facility is licensed with the classification;

~~(47)~~(46) Failure to comply with the requirement regarding maintaining notes described in division (B) of section 2919.191 of the Revised Code or failure to satisfy the requirements of section 2919.191 of the Revised Code prior to performing or inducing an abortion upon a pregnant woman;

~~(48)~~(47) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing to a minor a prescription for a controlled substance containing an opioid.

(C) Disciplinary actions taken by the state medical board under divisions (A) and (B) of this section shall be taken pursuant to an adjudication under Chapter 119. of the Revised Code, except that in lieu of an adjudication, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by an affirmative vote of not fewer than six members of the board, shall

constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the consent agreement shall be of no force or effect.

A telephone conference call may be utilized for ratification of a consent agreement that revokes or suspends an individual's certificate to practice. The telephone conference call shall be considered a special meeting under division (F) of section 121.22 of the Revised Code.

If the state medical board takes disciplinary action against an individual under division (B) of this section for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code, the disciplinary action shall consist of a suspension of the individual's certificate to practice for a period of at least one year or, if determined appropriate by the board, a more serious sanction involving the individual's certificate to practice. Any consent agreement entered into under this division with an individual that pertains to a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of that section shall provide for a suspension of the individual's certificate to practice for a period of at least one year or, if determined appropriate by the board, a more serious sanction involving the individual's certificate to practice.

(D) For purposes of divisions (B)(10), (12), and (14) of this section, the commission of the act may be established by a finding by the state medical board, pursuant to an adjudication under Chapter 119. of the Revised Code, that the individual committed the act. The board does not have jurisdiction under

those divisions if the trial court renders a final judgment in the individual's favor and that judgment is based upon an adjudication on the merits. The board has jurisdiction under those divisions if the trial court issues an order of dismissal upon technical or procedural grounds.

(E) The sealing of conviction records by any court shall have no effect upon a prior state medical board order entered under this section or upon the board's jurisdiction to take action under this section if, based upon a plea of guilty, a judicial finding of guilt, or a judicial finding of eligibility for intervention in lieu of conviction, the board issued a notice of opportunity for a hearing prior to the court's order to seal the records. The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F)(1) The state medical board shall investigate evidence that appears to show that a person has violated any provision of this chapter or any rule adopted under it. Any person may report to the board in a signed writing any information that the person may have that appears to show a violation of any provision of this chapter or any rule adopted under it. In the absence of bad faith, any person who reports information of that nature or who testifies before the board in any adjudication conducted under Chapter 119. of the Revised Code shall not be liable in damages in a civil action as a result of the report or testimony. Each complaint or allegation of a violation received by the board shall be assigned a case number and shall be recorded by the board.

(2) Investigations of alleged violations of this chapter or any rule adopted under it shall be supervised by the

supervising member elected by the state medical board in accordance with section 4731.02 of the Revised Code and by the secretary as provided in section 4731.39 of the Revised Code. The president may designate another member of the board to supervise the investigation in place of the supervising member. No member of the board who supervises the investigation of a case shall participate in further adjudication of the case.

(3) In investigating a possible violation of this chapter or any rule adopted under this chapter, or in conducting an inspection under division (E) of section 4731.054 of the Revised Code, the state medical board may question witnesses, conduct interviews, administer oaths, order the taking of depositions, inspect and copy any books, accounts, papers, records, or documents, issue subpoenas, and compel the attendance of witnesses and production of books, accounts, papers, records, documents, and testimony, except that a subpoena for patient record information shall not be issued without consultation with the attorney general's office and approval of the secretary and supervising member of the board.

(a) Before issuance of a subpoena for patient record information, the secretary and supervising member shall determine whether there is probable cause to believe that the complaint filed alleges a violation of this chapter or any rule adopted under it and that the records sought are relevant to the alleged violation and material to the investigation. The subpoena may apply only to records that cover a reasonable period of time surrounding the alleged violation.

(b) On failure to comply with any subpoena issued by the state medical board and after reasonable notice to the person being subpoenaed, the board may move for an order compelling the

production of persons or records pursuant to the Rules of Civil Procedure.

(c) A subpoena issued by the state medical board may be served by a sheriff, the sheriff's deputy, or a board employee designated by the board. Service of a subpoena issued by the board may be made by delivering a copy of the subpoena to the person named therein, reading it to the person, or leaving it at the person's usual place of residence, usual place of business, or address on file with the board. When serving a subpoena to an applicant for or the holder of a certificate issued under this chapter, service of the subpoena may be made by certified mail, return receipt requested, and the subpoena shall be deemed served on the date delivery is made or the date the person refuses to accept delivery. If the person being served refuses to accept the subpoena or is not located, service may be made to an attorney who notifies the board that the attorney is representing the person.

(d) A sheriff's deputy who serves a subpoena shall receive the same fees as a sheriff. Each witness who appears before the board in obedience to a subpoena shall receive the fees and mileage provided for under section 119.094 of the Revised Code.

(4) All hearings, investigations, and inspections of the state medical board shall be considered civil actions for the purposes of section 2305.252 of the Revised Code.

(5) A report required to be submitted to the state medical board under this chapter, a complaint, or information received by the board pursuant to an investigation or pursuant to an inspection under division (E) of section 4731.054 of the Revised Code is confidential and not subject to discovery in any civil action.

The state medical board shall conduct all investigations or inspections and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that consent or a waiver of that nature is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The state medical board may share any information it receives pursuant to an investigation or inspection, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board's possession. Measures to ensure confidentiality that

may be taken by the court include sealing its records or deleting specific information from its records.

(6) On a quarterly basis, the state medical board shall prepare a report that documents the disposition of all cases during the preceding three months. The report shall contain the following information for each case with which the board has completed its activities:

(a) The case number assigned to the complaint or alleged violation;

(b) The type of certificate to practice, if any, held by the individual against whom the complaint is directed;

(c) A description of the allegations contained in the complaint;

(d) The disposition of the case.

The report shall state how many cases are still pending and shall be prepared in a manner that protects the identity of each person involved in each case. The report shall be a public record under section 149.43 of the Revised Code.

(G) If the secretary and supervising member determine both of the following, they may recommend that the state medical board suspend an individual's certificate to practice without a prior hearing:

(1) That there is clear and convincing evidence that an individual has violated division (B) of this section;

(2) That the individual's continued practice presents a danger of immediate and serious harm to the public.

Written allegations shall be prepared for consideration by

the state medical board. The board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a certificate without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension.

The state medical board shall issue a written order of suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during pendency of any appeal filed under section 119.12 of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual.

Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the state medical board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudicative order within seventy-five days after completion of its hearing. A failure to issue the order within seventy-five days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order.

(H) If the state medical board takes action under division (B)(9), (11), or (13) of this section and the judicial finding of guilt, guilty plea, or judicial finding of eligibility for intervention in lieu of conviction is overturned on appeal, upon exhaustion of the criminal appeal, a petition for

reconsideration of the order may be filed with the board along with appropriate court documents. Upon receipt of a petition of that nature and supporting court documents, the board shall reinstate the individual's certificate to practice. The board may then hold an adjudication under Chapter 119. of the Revised Code to determine whether the individual committed the act in question. Notice of an opportunity for a hearing shall be given in accordance with Chapter 119. of the Revised Code. If the board finds, pursuant to an adjudication held under this division, that the individual committed the act or if no hearing is requested, the board may order any of the sanctions identified under division (B) of this section.

(I) The certificate to practice issued to an individual under this chapter and the individual's practice in this state are automatically suspended as of the date of the individual's second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code, or the date the individual pleads guilty to, is found by a judge or jury to be guilty of, or is subject to a judicial finding of eligibility for intervention in lieu of conviction in this state or treatment or intervention in lieu of conviction in another jurisdiction for any of the following criminal offenses in this state or a substantially equivalent criminal offense in another jurisdiction: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary. Continued practice after suspension shall be considered practicing without a certificate.

The state medical board shall notify the individual subject to the suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. If an

individual whose certificate is automatically suspended under this division fails to make a timely request for an adjudication under Chapter 119. of the Revised Code, the board shall do whichever of the following is applicable:

(1) If the automatic suspension under this division is for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section 2919.123 of the Revised Code, the state medical board shall enter an order suspending the individual's certificate to practice for a period of at least one year or, if determined appropriate by the board, imposing a more serious sanction involving the individual's certificate to practice.

(2) In all circumstances in which division (I)(1) of this section does not apply, enter a final order permanently revoking the individual's certificate to practice.

(J) If the state medical board is required by Chapter 119. of the Revised Code to give notice of an opportunity for a hearing and if the individual subject to the notice does not timely request a hearing in accordance with section 119.07 of the Revised Code, the board is not required to hold a hearing, but may adopt, by an affirmative vote of not fewer than six of its members, a final order that contains the board's findings. In that final order, the board may order any of the sanctions identified under division (A) or (B) of this section.

(K) Any action taken by the state medical board under division (B) of this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the individual's certificate to practice may be reinstated. The board shall adopt rules governing conditions to be imposed for reinstatement. Reinstatement of a

certificate suspended pursuant to division (B) of this section requires an affirmative vote of not fewer than six members of the board.

(L) When the state medical board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.

(M) Notwithstanding any other provision of the Revised Code, all of the following apply:

(1) The surrender of a certificate issued under this chapter shall not be effective unless or until accepted by the state medical board. A telephone conference call may be utilized for acceptance of the surrender of an individual's certificate to practice. The telephone conference call shall be considered a special meeting under division (F) of section 121.22 of the Revised Code. Reinstatement of a certificate surrendered to the board requires an affirmative vote of not fewer than six members of the board.

(2) An application for a certificate made under the provisions of this chapter may not be withdrawn without approval of the state medical board.

(3) Failure by an individual to renew a certificate of registration in accordance with this chapter shall not remove or limit the state medical board's jurisdiction to take any

disciplinary action under this section against the individual.

(4) At the request of the state medical board, a certificate holder shall immediately surrender to the board a certificate that the board has suspended, revoked, or permanently revoked.

(N) Sanctions shall not be imposed under division (B)(28) of this section against any person who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the state medical board upon request.

(2) For professional services rendered to any other person authorized to practice pursuant to this chapter, to the extent allowed by this chapter and rules adopted by the state medical board.

(O) Under the state medical board's investigative duties described in this section and subject to division (F) of this section, the board shall develop and implement a quality intervention program designed to improve through remedial education the clinical and communication skills of individuals authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, and podiatric medicine and surgery. In developing and implementing the quality intervention program, the board may do all of the following:

(1) Offer in appropriate cases as determined by the board an educational and assessment program pursuant to an

investigation the board conducts under this section;

(2) Select providers of educational and assessment services, including a quality intervention program panel of case reviewers;

(3) Make referrals to educational and assessment service providers and approve individual educational programs recommended by those providers. The board shall monitor the progress of each individual undertaking a recommended individual educational program.

(4) Determine what constitutes successful completion of an individual educational program and require further monitoring of the individual who completed the program or other action that the board determines to be appropriate;

(5) Adopt rules in accordance with Chapter 119. of the Revised Code to further implement the quality intervention program.

An individual who participates in an individual educational program pursuant to this division shall pay the financial obligations arising from that educational program.

(P) If an individual who holds a certificate issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state medical board shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state medical board shall take any disciplinary action

required by the health care professional standards board against a certificate holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate holder, the state medical board shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state medical board may account for that disciplinary action in any future disciplinary action taken against the certificate holder.

Sec. 4731.224. (A) Within sixty days after the imposition of any formal disciplinary action taken by any health care facility, including a hospital, health care facility operated by a health insuring corporation, ambulatory surgical center, or similar facility, against any individual holding a valid certificate to practice issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the state medical board and the health care professional standards board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, the requesting board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility. As used in this division, "formal disciplinary action" means any action resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse. "Formal disciplinary action" includes a summary action, an

action that takes effect notwithstanding any appeal rights that may exist, and an action that results in an individual surrendering clinical privileges while under investigation and during proceedings regarding the action being taken or in return for not being investigated or having proceedings held. "Formal disciplinary action" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or section meetings.

The filing or nonfiling of a report with ~~the~~ either board, investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, shall not preclude any action by a health care facility to suspend, restrict, or revoke the individual's clinical privileges.

In the absence of fraud or bad faith, no individual or entity that provides patient records to ~~the~~ either board shall be liable in damages to any person as a result of providing the records.

(B) If any individual authorized to practice under this chapter or any professional association or society of such individuals believes that a violation of any provision of this chapter, Chapter 4730., 4760., 4762., 4774., or 4778. of the Revised Code, or any rule of the board has occurred, the individual, association, or society shall report to the state medical board and the health care professional standards board the information upon which the belief is based. This division does not require any treatment provider approved by the state medical board under section 4731.25 of the Revised Code or any employee, agent, or representative of such a provider to make reports with respect to an impaired practitioner participating in treatment or aftercare for substance abuse as long as the

practitioner maintains participation in accordance with the requirements of section 4731.25 of the Revised Code, and as long as the treatment provider or employee, agent, or representative of the provider has no reason to believe that the practitioner has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of individuals authorized to practice under this chapter to provide peer assistance to practitioners with substance abuse problems with respect to a practitioner who has been referred for examination to a treatment program approved by the state medical board under section 4731.25 of the Revised Code if the practitioner cooperates with the referral for examination and with any determination that the practitioner should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the practitioner has ceased to participate in the treatment program in accordance with section 4731.25 of the Revised Code or has violated any provision of this chapter or any rule adopted under it, other than the provisions of division (B)(26) of section 4731.22 of the Revised Code.

(C) Any professional association or society composed primarily of doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, or practitioners of limited branches of medicine that suspends or revokes an individual's membership for violations of professional ethics, or for reasons of

professional incompetence or professional malpractice, within sixty days after a final decision shall report to the state medical board and the health care professional standards board, on forms prescribed and provided by the state medical board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing of a report with ~~the~~ either board or decision not to file a report, investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, does not preclude a professional organization from taking disciplinary action against an individual.

(D) Any insurer providing professional liability insurance to an individual authorized to practice under this chapter, or any other entity that seeks to indemnify the professional liability of such an individual, shall notify the state medical board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;

(2) The name and address of the insured who is the subject of the claim;

(3) The name of the person filing the written claim;

(4) The date of final disposition;

(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) ~~The~~ Either board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the state medical board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, "repeated malpractice" means three or more claims for medical malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the practicing individual.

(F) All summaries, reports, and records received and maintained by the state medical board and the health care professional standards board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a health care professional or facility arising out of matters that are the subject of the reporting required by this section. ~~The~~ Either board may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against an individual whose practice is regulated under this chapter, or in any subsequent trial or appeal of a board action or order.

~~The~~ Either board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing the individual or in reviewing the individual's clinical privileges. The state medical board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.

(G) Except for reports filed by an individual pursuant to division (B) of this section, the state medical board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries. The individual shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that, pursuant to this section, reports to ~~the~~ either board or refers an impaired practitioner to a treatment provider approved by the state medical board under section 4731.25 of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, no professional association or society of individuals authorized to practice under this chapter that sponsors a committee or program to provide peer assistance to practitioners with substance abuse problems, no representative or agent of such a committee or program, and no member of the state medical board shall be held liable in damages to any person by reason of actions taken to refer a practitioner to a treatment provider approved under section 4731.25 of the Revised Code for examination or treatment.

Sec. 4731.281. (A) On or before the deadline established under division (B) of this section for applying for renewal of a certificate of registration, each person holding a certificate under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery shall certify to the state medical board that in the preceding two

years the person has completed one hundred hours of continuing medical education. The certification shall be made upon the application for biennial registration submitted pursuant to division (B) of this section. The board shall adopt rules providing for pro rata reductions by month of the number of hours of continuing education required for persons who are in their first registration period, who have been disabled due to illness or accident, or who have been absent from the country.

In determining whether a course, program, or activity qualifies for credit as continuing medical education, the board shall approve all continuing medical education taken by persons holding a certificate to practice medicine and surgery that is certified by the Ohio state medical association, all continuing medical education taken by persons holding a certificate to practice osteopathic medicine and surgery that is certified by the Ohio osteopathic association, and all continuing medical education taken by persons holding a certificate to practice podiatric medicine and surgery that is certified by the Ohio podiatric medical association. Each person holding a certificate to practice under this chapter shall be given sufficient choice of continuing education programs to ensure that the person has had a reasonable opportunity to participate in continuing education programs that are relevant to the person's medical practice in terms of subject matter and level.

The board may require a random sample of persons holding a certificate to practice under this chapter to submit materials documenting completion of the continuing medical education requirement during the preceding registration period, but this provision shall not limit the board's authority to investigate pursuant to section 4731.22 of the Revised Code.

(B)(1) Every person holding a certificate under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery wishing to renew that certificate shall apply to the board for a certificate of registration upon an application furnished by the board, and pay to the board at the time of application a fee of three hundred five dollars, according to the following schedule:

(a) Persons whose last name begins with the letters "A" through "B," on or before April 1, 2001, and the first day of April of every odd-numbered year thereafter;

(b) Persons whose last name begins with the letters "C" through "D," on or before January 1, 2001, and the first day of January of every odd-numbered year thereafter;

(c) Persons whose last name begins with the letters "E" through "G," on or before October 1, 2000, and the first day of October of every even-numbered year thereafter;

(d) Persons whose last name begins with the letters "H" through "K," on or before July 1, 2000, and the first day of July of every even-numbered year thereafter;

(e) Persons whose last name begins with the letters "L" through "M," on or before April 1, 2000, and the first day of April of every even-numbered year thereafter;

(f) Persons whose last name begins with the letters "N" through "R," on or before January 1, 2000, and the first day of January of every even-numbered year thereafter;

(g) Persons whose last name begins with the letter "S," on or before October 1, 1999, and the first day of October of every odd-numbered year thereafter;

(h) Persons whose last name begins with the letters "T" through "Z," on or before July 1, 1999, and the first day of July of every odd-numbered year thereafter.

The board shall deposit the fee in accordance with section 4731.24 of the Revised Code, except that the board shall deposit twenty dollars of the fee into the state treasury to the credit of the physician loan repayment fund created by section 3702.78 of the Revised Code.

(2) The board shall mail or cause to be mailed to every person registered to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, a notice of registration renewal addressed to the person's last known address or may cause the notice to be sent to the person through the secretary of any recognized medical, osteopathic, or podiatric society, according to the following schedule:

(a) To persons whose last name begins with the letters "A" through "B," on or before January 1, 2001, and the first day of January of every odd-numbered year thereafter;

(b) To persons whose last name begins with the letters "C" through "D," on or before October 1, 2000, and the first day of October of every even-numbered year thereafter;

(c) To persons whose last name begins with the letters "E" through "G," on or before July 1, 2000, and the first day of July of every even-numbered year thereafter;

(d) To persons whose last name begins with the letters "H" through "K," on or before April 1, 2000, and the first day of April of every even-numbered year thereafter;

(e) To persons whose last name begins with the letters "L" through "M," on or before January 1, 2000, and the first day of

January of every even-numbered year thereafter;

(f) To persons whose last name begins with the letters "N" through "R," on or before October 1, 1999, and the first day of October of every odd-numbered year thereafter;

(g) To persons whose last name begins with the letter "S," on or before July 1, 1999, and the first day of July of every odd-numbered year thereafter;

(h) To persons whose last name begins with the letters "T" through "Z," on or before April 1, 1999, and the first day of April of every odd-numbered year thereafter.

(3) Failure of any person to receive a notice of renewal from the board shall not excuse the person from the requirements contained in this section.

(4) The board's notice shall inform the applicant of the renewal procedure. The board shall provide the application for registration renewal in a form determined by the board.

(5) The applicant shall provide in the application the applicant's full name, principal practice address and residence address, the number of the applicant's certificate to practice, and any other information required by the board.

(6)(a) Except as provided in division (B)(6)(b) of this section, in the case of an applicant who prescribes or personally furnishes opioid analgesics or benzodiazepines, the applicant shall certify to the board whether the applicant has been granted access to the drug database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(b) The requirement in division (B)(6)(a) of this section

does not apply if either of the following is the case:

(i) The state board of pharmacy notifies the state medical board pursuant to section 4729.861 of the Revised Code that the applicant has been restricted from obtaining further information from the drug database.

(ii) The state board of pharmacy no longer maintains the drug database.

(c) If an applicant certifies to the state medical board that the applicant has been granted access to the drug database and the board finds through an audit or other means that the applicant has not been granted access, the board may take action under section 4731.22 of the Revised Code.

(7) The applicant shall include with the application a list of the names and addresses of any clinical nurse specialists, certified nurse-midwives, or certified nurse practitioners with whom the applicant is currently collaborating, as defined in section 4723.01 of the Revised Code. Every person registered under this section shall give written notice to the state medical board of any change of principal practice address or residence address or in the list within thirty days of the change.

(8) The applicant shall report any criminal offense to which the applicant has pleaded guilty, of which the applicant has been found guilty, or for which the applicant has been found eligible for intervention in lieu of conviction, since last filing an application for a certificate of registration.

(9) The applicant shall execute and deliver the application to the board in a manner prescribed by the board.

(C) The board shall issue to any person holding a

certificate under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, upon application and qualification therefor in accordance with this section, a certificate of registration under the seal of the board. A certificate of registration shall be valid for a two-year period.

(D) Failure of any certificate holder to register and comply with this section shall operate automatically to suspend the holder's certificate to practice. Continued practice after the suspension of the certificate to practice shall be considered as practicing in violation of section 4731.41, 4731.43, or 4731.60 of the Revised Code. If the certificate has been suspended pursuant to this division for two years or less, it may be reinstated. The board shall reinstate a certificate to practice suspended for failure to register upon an applicant's submission of a renewal application, the biennial registration fee, and the applicable monetary penalty. The penalty for reinstatement shall be fifty dollars. If the certificate has been suspended pursuant to this division for more than two years, it may be restored. Subject to section 4731.222 of the Revised Code, the board may restore a certificate to practice suspended for failure to register upon an applicant's submission of a restoration application, the biennial registration fee, and the applicable monetary penalty and compliance with sections 4776.01 to 4776.04 of the Revised Code. The board shall not restore to an applicant a certificate to practice unless the board, in its discretion, decides that the results of the criminal records check do not make the applicant ineligible for a certificate issued pursuant to section 4731.14, 4731.56, or 4731.57 of the Revised Code. The penalty for restoration shall be one hundred dollars. The board shall deposit the penalties in

accordance with section 4731.24 of the Revised Code.

(E) If an individual certifies completion of the number of hours and type of continuing medical education required to receive a certificate of registration or reinstatement of a certificate to practice, and the board finds through the random samples it conducts under this section or through any other means that the individual did not complete the requisite continuing medical education, the board may impose a civil penalty of not more than five thousand dollars. The board's finding shall be made pursuant to an adjudication under Chapter 119. of the Revised Code and by an affirmative vote of not fewer than six members.

A civil penalty imposed under this division may be in addition to or in lieu of any other action the board may take under section 4731.22 of the Revised Code. The board shall deposit civil penalties in accordance with section 4731.24 of the Revised Code.

(F) The state medical board and the health care professional standards board may obtain information not protected by statutory or common law privilege from courts and other sources concerning malpractice claims against any person holding a certificate to practice under this chapter or practicing as provided in section 4731.36 of the Revised Code.

(G) Each mailing sent by the state medical board under division (B)(2) of this section to a person registered to practice medicine and surgery or osteopathic medicine and surgery shall inform the applicant of the reporting requirement established by division (H) of section 3701.79 of the Revised Code. At the discretion of the board, the information may be included on the application for registration or on an

accompanying page.

Sec. 4731.74. Implementation of this section is subject to section 5166.50 of the Revised Code.

For purposes of section 3727.61 of the Revised Code, the state medical board shall establish a list of nonemergency medical conditions. A condition on the list may not be an "emergency medical condition" as defined in 42 C.F.R. 489.24. For each condition on the list, the board shall identify symptoms that are associated with the condition.

Sec. 4734.31. (A) The state chiropractic board may take any of the actions specified in division (B) of this section against an individual who has applied for or holds a license to practice chiropractic in this state if any of the reasons specified in division (C) of this section for taking action against an individual are applicable. Except as provided in division (D) of this section, actions taken against an individual shall be taken in accordance with Chapter 119. of the Revised Code. The board may specify that any action it takes is a permanent action. The board's authority to take action against an individual is not removed or limited by the individual's failure to renew a license.

(B) In its imposition of sanctions against an individual, the state chiropractic board may do any of the following:

(1) Refuse to issue, renew, restore, or reinstate a license to practice chiropractic or a certificate to practice acupuncture;

(2) Reprimand or censure a license holder;

(3) Place limits, restrictions, or probationary conditions on a license holder's practice;

(4) Impose a civil fine of not more than five thousand dollars according to a schedule of fines specified in rules that the state chiropractic board shall adopt in accordance with Chapter 119. of the Revised Code~~.~~;

(5) Suspend a license to practice chiropractic or a certificate to practice acupuncture for a limited or indefinite period;

(6) Revoke a license to practice chiropractic or a certificate to practice acupuncture.

(C) The state chiropractic board may take the actions specified in division (B) of this section for any of the following reasons:

(1) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony in any jurisdiction, in which case a certified copy of the court record shall be conclusive evidence of the conviction;

(2) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(3) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude, as determined by the board, in which case a certified copy of the court record shall be conclusive evidence of the matter;

(4) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(5) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in the course of practice, in which case a certified copy of the court record shall be conclusive evidence of the matter;

(6) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(7) A violation or attempted violation of this chapter or the rules adopted under it governing the practice of chiropractic and the practice of acupuncture by a chiropractor licensed under this chapter;

(8) Failure to cooperate in an investigation conducted by the state chiropractic board or the health care professional standards board, including failure to comply with a subpoena or order issued by ~~the~~ either board or failure to answer truthfully a question presented by ~~the~~ either board at a deposition or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if the board or a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;

(9) Engaging in an ongoing professional relationship with a person or entity that violates any provision of this chapter or the rules adopted under it, unless the chiropractor makes a good faith effort to have the person or entity comply with the provisions;

(10) Retaliating against a chiropractor for the

chiropractor's reporting to the state chiropractic board or any other agency with jurisdiction any violation of the law or for cooperating with the board of another agency in the investigation of any violation of the law;

(11) Aiding, abetting, assisting, counseling, or conspiring with any person in that person's violation of any provision of this chapter or the rules adopted under it, including the practice of chiropractic without a license, the practice of acupuncture without a certificate, or aiding, abetting, assisting, counseling, or conspiring with any person in that person's unlicensed practice of any other health care profession that has licensing requirements;

(12) With respect to a report or record that is made, filed, or signed in connection with the practice of chiropractic or acupuncture, knowingly making or filing a report or record that is false, intentionally or negligently failing to file a report or record required by federal, state, or local law or willfully impeding or obstructing the required filing, or inducing another person to engage in any such acts;

(13) Making a false, fraudulent, or deceitful statement to the state chiropractic board or the health care professional standards board or any agent of ~~the~~ either board during any investigation or other official proceeding conducted by ~~the~~ either board under this chapter or Chapter 4746. of the Revised Code or in any filing that must be submitted to ~~the~~ either board;

(14) Attempting to secure a license to practice chiropractic or certificate to practice acupuncture or to corrupt the outcome of an official state chiropractic board proceeding through bribery or any other improper means;

(15) Willfully obstructing or hindering the state chiropractic board or any agent of the board in the discharge of the board's duties;

(16) Habitually using drugs or intoxicants to the extent that the person is rendered unfit for the practice of chiropractic or acupuncture;

(17) Inability to practice chiropractic or acupuncture according to acceptable and prevailing standards of care by reason of chemical dependency, mental illness, or physical illness, including conditions in which physical deterioration has adversely affected the person's cognitive, motor, or perceptive skills and conditions in which a chiropractor's continued practice may pose a danger to the chiropractor or the public;

(18) Any act constituting gross immorality relative to the person's practice of chiropractic or acupuncture, including acts involving sexual abuse, sexual misconduct, or sexual exploitation;

(19) Exploiting a patient for personal or financial gain;

(20) Failing to maintain proper, accurate, and legible records in the English language documenting each patient's care, including, as appropriate, records of the following: dates of treatment, services rendered, examinations, tests, x-ray reports, referrals, and the diagnosis or clinical impression and clinical treatment plan provided to the patient;

(21) Except as otherwise required by the state chiropractic board or by law, disclosing patient information gained during the chiropractor's professional relationship with a patient without obtaining the patient's authorization for the

disclosure;

(22) Commission of willful or gross malpractice, or willful or gross neglect, in the practice of chiropractic or acupuncture;

(23) Failing to perform or negligently performing an act recognized by the board as a general duty or the exercise of due care in the practice of chiropractic or acupuncture, regardless of whether injury results to a patient from the failure to perform or negligent performance of the act;

(24) Engaging in any conduct or practice that impairs or may impair the ability to practice chiropractic or acupuncture safely and skillfully;

(25) Practicing, or claiming to be capable of practicing, beyond the scope of the practice of chiropractic or acupuncture as established under this chapter and the rules adopted under this chapter;

(26) Accepting and performing professional responsibilities as a chiropractor or chiropractor with a certificate to practice acupuncture when not qualified to perform those responsibilities, if the person knew or had reason to know that the person was not qualified to perform them;

(27) Delegating any of the professional responsibilities of a chiropractor or chiropractor with a certificate to practice acupuncture to an employee or other individual when the delegating chiropractor knows or had reason to know that the employee or other individual is not qualified by training, experience, or professional licensure to perform the responsibilities;

(28) Delegating any of the professional responsibilities

of a chiropractor or chiropractor with a certificate to practice acupuncture to an employee or other individual in a negligent manner or failing to provide proper supervision of the employee or other individual to whom the responsibilities are delegated;

(29) Failing to refer a patient to another health care practitioner for consultation or treatment when the chiropractor knows or has reason to know that the referral is in the best interest of the patient;

(30) Obtaining or attempting to obtain any fee or other advantage by fraud or misrepresentation;

(31) Making misleading, deceptive, false, or fraudulent representations in the practice of chiropractic or acupuncture;

(32) Being guilty of false, fraudulent, deceptive, or misleading advertising or other solicitations for patients or knowingly having professional connection with any person that advertises or solicits for patients in such a manner;

(33) Violation of a provision of any code of ethics established or adopted by the board under section 4734.16 of the Revised Code;

(34) Failing to meet the examination requirements for receipt of a license specified under section 4734.20 of the Revised Code;

(35) Actions taken for any reason, other than nonpayment of fees, by the chiropractic or acupuncture licensing authority of another state or country;

(36) Failing to maintain clean and sanitary conditions at the clinic, office, or other place in which chiropractic services or acupuncture services are provided;

(37) Except as provided in division (G) of this section:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the chiropractor's services, otherwise would be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that chiropractor;

(b) Advertising that the chiropractor will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the chiropractor's services, otherwise would be required to pay.

(38) Failure to supervise an oriental medicine practitioner performing acupuncture or an acupuncturist in accordance with the provisions of section 4762.11 of the Revised Code that are applicable to a supervising chiropractor.

(D) The adjudication requirements of Chapter 119. of the Revised Code apply to the state chiropractic board when taking actions against an individual under this section, except as follows:

(1) An applicant is not entitled to an adjudication for failing to meet the conditions specified under section 4734.20 of the Revised Code for receipt of a license that involve the board's examination on jurisprudence or the examinations of the national board of chiropractic examiners.

(2) A person is not entitled to an adjudication if the person fails to make a timely request for a hearing, in accordance with Chapter 119. of the Revised Code.

(3) In lieu of an adjudication, the board may accept the

surrender of a license to practice chiropractic or certificate to practice acupuncture from a chiropractor.

(4) In lieu of an adjudication, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by the board, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the consent agreement shall be of no force or effect.

(E) This section does not require the state chiropractic board to hire, contract with, or retain the services of an expert witness when the board takes action against a chiropractor concerning compliance with acceptable and prevailing standards of care in the practice of chiropractic or acupuncture. As part of an action taken concerning compliance with acceptable and prevailing standards of care, the board may rely on the knowledge of its members for purposes of making a determination of compliance, notwithstanding any expert testimony presented by the chiropractor that contradicts the knowledge and opinions of the members of the board.

(F) The sealing of conviction records by a court shall have no effect on a prior state chiropractic board order entered under this section or on the board's jurisdiction to take action under this section if, based on a plea of guilty, a judicial finding of guilt, or a judicial finding of eligibility for intervention in lieu of conviction, the board issued a notice of opportunity for a hearing prior to the court's order to seal the records. The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's

sealing of conviction records.

(G) Actions shall not be taken pursuant to division (C)(37) of this section against any chiropractor who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows a practice of that nature. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the state chiropractic board upon request.

(2) For professional services rendered to any other person licensed pursuant to this chapter, to the extent allowed by this chapter and the rules of the state chiropractic board.

(H) If an individual who holds a certificate or license issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state chiropractic board shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The state chiropractic board shall take any disciplinary action required by the health care professional standards board against a certificate or license holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate or license holder, the state chiropractic board shall not take disciplinary action for the same conduct that is

the subject of the disciplinary action ordered by the health care professional standards board. However, the state chiropractic board may account for that disciplinary action in any future disciplinary action taken against the certificate or license holder.

Sec. 4734.32. (A)(1) Except as provided in division (A)(2) of this section, if formal disciplinary action is taken against a chiropractor by any health care facility, including a clinic, hospital, or similar facility, the chief administrator or executive officer of the facility shall file a report with the state chiropractic board and the health care professional standards board not later than sixty days after the disciplinary action is imposed. The report shall include the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. On request, the state chiropractic board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to ~~the~~ either board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility.

The filing of a report with ~~the~~ either board, a decision not to file a report with ~~the~~ either board, an investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, does not preclude a health care facility from taking disciplinary action against a chiropractor.

In the absence of fraud or bad faith, no individual or entity that provides patient records to ~~the~~ either board shall be liable in damages to any person as a result of providing the records.

(2) Disciplinary action taken against a chiropractor by a

chiropractic clinic need not be reported to the state chiropractic board or the health care professional standards board in either of the following circumstances:

(a) The clinic takes the disciplinary action for reasons that do not involve clinical or patient care issues.

(b) The clinic employs fewer than five chiropractors and the disciplinary action taken does not rise above the level of a written reprimand.

(B) A chiropractor or professional association or society of chiropractors that believes a violation of any provision of this chapter or rule of the state chiropractic board has occurred shall report to the state chiropractic board and the health care professional standards board the information upon which the belief is based. This division does not require any treatment provider approved by the state chiropractic board under section 4734.40 of the Revised Code or any employee, agent, or representative of such a provider to make reports with respect to a chiropractor participating in treatment or aftercare for substance abuse as long as the chiropractor maintains participation in accordance with the requirements of section 4734.40 of the Revised Code and the treatment provider or employee, agent, or representative of the provider has no reason to believe that the chiropractor has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances. This division does not require reporting by any member of an impaired practitioner committee established by a health care facility or by any representative or agent of a committee or program sponsored by a professional association or society of chiropractors to provide peer assistance to chiropractors with

substance abuse problems with respect to a chiropractor who has been referred for examination to a treatment program approved by the state chiropractic board under section 4734.40 of the Revised Code if the chiropractor cooperates with the referral for examination and with any determination that the chiropractor should enter treatment and as long as the committee member, representative, or agent has no reason to believe that the chiropractor has ceased to participate in the treatment program in accordance with section 4734.40 of the Revised Code or has violated any provision of this chapter or rule adopted under it, other than being impaired by alcohol, drugs, or other substances.

(C) Any professional association or society composed primarily of chiropractors that suspends or revokes an individual's membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision, shall report to the state chiropractic board and the health care professional standards board, on forms prescribed and provided by the state chiropractic board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing of a report with ~~the~~ either board, a decision not to file a report with ~~the~~ either board, an investigation by ~~the~~ either board, or any disciplinary action taken by ~~the~~ either board, shall not preclude a professional organization from taking disciplinary action against a chiropractor.

(D) Any insurer providing professional liability insurance to any person holding a valid license as a chiropractor or any other entity that seeks to indemnify the professional liability

of a chiropractor shall notify the state chiropractic board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding ten thousand dollars. The notice shall contain the following information:

(1) The name and address of the person submitting the notification;

(2) The name and address of the insured who is the subject of the claim;

(3) The name of the person filing the written claim;

(4) The date of final disposition;

(5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) ~~The~~ Either board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the state chiropractic board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, "repeated malpractice" means three or more claims for malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of ten thousand dollars in favor of the claimant, and each involving tortious conduct by the chiropractor.

(F) All summaries, reports, and records received and maintained by the state chiropractic board and the health care professional standards board pursuant to this section shall be held in confidence and shall not be subject to discovery or introduction in evidence in any federal or state civil action

involving a chiropractor or health care facility arising out of matters that are the subject of the reporting required by this section. The ~~board~~ boards may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against a chiropractor, or in any subsequent trial or appeal of a board action or order.

The state chiropractic board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing a chiropractor or reviewing the chiropractor's privilege to practice within a particular facility. The board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.

(G) Except for reports filed by an individual pursuant to division (B) of this section, the state chiropractic board shall send a copy of any reports or summaries it receives pursuant to this section to the chiropractor. The chiropractor shall have the right to file a statement with ~~the board~~ both boards concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that reports to ~~the~~ either board or refers an impaired chiropractor to a treatment provider approved by the board under section 4734.40 of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, a professional association or society of chiropractors that sponsors a

committee or program to provide peer assistance to a chiropractor with substance abuse problems, a representative or agent of such a committee or program, and a member of the state chiropractic board shall not be held liable in damages to any person by reason of actions taken to refer a chiropractor to a treatment provider approved under section 4734.40 of the Revised Code for examination or treatment.

Sec. 4743.08. (A) As used in this section and in section 4743.09 of the Revised Code:

(1) "Dangerous drug" has the same meaning as in section 4729.01 of the Revised Code.

(2) "Health care provider" or "provider" means an individual who is licensed, certified, or registered by a board, commission, or agency that is created under or by virtue of Title XLVII of the Revised Code and provides health-related diagnostic, evaluative, or treatment services. In accordance with Chapter 119. of the Revised Code, the director of health may adopt rules further defining "health care provider."

(3) "Insurer" means any person that is authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, the Ohio fair plan underwriting association created under section 3929.43 of the Revised Code, any health insuring corporation, or any legal entity that is self-insured and provides benefits to its employees or members.

(B)(1) Except as provided in division (D) of this section, before a health care provider dispenses a dangerous drug or provides a medical product or service to a patient, the provider shall notify the patient or the patient's representative of all of the following:

(a) The provider's usual and customary charge for the drug or medical product or service;

(b) The portion of the charge described in division (B)(1)(a) of this section that the patient's insurer will pay for the drug, medical product, or service or, if the patient is a medicaid recipient, the portion the medicaid program will pay for the medicaid service;

(c) Any out-of-pocket amount the patient will be charged for the drug, medical product, or service.

(2) The notifications required by division (B)(1) of this section shall be provided in writing unless the patient and the provider are in different locations. Under those circumstances, the notifications may be given verbally.

To assist in providing the notification in writing, a health care provider may create forms that contain lists of commonly provided services and that identify for each of the services the information described in divisions (B)(1)(a) to (c) of this section. As necessary, separate forms may be created for different insurers and the medicaid program. Any form created shall be not more than eight and one-half inches by five and one-half inches in size. The list of services and the associated information shall be presented on one side of the form and shall be printed in not less than twelve-point type.

(C) Except as provided in division (D) of this section, a health care provider shall not dispense a dangerous drug or provide a medical product or service to a patient unless the patient or the patient's representative consents to being charged the out-of-pocket amount for the item. Consent shall be given in writing unless the patient and the provider are in

different locations. Under those circumstances, consent may be given verbally if the verbal consent is recorded by the provider.

(D) The requirements of divisions (B) and (C) of this section do not apply in emergency situations. The director of health may adopt rules specifying which situations are emergency situations. Application of the requirement of division (C) of this section is subject to section 5166.50 of the Revised Code when the patient is a medicaid recipient.

Sec. 4743.09. Notwithstanding any provision of the Revised Code to the contrary, a health care provider may advertise the provider's usual and customary charge for any product, procedure, or service that is provided, performed, or rendered by the provider. Any provision in a contract that prohibits this practice is void.

Sec. 4746.01. As used in this chapter:

(A) "Chiropractic claim," "dental claim," "medical claim," "optometric claim," "derivative claim," and "provider" have the same meanings as in section 3965.01 of the Revised Code.

(B) "Claim" means a chiropractic, dental, medical, optometric, or derivative claim filed under Chapter 3965. or 3967. of the Revised Code.

(C) "License" means an authorization evidenced by a license, certificate, registration, permit, card, or other authority that is issued or conferred by a regulatory authority to a provider or to an applicant for an initial license by which the provider or initial license applicant has or claims the privilege to engage in a profession, occupation, or occupational activity.

(D) "Regulatory authority" means the state medical board, state dental board, state nursing board, state board of optometry, state chiropractic board, state board of pharmacy, Ohio occupational therapy, physical therapy, and athletic trainers board, and the state board of emergency medical, fire, and transportation services.

Sec. 4746.02. (A)(1) There is hereby created the health care professional standards board consisting of nine members appointed as follows, within ninety days after the effective date of this section:

(a) Three members appointed by the state medical board, one for a term ending one year after the effective date of this section, one for a term ending two years after the effective date of this section, and one for a term ending three years after the effective date of this section;

(b) One member appointed by the state dental board, for a term ending four years after the effective date of this section;

(c) One member appointed by the state chiropractic board, for a term ending five years after the effective date of this section;

(d) One member appointed by the state board of pharmacy, for a term ending five years after the effective date of this section;

(e) Two members appointed by the state board of nursing, one for a term ending three years after the effective date of this section, and one for a term ending four years after the effective date of this section;

(f) One member appointed by the state board of optometry, for a term ending two years after the effective date of this

section.

(2) Members shall be appointed in consultation with the Ohio board of regents and shall either be the members of the respective boards who are responsible for developing, evaluating, or revising the applicable examinations for licensure of the respective occupation or profession or be members of the national organization responsible for creating such examinations.

(B) Except as otherwise provided in this division, after initial appointment, terms of office shall be for five years, each term ending on the same day of the same month as did the term that it succeeds.

A member appointed under division (A)(1)(f) of this section shall be appointed for a period of two years. Upon expiration of the term of the initial member appointed under that division, the Ohio occupational therapy, physical therapy, and athletic trainers board shall appoint the succeeding member. Upon expiration of the term of the member appointed by the Ohio occupational therapy, physical therapy, and athletic trainers board, the state board of emergency medical, fire, and transportation services shall appoint the succeeding member. Thereafter, the three boards shall rotate appointing that member in the order described in this division.

Each member shall hold office from the date of appointment until the end of the term for which the member was appointed. A vacancy shall be filled in the same manner prescribed for filling the position in which the vacancy occurs. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of the term. Any member shall

continue in office subsequent to the expiration date of the member's term until a successor takes office, or until a period of sixty days has elapsed, whichever occurs first.

(C) Each member of the board shall receive an amount fixed pursuant to division (J) of section 124.15 of the Revised Code for each day, or portion thereof, actually engaged in the discharge of official duties. Each member also shall be reimbursed for actual and necessary expenses incurred in the performance of those duties.

Sec. 4746.03. (A) The health care professional standards board shall do all of the following:

(1) Determine, pursuant to section 4746.04 of the Revised Code and in accordance with the appropriate standard of care of the occupation or profession, whether an action or omission by a provider in a claim constitutes gross negligence or whether a provider has engaged in a pattern of negligent behavior;

(2) Impose discipline in accordance with section 4746.05 of the Revised Code, or designate the appropriate regulatory authority to impose the disciplinary action recommended by the board;

(3) Create and maintain the database required under section 4746.06 of the Revised Code;

(4) Prepare and submit to the office of budget and management a budget for each biennium;

(5) Create and maintain a public web site;

(6) Coordinate and cooperate with the appropriate regulatory authority in conducting investigations and imposing discipline under this chapter;

(7) Perform any other duties as prescribed under this chapter;

(8) Adopt rules in accordance with Chapter 119. of the Revised Code as the board considers necessary to administer this chapter.

(B) The board may employ staff as the board determines necessary in carrying out the duties of the board under this chapter.

Sec. 4746.04. Within thirty days after a claim is filed under Chapter 3965. of the Revised Code, the administrator of medical injury compensation shall provide a copy of the claim to the health care professional standards board. The board shall investigate the claim to determine whether an action or omission by a provider listed in the claim was filed constitutes gross negligence or whether such a provider has engaged in a pattern of negligent behavior over a short period of time, as defined in rules adopted by the board. In conducting an investigation, the board may issue subpoenas, examine witnesses, and administer oaths. The board may request the appropriate regulatory authority to conduct the investigation. Neither the board nor the appropriate regulatory authority shall review or consider a determination of liability made under Chapter 3965. or 3967. of the Revised Code when conducting an investigation or making a determination under this section as to whether a provider's acts or omissions constitute gross negligence. If, after an investigation, the board determines that a provider's act or omission constitutes gross negligence or that a provider has engaged in a pattern of negligent behavior over a short period of time, the board shall send the provider a written notice of that determination in accordance with section 119.07 of the

Revised Code. If a provider requests a hearing in accordance with that section, the board shall conduct a hearing in accordance with Chapter 119. of the Revised Code. If, after a hearing, the board determines that a provider's act or omission constitutes gross negligence or that a provider has engaged in a pattern of negligent behavior over a short period of time, or if a provider fails to request a hearing as provided in that section, discipline shall be imposed against the provider in accordance with section 4746.05 of the Revised Code.

Sec. 4746.05. (A) The health care professional standards board may take any of the following actions against a provider's license if the board determines under section 4746.04 of the Revised Code that the provider's act or omission in a claim constitutes gross negligence or that the provider has engaged in a pattern of negligent behavior over a short period of time with respect to claims:

(1) A public reprimand;

(2) A license suspension for a definite period of time that is not less than two months nor more than two years;

(3) An indefinite license suspension, or a license suspension for an indefinite period of time that is at least two years;

(4) Permanent revocation of a license.

(B) In lieu of the board imposing a disciplinary action as described in division (A) of this section, the board may require the appropriate regulatory authority to impose the discipline.

(C) If the board disciplines a provider under this section or directs a regulatory authority to discipline a provider, the board shall do all of the following:

(1) Notify the United States secretary of health and human services in accordance with the federal "Health Care Quality Improvement Act of 1986," 100 Stat. 3743, 42 U.S.C. 11101 et seq., as amended;

(2) Notify the appropriate authority in each state other than this state that regulates the profession in which the provider is engaged;

(3) Publish the board's decision on the web site created and maintained by the board.

Sec. 4746.06. (A) The health care professional standards board, beginning one year after the effective date of this section, shall create and maintain a database of all claims and any reports or complaints about which the board receives notice. The board shall use the database to set standards for process improvements throughout the health care industry.

(B) The board shall use information from the database created under division (A) of this section to publish statistics of medical error and its costs in money, morbidity, and mortality and to estimate and publish the percentage of errors that are process related. The board shall publish the information required under this division beginning one year after the database is operational and each year thereafter.

(C) The board shall adopt rules in accordance with Chapter 119. of the Revised Code to set standards to discourage the practice of defensive medicine.

(D) The board shall examine the feasibility of a program to have all medical errors and near errors reported to the board by providers, similar to the federal "Aviation Safety Reporting Program." If the board determines that this reporting program is

feasible, the board shall adopt rules in accordance with Chapter 119. of the Revised Code to implement the reporting program.

Sec. 4755.47. (A) In accordance with Chapter 119. of the Revised Code, the physical therapy section of the Ohio occupational therapy, physical therapy, and athletic trainers board may refuse to grant a license to an applicant for an initial or renewed license as a physical therapist or physical therapist assistant or, by an affirmative vote of not less than five members, may limit, suspend, or revoke the license of a physical therapist or physical therapist assistant or reprimand, fine, place a license holder on probation, or require the license holder to take corrective action courses, on any of the following grounds:

(1) Habitual indulgence in the use of controlled substances, other habit-forming drugs, or alcohol to an extent that affects the individual's professional competency;

(2) Conviction of a felony or a crime involving moral turpitude, regardless of the state or country in which the conviction occurred;

(3) Obtaining or attempting to obtain a license issued by the physical therapy section by fraud or deception, including the making of a false, fraudulent, deceptive, or misleading statement;

(4) An adjudication by a court, as provided in section 5122.301 of the Revised Code, that the applicant or licensee is incompetent for the purpose of holding the license and has not thereafter been restored to legal capacity for that purpose;

(5) Subject to section 4755.471 of the Revised Code, violation of the code of ethics adopted by the physical therapy

section;

(6) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate sections 4755.40 to 4755.56 of the Revised Code or any order issued or rule adopted under those sections;

(7) Failure of one or both of the examinations required under section 4755.43 or 4755.431 of the Revised Code;

(8) Permitting the use of one's name or license by a person, group, or corporation when the one permitting the use is not directing the treatment given;

(9) Denial, revocation, suspension, or restriction of authority to practice a health care occupation, including physical therapy, for any reason other than a failure to renew, in Ohio or another state or jurisdiction;

(10) Failure to maintain minimal standards of practice in the administration or handling of drugs, as defined in section 4729.01 of the Revised Code, or failure to employ acceptable scientific methods in the selection of drugs, as defined in section 4729.01 of the Revised Code, or other modalities for treatment;

(11) Willful betrayal of a professional confidence;

(12) Making a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients in relation to the practice of physical therapy;

(13) A departure from, or the failure to conform to, minimal standards of care required of licensees when under the same or similar circumstances, whether or not actual injury to a patient is established;

(14) Obtaining, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(15) Violation of the conditions of limitation or agreements placed by the physical therapy section on a license to practice;

(16) Failure to renew a license in accordance with section 4755.46 of the Revised Code;

(17) Except as provided in section 4755.471 of the Revised Code, engaging in the division of fees for referral of patients or receiving anything of value in return for a specific referral of a patient to utilize a particular service or business;

(18) Inability to practice according to acceptable and prevailing standards of care because of mental illness or physical illness, including physical deterioration that adversely affects cognitive, motor, or perception skills;

(19) The revocation, suspension, restriction, or termination of clinical privileges by the United States department of defense or department of veterans affairs;

(20) Termination or suspension from participation in the medicare or medicaid program established under Title XVIII and Title XIX, respectively, of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, for an act or acts that constitute a violation of sections 4755.40 to 4755.56 of the Revised Code;

(21) Failure of a physical therapist to maintain supervision of a student, physical therapist assistant, unlicensed support personnel, other assistant personnel, or a license applicant in accordance with the requirements of

sections 4755.40 to 4755.56 of the Revised Code and rules adopted under those sections;

(22) Failure to complete continuing education requirements as prescribed in section 4755.51 or 4755.511 of the Revised Code or to satisfy any rules applicable to continuing education requirements that are adopted by the physical therapy section;

(23) Conviction of a misdemeanor when the act that constitutes the misdemeanor occurs during the practice of physical therapy;

(24)(a) Except as provided in division (A)(24)(b) of this section, failure to cooperate with an investigation conducted by the physical therapy section or the health care professional standards board, including failure to comply with a subpoena or orders issued by the section or the board or failure to answer truthfully a question presented by the section or the board at a deposition or in written interrogatories.

(b) Failure to cooperate with an investigation does not constitute grounds for discipline under this section if a court of competent jurisdiction issues an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence at issue.

(25) Regardless of whether the contact or verbal behavior is consensual, engaging with a patient other than the spouse of the physical therapist or physical therapist assistant, in any of the following:

(a) Sexual contact, as defined in section 2907.01 of the Revised Code;

(b) Verbal behavior that is sexually demeaning to the patient or may be reasonably interpreted by the patient as

sexually demeaning.

(26) Failure to notify the physical therapy section of a change in name, business address, or home address within thirty days after the date of change;

(27) Except as provided in division (B) of this section:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers physical therapy, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that provider;

(b) Advertising that the individual will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers physical therapy, would otherwise be required to pay~~;~~.

(28) Violation of any section of this chapter or rule adopted under it.

(B) Sanctions shall not be imposed under division (A)(27) of this section against any individual who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the physical therapy section upon request.

(2) For professional services rendered to any other person

licensed pursuant to sections 4755.40 to 4755.56 of the Revised Code to the extent allowed by those sections and the rules of the physical therapy section.

(C) When a license is revoked under this section, application for reinstatement may not be made sooner than one year after the date of revocation. The physical therapy section may accept or refuse an application for reinstatement and may require that the applicant pass an examination as a condition for reinstatement.

When a license holder is placed on probation under this section, the physical therapy section's order for placement on probation shall be accompanied by a statement of the conditions under which the individual may be removed from probation and restored to unrestricted practice.

(D) When an application for an initial or renewed license is refused under this section, the physical therapy section shall notify the applicant in writing of the section's decision to refuse issuance of a license and the reason for its decision.

(E) On receipt of a complaint that a person licensed by the physical therapy section has committed any of the actions listed in division (A) of this section, the physical therapy section may immediately suspend the license of the physical therapist or physical therapist assistant prior to holding a hearing in accordance with Chapter 119. of the Revised Code if it determines, based on the complaint, that the person poses an immediate threat to the public. The physical therapy section may review the allegations and vote on the suspension by telephone conference call. If the physical therapy section votes to suspend a license under this division, the physical therapy section shall issue a written order of summary suspension to the

person in accordance with section 119.07 of the Revised Code. If the person fails to make a timely request for an adjudication under Chapter 119. of the Revised Code, the physical therapy section shall enter a final order permanently revoking the person's license. Notwithstanding section 119.12 of the Revised Code, a court of common pleas shall not grant a suspension of the physical therapy section's order of summary suspension pending the determination of an appeal filed under that section. Any order of summary suspension issued under this division shall remain in effect, unless reversed on appeal, until a final adjudication order issued by the physical therapy section pursuant to division (A) of this section becomes effective. The physical therapy section shall issue its final adjudication order regarding an order of summary suspension issued under this division not later than ninety days after completion of its hearing. Failure to issue the order within ninety days shall result in immediate dissolution of the suspension order, but shall not invalidate any subsequent, final adjudication order.

(F) If an individual who holds a license issued under sections 4755.40 to 4755.56 of the Revised Code is listed in a claim filed under Chapter 3965. of the Revised Code, the physical therapy section shall suspend any investigation and shall not take disciplinary action under this section against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its investigation under Chapter 4746. of the Revised Code.

The physical therapy section shall take any disciplinary action required by the health care professional standards board against a license holder under sections 4755.40 to 4755.56 of

the Revised Code pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a license holder, the physical therapy section shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the physical therapy section may account for that disciplinary action in any future disciplinary action taken against the license holder.

Sec. 4765.11. (A) The state board of emergency medical, fire, and transportation services shall adopt, and may amend and rescind, rules in accordance with Chapter 119. of the Revised Code and division (C) of this section that establish all of the following:

(1) Procedures for its governance and the control of its actions and business affairs;

(2) Standards for the performance of emergency medical services by first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, and emergency medical technicians-paramedic;

(3) Application fees for certificates of accreditation, certificates of approval, certificates to teach, and certificates to practice, which shall be deposited into the trauma and emergency medical services fund created in section 4513.263 of the Revised Code;

(4) Criteria for determining when the application or renewal fee for a certificate to practice may be waived because an applicant cannot afford to pay the fee;

(5) Procedures for issuance and renewal of certificates of accreditation, certificates of approval, certificates to teach,

and certificates to practice, including any procedures necessary to ensure that adequate notice of renewal is provided in accordance with division (D) of section 4765.30 of the Revised Code;

(6) Procedures for suspending or revoking certificates of accreditation, certificates of approval, certificates to teach, and certificates to practice;

(7) Grounds for suspension or revocation of a certificate to practice issued under section 4765.30 of the Revised Code and for taking any other disciplinary action against a first responder, EMT-basic, EMT-I, or paramedic;

(8) Procedures for taking disciplinary action against a first responder, EMT-basic, EMT-I, or paramedic;

(9) Standards for certificates of accreditation and certificates of approval;

(10) Qualifications for certificates to teach;

(11) Requirements for a certificate to practice;

(12) The curricula, number of hours of instruction and training, and instructional materials to be used in adult and pediatric emergency medical services training programs and adult and pediatric emergency medical services continuing education programs;

(13) Procedures for conducting courses in recognizing symptoms of life-threatening allergic reactions and in calculating proper dosage levels and administering injections of epinephrine to adult and pediatric patients who suffer life-threatening allergic reactions;

(14) Examinations for certificates to practice;

(15) Procedures for administering examinations for certificates to practice;

(16) Procedures for approving examinations that demonstrate competence to have a certificate to practice renewed without completing an emergency medical services continuing education program;

(17) Procedures for granting extensions and exemptions of emergency medical services continuing education requirements;

(18) Procedures for approving the additional emergency medical services first responders are authorized by division (C) of section 4765.35 of the Revised Code to perform, EMTs-basic are authorized by division (C) of section 4765.37 of the Revised Code to perform, EMTs-I are authorized by division (B)(5) of section 4765.38 of the Revised Code to perform, and paramedics are authorized by division (B)(6) of section 4765.39 of the Revised Code to perform;

(19) Standards and procedures for implementing the requirements of section 4765.06 of the Revised Code, including designations of the persons who are required to report information to the board and the types of information to be reported;

(20) Procedures for administering the emergency medical services grant program established under section 4765.07 of the Revised Code;

(21) Procedures consistent with Chapter 119. of the Revised Code for appealing decisions of the board;

(22) Minimum qualifications and peer review and quality improvement requirements for persons who provide medical direction to emergency medical service personnel;

(23) The manner in which a patient, or a patient's parent, guardian, or custodian may consent to the board releasing identifying information about the patient under division (D) of section 4765.102 of the Revised Code;

(24) Circumstances under which a training program or continuing education program, or portion of either type of program, may be taught by a person who does not hold a certificate to teach issued under section 4765.23 of the Revised Code;

(25) Certification cycles for certificates issued under sections 4765.23 and 4765.30 of the Revised Code and certificates issued by the executive director of the state board of emergency medical, fire, and transportation services under section 4765.55 of the Revised Code that establish a common expiration date for all certificates.

(B) The state board of emergency medical, fire, and transportation services may adopt, and may amend and rescind, rules in accordance with Chapter 119. of the Revised Code and division (C) of this section that establish the following:

(1) Specifications of information that may be collected under the trauma system registry and incidence reporting system created under section 4765.06 of the Revised Code;

(2) Standards and procedures for implementing any of the recommendations made by any committees of the board or under section 4765.04 of the Revised Code;

(3) Requirements that a person must meet to receive a certificate to practice as a first responder pursuant to division (A)(2) of section 4765.30 of the Revised Code;

(4) Any other rules necessary to implement this chapter.

(C) In developing and administering rules adopted under this chapter, the state board of emergency medical, fire, and transportation services shall consult with regional directors and regional physician advisory boards created by section 4765.05 of the Revised Code and emphasize the special needs of pediatric and geriatric patients.

(D) Except as otherwise provided in this division, before adopting, amending, or rescinding any rule under this chapter, the state board of emergency medical, fire, and transportation services shall submit the proposed rule to the director of public safety for review. The director may review the proposed rule for not more than sixty days after the date it is submitted. If, within this sixty-day period, the director approves the proposed rule or does not notify the board that the rule is disapproved, the board may adopt, amend, or rescind the rule as proposed. If, within this sixty-day period, the director notifies the board that the proposed rule is disapproved, the board shall not adopt, amend, or rescind the rule as proposed unless at least twelve members of the board vote to adopt, amend, or rescind it.

This division does not apply to an emergency rule adopted in accordance with section 119.03 of the Revised Code.

(E) If an individual who holds a certificate issued under this chapter is listed in a claim filed under Chapter 3965. of the Revised Code, the state board of emergency medical, fire, and transportation services shall suspend any investigation and shall not take disciplinary action against that individual for conduct relating to that claim unless otherwise required by the health care professional standards board or until the health care professional standards board has concluded its

investigation under Chapter 4746. of the Revised Code.

The state board of emergency medical, fire, and transportation services shall take any disciplinary action required by the health care professional standards board against a certificate holder under this chapter pursuant to section 4746.05 of the Revised Code. If the health care professional standards board imposes discipline on a certificate holder, the state board of emergency medical, fire, and transportation services shall not take disciplinary action for the same conduct that is the subject of the disciplinary action ordered by the health care professional standards board. However, the state board of emergency medical, fire, and transportation services may account for that disciplinary action in any future disciplinary action taken against the certificate holder.

Sec. 5162.63. The medicaid director shall seek government and nongovernment grants and donations to help fund the medicaid components authorized by section 5166.53 of the Revised Code. All such grants and donations shall be deposited into the medicaid donations fund, which is hereby created in the state treasury. All money in the fund shall be used for the medicaid components authorized by section 5166.53 of the Revised Code.

Sec. 5164.01. As used in this chapter:

(A) "DRG" means diagnosis-related group.

(B) "Early and periodic screening, diagnostic, and treatment services" has the same meaning as in the "Social Security Act," section 1905(r), 42 U.S.C. 1396d(r).

~~(B)~~ (C) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

~~(C)~~ (D) "Healthcheck" means the component of the medicaid

program that provides early and periodic screening, diagnostic, and treatment services.

~~(D)~~ (E) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(E)~~ (F) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

~~(F)~~ (G) "ICDS participant" means a dual eligible individual who participates in the integrated care delivery system.

~~(G)~~ (H) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

~~(H)~~ (I) "Integrated care delivery system" and "ICDS" mean the demonstration project authorized by section 5164.91 of the Revised Code.

~~(I)~~ (J) "Mandatory services" means the health care services and items that must be covered by the medicaid state plan as a condition of the state receiving federal financial participation for the medicaid program.

~~(J)~~ (K) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

~~(K)~~ (L) "Medicaid provider" means a person or government entity with a valid provider agreement to provide medicaid services to medicaid recipients. To the extent appropriate in the context, "medicaid provider" includes a person or government entity applying for a provider agreement, a former medicaid provider, or both.

~~(L)~~ (M) "Medicaid services" means either or both of the

following:

(1) Mandatory services;

(2) Optional services that the medicaid program covers.

~~(M)~~ (N) "Noninstitutional provider" means any medicaid provider other than a hospital, nursing facility, or ICF/IID.

(O) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(N)~~ (P) "Optional services" means the health care services and items that may be covered by the medicaid state plan or a federal medicaid waiver and for which the medicaid program receives federal financial participation.

~~(O)~~ (Q) "Prescribed drug" has the same meaning as in 42 C.F.R. 440.120.

~~(P)~~ (R) "Provider agreement" means an agreement to which all of the following apply:

(1) It is between a medicaid provider and the department of medicaid;

(2) It provides for the medicaid provider to provide medicaid services to medicaid recipients;

(3) It complies with 42 C.F.R. 431.107(b).

~~(Q)~~ (S) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

Sec. 5164.07. (A) The medicaid program shall include coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The medicaid program shall cover a minimum of forty-

eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The medicaid program shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within forty-eight hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or

newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C) The department of medicaid, in administering the medicaid program, may not do either of the following:

(1) Terminate the provider agreement of a health care professional or health care facility solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(2) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(D) This section does not do any of the following:

(1) Require the medicaid program to cover inpatient or follow-up care that is not received in accordance with the program's terms pertaining to the health care professionals and facilities from which a medicaid recipient is authorized to receive health care services.

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.113 or 3965.01 of the Revised Code.

Sec. 5164.78. This section is subject to section 5166.50 of the Revised Code.

If a hospital, hospital-owned provider, or institutional provider provides to a medicaid recipient an outpatient service that may also be provided to a medicaid recipient by a noninstitutional provider, the total medicaid payment made to the hospital, hospital-owned provider, or institutional provider for the service shall not exceed by more than ten per cent the total medicaid payment that would be made to a noninstitutional provider for the service.

Sec. 5164.83. (A) Except as provided in division (B) of this section, if a hospital emergency department provides medicaid services to a medicaid recipient who has been determined under section 3727.61 of the Revised Code to have a

nonemergency medical condition, the medicaid services that the hospital emergency department provides to the recipient to diagnose and treat the nonemergency medical condition shall not be billed to the medicaid program as an emergency room visit claim, as that term is defined in rules adopted under section 5164.02 of the Revised Code.

(B) Division (A) of this section does not apply in the case of medicaid services provided by a hospital emergency department to diagnose and treat a medicaid recipient who was determined under section 3727.61 of the Revised Code to have a nonemergency medical condition if both of the following are the case:

(1) The recipient was referred, pursuant to section 3727.61 of the Revised Code, to receive services at the space within or adjacent to the hospital that is described in division (C)(1) or (2) of that section.

(2) A determination was made while services were being provided at the space to which the recipient was referred that the recipient had an emergency medical condition, the recipient was returned to the hospital emergency department for treatment of the emergency medical condition, and the hospital emergency department treated the recipient's emergency medical condition.

Sec. 5165.15. (A) Except as otherwise provided by sections 5165.151 to 5165.157 and 5165.34 of the Revised Code, the total per medicaid day payment rate that the department of medicaid shall pay a nursing facility provider for nursing facility services the provider's nursing facility provides during a fiscal year shall ~~equal~~ be determined as follows:

(1) Determine the sum of all of the following:

~~(1)~~(a) The per medicaid day payment rate for ancillary and support costs determined for the nursing facility under section 5165.16 of the Revised Code;

~~(2)~~(b) The per medicaid day payment rate for capital costs determined for the nursing facility under section 5165.17 of the Revised Code;

~~(3)~~(c) The per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code;

~~(4)~~(d) The per medicaid day payment rate for tax costs determined for the nursing facility under section 5165.21 of the Revised Code;

~~(5)~~(e) If the nursing facility qualifies as a critical access nursing facility, the nursing facility's critical access incentive payment paid under section 5165.23 of the Revised Code~~;~~.

~~(6) The~~(2) Reduce the sum determined under division (A)(1) of this section by the following:

(a) For fiscal year 2016, two per cent;

(b) For fiscal year 2017, four per cent;

(c) For fiscal year 2018 and each fiscal year thereafter, six per cent.

(3) Add the per medicaid day valued-based purchasing payment determined for the nursing facility under section 5165.24 of the Revised Code to the amount determined under division (A)(2) of this section;

(4) Add the per medicaid day quality incentive payment

~~paid to~~ determined for the nursing facility under section 5165.25 of the Revised Code to the amount determined under division (A)(3) of this section.

(B) In addition to paying a nursing facility provider the nursing facility's total rate determined under division (A) of this section for a fiscal year, the department shall pay the provider a quality bonus under section 5165.26 of the Revised Code for that fiscal year if the provider's nursing facility is a qualifying nursing facility, as defined in that section, for that fiscal year. The quality bonus shall not be part of the total rate.

Sec. 5165.23. (A) Each fiscal year, the department of medicaid shall determine the critical access incentive payment for each nursing facility that qualifies as a critical access nursing facility. To qualify as a critical access nursing facility for a fiscal year, a nursing facility must meet all of the following requirements:

(1) The nursing facility must be located in an area that, on December 31, 2011, was designated an empowerment zone under the "Internal Revenue Code of 1986," section 1391, 26 U.S.C. 1391.

(2) The nursing facility must have an occupancy rate of at least eighty-five per cent as of the last day of the calendar year immediately preceding the fiscal year.

(3) The nursing facility must have a medicaid utilization rate of at least sixty-five per cent as of the last day of the calendar year immediately preceding the fiscal year.

(4) The nursing facility must have been awarded at least five points for meeting accountability measures under section

5165.25 of the Revised Code for the fiscal year and at least one of the five points must have been awarded for meeting the accountability measures identified in divisions (C)(9), (10), (11), (12), and (14) of section 5165.25 of the Revised Code.

(B) A critical access nursing facility's critical access incentive payment for a fiscal year shall equal five per cent of the ~~portion of the~~ nursing facility's total rate for the fiscal year ~~that is the sum of the rates and payment identified in divisions (A)(1) to (4) and (6) of~~ , as determined under division (A) of section 5165.15 of the Revised Code, excluding the portions of the rate that represent the critical access payment and the value based purchasing payment.

Sec. 5165.24. (A) As used in this section:

(1) "Electronic medication administration record system" means technology that automatically documents the administration of medication into electronic health record technology by using electronic tracking sensors.

(2) "Long-stay resident" means an individual who has resided in a nursing facility for at least one hundred one days.

(3) "Measurement period" means the following:

(a) For fiscal year 2016, the period beginning July 1, 2014, and ending December 31, 2014;

(b) For each subsequent fiscal year, the calendar year immediately preceding the fiscal year.

(4) "Nurse aide" has the same meaning as in section 3721.21 of the Revised Code.

(5) "Preferences for everyday living inventory" means a tool used to document the lifestyle preferences of older persons

and to provide information to caregivers to assist in customizing care delivery.

(6) "Short-stay resident" means a nursing facility resident who is not a long-stay resident.

(B) Using the funds made available for a fiscal year by the rate reductions made under division (A)(2) of section 5165.15 of the Revised Code, the department of medicaid shall determine each nursing facility's value based purchasing payment for that fiscal year. A nursing facility's value based purchasing payment shall be based on its ranking under division (C) of this section. The largest value based purchasing payment shall be made to nursing facilities with the highest ranking.

(C)(1) For each fiscal year, the department shall rank each nursing facility based on the number of the following quality indicators that the nursing facility meets for the measurement period:

(a) The nursing facility's residents received an average of at least two and eight-tenths hours of direct care per inpatient day from nurse aides and an average of at least one and three-tenths hours of nursing care per inpatient day from registered nurses, other than the nursing facility's director of nursing, and from licensed practical nurses.

(b) At least eighty-five per cent of the nursing facility's long-stay residents received direct care from not more than twelve different nurse aides during any thirty-day period.

(c) Not more than the target percentage of the nursing facility's short-stay residents had new or worsened pressure ulcers and not more than the target percentage of long-stay

residents at high risk for pressure ulcers had pressure ulcers.

(d) Not more than the target percentage of the nursing facility's short-stay residents newly received an antipsychotic medication and not more than the target percentage of the nursing facility's long-stay residents received an antipsychotic medication.

(e) The number of the nursing facility's residents who had avoidable inpatient hospital admissions did not exceed the target rate.

(f) The nursing facility uses the preferences for everyday living inventory.

(g) The nursing facility uses the electronic medication administration record system.

(2) The department shall specify the target percentage for the purpose of divisions (C)(1)(c) and (d) of this section. The amount specified for division (C)(1)(c) of this section may differ from the amount specified for division (C)(1)(d) of this section and the amount specified for short-stay residents may differ from the amount specified for long-stay residents. The department also shall specify the target rate for the purpose of division (C)(1)(e) of this section.

Sec. 5165.98. This section is subject to section 5166.50 of the Revised Code.

If a medicaid recipient receiving nursing facility services has resided in this state for less than one year, the department of medicaid shall seek to have the state in which the recipient resided immediately before coming to this state pay for the services.

Sec. 5166.01. As used in this chapter:

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of medicaid or, if a state agency or political subdivision contracts with the department under section 5162.35 of the Revised Code to administer the component, that state agency or political subdivision.

"Care management system" means the system established under section 5167.03 of the Revised Code.

"Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

"Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital services, nursing facility services, or ICF/IID services.

"Hospital" has the same meaning as in section 3727.01 of the Revised Code.

"Hospital long-term care unit" has the same meaning as in section 5168.40 of the Revised Code.

"ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.

"ICF/IID" and "ICF/IID services" have the same meanings as

in section 5124.01 of the Revised Code.

"Integrated care delivery system" and "ICDS" have the same meanings as in section 5164.01 of the Revised Code.

"Level of care determination" means a determination of whether an individual needs the level of care provided by a hospital, nursing facility, or ICF/IID and whether the individual, if determined to need that level of care, would receive hospital services, nursing facility services, or ICF/IID services if not for a home and community-based services medicaid waiver component.

"Medicaid buy-in for workers with disabilities program" has the same meaning as in section 5163.01 of the Revised Code.

"Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under the "Social Security Act," section 1115 or 1915, 42 U.S.C. 1315 or 1396n. "Medicaid waiver component" does not include a care management system established under section 5167.03 of the Revised Code.

"Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

"Ohio home care waiver program" means the home and community-based services medicaid waiver component that is known as Ohio home care and was created pursuant to section 5166.11 of the Revised Code.

"Ohio transitions II aging carve-out program" means the home and community-based services medicaid waiver component that

is known as Ohio transitions II aging carve-out and was created pursuant to section 5166.11 of the Revised Code.

"Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

"Residential treatment facility" means a residential facility licensed by the department of mental health and addiction services under section 5119.34 of the Revised Code, or an institution certified by the department of job and family services under section 5103.03 of the Revised Code, that serves children and either has more than sixteen beds or is part of a campus of multiple facilities or institutions that, combined, have a total of more than sixteen beds.

"Skilled nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

"Unified long-term services and support medicaid waiver component" means the medicaid waiver component authorized by section 5166.14 of the Revised Code.

Sec. 5166.50. (A) The medicaid director shall request that the United States secretary of health and human services enter into an enforceable agreement with the director that provides for at least all of the following:

(1) The implementation of Chapter 195. of the Revised Code;

(2) Hospitals to be able to implement section 3727.61 of the Revised Code despite federal requirements;

(3) Health care providers to be able to comply with division (C) of section 4743.08 of the Revised Code when a patient is a medicaid recipient;

(4) No federal financial participation to be withheld due to any of the following:

(a) Implementation of Chapter 195. or sections 3727.61, 4731.74, 5164.78, 5165.98, 5166.52 to 5166.5210, 5166.53, 5167.16, 5167.32, and 5167.33 of the Revised Code;

(b) Application of division (C) of section 4743.08 of the Revised Code when a patient is a medicaid recipient;

(c) For the purpose of section 5167.04 of the Revised Code, enrollment of individuals designated for participation in the care management system pursuant to divisions (B)(1) and (2) of section 5167.03 of the Revised Code in medicaid managed care organizations that are regional networks consisting of hospitals.

(5) The federal government to pay the state a penalty for failure to comply in full with any provision of the agreement.

(B) Unless the agreement specified in division (A) of this section is in effect:

(1) Chapter 195. and sections 3727.61, 4731.74, 5164.78, 5165.98, 5166.52 to 5166.5210, 5166.53, 5167.16, 5167.32, and 5167.33 of the Revised Code shall not be implemented.

(2) Division (C) of section 4743.08 of the Revised Code shall not apply when a patient is a medicaid recipient.

(3) For the purpose of section 5167.04 of the Revised Code, the department shall not enroll individuals designated for participation in the care management system pursuant to divisions (B)(1) and (2) of section 5167.03 of the Revised Code in medicaid managed care organizations that are regional networks consisting of hospitals.

Sec. 5166.52. (A) As used in sections 5166.52 to 5166.5210 of the Revised Code:

(1) "Adult" means an individual who is at least eighteen years of age.

(2) "Buckeye account" means a modified health savings account established under section 5166.522 of the Revised Code.

(3) "Contribution" means the amounts that an individual contributes to the individual's buckeye account and are contributed to the account on the individual's behalf under divisions (C) and (D) of section 5166.522 of the Revised Code. "Contribution" does not mean the portion of an individual's buckeye account that consists of medicaid funds deposited under division (B) of section 5166.522 of the Revised Code or section 5166.524 of the Revised Code.

(4) "Core portion" means the portion of a healthy Ohio program participant's buckeye account that consists of the following:

(a) The amount of contributions to the account;

(b) The amounts awarded to the account under divisions (C) and (D) of section 5166.524 of the Revised Code.

(5) "Eligible employer-sponsored health plan" has the same meaning as in section 5000A(f)(2) of the "Internal Revenue Code of 1986," 26 U.S.C. 5000A(f)(2).

(6) "Healthy Ohio program" means the medicaid waiver component established under sections 5166.52 to 5166.5210 of the Revised Code under which medicaid recipients specified in division (B)(2) of this section enroll in comprehensive health plans and contribute to buckeye accounts.

(7) "Healthy Ohio program debit swipe card" means a debit swipe card issued by a managed care organization to a healthy Ohio program participant under section 5166.523 of the Revised Code.

(8) "Minor" means an individual who is less than eighteen years of age.

(9) "Not-for-profit organization" means an organization that is exempt from federal income taxation under section 501(a) and (c)(3) of the "Internal Revenue Code of 1986," 26 U.S.C. 501(a) and (c)(3).

(10) "Ward of the state" means both of the following:

(a) An individual who is a ward, as defined in section 2111.01 of the Revised Code;

(b) A minor who is in the temporary or permanent custody of a public children services agency or private child placing agency.

(11) "Workforce development activity" and "workforce development agency" have the same meanings as in section 6301.01 of the Revised Code.

(B) Subject to section 5166.50 of the Revised Code, all of the following apply:

(1) The medicaid director shall establish a medicaid waiver component to be known as the healthy Ohio program.

(2) Each individual, other than a ward of the state, to whom either of the following applies shall participate in the healthy Ohio program as a condition of medicaid eligibility:

(a) The individual is determined to be eligible for

medicaid on the basis of being included in the category identified by the department of medicaid as covered families and children.

(b) If, pursuant to section 5166.53 of the Revised Code, the medicaid program covers the group described in division (C)(4)(d) of that section or, pursuant to the priorities specified in division (D) of that section, a portion of that group, the individual is determined to be eligible for medicaid on the basis of being included in that group or portion of that group.

(3) A healthy Ohio program participant shall not receive medicaid services under the fee-for-service component of medicaid or participate in the care management system.

(4) Notwithstanding any other state statute, only medicaid recipients not required to participate in the healthy Ohio program shall receive medicaid services under the fee-for-service component of medicaid or participate in the care management system.

Sec. 5166.521. A healthy Ohio program participant shall enroll in a comprehensive health plan offered by a managed care organization under contract with the department of medicaid. All of the following apply to the health plan:

(A) It shall cover physician, hospital inpatient, hospital outpatient, pregnancy-related, mental health, pharmaceutical, laboratory, and other health care services the medicaid director determines necessary.

(B) In the case of a health professional service also covered by the medicare program, it shall have the same payment rate as the medicare payment rate for the health professional service.

(C) It shall not begin to pay for any services it covers until the amount of the noncore portion of the participant's buckeye account is zero.

(D) It shall require copayments for services covered by the health plan, except that a participant's copayments shall be waived whenever the amount of the core portion of the participant's buckeye account is zero.

(E) It shall have the following payout limits:

(1) Three hundred thousand dollars per year;

(2) One million dollars for a participant's lifetime.

Sec. 5166.522. (A)(1) A buckeye account shall be established for each individual who is determined to be eligible for the healthy Ohio program. Subject to division (A)(2) of this section, an individual's buckeye account shall consist of both of the following:

(a) The medicaid funds deposited into the account under division (B) of this section and division (A) of section 5166.524 of the Revised Code;

(b) Contributions made by the individual and on the individual's behalf under divisions (C) and (D) of this section.

(2) A buckeye account shall not have more than ten thousand dollars in it at one time.

(B)(1) Subject to division (A)(2) of this section, the following amount of medicaid funds shall be deposited each year into the buckeye account of an individual participating in the healthy Ohio program:

(a) If the individual is an adult, one thousand dollars;

(b) If the individual is a minor, five hundred dollars.

(2) Except in the case of an individual who is not required to make contributions to the individual's buckeye account, the initial deposit of medicaid funds into an individual's buckeye account shall not occur until the initial contribution to the individual's account is made under division (C) or (D) of this section.

(C) Subject to divisions (A)(2), (D), and (F) of this section, an individual who is seeking to participate, or is participating, in the healthy Ohio program shall contribute at least the greater of the following each year to the individual's buckeye account:

(1) One dollar;

(2) The lesser of the following:

(a) Two per cent of the individual's annual countable family income;

(b) The following amount:

(i) If the individual is an adult who is not a smoker, ninety-nine dollars;

(ii) If the individual is a minor who is not a smoker, forty-nine dollars;

(iii) If the individual is a smoker, regardless of age, one hundred forty-nine dollars.

(D)(1) Subject to division (D)(2) of this section, the following may make contributions to an individual's buckeye account on the individual's behalf:

(a) If the individual is a minor, the individual's parent

or caretaker relative;

(b) The individual's employer, but only up to fifty per cent of the contributions the individual is required to make;

(c) A not-for-profit organization, but only up to seventy-five per cent of the contributions the individual is required to make;

(d) The managed care organization that offers the health plan in which the individual enrolls under the healthy Ohio program, but both of the following apply to such contributions:

(i) They shall be used only to pay the costs for the individual to participate in a health-related incentive available under the health plan, such as completion of a risk assessment or participation in a smoking cessation program.

(ii) They cannot reduce the amount the individual is required to contribute.

(2) Contributions made on an individual's behalf under divisions (D)(1)(b) and (c) of this section shall be coordinated in a manner so that the individual, or if the individual is a minor, the individual's parent or caretaker relative, makes at least twenty-five per cent of the contributions the individual is required to make.

(E) Except in the case of an individual who is not required to make contributions to the individual's buckeye account, an individual shall not begin to participate in the healthy Ohio program until the initial contribution to the individual's buckeye account is made under division (C) or (D) of this section. The contributions may be made in twelve monthly installments. The first monthly installment counts as the initial contribution.

(F)(1) The following portion of the amount that remains in a healthy Ohio program participant's buckeye account at the end of a year shall carry forward in the account for the next year:

(a) If the participant satisfies requirements regarding preventative health services established in rules authorized by section 5166.5210 of the Revised Code, the entire amount;

(b) If division (F)(1)(a) of this section does not apply, the core portion of the account.

(2) The amount of contributions that must be made to a healthy Ohio program participant's buckeye account for a year shall be reduced by the amount that is carried forward under division (F)(1) of this section. If the amount carried forward is at least the amount of contributions that division (C) of this section requires for that year, no contributions are required to be made for the participant that year.

(G) A buckeye account shall be used only for the following:

(1) To pay for the expenses for which a healthy Ohio program debit swipe card may be used as specified in division (A) of section 5166.523 of the Revised Code;

(2) Other purposes authorized by rules adopted under section 5166.5210 of the Revised Code.

(H) The department of medicaid shall provide for a healthy Ohio program participant to receive monthly statements showing the current amount in the participant's buckeye account and the previous month's expenditures from the account. The statement shall specify how much of the amount in the participant's buckeye account is the core portion and how much is the noncore portion. The department may arrange for the statements to be

provided in an electronic format.

Sec. 5166.523. (A) A managed care organization that offers the health plan in which a healthy Ohio program participant enrolls shall issue a debit swipe card to be used to pay only for the following:

(1) Until the amount of the noncore portion of the participant's buckeye account is zero, the costs of health care services that are covered by the health plan and provided to the participant by a provider participating in the health plan;

(2) The participant's copayments under division (A)(4) of section 5166.521 of the Revised Code;

(3) Subject to rules authorized by section 5166.5210 of the Revised Code, the costs of health care services, including dental and vision services, that are medically necessary for the participant but not covered by the health plan.

(B)(1) A healthy Ohio program participant's debit swipe card shall be credited with one point for each of the following:

(a) Each dollar of medicaid funds deposited into the participant's buckeye account under division (B) of section 5166.522 of the Revised Code;

(b) Each dollar contributed to the participant's buckeye account under divisions (C) and (D) of section 5166.522 of the Revised Code;

(c) Each point awarded to the participant under section 5166.524 of the Revised Code.

(2) Each time a healthy Ohio program participant uses the participant's debit swipe card, the amount for which the card is used shall be deducted from the number of points on the card as

follows:

(a) If the card is used for the purpose specified in division (A)(1) of this section, the deduction shall come from the points representing the noncore portion of the participant's buckeye account.

(b) If the card is used for the purpose specified in division (A)(2) or (3) of this section, the deduction shall come from the points representing the core portion of the participant's buckeye account.

(C) A healthy Ohio program participant's debit swipe card shall do all of the following:

(1) Verify the participant's eligibility for the healthy Ohio program;

(2) Determine whether the service the participant seeks is covered under the health plan;

(3) Determine whether the provider from which the participant seeks the service is a participating provider under the health plan;

(4) Be linked to the participant's buckeye account in a manner that enables the participant to know at the point of service what will be deducted from the noncore portion and core portion of the participant's buckeye account for the service and how much will remain in each portion of the account after the deduction.

Sec. 5166.524. (A) The medicaid director shall establish a system under which points are awarded in accordance with this section to healthy Ohio program debit swipe cards. One dollar of medicaid funds shall be deposited into a healthy Ohio program

participant's buckeye account for each point awarded to the participant under this section.

(B) The director shall provide a one-time award of twenty points to a healthy Ohio program participant who provides for the participant's contributions under division (C) of section 5166.522 of the Revised Code to be made by electronic funds transfers from the participant's checking or savings account. Twenty points shall be deducted from the participant's card if the participant terminates the electronic funds transfers.

(C) The director may award up to two hundred points annually to a healthy Ohio program participant who achieves health care goals. The points shall be awarded in accordance with the rules authorized by section 5166.5210 of the Revised Code. A participant shall not be awarded more than two hundred points per year under this division regardless of the number of health care goals the participant achieves that year.

(D) Up to one hundred points may be awarded annually to a healthy Ohio program participant by one or more primary care physicians who verify that the participant has satisfied health care benchmarks set by the physicians. A participant shall not be awarded more than one hundred points per year under this division regardless of how many primary care physicians award points to the participant that year and the number of points the primary care physicians award the participant that year.

Sec. 5166.525. An individual's participation in the healthy Ohio program shall be suspended if the individual exhausts the individual's annual payout limit specified in division (A)(5)(a) of section 5166.521 of the Revised Code. The suspension shall end on the first day of the following year.

Sec. 5166.526. (A) An individual's participation in the healthy Ohio program shall cease if any of the following applies:

(1) A monthly installment payment to the individual's buckeye account is sixty days late.

(2) The individual, or if the individual is a minor, the individual's parent or caretaker relative, fails to submit documentation needed for a redetermination of the individual's eligibility for medicaid before the sixty-first day after the documentation is requested.

(3) The individual becomes eligible for medicaid on a basis other than being included in the category identified by the department of medicaid as covered families and children or being included in the eligibility group described in section 1902(a)(10)(A)(i)(VIII) of the "Social Security Act," 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

(4) The individual becomes a ward of the state.

(5) The individual ceases to be eligible for medicaid.

(6) The individual exhausts the individual's lifetime payout limit specified in division (A)(5)(b) of section 5166.521 of the Revised Code.

(7) The individual, or if the individual is a minor, the individual's parent or caretaker relative, requests that the individual's participation be terminated.

(B) An individual who ceases to participate in the healthy Ohio program under division (A)(1) or (2) of this section may not resume participation earlier than twelve months after the participation ceases.

(C) Except as provided in section 5166.528 of the Revised Code, an individual who ceases to participate in the healthy Ohio program shall be provided the contributions that are in the individual's buckeye account at the time the individual ceases participation. If the individual is a minor, the individual's contribution shall be provided to the individual's parent or caretaker relative.

Sec. 5166.527. If a healthy Ohio program participant exhausts the annual or lifetime payout limits specified in division (A)(5) of section 5166.521 of the Revised Code, the participant shall be transferred to a catastrophic health care plan established in rules authorized by section 5166.5210 of the Revised Code. A participant who exhausts the annual payout limit for a year may resume participation in the healthy Ohio program at the beginning of the immediately following year.

Sec. 5166.528. (A) If a healthy Ohio program participant ceases to qualify for medicaid due to increased family countable income and purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan, the amount remaining in the former participant's buckeye account shall be transferred to an account to be known as a bridge account. The amount so transferred may be used only to pay for the following:

(1) If the former participant has purchased a health insurance policy, the former participant's costs in purchasing the policy and paying for the former participant's out-of-pocket expenses under the policy for health care services and prescription drugs covered by the policy;

(2) If the former participant has obtained health care coverage under an eligible employer-sponsored health plan, the

former participant's out-of-pocket expenses under the plan for health care services and prescription drugs covered by the plan.

(B) Only the amount remaining in a former healthy Ohio program participant's buckeye account at the time the former participant ceased to participate in the healthy Ohio program shall be deposited into the bridge account. The bridge account shall be closed once the amount transferred to it under division (A) of this section is exhausted.

(C) The medicaid director shall notify a former healthy Ohio program participant when a bridge account is established for the former participant under this section.

(D) The medicaid director shall provide for a former healthy Ohio program participant to be able to use either of the following to access, for the purposes specified in division (A) of this section, the amount transferred to the former participant's bridge account:

(1) To the extent possible, the former participant's healthy Ohio program debit card;

(2) Another debit swipe card issued to the former participant.

Sec. 5166.529. Each county department of job and family services shall offer to refer to a workforce development agency each healthy Ohio program participant who resides in the county served by the county department, is an adult, and is either unemployed or employed for less than an average of twenty hours per week. The referral shall include information about the workforce development activities available from the workforce development agency. A participant may refuse to accept the referral and to participate in the workforce development

activities without any affect on the participant's eligibility for, or participation in, the healthy Ohio program.

Sec. 5166.5210. The medicaid director shall adopt rules under section 5166.02 of the Revised Code to do all of the following:

(A) For the purpose of division (F)(1)(a) of section 5166.522 of the Revised Code, establish requirements regarding preventative health services for healthy Ohio program participants. The requirements may differ for participants of different ages and genders.

(B) For the purpose of division (G)(2) of section 5166.522 of the Revised Code, authorize additional uses of a buckeye account and establish the means for using the account for those purposes.

(C) For the purpose of division (A)(3) of section 5166.523 of the Revised Code, establish requirements for the use of a healthy Ohio program debit swipe card to pay for the costs of medically necessary health care services not covered by the health plan in which a healthy Ohio program participant enrolls.

(D) For the purpose of division (C) of section 5166.524 of the Revised Code, establish a system under which the director may award points to healthy Ohio program participants who achieve health care goals. The rules shall specify the goals that qualify for points and the number of points each goal is worth. The number of points may vary for different goals.

(E) For the purpose of section 5166.527 of the Revised Code, establish a catastrophic health care plan for healthy Ohio program participants who exhaust the annual or lifetime payout limit specified in division (A)(5) of section 5166.521 of the

Revised Code.

(F) For the purpose of section 5166.528 of the Revised Code, establish procedures and requirements for the transfer of the amounts remaining in former healthy Ohio program participants' buckeye accounts to bridge accounts.

Sec. 5166.53. (A) As used in this section:

"Disproportionate share hospital" has the same meaning as in section 5168.01 of the Revised Code.

"Department of developmental disabilities-administered home and community-based services" means home and community-based services, as defined in section 5123.01 of the Revised Code.

"Hospital care assurance program" means the program established under sections 5168.01 to 5168.14 of the Revised Code.

"Veteran" means an individual who served in the active military, naval, or air service, as defined in 38 U.S.C. 101(24), for at least ninety days and was honorably discharged from the service.

"Veterans affairs medical facility" means any facility or part thereof that is under the jurisdiction of the United States secretary of veterans affairs for the provision of health care services.

(B) For fiscal year 2018 and each fiscal year thereafter, the medicaid director shall determine the amount to be used for the purpose of division (C) of this section as follows:

(1) Determine the total amount of the actual expenditures for the medicaid program for fiscal year 2016;

(2) Adjust the amount determined under division (B)(1) of this section by the cumulative rate of core inflation, determined using the consumer price index for all items for all urban consumers, for the period beginning July 1, 2016, and ending the last day of the most recent month for which the rate of core inflation is known preceding the first month of the fiscal year for which the determination is being made;

(3) From the adjusted amount determined under division (B)(2) of this section, subtract the total amount of expenditures (as estimated at the time the determination is made) for the medicaid program for the fiscal year immediately preceding the fiscal year for which the determination is being made.

(C) Subject to section 5166.50 of the Revised Code, the director shall use the amount determined under division (B) of this section for a fiscal year and the amount in the medicaid donations fund created under section 5162.63 of the Revised Code to fund, to the extent possible, all of the following for that fiscal year:

(1) Annual payments to each disproportionate share hospital in the amount of the difference between the following:

(a) The amount the disproportionate share hospital would have received under the hospital care assurance program for the year if not for the amendments made to section 1923 of the "Social Security Act," 42 U.S.C. 1396r-4, by the "Patient Protection and Affordable Care Act" (Pub. L. No. 111-148) and the "Health Care and Education Reconciliation Act of 2010" (Pub. L. No. 111-152);

(b) The amount the disproportionate share hospital is paid under the hospital care assurance program for that year.

(2) Department of developmental disabilities-administered home and community-based services;

(3) Community behavioral health services covered by the medicaid program;

(4) The costs of having the medicaid program cover all of the following:

(a) Veterans who do not otherwise qualify for medicaid and are either ineligible for medical benefits from the United States department of veterans affairs or reside more than one hundred miles away from a veterans affairs medical facility;

(b) Individuals who are considered to have serious mental illnesses under 42 C.F.R. 483.102(b) and do not otherwise qualify for medicaid;

(c) Individuals who would qualify for medicaid if the income eligibility threshold specified in section 5163.07 of the Revised Code were one hundred, rather than ninety, per cent of the federal poverty line;

(d) Subject to division (D) of this section, individuals to whom all of the following apply:

(i) They are under sixty-five years of age.

(ii) They are not pregnant.

(iii) They are not entitled to or enrolled for benefits under medicare part A.

(iv) They are not enrolled for benefits under medicare part B.

(v) They are not otherwise eligible for medicaid.

(vi) They have family countable incomes equal to at least

fifty but not more than one hundred per cent of the federal poverty line.

(5) The costs of providing under the medicaid program maintenance therapies for chronic conditions specified in rules adopted under section 5166.02 of the Revised Code to individuals to whom all of the following apply:

(a) They have one or more of the chronic conditions specified in the rules.

(b) They are not entitled to or enrolled for benefits under medicare part A.

(c) They are not enrolled for benefits under medicare part B.

(d) They are not otherwise eligible for medicaid.

(D) If the medicaid director determines that the amount available for this section for a fiscal year is insufficient to pay the costs of having the medicaid program cover the individuals described in division (C)(4)(d) of this section, the director shall limit medicaid coverage of those individuals to the extent necessary. In limiting medicaid coverage, the director shall prioritize coverage as follows:

(1) First priority shall be given to the individuals who have family countable incomes equal to at least ninety but not more than one hundred per cent of the federal poverty line.

(2) Second priority shall be given to the individuals who have family countable incomes equal to at least eighty but less than ninety per cent of the federal poverty line.

(3) Third priority shall be given to the individuals who have family countable incomes equal to at least seventy but less

than eighty per cent of the federal poverty line.

(4) Fourth priority shall be given to the individuals who have family countable incomes equal to at least sixty but less than seventy per cent of the federal poverty line.

(5) Fifth priority shall be given to the individuals who have family countable incomes equal to at least fifty but less than sixty per cent of the federal poverty line.

Sec. 5167.01. As used in this chapter:

(A) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(B) "CPI-U medical inflation rate" means the percentage increase in the prices for medical care as specified in the consumer price index for all urban consumers for the midwest region published by the United States bureau of labor statistics.

(C) "DRG" means diagnosis-related group.

(D) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(C)~~ (E) "Emergency services" has the same meaning as in the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-2(b)(2).

~~(D)~~ (F) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(E)~~ (G) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

(H) "Medicaid managed care organization" means a managed

care organization under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

~~(F)~~ (I) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(G)~~ (J) "Noninstitutional provider" means any provider other than a hospital, nursing facility, or ICF/IID.

(K) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(H)~~ (L) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(I)~~ (M) "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid managed care organization, regardless of whether the person or entity has a provider agreement.

~~(J)~~ (N) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

Sec. 5167.03. (A) As part of the medicaid program, the department of medicaid shall establish a care management system.

(B) The department shall implement the care management system in some or all counties and, subject to division (B)(4) of section 5166.52 of the Revised Code, shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. ~~All~~

Except as provided in division (C) of this section, all individuals included in the category shall be designated for participation~~, except for individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall ensure that all participants are enrolled in medicaid managed care organizations that are health insuring corporations~~.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, the department shall implement the care management system in all counties. Except as provided in division (C) of this section, all individuals included in the category shall be designated for participation. ~~The department shall ensure that all participants are enrolled in medicaid managed care organizations that are health insuring corporations.~~

(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of medicaid, but, subject to division (B)(4) of section 5166.52 of the Revised Code, the recipients of those services may otherwise be designated for participation in the system.

(C)(1) In designating participants who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall do both of the following:

(a) Exclude individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d);

(b) If the healthy Ohio program is established under sections 5166.52 to 5166.5210 of the Revised Code, exclude individuals who are required to participate in the healthy Ohio program.

(2) In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following, except as provided under division (C) ~~(2)~~ (3) of this section:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Dual eligible individuals;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component.

~~(2)~~ (3) The department may designate any of the following individuals who receive medicaid on the basis of being aged, blind, or disabled as individuals who are permitted or required to participate in the care management system:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who reside in a nursing facility;

(c) Individuals who, as an alternative to receiving nursing facility services, are participating in a home and community-based services medicaid waiver component;

(d) Dual eligible individuals.

(D) Subject to division (B) of this section, the

department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) Require or permit participants in the system to obtain health care services through medicaid managed care organizations.

Sec. 5167.04. The department of medicaid shall ensure that each individual designated for participation in the care management system pursuant to division (B)(1) or (2) of section 5167.03 of the Revised Code is enrolled in a medicaid managed care organization that is either of the following:

(A) A health insuring corporation;

(B) Subject to section 5166.50 of the Revised Code, a regional network consisting of hospitals that accepts a capitated payment from the department that is not more than ninety per cent of the lowest capitated payment made to a medicaid managed care organization that is a health insuring corporation.

Sec. 5167.10. (A) The department of medicaid may enter into contracts with managed care organizations~~, including health insuring corporations,~~ under which the organizations are authorized to provide, or arrange for the provision of, health care services to medicaid recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5167.03 of the Revised Code. The managed care organizations with which the department may enter into contract

include health insuring corporations and, pursuant to division (B) of section 5167.04 of the Revised Code, regional networks consisting of hospitals.

(B)(1) Subject to division (B)(2)(a) of this section, the department or its actuary shall base the hospital inpatient capital payment portion of the payment made to managed care organizations on data for services provided to all recipients enrolled in managed care organizations with which the department contracts, as reported by hospitals on relevant cost reports submitted pursuant to rules adopted under section 5167.02 of the Revised Code.

(2)(a) The hospital inpatient capital payment portion of the payment made to medicaid managed care organizations shall not exceed any maximum rate established by the department pursuant to rules adopted under this section.

(b) If a maximum rate is established, a medicaid managed care organization shall not compensate hospitals for inpatient capital costs in an amount that exceeds that rate.

(C) The department of medicaid shall allow a medicaid managed care organization to use providers to render care upon completion of the medicaid managed care organization's credentialing process.

Sec. 5167.16. (A) As used in this section:

(1) "Applicable percentage" means the following:

(a) For the first year that incentive payments are made under this section, two per cent;

(b) For the second year that the incentive payments are made, four per cent;

(c) For the third and subsequent years that the incentive payments are made, six per cent.

(2) "Base operating DRG payment amount" has the meaning specified in rules authorized by this section.

(3) "Medicare hospital value-based purchasing program" means the program that the United States secretary of health and human services must establish under section 1886(o) of the "Social Security Act," 42 U.S.C. 1395ww(o).

(4) "Participating hospital" means a hospital under contract with a medicaid managed care organization to provide inpatient hospital services to medicaid recipients enrolled in the medicaid managed care organization.

(B) Subject to section 5166.50 of the Revised Code, each contract the department of medicaid enters into with a managed care organization under section 5167.10 of the Revised Code shall require the organization to implement a hospital value-based purchasing program that, except as otherwise provided by this section, is identical to the medicare hospital value-based purchasing program. Under the program, a medicaid managed care organization shall make incentive payments to participating hospitals based only on the participating hospitals' successes in meeting the clinical process of care measures used for the medicare hospital value-based purchasing program. The total amount that a medicaid managed care organization shall make available for the incentive payments for a year shall be equal to the total amount of the savings achieved for that year due to the reduced hospital payments the organization makes under division (C) of this section.

(C) Subject to section 5166.50 of the Revised Code, each

medicaid managed care organization shall reduce each participating hospital's base operating DRG payment amount for each discharge in a year by an amount equal to the applicable percentage of the participating hospital's base operating DRG payment amount for the discharge for that year. The reduction shall be made for all participating hospitals each year regardless of whether a participating hospital has earned an incentive payment under this section for that year.

(D) The medicaid director shall adopt rules under section 5167.02 of the Revised Code as necessary to implement this section, including rules that define the term "base operating DRG payment amount."

Sec. 5167.30. (A) ~~(1)~~ The department of medicaid shall establish a managed care performance payment program. Under the program, the department ~~may~~ shall provide payments to medicaid managed care organizations that meet performance standards established by the department.

~~(2)~~ (B) In establishing performance standards, the department may consult any of the following:

~~(a)~~ (1) Any quality measurements developed under the pediatric quality measures program established pursuant to section 1139A of the "Social Security Act," ~~section 1139A,~~ 42 U.S.C. 1320b-9a;

~~(b)~~ (2) Any core set of adult health quality measures for medicaid eligible adults used for purposes of section 1139A of the "Social Security Act," ~~section 1139A,~~ 42 U.S.C. 1320b-9b, and any adult health quality used for purposes of the medicaid quality measurement program when the program is established under that section of the "Social Security Act";

~~(c)~~ (3) The most recent healthcare effectiveness data and information set and quality measurement tool established by the national committee for quality assurance.

~~(3)~~ (B) The standards that must be met to receive the payments may be specified in the contract the department enters into with a medicaid managed care organization under section 5167.10 of the Revised Code.

~~(4)~~ (C) If a medicaid managed care organization meets the performance standards established by the department, the department shall make one or more performance payments to the organization. ~~The~~

(D) The amount of each performance payment, the number of payments, and the schedule for making the payments shall be established by the department. The department shall establish the amount of each performance payment in an equitable manner that results in the total amount withheld from all medicaid managed care organizations' premium payments for a fiscal year pursuant to division (E) of this section being spent on the performance payments for that fiscal year.

The performance payments to a medicaid managed care organization shall be discontinued if the department determines that the organization no longer meets the performance standards. The department shall not make or discontinue performance payments based on any performance standard that has been in effect as part of ~~the~~ a medicaid managed care organization's contract for less than six months.

~~(B)~~ (E)(1) For purposes of the program, the department shall ~~establish an amount that is to be withheld~~ withhold the following amount of each ~~time a~~ premium payment ~~is made~~ the

department makes to a medicaid managed care organization during a fiscal year:

(a) For fiscal year 2016, two per cent of the payment;

(b) For fiscal year 2017, four per cent of the payment;

(c) For fiscal year 2018 and each fiscal year thereafter, six per cent of the payment. ~~The amount shall be established as a percentage of each premium payment. The percentage shall be the same for all medicaid managed care organizations. The sum of all withholdings under this division shall not exceed two per cent of the total of all premium payments made to all medicaid managed care organizations.~~

(2) Each medicaid managed care organization shall agree to the withholding as a condition of receiving or maintaining its provider agreement with the department.

~~When the amount is established and each time the amount is modified thereafter, the~~(3) The department shall certify ~~the amount~~ to the director of budget and management ~~and begin withholding the amount from each premium the department pays to a medicaid managed care organization~~ the total amount of the withholdings made under division (E)(1) of this section for each fiscal year.

Sec. 5167.32. (A) As used in this section, " specified states" means the following states: Illinois, Indiana, Michigan, Ohio, Pennsylvania, and West Virginia.

(B) This section is subject to section 5166.50 of the Revised Code.

(C) The department of medicaid shall determine both of the following before the beginning of each fiscal year:

(1) The average of the per recipient capitated payment rate for each medicaid managed care organization for the three fiscal years immediately preceding the fiscal year for which the determination is made;

(2) The average per recipient cost to the medicaid programs in the specified states for the eligibility groups that are designated for participation in the care management system pursuant to division (B)(1) or (2) of section 5167.03 of the Revised Code for the three fiscal years immediately preceding the fiscal year for which the determination is made.

(D) If the three-year average determined under division (C)(1) of this section for a medicaid managed care organization for a fiscal year is less than the three-year average determined under division (C)(2) of this section for that fiscal year, the department shall pay the organization a shared savings bonus. The amount of the bonus shall be equal to the amount that is twenty per cent of the difference between the three-year average determined under division (C)(1) of this section for the medicaid managed care organization for that fiscal year and the three-year average determined under division (C)(2) of this section for that fiscal year.

(E) If the three-year average determined under division (C)(1) of this section for a medicaid managed care organization for a fiscal year is more than the three-year average determined under division (C)(2) of this section for that fiscal year, the department shall terminate the organization's contract with the department and enter into a contract with another managed care organization under section 5167.10 of the Revised Code.

Sec. 5167.33. Subject to section 5166.50 of the Revised Code, the department of medicaid shall penalize a medicaid

managed care organization if the organization pays a rate for a hospital outpatient service provided to a medicaid recipient enrolled in the organization that is more than ten per cent higher than the rate it pays for the same service when provided by a noninstitutional provider.

Section 2. That existing sections 1751.67, 2117.06, 2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.171, 3923.63, 3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.28, 3937.29, 3955.05, 4715.30, 4723.28, 4723.341, 4725.19, 4729.16, 4730.25, 4730.32, 4731.22, 4731.224, 4731.281, 4734.31, 4734.32, 4755.47, 4765.11, 5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 5167.01, 5167.03, 5167.10, and 5167.30 and section 4731.143 of the Revised Code are hereby repealed.

Section 3. Thirty days after the effective date of this act, or as soon as possible thereafter, the Director of Budget and Management shall transfer cash from the GRF to the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund in an amount determined by the Superintendent of Insurance sufficient to fund the reinsurance and guarantee portions of the Nonstandard Multiple Employer Welfare Arrangement Program, as prescribed in sections 1739.32 and 1739.33 of the Revised Code.

Section 4. That sections 1739.30, 1739.31, 1739.32, and 1739.33 of the Revised Code are hereby repealed.

Section 5. Section 4 of this act shall take effect five years after the effective date of this act.

Section 6. Five years after the effective date of this act, or as soon as possible thereafter, the Director of Budget and Management shall transfer all cash credited to the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund to the GRF. Upon completion of the transfers, the funds are abolished.

Section 7. The amendments to sections 1751.67, 2117.06, 2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 2711.22, 2743.02, 2743.43, 3923.63, 3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.29, 3955.05, and 5164.07 of the Revised Code by this act shall take effect one year after the effective date of this act.

The amendments to sections 2919.171, 4715.30, 4723.28, 4723.341, 4725.19, 4729.16, 4730.25, 4730.32, 4731.22, 4731.224, 4731.281, 4734.31, 4734.32, 4755.47, and 4765.11 of the Revised Code and the enactment of sections 4746.04, 4746.05, and 4746.06 of the Revised Code by this act shall take effect two years after the effective date of this act.

Section 8. Sections 5165.15, 5165.23, and 5165.24 of the Revised Code, as amended or enacted by this act, take effect on the later of the following:

(A) July 1, 2015;

(B) The earliest time permitted by law.

Section 9. (A) As used in this section, "chiropractic claim," "dental claim," "medical claim," "optometric claim," and "derivative claim" have the same meanings as in section 3965.01

of the Revised Code, as enacted by this act.

(B) Notwithstanding sections 3965.30, 3965.31, 3965.32, 3965.33, 3965.50, and 3965.51 of the Revised Code, as enacted by this act, no claim shall be filed with the Medical Injury Compensation Center for a period beginning on the effective date of this act and ending one year after the effective date of this act. Any chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim that accrues prior to one year after the effective date of this act may be brought in a court of competent jurisdiction in accordance with the applicable laws as those laws existed immediately prior to the effective date of this act.

(C) Notwithstanding sections 1751.67, 2117.06, 2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 2711.22, 2743.02, 2743.43, 2919.171, 3923.63, 3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.29, 3955.05, and 5164.07 of the Revised Code, as amended by this act, and sections 3965.30, 3965.31, 3965.32, 3965.33, 3965.50, and 3965.51 of the Revised Code, as enacted by this act, if a chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim accrues during the time period beginning one year after the effective date of this act and ending the date that is two years after the effective date of this act, a claimant may elect to file a claim with the Medical Injury Compensation Center or may elect to bring a cause of action in a court of competent jurisdiction in accordance with the applicable laws as those laws existed immediately prior to the effective date of this act. A claimant may not file with both a court and the Center.

(D) A chiropractic claim, dental claim, medical claim, optometric claim, or derivative claim that accrues more than two years after the effective date of this act shall be filed in accordance with sections 3965.30, 3965.31, 3965.32, 3965.33, 3965.50, and 3965.51 of the Revised Code, as enacted by this act.

Section 10. (A) As used in this section:

(1) "Addiction services" has the same meaning as in section 5119.01 of the Revised Code.

(2) "Child care" has the same meaning as in section 5104.01 of the Revised Code.

(3) "Ex-offender reentry services" means the services available under reentry programs identified in the reports that the Ex-Offender Reentry Coalition is required by section 5120.07 of the Revised Code to prepare.

(4) "Housing services" means services or activities designed to assist individuals or families in locating, obtaining, or retaining suitable housing.

(5) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

(6) "Mental health services" has the same meaning as in section 5119.01 of the Revised Code.

(7) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

(8) "Publicly funded child care" has the same meaning as in section 5104.01 of the Revised Code.

(9) "Supplemental Nutrition Assistance Program" means the

program administered by the Director of Job and Family Services pursuant to section 5101.54 of the Revised Code.

(10) "WIC program" has the same meaning as in section 3701.132 of the Revised Code.

(11) "Workforce development activity" has the same meaning as in section 6301.01 of the Revised Code.

(B) The Department of Medicaid shall establish, and operate for two years, a pilot program under which one or more Medicaid managed care organizations help coordinate all of the following services that Medicaid recipients enrolled in the organizations receive:

(1) The health care services that the Medicaid managed care organizations, pursuant to their provider agreements, provide to, or arrange for, the recipients;

(2) Addiction services;

(3) Mental health services;

(4) Support services for children, including child care and publicly funded child care;

(5) Services made available under Chapters 5123. and 5126. of the Revised Code for individuals with mental retardation and other developmental disabilities;

(6) Services made available under Chapter 173. of the Revised Code for individuals sixty years of age or older;

(7) Housing services;

(8) Workforce development activities;

(9) Food assistance, including the Supplemental Nutrition Assistance Program and the WIC program;

(10) Ex-offender reentry services.

(C) All of the following shall assist the Department of Medicaid in establishing the pilot program:

(1) The Department of Aging;

(2) The Department of Developmental Disabilities;

(3) The Development Services Agency;

(4) The Department of Health;

(5) The Department of Job and Family Services;

(6) The Department of Mental Health and Addiction Services;

(7) The Department of Rehabilitation and Correction.

(D) The Department of Medicaid shall select the Medicaid managed care organizations that are to participate in the pilot program through a request for proposals process.

(E) The Department shall provide for a Medicaid managed care organization participating in the pilot program to receive a bonus payment if the organization succeeds in coordinating the services specified in division (B) of this section in an efficient and effective manner that prevents the Medicaid program and other programs from incurring costs that would have been incurred if not for the coordination.

(F) A service specified in division (B) of this section is to be coordinated with the other services specified in that division for a Medicaid recipient only to the extent, if any, that the recipient is eligible for and receiving the service. This section shall not be construed as making an individual eligible for a service that the individual is not otherwise

eligible to receive.

(G) All persons and state and local government entities overseeing or operating a program offering any of the services specified in division (B) of this section, or providing the services, shall cooperate with the Medicaid managed care organizations participating in the pilot program for the purpose of coordinating the services.

(H) Not later than ninety days after the pilot program ends, the Department of Medicaid shall complete a report regarding the pilot program. The report shall specify the pilot program's successes and problems and include the Department's recommendations for resolving the problems. The Department shall submit copies of the report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly.

Section 11. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting versions of the sections in effect prior to the effective date of the sections as presented in this act:

Section 109.572 of the Revised Code as amended by both Am. Sub. H.B. 483 and Am. Sub. S.B. 143 of the 130th General Assembly.

Section 4715.30 of the Revised Code as amended by Sub. H.B. 314, Am. Sub. H.B. 341, and Am. Sub. H.B. 483, all of the 130th General Assembly.

Section 4723.28 of the Revised Code as amended by both Am.

Sub. H.B. 341 and Am Sub. H.B. 483 of the 130th General Assembly.

Section 4725.19 of the Revised Code as amended by both Am. Sub. H.B. 341 and Am Sub. H.B. 483 of the 130th General Assembly.

Section 4730.25 of the Revised Code as amended by both Am. Sub. H.B. 341 and Am Sub. H.B. 483 of the 130th General Assembly.

Section 4731.22 of the Revised Code as amended by both Am. Sub. H.B. 341 and Am Sub. H.B. 483 of the 130th General Assembly.