

As Introduced

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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, 1
2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2
2305.231, 2305.234, 2305.25, 2307.24, 2307.26, 3
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4731.281, 4734.31, 4734.32, 4755.47, 4765.11, 11
5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 12
5167.01, 5167.03, 5167.10, and 5167.30 and to 13
enact sections 195.01, 195.02, 195.03, 195.04, 14
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5166.526, 5166.527, 5166.528, 5166.529, 35
5166.5210, 5166.53, 5167.04, 5167.16, 5167.32, 36
and 5167.33, and to repeal section 4731.143 of 37
the Revised Code to revise the laws governing 38
health insurance coverage, medical malpractice 39
claims, the Medicaid program, health care 40
provider discipline, and required and permitted 41
health care provider disclosures; and to create 42
the Nonstandard Multiple Employer Welfare 43
Arrangement Program and to terminate that 44
program after five years. 45

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

Section 1. That sections 1751.67, 2117.06, 2125.01, 46
2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 47
2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 48
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4755.47, 4765.11, 5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 54
5167.01, 5167.03, 5167.10, and 5167.30 be amended and sections 55
195.01, 195.02, 195.03, 195.04, 195.05, 195.06, 1739.30, 56
1739.31, 1739.32, 1739.33, 3727.61, 3728.04, 3728.99, 3937.24, 57
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5166.50, 5166.52, 5166.521, 5166.522, 5166.523, 5166.524, 70
5166.525, 5166.526, 5166.527, 5166.528, 5166.529, 5166.5210, 71
5166.53, 5167.04, 5167.16, 5167.32, and 5167.33 of the Revised 72
Code be enacted to read as follows: 73

Sec. 195.01. As used in this chapter: 74

(A) "Administrator" means an administrator subject to 75
Chapter 3959. of the Revised Code. 76

(B) "Insurer" means any of the following: 77

(1) A person authorized under Title XXXIX of the Revised 78
Code to engage in the business of sickness and accident 79

<u>insurance in this state;</u>	80
<u>(2) A health insuring corporation;</u>	81
<u>(3) A multiple employer welfare arrangement;</u>	82
<u>(4) A legal entity that is self-insured and provides</u> <u>benefits to its employees or members;</u>	83 84
<u>(5) Any other person that is obligated pursuant to a</u> <u>benefits contract to reimburse for covered health care services</u> <u>rendered to beneficiaries under such a contract.</u>	85 86 87
<u>(C) "Participant" means a person or government entity that</u> <u>accepts money from the state or a county for any of the</u> <u>following reasons:</u>	88 89 90
<u>(1) The person or government entity purchases drugs</u> <u>eligible for partial or full reimbursement from the state or a</u> <u>county or purchases, leases, or uses medical equipment eligible</u> <u>for partial or full reimbursement from the state or a county.</u>	91 92 93 94
<u>(2) The person or government entity reimburses another</u> <u>person or government entity for the expenses described in</u> <u>division (C) (1) of this section.</u>	95 96 97
<u>(3) The person or government entity uses the money to pay</u> <u>for the expenses described in division (C) (1) of this section.</u>	98 99
<u>Sec. 195.02. Sections 195.03 to 195.06 of the Revised Code</u> <u>are subject to section 5166.50 of the Revised Code.</u>	100 101
<u>Sec. 195.03. There is hereby created the office of medical</u> <u>purchasing in the department of administrative services. The</u> <u>office shall be under the supervision of a manager, who shall be</u> <u>appointed by the director of administrative services. The</u> <u>director, in consultation with the manager, shall hire or assign</u>	102 103 104 105 106

employees. The director shall furnish equipment and supplies, as 107
necessary, for the fulfillment of the office's purpose as stated 108
in section 195.04 of the Revised Code. Administrative costs 109
associated with the operation of the office shall be paid from 110
amounts appropriated to the department for such purposes. 111

Sec. 195.04. The purpose of the office of medical 112
purchasing is to maximize the purchasing power of participants, 113
insurers, and administrators so that expenses for drugs and 114
medical equipment are minimized. In furtherance of this purpose, 115
the office shall seek to enter into a pact with other states and 116
Canadian provinces to negotiate discounted prices for drugs and 117
medical equipment with the suppliers of those items. 118

Sec. 195.05. If the office of medical purchasing enters 119
into a pact described in section 195.04 of the Revised Code, the 120
office shall collaborate with the other pact members to ensure 121
that the prices that are negotiated are the lowest prices that 122
can be attained. The office shall seek to negotiate prices that 123
do not exceed those negotiated by Canadian provinces that are 124
not pact members. 125

Sec. 195.06. (A) A participant described in division (C) 126
(1) or (3) of section 195.01 of the Revised Code shall purchase 127
drugs or purchase, lease, or use medical equipment from 128
suppliers that have agreed to provide those items at the 129
discounted prices negotiated by members of a pact described in 130
section 193.04 of the Revised Code. 131

(B) A participant described in division (C) (2) of section 132
195.01 of the Revised Code shall reimburse a person or 133
government entity for the expenses described in division (C) (1) 134
of this section only if those expenses are incurred as a result 135
of a relationship with a supplier that has agreed to provide 136

those items at the discounted prices negotiated by pact members. 137

(C) An insurer or administrator may purchase drugs or 138
purchase, lease, or use medical equipment from suppliers that 139
have agreed to provide those items at the discounted prices 140
negotiated by pact members. 141

Sec. 1739.30. As used in sections 1739.30 to 1739.33 of 142
the Revised Code: 143

(A) "Medicare physician fee schedule" means the medicare 144
physician fee schedule produced by the centers for medicare and 145
medicaid services. 146

(B) "Program" means the nonstandard multiple employer 147
welfare arrangement program prescribed in sections 1739.30 to 148
1739.33 of the Revised Code. 149

(C) "Program participant" means a multiple employer 150
welfare arrangement formed under sections 1739.30 to 1739.33 of 151
the Revised Code. 152

(D) "Program participant insurer" means any insurer that 153
provides stop-loss insurance to a multiple employer welfare 154
arrangement under section 1739.12 of the Revised Code that is a 155
program participant. 156

(E) "Reference-based pricing" means an insurance model 157
through which the insurer provides benefits according to a 158
predetermined reference cost for each covered service. 159

(F) "Stop-loss insurance" has the same meaning as in 160
section 1739.01 of the Revised Code. 161

Sec. 1739.31. (A) Notwithstanding any provision of 162
sections 1739.01 to 1739.27 of the Revised Code, the department 163
of insurance shall operate a nonstandard multiple employer 164

welfare arrangement program for the purpose of enabling a group 165
of employers that is a bona fide association, as defined in 45 166
C.F.R. 144.103, to form a self-insured multiple employer welfare 167
arrangement that does not meet the criteria or standards 168
necessary for certification prescribed in sections 1739.01 to 169
1739.27 of the Revised Code. 170

(B) Program participants shall have a projected enrollment 171
of at least two individuals and not more than five hundred 172
individuals. 173

(C) The department of insurance shall provide reinsurance 174
coverage for program participants as prescribed in section 175
1739.32 of the Revised Code. 176

(D) The department of insurance shall guarantee the 177
liabilities of program participants as prescribed in section 178
1739.33 of the Revised Code. 179

(E) A multiple employer welfare arrangement shall not 180
participate in the program for a period greater than five years. 181

(F) While participating in the program, a multiple 182
employer welfare arrangement shall adhere to both of the 183
following: 184

(1) A program participant shall have appointed to its 185
board of trustees a representative of the department of 186
insurance and at least one representative of the participating 187
members of the arrangement. 188

(2) (a) A program participant shall reimburse health care 189
providers using reference-based pricing. 190

(b) The reference cost for such reimbursements shall be 191
set at an amount not to exceed the rate prescribed for a 192

specific service in the medicare physician fee schedule 193
multiplied by one and two-tenths. 194

(G) The superintendent of insurance shall adopt rules for 195
the implementation of sections 1739.30 to 1739.33 of the Revised 196
Code. The rules shall address all of the following: 197

(1) Eligibility for the program; 198

(2) Enabling a group of employers to participate in the 199
program with relative ease and simplicity; 200

(3) (a) (i) Fees to be paid to the department of insurance 201
by program participants; 202

(ii) Fees to be paid by program participant insurers 203
receiving reinsurance coverage under section 1739.32 of the 204
Revised Code. 205

(b) Such fees shall be set at an amount necessary to 206
ensure the continued operation of the program. 207

(4) When payment is to be made under sections 1739.32 and 208
1739.33 of the Revised Code; 209

(5) Any other topic the superintendent considers relevant 210
to the operation of the program. 211

Sec. 1739.32. (A) There is hereby created in the state 212
treasury the nonstandard multiple employer welfare arrangement 213
reinsurance fund. Revenues to the fund shall consist of fees 214
collected by the department of insurance from insurers providing 215
stop-loss insurance coverage to program participants, as 216
required under section 1739.12 of the Revised Code, and any 217
other transfers made to the fund. The fund shall be used to 218
reduce the cost of purchasing stop-loss insurance coverage for 219
program participants and pay any related expenses. 220

(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. 221
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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. 226
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(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. 234
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(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. 240
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(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. 244
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(3) Any amount paid out by the department of insurance under this section shall be repaid to the department of 248
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insurance by the respective program participant, if the program 250
participant is still in existence, according to a timetable and 251
terms set by the department of insurance in rule. 252

(C) A program participant's guarantee amount shall be set 253
according to the following: 254

(1) One hundred per cent of the surplus amount required 255
pursuant to section 1739.31 of the Revised Code for the first 256
year of participation; 257

(2) Eighty per cent of the surplus amount required 258
pursuant to section 1739.13 of the Revised Code for the second 259
year of participation; 260

(3) Sixty per cent of the surplus amount required pursuant 261
to section 1739.13 of the Revised Code for the third year of 262
participation; 263

(4) Forty per cent of the surplus amount required pursuant 264
to section 1739.13 of the Revised Code for the fourth year of 265
participation; 266

(5) Twenty per cent of the surplus amount required 267
pursuant to section 1739.13 of the Revised Code for the fifth 268
year of participation. 269

(D) Guarantees provided under this section do not preclude 270
a multiple employer welfare arrangement from obtaining stop-loss 271
insurance coverage as required by section 1739.12 of the Revised 272
Code. 273

Sec. 1751.67. (A) Each individual or group health insuring 274
corporation policy, contract, or agreement delivered, issued for 275
delivery, or renewed in this state that provides maternity 276
benefits shall provide coverage of inpatient care and follow-up 277

care for a mother and her newborn as follows: 278

(1) The policy, contract, or agreement shall cover a 279
minimum of forty-eight hours of inpatient care following a 280
normal vaginal delivery and a minimum of ninety-six hours of 281
inpatient care following a cesarean delivery. Services covered 282
as inpatient care shall include medical, educational, and any 283
other services that are consistent with the inpatient care 284
recommended in the protocols and guidelines developed by 285
national organizations that represent pediatric, obstetric, and 286
nursing professionals. 287

(2) The policy, contract, or agreement shall cover a 288
physician-directed source of follow-up care. Services covered as 289
follow-up care shall include physical assessment of the mother 290
and newborn, parent education, assistance and training in breast 291
or bottle feeding, assessment of the home support system, 292
performance of any medically necessary and appropriate clinical 293
tests, and any other services that are consistent with the 294
follow-up care recommended in the protocols and guidelines 295
developed by national organizations that represent pediatric, 296
obstetric, and nursing professionals. The coverage shall apply 297
to services provided in a medical setting or through home health 298
care visits. The coverage shall apply to a home health care 299
visit only if the provider who conducts the visit is 300
knowledgeable and experienced in maternity and newborn care. 301

When a decision is made in accordance with division (B) of 302
this section to discharge a mother or newborn prior to the 303
expiration of the applicable number of hours of inpatient care 304
required to be covered, the coverage of follow-up care shall 305
apply to all follow-up care that is provided within seventy-two 306
hours after discharge. When a mother or newborn receives at 307

least the number of hours of inpatient care required to be 308
covered, the coverage of follow-up care shall apply to follow-up 309
care that is determined to be medically necessary by the 310
provider responsible for discharging the mother or newborn. 311

(B) Any decision to shorten the length of inpatient stay 312
to less than that specified under division (A) (1) of this 313
section shall be made by the physician attending the mother or 314
newborn, except that if a nurse-midwife is attending the mother 315
in collaboration with a physician, the decision may be made by 316
the nurse-midwife. Decisions regarding early discharge shall be 317
made only after conferring with the mother or a person 318
responsible for the mother or newborn. For purposes of this 319
division, a person responsible for the mother or newborn may 320
include a parent, guardian, or any other person with authority 321
to make medical decisions for the mother or newborn. 322

(C) (1) No health insuring corporation may do either of the 323
following: 324

(a) Terminate the participation of a provider or health 325
care facility in an individual or group health care plan solely 326
for making recommendations for inpatient or follow-up care for a 327
particular mother or newborn that are consistent with the care 328
required to be covered by this section; 329

(b) Establish or offer monetary or other financial 330
incentives for the purpose of encouraging a person to decline 331
the inpatient or follow-up care required to be covered by this 332
section. 333

(2) Whoever violates division (C) (1) (a) or (b) of this 334
section has engaged in an unfair and deceptive act or practice 335
in the business of insurance under sections 3901.19 to 3901.26 336

of the Revised Code.	337
(D) This section does not do any of the following:	338
(1) Require a policy, contract, or agreement to cover	339
inpatient or follow-up care that is not received in accordance	340
with the policy's, contract's, or agreement's terms pertaining	341
to the providers and facilities from which an individual is	342
authorized to receive health care services;	343
(2) Require a mother or newborn to stay in a hospital or	344
other inpatient setting for a fixed period of time following	345
delivery;	346
(3) Require a child to be delivered in a hospital or other	347
inpatient setting;	348
(4) Authorize a nurse-midwife to practice beyond the	349
authority to practice nurse-midwifery in accordance with Chapter	350
4723. of the Revised Code;	351
(5) Establish minimum standards of medical diagnosis,	352
care, or treatment for inpatient or follow-up care for a mother	353
or newborn. A deviation from the care required to be covered	354
under this section shall not, solely on the basis of this	355
section, give rise to a medical claim or to derivative claims	356
for relief, as those terms are defined in section 2305.113 <u>or</u>	357
<u>3965.01</u> of the Revised Code.	358
Sec. 2117.06. (A) All creditors having claims against an	359
estate, including claims arising out of contract, out of tort,	360
on cognovit notes, or on judgments, whether due or not due,	361
secured or unsecured, liquidated or unliquidated, shall present	362
their claims in one of the following manners:	363
(1) After the appointment of an executor or administrator	364

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 394
provided in sections 2117.37 to 2117.42 of the Revised Code with 395
reference to contingent claims. 396

(D) In the absence of any prior demand for allowance, the 397
executor or administrator shall allow or reject all claims, 398
except tax assessment claims, within thirty days after their 399
presentation, provided that failure of the executor or 400
administrator to allow or reject within that time shall not 401
prevent the executor or administrator from doing so after that 402
time and shall not prejudice the rights of any claimant. Upon 403
the allowance of a claim, the executor or the administrator, on 404
demand of the creditor, shall furnish the creditor with a 405
written statement or memorandum of the fact and date of the 406
allowance. 407

(E) If the executor or administrator has actual knowledge 408
of a pending action commenced against the decedent prior to the 409
decedent's death in a court of record in this state, the 410
executor or administrator shall file a notice of the appointment 411
of the executor or administrator in the pending action within 412
ten days after acquiring that knowledge. If the administrator or 413
executor is not a natural person, actual knowledge of a pending 414
suit against the decedent shall be limited to the actual 415
knowledge of the person charged with the primary responsibility 416
of administering the estate of the decedent. Failure to file the 417
notice within the ten-day period does not extend the claim 418
period established by this section. 419

(F) This section applies to any person who is required to 420
give written notice to the executor or administrator of a motion 421
or application to revive an action pending against the decedent 422
at the date of the death of the decedent. 423

(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 454
presented after the filing of the final account up to the value 455
of the distribution and may be required to return all or any 456
part of the value of the distribution if a valid claim is 457
subsequently made against the estate within the time permitted 458
under this section. 459

Sec. 2125.01. (A) (1) When the death of a person is caused 460
by wrongful act, neglect, or default which would have entitled 461
the party injured to maintain an action and recover damages if 462
death had not ensued, the person who would have been liable if 463
death had not ensued, or the administrator or executor of the 464
estate of such person, as such administrator or executor, shall 465
be liable to an action for damages, notwithstanding the death of 466
the person injured and although the death was caused under 467
circumstances which make it aggravated murder, murder, or 468
manslaughter. When the action is against such administrator or 469
executor, the damages recovered shall be a valid claim against 470
the estate of such deceased person. No action for the wrongful 471
death of a person may be maintained against the owner or lessee 472
of the real property upon which the death occurred if the cause 473
of the death was the violent unprovoked act of a party other 474
than the owner, lessee, or a person under the control of the 475
owner or lessee, unless the acts or omissions of the owner, 476
lessee, or person under the control of the owner or lessee 477
constitute gross negligence. This section does not apply to a 478
claim filed under Chapters 3965. and 3967. of the Revised Code. 479
With respect to a chiropractic claim, dental claim, medical 480
claim, or optometric claim, this section shall apply only in 481
either of the following circumstances: 482

(a) The claim alleges that the health care provider 483
against whom the claim is brought intentionally caused the 484

injury, as defined in section 3965.02 of the Revised Code, that 485
resulted in the death of the person. 486

(b) The health care provider against whom the claim is 487
brought was not in compliance with division (A) of section 488
3965.02 of the Revised Code at the time the claim accrued. 489

(2) As used in division (A) of this section, "chiropractic 490
claim," "dental claim," "health care provider," "medical claim," 491
and "optometric claim" have the same meanings as in section 492
2305.113 of the Revised Code. 493

(B) When death is caused by a wrongful act, neglect, or 494
default in another state or foreign country, for which a right 495
to maintain an action and recover damages is given by a statute 496
of such other state or foreign country, such right of action may 497
be enforced in this state. Every such action shall be commenced 498
within the time prescribed for the commencement of such actions 499
by the statute of such other state or foreign country. 500

(C) The same remedy shall apply to any such cause of 501
action now existing and to any such action commenced before 502
January 1, 1932, or attempted to be commenced in proper time and 503
now appearing on the files of any court within this state, and 504
no prior law of this state shall prevent the maintenance of such 505
cause of action. 506

Sec. 2125.02. (A) (1) Except as provided in this division, 507
a civil action for wrongful death shall be brought in the name 508
of the personal representative of the decedent for the exclusive 509
benefit of the surviving spouse, the children, and the parents 510
of the decedent, all of whom are rebuttably presumed to have 511
suffered damages by reason of the wrongful death, and for the 512
exclusive benefit of the other next of kin of the decedent. A 513

parent who abandoned a minor child who is the decedent shall not 514
receive a benefit in a civil action for wrongful death brought 515
under this division. 516

(2) The jury, or the court if the civil action for 517
wrongful death is not tried to a jury, may award damages 518
authorized by division (B) of this section, as it determines are 519
proportioned to the injury and loss resulting to the 520
beneficiaries described in division (A) (1) of this section by 521
reason of the wrongful death and may award the reasonable 522
funeral and burial expenses incurred as a result of the wrongful 523
death. In its verdict, the jury or court shall set forth 524
separately the amount, if any, awarded for the reasonable 525
funeral and burial expenses incurred as a result of the wrongful 526
death. 527

(3) (a) The date of the decedent's death fixes, subject to 528
division (A) (3) (b) (iii) of this section, the status of all 529
beneficiaries of the civil action for wrongful death for 530
purposes of determining the damages suffered by them and the 531
amount of damages to be awarded. A person who is conceived prior 532
to the decedent's death and who is born alive after the 533
decedent's death is a beneficiary of the action. 534

(b) (i) In determining the amount of damages to be awarded, 535
the jury or court may consider all factors existing at the time 536
of the decedent's death that are relevant to a determination of 537
the damages suffered by reason of the wrongful death. 538

(ii) Consistent with the Rules of Evidence, a party to a 539
civil action for wrongful death may present evidence of the cost 540
of an annuity in connection with an issue of recoverable future 541
damages. If that evidence is presented, then, in addition to the 542
factors described in division (A) (3) (b) (i) of this section and, 543

if applicable, division (A) (3) (b) (iii) of this section, the jury 544
or court may consider that evidence in determining the future 545
damages suffered by reason of the wrongful death. If that 546
evidence is presented, the present value in dollars of an 547
annuity is its cost. 548

(iii) Consistent with the Rules of Evidence, a party to a 549
civil action for wrongful death may present evidence that the 550
surviving spouse of the decedent is remarried. If that evidence 551
is presented, then, in addition to the factors described in 552
divisions (A) (3) (b) (i) and (ii) of this section, the jury or 553
court may consider that evidence in determining the damages 554
suffered by the surviving spouse by reason of the wrongful 555
death. 556

(B) Compensatory damages may be awarded in a civil action 557
for wrongful death and may include damages for the following: 558

(1) Loss of support from the reasonably expected earning 559
capacity of the decedent; 560

(2) Loss of services of the decedent; 561

(3) Loss of the society of the decedent, including loss of 562
companionship, consortium, care, assistance, attention, 563
protection, advice, guidance, counsel, instruction, training, 564
and education, suffered by the surviving spouse, dependent 565
children, parents, or next of kin of the decedent; 566

(4) Loss of prospective inheritance to the decedent's 567
heirs at law at the time of the decedent's death; 568

(5) The mental anguish incurred by the surviving spouse, 569
dependent children, parents, or next of kin of the decedent. 570

(C) A personal representative appointed in this state, 571

with the consent of the court making the appointment and at any 572
time before or after the commencement of a civil action for 573
wrongful death, may settle with the defendant the amount to be 574
paid. 575

(D) (1) Except as provided in division (D) (2) of this 576
section, a civil action for wrongful death shall be commenced 577
within two years after the decedent's death. 578

(2) (a) Except as otherwise provided in divisions (D) (2) 579
(b), (c), (d), (e), (f), and (g) of this section or in section 580
2125.04 of the Revised Code, no cause of action for wrongful 581
death involving a product liability claim shall accrue against 582
the manufacturer or supplier of a product later than ten years 583
from the date that the product was delivered to its first 584
purchaser or first lessee who was not engaged in a business in 585
which the product was used as a component in the production, 586
construction, creation, assembly, or rebuilding of another 587
product. 588

(b) Division (D) (2) (a) of this section does not apply if 589
the manufacturer or supplier of a product engaged in fraud in 590
regard to information about the product and the fraud 591
contributed to the harm that is alleged in a product liability 592
claim involving that product. 593

(c) Division (D) (2) (a) of this section does not bar a 594
civil action for wrongful death involving a product liability 595
claim against a manufacturer or supplier of a product who made 596
an express, written warranty as to the safety of the product 597
that was for a period longer than ten years and that, at the 598
time of the decedent's death, has not expired in accordance with 599
the terms of that warranty. 600

(d) If the decedent's death occurs during the ten-year 601
period described in division (D) (2) (a) of this section but less 602
than two years prior to the expiration of that period, a civil 603
action for wrongful death involving a product liability claim 604
may be commenced within two years after the decedent's death. 605

(e) If the decedent's death occurs during the ten-year 606
period described in division (D) (2) (a) of this section and the 607
claimant cannot commence an action during that period due to a 608
disability described in section 2305.16 of the Revised Code, a 609
civil action for wrongful death involving a product liability 610
claim may be commenced within two years after the disability is 611
removed. 612

(f) (i) Division (D) (2) (a) of this section does not bar a 613
civil action for wrongful death based on a product liability 614
claim against a manufacturer or supplier of a product if the 615
product involved is a substance or device described in division 616
(B) (1), (2), (3), or (4) of section 2305.10 of the Revised Code 617
and the decedent's death resulted from exposure to the product 618
during the ten-year period described in division (D) (2) (a) of 619
this section. 620

(ii) If division (D) (2) (f) (i) of this section applies 621
regarding a civil action for wrongful death, the cause of action 622
that is the basis of the action accrues upon the date on which 623
the claimant is informed by competent medical authority that the 624
decedent's death was related to the exposure to the product or 625
upon the date on which by the exercise of reasonable diligence 626
the claimant should have known that the decedent's death was 627
related to the exposure to the product, whichever date occurs 628
first. A civil action for wrongful death based on a cause of 629
action described in division (D) (2) (f) (i) of this section shall 630

be commenced within two years after the cause of action accrues 631
and shall not be commenced more than two years after the cause 632
of action accrues. 633

(g) Division (D) (2) (a) of this section does not bar a 634
civil action for wrongful death based on a product liability 635
claim against a manufacturer or supplier of a product if the 636
product involved is a substance or device described in division 637
(B) (5) of section 2315.10 of the Revised Code. If division (D) 638
(2) (g) of this section applies regarding a civil action for 639
wrongful death, the cause of action that is the basis of the 640
action accrues upon the date on which the claimant is informed 641
by competent medical authority that the decedent's death was 642
related to the exposure to the product or upon the date on which 643
by the exercise of reasonable diligence the claimant should have 644
known that the decedent's death was related to the exposure to 645
the product, whichever date occurs first. A civil action for 646
wrongful death based on a cause of action described in division 647
(D) (2) (g) of this section shall be commenced within two years 648
after the cause of action accrues and shall not be commenced 649
more than two years after the cause of action accrues. 650

(E) (1) If the personal representative of a deceased minor 651
has actual knowledge or reasonable cause to believe that the 652
minor was abandoned by a parent seeking to benefit from a civil 653
action for wrongful death or if any person listed in division 654
(A) (1) of this section who is permitted to benefit from a civil 655
action for wrongful death commenced in relation to a deceased 656
minor has actual knowledge or reasonable cause to believe that 657
the minor was abandoned by a parent seeking to benefit from the 658
action, the personal representative or the person may file a 659
motion in the court in which the action is commenced requesting 660
the court to issue an order finding that the parent abandoned 661

the minor and is not entitled to recover damages in the action 662
based on the death of the minor. 663

(2) The movant who files a motion described in division 664
(E)(1) of this section shall name the parent who abandoned the 665
deceased minor and, whether or not that parent is a resident of 666
this state, the parent shall be served with a summons and a copy 667
of the motion in accordance with the Rules of Civil Procedure. 668
Upon the filing of the motion, the court shall conduct a 669
hearing. In the hearing on the motion, the movant has the burden 670
of proving, by a preponderance of the evidence, that the parent 671
abandoned the minor. If, at the hearing, the court finds that 672
the movant has sustained that burden of proof, the court shall 673
issue an order that includes its findings that the parent 674
abandoned the minor and that, because of the prohibition set 675
forth in division (A)(1) of this section, the parent is not 676
entitled to recover damages in the action based on the death of 677
the minor. 678

(3) A motion requesting a court to issue an order finding 679
that a specified parent abandoned a minor child and is not 680
entitled to recover damages in a civil action for wrongful death 681
based on the death of the minor may be filed at any time during 682
the pendency of the action. 683

(F) This section does not create a new cause of action or 684
substantive legal right against any person involving a product 685
liability claim. 686

(G) As used in this section: 687

(1) "Annuity" means an annuity that would be purchased 688
from either of the following types of insurance companies: 689

(a) An insurance company that the A. M. Best Company, in 690

its most recently published rating guide of life insurance 691
companies, has rated A or better and has rated XII or higher as 692
to financial size or strength; 693

(b) (i) An insurance company that the superintendent of 694
insurance, under rules adopted pursuant to Chapter 119. of the 695
Revised Code for purposes of implementing this division, 696
determines is licensed to do business in this state and, 697
considering the factors described in division (G) (1) (b) (ii) of 698
this section, is a stable insurance company that issues 699
annuities that are safe and desirable. 700

(ii) In making determinations as described in division (G) 701
(1) (b) (i) of this section, the superintendent shall be guided by 702
the principle that the jury or court in a civil action for 703
wrongful death should be presented only with evidence as to the 704
cost of annuities that are safe and desirable for the 705
beneficiaries of the action who are awarded compensatory damages 706
under this section. In making the determinations, the 707
superintendent shall consider the financial condition, general 708
standing, operating results, profitability, leverage, liquidity, 709
amount and soundness of reinsurance, adequacy of reserves, and 710
the management of a particular insurance company involved and 711
also may consider ratings, grades, and classifications of any 712
nationally recognized rating services of insurance companies and 713
any other factors relevant to the making of the determinations. 714

(2) "Civil action for wrongful death" means an action 715
described in section 2125.01 of the Revised Code. 716

(3) "Future damages" means damages that result from the 717
wrongful death and that will accrue after the verdict or 718
determination of liability by the jury or court is rendered in 719
the civil action for wrongful death. 720

~~(3)~~(4) "Abandoned" means that a parent of a minor failed 721
without justifiable cause to communicate with the minor, care 722
for the minor, and provide for the maintenance or support of the 723
minor as required by law or judicial decree for a period of at 724
least one year immediately prior to the date of the death of the 725
minor. 726

~~(4)~~(5) "Minor" means a person who is less than eighteen 727
years of age. 728

~~(5)~~(6) "Harm" means death. 729

~~(6)~~(7) "Manufacturer," "product," "product liability 730
claim," and "supplier" have the same meanings as in section 731
2307.71 of the Revised Code. 732

(H) Divisions (D), (G) (5), and (G) ~~(6)~~(7) of this section 733
shall be considered to be purely remedial in operation and shall 734
be applied in a remedial manner in any civil action commenced on 735
or after ~~the effective date of this amendment~~ April 7, 2005, in 736
which those divisions are relevant, regardless of when the cause 737
of action accrued and notwithstanding any other section of the 738
Revised Code or prior rule of law of this state, but shall not 739
be construed to apply to any civil action pending prior to ~~the~~ 740
~~effective date of this amendment~~ April 7, 2005. 741

Sec. 2305.11. (A) An action for libel, slander, malicious 742
prosecution, or false imprisonment, an action for malpractice 743
other than an action upon a medical, dental, optometric, or 744
chiropractic claim, or an action upon a statute for a penalty or 745
forfeiture shall be commenced within one year after the cause of 746
action accrued, provided that an action by an employee for the 747
payment of unpaid minimum wages, unpaid overtime compensation, 748
or liquidated damages by reason of the nonpayment of minimum 749

wages or overtime compensation shall be commenced within two 750
years after the cause of action accrued. 751

(B) A civil action for unlawful abortion pursuant to 752
section 2919.12 of the Revised Code, a civil action authorized 753
by division (H) of section 2317.56 of the Revised Code, a civil 754
action pursuant to division (B) (1) or (2) of section 2307.51 of 755
the Revised Code for performing a dilation and extraction 756
procedure or attempting to perform a dilation and extraction 757
procedure in violation of section 2919.15 of the Revised Code, 758
and a civil action pursuant to division (B) of section 2307.52 759
of the Revised Code for terminating or attempting to terminate a 760
human pregnancy after viability in violation of division (A) of 761
section 2919.17 of the Revised Code shall be commenced within 762
one year after the performance or inducement of the abortion, 763
within one year after the attempt to perform or induce the 764
abortion in violation of division (A) of section 2919.17 of the 765
Revised Code, within one year after the performance of the 766
dilation and extraction procedure, or, in the case of a civil 767
action pursuant to division (B) (2) of section 2307.51 of the 768
Revised Code, within one year after the attempt to perform the 769
dilation and extraction procedure. 770

(C) This section does not apply to a claim brought 771
pursuant to Chapter 3965. of the Revised Code. 772

(D) As used in this section, "medical claim," "dental 773
claim," "optometric claim," and "chiropractic claim" have the 774
same meanings as in section 2305.113 of the Revised Code. 775

Sec. 2305.113. (A) This section shall apply only to a 776
medical, dental, optometric, or chiropractic claim in which 777
either of the following applies: 778

(1) A claimant alleges that the individual or entity 779
against whom the claim is brought intentionally caused, as 780
defined in section 3965.02 of the Revised Code, the injury to or 781
death of the claimant or the individual upon whose behalf the 782
claimant brought the claim. 783

(2) The individual or entity against whom the claim is 784
brought was not in compliance with division (A) of section 785
3965.02 of the Revised Code at the time the action accrued. 786

(B) Except as otherwise provided in this section, an 787
action upon a medical, dental, optometric, or chiropractic claim 788
shall be commenced within one year after the cause of action 789
accrued. 790

~~(B)~~ (C) (1) If prior to the expiration of the one-year 791
period specified in division ~~(A)~~ (B) of this section, a claimant 792
who allegedly possesses a medical, dental, optometric, or 793
chiropractic claim gives to the person who is the subject of 794
that claim written notice that the claimant is considering 795
bringing an action upon that claim, that action may be commenced 796
against the person notified at any time within one hundred 797
eighty days after the notice is so given. 798

(2) An insurance company shall not consider the existence 799
or nonexistence of a written notice described in division ~~(B)~~ (C) 800
(1) of this section in setting the liability insurance premium 801
rates that the company may charge the company's insured person 802
who is notified by that written notice. 803

~~(C)~~ (D) Except as to persons within the age of minority or 804
of unsound mind as provided by section 2305.16 of the Revised 805
Code, and except as provided in division ~~(D)~~ (E) of this 806
section, both of the following apply: 807

(1) No action upon a medical, dental, optometric, or 808
chiropractic claim shall be commenced more than four years after 809
the occurrence of the act or omission constituting the alleged 810
basis of the medical, dental, optometric, or chiropractic claim. 811

(2) If an action upon a medical, dental, optometric, or 812
chiropractic claim is not commenced within four years after the 813
occurrence of the act or omission constituting the alleged basis 814
of the medical, dental, optometric, or chiropractic claim, then, 815
any action upon that claim is barred. 816

~~(D)~~ (E) (1) If a person making a medical claim, dental 817
claim, optometric claim, or chiropractic claim, in the exercise 818
of reasonable care and diligence, could not have discovered the 819
injury resulting from the act or omission constituting the 820
alleged basis of the claim within three years after the 821
occurrence of the act or omission, but, in the exercise of 822
reasonable care and diligence, discovers the injury resulting 823
from that act or omission before the expiration of the four-year 824
period specified in division ~~(C)~~ (D) (1) of this section, the 825
person may commence an action upon the claim not later than one 826
year after the person discovers the injury resulting from that 827
act or omission. 828

(2) If the alleged basis of a medical claim, dental claim, 829
optometric claim, or chiropractic claim is the occurrence of an 830
act or omission that involves a foreign object that is left in 831
the body of the person making the claim, the person may commence 832
an action upon the claim not later than one year after the 833
person discovered the foreign object or not later than one year 834
after the person, with reasonable care and diligence, should 835
have discovered the foreign object. 836

(3) A person who commences an action upon a medical claim, 837

dental claim, optometric claim, or chiropractic claim under the 838
circumstances described in division ~~(D)~~(E) (1) or (2) of this 839
section has the affirmative burden of proving, by clear and 840
convincing evidence, that the person, with reasonable care and 841
diligence, could not have discovered the injury resulting from 842
the act or omission constituting the alleged basis of the claim 843
within the three-year period described in division ~~(D)~~(E) (1) of 844
this section or within the one-year period described in division 845
~~(D)~~(E) (2) of this section, whichever is applicable. 846

~~(E)~~(F) As used in this section: 847

(1) "Hospital" includes any person, corporation, 848
association, board, or authority that is responsible for the 849
operation of any hospital licensed or registered in the state, 850
including, but not limited to, those that are owned or operated 851
by the state, political subdivisions, any person, any 852
corporation, or any combination of the state, political 853
subdivisions, persons, and corporations. "Hospital" also 854
includes any person, corporation, association, board, entity, or 855
authority that is responsible for the operation of any clinic 856
that employs a full-time staff of physicians practicing in more 857
than one recognized medical specialty and rendering advice, 858
diagnosis, care, and treatment to individuals. "Hospital" does 859
not include any hospital operated by the government of the 860
United States or any of its branches. 861

(2) "Physician" means a person who is licensed to practice 862
medicine and surgery or osteopathic medicine and surgery by the 863
state medical board or a person who otherwise is authorized to 864
practice medicine and surgery or osteopathic medicine and 865
surgery in this state. 866

(3) "Medical claim" means any claim that is asserted in 867

any civil action against a physician, podiatrist, hospital, 868
home, or residential facility, against any employee or agent of 869
a physician, podiatrist, hospital, home, or residential 870
facility, or against a licensed practical nurse, registered 871
nurse, advanced practice registered nurse, physical therapist, 872
physician assistant, emergency medical technician-basic, 873
emergency medical technician-intermediate, or emergency medical 874
technician-paramedic, and that arises out of the medical 875
diagnosis, care, or treatment of any person. "Medical claim" 876
includes the following: 877

(a) Derivative claims for relief that arise from the 878
medical diagnosis, care, or treatment of a person; 879

(b) Claims that arise out of the medical diagnosis, care, 880
or treatment of any person and to which either of the following 881
applies: 882

(i) The claim results from acts or omissions in providing 883
medical care. 884

(ii) The claim results from the hiring, training, 885
supervision, retention, or termination of caregivers providing 886
medical diagnosis, care, or treatment. 887

(c) Claims that arise out of the medical diagnosis, care, 888
or treatment of any person and that are brought under section 889
3721.17 of the Revised Code. 890

(4) "Podiatrist" means any person who is licensed to 891
practice podiatric medicine and surgery by the state medical 892
board. 893

(5) "Dentist" means any person who is licensed to practice 894
dentistry by the state dental board. 895

(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 926
in any civil action against a chiropractor, or against any 927
employee or agent of a chiropractor, and that arises out of the 928
chiropractic diagnosis, care, or treatment of any person. 929
"Chiropractic claim" includes derivative claims for relief that 930
arise from the chiropractic diagnosis, care, or treatment of a 931
person. 932

(10) "Chiropractor" means any person who is licensed to 933
practice chiropractic by the state chiropractic board. 934

(11) "Optometric claim" means any claim that is asserted 935
in any civil action against an optometrist, or against any 936
employee or agent of an optometrist, and that arises out of the 937
optometric diagnosis, care, or treatment of any person. 938
"Optometric claim" includes derivative claims for relief that 939
arise from the optometric diagnosis, care, or treatment of a 940
person. 941

(12) "Optometrist" means any person licensed to practice 942
optometry by the state board of optometry. 943

(13) "Physical therapist" means any person who is licensed 944
to practice physical therapy under Chapter 4755. of the Revised 945
Code. 946

(14) "Home" has the same meaning as in section 3721.10 of 947
the Revised Code. 948

(15) "Residential facility" means a facility licensed 949
under section 5123.19 of the Revised Code. 950

(16) "Advanced practice registered nurse" means any 951
certified nurse practitioner, clinical nurse specialist, 952
certified registered nurse anesthetist, or certified nurse- 953
midwife who holds a certificate of authority issued by the board 954

of nursing under Chapter 4723. of the Revised Code. 955

(17) "Licensed practical nurse" means any person who is 956
licensed to practice nursing as a licensed practical nurse by 957
the board of nursing pursuant to Chapter 4723. of the Revised 958
Code. 959

(18) "Physician assistant" means any person who holds a 960
valid certificate to practice issued pursuant to Chapter 4730. 961
of the Revised Code. 962

(19) "Emergency medical technician-basic," "emergency 963
medical technician-intermediate," and "emergency medical 964
technician-paramedic" means any person who is certified under 965
Chapter 4765. of the Revised Code as an emergency medical 966
technician-basic, emergency medical technician-intermediate, or 967
emergency medical technician-paramedic, whichever is applicable. 968

Sec. 2305.15. (A) When a cause of action accrues against a 969
person, if the person is out of the state, has absconded, or 970
conceals self, the period of limitation for the commencement of 971
the action as provided in sections 2305.04 to 2305.14, 1302.98, 972
and 1304.35 of the Revised Code does not begin to run until the 973
person comes into the state or while the person is so absconded 974
or concealed. After the cause of action accrues if the person 975
departs from the state, absconds, or conceals self, the time of 976
the person's absence or concealment shall not be computed as any 977
part of a period within which the action must be brought. 978

(B) When a person is imprisoned for the commission of any 979
offense, the time of the person's imprisonment shall not be 980
computed as any part of any period of limitation, as provided in 981
section 2305.09, 2305.10, 2305.11, 2305.113, ~~or~~ 2305.14, or 982
3965.30 of the Revised Code, within which any person must bring 983

any action against the imprisoned person. 984

Sec. 2305.23. No person shall be liable in civil damages 985
or under Chapter 3965. or 3967. of the Revised Code for 986
administering emergency care or treatment at the scene of an 987
emergency outside of a hospital, doctor's office, or other place 988
having proper medical equipment, for acts performed at the scene 989
of such emergency, unless such acts constitute willful or wanton 990
misconduct. 991

Nothing in this section applies to the administering of 992
such care or treatment where the same is rendered for 993
remuneration, or with the expectation of remuneration, from the 994
recipient of such care or treatment or someone on ~~his~~ the 995
recipient's behalf. The administering of such care or treatment 996
by one as a part of ~~his~~ a person's duties as a paid member of 997
any organization of law enforcement officers or fire fighters 998
does not cause such to be a rendering for remuneration or 999
expectation of remuneration. 1000

Sec. 2305.231. (A) As used in this section: 1001

(1) "Dentist" means a person who is licensed under Chapter 1002
4715. of the Revised Code to practice dentistry. 1003

(2) "Physician" means a person who holds a certificate 1004
issued by the state medical board to practice medicine and 1005
surgery, osteopathic medicine and surgery, or podiatric medicine 1006
and surgery. 1007

(3) "Registered nurse" means a nurse who is licensed as a 1008
registered nurse under Chapter 4723. of the Revised Code. 1009

(B) No physician who volunteers the physician's services 1010
as a team physician or team podiatrist to a school's athletics 1011
program, no dentist who volunteers the dentist's services as a 1012

team dentist to a school's athletics program, and no registered 1013
nurse who volunteers the registered nurse's services as a team 1014
nurse to a school's athletics program is liable in damages in a 1015
civil action or in a claim filed under Chapters 3965. and 3967. 1016
of the Revised Code for administering emergency medical care, 1017
emergency dental care, other emergency professional care, or 1018
first aid treatment to a participant in an athletic event 1019
involving the school, at the scene of the event or while the 1020
participant is being transported to a hospital, physician's or 1021
dentist's office, or other medical or dental facility, or for 1022
acts performed in administering the care or treatment, unless 1023
the acts of the physician, dentist, or registered nurse 1024
constitute willful or wanton misconduct. 1025

(C) This section does not apply if the administration of 1026
emergency medical care, emergency dental care, other emergency 1027
professional care, or first aid treatment is rendered for 1028
remuneration, or with the expectation of remuneration, from the 1029
recipient of the care or treatment or from someone on the 1030
recipient's behalf. 1031

Sec. 2305.234. (A) As used in this section: 1032

(1) "Chiropractic claim," "medical claim," and "optometric 1033
claim" have the same meanings as in section 2305.113 or 3965.01 1034
of the Revised Code. 1035

(2) "Dental claim" has the same meaning as in section 1036
2305.113 or 3965.01 of the Revised Code, except that it does not 1037
include any claim arising out of a dental operation or any 1038
derivative claim for relief that arises out of a dental 1039
operation. 1040

(3) "Governmental health care program" has the same 1041

meaning as in section 4731.65 of the Revised Code. 1042

(4) "Health care facility or location" means a hospital, 1043
clinic, ambulatory surgical facility, office of a health care 1044
professional or associated group of health care professionals, 1045
training institution for health care professionals, or any other 1046
place where medical, dental, or other health-related diagnosis, 1047
care, or treatment is provided to a person. 1048

(5) "Health care professional" means any of the following 1049
who provide medical, dental, or other health-related diagnosis, 1050
care, or treatment: 1051

(a) Physicians authorized under Chapter 4731. of the 1052
Revised Code to practice medicine and surgery or osteopathic 1053
medicine and surgery; 1054

(b) Registered nurses and licensed practical nurses 1055
licensed under Chapter 4723. of the Revised Code and individuals 1056
who hold a certificate of authority issued under that chapter 1057
that authorizes the practice of nursing as a certified 1058
registered nurse anesthetist, clinical nurse specialist, 1059
certified nurse-midwife, or certified nurse practitioner; 1060

(c) Physician assistants authorized to practice under 1061
Chapter 4730. of the Revised Code; 1062

(d) Dentists and dental hygienists licensed under Chapter 1063
4715. of the Revised Code; 1064

(e) Physical therapists, physical therapist assistants, 1065
occupational therapists, occupational therapy assistants, and 1066
athletic trainers licensed under Chapter 4755. of the Revised 1067
Code; 1068

(f) Chiropractors licensed under Chapter 4734. of the 1069

Revised Code;	1070
(g) Optometrists licensed under Chapter 4725. of the	1071
Revised Code;	1072
(h) Podiatrists authorized under Chapter 4731. of the	1073
Revised Code to practice podiatry;	1074
(i) Dietitians licensed under Chapter 4759. of the Revised	1075
Code;	1076
(j) Pharmacists licensed under Chapter 4729. of the	1077
Revised Code;	1078
(k) Emergency medical technicians-basic, emergency medical	1079
technicians-intermediate, and emergency medical technicians-	1080
paramedic, certified under Chapter 4765. of the Revised Code;	1081
(l) Respiratory care professionals licensed under Chapter	1082
4761. of the Revised Code;	1083
(m) Speech-language pathologists and audiologists licensed	1084
under Chapter 4753. of the Revised Code;	1085
(n) Licensed professional clinical counselors, licensed	1086
professional counselors, independent social workers, social	1087
workers, independent marriage and family therapists, and	1088
marriage and family therapists, licensed under Chapter 4757. of	1089
the Revised Code;	1090
(o) Psychologists licensed under Chapter 4732. of the	1091
Revised Code;	1092
(p) Individuals licensed or certified under Chapter 4758.	1093
of the Revised Code who are acting within the scope of their	1094
license or certificate as members of the profession of chemical	1095
dependency counseling or alcohol and other drug prevention	1096

services. 1097

(6) "Health care worker" means a person other than a 1098
health care professional who provides medical, dental, or other 1099
health-related care or treatment under the direction of a health 1100
care professional with the authority to direct that individual's 1101
activities, including medical technicians, medical assistants, 1102
dental assistants, orderlies, aides, and individuals acting in 1103
similar capacities. 1104

(7) "Indigent and uninsured person" means a person who 1105
meets all of the following requirements: 1106

(a) The person's income is not greater than two hundred 1107
per cent of the current poverty line as defined by the United 1108
States office of management and budget and revised in accordance 1109
with section 673(2) of the "Omnibus Budget Reconciliation Act of 1110
1981," 95 Stat. 511, 42 U.S.C. 9902, as amended. 1111

(b) The person is not eligible for the medicaid program or 1112
any other governmental health care program. 1113

(c) Either of the following applies: 1114

(i) The person is not a policyholder, certificate holder, 1115
insured, contract holder, subscriber, enrollee, member, 1116
beneficiary, or other covered individual under a health 1117
insurance or health care policy, contract, or plan. 1118

(ii) The person is a policyholder, certificate holder, 1119
insured, contract holder, subscriber, enrollee, member, 1120
beneficiary, or other covered individual under a health 1121
insurance or health care policy, contract, or plan, but the 1122
insurer, policy, contract, or plan denies coverage or is the 1123
subject of insolvency or bankruptcy proceedings in any 1124
jurisdiction. 1125

(8) "Nonprofit health care referral organization" means an 1126
entity that is not operated for profit and refers patients to, 1127
or arranges for the provision of, health-related diagnosis, 1128
care, or treatment by a health care professional or health care 1129
worker. 1130

(9) "Operation" means any procedure that involves cutting 1131
or otherwise infiltrating human tissue by mechanical means, 1132
including surgery, laser surgery, ionizing radiation, 1133
therapeutic ultrasound, or the removal of intraocular foreign 1134
bodies. "Operation" does not include the administration of 1135
medication by injection, unless the injection is administered in 1136
conjunction with a procedure infiltrating human tissue by 1137
mechanical means other than the administration of medicine by 1138
injection. "Operation" does not include routine dental 1139
restorative procedures, the scaling of teeth, or extractions of 1140
teeth that are not impacted. 1141

(10) "Tort action" means a civil action for damages for 1142
injury, death, or loss to person or property other than a civil 1143
action for damages for a breach of contract or another agreement 1144
between persons or government entities. 1145

(11) "Volunteer" means an individual who provides any 1146
medical, dental, or other health-care related diagnosis, care, 1147
or treatment without the expectation of receiving and without 1148
receipt of any compensation or other form of remuneration from 1149
an indigent and uninsured person, another person on behalf of an 1150
indigent and uninsured person, any health care facility or 1151
location, any nonprofit health care referral organization, or 1152
any other person or government entity. 1153

(12) "Community control sanction" has the same meaning as 1154
in section 2929.01 of the Revised Code. 1155

(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) 1186
(1) of this section, a health care professional shall do all of 1187
the following prior to providing diagnosis, care, or treatment: 1188

(a) Determine, in good faith, that the indigent and 1189
uninsured person is mentally capable of giving informed consent 1190
to the provision of the diagnosis, care, or treatment and is not 1191
subject to duress or under undue influence; 1192

(b) Inform the person of the provisions of this section, 1193
including notifying the person that, by giving informed consent 1194
to the provision of the diagnosis, care, or treatment, the 1195
person cannot hold the health care professional liable for 1196
damages in a tort or other civil action, including an action on 1197
a medical, dental, chiropractic, optometric, or other health- 1198
related claim, unless the action or omission of the health care 1199
professional constitutes willful or wanton misconduct or under a 1200
claim filed under Chapter 3965. or 3967. of the Revised Code 1201
unless the act or omission of the health care professional was 1202
intentional as described in section 3965.02 of the Revised Code 1203
or the health care professional was not in compliance with 1204
division (A) of section 3965.02 of the Revised Code at the time 1205
the claim accrued; 1206

(c) Obtain the informed consent of the person and a 1207
written waiver, signed by the person or by another individual on 1208
behalf of and in the presence of the person, that states that 1209
the person is mentally competent to give informed consent and, 1210
without being subject to duress or under undue influence, gives 1211
informed consent to the provision of the diagnosis, care, or 1212
treatment subject to the provisions of this section. A written 1213
waiver under division (B) (2) (c) of this section shall state 1214
clearly and in conspicuous type that the person or other 1215

individual who signs the waiver is signing it with full 1216
knowledge that, by giving informed consent to the provision of 1217
the diagnosis, care, or treatment, the person cannot bring a 1218
tort or other civil action, including an action on a medical, 1219
dental, chiropractic, optometric, or other health-related claim, 1220
against the health care professional unless the action or 1221
omission of the health care professional constitutes willful or 1222
wanton misconduct or file a claim under Chapter 3965. or 3967. 1223
of the Revised Code against the health care professional unless 1224
the act or omission of the health care professional was 1225
intentional as described in section 3965.02 of the Revised Code 1226
or the health care professional was not in compliance with 1227
division (A) of section 3965.02 of the Revised Code at the time 1228
the claim accrued. 1229

~~(3) A physician or podiatrist who is not covered by 1230
medical malpractice insurance, but complies with division (B) (2) 1231
of this section, is not required to comply with division (A) of 1232
section 4731.143 of the Revised Code. 1233~~

(C) Subject to divisions (F) and (G) (3) of this section, 1234
health care workers who are volunteers are not liable in damages 1235
to any person or government entity in a tort or other civil 1236
action, including an action upon a medical, dental, 1237
chiropractic, optometric, or other health-related claim, for 1238
injury, death, or loss to person or property that allegedly 1239
arises from an action or omission of the health care worker in 1240
the provision to an indigent and uninsured person of medical, 1241
dental, or other health-related diagnosis, care, or treatment, 1242
unless the action or omission constitutes willful or wanton 1243
misconduct or in a claim filed under Chapter 3965. or 3967. of 1244
the Revised Code against the health care worker unless the act 1245
or omission of the health care worker was intentional as 1246

described in section 3965.02 of the Revised Code or the health 1247
care worker was not in compliance with division (A) of section 1248
3965.02 of the Revised Code at the time the claim accrued. 1249

(D) Subject to divisions (F) and (G) (3) of this section, a 1250
nonprofit health care referral organization is not liable in 1251
damages to any person or government entity in a tort or other 1252
civil action, including an action on a medical, dental, 1253
chiropractic, optometric, or other health-related claim, for 1254
injury, death, or loss to person or property that allegedly 1255
arises from an action or omission of the nonprofit health care 1256
referral organization in referring indigent and uninsured 1257
persons to, or arranging for the provision of, medical, dental, 1258
or other health-related diagnosis, care, or treatment by a 1259
health care professional described in division (B) (1) of this 1260
section or a health care worker described in division (C) of 1261
this section, unless the action or omission constitutes willful 1262
or wanton misconduct. 1263

(E) Subject to divisions (F) and (G) (3) of this section 1264
and to the extent that the registration requirements of section 1265
3701.071 of the Revised Code apply, a health care facility or 1266
location associated with a health care professional described in 1267
division (B) (1) of this section, a health care worker described 1268
in division (C) of this section, or a nonprofit health care 1269
referral organization described in division (D) of this section 1270
is not liable in damages to any person or government entity in a 1271
tort or other civil action, including an action on a medical, 1272
dental, chiropractic, optometric, or other health-related claim, 1273
for injury, death, or loss to person or property that allegedly 1274
arises from an action or omission of the health care 1275
professional or worker or nonprofit health care referral 1276
organization relative to the medical, dental, or other health- 1277

related diagnosis, care, or treatment provided to an indigent 1278
and uninsured person on behalf of or at the health care facility 1279
or location, unless the action or omission constitutes willful 1280
or wanton misconduct. 1281

(F) (1) Except as provided in division (F) (2) of this 1282
section, the immunities provided by divisions (B), (C), (D), and 1283
(E) of this section are not available to a health care 1284
professional, health care worker, nonprofit health care referral 1285
organization, or health care facility or location if, at the 1286
time of an alleged injury, death, or loss to person or property, 1287
the health care professionals or health care workers involved 1288
are providing one of the following: 1289

(a) Any medical, dental, or other health-related 1290
diagnosis, care, or treatment pursuant to a community service 1291
work order entered by a court under division (B) of section 1292
2951.02 of the Revised Code or imposed by a court as a community 1293
control sanction; 1294

(b) Performance of an operation to which any one of the 1295
following applies: 1296

(i) The operation requires the administration of deep 1297
sedation or general anesthesia. 1298

(ii) The operation is a procedure that is not typically 1299
performed in an office. 1300

(iii) The individual involved is a health care 1301
professional, and the operation is beyond the scope of practice 1302
or the education, training, and competence, as applicable, of 1303
the health care professional. 1304

(c) Delivery of a baby or any other purposeful termination 1305
of a human pregnancy. 1306

(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, 1336
or local code, ordinance, or regulation that pertains to or 1337
regulates building, housing, air pollution, water pollution, 1338
sanitation, health, fire, zoning, or safety. 1339

Sec. 2305.25. As used in this section and sections 1340
2305.251 to 2305.253 of the Revised Code: 1341

(A) (1) "Health care entity" means an entity, whether 1342
acting on its own behalf or on behalf of or in affiliation with 1343
other health care entities, that conducts as part of its regular 1344
business activities professional credentialing or quality review 1345
activities involving the competence of, professional conduct of, 1346
or quality of care provided by health care providers, including 1347
both individuals who provide health care and entities that 1348
provide health care. 1349

(2) "Health care entity" includes any entity described in 1350
division (A) (1) of this section, regardless of whether it is a 1351
government entity; for-profit or nonprofit corporation; limited 1352
liability company; partnership; professional corporation; state 1353
or local society composed of physicians, dentists, optometrists, 1354
psychologists, or pharmacists; accountable care organization; 1355
other health care organization; or combination of any of the 1356
foregoing entities. 1357

(B) "Health insuring corporation" means an entity that 1358
holds a certificate of authority under Chapter 1751. of the 1359
Revised Code. "Health insuring corporation" includes wholly 1360
owned subsidiaries of a health insuring corporation. 1361

(C) "Hospital" means any of the following: 1362

(1) An institution that has been registered or licensed by 1363
the department of health as a hospital; 1364

(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;	1394
(b) A peer review committee of a community mental health center;	1395 1396
(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;	1397 1398 1399 1400 1401
(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;	1402 1403 1404 1405
(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;	1406 1407 1408 1409 1410 1411 1412
(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;	1413 1414 1415 1416 1417 1418 1419 1420 1421
(g) A peer review committee of a sickness and accident	1422

insurer that has at least a two-thirds majority of physicians in 1423
active practice and that conducts professional credentialing and 1424
quality review activities involving the competence or 1425
professional conduct of health care providers that adversely 1426
affects or could adversely affect the health or welfare of any 1427
patient; 1428

(h) A peer review committee of a sickness and accident 1429
insurer that has at least a two-thirds majority of physicians in 1430
active practice and that conducts professional credentialing and 1431
quality review activities involving the competence or 1432
professional conduct of a health care facility that has 1433
contracted with the insurer to provide health care services to 1434
insureds, which conduct adversely affects, or could adversely 1435
affect, the health or welfare of any patient; 1436

(i) A peer review committee of any insurer authorized 1437
under Title XXXIX of the Revised Code to do the business of 1438
medical professional liability insurance in this state that 1439
conducts professional quality review activities involving the 1440
competence or professional conduct of health care providers that 1441
adversely affects or could affect the health or welfare of any 1442
patient; 1443

(j) A peer review committee of the bureau of workers' 1444
compensation or the industrial commission that is responsible 1445
for reviewing the professional qualifications and the 1446
performance of providers certified by the bureau to participate 1447
in the health partnership program or of providers conducting 1448
medical examinations or file reviews for the bureau or the 1449
commission; 1450

(k) Any other peer review committee of a health care 1451
entity. 1452

(F) "Physician" means an individual authorized to practice 1453
medicine and surgery, osteopathic medicine and surgery, or 1454
podiatric medicine and surgery. 1455

(G) "Sickness and accident insurer" means an entity 1456
authorized under Title XXXIX of the Revised Code to do the 1457
business of sickness and accident insurance in this state. 1458

(H) "Tort action" means a civil action for damages or a 1459
claim filed under Chapters 3965. and 3967. of the Revised Code 1460
for injury, death, or loss to a patient of a health care entity. 1461
"Tort action" includes a product liability claim, as defined in 1462
section 2307.71 of the Revised Code, and an asbestos claim, as 1463
defined in section 2307.91 of the Revised Code, but does not 1464
include a civil action for a breach of contract or another 1465
agreement between persons. 1466

(I) "Accountable care organization" means such an 1467
organization as defined in 42 C.F.R. 425.20. 1468

Sec. 2307.24. (A) Sections 2307.22 and 2307.23 of the 1469
Revised Code do not affect joint and several liability that is 1470
not based in tort. 1471

(B) Sections 2307.22 and 2307.23 of the Revised Code do 1472
not affect any other section of the Revised Code or the common 1473
law of this state to the extent that the other section or common 1474
law makes a principal, master, or other person vicariously 1475
liable for the tortious conduct of an agent, servant, or other 1476
person. For purposes of section 2307.22 of the Revised Code, a 1477
principal and agent, a master and servant, or other persons 1478
having a vicarious liability relationship shall constitute a 1479
single party when determining percentages of tortious conduct in 1480
a tort action in which vicarious liability is asserted. 1481

(C) Sections 2307.22 and 2307.23 of the Revised Code do 1482
not apply to claims filed under Chapters 3965. and 3967. of the 1483
Revised Code. 1484

Sec. 2307.26. (A) If a judgment that imposes joint and 1485
several liability has been entered in an action against one or 1486
more tortfeasors for the same injury or loss to person or 1487
property or for the same wrongful death, contribution may be 1488
enforced in that action by judgment in favor of one against 1489
other judgment debtors, by motion, upon notice to all parties to 1490
the action. If there is a judgment for the injury or loss to 1491
person or property or the wrongful death against the tortfeasor 1492
seeking contribution, that tortfeasor shall commence any 1493
separate action to enforce contribution within one year after 1494
the judgment has become final by lapse of time for appeal or 1495
after appellate review. 1496

If there is no judgment for the injury or loss to person 1497
or property or the wrongful death against the tortfeasor seeking 1498
contribution, that tortfeasor's right of contribution is barred 1499
unless either of the following applies: 1500

~~(A)~~ (1) That tortfeasor has discharged by payment the 1501
common liability within the statute of limitations period 1502
applicable to the claimant's right of action against that 1503
tortfeasor and has commenced that tortfeasor's action for 1504
contribution within one year after the payment. 1505

~~(B)~~ (2) That tortfeasor has agreed while an action is 1506
pending against that tortfeasor to discharge the common 1507
liability and has paid within one year after the agreement the 1508
common liability and commenced that tortfeasor's action for 1509
contribution. 1510

(B) Sections 2307.222 and 2307.23 of the Revised Code do 1511
not apply to claims filed under Chapters 3965. and 3967. of the 1512
Revised Code. 1513

Sec. 2315.21. (A) As used in this section: 1514

(1) "Tort action" means a civil action for damages for 1515
injury or loss to person or property. "Tort action" includes a 1516
product liability claim for damages for injury or loss to person 1517
or property that is subject to sections 2307.71 to 2307.80 of 1518
the Revised Code, but does not include ~~a~~ either of the 1519
following: 1520

(a) A civil action for damages for a breach of contract or 1521
another agreement between persons; 1522

(b) A claim filed under Chapters 3965. and 3967. of the 1523
Revised Code. 1524

(2) "Trier of fact" means the jury or, in a nonjury 1525
action, the court. 1526

(3) "Home" has the same meaning as in section 3721.10 of 1527
the Revised Code. 1528

(4) "Employer" includes, but is not limited to, a parent, 1529
subsidiary, affiliate, division, or department of the employer. 1530
If the employer is an individual, the individual shall be 1531
considered an employer under this section only if the subject of 1532
the tort action is related to the individual's capacity as an 1533
employer. 1534

(5) "Small employer" means an employer who employs not 1535
more than one hundred persons on a full-time permanent basis, 1536
or, if the employer is classified as being in the manufacturing 1537
sector by the North American industrial classification system, 1538

"small employer" means an employer who employs not more than 1539
five hundred persons on a full-time permanent basis. 1540

(B)(1) In a tort action that is tried to a jury and in 1541
which a plaintiff makes a claim for compensatory damages and a 1542
claim for punitive or exemplary damages, upon the motion of any 1543
party, the trial of the tort action shall be bifurcated as 1544
follows: 1545

(a) The initial stage of the trial shall relate only to 1546
the presentation of evidence, and a determination by the jury, 1547
with respect to whether the plaintiff is entitled to recover 1548
compensatory damages for the injury or loss to person or 1549
property from the defendant. During this stage, no party to the 1550
tort action shall present, and the court shall not permit a 1551
party to present, evidence that relates solely to the issue of 1552
whether the plaintiff is entitled to recover punitive or 1553
exemplary damages for the injury or loss to person or property 1554
from the defendant. 1555

(b) If the jury determines in the initial stage of the 1556
trial that the plaintiff is entitled to recover compensatory 1557
damages for the injury or loss to person or property from the 1558
defendant, evidence may be presented in the second stage of the 1559
trial, and a determination by that jury shall be made, with 1560
respect to whether the plaintiff additionally is entitled to 1561
recover punitive or exemplary damages for the injury or loss to 1562
person or property from the defendant. 1563

(2) In a tort action that is tried to a jury and in which 1564
a plaintiff makes a claim for both compensatory damages and 1565
punitive or exemplary damages, the court shall instruct the jury 1566
to return, and the jury shall return, a general verdict and, if 1567
that verdict is in favor of the plaintiff, answers to an 1568

interrogatory that specifies the total compensatory damages 1569
recoverable by the plaintiff from each defendant. 1570

(3) In a tort action that is tried to a court and in which 1571
a plaintiff makes a claim for both compensatory damages and 1572
punitive or exemplary damages, the court shall make its 1573
determination with respect to whether the plaintiff is entitled 1574
to recover compensatory damages for the injury or loss to person 1575
or property from the defendant and, if that determination is in 1576
favor of the plaintiff, shall make findings of fact that specify 1577
the total compensatory damages recoverable by the plaintiff from 1578
the defendant. 1579

(C) Subject to division (E) of this section, punitive or 1580
exemplary damages are not recoverable from a defendant in 1581
question in a tort action unless both of the following apply: 1582

(1) The actions or omissions of that defendant demonstrate 1583
malice or aggravated or egregious fraud, or that defendant as 1584
principal or master knowingly authorized, participated in, or 1585
ratified actions or omissions of an agent or servant that so 1586
demonstrate. 1587

(2) The trier of fact has returned a verdict or has made a 1588
determination pursuant to division (B) (2) or (3) of this section 1589
of the total compensatory damages recoverable by the plaintiff 1590
from that defendant. 1591

(D) (1) In a tort action, the trier of fact shall determine 1592
the liability of any defendant for punitive or exemplary damages 1593
and the amount of those damages. 1594

(2) Except as provided in division (D) (6) of this section, 1595
all of the following apply regarding any award of punitive or 1596
exemplary damages in a tort action: 1597

(a) The court shall not enter judgment for punitive or 1598
exemplary damages in excess of two times the amount of the 1599
compensatory damages awarded to the plaintiff from that 1600
defendant, as determined pursuant to division (B) (2) or (3) of 1601
this section. 1602

(b) If the defendant is a small employer or individual, 1603
the court shall not enter judgment for punitive or exemplary 1604
damages in excess of the lesser of two times the amount of the 1605
compensatory damages awarded to the plaintiff from the defendant 1606
or ~~ten percent~~ per cent of the employer's or individual's net 1607
worth when the tort was committed up to a maximum of three 1608
hundred fifty thousand dollars, as determined pursuant to 1609
division (B) (2) or (3) of this section. 1610

(c) Any ~~attorneys~~ attorney's fees awarded as a result of a 1611
claim for punitive or exemplary damages shall not be considered 1612
for purposes of determining the cap on punitive damages. 1613

(3) No award of prejudgment interest under division (C) (1) 1614
of section 1343.03 of the Revised Code shall include any 1615
prejudgment interest on punitive or exemplary damages found by 1616
the trier of fact. 1617

(4) In a tort action, the burden of proof shall be upon a 1618
plaintiff in question, by clear and convincing evidence, to 1619
establish that the plaintiff is entitled to recover punitive or 1620
exemplary damages. 1621

(5) (a) In any tort action, except as provided in division 1622
(D) (5) (b) or (6) of this section, punitive or exemplary damages 1623
shall not be awarded against a defendant if that defendant files 1624
with the court a certified judgment, judgment entries, or other 1625
evidence showing that punitive or exemplary damages have already 1626

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 1657
convincing evidence that the total amount of prior punitive or 1658
exemplary damages awards was totally insufficient to punish that 1659
defendant's behavior of a type described in division (C) of this 1660
section and to deter that defendant and others from similar 1661
behavior in the future. In that case, the court shall make 1662
specific findings of fact in the record to support its 1663
conclusion. The court shall reduce the amount of any punitive or 1664
exemplary damages otherwise awardable pursuant to this section 1665
by the sum of the punitive or exemplary damages awards 1666
previously rendered against that defendant in any state or 1667
federal court. The court shall not inform the jury about the 1668
court's determination and action under division (D) (5) (b) (ii) of 1669
this section. 1670

(6) Division (D) (2) of this section does not apply to a 1671
tort action where the alleged injury, death, or loss to person 1672
or property resulted from the defendant acting with one or more 1673
of the culpable mental states of purposely and knowingly as 1674
described in section 2901.22 of the Revised Code and when the 1675
defendant has been convicted of or pleaded guilty to a criminal 1676
offense that is a felony, that had as an element of the offense 1677
one or more of the culpable mental states of purposely and 1678
knowingly as described in that section, and that is the basis of 1679
the tort action. 1680

(E) This section does not apply to tort actions against 1681
the state in the court of claims, including, but not limited to, 1682
tort actions against a state university or college that are 1683
subject to division (B) (1) of section 3345.40 of the Revised 1684
Code, to tort actions against political subdivisions of this 1685
state that are commenced under or are subject to Chapter 2744. 1686
of the Revised Code, or to the extent that another section of 1687

the Revised Code expressly provides any of the following: 1688

(1) Punitive or exemplary damages are recoverable from a 1689
defendant in question in a tort action on a basis other than 1690
that the actions or omissions of that defendant demonstrate 1691
malice or aggravated or egregious fraud or on a basis other than 1692
that the defendant in question as principal or master knowingly 1693
authorized, participated in, or ratified actions or omissions of 1694
an agent or servant that so demonstrate. 1695

(2) Punitive or exemplary damages are recoverable from a 1696
defendant in question in a tort action irrespective of whether 1697
the plaintiff in question has adduced proof of actual damages. 1698

(3) The burden of proof upon a plaintiff in question to 1699
recover punitive or exemplary damages from a defendant in 1700
question in a tort action is one other than clear and convincing 1701
evidence. 1702

(4) Punitive or exemplary damages are not recoverable from 1703
a defendant in question in a tort action. 1704

(F) If the trier of fact is a jury, the court shall not 1705
instruct the jury with respect to the limits on punitive or 1706
exemplary damages pursuant to division (D) of this section, and 1707
neither counsel for any party or a witness shall inform the jury 1708
or potential jurors of those limits. 1709

(G) When determining the amount of an award of punitive or 1710
exemplary damages against either a home or a residential 1711
facility licensed under section 5123.19 of the Revised Code, the 1712
trier of fact shall consider all of the following: 1713

(1) The ability of the home or residential facility to pay 1714
the award of punitive or exemplary damages based on the home's 1715
or residential facility's assets, income, and net worth; 1716

(2) Whether the amount of punitive or exemplary damages is 1717
sufficient to deter future tortious conduct; 1718

(3) The financial ability of the home or residential 1719
facility, both currently and in the future, to provide 1720
accommodations, personal care services, and skilled nursing 1721
care. 1722

Sec. 2315.32. (A) Sections 2315.32 to 2315.36 of the 1723
Revised Code do not apply to actions described in section 1724
4113.03 of the Revised Code or to claims filed under Chapters 1725
3965. and 3967. of the Revised Code. 1726

(B) The contributory fault of the plaintiff may be 1727
asserted as an affirmative defense to a tort claim, except that 1728
the contributory fault of the plaintiff may not be asserted as 1729
an affirmative defense to an intentional tort claim. 1730

Sec. 2317.02. The following persons shall not testify in 1731
certain respects: 1732

(A) (1) An attorney, concerning a communication made to the 1733
attorney by a client in that relation or concerning the 1734
attorney's advice to a client, except that the attorney may 1735
testify by express consent of the client or, if the client is 1736
deceased, by the express consent of the surviving spouse or the 1737
executor or administrator of the estate of the deceased client. 1738
However, if the client voluntarily reveals the substance of 1739
attorney-client communications in a nonprivileged context or is 1740
deemed by section 2151.421 of the Revised Code to have waived 1741
any testimonial privilege under this division, the attorney may 1742
be compelled to testify on the same subject. 1743

The testimonial privilege established under this division 1744
does not apply concerning a communication between a client who 1745

has since died and the deceased client's attorney if the 1746
communication is relevant to a dispute between parties who claim 1747
through that deceased client, regardless of whether the claims 1748
are by testate or intestate succession or by inter vivos 1749
transaction, and the dispute addresses the competency of the 1750
deceased client when the deceased client executed a document 1751
that is the basis of the dispute or whether the deceased client 1752
was a victim of fraud, undue influence, or duress when the 1753
deceased client executed a document that is the basis of the 1754
dispute. 1755

(2) An attorney, concerning a communication made to the 1756
attorney by a client in that relationship or the attorney's 1757
advice to a client, except that if the client is an insurance 1758
company, the attorney may be compelled to testify, subject to an 1759
in camera inspection by a court, about communications made by 1760
the client to the attorney or by the attorney to the client that 1761
are related to the attorney's aiding or furthering an ongoing or 1762
future commission of bad faith by the client, if the party 1763
seeking disclosure of the communications has made a prima-facie 1764
showing of bad faith, fraud, or criminal misconduct by the 1765
client. 1766

(B) (1) A physician or a dentist concerning a communication 1767
made to the physician or dentist by a patient in that relation 1768
or the physician's or dentist's advice to a patient, except as 1769
otherwise provided in this division, division (B) (2), and 1770
division (B) (3) of this section, and except that, if the patient 1771
is deemed by section 2151.421 of the Revised Code to have waived 1772
any testimonial privilege under this division, the physician may 1773
be compelled to testify on the same subject. 1774

The testimonial privilege established under this division 1775

does not apply, and a physician or dentist may testify or may be compelled to testify, in any of the following circumstances: 1776
1777

(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: 1778
1779
1780
1781

(i) If the patient or the guardian or other legal representative of the patient gives express consent; 1782
1783

(ii) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent; 1784
1785
1786

(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. 1787
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(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. 1794
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(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 1801
1802
1803
1804

substance in the patient's whole blood, blood serum or plasma, 1805
breath, urine, or other bodily substance at any time relevant to 1806
the criminal offense in question. 1807

(d) In any criminal action against a physician or dentist. 1808
In such an action, the testimonial privilege established under 1809
this division does not prohibit the admission into evidence, in 1810
accordance with the Rules of Evidence, of a patient's medical or 1811
dental records or other communications between a patient and the 1812
physician or dentist that are related to the action and obtained 1813
by subpoena, search warrant, or other lawful means. A court that 1814
permits or compels a physician or dentist to testify in such an 1815
action or permits the introduction into evidence of patient 1816
records or other communications in such an action shall require 1817
that appropriate measures be taken to ensure that the 1818
confidentiality of any patient named or otherwise identified in 1819
the records is maintained. Measures to ensure confidentiality 1820
that may be taken by the court include sealing its records or 1821
deleting specific information from its records. 1822

(e) (i) If the communication was between a patient who has 1823
since died and the deceased patient's physician or dentist, the 1824
communication is relevant to a dispute between parties who claim 1825
through that deceased patient, regardless of whether the claims 1826
are by testate or intestate succession or by inter vivos 1827
transaction, and the dispute addresses the competency of the 1828
deceased patient when the deceased patient executed a document 1829
that is the basis of the dispute or whether the deceased patient 1830
was a victim of fraud, undue influence, or duress when the 1831
deceased patient executed a document that is the basis of the 1832
dispute. 1833

(ii) If neither the spouse of a patient nor the executor 1834

or administrator of that patient's estate gives consent under 1835
division (B) (1) (a) (ii) of this section, testimony or the 1836
disclosure of the patient's medical records by a physician, 1837
dentist, or other health care provider under division (B) (1) (e) 1838
(i) of this section is a permitted use or disclosure of 1839
protected health information, as defined in 45 C.F.R. 160.103, 1840
and an authorization or opportunity to be heard shall not be 1841
required. 1842

(iii) Division (B) (1) (e) (i) of this section does not 1843
require a mental health professional to disclose psychotherapy 1844
notes, as defined in 45 C.F.R. 164.501. 1845

(iv) An interested person who objects to testimony or 1846
disclosure under division (B) (1) (e) (i) of this section may seek 1847
a protective order pursuant to Civil Rule 26. 1848

(v) A person to whom protected health information is 1849
disclosed under division (B) (1) (e) (i) of this section shall not 1850
use or disclose the protected health information for any purpose 1851
other than the litigation or proceeding for which the 1852
information was requested and shall return the protected health 1853
information to the covered entity or destroy the protected 1854
health information, including all copies made, at the conclusion 1855
of the litigation or proceeding. 1856

(2) (a) If any law enforcement officer submits a written 1857
statement to a health care provider that states that an official 1858
criminal investigation has begun regarding a specified person or 1859
that a criminal action or proceeding has been commenced against 1860
a specified person, that requests the provider to supply to the 1861
officer copies of any records the provider possesses that 1862
pertain to any test or the results of any test administered to 1863
the specified person to determine the presence or concentration 1864

of alcohol, a drug of abuse, a combination of them, a controlled 1865
substance, or a metabolite of a controlled substance in the 1866
person's whole blood, blood serum or plasma, breath, or urine at 1867
any time relevant to the criminal offense in question, and that 1868
conforms to section 2317.022 of the Revised Code, the provider, 1869
except to the extent specifically prohibited by any law of this 1870
state or of the United States, shall supply to the officer a 1871
copy of any of the requested records the provider possesses. If 1872
the health care provider does not possess any of the requested 1873
records, the provider shall give the officer a written statement 1874
that indicates that the provider does not possess any of the 1875
requested records. 1876

(b) If a health care provider possesses any records of the 1877
type described in division (B) (2) (a) of this section regarding 1878
the person in question at any time relevant to the criminal 1879
offense in question, in lieu of personally testifying as to the 1880
results of the test in question, the custodian of the records 1881
may submit a certified copy of the records, and, upon its 1882
submission, the certified copy is qualified as authentic 1883
evidence and may be admitted as evidence in accordance with the 1884
Rules of Evidence. Division (A) of section 2317.422 of the 1885
Revised Code does not apply to any certified copy of records 1886
submitted in accordance with this division. Nothing in this 1887
division shall be construed to limit the right of any party to 1888
call as a witness the person who administered the test to which 1889
the records pertain, the person under whose supervision the test 1890
was administered, the custodian of the records, the person who 1891
made the records, or the person under whose supervision the 1892
records were made. 1893

(3) (a) If the testimonial privilege described in division 1894
(B) (1) of this section does not apply as provided in division 1895

(B) (1) (a) (iii) of this section, a physician or dentist may be 1896
compelled to testify or to submit to discovery under the Rules 1897
of Civil Procedure only as to a communication made to the 1898
physician or dentist by the patient in question in that 1899
relation, or the physician's or dentist's advice to the patient 1900
in question, that related causally or historically to physical 1901
or mental injuries that are relevant to issues in the medical 1902
claim, dental claim, chiropractic claim, or optometric claim, 1903
action for wrongful death, other civil action, or claim under 1904
Chapter 4123. of the Revised Code. 1905

(b) If the testimonial privilege described in division (B) 1906
(1) of this section does not apply to a physician or dentist as 1907
provided in division (B) (1) (c) of this section, the physician or 1908
dentist, in lieu of personally testifying as to the results of 1909
the test in question, may submit a certified copy of those 1910
results, and, upon its submission, the certified copy is 1911
qualified as authentic evidence and may be admitted as evidence 1912
in accordance with the Rules of Evidence. Division (A) of 1913
section 2317.422 of the Revised Code does not apply to any 1914
certified copy of results submitted in accordance with this 1915
division. Nothing in this division shall be construed to limit 1916
the right of any party to call as a witness the person who 1917
administered the test in question, the person under whose 1918
supervision the test was administered, the custodian of the 1919
results of the test, the person who compiled the results, or the 1920
person under whose supervision the results were compiled. 1921

(4) The testimonial privilege described in division (B) (1) 1922
of this section is not waived when a communication is made by a 1923
physician to a pharmacist or when there is communication between 1924
a patient and a pharmacist in furtherance of the physician- 1925
patient relation. 1926

(5) (a) As used in divisions (B) (1) to (4) of this section, 1927
"communication" means acquiring, recording, or transmitting any 1928
information, in any manner, concerning any facts, opinions, or 1929
statements necessary to enable a physician or dentist to 1930
diagnose, treat, prescribe, or act for a patient. A 1931
"communication" may include, but is not limited to, any medical 1932
or dental, office, or hospital communication such as a record, 1933
chart, letter, memorandum, laboratory test and results, x-ray, 1934
photograph, financial statement, diagnosis, or prognosis. 1935

(b) As used in division (B) (2) of this section, "health 1936
care provider" means a hospital, ambulatory care facility, long- 1937
term care facility, pharmacy, emergency facility, or health care 1938
practitioner. 1939

(c) As used in division (B) (5) (b) of this section: 1940

(i) "Ambulatory care facility" means a facility that 1941
provides medical, diagnostic, or surgical treatment to patients 1942
who do not require hospitalization, including a dialysis center, 1943
ambulatory surgical facility, cardiac catheterization facility, 1944
diagnostic imaging center, extracorporeal shock wave lithotripsy 1945
center, home health agency, inpatient hospice, birthing center, 1946
radiation therapy center, emergency facility, and an urgent care 1947
center. "Ambulatory health care facility" does not include the 1948
private office of a physician or dentist, whether the office is 1949
for an individual or group practice. 1950

(ii) "Emergency facility" means a hospital emergency 1951
department or any other facility that provides emergency medical 1952
services. 1953

(iii) "Health care practitioner" has the same meaning as 1954
in section 4769.01 of the Revised Code. 1955

(iv) "Hospital" has the same meaning as in section 3727.01 1956
of the Revised Code. 1957

(v) "Long-term care facility" means a nursing home, 1958
residential care facility, or home for the aging, as those terms 1959
are defined in section 3721.01 of the Revised Code; a 1960
residential facility licensed under section 5119.34 of the 1961
Revised Code that provides accommodations, supervision, and 1962
personal care services for three to sixteen unrelated adults; a 1963
nursing facility, as defined in section 5165.01 of the Revised 1964
Code; a skilled nursing facility, as defined in section 5165.01 1965
of the Revised Code; and an intermediate care facility for 1966
individuals with intellectual disabilities, as defined in 1967
section 5124.01 of the Revised Code. 1968

(vi) "Pharmacy" has the same meaning as in section 4729.01 1969
of the Revised Code. 1970

(d) As used in divisions (B)(1) and (2) of this section, 1971
"drug of abuse" has the same meaning as in section 4506.01 of 1972
the Revised Code. 1973

(6) Divisions (B)(1), (2), (3), (4), and (5) of this 1974
section apply to doctors of medicine, doctors of osteopathic 1975
medicine, doctors of podiatry, and dentists. 1976

(7) Nothing in divisions (B)(1) to (6) of this section 1977
affects, or shall be construed as affecting, the immunity from 1978
civil liability conferred by section 307.628 of the Revised Code 1979
or the immunity from civil liability conferred by section 1980
2305.33 of the Revised Code upon physicians who report an 1981
employee's use of a drug of abuse, or a condition of an employee 1982
other than one involving the use of a drug of abuse, to the 1983
employer of the employee in accordance with division (B) of that 1984

section. As used in division (B) (7) of this section, "employee," 1985
"employer," and "physician" have the same meanings as in section 1986
2305.33 of the Revised Code. 1987

(C) (1) A cleric, when the cleric remains accountable to 1988
the authority of that cleric's church, denomination, or sect, 1989
concerning a confession made, or any information confidentially 1990
communicated, to the cleric for a religious counseling purpose 1991
in the cleric's professional character. The cleric may testify 1992
by express consent of the person making the communication, 1993
except when the disclosure of the information is in violation of 1994
a sacred trust and except that, if the person voluntarily 1995
testifies or is deemed by division (A) (4) (c) of section 2151.421 1996
of the Revised Code to have waived any testimonial privilege 1997
under this division, the cleric may be compelled to testify on 1998
the same subject except when disclosure of the information is in 1999
violation of a sacred trust. 2000

(2) As used in division (C) of this section: 2001

(a) "Cleric" means a member of the clergy, rabbi, priest, 2002
Christian Science practitioner, or regularly ordained, 2003
accredited, or licensed minister of an established and legally 2004
cognizable church, denomination, or sect. 2005

(b) "Sacred trust" means a confession or confidential 2006
communication made to a cleric in the cleric's ecclesiastical 2007
capacity in the course of discipline enjoined by the church to 2008
which the cleric belongs, including, but not limited to, the 2009
Catholic Church, if both of the following apply: 2010

(i) The confession or confidential communication was made 2011
directly to the cleric. 2012

(ii) The confession or confidential communication was made 2013

in the manner and context that places the cleric specifically 2014
and strictly under a level of confidentiality that is considered 2015
inviolable by canon law or church doctrine. 2016

(D) Husband or wife, concerning any communication made by 2017
one to the other, or an act done by either in the presence of 2018
the other, during coverture, unless the communication was made, 2019
or act done, in the known presence or hearing of a third person 2020
competent to be a witness; and such rule is the same if the 2021
marital relation has ceased to exist; 2022

(E) A person who assigns a claim or interest, concerning 2023
any matter in respect to which the person would not, if a party, 2024
be permitted to testify; 2025

(F) A person who, if a party, would be restricted under 2026
section 2317.03 of the Revised Code, when the property or thing 2027
is sold or transferred by an executor, administrator, guardian, 2028
trustee, heir, devisee, or legatee, shall be restricted in the 2029
same manner in any action or proceeding concerning the property 2030
or thing. 2031

(G) (1) A school guidance counselor who holds a valid 2032
educator license from the state board of education as provided 2033
for in section 3319.22 of the Revised Code, a person licensed 2034
under Chapter 4757. of the Revised Code as a licensed 2035
professional clinical counselor, licensed professional 2036
counselor, social worker, independent social worker, marriage 2037
and family therapist or independent marriage and family 2038
therapist, or registered under Chapter 4757. of the Revised Code 2039
as a social work assistant concerning a confidential 2040
communication received from a client in that relation or the 2041
person's advice to a client unless any of the following applies: 2042

(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 2072
registered under Chapter 4757. of the Revised Code from the 2073
requirement to report information concerning child abuse or 2074
neglect under section 2151.421 of the Revised Code. 2075

(H) A mediator acting under a mediation order issued under 2076
division (A) of section 3109.052 of the Revised Code or 2077
otherwise issued in any proceeding for divorce, dissolution, 2078
legal separation, annulment, or the allocation of parental 2079
rights and responsibilities for the care of children, in any 2080
action or proceeding, other than a criminal, delinquency, child 2081
abuse, child neglect, or dependent child action or proceeding, 2082
that is brought by or against either parent who takes part in 2083
mediation in accordance with the order and that pertains to the 2084
mediation process, to any information discussed or presented in 2085
the mediation process, to the allocation of parental rights and 2086
responsibilities for the care of the parents' children, or to 2087
the awarding of parenting time rights in relation to their 2088
children; 2089

(I) A communications assistant, acting within the scope of 2090
the communication assistant's authority, when providing 2091
telecommunications relay service pursuant to section 4931.06 of 2092
the Revised Code or Title II of the "Communications Act of 2093
1934," 104 Stat. 366 (1990), 47 U.S.C. 225, concerning a 2094
communication made through a telecommunications relay service. 2095
Nothing in this section shall limit the obligation of a 2096
communications assistant to divulge information or testify when 2097
mandated by federal law or regulation or pursuant to subpoena in 2098
a criminal proceeding. 2099

Nothing in this section shall limit any immunity or 2100
privilege granted under federal law or regulation. 2101

(J) (1) A chiropractor in a civil proceeding concerning a 2102
communication made to the chiropractor by a patient in that 2103
relation or the chiropractor's advice to a patient, except as 2104
otherwise provided in this division. The testimonial privilege 2105
established under this division does not apply, and a 2106
chiropractor may testify or may be compelled to testify, in any 2107
civil action, in accordance with the discovery provisions of the 2108
Rules of Civil Procedure in connection with a civil action, or 2109
in connection with a claim under Chapter 4123. of the Revised 2110
Code, under any of the following circumstances: 2111

(a) If the patient or the guardian or other legal 2112
representative of the patient gives express consent. 2113

(b) If the patient is deceased, the spouse of the patient 2114
or the executor or administrator of the patient's estate gives 2115
express consent. 2116

(c) If a medical claim, dental claim, chiropractic claim, 2117
or optometric claim, as defined in section 2305.113 of the 2118
Revised Code, an action for wrongful death, any other type of 2119
civil action, or a claim under Chapter 4123. of the Revised Code 2120
is filed by the patient, the personal representative of the 2121
estate of the patient if deceased, or the patient's guardian or 2122
other legal representative. 2123

(2) If the testimonial privilege described in division (J) 2124
(1) of this section does not apply as provided in division (J) 2125
(1)(c) of this section, a chiropractor may be compelled to 2126
testify or to submit to discovery under the Rules of Civil 2127
Procedure only as to a communication made to the chiropractor by 2128
the patient in question in that relation, or the chiropractor's 2129
advice to the patient in question, that related causally or 2130
historically to physical or mental injuries that are relevant to 2131

issues in the medical claim, dental claim, chiropractic claim, 2132
or optometric claim, action for wrongful death, other civil 2133
action, or claim under Chapter 4123. of the Revised Code. 2134

(3) The testimonial privilege established under this 2135
division does not apply, and a chiropractor may testify or be 2136
compelled to testify, in any criminal action or administrative 2137
proceeding. 2138

(4) As used in this division, "communication" means 2139
acquiring, recording, or transmitting any information, in any 2140
manner, concerning any facts, opinions, or statements necessary 2141
to enable a chiropractor to diagnose, treat, or act for a 2142
patient. A communication may include, but is not limited to, any 2143
chiropractic, office, or hospital communication such as a 2144
record, chart, letter, memorandum, laboratory test and results, 2145
x-ray, photograph, financial statement, diagnosis, or prognosis. 2146

(K) (1) Except as provided under division (K) (2) of this 2147
section, a critical incident stress management team member 2148
concerning a communication received from an individual who 2149
receives crisis response services from the team member, or the 2150
team member's advice to the individual, during a debriefing 2151
session. 2152

(2) The testimonial privilege established under division 2153
(K) (1) of this section does not apply if any of the following 2154
are true: 2155

(a) The communication or advice indicates clear and 2156
present danger to the individual who receives crisis response 2157
services or to other persons. For purposes of this division, 2158
cases in which there are indications of present or past child 2159
abuse or neglect of the individual constitute a clear and 2160

present danger. 2161

(b) The individual who received crisis response services 2162
gives express consent to the testimony. 2163

(c) If the individual who received crisis response 2164
services is deceased, the surviving spouse or the executor or 2165
administrator of the estate of the deceased individual gives 2166
express consent. 2167

(d) The individual who received crisis response services 2168
voluntarily testifies, in which case the team member may be 2169
compelled to testify on the same subject. 2170

(e) The court in camera determines that the information 2171
communicated by the individual who received crisis response 2172
services is not germane to the relationship between the 2173
individual and the team member. 2174

(f) The communication or advice pertains or is related to 2175
any criminal act. 2176

(3) As used in division (K) of this section: 2177

(a) "Crisis response services" means consultation, risk 2178
assessment, referral, and on-site crisis intervention services 2179
provided by a critical incident stress management team to 2180
individuals affected by crisis or disaster. 2181

(b) "Critical incident stress management team member" or 2182
"team member" means an individual specially trained to provide 2183
crisis response services as a member of an organized community 2184
or local crisis response team that holds membership in the Ohio 2185
critical incident stress management network. 2186

(c) "Debriefing session" means a session at which crisis 2187
response services are rendered by a critical incident stress 2188

management team member during or after a crisis or disaster.	2189
(L) (1) Subject to division (L) (2) of this section and	2190
except as provided in division (L) (3) of this section, an	2191
employee assistance professional, concerning a communication	2192
made to the employee assistance professional by a client in the	2193
employee assistance professional's official capacity as an	2194
employee assistance professional.	2195
(2) Division (L) (1) of this section applies to an employee	2196
assistance professional who meets either or both of the	2197
following requirements:	2198
(a) Is certified by the employee assistance certification	2199
commission to engage in the employee assistance profession;	2200
(b) Has education, training, and experience in all of the	2201
following:	2202
(i) Providing workplace-based services designed to address	2203
employer and employee productivity issues;	2204
(ii) Providing assistance to employees and employees'	2205
dependents in identifying and finding the means to resolve	2206
personal problems that affect the employees or the employees'	2207
performance;	2208
(iii) Identifying and resolving productivity problems	2209
associated with an employee's concerns about any of the	2210
following matters: health, marriage, family, finances, substance	2211
abuse or other addiction, workplace, law, and emotional issues;	2212
(iv) Selecting and evaluating available community	2213
resources;	2214
(v) Making appropriate referrals;	2215

(vi) Local and national employee assistance agreements;	2216
(vii) Client confidentiality.	2217
(3) Division (L) (1) of this section does not apply to any	2218
of the following:	2219
(a) A criminal action or proceeding involving an offense	2220
under sections 2903.01 to 2903.06 of the Revised Code if the	2221
employee assistance professional's disclosure or testimony	2222
relates directly to the facts or immediate circumstances of the	2223
offense;	2224
(b) A communication made by a client to an employee	2225
assistance professional that reveals the contemplation or	2226
commission of a crime or serious, harmful act;	2227
(c) A communication that is made by a client who is an	2228
unemancipated minor or an adult adjudicated to be incompetent	2229
and indicates that the client was the victim of a crime or	2230
abuse;	2231
(d) A civil proceeding to determine an individual's mental	2232
competency or a criminal action in which a plea of not guilty by	2233
reason of insanity is entered;	2234
(e) A civil or criminal malpractice action brought against	2235
the employee assistance professional;	2236
(f) When the employee assistance professional has the	2237
express consent of the client or, if the client is deceased or	2238
disabled, the client's legal representative;	2239
(g) When the testimonial privilege otherwise provided by	2240
division (L) (1) of this section is abrogated under law.	2241
Sec. 2323.41. (A) In any civil action upon a medical,	2242

dental, optometric, or chiropractic claim, the defendant may 2243
introduce evidence of any amount payable as a benefit to the 2244
plaintiff as a result of the damages that result from an injury, 2245
death, or loss to person or property that is the subject of the 2246
claim, except if the source of collateral benefits has a 2247
mandatory self-effectuating federal right of subrogation, a 2248
contractual right of subrogation, or a statutory right of 2249
subrogation. 2250

(B) If the defendant elects to introduce evidence 2251
described in division (A) of this section, the plaintiff may 2252
introduce evidence of any amount that the plaintiff has paid or 2253
contributed to secure the plaintiff's right to receive the 2254
benefits of which the defendant has introduced evidence. 2255

(C) A source of collateral benefits of which evidence is 2256
introduced pursuant to division (A) of this section shall not 2257
recover any amount against the plaintiff nor shall it be 2258
subrogated to the rights of the plaintiff against a defendant. 2259

(D) This section shall apply only to a medical, dental, 2260
optometric, or chiropractic claim in which either of the 2261
following applies: 2262

(1) A claimant alleges that the individual or entity 2263
against whom the claim is brought intentionally caused, as 2264
defined in section 3965.02 of the Revised Code, the injury to or 2265
death of the claimant or the individual upon whose behalf the 2266
claimant brought the claim. 2267

(2) The individual or entity against whom the claim is 2268
brought was not in compliance with division (A) of section 2269
3965.02 of the Revised Code at the time the claim accrued. 2270

(E) As used in this section, "medical claim," "dental 2271

claim," "optometric claim," and "chiropractic claim" have the 2272
same meanings as in section 2305.113 of the Revised Code. 2273

Sec. 2323.42. (A) Upon the motion of any defendant in a 2274
civil action based upon a medical claim, dental claim, 2275
optometric claim, or chiropractic claim, the court shall conduct 2276
a hearing regarding the existence or nonexistence of a 2277
reasonable good faith basis upon which the particular claim is 2278
asserted against the moving defendant. The defendant shall file 2279
the motion not earlier than the close of discovery in the action 2280
and not later than thirty days after the court or jury renders 2281
any verdict or award in the action. After the motion is filed, 2282
the plaintiff shall have not less than fourteen days to respond 2283
to the motion. Upon good cause shown by the plaintiff, the court 2284
shall grant an extension of the time for the plaintiff to 2285
respond as necessary to obtain evidence demonstrating the 2286
existence of a reasonable good faith basis for the claim. 2287

(B) At the request of any party to the good faith motion 2288
described in division (A) of this section, the court shall order 2289
the motion to be heard at an oral hearing and shall consider all 2290
evidence and arguments submitted by the parties. In determining 2291
whether a plaintiff has a reasonable good faith basis upon which 2292
to assert the claim in question against the moving defendant, 2293
the court shall take into consideration, in addition to the 2294
facts of the underlying claim, whether the plaintiff did any of 2295
the following: 2296

(1) Obtained a reasonably timely review of the merits of 2297
the particular claim by a qualified medical, dental, optometric, 2298
or chiropractic expert, as appropriate; 2299

(2) Reasonably relied upon the results of that review in 2300
supporting the assertion of the particular claim; 2301

(3) Had an opportunity to conduct a pre-suit investigation	2302
or was afforded by the defendant full and timely discovery	2303
during litigation;	2304
(4) Reasonably relied upon evidence discovered during the	2305
course of litigation in support of the assertion of the claim in	2306
question;	2307
(5) Took appropriate and reasonable steps to timely	2308
dismiss any defendant on behalf of whom it was alleged or	2309
determined that no reasonable good faith basis existed for	2310
continued assertion of the claim in question.	2311
(C) If the court determines that there was no reasonable	2312
good faith basis upon which the plaintiff asserted the claim in	2313
question against the moving defendant or that, at some point	2314
during the litigation, the plaintiff lacked a good faith basis	2315
for continuing to assert that claim, the court shall award all	2316
of the following in favor of the moving defendant:	2317
(1) All court costs incurred by the moving defendant;	2318
(2) Reasonable attorneys' fees incurred by the moving	2319
defendant in defense of the claim after the time that the court	2320
determines that no reasonable good faith basis existed upon	2321
which to assert or continue to assert the claim;	2322
(3) Reasonable attorneys' fees incurred in support of the	2323
good faith motion.	2324
(D) Prior to filing a good faith motion as described in	2325
division (A) of this section, any defendant that intends to file	2326
that type of motion shall serve a "notice of demand for	2327
dismissal and intention to file a good faith motion." If, within	2328
fourteen days of service of that notice, the plaintiff dismisses	2329
the defendant from the action, the defendant after the dismissal	2330

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, 2360
dental, optometric, or chiropractic claim to recover damages for 2361
injury, death, or loss to person or property, all of the 2362
following apply: 2363

(1) There shall not be any limitation on compensatory 2364
damages that represent the economic loss of the person who is 2365
awarded the damages in the civil action. 2366

(2) Except as otherwise provided in division (A) (3) of 2367
this section, the amount of compensatory damages that represents 2368
damages for noneconomic loss that is recoverable in a civil 2369
action under this section to recover damages for injury, death, 2370
or loss to person or property shall not exceed the greater of 2371
two hundred fifty thousand dollars or an amount that is equal to 2372
three times the plaintiff's economic loss, as determined by the 2373
trier of fact, to a maximum of three hundred fifty thousand 2374
dollars for each plaintiff or a maximum of five hundred thousand 2375
dollars for each occurrence. 2376

(3) The amount recoverable for noneconomic loss in a civil 2377
action under this section may exceed the amount described in 2378
division (A) (2) of this section but shall not exceed five 2379
hundred thousand dollars for each plaintiff or one million 2380
dollars for each occurrence if the noneconomic losses of the 2381
plaintiff are for either of the following: 2382

(a) Permanent and substantial physical deformity, loss of 2383
use of a limb, or loss of a bodily organ system; 2384

(b) Permanent physical functional injury that permanently 2385
prevents the injured person from being able to independently 2386
care for self and perform life sustaining activities. 2387

(B) If a trial is conducted in a civil action upon a 2388

medical, dental, optometric, or chiropractic claim to recover 2389
damages for injury, death, or loss to person or property and a 2390
plaintiff prevails with respect to that claim, the court in a 2391
nonjury trial shall make findings of fact, and the jury in a 2392
jury trial shall return a general verdict accompanied by answers 2393
to interrogatories, that shall specify all of the following: 2394

(1) The total compensatory damages recoverable by the 2395
plaintiff; 2396

(2) The portion of the total compensatory damages that 2397
represents damages for economic loss; 2398

(3) The portion of the total compensatory damages that 2399
represents damages for noneconomic loss. 2400

(C) (1) After the trier of fact in a civil action upon a 2401
medical, dental, optometric, or chiropractic claim to recover 2402
damages for injury, death, or loss to person or property 2403
complies with division (B) of this section, the court shall 2404
enter a judgment in favor of the plaintiff for compensatory 2405
damages for economic loss in the amount determined pursuant to 2406
division (B) (2) of this section, and, subject to division (D) (1) 2407
of this section, the court shall enter a judgment in favor of 2408
the plaintiff for compensatory damages for noneconomic loss. In 2409
no event shall a judgment for compensatory damages for 2410
noneconomic loss exceed the maximum recoverable amount that 2411
represents damages for noneconomic loss as provided in divisions 2412
(A) (2) and (3) of this section. Division (A) of this section 2413
shall be applied in a jury trial only after the jury has made 2414
its factual findings and determination as to the damages. 2415

(2) Prior to the trial in the civil action, any party may 2416
seek summary judgment with respect to the nature of the alleged 2417

injury or loss to person or property, seeking a determination of 2418
the damages as described in division (A) (2) or (3) of this 2419
section. 2420

(D) (1) A court of common pleas has no jurisdiction to 2421
enter judgment on an award of compensatory damages for 2422
noneconomic loss in excess of the limits set forth in this 2423
section. 2424

(2) If the trier of fact is a jury, the court shall not 2425
instruct the jury with respect to the limit on compensatory 2426
damages for noneconomic loss described in divisions (A) (2) and 2427
(3) of this section, and neither counsel for any party nor a 2428
witness shall inform the jury or potential jurors of that limit. 2429

(E) Any excess amount of compensatory damages for 2430
noneconomic loss that is greater than the applicable amount 2431
specified in division (A) (2) or (3) of this section shall not be 2432
reallocated to any other tortfeasor beyond the amount of 2433
compensatory damages that that tortfeasor would otherwise be 2434
responsible for under the laws of this state. 2435

(F) (1) If pursuant to a contingency fee agreement between 2436
an attorney and a plaintiff in a civil action upon a medical 2437
claim, dental claim, optometric claim, or chiropractic claim, 2438
the amount of the attorney's fees exceed the applicable amount 2439
of the limits on compensatory damages for noneconomic loss as 2440
provided in division (A) (2) or (3) of this section, the attorney 2441
shall make an application in the probate court of the county in 2442
which the civil action was commenced or in which the settlement 2443
was entered. The application shall contain a statement of facts, 2444
including the amount to be allocated to the settlement of the 2445
claim, the amount of the settlement or judgment that represents 2446
the compensatory damages for economic loss and noneconomic loss, 2447

the relevant provision in the contingency fee agreement, and the 2448
dollar amount of the attorney's fees under the contingency fee 2449
agreement. The application shall include the proposed 2450
distribution of the amount of the judgment or settlement. 2451

(2) The attorney shall give written notice of the hearing 2452
and a copy of the application to all interested persons who have 2453
not waived notice of the hearing. Notwithstanding the waivers 2454
and consents of the interested persons, the probate court shall 2455
retain jurisdiction over the settlement, allocation, and 2456
distribution of the claim. 2457

(3) The application shall state the arrangements, if any, 2458
that have been made with respect to the attorney's fees. The 2459
attorney's fees shall be subject to the approval of the probate 2460
court. 2461

(G) This section does not apply to any of the following: 2462

(1) Civil actions upon a medical, dental, optometric, or 2463
chiropractic claim that are brought against the state in the 2464
court of claims, including, but not limited to, those actions in 2465
which a state university or college is a defendant and to which 2466
division (B) (3) of section 3345.40 of the Revised Code applies; 2467

(2) Civil actions upon a medical, dental, optometric, or 2468
chiropractic claim that are brought against political 2469
subdivisions of this state and that are commenced under or are 2470
subject to Chapter 2744. of the Revised Code. Division (C) of 2471
section 2744.05 of the Revised Code applies to recoverable 2472
damages in those actions; 2473

(3) Wrongful death actions brought pursuant to Chapter 2474
2125. of the Revised Code. 2475

(H) This section shall apply only to a medical, dental, 2476

<u>optometric, or chiropractic claim in which either of the</u>	2477
<u>following applies:</u>	2478
<u>(1) A claimant alleges that the individual or entity</u>	2479
<u>against whom the claim is brought intentionally caused, as</u>	2480
<u>defined in section 3965.02 of the Revised Code, the injury to or</u>	2481
<u>death of the claimant or the individual upon whose behalf the</u>	2482
<u>claimant brought the claim.</u>	2483
<u>(2) The individual or entity against whom the claim is</u>	2484
<u>brought was not in compliance with division (A) of section</u>	2485
<u>3965.02 of the Revised Code at the time the claim accrued.</u>	2486
<u>(I) As used in this section:</u>	2487
(1) "Economic loss" means any of the following types of	2488
pecuniary harm:	2489
(a) All wages, salaries, or other compensation lost as a	2490
result of an injury, death, or loss to person or property that	2491
is a subject of a civil action upon a medical, dental,	2492
optometric, or chiropractic claim;	2493
(b) All expenditures for medical care or treatment,	2494
rehabilitation services, or other care, treatment, services,	2495
products, or accommodations as a result of an injury, death, or	2496
loss to person or property that is a subject of a civil action	2497
upon a medical, dental, optometric, or chiropractic claim;	2498
(c) Any other expenditures incurred as a result of an	2499
injury, death, or loss to person or property that is a subject	2500
of a civil action upon a medical, dental, optometric, or	2501
chiropractic claim, other than attorney's fees incurred in	2502
connection with that action.	2503
(2) "Medical claim," "dental claim," "optometric claim,"	2504

and "chiropractic claim" have the same meanings as in section 2505
2305.113 of the Revised Code. 2506

(3) "Noneconomic loss" means nonpecuniary harm that 2507
results from an injury, death, or loss to person or property 2508
that is a subject of a civil action upon a medical, dental, 2509
optometric, or chiropractic claim, including, but not limited 2510
to, pain and suffering, loss of society, consortium, 2511
companionship, care, assistance, attention, protection, advice, 2512
guidance, counsel, instruction, training, or education, 2513
disfigurement, mental anguish, and any other intangible loss. 2514

(4) "Trier of fact" means the jury or, in a nonjury 2515
action, the court. 2516

Sec. 2323.45. (A) (1) A health care provider named as a 2517
defendant in a civil action based upon a medical claim is 2518
permitted to file a motion with the court for dismissal of the 2519
claim accompanied by an affidavit of noninvolvement. The 2520
defendant shall notify all parties in writing of the filing of 2521
the motion. Prior to ruling on the motion, the court shall allow 2522
the parties not less than thirty days from the date that the 2523
parties were served with the notice to respond to the motion. 2524

(2) An affidavit of noninvolvement shall set forth, with 2525
particularity, the facts that demonstrate that the defendant was 2526
misidentified or otherwise not involved individually or through 2527
the action of the defendant's agents or employees in the care 2528
and treatment of the plaintiff, was not obligated individually 2529
or through the defendant's agents or employees to provide for 2530
the care and treatment of the plaintiff, and could not have 2531
caused the alleged malpractice individually or through the 2532
defendant's agents or employees in any way. 2533

(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.

<u>(G)</u> As used in this section:	2593
(1) "Health care provider" has the same meaning as in	2594
division (B) (5) of section 2317.02 of the Revised Code.	2595
(2) "Medical claim" means any claim that is asserted in	2596
any civil action against a health care provider and that arises	2597
out of the medical diagnosis, care, or treatment of any person.	2598
"Medical claim" includes derivative claims for relief.	2599
Sec. 2323.55. (A) As used in this section:	2600
(1) "Economic loss" means any of the following types of	2601
pecuniary harm:	2602
(a) All wages, salaries, or other compensation lost as a	2603
result of an injury, death, or loss to person or property that	2604
is a subject of a civil action upon a medical, dental,	2605
optometric, or chiropractic claim;	2606
(b) All expenditures for medical care or treatment,	2607
rehabilitation services, or other care, treatment, services,	2608
products, or accommodations as a result of an injury, death, or	2609
loss to person or property that is a subject of a civil action	2610
upon a medical, dental, optometric, or chiropractic claim;	2611
(c) Any other expenditures incurred as a result of an	2612
injury, death, or loss to person or property that is a subject	2613
of a civil action upon a medical, dental, optometric, or	2614
chiropractic claim, other than attorney's fees incurred in	2615
connection with that action.	2616
(2) "Future damages" means any damages that result from an	2617
injury, death, or loss to person or property that is a subject	2618
of a civil action upon a medical, dental, optometric, or	2619
chiropractic claim and that will accrue after the verdict or	2620

determination of liability is rendered in that action by the 2621
trier of fact. "Future damages" includes both economic and 2622
noneconomic loss. 2623

(3) "Medical claim," "dental claim," "optometric claim," 2624
and "chiropractic claim" have the same meanings as in section 2625
2305.113 of the Revised Code. 2626

(4) "Noneconomic loss" means nonpecuniary harm that 2627
results from an injury, death, or loss to person or property 2628
that is a subject of a civil action upon a medical, dental, 2629
optometric, or chiropractic claim, including, but not limited 2630
to, pain and suffering, loss of society, consortium, 2631
companionship, care, assistance, attention, protection, advice, 2632
guidance, counsel, instruction, training, or education, 2633
disfigurement, mental anguish, and any other intangible loss. 2634

(5) "Past damages" means any damages that result from an 2635
injury, death, or loss to person or property that is a subject 2636
of a civil action upon a medical, dental, optometric, or 2637
chiropractic claim and that have accrued by the time that the 2638
verdict or determination of liability is rendered in that action 2639
by the trier of fact. "Past damages" include both economic loss 2640
and noneconomic loss. 2641

(6) "Trier of fact" means the jury or, in a nonjury 2642
action, the court. 2643

(B) In any civil action upon a medical, dental, 2644
optometric, or chiropractic claim in which a plaintiff makes a 2645
good faith claim against the defendant for future damages that 2646
exceed fifty thousand dollars, upon motion of that plaintiff or 2647
the defendant, the trier of fact shall return a general verdict 2648
and, if that verdict is in favor of that plaintiff, answers to 2649

interrogatories or findings of fact that specify both of the 2650
following: 2651

(1) The past damages recoverable by that plaintiff; 2652

(2) The future damages recoverable by that plaintiff. 2653

(C) If answers to interrogatories are returned or findings 2654
of fact are made pursuant to division (B) of this section and if 2655
the future damages recoverable by that plaintiff exceeds fifty 2656
thousand dollars, the plaintiff or defendant may file a motion 2657
with the court that seeks a determination under division (D) of 2658
this section. The plaintiff or defendant shall file the motion 2659
at any time after the verdict or determination in favor of the 2660
plaintiff is rendered by the trier of fact but prior to the 2661
entry of judgment in accordance with Civil Rule 58. 2662

(D) (1) Upon the filing of a motion pursuant to division 2663
(C) of this section and prior to the entry of judgment in 2664
accordance with Civil Rule 58, the court shall do all of the 2665
following: 2666

(a) Set a date for a hearing to address whether all or any 2667
part of the future damages recoverable by the plaintiff shall be 2668
received by the plaintiff in a series of periodic payments 2669
rather than in a lump sum; 2670

(b) Give notice of the date of the hearing described in 2671
division (D) (1) (a) of this section to the parties involved and 2672
their counsel of record; 2673

(c) Conduct the hearing described in division (D) (1) (a) of 2674
this section, allow the parties involved to present any relevant 2675
evidence at the hearing, consider the factors described in 2676
division (D) (2) of this section in making its determination, and 2677
make its determination in accordance with division (D) (3) of 2678

this section. 2679

(2) In determining whether all or any part of the future 2680
damages recoverable by the plaintiff shall be received by the 2681
plaintiff in a series of periodic payments rather than in a lump 2682
sum, the court shall consider all of the following factors: 2683

(a) The purposes for which those portions of the future 2684
damages were awarded to that plaintiff; 2685

(b) The business or occupational experience of that 2686
plaintiff; 2687

(c) The age of that plaintiff; 2688

(d) The physical and mental condition of that plaintiff; 2689

(e) Whether that plaintiff or the parent, guardian, or 2690
custodian of that plaintiff is able to competently manage the 2691
future damages; 2692

(f) Any other circumstance that relates to whether the 2693
injury sustained by that plaintiff would be better compensated 2694
by the payment of the future damages in a lump sum or by their 2695
receipt in a series of periodic payments. 2696

(3) After the hearing described in division (D)(1) of this 2697
section and prior to the entry of judgment in accordance with 2698
Civil Rule 58, the court shall determine, in its discretion, 2699
whether all or any part of the future damages recoverable by the 2700
plaintiff shall be received by the plaintiff in a series of 2701
periodic payments rather than in a lump sum. If the court 2702
determines that a plaintiff shall receive the future damages 2703
recoverable by the plaintiff in a series of periodic payments, 2704
it may order the payments only as to the amount of the future 2705
damages recoverable by the plaintiff that exceeds fifty thousand 2706

dollars. If the court determines that the plaintiff shall 2707
receive the future damages recoverable by the plaintiff in a 2708
lump sum, the future damages shall be paid in a lump sum. 2709

(E) If the court determines pursuant to division (D) of 2710
this section that a plaintiff shall receive the future damages 2711
recoverable by the plaintiff in a series of periodic payments, 2712
both of the following apply: 2713

(1) Within twenty days after the court makes that 2714
determination, the plaintiff shall submit a periodic payments 2715
plan to the court. The plan may include, but is not limited to, 2716
a provision for a trust or an annuity and may be submitted by 2717
that plaintiff alone or by that plaintiff and the defendant. 2718

(2) Within twenty days after the court makes that 2719
determination, the defendant may submit to the court, alone or 2720
jointly with the plaintiff, a periodic payments plan. If the 2721
defendant submits a periodic payments plan, the plan may 2722
include, but is not limited to, a provision for a trust or an 2723
annuity. 2724

(F) (1) If the defendant and plaintiff do not jointly 2725
submit a periodic payments plan and if the defendant does not 2726
separately submit a periodic payments plan, then, within ten 2727
days after that plaintiff submits a plan, the defendant may 2728
submit to the court written comments relative to the periodic 2729
payments plan of the plaintiff. 2730

(2) If the defendant and plaintiff do not jointly submit a 2731
periodic payments plan and if the defendant separately submits a 2732
periodic payments plan, then, within ten days after the 2733
defendant submits the plan, the plaintiff may submit to the 2734
court written comments relative to the periodic payments plan of 2735

the defendant. 2736

(G) (1) The court, in its discretion, may modify, approve, 2737
or reject any submitted periodic payments plan. In approving any 2738
periodic payments plan, the court shall require interest on the 2739
judgment in question in accordance with section 1343.03 of the 2740
Revised Code. Additionally, in approving any periodic payments 2741
plan, the court is not required to ensure that payments under 2742
the periodic payments plan are equal in amount or that the total 2743
amount paid each year under the periodic payments plan is equal 2744
in amount to the total amount paid in other years under the 2745
plan; rather, a periodic payments plan may provide for payments 2746
to be made in irregular or varied amounts, or to be graduated 2747
upward or downward in amount over the duration of the periodic 2748
payments plan. 2749

(2) The court shall include in any approved periodic 2750
payments plan adequate security to insure that the plaintiff 2751
will receive all of the periodic payments under that plan. If 2752
the approved periodic payments plan includes a provision for an 2753
annuity as the adequate security or otherwise, the defendant 2754
shall purchase the annuity from either of the following types of 2755
insurance companies: 2756

(a) An insurance company that the A.M. Best Company, in 2757
its most recently published rating guide of life insurance 2758
companies, has rated A or better and has rated XII or higher as 2759
to financial size or strength; 2760

(b) An insurance company that the superintendent of 2761
insurance, under rules adopted pursuant to Chapter 119. of the 2762
Revised Code for purposes of implementing this division, 2763
determines is licensed to do business in this state and, 2764
considering the factors described in this division, is a stable 2765

insurance company that issues annuities that are safe and 2766
desirable. In making determinations as described in this 2767
division, the superintendent shall be guided by the principle 2768
that annuities should be safe and desirable for plaintiffs who 2769
are awarded damages. In making those determinations, the 2770
superintendent shall consider the financial condition, general 2771
standing, operating results, profitability, leverage, liquidity, 2772
amount and soundness of reinsurance, adequacy of reserves, and 2773
the management of any insurance company in question and also may 2774
consider ratings, grades, and classifications of any nationally 2775
recognized rating services of insurance companies and any other 2776
factors relevant to the making of such determinations. 2777

(3) If a periodic payments plan provides for periodic 2778
payments over a period of five years or more to the plaintiff, 2779
the court, in its discretion, may include in the approved 2780
periodic payments plan a provision in which it reserves to 2781
itself continuing jurisdiction over that plan, including 2782
jurisdiction to review and modify that plan. 2783

(4) The court shall specify in the entry of judgment in 2784
the tort action the determination made pursuant to division (D) 2785
of this section and, if applicable, the terms of any approved 2786
periodic payments plan. 2787

(H) After a periodic payments plan is approved, the future 2788
damages that are to be received in periodic payments shall be 2789
paid in accordance with the plan, including, if applicable, 2790
payment over to a trust or annuity provided for in the plan. 2791

(I) If a court orders a series of periodic payments of 2792
future damages in accordance with this section and the plaintiff 2793
dies prior to the receipt of all of the future damages, the 2794
liability for the unpaid portion of those damages that is not 2795

yet due at the time of the death of that plaintiff shall 2796
continue, but the payments shall be paid to the heirs of that 2797
plaintiff as scheduled in and otherwise in accordance with the 2798
approved periodic payments plan or, if the plan does not contain 2799
a relevant provision, as the court shall order. 2800

(J) (1) Nothing in this section precludes a plaintiff and a 2801
defendant from mutually agreeing to a settlement of the action. 2802

(2) Except as otherwise provided in this section, nothing 2803
in this section increases the time for filing any motion or 2804
notice of appeal or taking any other action relative to a civil 2805
action upon a medical, dental, optometric, or chiropractic 2806
claim, alters the amount of any verdict or determination of 2807
damages by the trier of fact in a civil action upon a medical, 2808
dental, optometric, or chiropractic claim, or alters the 2809
liability of any party to pay or satisfy the verdict or 2810
determination. 2811

(K) This section does not apply to tort actions that are 2812
brought against political subdivisions of this state and that 2813
are commenced under or are subject to Chapter 2744. of the 2814
Revised Code or to tort actions brought against the state in the 2815
court of claims. This section shall apply only to a medical, 2816
dental, optometric, or chiropractic claim in which either of the 2817
following applies: 2818

(1) A claimant alleges that the individual or entity 2819
against whom the claim is brought intentionally caused, as 2820
defined in section 3965.02 of the Revised Code, the injury to or 2821
death of the claimant or the individual upon whose behalf the 2822
claimant brought the claim. 2823

(2) The individual or entity against whom the claim is 2824

brought was not in compliance with division (A) of section 2825
3965.02 of the Revised Code at the time the claim accrued. 2826

Sec. 2711.21. (A) This section shall apply only to a 2827
medical, dental, optometric, or chiropractic claim in which 2828
either of the following applies: 2829

(1) A plaintiff alleges that the individual or entity 2830
against whom the claim is brought intentionally caused, as 2831
defined in section 3965.02 of the Revised Code, the injury to or 2832
death of the plaintiff or the individual upon whose behalf the 2833
claimant brought the claim. 2834

(2) The individual or entity against whom the claim is 2835
brought was not in compliance with division (A) of section 2836
3965.02 of the Revised Code at the time the claim accrued. 2837

(B) Upon the filing of any medical, dental, optometric, or 2838
chiropractic claim as defined in section 2305.113 of the Revised 2839
Code, if all of the parties to the medical, dental, optometric, 2840
or chiropractic claim agree to submit it to nonbinding 2841
arbitration, the controversy shall be submitted to an 2842
arbitration board consisting of three arbitrators to be named by 2843
the court. The arbitration board shall consist of one person 2844
designated by the plaintiff or plaintiffs, one person designated 2845
by the defendant or defendants, and a person designated by the 2846
court. The person designated by the court shall serve as the 2847
chairperson of the board. Each member of the board shall receive 2848
a reasonable compensation based on the extent and duration of 2849
actual service rendered, and shall be paid in equal proportions 2850
by the parties in interest. In a claim accompanied by a poverty 2851
affidavit, the cost of the arbitration shall be borne by the 2852
court. 2853

~~(B)~~-(C) The arbitration proceedings shall be conducted in 2854
accordance with sections 2711.06 to 2711.16 of the Revised Code 2855
insofar as they are applicable. Such proceedings shall be 2856
conducted in the county in which the trial is to be held. 2857

~~(C)~~-(D) If the decision of the arbitration board is not 2858
accepted by all parties to the medical, dental, optometric, or 2859
chiropractic claim, the claim shall proceed as if it had not 2860
been submitted to nonbinding arbitration pursuant to this 2861
section. The decision of the arbitration board and any 2862
dissenting opinion written by any board member are not 2863
admissible into evidence at the trial. 2864

~~(D)~~-(E) Nothing in this section shall be construed to 2865
limit the right of any person to enter into an agreement to 2866
submit a controversy underlying a medical, dental, optometric, 2867
or chiropractic claim to binding arbitration. 2868

Sec. 2711.22. (A) Except as otherwise provided in this 2869
section, a written contract between a patient and a hospital or 2870
healthcare provider to settle by binding arbitration any dispute 2871
or controversy arising out of the diagnosis, treatment, or care 2872
of the patient rendered by a hospital or healthcare provider, 2873
that is entered into prior to the diagnosis, treatment, or care 2874
of the patient is valid, irrevocable, and enforceable ~~once-if~~ 2875
the contract is signed by all parties and specifically 2876
references the patient's ability to file a claim under Chapters 2877
3965. and 3967. of the Revised Code. The contract remains valid, 2878
irrevocable, and enforceable until or unless the patient or the 2879
patient's legal representative rescinds the contract by written 2880
notice within thirty days of the signing of the contract. A 2881
guardian or other legal representative of the patient may give 2882
written notice of the rescission of the contract if the patient 2883

is incapacitated or a minor. No contract described in this 2884
division shall limit a patient's ability to file a claim under 2885
Chapters 3965. and 3967. of the Revised Code. 2886

(B) As used in this section and in sections 2711.23 and 2887
2711.24 of the Revised Code: 2888

(1) "Healthcare provider" means a physician, podiatrist, 2889
dentist, licensed practical nurse, registered nurse, advanced 2890
practice registered nurse, chiropractor, optometrist, physician 2891
assistant, emergency medical technician-basic, emergency medical 2892
technician-intermediate, emergency medical technician-paramedic, 2893
or physical therapist. 2894

(2) "Hospital," "physician," "podiatrist," "dentist," 2895
"licensed practical nurse," "registered nurse," "advanced 2896
practice registered nurse," "chiropractor," "optometrist," 2897
"physician assistant," "emergency medical technician-basic," 2898
"emergency medical technician-intermediate," "emergency medical 2899
technician-paramedic," "physical therapist," "medical claim," 2900
"dental claim," "optometric claim," and "chiropractic claim" 2901
have the same meanings as in section 2305.113 of the Revised 2902
Code. 2903

Sec. 2711.23. To be valid and enforceable any arbitration 2904
agreements pursuant to sections 2711.01 and 2711.22 of the 2905
Revised Code for controversies involving a medical, dental, 2906
chiropractic, or optometric claim that is entered into prior to 2907
a patient receiving any care, diagnosis, or treatment shall 2908
include or be subject to the following conditions: 2909

(A) The agreement shall provide that the care, diagnosis, 2910
or treatment will be provided whether or not the patient signs 2911
the agreement to arbitrate; 2912

(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 2942
withdrawal from the agreement; 2943

(J) The agreement shall contain a separately stated notice 2944
that clearly informs the patient of the patient's rights under 2945
division (B) of this section; 2946

(K) The agreement shall specify that the patient has a 2947
right to bring a claim under Chapters 3965. and 3967. of the 2948
Revised Code. 2949

Sec. 2711.24. To the extent it is in ten-point type and is 2950
executed in the following form, an arbitration agreement of the 2951
type stated in section 2711.23 of the Revised Code shall be 2952
presumed valid and enforceable in the absence of proof by a 2953
preponderance of the evidence that the execution of the 2954
agreement was induced by fraud, that the patient executed the 2955
agreement as a direct result of the willful or negligent 2956
disregard by the healthcare provider of the patient's right not 2957
to so execute, or that the patient executing the agreement was 2958
not able to communicate effectively in spoken and written 2959
English or any other language in which the agreement is written: 2960

"AGREEMENT TO RESOLVE FUTURE MALPRACTICE 2961

CLAIM BY BINDING ARBITRATION 2962

In the event of any dispute or controversy arising out of 2963
the diagnosis, treatment, or care of the patient by the 2964
healthcare provider, the dispute or controversy shall be 2965
submitted to binding arbitration. 2966

Within fifteen days after a party to this agreement has 2967
given written notice to the other of demand for arbitration of 2968
said dispute or controversy, the parties to the dispute or 2969
controversy shall each appoint an arbitrator and give notice of 2970

such appointment to the other. Within a reasonable time after 2971
such notices have been given the two arbitrators so selected 2972
shall select a neutral arbitrator and give notice of the 2973
selection thereof to the parties. The arbitrators shall hold a 2974
hearing within a reasonable time from the date of notice of 2975
selection of the neutral arbitrator. 2976

Expenses of the arbitration shall be shared equally by the 2977
parties to this agreement. 2978

The patient, by signing this agreement, also acknowledges 2979
that the patient has been informed that: 2980

(1) Care, diagnosis, or treatment will be provided whether 2981
or not the patient signs the agreement to arbitrate; 2982

(2) The agreement may not even be submitted to a patient 2983
for approval when the patient's condition prevents the patient 2984
from making a rational decision whether or not to agree; 2985

(3) The decision whether or not to sign the agreement is 2986
solely a matter for the patient's determination without any 2987
influence; 2988

(4) The agreement waives the patient's right to a trial in 2989
court for any future malpractice claim the patient may have 2990
against the healthcare provider; 2991

(5) The patient must be furnished with two copies of this 2992
agreement. 2993

PATIENT'S RIGHT TO CANCEL 2994

AGREEMENT TO ARBITRATE 2995

The patient, or the patient's spouse or the personal 2996
representative of the patient's estate in the event of the 2997

patient's death or incapacity, has the right to cancel this 2998
agreement to arbitrate by notifying the healthcare provider in 2999
writing within thirty days after the patient's signing of the 3000
agreement. The patient, or the patient's spouse or 3001
representative, as appropriate, may cancel this agreement by 3002
merely writing "cancelled" on the face of one of the patient's 3003
copies of the agreement, signing the patient's name under such 3004
word, and mailing, by certified mail, return receipt requested, 3005
the copy to the healthcare provider within the thirty-day 3006
period. 3007

Filing of a medical claim in a court within the thirty 3008
days provided for cancellation of the arbitration agreement by 3009
the patient will cancel the agreement without any further action 3010
by the patient. However, a patient retains the right to file a 3011
claim with the Medical Injury Compensation Center. 3012

Date: 3013

..... 3014

Signature of Provider of Medical Services 3015

..... 3016

Signature of Patient" 3017

Sec. 2743.02. (A) (1) The state hereby waives its immunity 3018
from liability, except as provided for the office of the state 3019
fire marshal in division (G) (1) of section 9.60 and division (B) 3020
of section 3737.221 of the Revised Code and subject to division 3021
(H) of this section, and consents to be sued, and have its 3022
liability determined, in the court of claims created in this 3023
chapter in accordance with the same rules of law applicable to 3024
suits between private parties, except that the determination of 3025
liability is subject to the limitations set forth in this 3026

chapter and, in the case of state universities or colleges, in 3027
section 3345.40 of the Revised Code, and except as provided in 3028
division (A) (2) or (3) of this section. To the extent that the 3029
state has previously consented to be sued, this chapter has no 3030
applicability. 3031

Except in the case of a civil action filed by the state, 3032
filing a civil action in the court of claims results in a 3033
complete waiver of any cause of action, based on the same act or 3034
omission, that the filing party has against any officer or 3035
employee, as defined in section 109.36 of the Revised Code. The 3036
waiver shall be void if the court determines that the act or 3037
omission was manifestly outside the scope of the officer's or 3038
employee's office or employment or that the officer or employee 3039
acted with malicious purpose, in bad faith, or in a wanton or 3040
reckless manner. 3041

(2) If a claimant proves in the court of claims that an 3042
officer or employee, as defined in section 109.36 of the Revised 3043
Code, would have personal liability for the officer's or 3044
employee's acts or omissions but for the fact that the officer 3045
or employee has personal immunity under section 9.86 of the 3046
Revised Code, the state shall be held liable in the court of 3047
claims in any action that is timely filed pursuant to section 3048
2743.16 of the Revised Code and that is based upon the acts or 3049
omissions. 3050

(3) (a) Except as provided in division (A) (3) (b) of this 3051
section, the state is immune from liability in any civil action 3052
or proceeding involving the performance or nonperformance of a 3053
public duty, including the performance or nonperformance of a 3054
public duty that is owed by the state in relation to any action 3055
of an individual who is committed to the custody of the state. 3056

(b) The state immunity provided in division (A) (3) (a) of 3057
this section does not apply to any action of the state under 3058
circumstances in which a special relationship can be established 3059
between the state and an injured party. A special relationship 3060
under this division is demonstrated if all of the following 3061
elements exist: 3062

(i) An assumption by the state, by means of promises or 3063
actions, of an affirmative duty to act on behalf of the party 3064
who was allegedly injured; 3065

(ii) Knowledge on the part of the state's agents that 3066
inaction of the state could lead to harm; 3067

(iii) Some form of direct contact between the state's 3068
agents and the injured party; 3069

(iv) The injured party's justifiable reliance on the 3070
state's affirmative undertaking. 3071

(B) The state hereby waives the immunity from liability of 3072
all hospitals owned or operated by one or more political 3073
subdivisions and consents for them to be sued, and to have their 3074
liability determined, in the court of common pleas, in 3075
accordance with the same rules of law applicable to suits 3076
between private parties, subject to the limitations set forth in 3077
this chapter. This division is also applicable to hospitals 3078
owned or operated by political subdivisions that have been 3079
determined by the supreme court to be subject to suit prior to 3080
July 28, 1975. 3081

(C) Any hospital, as defined in section 2305.113 of the 3082
Revised Code, may purchase liability insurance covering its 3083
operations and activities and its agents, employees, nurses, 3084
interns, residents, staff, and members of the governing board 3085

and committees, and, whether or not such insurance is purchased, 3086
may, to the extent that its governing board considers 3087
appropriate, indemnify or agree to indemnify and hold harmless 3088
any such person against expense, including attorney's fees, 3089
damage, loss, or other liability arising out of, or claimed to 3090
have arisen out of, the death, disease, or injury of any person 3091
as a result of the negligence, malpractice, or other action or 3092
inaction of the indemnified person while acting within the scope 3093
of the indemnified person's duties or engaged in activities at 3094
the request or direction, or for the benefit, of the hospital. A 3095
hospital may obtain this insurance to cover claims filed under 3096
Chapters 3965. and 3967. of the Revised Code. Any hospital 3097
electing to indemnify those persons, or to agree to so 3098
indemnify, shall reserve any funds that are necessary, in the 3099
exercise of sound and prudent actuarial judgment, to cover the 3100
potential expense, fees, damage, loss, or other liability. The 3101
superintendent of insurance may recommend, or, if the hospital 3102
requests the superintendent to do so, the superintendent shall 3103
recommend, a specific amount for any period that, in the 3104
superintendent's opinion, represents such a judgment. This 3105
authority is in addition to any authorization otherwise provided 3106
or permitted by law. 3107

(D) Recoveries against the state shall be reduced by the 3108
aggregate of insurance proceeds, disability award, or other 3109
collateral recovery received by the claimant. This division does 3110
not apply to civil actions in the court of claims against a 3111
state university or college under the circumstances described in 3112
section 3345.40 of the Revised Code. The collateral benefits 3113
provisions of division (B) (2) of that section apply under those 3114
circumstances. 3115

(E) The only defendant in original actions in the court of 3116

claims is the state. The state may file a third-party complaint 3117
or counterclaim in any civil action, except a civil action for 3118
ten thousand dollars or less, that is filed in the court of 3119
claims. 3120

(F) A civil action against an officer or employee, as 3121
defined in section 109.36 of the Revised Code, that alleges that 3122
the officer's or employee's conduct was manifestly outside the 3123
scope of the officer's or employee's employment or official 3124
responsibilities, or that the officer or employee acted with 3125
malicious purpose, in bad faith, or in a wanton or reckless 3126
manner shall first be filed against the state in the court of 3127
claims that has exclusive, original jurisdiction to determine, 3128
initially, whether the officer or employee is entitled to 3129
personal immunity under section 9.86 of the Revised Code and 3130
whether the courts of common pleas have jurisdiction over the 3131
civil action. The officer or employee may participate in the 3132
immunity determination proceeding before the court of claims to 3133
determine whether the officer or employee is entitled to 3134
personal immunity under section 9.86 of the Revised Code. 3135

The filing of a claim against an officer or employee under 3136
this division tolls the running of the applicable statute of 3137
limitations until the court of claims determines whether the 3138
officer or employee is entitled to personal immunity under 3139
section 9.86 of the Revised Code. 3140

(G) If a claim lies against an officer or employee who is 3141
a member of the Ohio national guard, and the officer or employee 3142
was, at the time of the act or omission complained of, subject 3143
to the "Federal Tort Claims Act," 60 Stat. 842 (1946), 28 U.S.C. 3144
2671, et seq., the Federal Tort Claims Act is the exclusive 3145
remedy of the claimant and the state has no liability under this 3146

section. 3147

(H) If an inmate of a state correctional institution has a 3148
claim against the state for the loss of or damage to property 3149
and the amount claimed does not exceed three hundred dollars, 3150
before commencing an action against the state in the court of 3151
claims, the inmate shall file a claim for the loss or damage 3152
under the rules adopted by the director of rehabilitation and 3153
correction pursuant to this division. The inmate shall file the 3154
claim within the time allowed for commencement of a civil action 3155
under section 2743.16 of the Revised Code. If the state admits 3156
or compromises the claim, the director shall make payment from a 3157
fund designated by the director for that purpose. If the state 3158
denies the claim or does not compromise the claim at least sixty 3159
days prior to expiration of the time allowed for commencement of 3160
a civil action based upon the loss or damage under section 3161
2743.16 of the Revised Code, the inmate may commence an action 3162
in the court of claims under this chapter to recover damages for 3163
the loss or damage. 3164

The director of rehabilitation and correction shall adopt 3165
rules pursuant to Chapter 119. of the Revised Code to implement 3166
this division. 3167

Sec. 2743.43. (A) No person shall be deemed competent to 3168
give expert testimony on the liability issues in a medical 3169
claim, as defined in section 2305.113 of the Revised Code, 3170
unless: 3171

(1) Such person is licensed to practice medicine and 3172
surgery, osteopathic medicine and surgery, or podiatric medicine 3173
and surgery by the state medical board or by the licensing 3174
authority of any state; 3175

(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 3205
death of the plaintiff or the individual upon whose behalf the 3206
claimant brought the claim. 3207

(2) The individual or entity against whom the claim is 3208
brought was not in compliance with division (A) of section 3209
3965.02 of the Revised Code at the time the claim accrued. 3210

Sec. 2919.171. (A) A physician who performs or induces or 3211
attempts to perform or induce an abortion on a pregnant woman 3212
shall submit a report to the department of health in accordance 3213
with the forms, rules, and regulations adopted by the department 3214
that includes all of the information the physician is required 3215
to certify in writing or determine under sections 2919.17 and 3216
2919.18 of the Revised Code: 3217

(B) By September 30 of each year, the department of health 3218
shall issue a public report that provides statistics for the 3219
previous calendar year compiled from all of the reports covering 3220
that calendar year submitted to the department in accordance 3221
with this section for each of the items listed in division (A) 3222
of this section. The report shall also provide the statistics 3223
for each previous calendar year in which a report was filed with 3224
the department pursuant to this section, adjusted to reflect any 3225
additional information that a physician provides to the 3226
department in a late or corrected report. The department shall 3227
ensure that none of the information included in the report could 3228
reasonably lead to the identification of any pregnant woman upon 3229
whom an abortion is performed. 3230

(C) (1) The physician shall submit the report described in 3231
division (A) of this section to the department of health within 3232
fifteen days after the woman is discharged. If the physician 3233
fails to submit the report more than thirty days after that 3234

fifteen-day deadline, the physician shall be subject to a late 3235
fee of five hundred dollars for each additional thirty-day 3236
period or portion of a thirty-day period the report is overdue. 3237
A physician who is required to submit to the department of 3238
health a report under division (A) of this section and who has 3239
not submitted a report or has submitted an incomplete report 3240
more than one year following the fifteen-day deadline may, in an 3241
action brought by the department of health, be directed by a 3242
court of competent jurisdiction to submit a complete report to 3243
the department of health within a period of time stated in a 3244
court order or be subject to contempt of court. 3245

(2) If a physician fails to comply with the requirements 3246
of this section, other than filing a late report with the 3247
department of health, or fails to submit a complete report to 3248
the department of health in accordance with a court order, the 3249
physician is subject to division (B) ~~(41)~~ (43) of section 4731.22 3250
of the Revised Code. 3251

(3) No person shall falsify any report required under this 3252
section. Whoever violates this division is guilty of abortion 3253
report falsification, a misdemeanor of the first degree. 3254

(D) Within ninety days of ~~the effective date of this~~ 3255
~~section~~ October 20, 2011, the department of health shall adopt 3256
rules pursuant to section 111.15 of the Revised Code to assist 3257
in compliance with this section. 3258

Sec. 3727.61. (A) As used in this section: 3259

(1) "Emergency department" means either of the following: 3260

(a) The area operated as an emergency department by a 3261
hospital subject to section 1867 of the "Social Security Act," 3262
42 U.S.C. 1985dd, also known as the "Emergency Medical Treatment 3263

and Labor Act," and the corresponding federal regulations, 3264
including the requirements of 42 C.F.R. 489.24; 3265

(b) A facility operated as a freestanding emergency 3266
department. 3267

(2) "Federally-qualified health center" has the same 3268
meaning as in section 1905(1)(2)(B) of the "Social Security 3269
Act," 42 U.S.C. 1396d(1)(2)(B). 3270

(3) "Nonemergency medical condition" means a condition on 3271
the list established by the state medical board under section 3272
4731.74 of the Revised Code. 3273

(4) "Qualified staff member" means an individual who is 3274
determined by the operator of an emergency department through 3275
the operator's bylaws or rules and regulations to be qualified 3276
to conduct a medical screening examination, as described in 42 3277
C.F.R. 489.24(a)(1)(i). 3278

(B) Implementation of this section is subject to section 3279
5166.50 of the Revised Code. 3280

(C) Each operator of an emergency department shall do 3281
either of the following: 3282

(1) Designate a space within the operator's facility that 3283
is separate from the area operated as an emergency department, 3284
or that is adjacent to the operator's facility, where services 3285
may be provided twenty-four hours a day, seven days a week, to 3286
patients who have nonemergency medical conditions; 3287

(2) Authorize a federally-qualified health center to 3288
operate twenty-four hours a day, seven days a week, in a space 3289
within or adjacent to the operator's facility. 3290

(D)(1) Except as provided in division (D)(2) of this 3291

section, if medical treatment is sought for an individual at an 3292
emergency department, a qualified staff member shall request a 3293
description of the individual's symptoms before any treatment is 3294
provided to the individual. The description shall be requested 3295
from the individual, the individual's representative, or if the 3296
individual is a minor, the minor's parent, guardian, or other 3297
person responsible for the individual's care. 3298

If the individual, representative, or other person 3299
responsible for the individual's care reports that the 3300
individual has symptoms that are associated with a nonemergency 3301
medical condition, as specified by the state medical board under 3302
section 4731.73 of the Revised Code, the qualified staff member 3303
may refer the individual to receive services at the space within 3304
or adjacent to the facility that is described in division (C) (1) 3305
or (2) of this section. The decision to make the referral shall 3306
be based only on the description of the individual's symptoms 3307
given by the individual, representative, or other person 3308
responsible for the individual's care. The qualified staff 3309
member may assign another employee of the facility or a 3310
volunteer to escort the individual to the space and ensure that 3311
the individual is registered to be seen by a health care 3312
professional. 3313

(2) The request for a description of the individual's 3314
symptoms is not required if a qualified staff member determines 3315
either of the following: 3316

(a) That the individual is unable to respond and no other 3317
person responsible for the individual's care is present to 3318
provide the description; 3319

(b) That the individual's medical condition requires 3320
immediate emergency care. 3321

(E) There is a rebuttable presumption that a referral made 3322
under division (D) (1) of this section was not negligent. 3323

(F) Each operator of an emergency department shall 3324
implement this section in such a manner that an individual is 3325
not required to duplicate any application or other 3326
administrative procedures relative to the receipt of services 3327
when a referral is made under division (D) (1) of this section or 3328
when, subsequent to the referral, it is determined that the 3329
individual requires emergency medical care and must return to 3330
the area operated as an emergency department. 3331

(G) In addition to the provisions of section 5164.83 of 3332
the Revised Code relative to hospitals participating in the 3333
medicaid program, any health care services that are provided to 3334
an individual in an emergency department shall not be charged to 3335
any person or government entity as emergency services if, at the 3336
time the services are provided, the individual has a 3337
nonemergency medical condition. If health care services are 3338
provided in an emergency department for a nonemergency medical 3339
condition, the amount that is charged for the services shall not 3340
exceed the usual and customary charge that would have been 3341
charged if the services were provided at a space within or 3342
adjacent to the facility, as described in division (C) (1) or (2) 3343
of this section. 3344

Sec. 3923.63. (A) Notwithstanding section 3901.71 of the 3345
Revised Code, each individual or group policy of sickness and 3346
accident insurance delivered, issued for delivery, or renewed in 3347
this state that provides maternity benefits shall provide 3348
coverage of inpatient care and follow-up care for a mother and 3349
her newborn as follows: 3350

(1) The policy shall cover a minimum of forty-eight hours 3351

of inpatient care following a normal vaginal delivery and a 3352
minimum of ninety-six hours of inpatient care following a 3353
cesarean delivery. Services covered as inpatient care shall 3354
include medical, educational, and any other services that are 3355
consistent with the inpatient care recommended in the protocols 3356
and guidelines developed by national organizations that 3357
represent pediatric, obstetric, and nursing professionals. 3358

(2) The policy shall cover a physician-directed source of 3359
follow-up care. Services covered as follow-up care shall include 3360
physical assessment of the mother and newborn, parent education, 3361
assistance and training in breast or bottle feeding, assessment 3362
of the home support system, performance of any medically 3363
necessary and appropriate clinical tests, and any other services 3364
that are consistent with the follow-up care recommended in the 3365
protocols and guidelines developed by national organizations 3366
that represent pediatric, obstetric, and nursing professionals. 3367
The coverage shall apply to services provided in a medical 3368
setting or through home health care visits. The coverage shall 3369
apply to a home health care visit only if the health care 3370
professional who conducts the visit is knowledgeable and 3371
experienced in maternity and newborn care. 3372

When a decision is made in accordance with division (B) of 3373
this section to discharge a mother or newborn prior to the 3374
expiration of the applicable number of hours of inpatient care 3375
required to be covered, the coverage of follow-up care shall 3376
apply to all follow-up care that is provided within seventy-two 3377
hours after discharge. When a mother or newborn receives at 3378
least the number of hours of inpatient care required to be 3379
covered, the coverage of follow-up care shall apply to follow-up 3380
care that is determined to be medically necessary by the health 3381
care professionals responsible for discharging the mother or 3382

newborn. 3383

(B) Any decision to shorten the length of inpatient stay 3384
to less than that specified under division (A)(1) of this 3385
section shall be made by the physician attending the mother or 3386
newborn, except that if a nurse-midwife is attending the mother 3387
in collaboration with a physician, the decision may be made by 3388
the nurse-midwife. Decisions regarding early discharge shall be 3389
made only after conferring with the mother or a person 3390
responsible for the mother or newborn. For purposes of this 3391
division, a person responsible for the mother or newborn may 3392
include a parent, guardian, or any other person with authority 3393
to make medical decisions for the mother or newborn. 3394

(C)(1) No sickness and accident insurer may do either of 3395
the following: 3396

(a) Terminate the participation of a health care 3397
professional or health care facility as a provider under a 3398
sickness and accident insurance policy solely for making 3399
recommendations for inpatient or follow-up care for a particular 3400
mother or newborn that are consistent with the care required to 3401
be covered by this section; 3402

(b) Establish or offer monetary or other financial 3403
incentives for the purpose of encouraging a person to decline 3404
the inpatient or follow-up care required to be covered by this 3405
section. 3406

(2) Whoever violates division (C)(1)(a) or (b) of this 3407
section has engaged in an unfair and deceptive act or practice 3408
in the business of insurance under sections 3901.19 to 3901.26 3409
of the Revised Code. 3410

(D) This section does not do any of the following: 3411

(1) Require a policy to cover inpatient or follow-up care 3412
that is not received in accordance with the policy's terms 3413
pertaining to the health care professionals and facilities from 3414
which an individual is authorized to receive health care 3415
services; 3416

(2) Require a mother or newborn to stay in a hospital or 3417
other inpatient setting for a fixed period of time following 3418
delivery; 3419

(3) Require a child to be delivered in a hospital or other 3420
inpatient setting; 3421

(4) Authorize a nurse-midwife to practice beyond the 3422
authority to practice nurse-midwifery in accordance with Chapter 3423
4723. of the Revised Code; 3424

(5) Establish minimum standards of medical diagnosis, care 3425
or treatment for inpatient or follow-up care for a mother or 3426
newborn. A deviation from the care required to be covered under 3427
this section shall not, solely on the basis of this section, 3428
give rise to a medical claim or derivative medical claim, as 3429
those terms are defined in section 2305.113 or 3965.01 of the 3430
Revised Code. 3431

Sec. 3923.64. (A) Notwithstanding section 3901.71 of the 3432
Revised Code, each public employee benefit plan established or 3433
modified in this state that provides maternity benefits shall 3434
provide coverage of inpatient care and follow-up care for a 3435
mother and her newborn as follows: 3436

(1) The plan shall cover a minimum of forty-eight hours of 3437
inpatient care following a normal vaginal delivery and a minimum 3438
of ninety-six hours of inpatient care following a cesarean 3439
delivery. Services covered as inpatient care shall include 3440

medical, educational, and any other services that are consistent 3441
with the inpatient care recommended in the protocols and 3442
guidelines developed by national organizations that represent 3443
pediatric, obstetric, and nursing professionals. 3444

(2) The plan shall cover a physician-directed source of 3445
follow-up care. Services covered as follow-up care shall include 3446
physical assessment of the mother and newborn, parent education, 3447
assistance and training in breast or bottle feeding, assessment 3448
of the home support system, performance of any medically 3449
necessary and appropriate clinical tests, and any other services 3450
that are consistent with the follow-up care recommended in the 3451
protocols and guidelines developed by national organizations 3452
that represent pediatric, obstetric, and nursing professionals. 3453
The coverage shall apply to services provided in a medical 3454
setting or through home health care visits. The coverage shall 3455
apply to a home health care visit only if the health care 3456
professional who conducts the visit is knowledgeable and 3457
experienced in maternity and newborn care. 3458

When a decision is made in accordance with division (B) of 3459
this section to discharge a mother or newborn prior to the 3460
expiration of the applicable number of hours of inpatient care 3461
required to be covered, the coverage of follow-up care shall 3462
apply to all follow-up care that is provided within seventy-two 3463
hours after discharge. When a mother or newborn receives at 3464
least the number of hours of inpatient care required to be 3465
covered, the coverage of follow-up care shall apply to follow-up 3466
care that is determined to be medically necessary by the health 3467
care professionals responsible for discharging the mother or 3468
newborn. 3469

(B) Any decision to shorten the length of inpatient stay 3470

to less than that specified under division (A) (1) of this 3471
section shall be made by the physician attending the mother or 3472
newborn, except that if a nurse-midwife is attending the mother 3473
in collaboration with a physician, the decision may be made by 3474
the nurse-midwife. Decisions regarding early discharge shall be 3475
made only after conferring with the mother or a person 3476
responsible for the mother or newborn. For purposes of this 3477
division, a person responsible for the mother or newborn may 3478
include a parent, guardian, or any other person with authority 3479
to make medical decisions for the mother or newborn. 3480

(C) (1) No public employer who offers an employee benefit 3481
plan may do either of the following: 3482

(a) Terminate the participation of a health care 3483
professional or health care facility as a provider under the 3484
plan solely for making recommendations for inpatient or follow- 3485
up care for a particular mother or newborn that are consistent 3486
with the care required to be covered by this section; 3487

(b) Establish or offer monetary or other financial 3488
incentives for the purpose of encouraging a person to decline 3489
the inpatient or follow-up care required to be covered by this 3490
section. 3491

(2) Whoever violates division (C) (1) (a) or (b) of this 3492
section has engaged in an unfair and deceptive act or practice 3493
in the business of insurance under sections 3901.19 to 3901.26 3494
of the Revised Code. 3495

(D) This section does not do any of the following: 3496

(1) Require a plan to cover inpatient or follow-up care 3497
that is not received in accordance with the plan's terms 3498
pertaining to the health care professionals and facilities from 3499

which an individual is authorized to receive health care 3500
services; 3501

(2) Require a mother or newborn to stay in a hospital or 3502
other inpatient setting for a fixed period of time following 3503
delivery; 3504

(3) Require a child to be delivered in a hospital or other 3505
inpatient setting; 3506

(4) Authorize a nurse-midwife to practice beyond the 3507
authority to practice nurse-midwifery in accordance with Chapter 3508
4723. of the Revised Code; 3509

(5) Establish minimum standards of medical diagnosis, 3510
care, or treatment for inpatient or follow-up care for a mother 3511
or newborn. A deviation from the care required to be covered 3512
under this section shall not, solely on the basis of this 3513
section, give rise to a medical claim or derivative medical 3514
claim, as those terms are defined in section 2305.113 or 3965.01 3515
of the Revised Code. 3516

Sec. 3929.302. (A) The superintendent of insurance, by 3517
rule adopted in accordance with Chapter 119. of the Revised 3518
Code, shall require the medical injury compensation center and 3519
each authorized insurer, surplus lines insurer, risk retention 3520
group, self-insurer, captive insurer, the medical liability 3521
underwriting association if created under section 3929.63 of the 3522
Revised Code, and any other entity that provides medical 3523
malpractice insurance to risks located in this state, to report 3524
information to the department of insurance at least annually 3525
regarding any medical, dental, optometric, or chiropractic claim 3526
asserted against a risk located in this state, if the claim 3527
resulted in any of the following results: 3528

(1) A final judgment in any amount;	3529
(2) A settlement in any amount;	3530
(3) A final disposition of the claim resulting in no indemnity payment on behalf of the insured.	3531 3532
(B) <u>(1)</u> 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:	3533 3534 3535 3536
(1) <u>(a)</u> The name, address, and specialty coverage of the insured;	3537 3538
(2) <u>(b)</u> The insured's policy number;	3539
(3) <u>(c)</u> The date of the occurrence that created the claim;	3540
(4) <u>(d)</u> The name and address of the injured person;	3541
(5) <u>(e)</u> 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;	3542 3543 3544 3545
(6) <u>(f)</u> In the case of a settlement, the date and amount of the settlement;	3546 3547
(7) <u>(g)</u> Any allocated loss adjustment expenses;	3548
(8) <u>(h)</u> Any other information required by the superintendent pursuant to rules adopted in accordance with Chapter 119. of the Revised Code.	3549 3550 3551
<u>(2) Notwithstanding division (B) (1) of this section, the center shall include the following information in the center's report:</u>	3552 3553 3554

<u>(a) The name of the insured;</u>	3555
<u>(b) The amount of compensation awarded in a claim filed</u> <u>under Chapters 3965. and 3967. of the Revised Code;</u>	3556 3557
<u>(c) The information required under divisions (B) (1) (c),</u> <u>(d), (f), and (h) of this section.</u>	3558 3559
(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.	3560 3561 3562 3563 3564 3565
(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.	3566 3567 3568 3569 3570
(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.	3571 3572 3573 3574 3575
(F) The <u>Except with respect to the center, the</u> 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.	3576 3577 3578 3579 3580 3581 3582 3583

(G) Except as specifically provided in division (H) of 3584
this section, the information required by this section shall be 3585
confidential and privileged and is not a public record as 3586
defined in section 149.43 of the Revised Code. The information 3587
provided under this section is not subject to discovery or 3588
subpoena and shall not be made public by the superintendent or 3589
any other person. 3590

(H) The department of insurance shall prepare an annual 3591
report that summarizes the closed claims reported under this 3592
section. The annual report shall summarize the closed claim 3593
reports on a statewide basis, and also by specialty and 3594
geographic region. Individual claims data shall not be released 3595
in the annual report. Copies of the report shall be provided to 3596
the members of the general assembly. 3597

(I) (1) Except as specifically provided in division (I) (2) 3598
of this section, any information submitted to the department of 3599
insurance by an attorney, law firm, or legal professional 3600
association pursuant to rules promulgated by the Ohio supreme 3601
court shall be confidential and privileged and is not a public 3602
record as defined in section 149.43 of the Revised Code. The 3603
information submitted is not subject to discovery or subpoena 3604
and shall not be made public by the department of insurance or 3605
any other person. 3606

(2) The department of insurance shall summarize the 3607
information submitted by attorneys, law firms, and legal 3608
professional associations and include the information in the 3609
annual report required by division (H) of this section. 3610
Individual claims data shall not be released in the annual 3611
report. 3612

(J) As used in this section, medical, dental, optometric, 3613

and chiropractic claims include those claims asserted against a 3614
risk located in this state that either: 3615

(1) Meet the definition of a "medical claim," "dental 3616
claim," "optometric claim," or "chiropractic claim" under 3617
section 2305.113 or 3965.01 of the Revised Code; 3618

(2) Have not been asserted in any civil action, but that 3619
otherwise meet the definition of a "medical claim," "dental 3620
claim," "optometric claim," or "chiropractic claim" under 3621
section 2305.113 or 3965.01 of the Revised Code. 3622

Sec. 3929.62. As used in sections 3929.62 to 3929.70 of 3623
the Revised Code and any rules adopted pursuant to those 3624
sections: 3625

(A) "Applicant" means any licensed physician, podiatrist, 3626
or hospital as those terms are defined in section 2305.113 of 3627
the Revised Code. 3628

(B) "Medical liability underwriting association" means a 3629
nonprofit unincorporated underwriting association for medical 3630
liability insurance established under section 3929.63 of the 3631
Revised Code. 3632

(C) "Medical liability insurance" means insurance coverage 3633
against the legal liability of the insured and against loss, 3634
damage, or expense incident to a claim arising out of the death, 3635
disease, or injury of any person as the result of negligence or 3636
malpractice in rendering professional service or related to the 3637
credentialing or accreditation of any medical professional or 3638
hospital by any licensed physician, podiatrist, or hospital, as 3639
those terms are defined in section 2305.113 of the Revised Code, 3640
or any employee or agent acting within the scope of their duties 3641
for a physician, podiatrist, or hospital or by any provider as 3642

defined in section 3965.01 of the Revised Code. 3643

Sec. 3929.67. (A) A medical liability insurance policy 3644
that insures a provider as defined in section 3965.01 of the 3645
Revised Code or a physician or podiatrist, written by or on 3646
behalf of the medical liability underwriting association 3647
pursuant to sections 3929.62 to 3929.70 of the Revised Code, may 3648
only be cancelled during the term of the policy for one of the 3649
following reasons: 3650

(1) Nonpayment of premiums; 3651

(2) The license of the insured to practice the provider's 3652
profession or to practice medicine and surgery, osteopathic 3653
medicine and surgery, or podiatric medicine and surgery has been 3654
suspended or revoked; 3655

(3) The insured's failure to meet minimum eligibility and 3656
underwriting standards; 3657

(4) The occurrence of a change in the individual risk that 3658
substantially increases any hazard insured against after the 3659
coverage has been issued or renewed, except to the extent that 3660
the medical liability underwriting association reasonably should 3661
have foreseen the change or contemplated the risk in writing the 3662
policy; 3663

(5) Discovery of fraud or material misrepresentation in 3664
the procurement of insurance or with respect to any claim 3665
submitted thereunder. 3666

(B) A medical liability insurance policy that insures a 3667
hospital, written by or on behalf of the medical liability 3668
underwriting association pursuant to sections 3929.62 to 3929.70 3669
of the Revised Code, may only be cancelled during the term of 3670
the policy for one of the following reasons: 3671

(1) Nonpayment of premiums;	3672
(2) The hospital is not certified or accredited in accordance with Chapter 3727. of the Revised Code;	3673 3674
(3) An injunction against the hospital has been granted under section 3727.05 of the Revised Code;	3675 3676
(4) The insured's failure to meet minimum eligibility and underwriting standards;	3677 3678
(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;	3679 3680 3681 3682 3683 3684
(6) Discovery of fraud or material misrepresentation in the procurement of insurance or with respect to any claim submitted thereunder.	3685 3686 3687
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	3688 3689 3690 3691 3692 3693 3694 3695 3696 3697 3698 3699 3700

than two and one-half million dollars and provided that this 3701
exception shall not prohibit the exchanging of contracts of 3702
indemnity against any form of liability otherwise authorized and 3703
arising out of any business or commercial enterprise. Such 3704
contracts and the exchange thereof and such subscribers, their 3705
attorneys, and representatives shall be regulated by such 3706
sections, and no law enacted after July 4, 1917, shall apply to 3707
them, unless they are expressly designated therein. 3708

Such a contract may be executed by an attorney or other 3709
representative designated "attorney," in sections 3931.01 to 3710
3931.12 of the Revised Code, authorized by and acting for such 3711
subscribers under powers of attorney. Such attorney may be a 3712
corporation. The principal office of such attorney shall be 3713
maintained at the place designated by the subscribers in the 3714
powers of attorney. 3715

Except for such limitations on assessability as are 3716
approved by the superintendent of insurance, every reciprocal or 3717
interinsurance contract written pursuant to this chapter for 3718
medical malpractice insurance shall be fully assessable and 3719
shall contain a statement, in boldface capital letters and in 3720
type more prominent than that of the balance of the contract, 3721
setting forth such terms of assessability. As used in this 3722
section, "medical malpractice insurance" means insurance 3723
coverage against the legal liability of the insured and against 3724
loss, damage, or expense incident to a claim arising out of the 3725
death, disease, or injury of any person as the result of 3726
negligence or malpractice in rendering professional service by 3727
any licensed physician, podiatrist, or hospital, as those terms 3728
are defined in section 2305.113 of the Revised Code or a 3729
provider as defined in section 3965.01 of the Revised Code. 3730

Sec. 3937.24. No insurer shall cancel, refuse to write or 3731
renew, or increase the premium rate of a policy of medical 3732
malpractice insurance, as defined in section 3937.25 of the 3733
Revised Code, based on a claim under Chapter 3965. or 3967. of 3734
the Revised Code that lists the insured as a provider. 3735

Sec. 3937.25. (A) As used in sections 3937.25 to 3937.29 3736
of the Revised Code, "medical malpractice insurance" means 3737
insurance coverage against the legal liability of the insured 3738
for loss, damage, or expense arising from a medical, optometric, 3739
or chiropractic claim, as those claims are defined in section 3740
2305.113 or 3965.01 of the Revised Code. 3741

(B) After a policy of commercial property insurance, 3742
commercial fire insurance, or commercial casualty insurance 3743
other than fidelity or surety bonds, medical malpractice 3744
insurance, and automobile insurance as defined in section 3745
3937.30 of the Revised Code, has been in effect for more than 3746
ninety days, a notice of cancellation for such policy shall not 3747
be issued by any licensed insurer unless it is based on one of 3748
the following grounds: 3749

(1) Nonpayment of premium; 3750

(2) Discovery of fraud or material misrepresentation in 3751
the procurement of the insurance or with respect to any claims 3752
submitted thereunder; 3753

(3) Discovery of a moral hazard or willful or reckless 3754
acts or omissions on the part of the named insured that increase 3755
any hazard insured against; 3756

(4) The occurrence of a change in the individual risk 3757
which substantially increases any hazard insured against after 3758
insurance coverage has been issued or renewed, except to the 3759

extent the insurer reasonably should have foreseen the change or 3760
contemplated the risk in writing the contract; 3761

(5) Loss of applicable reinsurance or a substantial 3762
decrease in applicable reinsurance, if the superintendent has 3763
determined that reasonable efforts have been made to prevent the 3764
loss of, or substantial decrease in, the applicable reinsurance, 3765
or to obtain replacement coverage; 3766

(6) Failure of an insured to correct material violations 3767
of safety codes or to comply with reasonable written loss 3768
control recommendations; 3769

(7) A determination by the superintendent of insurance 3770
that the continuation of the policy would create a condition 3771
that would be hazardous to the policyholders or the public. 3772

(C) The notice of cancellation required by this section 3773
must be in writing, be mailed to the insured at the insured's 3774
last known address, and contain all of the following: 3775

(1) The policy number; 3776

(2) The date of the notice; 3777

(3) The effective date of the cancellation; 3778

(4) An explanation of the reason for cancellation. 3779

Such notice of cancellation also shall be mailed to the 3780
insured's agent. 3781

(D) Except for nonpayment of premium, the effective date 3782
of cancellation must be no less than thirty days from the date 3783
of mailing the notice. When cancellation is for nonpayment of 3784
premium, the effective date of cancellation must be no less than 3785
ten days from the date of mailing the notice. 3786

(E) Nothing in division (B) of this section shall be 3787
construed to prevent an insurer from writing a policy of 3788
commercial property insurance, commercial fire insurance, or 3789
commercial casualty insurance other than medical malpractice 3790
insurance and automobile insurance as defined in section 3937.30 3791
of the Revised Code for a period greater than one year and 3792
providing in such policy that the insurer may issue a notice of 3793
cancellation of such policy at least thirty days prior to an 3794
anniversary of such policy, with the effective date of 3795
cancellation being that anniversary. 3796

The superintendent may prescribe that adequate disclosure 3797
be made to the insured when a policy is issued for a term of 3798
more than one year. 3799

(F) There is no liability on the part of, and no cause of 3800
action of any nature arises against, the superintendent of 3801
insurance, any insurer, or any person furnishing information 3802
requested by the superintendent, an insurer, the agent, 3803
employee, attorney, or other authorized representative of any 3804
such persons, for any oral or written statement made to supply 3805
information relevant to a determination on cancellation of any 3806
policy of commercial property insurance, commercial fire 3807
insurance, or commercial casualty insurance other than fidelity 3808
or surety bonds, medical malpractice insurance, and automobile 3809
insurance as defined in section 3937.30 of the Revised Code, or 3810
in connection with advising an insured or an insured's attorney 3811
of the reasons for a cancellation of such insurance, or in 3812
connection with any administrative or judicial proceeding 3813
arising out of or related to such cancellation. 3814

Sec. 3937.28. (A) A notice of cancellation of a policy of 3815
medical malpractice insurance shall not be issued by any 3816

licensed insurer unless it is based on one of the following 3817
grounds: 3818

(1) Nonpayment of premium; 3819

(2) Discovery of fraud or material misrepresentation in 3820
the procurement of the insurance or with respect to any claims 3821
submitted thereunder; 3822

(3) Discovery of a moral hazard or willful or reckless 3823
acts or omissions on the part of the named insured that increase 3824
any hazard insured against; 3825

(4) The occurrence of a change in the individual risk that 3826
substantially increases any hazard insured against after 3827
insurance coverage has been issued or renewed, except to the 3828
extent the insurer reasonably should have foreseen the change or 3829
contemplated the risk in writing the contract and except, as 3830
provided under section 3937.24 of the Revised Code, for a change 3831
based on a claim filed with the medical injury compensation 3832
center; 3833

(5) Loss of applicable reinsurance or a substantial 3834
decrease in applicable reinsurance, if the superintendent of 3835
insurance has determined that reasonable efforts have been made 3836
to prevent the loss of, or substantial decrease in, the 3837
applicable reinsurance, or to obtain replacement coverage; 3838

(6) Failure of an insured to correct material violations 3839
of safety codes or to comply with reasonable written loss 3840
control recommendations; 3841

(7) A determination by the superintendent that the 3842
continuation of the policy would create a condition that would 3843
be hazardous to the policyholders or the public. 3844

(B) The notice of cancellation required by this section 3845
shall be in writing, be mailed both to the insured at the 3846
insured's last known address and to the insured's agent, and 3847
contain all of the following: 3848

(1) The policy number; 3849

(2) The date of the notice; 3850

(3) The effective date of the cancellation; 3851

(4) An explanation of the grounds for cancellation. 3852

(C) Except when cancellation is for nonpayment of premium, 3853
the effective date of cancellation shall be not less than sixty 3854
days from the date of mailing the notice. When cancellation is 3855
for nonpayment of premium, the effective date of cancellation 3856
shall be not less than ten days from the date of mailing the 3857
notice. 3858

(D) Nothing in division (A) of this section shall be 3859
construed to prevent an insurer from writing a policy of medical 3860
malpractice insurance for a period greater than one year and 3861
providing in such policy that the insurer may issue a notice of 3862
cancellation of such policy at least sixty days prior to an 3863
anniversary of such policy, with the effective date of 3864
cancellation being that anniversary. 3865

The superintendent may prescribe that adequate disclosure 3866
be made to the insured when a policy is issued for a term of 3867
more than one year. 3868

(E) There is no liability on the part of, and no cause of 3869
action of any nature arises against, the superintendent, any 3870
insurer, or any person furnishing information requested by the 3871
superintendent or an insurer, or the agent, employee, attorney 3872

or other authorized representative of any such persons, for any 3873
oral or written statement made to supply information relevant to 3874
a determination on cancellation of any policy of medical 3875
malpractice insurance, or in connection with advising an insured 3876
or the insured's attorney of the grounds for a cancellation of 3877
such insurance, or in connection with any administrative or 3878
judicial proceeding arising out of or related to such 3879
cancellation. 3880

Sec. 3937.29. (A) An insurer that intends to cancel, 3881
terminate, or otherwise not renew all policies of medical 3882
malpractice insurance that it has issued to any class, type, or 3883
specialty of practitioner, or that intends to cancel, terminate, 3884
or otherwise not renew all policies of medical malpractice 3885
insurance in a specific geographic area, which may include the 3886
state as a whole, shall file written notice of its intended 3887
action with the superintendent of insurance. These actions by an 3888
insurer are not effective unless the written notice is filed 3889
with the superintendent within the following time frames: 3890

(1) At least one hundred eighty days prior to the insurer 3891
acting to cancel, terminate, or otherwise not renew all policies 3892
of medical malpractice insurance that the insurer has issued in 3893
this state; 3894

(2) At least one hundred twenty days prior to the insurer 3895
acting to cancel, terminate, or otherwise not renew all policies 3896
of medical malpractice insurance for a specific class, type, or 3897
specialty of practitioner or in a specific geographic area other 3898
than this state as a whole. 3899

Written notice also shall be filed with the superintendent 3900
at least one hundred twenty days prior to the insurer making 3901
changes in its underwriting guidelines, if the effect of the 3902

changes will be to cancel, terminate, or otherwise not renew all 3903
policies of medical malpractice insurance for a specific class, 3904
type, or specialty of practitioner or in a specific geographic 3905
area other than this state as a whole. 3906

(B) The written notice filed with the superintendent under 3907
division (A) of this section shall contain all of the following 3908
information: 3909

(1) The date of the notice; 3910

(2) The number of insureds with policies that will be 3911
cancelled, terminated, or not renewed; 3912

(3) The date that the insurer intends to cancel, 3913
terminate, or otherwise not renew all policies of medical 3914
malpractice insurance that the insurer has issued to any class, 3915
type, or specialty of practitioner, or that the insurer intends 3916
to cancel, terminate, or otherwise not renew all policies of 3917
medical malpractice insurance in a specific geographic area, 3918
including the state as a whole; 3919

(4) The specific geographic area, if any; 3920

(5) Any other information required by the superintendent. 3921

(C) An insurer who files a notice with the superintendent 3922
under division (A) of this section shall file a copy of that 3923
notice with the administrator of medical injury compensation 3924
within thirty days after filing the notice with the 3925
superintendent. 3926

(D) An insurer that intends to condition renewal of a 3927
policy of medical malpractice insurance upon an increase in 3928
premium shall mail a notice of the insurer's intention to the 3929
agent of record and to the insured at the insured's last known 3930

address at least sixty days prior to the expiration date of the 3931
policy. 3932

~~(D)~~ (E) An insurer may refuse to renew a policy of medical 3933
malpractice insurance by mailing a notice of the insurer's 3934
intention to the agent of record and to the insured at the 3935
insured's last known address at least sixty days prior to the 3936
expiration date of the policy. The notice mailed under this 3937
division shall contain all of the following information: 3938

(1) The policy number; 3939

(2) The date of the notice; 3940

(3) The expiration date of the policy; 3941

(4) An explanation of the grounds for nonrenewal. 3942

~~(E)~~ (F) If the notice required by divisions ~~(C)~~ and ~~(D)~~ 3943
and (E) of this section is mailed less than sixty days before 3944
the expiration date of the policy, the insured's coverage then 3945
in effect remains in effect until sixty days after the date of 3946
mailing the notice unless either of the following is true: 3947

(1) In the case of a premium increase, the insured accepts 3948
the increased premium. The change is then effective immediately 3949
following the expiration of the insured's coverage then in 3950
effect. 3951

(2) In the case of nonrenewal, the insured notifies the 3952
insurer in writing that the insured accepts the nonrenewal as 3953
stated. 3954

~~(F)~~ (G) If the insured's coverage is extended beyond the 3955
original expiration date of the policy as provided by division 3956
~~(E)~~ (F) of this section, the premium for the time after the 3957
original expiration date must be calculated using the rates 3958

originally applicable to the insured's coverage then in effect. 3959
The insurer shall notify the insured of the amount of the 3960
premium for the time after the expiration of the insured's 3961
coverage then in effect. The insured shall pay the premium 3962
unless either of the following is true: 3963

(1) In the case of a premium increase, the insured 3964
notifies the insurer in writing that the insured does not want 3965
the coverage then in effect to be extended past the expiration 3966
date. 3967

(2) In the case of nonrenewal, the insured notifies the 3968
insurer in writing that the insured accepts the nonrenewal as 3969
stated. 3970

Sec. 3955.05. Sections 3955.01 to 3955.19 of the Revised 3971
Code apply to all kinds of direct insurance, except: 3972

(A) Title insurance; 3973

(B) Fidelity or surety bonds, or any other bonding 3974
obligations; 3975

(C) Credit insurance, vendors' single interest insurance, 3976
collateral protection insurance, or any similar insurance 3977
protecting the interests of a creditor arising out of a 3978
creditor-debtor transaction; 3979

(D) Mortgage guaranty, financial guaranty, residual value, 3980
or other forms of insurance offering protection against 3981
investment risks; 3982

(E) Ocean marine insurance; 3983

(F) Any insurance provided by or guaranteed by government, 3984
including, but not limited to, any department, board, office, 3985
commission, agency, institution, or other instrumentality or 3986

entity of any branch of state government, any political	3987
subdivision of this state, the United States or any agency of	3988
the United States, or any separate or joint governmental self-	3989
insurance or risk-pooling program, plan, or pool;	3990
(G) Contracts of any corporation by which health services	3991
are to be provided to its subscribers;	3992
(H) Life, annuity, health, or disability insurance,	3993
including sickness and accident insurance written pursuant to	3994
Chapter 3923. of the Revised Code;	3995
(I) Fraternal benefit insurance;	3996
(J) Mutual protective insurance of persons or property;	3997
(K) Reciprocal or interinsurance contracts written	3998
pursuant to Chapter 3931. of the Revised Code for medical	3999
malpractice insurance if the reciprocal exchange or	4000
interinsurance exchange is not subject to the risk-based capital	4001
requirements in effect in the state of domicile of the	4002
reciprocal exchange or interinsurance exchange. As used in this	4003
division, "medical malpractice insurance" means insurance	4004
coverage against the legal liability of the insured and against	4005
loss, damage, or expense incident to a claim arising out of the	4006
death, disease, or injury of any person as the result of	4007
negligence or malpractice in rendering professional service by	4008
any licensed physician, podiatrist, or hospital, as those terms	4009
are defined in section 2305.113 of the Revised Code <u>or a</u>	4010
<u>provider as defined in section 3965.01 of the Revised Code.</u>	4011
(L) Any political subdivision self-insurance program or	4012
joint political subdivision self-insurance pool established	4013
under Chapter 2744. of the Revised Code;	4014
(M) Warranty or service contracts, or the insurance of	4015

those contracts; 4016

(N) Any state university or college self-insurance program 4017
established under section 3345.202 of the Revised Code; 4018

(O) Any transaction, or combination of transactions, 4019
between a person, including affiliates of such person, and an 4020
insurer, including affiliates of such insurer, that involves the 4021
transfer of investment or credit risk unaccompanied by a 4022
transfer of insurance risk; 4023

(P) Credit union share guaranty insurance issued pursuant 4024
to Chapter 1761. of the Revised Code; 4025

(Q) Insurance issued by risk retention groups as defined 4026
in Chapter 3960. of the Revised Code; 4027

(R) Workers' compensation insurance, including any 4028
contract indemnifying an employer who pays compensation directly 4029
to employees. 4030

Sec. 3965.01. As used in this chapter and Chapter 3967. of 4031
the Revised Code: 4032

(A) "Advanced practice registered nurse" means any 4033
certified nurse practitioner, clinical nurse specialist, 4034
certified registered nurse anesthetist, or certified nurse- 4035
midwife who holds a certificate of authority issued by the board 4036
of nursing under Chapter 4723. of the Revised Code. 4037

(B) "Chiropractic claim" means any claim under this 4038
chapter that lists a chiropractor or any employee or agent of a 4039
chiropractor and that arises out of the chiropractic diagnosis, 4040
care, or treatment of any person. 4041

For purposes of sections 2305.234, 2317.02, 3929.302, and 4042
3937.35 of the Revised Code, "chiropractic claim" includes 4043

derivative claims for relief that arise from the chiropractic 4044
diagnosis, care, or treatment of a person. 4045

(C) "Chiropractor" means any person who is licensed to 4046
practice chiropractic by the state chiropractic board. 4047

(D) "Claimant" means any individual who brings a claim 4048
under this chapter or who, if deceased, is the subject of a 4049
claim brought under this chapter. 4050

(E) "Dental claim" means any claim under this chapter that 4051
lists a dentist or any employee or agent of a dentist and that 4052
arises out of a dental operation or the dental diagnosis, care, 4053
or treatment of any person. 4054

For purposes of sections 2305.234, 2317.02, and 3929.302 4055
of the Revised Code, "dental claim" includes derivative claims 4056
for relief that arise from the dental diagnosis, care, or 4057
treatment of a person. 4058

(F) "Dentist" means any person who is licensed to practice 4059
dentistry by the state dental board. 4060

(G) "Derivative claim" includes a claim of a parent, 4061
guardian, custodian, or spouse of an individual who was the 4062
subject of any medical diagnosis, care, or treatment, dental 4063
diagnosis, care, or treatment, dental operation, optometric 4064
diagnosis, care, or treatment, or chiropractic diagnosis, care, 4065
or treatment, that arises from that diagnosis, care, treatment, 4066
or operation, and that seeks the recovery of damages for any of 4067
the following: 4068

(1) Loss of society, consortium, companionship, care, 4069
assistance, attention, protection, advice, guidance, counsel, 4070
instruction, training, or education, or any other intangible 4071
loss that was sustained by the parent, guardian, custodian, or 4072

spouse; 4073

(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. 4074
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(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. 4082
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(I) "Health care professional standards board" means the health care professional standards board created in section 4746.02 of the Revised Code. 4088
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(J) "Home" has the same meaning as in section 3721.10 of the Revised Code. 4091
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(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 4093
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physicians practicing in more than one recognized medical 4102
specialty and rendering advice, diagnosis, care, and treatment 4103
to individuals. "Hospital" does not include any hospital 4104
operated by the government of the United States or any of its 4105
branches. 4106

(L) "Insurer" and "liability insurer" include the medical 4107
liability underwriting association, unless the context clearly 4108
indicates otherwise. 4109

(M) "Liability insurance" means coverage against the legal 4110
liability of the insured and against loss, damage, or expense 4111
incident to a claim arising out of the death, disease, or injury 4112
of any person as the result of negligence or malpractice in 4113
rendering professional service or related to the credentialing 4114
or accreditation of any medical professional or hospital by any 4115
provider or any employee or agent acting within the scope of 4116
their duties for a provider. 4117

(N) "Licensed practical nurse" means any person who is 4118
licensed to practice nursing as a licensed practical nurse by 4119
the board of nursing pursuant to Chapter 4723. of the Revised 4120
Code. 4121

(O) "Medical claim" means any claim under this chapter 4122
that lists a physician, podiatrist, hospital, home, or 4123
residential facility; any employee or agent of a physician, 4124
podiatrist, hospital, home, or residential facility; or a 4125
licensed practical nurse, registered nurse, advanced practice 4126
registered nurse, pharmacist, physical therapist, physician 4127
assistant, emergency medical technician-basic, emergency medical 4128
technician-intermediate, or emergency medical technician- 4129
paramedic; and that arises out of the medical diagnosis, care, 4130
or treatment of any person. "Medical claim" includes both of the 4131

<u>following:</u>	4132
<u>(1) Claims that arise out of the medical diagnosis, care,</u>	4133
<u>or treatment of any person and to which either of the following</u>	4134
<u>applies:</u>	4135
<u>(a) The claim results from acts or omissions in providing</u>	4136
<u>medical care.</u>	4137
<u>(b) The claim results from the hiring, training,</u>	4138
<u>supervision, retention, or termination of caregivers providing</u>	4139
<u>medical diagnosis, care, or treatment.</u>	4140
<u>(2) Claims that arise out of the medical diagnosis, care,</u>	4141
<u>or treatment of any person and that are brought under section</u>	4142
<u>3721.17 of the Revised Code.</u>	4143
<u>For purposes of sections 2305.234, 2317.02, 3929.302, and</u>	4144
<u>3937.35 of the Revised Code, "medical claim" includes derivative</u>	4145
<u>claims for relief that arise from the medical diagnosis, care,</u>	4146
<u>or treatment of a person.</u>	4147
<u>(P) "Medical injury compensation panel" means a panel</u>	4148
<u>established pursuant to section 3967.02 of the Revised Code.</u>	4149
<u>(Q) "Medical liability underwriting association" has the</u>	4150
<u>same meaning as in section 3929.62 of the Revised Code.</u>	4151
<u>(R) "Optometric claim" means any claim under this chapter</u>	4152
<u>that lists an optometrist, or any employee or agent of an</u>	4153
<u>optometrist, and that arises out of the optometric diagnosis,</u>	4154
<u>care, or treatment of any person.</u>	4155
<u>For purposes of sections 2305.234, 2317.02, 3929.302, and</u>	4156
<u>3937.35 of the Revised Code, "optometric claim" includes</u>	4157
<u>derivative claims for relief that arise from the optometric</u>	4158
<u>diagnosis, care, or treatment of a person.</u>	4159

- (S) "Optometrist" means any person licensed to practice optometry by the state board of optometry. 4160
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- (T) "Pharmacist" means a person who is licensed to practice pharmacy under Chapter 4729. of the Revised Code. 4162
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- (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. 4164
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- (V) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code. 4169
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- (W) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code. 4172
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- (X) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board. 4175
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- (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. 4178
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- (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. 4184
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- (AA) "Residential facility" means a facility licensed 4187

under section 5123.19 of the Revised Code. 4188

Sec. 3965.02. (A) No provider shall fail to obtain 4189
liability insurance. 4190

(B)(1) Except as otherwise provided in division (D) of 4191
this section, a provider who complies with division (A) of this 4192
section shall not be liable to respond in damages at common law 4193
or by statute for any of the following occurring during the 4194
period covered by the premiums paid by the provider to the 4195
insurer: 4196

(a) An injury received by an individual that arises out of 4197
the chiropractic diagnosis, care, or treatment of the 4198
individual; 4199

(b) An injury received by an individual that arises from a 4200
dental operation or the dental diagnosis, care, or treatment of 4201
the individual; 4202

(c) An injury received by an individual that arises out of 4203
the medical diagnosis, care, or treatment of the individual; 4204

(d) An injury received by an individual that arises out of 4205
the optometric diagnosis, care, or treatment of the individual; 4206

(e) For the death of an individual resulting from an 4207
injury described in division (B)(1)(a), (b), (c), or (d) of this 4208
section; 4209

(f) For a derivative claim that results from an injury 4210
described in division (B)(1)(a), (b), (c), or (d) of this 4211
section from the death of an individual resulting from such an 4212
injury. 4213

(2) Division (B)(1) of this section applies to a common 4214
law or statutory claim as described in that division regardless 4215

of whether an injury or death is compensable under this chapter. 4216

(C) No employee of any provider shall be liable to respond 4217
in damages at common law or by statute for any injury, death, or 4218
derivative claim, as described in division (B) of this section 4219
on the condition that the injury, death, or derivative claim is 4220
found to be compensable under this chapter or Chapter 3967. of 4221
the Revised Code. 4222

(D) The immunity provided under division (B) or (C) of 4223
this section is not applicable in either of the following 4224
claims: 4225

(1) A claim that a provider or an employee of a provider 4226
intentionally caused an injury to or the death of an individual 4227
that arises out of any of the following: 4228

(a) The chiropractic diagnosis, care, or treatment of the 4229
individual; 4230

(b) A dental operation or the dental diagnosis, care, or 4231
treatment of the individual; 4232

(c) The medical diagnosis, care, or treatment of the 4233
individual; 4234

(d) The optometric diagnosis, care, or treatment of the 4235
individual. 4236

(2) A claim that lists a provider who violates division 4237
(A) of this section for an injury or death arising out of any of 4238
the following: 4239

(a) The chiropractic diagnosis, care, or treatment of the 4240
individual; 4241

(b) A dental operation or the dental diagnosis, care, or 4242

<u>treatment of the individual;</u>	4243
<u>(c) The medical diagnosis, care, or treatment of the individual;</u>	4244
<u>individual;</u>	4245
<u>(d) The optometric diagnosis, care, or treatment of the individual.</u>	4246
<u>individual.</u>	4247
<u>(E) As used in division (D) of this section,</u>	4248
<u>"intentionally caused" means that a provider acted with</u>	4249
<u>deliberate intent to cause another individual to suffer an</u>	4250
<u>injury or death.</u>	4251
<u>(F) Except as provided in division (D) of this section, a</u>	4252
<u>claim brought under this chapter and Chapter 3967. of the</u>	4253
<u>Revised Code shall be the exclusive remedy against a provider or</u>	4254
<u>the provider's liability insurer for any injury, death, or</u>	4255
<u>derivative claim, as described in division (B) of this section,</u>	4256
<u>including any action by the health insurer or employer of the</u>	4257
<u>individual who is the subject of the claim.</u>	4258
<u>Sec. 3965.03.</u> <u>A provider who fails to comply with division</u>	4259
<u>(A) of section 3965.02 of the Revised Code is not entitled to</u>	4260
<u>the benefits of this chapter in relation to chiropractic,</u>	4261
<u>dental, medical, optometric, or derivative claims that arise</u>	4262
<u>during the period of that noncompliance and is liable to an</u>	4263
<u>individual, and the individual's personal representatives, for</u>	4264
<u>damages suffered by reason of injury or death arising out of the</u>	4265
<u>circumstances described in division (B) of section 3965.02 of</u>	4266
<u>the Revised Code. In such a civil action, the defendant shall</u>	4267
<u>not avail the defendant's self of either of the following common</u>	4268
<u>law defenses:</u>	4269
<u>(A) The defense of the assumption of risk;</u>	4270
<u>(B) The defense of contributory negligence.</u>	4271

Sec. 3965.04. (A) If an individual files a chiropractic, 4272
dental, medical, optometric, or derivative claim for 4273
compensation under this chapter that lists a provider who was 4274
violating division (A) of section 3965.02 of the Revised Code at 4275
the time the claim arose, and it is determined under this 4276
chapter or Chapter 3967. of the Revised Code that the individual 4277
is entitled to compensation under this chapter, the 4278
administrator of medical injury compensation shall make and file 4279
for record in the office of the county recorder in the counties 4280
where the provider's real or tangible personal property is 4281
located, an affidavit that includes all of the following 4282
information: 4283

(1) The date on which the application was filed with the 4284
administrator; 4285

(2) The name and address of the provider listed in the 4286
claim; 4287

(3) The fact that the provider had not complied with 4288
section 3965.02 of the Revised Code. 4289

(B) The recorder shall accept and file the affidavit and 4290
record the same as a mortgage on real estate and shall file the 4291
same as a chattel mortgage, and the recorder shall index the 4292
same as a mortgage on real estate and as a chattel mortgage. A 4293
copy of the application or other record documenting the claim 4294
shall be filed with the affidavit. A copy of the affidavit shall 4295
be served upon the provider by the administrator. 4296

(C) The affidavit constitutes a valid lien from the time 4297
of filing, in favor of the administrator, upon the real property 4298
and tangible personal property of the provider located within 4299
the county. 4300

(D) The administrator shall have the lien canceled of 4301
record under the following circumstances: 4302

(1) After the provider has paid to the claimant the 4303
compensation owed to the claimant; 4304

(2) When the application has finally been denied after the 4305
claimant has exhausted the remedies provided by law; 4306

(3) When the provider has filed a bond in the amount and 4307
with surety as the administrator approves conditioned on the 4308
payment of all sums ordered paid to the claimant. 4309

(E) The recorder shall make no charge for the services 4310
provided by this section to be performed by the recorder. 4311

Sec. 3965.05. Any interested party may enjoin the further 4312
operation of a provider subject to this chapter who has violated 4313
division (A) of section 3965.02 of the Revised Code. The 4314
procedure to obtain an injunction is governed by Chapter 2727. 4315
of the Revised Code, and the right to such relief is in addition 4316
to the rights described in section 2727.02 of the Revised Code. 4317

Sec. 3965.06. No agreement by an individual to waive an 4318
individual's rights to compensation under this chapter is valid. 4319

No agreement by an individual to directly pay any portion 4320
of the premium paid by the individual's provider for liability 4321
insurance is valid. 4322

No provider shall directly charge an individual for any 4323
portion of the premium paid by the individual's provider for 4324
liability insurance. 4325

Sec. 3965.07. (A) Each provider who obtains liability 4326
insurance shall post conspicuously in the provider's place of 4327
business a notice provided by the provider's liability insurer 4328

that states all of the following information: 4329

(1) The fact that the provider has paid the premium due; 4330

(2) The date the premium was paid; 4331

(3) The time period to which the premium payment applies. 4332

(B) The liability insurer shall furnish an adequate number 4333
of copies of the notice to the provider at the time of the 4334
payment of the premium. The notice, when posted, constitutes 4335
sufficient notice to the provider's patients of the fact that 4336
the provider has made payment. 4337

Sec. 3965.10. A provider may obtain liability insurance 4338
necessary to comply with section 3965.02 of the Revised Code 4339
through an insurer authorized under Title XXXIX of the Revised 4340
Code to conduct the business of insurance in this state or 4341
through the medical liability underwriting association. 4342

Sec. 3965.11. An insurer providing liability insurance for 4343
purposes of this chapter and Chapter 3967. of the Revised Code 4344
shall pay compensation in any claim determined to be compensable 4345
under this chapter or Chapter 3967. of the Revised Code in 4346
accordance with the amount calculated pursuant to section 4347
3965.60 of the Revised Code. The insurer shall pay the claims in 4348
accordance with the schedule provided under section 3965.52 of 4349
the Revised Code. 4350

Sec. 3965.12. Beginning one hundred eighty days after the 4351
effective date of this section, and each year thereafter, each 4352
insurer providing liability insurance for purposes of this 4353
chapter and Chapter 3967. of the Revised Code shall submit a 4354
list to the administrator of medical injury compensation of the 4355
providers for whom the insurer provides coverage for purposes of 4356
this chapter and Chapter 3967. of the Revised Code. 4357

Beginning one hundred eighty days after the effective date 4358
of this section, and each year thereafter, the state medical 4359
board, state dental board, state nursing board, state board of 4360
optometry, state chiropractic board, state board of pharmacy, 4361
Ohio occupational therapy, physical therapy, and athletic 4362
trainers board, and the state board of emergency medical, fire, 4363
and transportation services shall submit a list to the 4364
administrator of the providers who are subject to the board's 4365
jurisdiction and who are subject to this chapter and Chapter 4366
3967. of the Revised Code. 4367

The administrator shall adopt rules to establish 4368
procedures to allow the reports required under this section to 4369
be submitted electronically. 4370

Sec. 3965.15. There is hereby created the medical injury 4371
compensation center, which shall be administered by the 4372
administrator of medical injury compensation. A person appointed 4373
to the position of administrator shall possess significant 4374
management experience in effectively managing an organization or 4375
organizations of substantial size and complexity. A person 4376
appointed to the position of administrator also shall possess a 4377
minimum of five years of experience in the field of insurance, 4378
particularly in the area of liability insurance, if possible. 4379
The governor shall appoint the administrator with the advice and 4380
consent of the senate, and the administrator shall serve at the 4381
pleasure of the governor. The governor shall fix the 4382
administrator's salary on the basis of the administrator's 4383
experience and the administrator's responsibilities and duties 4384
under this chapter and Chapter 3967. of the Revised Code. The 4385
governor shall not appoint to the position of administrator any 4386
person who has, or whose spouse has, given a contribution to the 4387
campaign committee of the governor in an amount greater than one 4388

thousand dollars during the two-year period immediately 4389
preceding the date of the appointment of the administrator. 4390

The administrator shall hold no other public office and 4391
shall devote full time to the duties of administrator. Before 4392
entering upon the duties of the office, the administrator shall 4393
take an oath of office as required by sections 3.22 and 3.23 of 4394
the Revised Code, and shall file in the office of the secretary 4395
of state a bond, signed by the administrator and by surety 4396
approved by the governor, for the sum of fifty thousand dollars 4397
payable to the state, conditioned upon the faithful performance 4398
of the administrator's duties. 4399

Sec. 3965.16. The administrator of medical injury 4400
compensation shall do all of the following: 4401

(A) Perform all acts and exercise all authorities and 4402
powers, discretionary and otherwise that are required of or 4403
vested in the medical injury compensation center or any of its 4404
employees in this chapter and Chapter 3967. of the Revised Code, 4405
except the acts and the exercise of authority and power that is 4406
required of and vested in a medical injury compensation panel 4407
pursuant to those chapters; 4408

(B) Employ, direct, and supervise all employees required 4409
in connection with the performance of the duties assigned to the 4410
center by this chapter and Chapter 3967. of the Revised Code, 4411
including actuaries appointed to make determinations with 4412
respect to compensation under division (D) of section 3965.41 of 4413
the Revised Code; 4414

(C) Provide offices, equipment, supplies, and other 4415
facilities for the center; 4416

(D) Purchase supplies, materials, equipment, and services; 4417

make contracts for, operate, and superintend the telephone, 4418
other telecommunication, and computer services for the use of 4419
the center and make contracts in connection with office 4420
reproduction, forms management, printing, and other services; 4421

(E) Prepare an annual budget for internal operating 4422
purposes; 4423

(F) Set standards for the reasonable and maximum handling 4424
time of claim processing and ensure, by rules, the impartial and 4425
prompt treatment of all claims, and establish a secure, accurate 4426
method of time stamping all incoming mail and documents hand 4427
delivered to center employees; 4428

(G) Manage and operate a data processing system and 4429
develop a claims tracking system that is sufficient to monitor 4430
the status of a claim at any time and that lists appeals that 4431
have been filed and orders or determinations that have been 4432
issued pursuant to section 3965.41, 3967.15, or 3967.20 of the 4433
Revised Code, including the dates of the filings and issuances; 4434

(H) Pursuant to section 3965.70 of the Revised Code, 4435
approve applications for the final settlement of claims for 4436
compensation under this chapter and Chapter 3967. of the Revised 4437
Code as the administrator determines appropriate; 4438

(I) Adopt rules for the operation of the center and adopt 4439
other rules as the administrator considers necessary to 4440
administer this chapter and Chapter 3967. of the Revised Code; 4441

(J) Review and process all claim applications; 4442

(K) Establish a program for quality control, systems 4443
design, and internal auditing and ensure that audits are 4444
performed at least annually to determine whether the center 4445
meets the performance goals the administrator establishes; 4446

- (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: 4447
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- (1) The rights and responsibilities of claimants, providers, and insurers; 4453
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- (2) The procedures for processing claims; 4455
- (3) The procedure for fulfilling provider and insurer responsibility; 4456
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- (4) All applicable statutes of limitation; 4458
- (5) The availability of services and benefits; 4459
- (6) The claimant's right to representation in the processing of a claim or to elect no representation. 4460
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- (M) Establish and maintain a program to identify providers subject to this chapter and Chapter 3967. of the Revised Code; 4462
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- (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; 4464
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- (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; 4469
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- (P) Study the feasibility of creating an online gateway 4473

similar to the one created in division (O) of this section, for 4474
pro se claimants; 4475

(Q) Create a gateway for a claimant to use if the claimant 4476
is representing the claimant's self if, pursuant to the study 4477
conducted under division (P) of this section, the administrator 4478
determines that a gateway for pro se litigants is feasible. 4479

Sec. 3965.17. No member of a medical injury compensation 4480
panel created under Chapter 3967. of the Revised Code or 4481
employee of the medical injury compensation center shall have 4482
any direct or indirect interest in the gains or profits of any 4483
insurer providing coverage for claims under this chapter and 4484
Chapter 3967. of the Revised Code. 4485

Sec. 3965.18. The attorney general shall be the legal 4486
adviser of the administrator of medical injury compensation and 4487
the medical injury compensation center. 4488

Sec. 3965.19. The administrator of medical injury 4489
compensation, for employees of the medical injury compensation 4490
center, may discipline, suspend, demote, or discharge any 4491
employee for misfeasance, malfeasance, or nonfeasance in 4492
accordance with Chapter 124. of the Revised Code. In the case of 4493
any employee assigned to the investigation or determination of 4494
claims, if the administrator determines that the employee is not 4495
efficient, impartial, or judicious, and if supported by evidence 4496
and not promoted by discrimination, the determination shall be 4497
accepted as a fact justifying the action taken by the 4498
administrator. 4499

The administrator shall adopt rules establishing a code of 4500
ethics for all employees of the center and post copies of the 4501
rules in a conspicuous place in each center office. 4502

The administrator shall adopt rules setting forth 4503
procedures designed to eliminate outside influence on center 4504
employees, produce an impartial claims handling process, and 4505
avoid favoritism in the claims handling process. Failure to 4506
adopt and enforce these rules constitutes grounds for removal of 4507
the administrator. 4508

Sec. 3965.20. (A) The administrator of medical injury 4509
compensation shall establish service offices around the state as 4510
needed, based on the anticipated utilization of each office by 4511
claimants and liability insurers. 4512

(B) The administrator shall appoint a service director for 4513
each service office. A service director shall do all of the 4514
following: 4515

(1) Provide each claimant and liability insurer fair, 4516
impartial, and equal treatment; 4517

(2) Recommend any needed improvements for changes in staff 4518
size and accessibility to service offices; 4519

(3) Recommend to the administrator appropriate action 4520
concerning any allegations of misconduct, abuse of authority, or 4521
fraud committed in the service office; 4522

(4) Ensure that all current center rules and operating 4523
procedures are carried out by all employees under the service 4524
director's direction; 4525

(5) Assist claimants and providers who contact the service 4526
office for information or assistance with respect to claims 4527
processing and coverage. 4528

(C) The administrator shall assign to each service office 4529
an adequate number of investigators and field auditors. A 4530

service director shall make investigators available to a medical 4531
injury compensation panel and reviewing health care providers as 4532
needed. 4533

Sec. 3965.21. (A) There is hereby created in the state 4534
treasury the medical injury compensation center operating fund, 4535
which shall consist of the assessments described in division (B) 4536
of this section. Any investment earnings of the fund shall be 4537
credited to the fund. The administrator shall use the fund to 4538
pay the costs attributable to the activities of the 4539
administrator, the medical injury compensation center, and any 4540
medical injury compensation panel. 4541

(B) (1) The administrator annually shall assess each 4542
provider an administrative assessment for the costs attributable 4543
to the activities of the administrator and center. Except as 4544
provided in division (B) (2) of this section, the administrator 4545
shall allocate the administrative assessment in a fair and 4546
equitable manner, as specified in rules adopted by the 4547
administrator, among the providers subject to this chapter and 4548
Chapter 3967. of the Revised Code based upon the number of 4549
patients seen by each of those providers during the preceding 4550
year. 4551

(2) For a provider who is an employee of a hospital, any 4552
patient seen in the hospital by that provider shall be 4553
attributable to the hospital for purposes of the administrator's 4554
annual assessment, and not to the employee provider. 4555

Sec. 3965.22. In addition to any other rules the 4556
administrator of medical injury compensation is required to 4557
adopt under this chapter, the administrator shall adopt the 4558
following rules: 4559

(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: 4560
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(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; 4565
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(2) The forms of application for those claiming to be entitled to compensation under this chapter; 4569
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(3) The method of making investigations, physical examinations, and inspections. 4571
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(B) Rules concerning the payment of attorney's fees and to resolve fee disputes; 4573
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(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; 4575
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(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. 4579
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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 4583
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treasurer of any county, required to be taken by this chapter. 4589
This section does not affect any right or defense in any action 4590
brought by the administrator, the center, or the state in 4591
pursuance of authority contained in this chapter. 4592

Sec. 3965.24. (A) No person shall, orally or in writing, 4593
directly or indirectly, or through any agent or other person 4594
fraudulently hold the person's self out or represent the 4595
person's self or any of the person's partners or associates as 4596
authorized by a claimant to take charge of, or represent the 4597
claimant in respect of, any claim or matter in connection 4598
therewith before the medical injury compensation center, a 4599
reviewing health care provider, or any medical injury 4600
compensation panel. No person shall, without prior authority 4601
from the administrator, a reviewing health care provider, a 4602
member of a panel, the claimant, or the liability insurer of a 4603
provider, examine or directly or indirectly cause or employ 4604
another person to examine any claim file or any other file 4605
pertaining thereto. No person shall forge an authorization for 4606
the purpose of examining or causing another person to examine a 4607
claim file. No employee of the center shall divulge any 4608
information in respect of any claim or appeal that is or may be 4609
filed with a reviewing health care provider, the center, or 4610
panel member to any person other than members of the panel or to 4611
the superior of the employee except upon authorization of the 4612
administrator or a panel member or upon authorization of the 4613
claimant or the liability insurer of a provider. 4614

(B) (1) All of the following records are not public records 4615
as defined in section 149.43 of the Revised Code: 4616

(a) The records described or referred to in division (A) 4617
of this section; 4618

(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; 4619
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(c) The identity of any provider who is named in a claim. 4622

(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. 4623
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(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. 4627
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(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. 4637
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(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. 4644
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(3) An individual described in division (D)(1) of this section shall include all of the following in the written request: 4648
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(a) The individual's name, title, and signature; 4651

(b) The name and title of the individual's employer; 4652

(c) A statement that the disclosure of the information sought is in the public interest. 4653
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(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. 4655
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(E) As used in this section, "journalist" has the same meaning as in section 149.43 of the Revised Code. 4658
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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. 4660
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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. 4672
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(B) Except as to an individual within the age of minority 4677
or of unsound mind as provided by section 2305.16 of the Revised 4678
Code, and except as provided in division (C) of this section, 4679
both of the following apply: 4680

(1) No action upon a chiropractic, dental, medical, 4681
optometric, or derivative claim under this chapter shall be 4682
commenced more than four years after the occurrence of the act 4683
or omission constituting the alleged basis of the claim; 4684

(2) If an action upon a chiropractic, dental, medical, 4685
optometric, or derivative claim is not commenced within four 4686
years after the occurrence of the act or omission constituting 4687
the alleged basis of the claim, then, any action upon that claim 4688
is barred. 4689

(C) (1) If an individual making a chiropractic claim, 4690
dental claim, medical claim, optometric claim, or derivative 4691
claim in the exercise of reasonable care and diligence, could 4692
not have discovered the injury resulting from the act or 4693
omission constituting the alleged basis of the claim within 4694
three years and six months after the occurrence of the act or 4695
omission, but, in the exercise of reasonable care and diligence, 4696
discovers the injury resulting from that act or omission before 4697
the expiration of the four-year period specified in division (B) 4698
(1) of this section, the individual may file a claim under this 4699
chapter not later than six months after the individual discovers 4700
the injury resulting from that act or omission. 4701

(2) If the alleged basis of a chiropractic claim, dental 4702
claim, medical claim, optometric claim, or derivative claim is 4703
the occurrence of an act or omission that involves a foreign 4704
object that is left in the body of an individual, the individual 4705
making the claim may file a claim under this chapter not later 4706

than the later of six months after the individual discovered the 4707
foreign object or six months after the individual, with 4708
reasonable care and diligence, should have discovered the 4709
foreign object. 4710

(3) An individual who files a chiropractic claim, dental 4711
claim, medical claim, optometric claim, or derivative claim 4712
under the circumstances described in division (C) (1) or (2) of 4713
this section has the affirmative burden of proving, by clear and 4714
convincing evidence, that the individual, with reasonable care 4715
and diligence, could not have discovered the injury resulting 4716
from the act or omission constituting the alleged basis of the 4717
claim within the three-year and six-month period described in 4718
division (C) (1) of this section or prior to the six-month period 4719
described in division (C) (2) of this section, whichever is 4720
applicable. 4721

Sec. 3965.31. (A) The administrator of medical injury 4722
compensation shall prepare and furnish all of the following 4723
blank forms: 4724

(1) Applications for compensation for a chiropractic, 4725
dental, medical, optometric, or derivative claim made under this 4726
chapter; 4727

(2) Notices to liability insurers of providers and 4728
individuals; 4729

(3) For proofs of injury or death and of medical 4730
attendance and hospital and nursing care; 4731

(4) Any other necessary applications. 4732

(B) The administrator, in the rules the administrator 4733
adopts under this chapter, shall provide for the preparation and 4734
distribution of the forms described in division (A) of this 4735

section. The rules shall require the forms to be readily 4736
available and prepared so that the furnishing of information 4737
required of any individual or liability insurer with respect to 4738
any aspect of a claim is not delayed by a requirement that 4739
information with respect to another aspect of the claim shall be 4740
furnished on the form by the same or another person. Service 4741
offices shall keep on hand a sufficient supply of these forms. 4742

Sec. 3965.32. The administrator of medical injury 4743
compensation, by published notices and other appropriate means, 4744
shall endeavor to cause claims to be filed in the service office 4745
of the medical injury compensation center from which the 4746
investigation and determination of the claim may be made most 4747
expeditiously. An individual may file a claim or appeal under 4748
this chapter or Chapter 3967. of the Revised Code with any 4749
office of the center within the required statutory period, and 4750
that claim or appeal is considered received for the purpose of 4751
processing claims or appeals. 4752

Sec. 3965.33. (A) Within seven days after receipt of any 4753
claim under this chapter, the medical injury compensation center 4754
shall notify the claimant, the health care professional 4755
standards board, and the liability insurer of the provider named 4756
in the claim of the receipt of the claim and of the facts 4757
alleged in the claim. Upon receipt of a claim, the center shall 4758
advise the claimant of the claim number assigned and the 4759
claimant's right to representation in the processing of a claim 4760
or to elect no representation. No center employee shall directly 4761
or indirectly convey any information in derogation of this 4762
right. This section shall in no way abrogate the center's 4763
responsibility to aid and assist a claimant in the filing of a 4764
claim and to advise the claimant of the claimant's rights under 4765
the law. 4766

(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. 4767
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(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. 4771
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(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. 4775
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(4) A reviewing health care provider may refer a claim to the administrator for reassignment if either of the following occur: 4781
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(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. 4784
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(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. 4789
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If the administrator receives a claim for reassignment under division (B) (4) of this section, the administrator 4794
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expeditiously shall reassign the claim in accordance with 4796
section 3965.40 of the Revised Code. 4797

Sec. 3965.34. (A) A reviewing health care provider 4798
appointed pursuant to section 3965.40 of the Revised Code or a 4799
medical injury compensation panel may require any individual 4800
claiming the right to receive compensation under this chapter to 4801
submit to a medical examination at any time, and from time to 4802
time, at a place reasonably convenient for the individual, and 4803
as provided by the rules of the administrator of medical injury 4804
compensation. A claimant required by a panel or a reviewing 4805
health care provider to submit to a medical examination, at a 4806
point outside of the place of permanent or temporary residence 4807
of the claimant, as provided in this section, is entitled to 4808
have paid to the claimant by the medical injury compensation 4809
center the necessary and actual expenses on account of the 4810
attendance for the medical examination after approval of the 4811
expense statement by the center. Under extraordinary 4812
circumstances and with the unanimous approval of the panel, if 4813
the panel requires the medical examination, or with the approval 4814
of the reviewing health care provider, if the reviewing health 4815
care provider requires the medical examination, the center shall 4816
pay an injured individual the necessary, actual, and authorized 4817
expenses of treatment at a point outside the place of permanent 4818
or temporary residence of the claimant. 4819

(B) If an individual refuses to submit to any medical 4820
examination scheduled pursuant to this section or obstructs the 4821
examination, the individual's right to have the individual's 4822
claim for compensation considered, if the claim is pending 4823
before a reviewing health care provider or a medical injury 4824
compensation panel, or to receive any payment for compensation 4825
previously granted, is suspended during the period of the 4826

refusal or obstruction. A reviewing health care provider or 4827
panel shall dismiss an individual's claim if the individual 4828
fails to submit to an examination for a period of six months or 4829
longer. 4830

(C) Examinations scheduled under this section do not limit 4831
examinations provided for in other provisions of this chapter. 4832

Sec. 3965.35. (A) The liability insurer of a provider 4833
listed in a claim filed under this chapter may require, without 4834
the approval of a reviewing health care provider or a medical 4835
injury compensation panel, that the claimant be examined by a 4836
physician of the liability insurer's choice one time. Any 4837
further requests for medical examinations shall be made to the 4838
administrator of medical injury compensation, who shall consider 4839
and rule on the request. The liability insurer shall pay the 4840
cost of any examinations initiated by the liability insurer. 4841

A provider selected by a liability insurer to conduct an 4842
examination under this division shall satisfy the requirements 4843
of division (A) of section 3965.43 of the Revised Code. With 4844
respect to a claim before a reviewing health care provider, a 4845
liability insurer may require a claimant to undergo an 4846
examination at the time permitted under division (D) of section 4847
3965.41 of the Revised Code. With respect to a claim before a 4848
medical injury compensation panel, the liability insurer may 4849
require a claim to undergo both an examination as the panel is 4850
determining whether the claim is compensable and, if a claim is 4851
compensable, prior to the award of compensation. 4852

(B) The medical injury compensation center shall prepare a 4853
form for the release of medical information, records, and 4854
reports relative to the issues necessary for the administration 4855
of a claim under this chapter. The claimant promptly shall 4856

provide a current signed release of the information, records, 4857
and reports when requested by the liability insurer of a 4858
provider listed in a claim. The liability insurer promptly shall 4859
provide copies of all information, records, and reports that 4860
relate to the claim to the center and to the claimant or the 4861
claimant's representative upon request. 4862

(C) If, without good cause, a claimant refuses to submit 4863
to any examination scheduled under this section or refuses to 4864
release or execute a release for any information, record, or 4865
report that is required to be released under this section and 4866
involves an issue pertinent to the condition alleged in the 4867
claim, the claimant's right to have the claimant's claim 4868
considered, if the claim is pending before a reviewing health 4869
care provider or a medical injury compensation panel, or to 4870
receive any payment for compensation previously granted, is 4871
suspended during the period of refusal. A reviewing health care 4872
provider or panel shall dismiss an individual's claim if the 4873
individual fails to submit to an examination for a period of six 4874
months or longer. 4875

(D) No center employee shall alter any medical report 4876
obtained from a health care provider the liability insurer, 4877
reviewing health care provider, or a panel has selected or cause 4878
or request the health care provider to alter or change a report. 4879
The reviewing health care provider and panel shall make any 4880
request for clarification of a health care provider's report in 4881
writing and shall provide a copy of the request to the affected 4882
parties and their representatives at the time of making the 4883
request. 4884

Sec. 3965.36. For the purpose of this chapter, a minor is 4885
sui juris, and no other person shall have any cause of action or 4886

right to compensation for an injury to the minor, but in the 4887
event of the award of a lump sum of compensation to the minor, 4888
the sum shall be paid to the legally appointed guardian of the 4889
minor or in accordance with section 2111.05 of the Revised Code. 4890

Sec. 3965.37. This chapter and Chapter 3967. of the 4891
Revised Code shall be liberally construed in favor of claimants. 4892

Sec. 3965.40. (A) The medical injury compensation center 4893
shall employ a pool of reviewing health care providers, who 4894
shall determine claims filed under this chapter. A provider who 4895
participates in the pool shall practice at least fifty per cent 4896
of the time in a clinical setting. Any type of provider may 4897
serve as a reviewing health care provider. The administrator of 4898
medical injury compensation shall set the compensation of a 4899
reviewing health care provider during the time the provider 4900
performs services for the medical injury compensation center 4901
under this chapter and Chapter 3967. of the Revised Code. 4902

(B) A reviewing health care provider who is appointed to 4903
determine a claim under this chapter shall serve for as long as 4904
is necessary to resolve the claim. A reviewing health care 4905
provider shall be assigned a claim based upon all of the 4906
following: 4907

(1) Whether the claim is a chiropractic, dental, medical, 4908
optometric, or derivative claim; 4909

(2) The type of practice in which the reviewing health 4910
care provider is engaged; 4911

(3) Where the injury or death occurred. 4912

(C) (1) The administrator shall periodically review the 4913
performance of each reviewing health care provider to ensure 4914
accuracy and impartiality in decisions made by the reviewing 4915

health care provider. 4916

(2) If the administrator, in conducting a review under 4917
division (C)(1) of this section, determines that the decisions 4918
of a reviewing health care provider are not accurate or 4919
impartial, the administrator may remove the reviewing health 4920
care provider from the pool described in division (A) of this 4921
section and from any claim being heard by the provider at the 4922
time of the determination. 4923

Sec. 3965.41. (A) A reviewing health care provider 4924
appointed under section 3965.40 of the Revised Code shall review 4925
the medical or applicable records submitted in the chiropractic, 4926
dental, medical, optometric, or derivative claim over which the 4927
reviewing health care provider is presiding pursuant to this 4928
chapter. No reviewing health care provider shall review or 4929
consider as evidence in a claim under this chapter a 4930
determination made by the health care professional standards 4931
board under section 4746.04 of the Revised Code that the 4932
provider's acts or omissions constitute gross negligence or that 4933
the provider engaged in a pattern of negligent behavior over a 4934
short period of time. 4935

(B) The reviewing health care provider shall review all 4936
chiropractic, dental, medical, or optometric records relevant to 4937
the claim. The reviewing health care provider may commission an 4938
expert witness in accordance with section 3965.43 of the Revised 4939
Code to present evidence regarding the claim. 4940

(C) A reviewing health care provider shall determine 4941
whether clear and convincing evidence exists that the provider 4942
did not breach the chiropractic, dental, medical, or optometric 4943
standard of care applicable to the claim. If the reviewing 4944
health care provider determines that such evidence exists, the 4945

claimant shall not be compensated under this chapter. If the 4946
reviewing health care provider determines that this evidence 4947
does not exist, the claimant shall be awarded compensation under 4948
this chapter. If the reviewing health care provider determines 4949
that such evidence exists with respect to the type of practice 4950
that is the primary issue of the claim, but is unable to 4951
determine whether such evidence exists with respect to other 4952
aspects of the claim, the reviewing health care provider may 4953
refer the portions of the claim for which the reviewing health 4954
care provider is unable to make a determination to the 4955
administrator for reassignment pursuant to section 3965.33 of 4956
the Revised Code. 4957

(D) If a reviewing health care provider determines that a 4958
claim is compensable under this chapter, the reviewing health 4959
care provider shall request the administrator to assign an 4960
actuary to the claim. The administrator shall randomly assign an 4961
actuary employed by the medical injury compensation center to 4962
determine the amount of compensation to be awarded in accordance 4963
with section 3965.60 of the Revised Code using the same evidence 4964
the reviewing health care provider used to determine that the 4965
claim is compensable. However, prior to awarding compensation, 4966
the reviewing health care provider shall allow the liability 4967
insurer of a provider identified in the claim to have a medical 4968
examination of the claimant conducted by an independent health 4969
care provider at the insurer's expense in accordance with 4970
section 3965.35 of the Revised Code. If the liability insurer 4971
elects to have an independent medical examination conducted, the 4972
claimant, at the claimant's expense, also may elect to have an 4973
independent medical examination conducted. The results of any 4974
independent medical examination conducted pursuant to this 4975
division shall be submitted to the actuary assigned to the 4976

claim, who shall use those results to determine the amount of 4977
compensation to award. 4978

(E) The insurer of a provider listed in a claim or a 4979
claimant may appeal the decision of the reviewing health care 4980
provider in accordance with the procedures prescribed in Chapter 4981
3967. of the Revised Code. 4982

Sec. 3965.42. (A) (1) The liability insurer of a provider 4983
listed in a claim filed under this chapter may file a motion 4984
with the reviewing health care provider assigned to the claim 4985
under section 3965.40 of the Revised Code for dismissal of the 4986
claim accompanied by an affidavit of noninvolvement. The 4987
liability insurer shall notify all parties to the claim in 4988
writing of the filing of the motion. Prior to ruling on the 4989
motion, the reviewing health care provider shall allow the 4990
parties not less than thirty days from the date that the parties 4991
were served with the notice to respond to the motion. 4992

(2) An affidavit of noninvolvement shall set forth, with 4993
particularity, the facts that demonstrate all of the following: 4994

(a) That the provider listed in the claim was 4995
misidentified or otherwise not involved individually or through 4996
the action of the provider's agents or employees in the care and 4997
treatment of the individual who is the subject of the claim; 4998

(b) That the provider was not obligated individually or 4999
through the provider's agents or employees to provide for the 5000
care and treatment of the individual who is the subject of the 5001
claim; 5002

(c) That the provider could not have caused the alleged 5003
malpractice individually or through the provider's agents or 5004
employees in any way. 5005

(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 5036
immediately reinstate the claim against that liability insurer, 5037
if previously dismissed. If a party is reinstated pursuant to 5038
this division, any period of limitations shall be considered to 5039
be tolled for the period beginning when the original affidavit 5040
was filed and ending upon reinstatement. 5041

(D) In any claim in which the liability insurer of the 5042
provider in question is found by the reviewing health care 5043
provider to have knowingly filed a false or inaccurate affidavit 5044
of noninvolvement, the reviewing health care provider shall 5045
request that the health care professional standards board or 5046
other appropriate disciplinary board impose upon the person who 5047
signed the affidavit or represented the provider, or both, an 5048
appropriate sanction. An appropriate sanction may include an 5049
order to pay to other parties to the claim the amount of the 5050
reasonable expenses that the parties incurred as a result of the 5051
filing of the false or inaccurate affidavit, including 5052
reasonable attorney's fees. 5053

(E) In any claim in which the reviewing health care 5054
provider determines that a party falsely objected to a liability 5055
insurer's affidavit of noninvolvement or knowingly provided an 5056
inaccurate statement regarding such an affidavit, the reviewing 5057
health care provider shall request the appropriate authority to 5058
impose upon the party or the party's counsel, or both, an 5059
appropriate sanction. An appropriate sanction may include an 5060
order to pay to the other parties to the claim the amount of the 5061
reasonable expenses that the parties incurred as a result of the 5062
submission of the false objection or inaccurate statement, 5063
including reasonable attorney's fees. 5064

Sec. 3965.43. (A) No individual shall be considered 5065

competent to give expert testimony on the liability or 5066
compensation issues in a chiropractic, dental, medical, or 5067
optometric claim filed under this chapter, unless all of the 5068
following apply to the individual: 5069

(1) The individual is licensed to practice the applicable 5070
profession by the appropriate agency in this state or any other 5071
state. 5072

(2) The individual devotes three-fourths of the 5073
individual's professional time to the active clinical practice 5074
or to instruction in an accredited university in the applicable 5075
subject area. 5076

(3) The individual practices in the same or a 5077
substantially similar specialty as the provider listed in the 5078
claim filed under this chapter. 5079

(4) If the person is certified in a specialty, the person 5080
must be certified by a nationally recognized board, as 5081
determined by the administrator of medical injury compensation, 5082
in a specialty having acknowledged expertise and training 5083
directly related to the particular health care matter at issue. 5084

(B) For purposes of division (A) (3) of this section, a 5085
reviewing health care provider or medical injury compensation 5086
panel shall not permit an expert in one medical specialty to 5087
testify against a provider in another medical specialty unless 5088
the expert shows both that the standards of care and practice in 5089
the two specialties are similar and that the expert has 5090
substantial familiarity between the specialties. 5091

(C) Nothing in division (A) of this section shall be 5092
construed to limit the power of the reviewing health care 5093
provider or panel to adjudge the testimony of any expert witness 5094

incompetent on any other ground. 5095

(D) Nothing in division (A) of this section shall be 5096
construed to limit the power of the reviewing health care 5097
provider or a panel to allow the testimony of any other witness, 5098
on a matter unrelated to the liability or compensation issues in 5099
the chiropractic, dental, medical, or optometric claim, when 5100
that testimony is relevant to the claim involved. 5101

Sec. 3965.44. Each member of a medical injury compensation 5102
panel and employees of the medical injury compensation center 5103
designated by the administrator of medical injury compensation, 5104
for the purposes of this chapter and Chapter 3967. of the 5105
Revised Code, may administer oaths, certify to official acts, 5106
take testimony or depositions, conduct hearings, inquiries, and 5107
investigations, issue subpoenas, and compel the attendance of 5108
witnesses and the production of books, accounts, papers, 5109
records, documents, evidence, and testimony. 5110

In claims filed before a medical injury compensation panel 5111
or the medical injury compensation center by an individual and 5112
the dependents of a deceased individual on account of injury or 5113
death sustained by the individual in the course of the 5114
diagnosis, care, or treatment of the individual, a panel, a 5115
reviewing health care provider or the center may cause 5116
depositions of witnesses residing within or without the state to 5117
be taken in the manner prescribed by law for the taking of 5118
depositions in civil actions in the court of common pleas. 5119

Sec. 3965.45. A transcribed copy of the evidence and 5120
proceedings, or any specific part thereof, or any investigation, 5121
by a stenographer appointed by the medical injury compensation 5122
center, that is certified by that stenographer to be a true and 5123
correct transcript of the testimony on the investigation or of a 5124

particular witness, or of a specific part of that testimony, 5125
carefully compared by the stenographer with the stenographer's 5126
original notes, and to be a correct statement of the evidence 5127
and proceedings had on that investigation so purporting to be 5128
taken and subscribed, may be received in evidence by a medical 5129
injury compensation panel with the same effect as if the 5130
stenographer were present and testified to the facts so 5131
certified. A copy of the transcript shall be furnished on demand 5132
to any party upon the payment of the fee therefor as provided 5133
for transcript in courts of common pleas. 5134

Sec. 3965.46. If any person fails to comply with a 5135
subpoena issued by or an order of a medical injury compensation 5136
panel or the administrator of medical injury compensation, or on 5137
the refusal of a witness to testify to any matter regarding 5138
which the witness may be lawfully interrogated, the probate 5139
judge of the county in which the person resides, on application 5140
of any member of the panel, the reviewing health care provider, 5141
or the administrator, shall compel obedience by attachment 5142
proceedings as for contempt, as in the case of disobedience of 5143
the requirements of subpoena issued from that court on a refusal 5144
to testify therein. 5145

Sec. 3965.47. Each officer who serves a subpoena issued 5146
under section 3965.44 of the Revised Code shall receive the same 5147
fees as a sheriff. Each witness who appears, in obedience to a 5148
subpoena, before a medical injury compensation panel, the 5149
administrator of medical injury compensation, or any inspector 5150
or examiner of the commission or administrator, shall receive 5151
the fees and mileage provided for under section 119.094 of the 5152
Revised Code. The fees shall be paid from the medical injury 5153
compensation center operating fund on the approval of the 5154
administrator. No witness subpoenaed at the instance of a party 5155

other than the persons listed in this section is entitled to 5156
compensation under this section unless the administrator 5157
certifies that the witness's testimony was material to the 5158
matter investigated. 5159

Sec. 3965.50. (A) Except as otherwise provided in section 5160
3965.54 of the Revised Code, each individual who suffers an 5161
injury arising out of the following events is entitled to 5162
compensation under this chapter and Chapter 3967. of the Revised 5163
Code, if it is determined that clear and convincing evidence 5164
does not exist that the provider did not breach the medical 5165
standard of care applicable to the claim: 5166

(1) The chiropractic diagnosis, care, or treatment of the 5167
individual; 5168

(2) The dental diagnosis, care, or treatment of the 5169
individual; 5170

(3) The medical diagnosis, care, or treatment of the 5171
individual; 5172

(4) The optometric diagnosis, care, or treatment of the 5173
individual. 5174

(B) A dependent of an individual whose death arises out of 5175
the services described under division (A) (1), (2), (3), or (4) 5176
of this section is entitled to compensation under this chapter 5177
and Chapter 3967. of the Revised Code if it is determined that 5178
clear and convincing evidence does not exist that the provider 5179
did not breach the medical standard of care applicable to the 5180
claim. 5181

Sec. 3965.51. (A) The right of an individual or the 5182
individual's dependents to compensation under this chapter is 5183
the exclusive remedy against a provider or the provider's 5184

liability insurer for any injury or death arising from any of 5185
the following: 5186

(1) The chiropractic diagnosis, care, or treatment of the 5187
individual; 5188

(2) The dental diagnosis, care, or treatment of the 5189
individual; 5190

(3) The medical diagnosis, care, or treatment of the 5191
individual; 5192

(4) The optometric diagnosis, care, or treatment of the 5193
individual. 5194

(B) Payment to an injured individual, or to the 5195
individual's dependents in case death has ensued, is in lieu of 5196
any and all rights of action against the provider who rendered 5197
the services described in division (A) of this section. 5198

(C) This section shall apply to any action brought against 5199
a provider by the health insurer of an individual, the employer 5200
of the individual, or any other person related to the injury 5201
that is the subject of the claim. 5202

Sec. 3965.52. Payments of compensation to a claimant or on 5203
behalf of a claimant as a result of any order issued under this 5204
chapter or Chapter 3967. of the Revised Code shall commence 5205
thirty days after the earlier of the following: 5206

(A) Fourteen days after the date the reviewing health care 5207
provider issues an order under section 3965.41 of the Revised 5208
Code, unless that order is appealed; 5209

(B) The date when the liability insurer of the provider 5210
listed in the claim has waived the right to appeal a decision 5211
issued under section 3965.41 of the Revised Code; 5212

(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; 5213
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5215

(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. 5216
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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. 5221
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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. 5229
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Sec. 3965.59. (A) The administrator of medical injury compensation shall do all of the following: 5233
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(1) Implement a program of impairment evaluation training for chiropractors, dentists, physicians, optometrists, and related professionals employed by the medical injury compensation center; 5235
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(2) Issue a policy manual covering impairment evaluation so as to increase consistency of medical reports; 5239
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(3) Develop a method of peer review of reports prepared by 5241

center referral chiropractors, dentists, physicians, 5242
optometrists, and related professionals; 5243

(4) Issue a policy manual as to the basis upon which 5244
referrals to other than center specialists will be made; 5245

(5) Designate two hearing examiners and two staff members 5246
who shall be specially trained in medical-legal analysis; 5247

(6) Require that prior to any examination a physician to 5248
whom a claimant is referred for examination receives all 5249
necessary medical information in the claim file about the 5250
claimant and a complete statement as to the purpose of the 5251
examination. 5252

(B) The policy manual created under division (A) (2) of 5253
this section shall be available to the public at cost but shall 5254
be provided free to all chiropractors, dentists, physicians, 5255
optometrists, and related professionals who treat claimants or 5256
to whom claimants are referred for evaluation. The administrator 5257
shall take steps to ensure that the manual receives the widest 5258
possible distribution to chiropractors, dentists, physicians, 5259
optometrists, and related professionals. 5260

(C) With respect to division (A) (5) of this section, the 5261
specialists shall write evaluations of medical-legal problems 5262
upon assignment by a reviewing health care provider or a medical 5263
injury compensation panel. The director of administrative 5264
services upon the advice of the administrator shall assign such 5265
employees to a salary schedule commensurate with expertise 5266
required of them. 5267

(D) The administrator may establish a medical section 5268
within the center to perform the duties assigned to the 5269
administrator under this section. 5270

Sec. 3965.60. (A) An actuary appointed by the 5271
administrator of medical injury compensation pursuant to section 5272
3965.41 of the Revised Code shall take the following factors 5273
into account when determining the amount of compensation awarded 5274
under this chapter or Chapter 3967. of the Revised Code: 5275

(1) All wages, salaries, or other compensation lost as a 5276
result of an injury, death, or loss to person or property that 5277
is a subject of a medical, dental, optometric, or chiropractic 5278
claim; 5279

(2) All expenditures for medical care or treatment, 5280
rehabilitation services, or other care, treatment, services, 5281
products, or accommodations as a result of an injury, death, or 5282
loss to person or property that is a subject of a medical, 5283
dental, optometric, or chiropractic claim; 5284

(3) Any other expenditures incurred as a result of an 5285
injury, death, or loss to person or property that is a subject 5286
of a medical, dental, optometric, or chiropractic claim, other 5287
than attorney's fees incurred in connection with that action; 5288

(4) With respect to a derivative claim, any nonpecuniary 5289
harm that results from an injury, death, or loss to person or 5290
property that is a subject of a medical, dental, optometric, or 5291
chiropractic claim, including pain and suffering, loss of 5292
society, consortium, companionship, care, assistance, attention, 5293
protection, advice, guidance, counsel, instruction, training, 5294
education, disfigurement, mental anguish, and any other 5295
intangible loss. 5296

(B) Except as provided in division (F) of section 3967.20 5297
of the Revised Code, compensation awarded under this chapter or 5298
Chapter 3967. of the Revised Code shall be reduced pursuant to 5299

division (C) of this section. 5300

(C) (1) The administrator shall have an actuary calculate 5301
the compensation modifier used in this section. To calculate the 5302
compensation modifier, the actuary shall do all of the 5303
following: 5304

(a) Not later than one year after the effective date of 5305
this section: 5306

(i) Determine the total cost of medical malpractice claims 5307
and services related to those claims during the two years 5308
immediately preceding the date on which the actuary makes the 5309
determination; 5310

(ii) Determine the projected total cost of medical 5311
malpractice claims and services related to those claims, during 5312
the two years immediately following the date on which the 5313
actuary makes the determination, and adjust those amounts to 5314
eliminate any increased cost due solely to inflation, in 5315
accordance with rules adopted by the administrator; 5316

(iii) If the amount determined in division (C) (1) (a) (ii) 5317
of this section is greater than the amount determined in 5318
division (C) (1) (a) (i) of this section, divide the lesser amount 5319
by the greater amount and report the quotient to the 5320
administrator. If the amount determined in division (C) (1) (a) 5321
(ii) of this section is less than the amount determined in 5322
division (C) (1) (a) (i) of this section, report the number one to 5323
the administrator. 5324

(b) Not earlier than two years or later than three years 5325
after the effective date of this section: 5326

(i) Determine the projected total costs of medical 5327
malpractice claims and services related to those claims during 5328

the three calendar years immediately preceding the date on which 5329
the actuary makes the determination; 5330

(ii) Determine the projected total costs of medical 5331
malpractice claims and services related to those claims during 5332
the three calendar years immediately following the date on which 5333
the actuary makes this determination and adjust those amounts to 5334
eliminate any increased cost due solely to inflation, in 5335
accordance with rules adopted by the administrator; 5336

(iii) If the amount determined in division (C) (1) (b) (ii) 5337
of this section is greater than the amount determined in 5338
division (C) (1) (b) (i) of this section, divide the lesser amount 5339
by the greater amount and report the quotient to the 5340
administrator. If the amount determined in division (C) (1) (b) 5341
(ii) of this section is less than the amount determined in 5342
division (C) (1) (b) (i) of this section, report the number one to 5343
the administrator. 5344

(c) Not earlier than four years or later than five years 5345
after the effective date of this section, and every five years 5346
thereafter: 5347

(i) Determine the total cost of medical malpractice claims 5348
and services related to those claims during the five years 5349
immediately preceding the date on which the actuary makes the 5350
determination; 5351

(ii) Determine the projected total costs of medical 5352
malpractice claims and services related to those claims during 5353
the five calendar years immediately following the date the 5354
administrator requests the determination and adjust those 5355
amounts to eliminate any increased cost due solely to inflation, 5356
in accordance with rules adopted by the administrator; 5357

(iii) If the amount determined in division (C) (1) (c) (ii) 5358
of this section is greater than the amount determined in 5359
division (C) (1) (c) (i) of this section, divide the lesser amount 5360
by the greater amount and report the quotient to the 5361
administrator. If the amount determined in division (C) (1) (c) 5362
(ii) of this section is less than the amount determined in 5363
division (C) (1) (c) (i) of this section, report the number one to 5364
the administrator. 5365

(2) An amount reported to the administrator under division 5366
(C) (1) of this section shall be the compensation modifier in 5367
effect for the period beginning on the first day of July 5368
immediately following the date the actuary reports the amount to 5369
the administrator and ending immediately after another 5370
compensation modifier takes effect pursuant to this section. 5371

(3) A reviewing health care provider or panel shall 5372
multiply the compensation awarded by the compensation modifier. 5373
The result shall be the amount of compensation to be paid for 5374
that claim. 5375

Sec. 3965.70. (A) The liability insurer of a provider 5376
listed in a claim filed under this chapter or the individual who 5377
filed the claim may file an application with the administrator 5378
of medical injury compensation for approval of a final 5379
settlement of a claim under this chapter. The application shall 5380
include the settlement agreement, and except as otherwise 5381
specified in this division, be signed by the claimant and the 5382
liability insurer, and clearly set forth the circumstances by 5383
reason of which the proposed settlement is considered desirable 5384
and that the parties agree to the terms of the settlement 5385
agreement. 5386

A claimant may file an application without a liability 5387

insurer's signature if the insurer is no longer doing business 5388
in this state. If a claimant files an application without a 5389
liability insurer's signature, and the insurer still is doing 5390
business in this state, the administrator shall send written 5391
notice of the application to the insurer immediately upon 5392
receipt of the application. If the liability insurer fails to 5393
respond to the notice within thirty days after the notice is 5394
sent, the application need not contain the liability insurer's 5395
signature. 5396

If a liability insurer or an individual has not filed an 5397
application for a final settlement under this division, the 5398
administrator may file an application on behalf of the liability 5399
insurer or the individual, provided that the administrator gives 5400
notice of the filing to the insurer and the individual and to 5401
the representative of record of the insurer and of the 5402
individual immediately upon the filing. An application filed by 5403
the administrator shall contain all of the information and 5404
signatures required of a liability insurer or an individual who 5405
files an application under this division. 5406

(B) Except as provided in divisions (C) and (D) of this 5407
section, a settlement agreed to under this section is binding 5408
upon all parties to it and as to items and injuries to which the 5409
settlement applies. 5410

(C) (1) No settlement agreed to under division (A) of this 5411
section shall take effect until thirty days after the 5412
administrator approves the settlement. During the thirty-day 5413
period, the liability insurer, individual, or administrator may 5414
withdraw consent to the settlement by: 5415

(a) A liability insurer providing written notice to the 5416
individual and the administrator; 5417

(b) An individual providing written notice to the 5418
liability insurer and the administrator; 5419

(c) The administrator providing written notice to the 5420
liability insurer and individual. 5421

(2) If an individual dies during the thirty-day waiting 5422
period following the approval of a settlement, the settlement 5423
can be voided by any party for good cause shown. 5424

(D) At the time of agreement to any final settlement 5425
agreement under division (A) of this section, the administrator 5426
immediately shall send a copy of the agreement to the reviewing 5427
health care provider who determined that the claim is 5428
compensable under this chapter. The reviewing health care 5429
provider shall determine, within the time limitations specified 5430
in division (C) of this section, whether the settlement 5431
agreement is or is not a gross miscarriage of justice. If the 5432
reviewing health care provider determines within that time 5433
period that the settlement agreement is clearly unfair, the 5434
reviewing health care provider shall issue an order disapproving 5435
the settlement agreement. If the reviewing health care provider 5436
determines that the settlement agreement is not clearly unfair 5437
or fails to act within those time limits, the settlement 5438
agreement is approved. 5439

(E) A settlement entered into under this section may 5440
pertain to one or more claims of a claimant, or one or more 5441
parts of a claim, or the compensation pertaining to either, or 5442
any combination thereof. Nothing in this section shall be 5443
interpreted to require a claimant to enter into a settlement 5444
agreement for each claim that has been filed with the medical 5445
injury compensation center by that claimant under this chapter. 5446

(F) A settlement entered into under this section is not 5447
appealable under sections 3967.10 to 3967.15 or 3967.20 of the 5448
Revised Code. 5449

Sec. 3965.71. Notwithstanding section 2315.21 of Revised 5450
Code, no punitive damages shall be awarded for any claim filed 5451
under this chapter or any appeal filed under Chapter 3967. of 5452
the Revised Code. 5453

Sec. 3965.75. (A) In determining the percentage of 5454
compensatory conduct attributable to a party in a claim filed 5455
under this chapter, the reviewing health care provider who 5456
determined that a claim is compensable under this chapter shall 5457
hold a hearing, make findings of fact, and issue an order that 5458
shall specify all of the following: 5459

(1) The percentage of compensatory conduct that 5460
proximately caused the injury or death that is attributable to 5461
each provider listed in a claim filed under this chapter for the 5462
same injury or death; 5463

(2) The percentage of compensatory conduct that 5464
proximately caused the injury or death that is attributable to 5465
each provider the claimant did not list in a claim filed under 5466
this chapter for the same injury or death. 5467

(B) The sum of the percentages of compensatory conduct as 5468
determined pursuant to division (A) of this section shall equal 5469
one hundred per cent. 5470

(C) For purposes of division (A) (2) of this section, it is 5471
an affirmative defense for the liability insurer of each 5472
provider listed in a claim filed under this chapter that a 5473
specific, positive percentage of the compensatory conduct that 5474
proximately caused the injury or death is attributable to one or 5475

more persons the claimant did not list in a claim filed under 5476
this chapter for the same injury or death. Any liability insurer 5477
of a provider listed in a claim may raise an affirmative defense 5478
under this division at any time before the hearing regarding the 5479
compensability of the claim. 5480

Sec. 3965.76. (A) Except as otherwise provided in sections 5481
2307.25 to 2307.28 of the Revised Code, if one or more persons 5482
are jointly and severally liable in a claim filed under this 5483
chapter for the same injury or death, a right of contribution 5484
may exist even though judgment has not been recovered against 5485
all or any of them. The right of contribution exists only in 5486
favor of a liability insurer of a provider who has paid more 5487
than that liability insurer's proportionate share of the common 5488
liability, and that liability insurer's total recovery is 5489
limited to the amount paid by that liability insurer in excess 5490
of that liability insurer's proportionate share. No liability 5491
insurer may be compelled to make contribution beyond that 5492
provider's own proportionate share of the common liability. 5493

(B) A liability insurer who enters into a settlement with 5494
a claimant under section 3965.70 of the Revised Code is not 5495
entitled to contribution from another liability insurer whose 5496
liability for the injury or death is not extinguished by the 5497
settlement, or in respect to any amount paid in a settlement 5498
that is in excess of what is reasonable. 5499

(C) If a liability insurer by payment has discharged in 5500
full or in part the liability of a provider and has discharged 5501
in full by the payment its obligation as insurer, that insurer 5502
is subrogated to the provider's right of contribution to the 5503
extent of the amount it has paid in excess of the provider's 5504
proportionate share of the common liability. This division does 5505

not limit or impair any right of subrogation arising from any 5506
other relationship. 5507

(D) This section does not impair any right of indemnity 5508
under existing law. If one liability insurer of a provider 5509
listed in a claim is entitled to indemnity from another, the 5510
right of the indemnity obligee is for indemnity and not 5511
contribution, and the indemnity obligor is not entitled to 5512
contribution from the obligee for any portion of the indemnity 5513
obligation. 5514

(E) The proportionate shares of providers in the common 5515
liability shall be based upon their relative degrees of legal 5516
responsibility. If equity requires the collective liability of 5517
some as a group, the group shall constitute a single share, and 5518
principles of equity applicable to contribution generally shall 5519
apply. 5520

(F) Regardless of whether an order has been issued in a 5521
claim filed under this chapter that lists two or more providers 5522
for the same injury or death, contribution may be enforced by 5523
separate action filed in a court of appropriate jurisdiction. 5524

Sec. 3965.77. If an order that imposes joint and several 5525
liability has been issued in a claim filed under this chapter 5526
against one or more liability insurers for the same injury or 5527
death, contribution may be enforced in that claim by an order in 5528
favor of one against other liability insurers, by a court of 5529
appropriate jurisdiction. If there is a determination for the 5530
injury or death against the liability insurer seeking 5531
contribution, that liability insurer shall file a claim for 5532
contribution in a court of appropriate jurisdiction to enforce 5533
contribution within one year after the order has become final by 5534
lapse of time for appeal or after appellate review. 5535

If no determination is made for the injury or death 5536
against the liability insurer seeking contribution, that 5537
liability insurer's right of contribution is barred unless 5538
either of the following applies: 5539

(A) That liability insurer has discharged by payment the 5540
common liability within the statute of limitations period 5541
applicable to the claimant's right of action against the 5542
provider listed in the claim and has commenced that liability 5543
insurer's claim for contribution within one year after the 5544
payment. 5545

(B) That liability insurer has agreed while a claim is 5546
pending against that liability insurer to discharge the common 5547
liability and has paid within one year after the agreement the 5548
common liability and commenced that liability insurer's claim 5549
for contribution. 5550

Sec. 3965.78. The recovery of an order for an injury or 5551
death in a claim filed under this chapter against the liability 5552
insurer of one provider does not of itself discharge the 5553
liability insurers of other providers from liability for the 5554
injury or death unless the order is satisfied. The satisfaction 5555
of the order does not impair any right of contribution. 5556

Sec. 3965.80. (A) Sections 2305.23, 2305.231, 2305.234, 5557
and 2305.235 of the Revised Code apply to claims filed under 5558
this chapter. 5559

(B) Section 2317.54 of the Revised Code applies to a claim 5560
filed under this chapter. 5561

Sec. 3967.01. (A) The definitions located in section 5562
3965.01 of the Revised Code apply to this chapter. 5563

(B) As used in the Revised Code, "medical injury 5564

compensation panel" means a panel established pursuant to 5565
section 3967.02 of the Revised Code. 5566

Sec. 3967.02. For the purpose of hearing an appeal of a 5567
claim filed under Chapter 3965. of the Revised Code, the 5568
administrator of medical injury compensation shall appoint a 5569
medical injury compensation panel consisting of providers. The 5570
administrator shall select the panel membership in the same 5571
manner as a reviewing health care provider is appointed under 5572
section 3965.40 of the Revised Code, except that the 5573
administrator may select a provider with a specialty based upon 5574
the nature of the claim. The reviewing health care provider who 5575
determined the compensability of a claim under Chapter 3965. of 5576
the Revised Code shall not serve as a member of a panel that is 5577
hearing the appeal of that claim. A provider selected to serve 5578
on the panel shall serve a term in accordance with section 5579
3965.40 of the Revised Code. The administrator, at the time a 5580
panel membership is selected, shall select one panel member to 5581
serve as chairperson of that panel. The chairperson, in 5582
consultation with the administrator, shall establish all hearing 5583
dates and times necessary for an appeal. The administrator shall 5584
provide administrative support and facilities for a panel to 5585
conduct its business. A majority of a panel constitutes a quorum 5586
to conduct business. 5587

Sec. 3967.03. The attorney general shall be the legal 5588
advisor for a medical injury compensation panel. 5589

Sec. 3967.05. A medical injury compensation panel shall 5590
have original jurisdiction over all appeals from a decision of a 5591
reviewing health care provider under section 3965.41 of the 5592
Revised Code and the determination of the amount of 5593
compensation, if any, awarded pursuant to that section. Members 5594

of a panel shall not engage in any other activity that 5595
interferes with their service on the panel during normal working 5596
hours. 5597

Sec. 3967.06. (A) The administrator of medical injury 5598
compensation shall adopt rules as to the conduct of all hearings 5599
before a medical injury compensation panel and the rendering of 5600
a decision. The administrator shall focus these rules on 5601
managing, directing, and otherwise ensuring a fair, equitable, 5602
and uniform hearing process. These rules shall provide for at 5603
least the following steps and procedures: 5604

(1) Adequate notice to all parties and their 5605
representatives to ensure that no hearing is conducted unless 5606
all parties have the opportunity to be present and to present 5607
evidence and arguments in support of their positions or in 5608
rebuttal to the evidence or arguments of other parties; 5609

(2) A public hearing; 5610

(3) Written decisions; 5611

(4) Impartial assignment of members of a panel and 5612
assignment of appeals from a decision of a reviewing health care 5613
provider to a panel; 5614

(5) Publication of a docket; 5615

(6) The securing of the attendance or testimony of 5616
witnesses; 5617

(7) Prehearing rules, including rules relative to 5618
discovery, the taking of depositions, and exchange of 5619
information relevant to a claim prior to the conduct of a 5620
hearing; 5621

(8) The issuance of orders by the panel that renders the 5622

decision. 5623

(B) Each decision by a panel shall be in writing and 5624
contain all of the following elements: 5625

(1) A concise statement of the order or award; 5626

(2) A notation as to notice provided and as to appearance 5627
of parties; 5628

(3) Signatures of each panel member on the original copy 5629
of the decision only, verifying the member's vote; 5630

(4) Description of the part of the body and nature of the 5631
disability recognized in the claim. 5632

(C) The administrator shall adopt rules that ensure that 5633
no panel hears a claim unless all interested and affected 5634
parties have the opportunity to be present and to present 5635
evidence and arguments in support of their positions or in 5636
rebuttal to the evidence or arguments of other parties. 5637

(D) All matters that, at the request of one of the parties 5638
or on the initiative of the administrator and any panel member, 5639
are to be expedited shall be given at least forty-eight hours' 5640
notice and a public hearing and shall include a statement in any 5641
order issued of the circumstances that justified an expeditious 5642
hearing. 5643

(E) All hearings held by a panel shall be public with 5644
adequate notice, including, if necessary, notice to the 5645
claimant, the provider's liability insurer, their 5646
representatives, and the administrator. Confidentiality of 5647
medical evidence presented at a hearing does not constitute a 5648
sufficient ground to relieve the requirement of a public 5649
hearing, but the presentation of privileged or confidential 5650

evidence shall not create any greater right of public inspection 5651
of evidence than presently exists. 5652

(F) The administrator shall compile all of each panel's 5653
original memoranda, orders, and decisions in a journal and make 5654
the journal available to the public with sufficient indexing to 5655
allow orderly review of documents. The journal shall indicate 5656
the vote of each panel member. 5657

(G)(1) All original orders, rules, memoranda, and 5658
decisions of a panel shall contain the signatures of two of the 5659
three panel members and state whether the order, rule, 5660
memorandum, or decision was adopted at a meeting of the panel or 5661
by circulation to individual panel members. Any facsimile or 5662
secretarial signature, initials of panel members, and any 5663
printed record of the "yes" and "no" vote of a panel member on 5664
that original is invalid. 5665

(2) Written copies of final decisions of reviewing health 5666
care providers or panel members that are mailed to the 5667
administrator, claimant, provider, the provider's liability 5668
insurer, and their respective representatives need not contain 5669
the signatures of the panel members if the panel members have 5670
complied with divisions (B)(3) and (G)(1) of this section. 5671

(H) The administrator shall appoint an individual as a 5672
hearing officer trainer who is in the unclassified civil service 5673
of the state and who serves at the pleasure of the 5674
administrator. The trainer shall be an attorney admitted to the 5675
practice of law in this state and have experience in training or 5676
education, and the ability to furnish the necessary training for 5677
reviewing health care providers and panel members. The hearing 5678
officer trainer shall develop and periodically update a training 5679
manual and any other training materials and courses as will 5680

adequately prepare reviewing health care providers and panel 5681
members for their duties under this chapter and Chapter 3965. of 5682
the Revised Code. All reviewing health care providers and panel 5683
members shall undergo the training courses developed by the 5684
hearing officer trainer, the cost of which the administrator 5685
shall pay. The administrator shall make the hearing manual and 5686
all revisions thereto available to the public at cost. The 5687
administrator shall have the final right of approval over all 5688
training manuals, courses, and other materials the hearing 5689
officer trainer develops and updates. 5690

(I) The administrator shall appoint a hearing 5691
administrator, who shall be in the classified civil service of 5692
the state, and sufficient support personnel for each hearing 5693
administrator. The support personnel shall be under the direct 5694
supervision of the hearing administrator. The hearing 5695
administrator shall do all of the following: 5696

(1) Provide information to requesting parties or their 5697
representatives on the status of their claim; 5698

(2) Issue compliance letters, upon a finding of good cause 5699
and without a formal hearing in all of the following areas: 5700

(a) Requests for the taking of depositions of medical 5701
injury compensation center physicians; 5702

(b) The issuance of subpoenas; 5703

(c) The granting or denying of requests for continuances; 5704

(d) Matters involving section 3967.24 of the Revised Code; 5705

(e) Requests for conducting telephone prehearing 5706
conferences; 5707

(f) Any other matter that will cause a free exchange of 5708

information prior to the formal hearing. 5709

(3) Take the necessary steps to prepare a claim to proceed 5710
to a hearing where the parties agree and advise the hearing 5711
administrator that the claim is not ready for a hearing. 5712

(J) The administrator shall permit any person direct 5713
access to information contained in electronic data processing 5714
equipment regarding the status of a claim in the hearing 5715
process. The information shall indicate the number of days that 5716
the claim has been in process, the number of days the claim has 5717
been in its current location, and the number of days in the 5718
current point of the process within that location. 5719

(K) (1) The administrator may establish an alternative 5720
dispute resolution process for claims that are within a panel's 5721
jurisdiction under this chapter when the administrator 5722
determines that such a process is necessary. The administrator 5723
may enter into personal service contracts with individuals who 5724
are qualified because of their education and experience to act 5725
as facilitators in the panel's alternative dispute resolution 5726
process. 5727

(2) The parties' use of the alternative dispute resolution 5728
process is voluntary, and requires the agreement of all 5729
necessary parties. The use of the alternative dispute resolution 5730
process does not alter the rights or obligations of the parties, 5731
nor does it delay the timelines set forth in sections 3967.10 5732
and 3967.15 of the Revised Code. 5733

(3) The administrator shall prepare reports every six 5734
months and submit those reports to the governor, the president 5735
of the senate, and the speaker of the house of representatives 5736
describing all of the following: 5737

<u>(a) The names of each facilitator employed under a</u>	5738
<u>personal service contract;</u>	5739
<u>(b) The hourly amount of money and the total amount of</u>	5740
<u>money paid to each facilitator;</u>	5741
<u>(c) The number of disputed issues resolved during that</u>	5742
<u>month by each facilitator;</u>	5743
<u>(d) The number of decisions of each facilitator that were</u>	5744
<u>appealed by a party;</u>	5745
<u>(e) A certification by the administrator that the</u>	5746
<u>alternative dispute resolution process did not delay any hearing</u>	5747
<u>timelines as set forth in sections 3967.10 and 3967.15 of the</u>	5748
<u>Revised Code for any disputed issue.</u>	5749
<u>(4) The administrator may adopt rules in accordance with</u>	5750
<u>Chapter 119. of the Revised Code for the administration of any</u>	5751
<u>alternative dispute resolution process that the administrator</u>	5752
<u>establishes.</u>	5753
<u>Sec. 3967.07. A reviewing health care provider or a</u>	5754
<u>medical injury compensation panel is not bound by the usual</u>	5755
<u>common law or statutory rules of evidence or by any technical or</u>	5756
<u>formal rules of procedure, other than as provided in this</u>	5757
<u>chapter and Chapter 3965. of the Revised Code. The provider or</u>	5758
<u>panel may make an investigation in such manner as in the</u>	5759
<u>provider's or panel's judgment is best calculated to ascertain</u>	5760
<u>the substantial rights of the parties and to carry out justly</u>	5761
<u>the spirit of those chapters.</u>	5762
<u>Sec. 3967.10. A liability insurer of a provider listed in</u>	5763
<u>a claim filed under Chapter 3965. of the Revised Code or a</u>	5764
<u>claimant may appeal an order issued pursuant to section 3965.41</u>	5765
<u>of the Revised Code within fourteen days after the date of the</u>	5766

receipt of the order. The liability insurer of the provider and 5767
the claimant may waive, in writing, their rights to an appeal 5768
under this section. The administrator of medical injury 5769
compensation shall select a medical injury compensation panel in 5770
accordance with section 3967.02 of the Revised Code within 5771
twenty-eight days after receiving the appeal request. Each 5772
notice of an appeal from an order issued under section 3965.41 5773
of the Revised Code shall state the names of the claimant and 5774
the liability insurer of the provider listed in the claim, the 5775
number of the claim, the date of the decision appealed from, and 5776
the fact that the appellant appeals the order. Except as 5777
otherwise provided in section 3967.24 of the Revised Code, an 5778
appeal is timely filed under this section only if the appeal is 5779
filed within the time limits set forth in this section. 5780

Sec. 3967.11. A medical injury compensation panel shall 5781
hold a hearing within forty-five days after the last member of 5782
the panel is selected in accordance with section 3967.02 of the 5783
Revised Code. The administrator of medical injury compensation, 5784
on behalf of the panel, shall notify the parties and their 5785
representatives of the time and place of the hearing. All of the 5786
following apply to a hearing before a medical injury 5787
compensation panel: 5788

(A) The parties shall proceed promptly and without 5789
continuances except for good cause. 5790

(B) The parties, in good faith, shall engage in the free 5791
exchange of information relevant to the claim prior to the 5792
conduct of a hearing according to the rules the administrator 5793
adopts under section 3967.06 of the Revised Code. 5794

(C) A panel shall hear an appeal de novo and shall make a 5795
decision using the standard described in section 3965.41 of the 5796

Revised Code. 5797

Sec. 3967.12. The sessions of a medical injury 5798
compensation panel shall be open to the public and shall stand 5799
and be adjourned without further notice thereof on its record. 5800
All of the proceedings of a panel shall be shown on its record, 5801
which shall be a public record except as provided in section 5802
3965.24 of the Revised Code. All voting shall be had by calling 5803
the name of each member of the panel by the administrator of 5804
medical injury compensation, and each member's vote shall be 5805
recorded on the record of proceedings as cast. The administrator 5806
shall keep a separate record of each panel's proceedings 5807
relative to claims coming before it for compensation for injured 5808
individuals and the dependents of deceased individuals. That 5809
record shall contain the panel's findings and the award in each 5810
such claim for compensation considered by the panel, and in all 5811
such claims the panel shall state in the record the reasons for 5812
the allowance or rejection of the claim. 5813

Sec. 3967.13. A medical injury compensation panel 5814
appointed to hear an appeal filed under this chapter may 5815
commission independent medical experts as the panel determines 5816
necessary to determine the compensability of the claim that is 5817
appealed. The panel shall comply with section 3965.43 of the 5818
Revised Code with respect to any expert witness commissioned by 5819
the panel. 5820

Sec. 3967.14. A claimant or the liability insurer of a 5821
provider listed in a claim filed under Chapter 3965. of the 5822
Revised Code, at a hearing before a medical injury compensation 5823
panel selected pursuant to this chapter, may each submit the 5824
following to the panel: 5825

(A) A statement regarding the claim; 5826

(B) An expert witness report.

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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.

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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.

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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

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appellant shall file the notice of appeal with a court of common 5857
pleas within sixty days after the date of the receipt of the 5858
order that the appellant is appealing. The filing of the notice 5859
of the appeal with the court is the only act required to perfect 5860
the appeal. 5861

If an action has been commenced in a court of a county 5862
other than a court of a county having jurisdiction over the 5863
action, the court, upon notice by any party or upon its own 5864
motion, shall transfer the action to a court of a county having 5865
jurisdiction. Notwithstanding anything to the contrary in this 5866
section, if the panel determines under section 3967.24 of the 5867
Revised Code that a claimant, liability insurer, or their 5868
respective representatives have not received written notice of 5869
an order or decision that is appealable to a court under this 5870
section and if the panel determines under section 3967.24 of the 5871
Revised Code that the party is entitled to appeal, the party has 5872
sixty days from receipt of the order under section 3967.24 of 5873
the Revised Code to file a notice of appeal under this section. 5874

(B) The notice of appeal shall state the names of the 5875
claimant and the liability insurer of the provider listed in the 5876
claim, the number of the claim, the date of the order appealed 5877
from, and the fact that the appellant appeals therefrom. The 5878
liability insurer of the provider listed in the claim and the 5879
claimant shall be parties to the appeal and the court, upon the 5880
application of the panel, shall make the panel a party. The 5881
party filing the appeal shall serve a copy of the notice of 5882
appeal on the administrator of medical injury compensation at 5883
the central office of the medical injury compensation center in 5884
Columbus. 5885

(C) The attorney general or one or more of the attorney 5886

general's assistants or special counsel designated by the 5887
attorney general shall represent the panel. In the event the 5888
attorney general or the attorney general's designated assistants 5889
or special counsel are absent, the administrator shall select 5890
one or more of the attorneys in the employ of the administrator 5891
as the panel's attorney in the appeal. Any attorney so employed 5892
shall continue the representation during the entire period of 5893
the appeal and in all hearings thereof except where the 5894
continued representation becomes impractical. 5895

(D) Upon receipt of a notice of appeal, the clerk of 5896
courts shall provide notice to all parties who are appellees and 5897
to the panel. The appellant shall, within thirty days after the 5898
filing of the notice of appeal, file a petition containing a 5899
statement of facts in ordinary and concise language explaining 5900
why the claim is or is not a compensable claim and setting forth 5901
the basis for the jurisdiction of the court over the action. 5902
Further pleadings shall be had in accordance with the Rules of 5903
Civil Procedure. The clerk of the court shall, upon receipt 5904
thereof, transmit by certified mail a copy thereof to each party 5905
named in the notice of appeal other than the claimant. Any party 5906
may file with the clerk prior to the trial of the action a 5907
deposition of any physician taken in accordance with the 5908
provisions of the Revised Code. That deposition may be read in 5909
the trial of the action even though the physician is a resident 5910
of or subject to service in the county in which the trial is 5911
held. The administrator shall pay the cost of the stenographic 5912
deposition filed in court and of copies of the stenographic 5913
deposition for each party and charge the costs thereof against 5914
the unsuccessful party if the claimant's right to having a 5915
compensable claim is finally sustained or established in the 5916
appeal. In the event the deposition is taken and filed, the 5917

physician whose deposition is taken is not required to respond 5918
to any subpoena issued in the trial of the action. The court, or 5919
the jury under the instructions of the court, if a jury is 5920
demanding, shall determine the compensability of the claim upon 5921
the evidence adduced at the hearing of the action. 5922

(E) The court shall certify its decision to the panel and 5923
the certificate shall be entered in the records of the court. 5924
Appeals from the judgment are governed by the law applicable to 5925
the appeal of civil actions. 5926

(F) If a liability insurer appeals an order of the panel 5927
and the claimant's claim is determined to be compensable upon 5928
the final determination of the appeal, the award shall not be 5929
reduced by the compensation modifier under division (C) of 5930
section 3965.60 of the Revised Code. 5931

(G) If the finding of the court or the verdict of the jury 5932
is that the claim is compensable, the panel and the 5933
administrator shall thereafter proceed in the matter of the 5934
claim as if the judgment were the decision of the panel. 5935

(H) An appeal from an order issued under section 3967.15 5936
of the Revised Code or any action filed in court in a case in 5937
which an award of compensation has been made shall stay the 5938
payment of compensation under the award during the pendency of 5939
the appeal. 5940

(I) All actions and proceedings under this section that 5941
are the subject of an appeal to the court of common pleas or the 5942
court of appeals shall be preferred over all other civil actions 5943
except election causes, regardless of position on the calendar. 5944

Sec. 3967.23. In the case of an appeal by a liability 5945
insurer of a provider listed in a claim filed under Chapter 5946

3965. of the Revised Code to a medical injury compensation panel 5947
selected under section 3965.40 of the Revised Code or to a court 5948
of common pleas, if upon deciding the appeal the panel or the 5949
court finds that the liability insurer appealed for the purpose 5950
of delay or other vexatious reason and without reasonable 5951
ground, the panel or the court may assess against the liability 5952
insurer attorney's fees and a sum not exceeding ten per cent of 5953
the total amount of the award in question as may be reasonable 5954
in the circumstances. 5955

Sec. 3967.24. A claimant, the liability insurer of a 5956
provider listed in a claim filed under Chapter 3965. of the 5957
Revised Code, and their respective representatives are entitled 5958
to written notice of any hearing, determination, order, award, 5959
or decision under this chapter. A claimant or insurer is 5960
considered not to have received notice until the notice is 5961
received from the panel or the administrator by both the 5962
claimant and the claimant's representative of record and by the 5963
insurer. 5964

If any person to whom a notice is mailed fails to receive 5965
the notice and if the panel, upon hearing, determines that the 5966
failure was due to cause beyond the control and without the 5967
fault or neglect of the person or the person's representative 5968
and that the person or representative did not have actual 5969
knowledge of the import of the information contained in the 5970
notice, the person may take the action afforded to the person 5971
within twenty-one days after the receipt of the notice of the 5972
determination of the panel. Delivery of the notice to the 5973
address of the person or the person's representative is prima 5974
facie evidence of receipt of the notice by the person. 5975

Sec. 3967.27. (A) The administrator of medical injury 5976

compensation may adopt rules in accordance with Chapter 119. of 5977
the Revised Code to do both of the following: 5978

(1) Provide for the destruction of files of cases in which 5979
no further action may be taken; 5980

(2) Provide for the retention and destruction of all other 5981
records in the administrator's possession or under the 5982
administrator's control pursuant to section 121.211 and sections 5983
149.34 to 149.36 of the Revised Code. 5984

(B) The medical injury compensation center may purchase or 5985
rent required equipment for the document retention media, as 5986
determined necessary to preserve the records. Photographs, 5987
microphotographs, microfilm, films, or other direct document 5988
retention media, when properly identified, have the same effect 5989
as the original record and may be offered in like manner and may 5990
be received as evidence in proceedings before a medical injury 5991
compensation panel and in any court where the original record 5992
could have been introduced. 5993

Sec. 3967.32. (A) In any claim regarding a medical, 5994
dental, optometric, chiropractic, or derivative claim, the 5995
liability insurer of a provider listed in the claim may 5996
introduce evidence of any amount payable as a benefit to the 5997
claimant as a result of the damages that result from an injury, 5998
death, or loss to person or property that is the subject of the 5999
claim, except if the source of collateral benefits has a 6000
mandatory self-effectuating federal right of subrogation, a 6001
contractual right of subrogation, or a statutory right of 6002
subrogation. 6003

(B) If the liability insurer elects to introduce evidence 6004
described in division (A) of this section, the claimant may 6005

introduce evidence of any amount that the claimant has paid or 6006
contributed to secure the claimant's right to receive the 6007
benefits of which the liability insurer has introduced evidence. 6008

(C) A source of collateral benefits of which evidence is 6009
introduced pursuant to division (A) of this section shall not 6010
recover any amount against the claimant nor shall it be 6011
subrogated to the rights of the claimant against the liability 6012
insurer of a provider. 6013

Sec. 3967.40. No person, other than an attorney admitted 6014
to the practice of law in this state, who solicits claims or who 6015
causes claims to be solicited shall be allowed to practice, or 6016
represent parties, before a medical injury compensation panel. 6017
An attorney admitted to the practice of law in this state shall 6018
comply with the rules of professional conduct adopted by the 6019
supreme court. 6020

Sec. 3967.42. (A) As used in this section: 6021

(1) "False" means wholly or partially untrue or deceptive. 6022

(2) "Goods" includes medical supplies, appliances, 6023
rehabilitative equipment, and any other apparatus or furnishing 6024
provided or used in the care, treatment, or rehabilitation of a 6025
claimant. 6026

(3) "Services" includes any service provided by any health 6027
care provider to a claimant and any and all services provided by 6028
the center or a liability insurer as part of liability insurance 6029
coverage. 6030

(4) "Remuneration" includes wages, commissions, rebates, 6031
and any other reward or consideration. 6032

(5) "Statement" includes any oral, written, electronic, 6033

electronic impulse, or magnetic communication notice, letter, 6034
memorandum, receipt for payment, invoice, account, financial 6035
statement, or bill for services; a diagnosis, prognosis, 6036
prescription, hospital, medical, or dental chart or other 6037
record; and a computer-generated document. 6038

(6) "Records" means any medical, professional, financial, 6039
or business record relating to the treatment or care of any 6040
person, to goods or services provided to any person, or to rates 6041
paid for goods or services provided to any person, or any record 6042
that the administrator of medical injury compensation requires 6043
pursuant to rule. 6044

(B) No person, with purpose to defraud or knowing that the 6045
person is facilitating a fraud, shall do any of the following: 6046

(1) Receive compensation under this chapter or Chapter 6047
3965. of the Revised Code to which the person is not entitled; 6048

(2) Make or present or cause to be made or presented a 6049
false or misleading statement with the purpose to secure payment 6050
for goods or services rendered under this chapter or Chapter 6051
3965. of the Revised Code or to secure compensation under those 6052
chapters; 6053

(3) Alter, falsify, destroy, conceal, or remove any record 6054
or document that is necessary to fully establish the validity of 6055
any claim filed with, or necessary to establish the nature and 6056
validity of all goods and services for which reimbursement or 6057
payment was received or is requested from, the medical injury 6058
compensation center or a liability insurer under this chapter or 6059
Chapter 3965. of the Revised Code; 6060

(4) Enter into an agreement or conspiracy to defraud the 6061
center or insurer by making or presenting or causing to be made 6062

or presented a false claim for compensation. 6063

(C) Whoever violates this section is guilty of medical 6064
injury compensation fraud. 6065

(D) Upon application of the governmental body that 6066
conducted the investigation and prosecution of a violation of 6067
this section, the court shall order the person who is convicted 6068
of the violation to pay the governmental body its costs of 6069
investigating and prosecuting the case. These costs are in 6070
addition to any other costs or penalty provided in the Revised 6071
Code or any other section of law. 6072

(E) The remedies and penalties provided in this section 6073
are not exclusive remedies and penalties and do not preclude the 6074
use of any other criminal or civil remedy or penalty for any act 6075
that is in violation of this section. 6076

Sec. 3967.99. Except as otherwise provided in this 6077
section, a violation of division (B) of section 3967.42 of the 6078
Revised Code is a misdemeanor of the first degree. If the value 6079
of the goods, services, property, or money stolen is one 6080
thousand dollars or more and is less than seven thousand five 6081
hundred dollars, the violation is a felony of the fifth degree. 6082
If the value of the goods, services, property, or money stolen 6083
is seven thousand five hundred dollars or more and is less than 6084
one hundred fifty thousand dollars, the violation is a felony of 6085
the fourth degree. If the value of the goods, services, 6086
property, or money stolen is one hundred fifty thousand dollars 6087
or more, the violation of that section is a felony of the third 6088
degree. 6089

Sec. 4715.30. (A) An applicant for or holder of a 6090
certificate or license issued under this chapter is subject to 6091

disciplinary action by the state dental board for any of the 6092
following reasons: 6093

(1) Employing or cooperating in fraud or material 6094
deception in applying for or obtaining a license or certificate; 6095

(2) Obtaining or attempting to obtain money or anything of 6096
value by intentional misrepresentation or material deception in 6097
the course of practice; 6098

(3) Advertising services in a false or misleading manner 6099
or violating the state dental board's rules governing time, 6100
place, and manner of advertising; 6101

(4) Commission of an act that constitutes a felony in this 6102
state, regardless of the jurisdiction in which the act was 6103
committed; 6104

(5) Commission of an act in the course of practice that 6105
constitutes a misdemeanor in this state, regardless of the 6106
jurisdiction in which the act was committed; 6107

(6) Conviction of, a plea of guilty to, a judicial finding 6108
of guilt of, a judicial finding of guilt resulting from a plea 6109
of no contest to, or a judicial finding of eligibility for 6110
intervention in lieu of conviction for, any felony or of a 6111
misdemeanor committed in the course of practice; 6112

(7) Engaging in lewd or immoral conduct in connection with 6113
the provision of dental services; 6114

(8) Selling, prescribing, giving away, or administering 6115
drugs for other than legal and legitimate therapeutic purposes, 6116
or conviction of, a plea of guilty to, a judicial finding of 6117
guilt of, a judicial finding of guilt resulting from a plea of 6118
no contest to, or a judicial finding of eligibility for 6119

intervention in lieu of conviction for, a violation of any 6120
federal or state law regulating the possession, distribution, or 6121
use of any drug; 6122

(9) Providing or allowing dental hygienists, expanded 6123
function dental auxiliaries, or other practitioners of auxiliary 6124
dental occupations working under the certificate or license 6125
holder's supervision, or a dentist holding a temporary limited 6126
continuing education license under division (C) of section 6127
4715.16 of the Revised Code working under the certificate or 6128
license holder's direct supervision, to provide dental care that 6129
departs from or fails to conform to accepted standards for the 6130
profession, whether or not injury to a patient results; 6131

(10) Inability to practice under accepted standards of the 6132
profession because of physical or mental disability, dependence 6133
on alcohol or other drugs, or excessive use of alcohol or other 6134
drugs; 6135

(11) Violation of any provision of this chapter or any 6136
rule adopted thereunder; 6137

(12) Failure to use universal blood and body fluid 6138
precautions established by rules adopted under section 4715.03 6139
of the Revised Code; 6140

(13) Except as provided in division (H) of this section, 6141
either of the following: 6142

(a) Waiving the payment of all or any part of a deductible 6143
or copayment that a patient, pursuant to a health insurance or 6144
health care policy, contract, or plan that covers dental 6145
services, would otherwise be required to pay if the waiver is 6146
used as an enticement to a patient or group of patients to 6147
receive health care services from that certificate or license 6148

holder; 6149

(b) Advertising that the certificate or license holder 6150
will waive the payment of all or any part of a deductible or 6151
copayment that a patient, pursuant to a health insurance or 6152
health care policy, contract, or plan that covers dental 6153
services, would otherwise be required to pay. 6154

(14) Failure to comply with section 4715.302 or 4729.79 of 6155
the Revised Code, unless the state board of pharmacy no longer 6156
maintains a drug database pursuant to section 4729.75 of the 6157
Revised Code; 6158

(15) Any of the following actions taken by an agency 6159
responsible for authorizing, certifying, or regulating an 6160
individual to practice a health care occupation or provide 6161
health care services in this state or another jurisdiction, for 6162
any reason other than the nonpayment of fees: the limitation, 6163
revocation, or suspension of an individual's license to 6164
practice; acceptance of an individual's license surrender; 6165
denial of a license; refusal to renew or reinstate a license; 6166
imposition of probation; or issuance of an order of censure or 6167
other reprimand; 6168

(16) Failure to cooperate in an investigation conducted by 6169
the state dental board under division (D) of section 4715.03 of 6170
the Revised Code or by the health care professional standards 6171
board under section 4746.04 of the Revised Code, including 6172
failure to comply with a subpoena or order issued by ~~the either~~ 6173
board or failure to answer truthfully a question presented by 6174
~~the either~~ board at a deposition or in written interrogatories, 6175
except that failure to cooperate with an investigation shall not 6176
constitute grounds for discipline under this section if a court 6177
of competent jurisdiction has issued an order that either 6178

quashes a subpoena or permits the individual to withhold the testimony or evidence in issue; 6179
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(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. 6181
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(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. 6184
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(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: 6192
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(1) Censure the license or certificate holder; 6196

(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: 6197
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(a) Report regularly to the state dental board upon the matters which are the basis of probation; 6200
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(b) Limit practice to those areas specified by the state dental board; 6202
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(c) Continue or renew professional education until a satisfactory degree of knowledge or clinical competency has been attained in specified areas. 6204
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(3) Suspend the certificate or license; 6207

(4) Revoke the certificate or license. 6208

Where the state dental board places a holder of a license 6209
or certificate on probationary status pursuant to division (C) 6210
(2) of this section, the board may subsequently suspend or 6211
revoke the license or certificate if it determines that the 6212
holder has not met the requirements of the probation or 6213
continues to engage in activities that constitute grounds for 6214
discipline pursuant to division (A) or (B) of this section. 6215

Any order suspending a license or certificate shall state 6216
the conditions under which the license or certificate will be 6217
restored, which may include a conditional restoration during 6218
which time the holder is in a probationary status pursuant to 6219
division (C)(2) of this section. The state dental board shall 6220
restore the license or certificate unconditionally when such 6221
conditions are met. 6222

(D) If the physical or mental condition of an applicant or 6223
a license or certificate holder is at issue in a disciplinary 6224
proceeding, the state dental board may order the license or 6225
certificate holder to submit to reasonable examinations by an 6226
individual designated or approved by the board and at the 6227
board's expense. The physical examination may be conducted by 6228
any individual authorized by the Revised Code to do so, 6229
including a physician assistant, a clinical nurse specialist, a 6230
certified nurse practitioner, or a certified nurse-midwife. Any 6231
written documentation of the physical examination shall be 6232
completed by the individual who conducted the examination. 6233

Failure to comply with an order for an examination shall 6234
be grounds for refusal of a license or certificate or summary 6235

suspension of a license or certificate under division (E) of 6236
this section. 6237

(E) If a license or certificate holder has failed to 6238
comply with an order under division (D) of this section, the 6239
state dental board may apply to the court of common pleas of the 6240
county in which the holder resides for an order temporarily 6241
suspending the holder's license or certificate, without a prior 6242
hearing being afforded by the board, until the board conducts an 6243
adjudication hearing pursuant to Chapter 119. of the Revised 6244
Code. If the court temporarily suspends a holder's license or 6245
certificate, the board shall give written notice of the 6246
suspension personally or by certified mail to the license or 6247
certificate holder. Such notice shall inform the license or 6248
certificate holder of the right to a hearing pursuant to Chapter 6249
119. of the Revised Code. 6250

(F) Any holder of a certificate or license issued under 6251
this chapter who has pleaded guilty to, has been convicted of, 6252
or has had a judicial finding of eligibility for intervention in 6253
lieu of conviction entered against the holder in this state for 6254
aggravated murder, murder, voluntary manslaughter, felonious 6255
assault, kidnapping, rape, sexual battery, gross sexual 6256
imposition, aggravated arson, aggravated robbery, or aggravated 6257
burglary, or who has pleaded guilty to, has been convicted of, 6258
or has had a judicial finding of eligibility for treatment or 6259
intervention in lieu of conviction entered against the holder in 6260
another jurisdiction for any substantially equivalent criminal 6261
offense, is automatically suspended from practice under this 6262
chapter in this state and any certificate or license issued to 6263
the holder under this chapter is automatically suspended, as of 6264
the date of the guilty plea, conviction, or judicial finding, 6265
whether the proceedings are brought in this state or another 6266

jurisdiction. Continued practice by an individual after the 6267
suspension of the individual's certificate or license under this 6268
division shall be considered practicing without a certificate or 6269
license. The state dental board shall notify the suspended 6270
individual of the suspension of the individual's certificate or 6271
license under this division by certified mail or in person in 6272
accordance with section 119.07 of the Revised Code. If an 6273
individual whose certificate or license is suspended under this 6274
division fails to make a timely request for an adjudicatory 6275
hearing, the board shall enter a final order revoking the 6276
individual's certificate or license. 6277

(G) If the supervisory investigative panel determines both 6278
of the following, the panel may recommend that the state dental 6279
board suspend an individual's certificate or license without a 6280
prior hearing: 6281

(1) That there is clear and convincing evidence that an 6282
individual has violated division (A) of this section; 6283

(2) That the individual's continued practice presents a 6284
danger of immediate and serious harm to the public. 6285

Written allegations shall be prepared for consideration by 6286
the state dental board. The board, upon review of those 6287
allegations and by an affirmative vote of not fewer than four 6288
dentist members of the board and seven of its members in total, 6289
excluding any member on the supervisory investigative panel, may 6290
suspend a certificate or license without a prior hearing. A 6291
telephone conference call may be utilized for reviewing the 6292
allegations and taking the vote on the summary suspension. 6293

The state dental board shall issue a written order of 6294
suspension by certified mail or in person in accordance with 6295

section 119.07 of the Revised Code. The order shall not be 6296
subject to suspension by the court during pendency or any appeal 6297
filed under section 119.12 of the Revised Code. If the 6298
individual subject to the summary suspension requests an 6299
adjudicatory hearing by the board, the date set for the hearing 6300
shall be within fifteen days, but not earlier than seven days, 6301
after the individual requests the hearing, unless otherwise 6302
agreed to by both the board and the individual. 6303

Any summary suspension imposed under this division shall 6304
remain in effect, unless reversed on appeal, until a final 6305
adjudicative order issued by the board pursuant to this section 6306
and Chapter 119. of the Revised Code becomes effective. The 6307
state dental board shall issue its final adjudicative order 6308
within seventy-five days after completion of its hearing. A 6309
failure to issue the order within seventy-five days shall result 6310
in dissolution of the summary suspension order but shall not 6311
invalidate any subsequent, final adjudicative order. 6312

(H) Sanctions shall not be imposed under division (A) (13) 6313
of this section against any certificate or license holder who 6314
waives deductibles and copayments as follows: 6315

(1) In compliance with the health benefit plan that 6316
expressly allows such a practice. Waiver of the deductibles or 6317
copayments shall be made only with the full knowledge and 6318
consent of the plan purchaser, payer, and third-party 6319
administrator. Documentation of the consent shall be made 6320
available to the state dental board upon request. 6321

(2) For professional services rendered to any other person 6322
who holds a certificate or license issued pursuant to this 6323
chapter to the extent allowed by this chapter and the rules of 6324
the board. 6325

(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 6357
Chapter 3965. of the Revised Code, the state dental board shall 6358
suspend any investigation and shall not take disciplinary action 6359
under this section against that individual for conduct relating 6360
to that claim unless otherwise required by the health care 6361
professional standards board or until the health care 6362
professional standards board has concluded its investigation 6363
under Chapter 4746. of the Revised Code. 6364

The state dental board shall take any disciplinary action 6365
required by the health care professional standards board against 6366
a certificate or license holder under this chapter pursuant to 6367
section 4746.05 of the Revised Code. If the health care 6368
professional standards board imposes discipline on a certificate 6369
or license holder, the state dental board shall not take 6370
disciplinary action for the same conduct that is the subject of 6371
the disciplinary action ordered by the health care professional 6372
standards board. However, the state dental board may account for 6373
that disciplinary action in any future disciplinary action taken 6374
against the certificate or license holder. 6375

Sec. 4723.28. (A) The board of nursing, by a vote of a 6376
quorum, may impose one or more of the following sanctions if it 6377
finds that a person committed fraud in passing an examination 6378
required to obtain a license, certificate of authority, or 6379
dialysis technician certificate issued by the board or to have 6380
committed fraud, misrepresentation, or deception in applying for 6381
or securing any nursing license, certificate of authority, or 6382
dialysis technician certificate issued by the board: deny, 6383
revoke, suspend, or place restrictions on any nursing license, 6384
certificate of authority, or dialysis technician certificate 6385
issued by the board; reprimand or otherwise discipline a holder 6386
of a nursing license, certificate of authority, or dialysis 6387

technician certificate; or impose a fine of not more than five 6388
hundred dollars per violation. 6389

(B) The board of nursing, by a vote of a quorum, may 6390
impose one or more of the following sanctions: deny, revoke, 6391
suspend, or place restrictions on any nursing license, 6392
certificate of authority, or dialysis technician certificate 6393
issued by the board; reprimand or otherwise discipline a holder 6394
of a nursing license, certificate of authority, or dialysis 6395
technician certificate; or impose a fine of not more than five 6396
hundred dollars per violation. The sanctions may be imposed for 6397
any of the following: 6398

(1) Denial, revocation, suspension, or restriction of 6399
authority to engage in a licensed profession or practice a 6400
health care occupation, including nursing or practice as a 6401
dialysis technician, for any reason other than a failure to 6402
renew, in Ohio or another state or jurisdiction; 6403

(2) Engaging in the practice of nursing or engaging in 6404
practice as a dialysis technician, having failed to renew a 6405
nursing license or dialysis technician certificate issued under 6406
this chapter, or while a nursing license or dialysis technician 6407
certificate is under suspension; 6408

(3) Conviction of, a plea of guilty to, a judicial finding 6409
of guilt of, a judicial finding of guilt resulting from a plea 6410
of no contest to, or a judicial finding of eligibility for a 6411
pretrial diversion or similar program or for intervention in 6412
lieu of conviction for, a misdemeanor committed in the course of 6413
practice; 6414

(4) Conviction of, a plea of guilty to, a judicial finding 6415
of guilt of, a judicial finding of guilt resulting from a plea 6416

of no contest to, or a judicial finding of eligibility for a 6417
pretrial diversion or similar program or for intervention in 6418
lieu of conviction for, any felony or of any crime involving 6419
gross immorality or moral turpitude; 6420

(5) Selling, giving away, or administering drugs or 6421
therapeutic devices for other than legal and legitimate 6422
therapeutic purposes; or conviction of, a plea of guilty to, a 6423
judicial finding of guilt of, a judicial finding of guilt 6424
resulting from a plea of no contest to, or a judicial finding of 6425
eligibility for a pretrial diversion or similar program or for 6426
intervention in lieu of conviction for, violating any municipal, 6427
state, county, or federal drug law; 6428

(6) Conviction of, a plea of guilty to, a judicial finding 6429
of guilt of, a judicial finding of guilt resulting from a plea 6430
of no contest to, or a judicial finding of eligibility for a 6431
pretrial diversion or similar program or for intervention in 6432
lieu of conviction for, an act in another jurisdiction that 6433
would constitute a felony or a crime of moral turpitude in Ohio; 6434

(7) Conviction of, a plea of guilty to, a judicial finding 6435
of guilt of, a judicial finding of guilt resulting from a plea 6436
of no contest to, or a judicial finding of eligibility for a 6437
pretrial diversion or similar program or for intervention in 6438
lieu of conviction for, an act in the course of practice in 6439
another jurisdiction that would constitute a misdemeanor in 6440
Ohio; 6441

(8) Self-administering or otherwise taking into the body 6442
any dangerous drug, as defined in section 4729.01 of the Revised 6443
Code, in any way that is not in accordance with a legal, valid 6444
prescription issued for that individual, or self-administering 6445
or otherwise taking into the body any drug that is a schedule I 6446

controlled substance;	6447
(9) Habitual or excessive use of controlled substances,	6448
other habit-forming drugs, or alcohol or other chemical	6449
substances to an extent that impairs the individual's ability to	6450
provide safe nursing care or safe dialysis care;	6451
(10) Impairment of the ability to practice according to	6452
acceptable and prevailing standards of safe nursing care or safe	6453
dialysis care because of the use of drugs, alcohol, or other	6454
chemical substances;	6455
(11) Impairment of the ability to practice according to	6456
acceptable and prevailing standards of safe nursing care or safe	6457
dialysis care because of a physical or mental disability;	6458
(12) Assaulting or causing harm to a patient or depriving	6459
a patient of the means to summon assistance;	6460
(13) Misappropriation or attempted misappropriation of	6461
money or anything of value in the course of practice;	6462
(14) Adjudication by a probate court of being mentally ill	6463
or mentally incompetent. The board may reinstate the person's	6464
nursing license or dialysis technician certificate upon	6465
adjudication by a probate court of the person's restoration to	6466
competency or upon submission to the board of other proof of	6467
competency.	6468
(15) The suspension or termination of employment by the	6469
department of defense or the veterans administration of the	6470
United States for any act that violates or would violate this	6471
chapter;	6472
(16) Violation of this chapter or any rules adopted under	6473
it;	6474

(17) Violation of any restrictions placed by the board on a nursing license or dialysis technician certificate;	6475 6476
(18) Failure to use universal and standard precautions established by rules adopted under section 4723.07 of the Revised Code;	6477 6478 6479
(19) Failure to practice in accordance with acceptable and prevailing standards of safe nursing care or safe dialysis care;	6480 6481
(20) In the case of a registered nurse, engaging in activities that exceed the practice of nursing as a registered nurse;	6482 6483 6484
(21) In the case of a licensed practical nurse, engaging in activities that exceed the practice of nursing as a licensed practical nurse;	6485 6486 6487
(22) In the case of a dialysis technician, engaging in activities that exceed those permitted under section 4723.72 of the Revised Code;	6488 6489 6490
(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;	6491 6492 6493
(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:	6494 6495 6496 6497
(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	6498 6499 6500 6501 6502

receive health care services from that provider; 6503

(b) Advertising that the nurse will waive the payment of 6504
all or any part of a deductible or copayment that a patient, 6505
pursuant to a health insurance or health care policy, contract, 6506
or plan that covers such nursing services, would otherwise be 6507
required to pay. 6508

(25) Failure to comply with the terms and conditions of 6509
participation in the chemical dependency monitoring program 6510
established under section 4723.35 of the Revised Code; 6511

(26) Failure to comply with the terms and conditions 6512
required under the practice intervention and improvement program 6513
established under section 4723.282 of the Revised Code; 6514

(27) In the case of a certified registered nurse 6515
anesthetist, clinical nurse specialist, certified nurse-midwife, 6516
or certified nurse practitioner: 6517

(a) Engaging in activities that exceed those permitted for 6518
the nurse's nursing specialty under section 4723.43 of the 6519
Revised Code; 6520

(b) Failure to meet the quality assurance standards 6521
established under section 4723.07 of the Revised Code. 6522

(28) In the case of a clinical nurse specialist, certified 6523
nurse-midwife, or certified nurse practitioner, failure to 6524
maintain a standard care arrangement in accordance with section 6525
4723.431 of the Revised Code or to practice in accordance with 6526
the standard care arrangement; 6527

(29) In the case of a clinical nurse specialist, certified 6528
nurse-midwife, or certified nurse practitioner who holds a 6529
certificate to prescribe issued under section 4723.48 of the 6530

Revised Code, failure to prescribe drugs and therapeutic devices 6531
in accordance with section 4723.481 of the Revised Code; 6532

(30) Prescribing any drug or device to perform or induce 6533
an abortion, or otherwise performing or inducing an abortion; 6534

(31) Failure to establish and maintain professional 6535
boundaries with a patient, as specified in rules adopted under 6536
section 4723.07 of the Revised Code; 6537

(32) Regardless of whether the contact or verbal behavior 6538
is consensual, engaging with a patient other than the spouse of 6539
the registered nurse, licensed practical nurse, or dialysis 6540
technician in any of the following: 6541

(a) Sexual contact, as defined in section 2907.01 of the 6542
Revised Code; 6543

(b) Verbal behavior that is sexually demeaning to the 6544
patient or may be reasonably interpreted by the patient as 6545
sexually demeaning. 6546

(33) Assisting suicide as defined in section 3795.01 of 6547
the Revised Code; 6548

(34) Failure to comply with the requirements in section 6549
3719.061 of the Revised Code before issuing to a minor a 6550
prescription for a controlled substance containing an opioid; 6551

~~(34)~~ (35) Failure to comply with section 4723.487 of the 6552
Revised Code, unless the state board of pharmacy no longer 6553
maintains a drug database pursuant to section 4729.75 of the 6554
Revised Code. 6555

(C) Disciplinary actions taken by the board of nursing 6556
under divisions (A) and (B) of this section shall be taken 6557
pursuant to an adjudication conducted under Chapter 119. of the 6558

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 6589
practical nurse, or dialysis technician committed the act, or if 6590
the registered nurse, licensed practical nurse, or dialysis 6591
technician fails to participate in the adjudication, the board 6592
may take action as though the registered nurse, licensed 6593
practical nurse, or dialysis technician had been convicted of 6594
the act. 6595

If the board of nursing takes action on the basis of a 6596
conviction, plea, or a judicial finding as described in 6597
divisions (B) (3) to (7) of this section that is overturned on 6598
appeal, the registered nurse, licensed practical nurse, or 6599
dialysis technician may, on exhaustion of the appeal process, 6600
petition the board for reconsideration of its action. On receipt 6601
of the petition and supporting court documents, the board shall 6602
temporarily rescind its action. If the board determines that the 6603
decision on appeal was a decision on the merits, it shall 6604
permanently rescind its action. If the board determines that the 6605
decision on appeal was not a decision on the merits, it shall 6606
conduct an adjudication to determine whether the registered 6607
nurse, licensed practical nurse, or dialysis technician 6608
committed the act on which the original conviction, plea, or 6609
judicial finding was based. If the board determines on the basis 6610
of the adjudication that the registered nurse, licensed 6611
practical nurse, or dialysis technician committed such act, or 6612
if the registered nurse, licensed practical nurse, or dialysis 6613
technician does not request an adjudication, the board shall 6614
reinstate its action; otherwise, the board shall permanently 6615
rescind its action. 6616

Notwithstanding the provision of division (C) (2) of 6617
section 2953.32 of the Revised Code specifying that if records 6618
pertaining to a criminal case are sealed under that section the 6619

proceedings in the case shall be deemed not to have occurred, 6620
sealing of the following records on which the board of nursing 6621
has based an action under this section shall have no effect on 6622
the board's action or any sanction imposed by the board under 6623
this section: records of any conviction, guilty plea, judicial 6624
finding of guilt resulting from a plea of no contest, or a 6625
judicial finding of eligibility for a pretrial diversion program 6626
or intervention in lieu of conviction. 6627

The board of nursing shall not be required to seal, 6628
destroy, redact, or otherwise modify its records to reflect the 6629
court's sealing of conviction records. 6630

(F) The board of nursing may investigate an individual's 6631
criminal background in performing its duties under this section. 6632
As part of such investigation, the board may order the 6633
individual to submit, at the individual's expense, a request to 6634
the bureau of criminal identification and investigation for a 6635
criminal records check and check of federal bureau of 6636
investigation records in accordance with the procedure described 6637
in section 4723.091 of the Revised Code. 6638

(G) During the course of an investigation conducted under 6639
this section, the board of nursing may compel any registered 6640
nurse, licensed practical nurse, or dialysis technician or 6641
applicant under this chapter to submit to a mental or physical 6642
examination, or both, as required by the board and at the 6643
expense of the individual, if the board finds reason to believe 6644
that the individual under investigation may have a physical or 6645
mental impairment that may affect the individual's ability to 6646
provide safe nursing care. Failure of any individual to submit 6647
to a mental or physical examination when directed constitutes an 6648
admission of the allegations, unless the failure is due to 6649

circumstances beyond the individual's control, and a default and 6650
final order may be entered without the taking of testimony or 6651
presentation of evidence. 6652

If the board of nursing finds that an individual is 6653
impaired, the board shall require the individual to submit to 6654
care, counseling, or treatment approved or designated by the 6655
board, as a condition for initial, continued, reinstated, or 6656
renewed authority to practice. The individual shall be afforded 6657
an opportunity to demonstrate to the board that the individual 6658
can begin or resume the individual's occupation in compliance 6659
with acceptable and prevailing standards of care under the 6660
provisions of the individual's authority to practice. 6661

For purposes of this division, any registered nurse, 6662
licensed practical nurse, or dialysis technician or applicant 6663
under this chapter shall be deemed to have given consent to 6664
submit to a mental or physical examination when directed to do 6665
so in writing by the board of nursing, and to have waived all 6666
objections to the admissibility of testimony or examination 6667
reports that constitute a privileged communication. 6668

(H) The board of nursing shall investigate evidence that 6669
appears to show that any person has violated any provision of 6670
this chapter or any rule of the board. Any person may report to 6671
the board any information the person may have that appears to 6672
show a violation of any provision of this chapter or rule of the 6673
board. In the absence of bad faith, any person who reports such 6674
information or who testifies before the board in any 6675
adjudication conducted under Chapter 119. of the Revised Code 6676
shall not be liable for civil damages as a result of the report 6677
or testimony. 6678

(I) All of the following apply under this chapter with 6679

respect to the confidentiality of information: 6680

(1) Information received by the board of nursing pursuant 6681
to a complaint or an investigation is confidential and not 6682
subject to discovery in any civil action, except that the board 6683
may disclose information to law enforcement officers and 6684
government entities for purposes of an investigation of either a 6685
licensed health care professional, including a registered nurse, 6686
licensed practical nurse, or dialysis technician, or a person 6687
who may have engaged in the unauthorized practice of nursing or 6688
dialysis care. No law enforcement officer or government entity 6689
with knowledge of any information disclosed by the board 6690
pursuant to this division shall divulge the information to any 6691
other person or government entity except for the purpose of a 6692
government investigation, a prosecution, or an adjudication by a 6693
court or government entity. 6694

(2) If an investigation requires a review of patient 6695
records, the investigation and proceeding shall be conducted in 6696
such a manner as to protect patient confidentiality. 6697

(3) All adjudications and investigations of the board of 6698
nursing shall be considered civil actions for the purposes of 6699
section 2305.252 of the Revised Code. 6700

(4) Any board activity that involves continued monitoring 6701
of an individual as part of or following any disciplinary action 6702
taken under this section shall be conducted in a manner that 6703
maintains the individual's confidentiality. Information received 6704
or maintained by the board of nursing with respect to the 6705
board's monitoring activities is not subject to discovery in any 6706
civil action and is confidential, except that the board may 6707
disclose information to law enforcement officers and government 6708
entities for purposes of an investigation of a licensee or 6709

certificate holder. 6710

(J) Any action taken by the board of nursing under this 6711
section resulting in a suspension from practice shall be 6712
accompanied by a written statement of the conditions under which 6713
the person may be reinstated to practice. 6714

(K) When the board of nursing refuses to grant a license 6715
or certificate to an applicant, revokes a license or 6716
certificate, or refuses to reinstate a license or certificate, 6717
the board may specify that its action is permanent. An 6718
individual subject to permanent action taken by the board is 6719
forever ineligible to hold a license or certificate of the type 6720
that was refused or revoked and the board shall not accept from 6721
the individual an application for reinstatement of the license 6722
or certificate or for a new license or certificate. 6723

(L) No unilateral surrender of a nursing license, 6724
certificate of authority, or dialysis technician certificate 6725
issued under this chapter shall be effective unless accepted by 6726
majority vote of the board of nursing. No application for a 6727
nursing license, certificate of authority, or dialysis 6728
technician certificate issued under this chapter may be 6729
withdrawn without a majority vote of the board. The board's 6730
jurisdiction to take disciplinary action under this section is 6731
not removed or limited when an individual has a license or 6732
certificate classified as inactive or fails to renew a license 6733
or certificate. 6734

(M) Sanctions shall not be imposed under division (B) (24) 6735
of this section against any licensee who waives deductibles and 6736
copayments as follows: 6737

(1) In compliance with the health benefit plan that 6738

expressly allows such a practice. Waiver of the deductibles or 6739
copayments shall be made only with the full knowledge and 6740
consent of the plan purchaser, payer, and third-party 6741
administrator. Documentation of the consent shall be made 6742
available to the board upon request. 6743

(2) For professional services rendered to any other person 6744
licensed pursuant to this chapter to the extent allowed by this 6745
chapter and the rules of the board of nursing. 6746

(N) If an individual who is registered or holds a 6747
certificate or license issued under this chapter is listed in a 6748
claim filed under Chapter 3965. of the Revised Code, the board 6749
of nursing shall suspend any investigation and shall not take 6750
disciplinary action under this section against that individual 6751
for conduct relating to that claim unless otherwise required by 6752
the health care professional standards board or until the health 6753
care professional standards board has concluded its 6754
investigation under Chapter 4746. of the Revised Code. 6755

The board of nursing shall take any disciplinary action 6756
required by the health care professional standards board against 6757
a registrant or certificate or license holder under this chapter 6758
pursuant to section 4746.05 of the Revised Code. If the health 6759
care professional standards board imposes discipline on a 6760
registrant or certificate or license holder, the board of 6761
nursing shall not take disciplinary action for the same conduct 6762
that is the subject of the disciplinary action ordered by the 6763
health care professional standards board. However, the board of 6764
nursing may account for that disciplinary action in any future 6765
disciplinary action taken against the registrant or certificate 6766
or license holder. 6767

Sec. 4723.341. (A) As used in this section, "person" has 6768

the same meaning as in section 1.59 of the Revised Code and also 6769
includes the board of nursing and its members and employees; 6770
health care facilities, associations, and societies; insurers; 6771
and individuals. 6772

(B) In the absence of fraud or bad faith, no person 6773
reporting to the board of nursing or the health care 6774
professional standards board or testifying in an adjudication 6775
conducted under Chapter 119. of the Revised Code with regard to 6776
alleged incidents of negligence or malpractice or matters 6777
subject to this chapter or sections 3123.41 to 3123.50 of the 6778
Revised Code and any applicable rules adopted under section 6779
3123.63 of the Revised Code shall be subject to either of the 6780
following based on making the report or testifying: 6781

(1) Liability in damages in a civil action for injury, 6782
death, or loss to person or property; 6783

(2) Discipline or dismissal by an employer. 6784

(C) An individual who is disciplined or dismissed in 6785
violation of division (B) (2) of this section has the same rights 6786
and duties accorded an employee under sections 4113.52 and 6787
4113.53 of the Revised Code. 6788

(D) In the absence of fraud or bad faith, no professional 6789
association of registered nurses, licensed practical nurses, 6790
dialysis technicians, community health workers, or medication 6791
aides that sponsors a committee or program to provide peer 6792
assistance to individuals with substance abuse problems, no 6793
representative or agent of such a committee or program, and no 6794
member of the board of nursing shall be liable to any person for 6795
damages in a civil action by reason of actions taken to refer a 6796
nurse, dialysis technician, community health worker, or 6797

medication aide to a treatment provider or actions or omissions 6798
of the provider in treating a nurse, dialysis technician, 6799
community health worker, or medication aide. 6800

Sec. 4725.19. (A) In accordance with Chapter 119. of the 6801
Revised Code and by an affirmative vote of a majority of its 6802
members, the state board of optometry, for any of the reasons 6803
specified in division (B) of this section, shall refuse to grant 6804
a certificate of licensure to an applicant and may, with respect 6805
to a licensed optometrist, do one or more of the following: 6806

(1) Suspend the operation of any certificate of licensure, 6807
topical ocular pharmaceutical agents certificate, or therapeutic 6808
pharmaceutical agents certificate, or all certificates granted 6809
by it to the optometrist; 6810

(2) Permanently revoke any or all of the certificates; 6811

(3) Limit or otherwise place restrictions on any or all of 6812
the certificates; 6813

(4) Reprimand the optometrist; 6814

(5) Impose a monetary penalty. If the reason for which the 6815
state board of optometry is imposing the penalty involves a 6816
criminal offense that carries a fine under the Revised Code, the 6817
penalty shall not exceed the maximum fine that may be imposed 6818
for the criminal offense. In any other case, the penalty imposed 6819
by the board shall not exceed five hundred dollars. 6820

(6) Require the optometrist to take corrective action 6821
courses. 6822

The amount and content of corrective action courses shall 6823
be established by the state board of optometry in rules adopted 6824
under section 4725.09 of the Revised Code. 6825

(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:	6882
(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.	6883 6884 6885 6886 6887 6888
(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.	6889 6890 6891 6892 6893
(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.	6894 6895 6896
(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 <u>state board of optometry</u> with a copy of the complaint and shall have a hearing before the board in accordance with Chapter 119. of the Revised Code.	6897 6898 6899 6900 6901 6902
(D) Sanctions shall not be imposed under division (B) (17) of this section against any optometrist who waives deductibles and copayments:	6903 6904 6905
(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	6906 6907 6908 6909 6910

available to the board upon request. 6911

(2) For professional services rendered to any other 6912
optometrist licensed by the board, to the extent allowed by 6913
sections 4725.01 to 4725.34 of the Revised Code and the rules of 6914
the state board of optometry. 6915

(E) If an individual who holds a certificate of licensure 6916
issued under this chapter is listed in a claim filed under 6917
Chapter 3965. of the Revised Code, the state board of optometry 6918
shall suspend any investigation and shall not take disciplinary 6919
action under this section against that individual for conduct 6920
relating to that claim unless otherwise required by the health 6921
care professional standards board or until the health care 6922
professional standards board has concluded its investigation 6923
under Chapter 4746. of the Revised Code. 6924

The state board of optometry shall take any disciplinary 6925
action required by the health care professional standards board 6926
against a certificate holder under this chapter pursuant to 6927
section 4746.05 of the Revised Code. If the health care 6928
professional standards board imposes discipline on a certificate 6929
holder, the state board of optometry shall not take disciplinary 6930
action for the same conduct that is the subject of the 6931
disciplinary action ordered by the health care professional 6932
standards board. However, the state board of optometry may 6933
account for that disciplinary action in any future disciplinary 6934
action taken against the certificate holder. 6935

Sec. 4729.16. (A) The state board of pharmacy, after 6936
notice and hearing in accordance with Chapter 119. of the 6937
Revised Code, may revoke, suspend, limit, place on probation, or 6938
refuse to grant or renew an identification card, or may impose a 6939
monetary penalty or forfeiture not to exceed in severity any 6940

fine designated under the Revised Code for a similar offense, or 6941
in the case of a violation of a section of the Revised Code that 6942
does not bear a penalty, a monetary penalty or forfeiture of not 6943
more than five hundred dollars, if the board finds a pharmacist 6944
or pharmacy intern: 6945

(1) Guilty of a felony or gross immorality; 6946

(2) Guilty of dishonesty or unprofessional conduct in the 6947
practice of pharmacy; 6948

(3) Addicted to or abusing liquor or drugs or impaired 6949
physically or mentally to such a degree as to render the 6950
pharmacist or pharmacy intern unfit to practice pharmacy; 6951

(4) Has been convicted of a misdemeanor related to, or 6952
committed in, the practice of pharmacy; 6953

(5) Guilty of willfully violating, conspiring to violate, 6954
attempting to violate, or aiding and abetting the violation of 6955
any of the provisions of this chapter, sections 3715.52 to 6956
3715.72 of the Revised Code, Chapter 2925. or 3719. of the 6957
Revised Code, or any rule adopted by the state board of pharmacy 6958
under those provisions; 6959

(6) Guilty of permitting anyone other than a pharmacist or 6960
pharmacy intern to practice pharmacy; 6961

(7) Guilty of knowingly lending the pharmacist's or 6962
pharmacy intern's name to an illegal practitioner of pharmacy or 6963
having professional connection with an illegal practitioner of 6964
pharmacy; 6965

(8) Guilty of dividing or agreeing to divide remuneration 6966
made in the practice of pharmacy with any other individual, 6967
including, but not limited to, any licensed health professional 6968

authorized to prescribe drugs or any owner, manager, or employee 6969
of a health care facility, residential care facility, or nursing 6970
home; 6971

(9) Has violated the terms of a consult agreement entered 6972
into pursuant to section 4729.39 of the Revised Code; 6973

(10) Has committed fraud, misrepresentation, or deception 6974
in applying for or securing a license or identification card 6975
issued by the board under this chapter or under Chapter 3715. or 6976
3719. of the Revised Code. 6977

(B) Any individual whose identification card is revoked, 6978
suspended, or refused, shall return the identification card and 6979
license to the offices of the state board of pharmacy within ten 6980
days after receipt of notice of such action. 6981

(C) As used in this section: 6982

"Unprofessional conduct in the practice of pharmacy" 6983
includes any of the following: 6984

(1) Advertising or displaying signs that promote dangerous 6985
drugs to the public in a manner that is false or misleading; 6986

(2) Except as provided in section 4729.281 of the Revised 6987
Code, the sale of any drug for which a prescription is required, 6988
without having received a prescription for the drug; 6989

(3) Knowingly dispensing medication pursuant to false or 6990
forged prescriptions; 6991

(4) Knowingly failing to maintain complete and accurate 6992
records of all dangerous drugs received or dispensed in 6993
compliance with federal laws and regulations and state laws and 6994
rules; 6995

(5) Obtaining any remuneration by fraud, 6996
misrepresentation, or deception. 6997

(D) The state board of pharmacy may suspend a license or 6998
identification card under division (B) of section 3719.121 of 6999
the Revised Code by utilizing a telephone conference call to 7000
review the allegations and take a vote. 7001

(E) If, pursuant to an adjudication under Chapter 119. of 7002
the Revised Code, the state board of pharmacy has reasonable 7003
cause to believe that a pharmacist or pharmacy intern is 7004
physically or mentally impaired, the board may require the 7005
pharmacist or pharmacy intern to submit to a physical or mental 7006
examination, or both. 7007

(F) If an individual who is licensed under this chapter is 7008
listed in a claim filed under Chapter 3965. of the Revised Code, 7009
the state board of pharmacy shall suspend any investigation and 7010
shall not take disciplinary action under this section against 7011
that individual for conduct relating to that claim unless 7012
otherwise required by the health care professional standards 7013
board or until the health care professional standards board has 7014
concluded its investigation under Chapter 4746. of the Revised 7015
Code. 7016

The state board of pharmacy shall take any disciplinary 7017
action required by the health care professional standards board 7018
against a license holder under this chapter pursuant to section 7019
4746.05 of the Revised Code. If the health care professional 7020
standards board imposes discipline on a license holder, the 7021
state board of pharmacy shall not take disciplinary action for 7022
the same conduct that is the subject of the disciplinary action 7023
ordered by the health care professional standards board. 7024
However, the state board of pharmacy may account for that 7025

disciplinary action in any future disciplinary action taken 7026
against the license holder. 7027

Sec. 4730.25. (A) The state medical board, by an 7028
affirmative vote of not fewer than six members, may revoke or 7029
may refuse to grant a certificate to practice as a physician 7030
assistant or a certificate to prescribe to a person found by the 7031
board to have committed fraud, misrepresentation, or deception 7032
in applying for or securing the certificate. 7033

(B) The state medical board, by an affirmative vote of not 7034
fewer than six members, shall, to the extent permitted by law, 7035
limit, revoke, or suspend an individual's certificate to 7036
practice as a physician assistant or certificate to prescribe, 7037
refuse to issue a certificate to an applicant, refuse to 7038
reinstate a certificate, or reprimand or place on probation the 7039
holder of a certificate for any of the following reasons: 7040

(1) Failure to practice in accordance with the conditions 7041
under which the supervising physician's supervision agreement 7042
with the physician assistant was approved, including the 7043
requirement that when practicing under a particular supervising 7044
physician, the physician assistant must practice only according 7045
to the physician supervisory plan the board approved for that 7046
physician or the policies of the health care facility in which 7047
the supervising physician and physician assistant are 7048
practicing; 7049

(2) Failure to comply with the requirements of this 7050
chapter, Chapter 4731. of the Revised Code, or any rules adopted 7051
by the state medical board; 7052

(3) Violating or attempting to violate, directly or 7053
indirectly, or assisting in or abetting the violation of, or 7054

conspiring to violate, any provision of this chapter, Chapter 7055
4731. of the Revised Code, or the rules adopted by the state 7056
medical board; 7057

(4) Inability to practice according to acceptable and 7058
prevailing standards of care by reason of mental illness or 7059
physical illness, including physical deterioration that 7060
adversely affects cognitive, motor, or perceptive skills; 7061

(5) Impairment of ability to practice according to 7062
acceptable and prevailing standards of care because of habitual 7063
or excessive use or abuse of drugs, alcohol, or other substances 7064
that impair ability to practice; 7065

(6) Administering drugs for purposes other than those 7066
authorized under this chapter; 7067

(7) Willfully betraying a professional confidence; 7068

(8) Making a false, fraudulent, deceptive, or misleading 7069
statement in soliciting or advertising for employment as a 7070
physician assistant; in connection with any solicitation or 7071
advertisement for patients; in relation to the practice of 7072
medicine as it pertains to physician assistants; or in securing 7073
or attempting to secure a certificate to practice as a physician 7074
assistant, a certificate to prescribe, or approval of a 7075
supervision agreement. 7076

As used in this division, "false, fraudulent, deceptive, 7077
or misleading statement" means a statement that includes a 7078
misrepresentation of fact, is likely to mislead or deceive 7079
because of a failure to disclose material facts, is intended or 7080
is likely to create false or unjustified expectations of 7081
favorable results, or includes representations or implications 7082
that in reasonable probability will cause an ordinarily prudent 7083

person to misunderstand or be deceived. 7084

(9) Representing, with the purpose of obtaining 7085
compensation or other advantage personally or for any other 7086
person, that an incurable disease or injury, or other incurable 7087
condition, can be permanently cured; 7088

(10) The obtaining of, or attempting to obtain, money or 7089
anything of value by fraudulent misrepresentations in the course 7090
of practice; 7091

(11) A plea of guilty to, a judicial finding of guilt of, 7092
or a judicial finding of eligibility for intervention in lieu of 7093
conviction for, a felony; 7094

(12) Commission of an act that constitutes a felony in 7095
this state, regardless of the jurisdiction in which the act was 7096
committed; 7097

(13) A plea of guilty to, a judicial finding of guilt of, 7098
or a judicial finding of eligibility for intervention in lieu of 7099
conviction for, a misdemeanor committed in the course of 7100
practice; 7101

(14) A plea of guilty to, a judicial finding of guilt of, 7102
or a judicial finding of eligibility for intervention in lieu of 7103
conviction for, a misdemeanor involving moral turpitude; 7104

(15) Commission of an act in the course of practice that 7105
constitutes a misdemeanor in this state, regardless of the 7106
jurisdiction in which the act was committed; 7107

(16) Commission of an act involving moral turpitude that 7108
constitutes a misdemeanor in this state, regardless of the 7109
jurisdiction in which the act was committed; 7110

(17) A plea of guilty to, a judicial finding of guilt of, 7111

or a judicial finding of eligibility for intervention in lieu of 7112
conviction for violating any state or federal law regulating the 7113
possession, distribution, or use of any drug, including 7114
trafficking in drugs; 7115

(18) Any of the following actions taken by the state 7116
agency responsible for regulating the practice of physician 7117
assistants in another state, for any reason other than the 7118
nonpayment of fees: the limitation, revocation, or suspension of 7119
an individual's license to practice; acceptance of an 7120
individual's license surrender; denial of a license; refusal to 7121
renew or reinstate a license; imposition of probation; or 7122
issuance of an order of censure or other reprimand; 7123

(19) A departure from, or failure to conform to, minimal 7124
standards of care of similar physician assistants under the same 7125
or similar circumstances, regardless of whether actual injury to 7126
a patient is established; 7127

(20) Violation of the conditions placed by the state 7128
medical board on a certificate to practice as a physician 7129
assistant, a certificate to prescribe, a physician supervisory 7130
plan, or supervision agreement; 7131

(21) Failure to use universal blood and body fluid 7132
precautions established by rules adopted under section 4731.051 7133
of the Revised Code; 7134

(22) Failure to cooperate in an investigation conducted by 7135
the board under section 4730.26 of the Revised Code, including 7136
failure to comply with a subpoena or order issued by the state 7137
medical board or the health care professional standards board or 7138
failure to answer truthfully a question presented by ~~the either~~ 7139
board at a deposition or in written interrogatories, except that 7140

failure to cooperate with an investigation shall not constitute 7141
grounds for discipline under this section if a court of 7142
competent jurisdiction has issued an order that either quashes a 7143
subpoena or permits the individual to withhold the testimony or 7144
evidence in issue; 7145

(23) Assisting suicide as defined in section 3795.01 of 7146
the Revised Code; 7147

(24) Prescribing any drug or device to perform or induce 7148
an abortion, or otherwise performing or inducing an abortion; 7149

(25) Failure to comply with section 4730.53 of the Revised 7150
Code, unless the board no longer maintains a drug database 7151
pursuant to section 4729.75 of the Revised Code; 7152

~~(25)~~ (26) Failure to comply with the requirements in 7153
section 3719.061 of the Revised Code before issuing to a minor a 7154
prescription for a controlled substance containing an opioid. 7155

(C) Disciplinary actions taken by the state medical board 7156
under divisions (A) and (B) of this section shall be taken 7157
pursuant to an adjudication under Chapter 119. of the Revised 7158
Code, except that in lieu of an adjudication, the board may 7159
enter into a consent agreement with a physician assistant or 7160
applicant to resolve an allegation of a violation of this 7161
chapter or any rule adopted under it. A consent agreement, when 7162
ratified by an affirmative vote of not fewer than six members of 7163
the board, shall constitute the findings and order of the board 7164
with respect to the matter addressed in the agreement. If the 7165
board refuses to ratify a consent agreement, the admissions and 7166
findings contained in the consent agreement shall be of no force 7167
or effect. 7168

(D) For purposes of divisions (B) (12), (15), and (16) of 7169

this section, the commission of the act may be established by a 7170
finding by the state medical board, pursuant to an adjudication 7171
under Chapter 119. of the Revised Code, that the applicant or 7172
certificate holder committed the act in question. The board 7173
shall have no jurisdiction under these divisions in cases where 7174
the trial court renders a final judgment in the certificate 7175
holder's favor and that judgment is based upon an adjudication 7176
on the merits. The board shall have jurisdiction under these 7177
divisions in cases where the trial court issues an order of 7178
dismissal upon technical or procedural grounds. 7179

(E) The sealing of conviction records by any court shall 7180
have no effect upon a prior state medical board order entered 7181
under the provisions of this section or upon the board's 7182
jurisdiction to take action under the provisions of this section 7183
if, based upon a plea of guilty, a judicial finding of guilt, or 7184
a judicial finding of eligibility for intervention in lieu of 7185
conviction, the board issued a notice of opportunity for a 7186
hearing prior to the court's order to seal the records. The 7187
board shall not be required to seal, destroy, redact, or 7188
otherwise modify its records to reflect the court's sealing of 7189
conviction records. 7190

(F) For purposes of this division, any individual who 7191
holds a certificate issued under this chapter, or applies for a 7192
certificate issued under this chapter, shall be deemed to have 7193
given consent to submit to a mental or physical examination when 7194
directed to do so in writing by the state medical board and to 7195
have waived all objections to the admissibility of testimony or 7196
examination reports that constitute a privileged communication. 7197

(1) In enforcing division (B) (4) of this section, the 7198
state medical board, upon a showing of a possible violation, may 7199

compel any individual who holds a certificate issued under this 7200
chapter or who has applied for a certificate pursuant to this 7201
chapter to submit to a mental examination, physical examination, 7202
including an HIV test, or both a mental and physical 7203
examination. The expense of the examination is the 7204
responsibility of the individual compelled to be examined. 7205
Failure to submit to a mental or physical examination or consent 7206
to an HIV test ordered by the board constitutes an admission of 7207
the allegations against the individual unless the failure is due 7208
to circumstances beyond the individual's control, and a default 7209
and final order may be entered without the taking of testimony 7210
or presentation of evidence. If the board finds a physician 7211
assistant unable to practice because of the reasons set forth in 7212
division (B)(4) of this section, the board shall require the 7213
physician assistant to submit to care, counseling, or treatment 7214
by physicians approved or designated by the board, as a 7215
condition for an initial, continued, reinstated, or renewed 7216
certificate. An individual affected under this division shall be 7217
afforded an opportunity to demonstrate to the board the ability 7218
to resume practicing in compliance with acceptable and 7219
prevailing standards of care. 7220

(2) For purposes of division (B)(5) of this section, if 7221
the state medical board has reason to believe that any 7222
individual who holds a certificate issued under this chapter or 7223
any applicant for a certificate suffers such impairment, the 7224
board may compel the individual to submit to a mental or 7225
physical examination, or both. The expense of the examination is 7226
the responsibility of the individual compelled to be examined. 7227
Any mental or physical examination required under this division 7228
shall be undertaken by a treatment provider or physician 7229
qualified to conduct such examination and chosen by the board. 7230

Failure to submit to a mental or physical examination 7231
ordered by the state medical board constitutes an admission of 7232
the allegations against the individual unless the failure is due 7233
to circumstances beyond the individual's control, and a default 7234
and final order may be entered without the taking of testimony 7235
or presentation of evidence. If the board determines that the 7236
individual's ability to practice is impaired, the board shall 7237
suspend the individual's certificate or deny the individual's 7238
application and shall require the individual, as a condition for 7239
initial, continued, reinstated, or renewed certification to 7240
practice or prescribe, to submit to treatment. 7241

Before being eligible to apply for reinstatement of a 7242
certificate suspended under this division, the physician 7243
assistant shall demonstrate to the state medical board the 7244
ability to resume practice or prescribing in compliance with 7245
acceptable and prevailing standards of care. The demonstration 7246
shall include the following: 7247

(a) Certification from a treatment provider approved under 7248
section 4731.25 of the Revised Code that the individual has 7249
successfully completed any required inpatient treatment; 7250

(b) Evidence of continuing full compliance with an 7251
aftercare contract or consent agreement; 7252

(c) Two written reports indicating that the individual's 7253
ability to practice has been assessed and that the individual 7254
has been found capable of practicing according to acceptable and 7255
prevailing standards of care. The reports shall be made by 7256
individuals or providers approved by the board for making such 7257
assessments and shall describe the basis for their 7258
determination. 7259

The state medical board may reinstate a certificate 7260
suspended under this division after such demonstration and after 7261
the individual has entered into a written consent agreement. 7262

When the impaired physician assistant resumes practice or 7263
prescribing, the state medical board shall require continued 7264
monitoring of the physician assistant. The monitoring shall 7265
include compliance with the written consent agreement entered 7266
into before reinstatement or with conditions imposed by board 7267
order after a hearing, and, upon termination of the consent 7268
agreement, submission to the board for at least two years of 7269
annual written progress reports made under penalty of 7270
falsification stating whether the physician assistant has 7271
maintained sobriety. 7272

(G) If the secretary and supervising member determine that 7273
there is clear and convincing evidence that a physician 7274
assistant has violated division (B) of this section and that the 7275
individual's continued practice or prescribing presents a danger 7276
of immediate and serious harm to the public, they may recommend 7277
that the state medical board suspend the individual's 7278
certificate to practice or prescribe without a prior hearing. 7279
Written allegations shall be prepared for consideration by the 7280
board. 7281

The state medical board, upon review of those allegations 7282
and by an affirmative vote of not fewer than six of its members, 7283
excluding the secretary and supervising member, may suspend a 7284
certificate without a prior hearing. A telephone conference call 7285
may be utilized for reviewing the allegations and taking the 7286
vote on the summary suspension. 7287

The state medical board shall issue a written order of 7288
suspension by certified mail or in person in accordance with 7289

section 119.07 of the Revised Code. The order shall not be 7290
subject to suspension by the court during pendency of any appeal 7291
filed under section 119.12 of the Revised Code. If the physician 7292
assistant requests an adjudicatory hearing by the board, the 7293
date set for the hearing shall be within fifteen days, but not 7294
earlier than seven days, after the physician assistant requests 7295
the hearing, unless otherwise agreed to by both the board and 7296
the certificate holder. 7297

A summary suspension imposed under this division shall 7298
remain in effect, unless reversed on appeal, until a final 7299
adjudicative order issued by the state medical board pursuant to 7300
this section and Chapter 119. of the Revised Code becomes 7301
effective. The board shall issue its final adjudicative order 7302
within sixty days after completion of its hearing. Failure to 7303
issue the order within sixty days shall result in dissolution of 7304
the summary suspension order, but shall not invalidate any 7305
subsequent, final adjudicative order. 7306

(H) If the state medical board takes action under division 7307
(B) (11), (13), or (14) of this section, and the judicial finding 7308
of guilt, guilty plea, or judicial finding of eligibility for 7309
intervention in lieu of conviction is overturned on appeal, upon 7310
exhaustion of the criminal appeal, a petition for 7311
reconsideration of the order may be filed with the board along 7312
with appropriate court documents. Upon receipt of a petition and 7313
supporting court documents, the board shall reinstate the 7314
certificate to practice or prescribe. The board may then hold an 7315
adjudication under Chapter 119. of the Revised Code to determine 7316
whether the individual committed the act in question. Notice of 7317
opportunity for hearing shall be given in accordance with 7318
Chapter 119. of the Revised Code. If the board finds, pursuant 7319
to an adjudication held under this division, that the individual 7320

committed the act, or if no hearing is requested, it may order 7321
any of the sanctions identified under division (B) of this 7322
section. 7323

(I) The certificate to practice issued to a physician 7324
assistant and the physician assistant's practice in this state 7325
are automatically suspended as of the date the physician 7326
assistant pleads guilty to, is found by a judge or jury to be 7327
guilty of, or is subject to a judicial finding of eligibility 7328
for intervention in lieu of conviction in this state or 7329
treatment or intervention in lieu of conviction in another state 7330
for any of the following criminal offenses in this state or a 7331
substantially equivalent criminal offense in another 7332
jurisdiction: aggravated murder, murder, voluntary manslaughter, 7333
felonious assault, kidnapping, rape, sexual battery, gross 7334
sexual imposition, aggravated arson, aggravated robbery, or 7335
aggravated burglary. Continued practice after the suspension 7336
shall be considered practicing without a certificate. 7337

The state medical board shall notify the individual 7338
subject to the suspension by certified mail or in person in 7339
accordance with section 119.07 of the Revised Code. If an 7340
individual whose certificate is suspended under this division 7341
fails to make a timely request for an adjudication under Chapter 7342
119. of the Revised Code, the board shall enter a final order 7343
permanently revoking the individual's certificate to practice. 7344

(J) In any instance in which the state medical board is 7345
required by Chapter 119. of the Revised Code to give notice of 7346
opportunity for hearing and the individual subject to the notice 7347
does not timely request a hearing in accordance with section 7348
119.07 of the Revised Code, the board is not required to hold a 7349
hearing, but may adopt, by an affirmative vote of not fewer than 7350

six of its members, a final order that contains the board's 7351
findings. In that final order, the board may order any of the 7352
sanctions identified under division (A) or (B) of this section. 7353

(K) Any action taken by the state medical board under 7354
division (B) of this section resulting in a suspension shall be 7355
accompanied by a written statement of the conditions under which 7356
the physician assistant's certificate may be reinstated. The 7357
board shall adopt rules in accordance with Chapter 119. of the 7358
Revised Code governing conditions to be imposed for 7359
reinstatement. Reinstatement of a certificate suspended pursuant 7360
to division (B) of this section requires an affirmative vote of 7361
not fewer than six members of the board. 7362

(L) When the state medical board refuses to grant to an 7363
applicant a certificate to practice as a physician assistant or 7364
a certificate to prescribe, revokes an individual's certificate, 7365
refuses to issue a certificate, or refuses to reinstate an 7366
individual's certificate, the board may specify that its action 7367
is permanent. An individual subject to a permanent action taken 7368
by the board is forever thereafter ineligible to hold the 7369
certificate and the board shall not accept an application for 7370
reinstatement of the certificate or for issuance of a new 7371
certificate. 7372

(M) Notwithstanding any other provision of the Revised 7373
Code, all of the following apply: 7374

(1) The surrender of a certificate issued under this 7375
chapter is not effective unless or until accepted by the state 7376
medical board. Reinstatement of a certificate surrendered to the 7377
board requires an affirmative vote of not fewer than six members 7378
of the board. 7379

(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 7410
facility against any individual holding a valid certificate to 7411
practice as a physician assistant, the chief administrator or 7412
executive officer of the facility shall report to the state 7413
medical board and the health care professional standards board 7414
the name of the individual, the action taken by the facility, 7415
and a summary of the underlying facts leading to the action 7416
taken. Upon request, ~~the either~~ board shall be provided 7417
certified copies of the patient records that were the basis for 7418
the facility's action. Prior to release to the board, the 7419
summary shall be approved by the peer review committee that 7420
reviewed the case or by the governing board of the facility. 7421

The filing of a report with ~~the each~~ board or decision not 7422
to file a report, investigation by ~~the either~~ board, or any 7423
disciplinary action taken by ~~the either~~ board, does not preclude 7424
a health care facility from taking disciplinary action against a 7425
physician assistant. 7426

In the absence of fraud or bad faith, no individual or 7427
entity that provides patient records to ~~the either~~ board shall 7428
be liable in damages to any person as a result of providing the 7429
records. 7430

(B) A physician assistant, professional association or 7431
society of physician assistants, physician, or professional 7432
association or society of physicians that believes a violation 7433
of any provision of this chapter, Chapter 4731. of the Revised 7434
Code, or rule of the state medical board has occurred shall 7435
report to the board and the health care professional standards 7436
board the information upon which the belief is based. This 7437
division does not require any treatment provider approved by the 7438
state medical board under section 4731.25 of the Revised Code or 7439

any employee, agent, or representative of such a provider to 7440
make reports with respect to a physician assistant participating 7441
in treatment or aftercare for substance abuse as long as the 7442
physician assistant maintains participation in accordance with 7443
the requirements of section 4731.25 of the Revised Code and the 7444
treatment provider or employee, agent, or representative of the 7445
provider has no reason to believe that the physician assistant 7446
has violated any provision of this chapter or rule adopted under 7447
it, other than being impaired by alcohol, drugs, or other 7448
substances. This division does not require reporting by any 7449
member of an impaired practitioner committee established by a 7450
health care facility or by any representative or agent of a 7451
committee or program sponsored by a professional association or 7452
society of physician assistants to provide peer assistance to 7453
physician assistants with substance abuse problems with respect 7454
to a physician assistant who has been referred for examination 7455
to a treatment program approved by the board under section 7456
4731.25 of the Revised Code if the physician assistant 7457
cooperates with the referral for examination and with any 7458
determination that the physician assistant should enter 7459
treatment and as long as the committee member, representative, 7460
or agent has no reason to believe that the physician assistant 7461
has ceased to participate in the treatment program in accordance 7462
with section 4731.25 of the Revised Code or has violated any 7463
provision of this chapter or rule adopted under it, other than 7464
being impaired by alcohol, drugs, or other substances. 7465

(C) Any professional association or society composed 7466
primarily of physician assistants that suspends or revokes an 7467
individual's membership for violations of professional ethics, 7468
or for reasons of professional incompetence or professional 7469
malpractice, within sixty days after a final decision, shall 7470

report to the state medical board and the health care 7471
professional standards board, on forms prescribed and provided 7472
by the state medical board, the name of the individual, the 7473
action taken by the professional organization, and a summary of 7474
the underlying facts leading to the action taken. 7475

The filing or nonfiling of a report with ~~the each~~ board, 7476
investigation by ~~the either~~ board, or any disciplinary action 7477
taken by ~~the either~~ board, shall not preclude a professional 7478
organization from taking disciplinary action against a physician 7479
assistant. 7480

(D) Any insurer providing professional liability insurance 7481
to any person holding a valid certificate to practice as a 7482
physician assistant or any other entity that seeks to indemnify 7483
the professional liability of a physician assistant shall notify 7484
the state medical board within thirty days after the final 7485
disposition of any written claim for damages where such 7486
disposition results in a payment exceeding twenty-five thousand 7487
dollars. The notice shall contain the following information: 7488

(1) The name and address of the person submitting the 7489
notification; 7490

(2) The name and address of the insured who is the subject 7491
of the claim; 7492

(3) The name of the person filing the written claim; 7493

(4) The date of final disposition; 7494

(5) If applicable, the identity of the court in which the 7495
final disposition of the claim took place. 7496

(E) ~~The Either~~ board may investigate possible violations 7497
of this chapter or the rules adopted under it that are brought 7498

to its attention as a result of the reporting requirements of 7499
this section, except that the state medical board shall conduct 7500
an investigation if a possible violation involves repeated 7501
malpractice. As used in this division, "repeated malpractice" 7502
means three or more claims for malpractice within the previous 7503
five-year period, each resulting in a judgment or settlement in 7504
excess of twenty-five thousand dollars in favor of the claimant, 7505
and each involving negligent conduct by the physician assistant. 7506

(F) All summaries, reports, and records received and 7507
maintained by the state medical board or the health care 7508
professional standards board pursuant to this section shall be 7509
held in confidence and shall not be subject to discovery or 7510
introduction in evidence in any federal or state civil action 7511
involving a physician assistant, supervising physician, or 7512
health care facility arising out of matters that are the subject 7513
of the reporting required by this section. The appropriate board 7514
may use the information obtained only as the basis for an 7515
investigation, as evidence in a disciplinary hearing against a 7516
physician assistant or supervising physician, or in any 7517
subsequent trial or appeal of a board action or order. 7518

The appropriate board may disclose the summaries and 7519
reports it receives under this section only to health care 7520
facility committees within or outside this state that are 7521
involved in credentialing or recredentialing a physician 7522
assistant or supervising physician or reviewing their privilege 7523
to practice within a particular facility. The board shall 7524
indicate whether or not the information has been verified. 7525
Information transmitted by the board shall be subject to the 7526
same confidentiality provisions as when maintained by the board. 7527

(G) Except for reports filed by an individual pursuant to 7528

division (B) of this section, the state medical board shall send 7529
a copy of any reports or summaries it receives pursuant to this 7530
section to the physician assistant. The physician assistant 7531
shall have the right to file a statement with the state medical 7532
board and the health care professional standards board 7533
concerning the correctness or relevance of the information. The 7534
statement shall at all times accompany that part of the record 7535
in contention. 7536

(H) An individual or entity that reports to the state 7537
medical board or the health care professional standards board or 7538
refers an impaired physician assistant to a treatment provider 7539
approved by the board under section 4731.25 of the Revised Code 7540
shall not be subject to suit for civil damages as a result of 7541
the report, referral, or provision of the information. 7542

(I) In the absence of fraud or bad faith, a professional 7543
association or society of physician assistants that sponsors a 7544
committee or program to provide peer assistance to a physician 7545
assistant with substance abuse problems, a representative or 7546
agent of such a committee or program, and a member of the state 7547
medical board shall not be held liable in damages to any person 7548
by reason of actions taken to refer a physician assistant to a 7549
treatment provider approved under section 4731.25 of the Revised 7550
Code for examination or treatment. 7551

Sec. 4731.22. (A) The state medical board, by an 7552
affirmative vote of not fewer than six of its members, may 7553
limit, revoke, or suspend an individual's certificate to 7554
practice, refuse to grant a certificate to an individual, refuse 7555
to register an individual, refuse to reinstate a certificate, or 7556
reprimand or place on probation the holder of a certificate if 7557
the individual or certificate holder is found by the board to 7558

have committed fraud during the administration of the 7559
examination for a certificate to practice or to have committed 7560
fraud, misrepresentation, or deception in applying for or 7561
securing any certificate to practice or certificate of 7562
registration issued by the board. 7563

(B) The state medical board, by an affirmative vote of not 7564
fewer than six members, shall, to the extent permitted by law, 7565
limit, revoke, or suspend an individual's certificate to 7566
practice, refuse to register an individual, refuse to reinstate 7567
a certificate, or reprimand or place on probation the holder of 7568
a certificate for one or more of the following reasons: 7569

(1) Permitting one's name or one's certificate to practice 7570
or certificate of registration to be used by a person, group, or 7571
corporation when the individual concerned is not actually 7572
directing the treatment given; 7573

(2) Failure to maintain minimal standards applicable to 7574
the selection or administration of drugs, or failure to employ 7575
acceptable scientific methods in the selection of drugs or other 7576
modalities for treatment of disease; 7577

(3) Selling, giving away, personally furnishing, 7578
prescribing, or administering drugs for other than legal and 7579
legitimate therapeutic purposes or a plea of guilty to, a 7580
judicial finding of guilt of, or a judicial finding of 7581
eligibility for intervention in lieu of conviction of, a 7582
violation of any federal or state law regulating the possession, 7583
distribution, or use of any drug; 7584

(4) Willfully betraying a professional confidence. 7585

For purposes of this division, "willfully betraying a 7586
professional confidence" does not include providing any 7587

information, documents, or reports to a child fatality review 7588
board under sections 307.621 to 307.629 of the Revised Code and 7589
does not include the making of a report of an employee's use of 7590
a drug of abuse, or a report of a condition of an employee other 7591
than one involving the use of a drug of abuse, to the employer 7592
of the employee as described in division (B) of section 2305.33 7593
of the Revised Code. Nothing in this division affects the 7594
immunity from civil liability conferred by that section upon a 7595
physician who makes either type of report in accordance with 7596
division (B) of that section. As used in this division, 7597
"employee," "employer," and "physician" have the same meanings 7598
as in section 2305.33 of the Revised Code. 7599

(5) Making a false, fraudulent, deceptive, or misleading 7600
statement in the solicitation of or advertising for patients; in 7601
relation to the practice of medicine and surgery, osteopathic 7602
medicine and surgery, podiatric medicine and surgery, or a 7603
limited branch of medicine; or in securing or attempting to 7604
secure any certificate to practice or certificate of 7605
registration issued by the board. 7606

As used in this division, "false, fraudulent, deceptive, 7607
or misleading statement" means a statement that includes a 7608
misrepresentation of fact, is likely to mislead or deceive 7609
because of a failure to disclose material facts, is intended or 7610
is likely to create false or unjustified expectations of 7611
favorable results, or includes representations or implications 7612
that in reasonable probability will cause an ordinarily prudent 7613
person to misunderstand or be deceived. 7614

(6) A departure from, or the failure to conform to, 7615
minimal standards of care of similar practitioners under the 7616
same or similar circumstances, whether or not actual injury to a 7617

- patient is established; 7618
- (7) Representing, with the purpose of obtaining 7619
compensation or other advantage as personal gain or for any 7620
other person, that an incurable disease or injury, or other 7621
incurable condition, can be permanently cured; 7622
- (8) The obtaining of, or attempting to obtain, money or 7623
anything of value by fraudulent misrepresentations in the course 7624
of practice; 7625
- (9) A plea of guilty to, a judicial finding of guilt of, 7626
or a judicial finding of eligibility for intervention in lieu of 7627
conviction for, a felony; 7628
- (10) Commission of an act that constitutes a felony in 7629
this state, regardless of the jurisdiction in which the act was 7630
committed; 7631
- (11) A plea of guilty to, a judicial finding of guilt of, 7632
or a judicial finding of eligibility for intervention in lieu of 7633
conviction for, a misdemeanor committed in the course of 7634
practice; 7635
- (12) Commission of an act in the course of practice that 7636
constitutes a misdemeanor in this state, regardless of the 7637
jurisdiction in which the act was committed; 7638
- (13) A plea of guilty to, a judicial finding of guilt of, 7639
or a judicial finding of eligibility for intervention in lieu of 7640
conviction for, a misdemeanor involving moral turpitude; 7641
- (14) Commission of an act involving moral turpitude that 7642
constitutes a misdemeanor in this state, regardless of the 7643
jurisdiction in which the act was committed; 7644
- (15) Violation of the conditions of limitation placed by 7645

the board upon a certificate to practice; 7646

(16) Failure to pay license renewal fees specified in this 7647
chapter; 7648

(17) Except as authorized in section 4731.31 of the 7649
Revised Code, engaging in the division of fees for referral of 7650
patients, or the receiving of a thing of value in return for a 7651
specific referral of a patient to utilize a particular service 7652
or business; 7653

(18) Subject to section 4731.226 of the Revised Code, 7654
violation of any provision of a code of ethics of the American 7655
medical association, the American osteopathic association, the 7656
American podiatric medical association, or any other national 7657
professional organizations that the state medical board 7658
specifies by rule. The state medical board shall obtain and keep 7659
on file current copies of the codes of ethics of the various 7660
national professional organizations. The individual whose 7661
certificate is being suspended or revoked shall not be found to 7662
have violated any provision of a code of ethics of an 7663
organization not appropriate to the individual's profession. 7664

For purposes of this division, a "provision of a code of 7665
ethics of a national professional organization" does not include 7666
any provision that would preclude the making of a report by a 7667
physician of an employee's use of a drug of abuse, or of a 7668
condition of an employee other than one involving the use of a 7669
drug of abuse, to the employer of the employee as described in 7670
division (B) of section 2305.33 of the Revised Code. Nothing in 7671
this division affects the immunity from civil liability 7672
conferred by that section upon a physician who makes either type 7673
of report in accordance with division (B) of that section. As 7674
used in this division, "employee," "employer," and "physician" 7675

have the same meanings as in section 2305.33 of the Revised Code. 7676
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(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. 7678
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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 7683
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under this chapter accepts the privilege of practicing in this 7707
state and, by so doing, shall be deemed to have given consent to 7708
submit to a mental or physical examination when directed to do 7709
so in writing by the board, and to have waived all objections to 7710
the admissibility of testimony or examination reports that 7711
constitute a privileged communication. 7712

(20) Except when civil penalties are imposed under section 7713
4731.225 or 4731.281 of the Revised Code, and subject to section 7714
4731.226 of the Revised Code, violating or attempting to 7715
violate, directly or indirectly, or assisting in or abetting the 7716
violation of, or conspiring to violate, any provisions of this 7717
chapter or any rule promulgated by the board. 7718

This division does not apply to a violation or attempted 7719
violation of, assisting in or abetting the violation of, or a 7720
conspiracy to violate, any provision of this chapter or any rule 7721
adopted by the state medical board that would preclude the 7722
making of a report by a physician of an employee's use of a drug 7723
of abuse, or of a condition of an employee other than one 7724
involving the use of a drug of abuse, to the employer of the 7725
employee as described in division (B) of section 2305.33 of the 7726
Revised Code. Nothing in this division affects the immunity from 7727
civil liability conferred by that section upon a physician who 7728
makes either type of report in accordance with division (B) of 7729
that section. As used in this division, "employee," "employer," 7730
and "physician" have the same meanings as in section 2305.33 of 7731
the Revised Code. 7732

(21) The violation of section 3701.79 of the Revised Code 7733
or of any abortion rule adopted by the ~~public health council~~ 7734
director of health pursuant to section 3701.341 of the Revised 7735
Code; 7736

(22) Any of the following actions taken by an agency 7737
responsible for authorizing, certifying, or regulating an 7738
individual to practice a health care occupation or provide 7739
health care services in this state or another jurisdiction, for 7740
any reason other than the nonpayment of fees: the limitation, 7741
revocation, or suspension of an individual's license to 7742
practice; acceptance of an individual's license surrender; 7743
denial of a license; refusal to renew or reinstate a license; 7744
imposition of probation; or issuance of an order of censure or 7745
other reprimand; 7746

(23) The violation of section 2919.12 of the Revised Code 7747
or the performance or inducement of an abortion upon a pregnant 7748
woman with actual knowledge that the conditions specified in 7749
division (B) of section 2317.56 of the Revised Code have not 7750
been satisfied or with a heedless indifference as to whether 7751
those conditions have been satisfied, unless an affirmative 7752
defense as specified in division (H) (2) of that section would 7753
apply in a civil action authorized by division (H) (1) of that 7754
section; 7755

(24) The revocation, suspension, restriction, reduction, 7756
or termination of clinical privileges by the United States 7757
department of defense or department of veterans affairs or the 7758
termination or suspension of a certificate of registration to 7759
prescribe drugs by the drug enforcement administration of the 7760
United States department of justice; 7761

(25) Termination or suspension from participation in the 7762
medicare or medicaid programs by the department of health and 7763
human services or other responsible agency for any act or acts 7764
that also would constitute a violation of division (B) (2), (3), 7765
(6), (8), or (19) of this section; 7766

(26) Impairment of ability to practice according to 7767
acceptable and prevailing standards of care because of habitual 7768
or excessive use or abuse of drugs, alcohol, or other substances 7769
that impair ability to practice. 7770

For the purposes of this division, any individual 7771
authorized to practice by this chapter accepts the privilege of 7772
practicing in this state subject to supervision by the state 7773
medical board. By filing an application for or holding a 7774
certificate to practice under this chapter, an individual shall 7775
be deemed to have given consent to submit to a mental or 7776
physical examination when ordered to do so by the board in 7777
writing, and to have waived all objections to the admissibility 7778
of testimony or examination reports that constitute privileged 7779
communications. 7780

If it has reason to believe that any individual authorized 7781
to practice by this chapter or any applicant for certification 7782
to practice suffers such impairment, the state medical board may 7783
compel the individual to submit to a mental or physical 7784
examination, or both. The expense of the examination is the 7785
responsibility of the individual compelled to be examined. Any 7786
mental or physical examination required under this division 7787
shall be undertaken by a treatment provider or physician who is 7788
qualified to conduct the examination and who is chosen by the 7789
board. 7790

Failure to submit to a mental or physical examination 7791
ordered by the state medical board constitutes an admission of 7792
the allegations against the individual unless the failure is due 7793
to circumstances beyond the individual's control, and a default 7794
and final order may be entered without the taking of testimony 7795
or presentation of evidence. If the board determines that the 7796

individual's ability to practice is impaired, the board shall 7797
suspend the individual's certificate or deny the individual's 7798
application and shall require the individual, as a condition for 7799
initial, continued, reinstated, or renewed certification to 7800
practice, to submit to treatment. 7801

Before being eligible to apply for reinstatement of a 7802
certificate suspended under this division, the impaired 7803
practitioner shall demonstrate to the state medical board the 7804
ability to resume practice in compliance with acceptable and 7805
prevailing standards of care under the provisions of the 7806
practitioner's certificate. The demonstration shall include, but 7807
shall not be limited to, the following: 7808

(a) Certification from a treatment provider approved under 7809
section 4731.25 of the Revised Code that the individual has 7810
successfully completed any required inpatient treatment; 7811

(b) Evidence of continuing full compliance with an 7812
aftercare contract or consent agreement; 7813

(c) Two written reports indicating that the individual's 7814
ability to practice has been assessed and that the individual 7815
has been found capable of practicing according to acceptable and 7816
prevailing standards of care. The reports shall be made by 7817
individuals or providers approved by the board for making the 7818
assessments and shall describe the basis for their 7819
determination. 7820

The state medical board may reinstate a certificate 7821
suspended under this division after that demonstration and after 7822
the individual has entered into a written consent agreement. 7823

When the impaired practitioner resumes practice, the state 7824
medical board shall require continued monitoring of the 7825

individual. The monitoring shall include, but not be limited to, 7826
compliance with the written consent agreement entered into 7827
before reinstatement or with conditions imposed by board order 7828
after a hearing, and, upon termination of the consent agreement, 7829
submission to the board for at least two years of annual written 7830
progress reports made under penalty of perjury stating whether 7831
the individual has maintained sobriety. 7832

(27) A second or subsequent violation of section 4731.66 7833
or 4731.69 of the Revised Code; 7834

(28) Except as provided in division (N) of this section: 7835

(a) Waiving the payment of all or any part of a deductible 7836
or copayment that a patient, pursuant to a health insurance or 7837
health care policy, contract, or plan that covers the 7838
individual's services, otherwise would be required to pay if the 7839
waiver is used as an enticement to a patient or group of 7840
patients to receive health care services from that individual; 7841

(b) Advertising that the individual will waive the payment 7842
of all or any part of a deductible or copayment that a patient, 7843
pursuant to a health insurance or health care policy, contract, 7844
or plan that covers the individual's services, otherwise would 7845
be required to pay. 7846

(29) Failure to use universal blood and body fluid 7847
precautions established by rules adopted under section 4731.051 7848
of the Revised Code; 7849

~~(30) Failure to provide notice to, and receive 7850
acknowledgment of the notice from, a patient when required by 7851
section 4731.143 of the Revised Code prior to providing 7852
nonemergency professional services, or failure to maintain that 7853
notice in the patient's file; 7854~~

~~(31)~~ Failure of a physician supervising a physician 7855
assistant to maintain supervision in accordance with the 7856
requirements of Chapter 4730. of the Revised Code and the rules 7857
adopted under that chapter; 7858

~~(32)~~ (31) Failure of a physician or podiatrist to enter 7859
into a standard care arrangement with a clinical nurse 7860
specialist, certified nurse-midwife, or certified nurse 7861
practitioner with whom the physician or podiatrist is in 7862
collaboration pursuant to section 4731.27 of the Revised Code or 7863
failure to fulfill the responsibilities of collaboration after 7864
entering into a standard care arrangement; 7865

~~(33)~~ (32) Failure to comply with the terms of a consult 7866
agreement entered into with a pharmacist pursuant to section 7867
4729.39 of the Revised Code; 7868

~~(34)~~ (33) Failure to cooperate in an investigation 7869
conducted by the state medical board under division (F) of this 7870
section or the health care professional standards board pursuant 7871
to section 4746.04 of the Revised Code, including failure to 7872
comply with a subpoena or order issued by ~~the~~ either board or 7873
failure to answer truthfully a question presented by ~~the~~ either 7874
board in an investigative interview, an investigative office 7875
conference, at a deposition, or in written interrogatories, 7876
except that failure to cooperate with an investigation shall not 7877
constitute grounds for discipline under this section if a court 7878
of competent jurisdiction has issued an order that either 7879
quashes a subpoena or permits the individual to withhold the 7880
testimony or evidence in issue; 7881

~~(35)~~ (34) Failure to supervise an oriental medicine 7882
practitioner or acupuncturist in accordance with Chapter 4762. 7883
of the Revised Code and the state medical board's rules for 7884

providing that supervision;	7885
(36) (35) Failure to supervise an anesthesiologist assistant in accordance with Chapter 4760. of the Revised Code and the <u>state medical board's</u> rules for supervision of an anesthesiologist assistant;	7886 7887 7888 7889
(37) (36) Assisting suicide as defined in section 3795.01 of the Revised Code;	7890 7891
(38) (37) Failure to comply with the requirements of section 2317.561 of the Revised Code;	7892 7893
(39) (38) Failure to supervise a radiologist assistant in accordance with Chapter 4774. of the Revised Code and the <u>state medical board's</u> rules for supervision of radiologist assistants;	7894 7895 7896
(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;	7897 7898 7899 7900
(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;	7901 7902 7903 7904
(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;	7905 7906 7907 7908
(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;	7909 7910 7911 7912

~~(44)~~(43) Failure to comply with the requirements of 7913
section 2919.171 of the Revised Code or failure to submit to the 7914
department of health in accordance with a court order a complete 7915
report as described in section 2919.171 of the Revised Code; 7916

~~(45)~~(44) Practicing at a facility that is subject to 7917
licensure as a category III terminal distributor of dangerous 7918
drugs with a pain management clinic classification unless the 7919
person operating the facility has obtained and maintains the 7920
license with the classification; 7921

~~(46)~~(45) Owning a facility that is subject to licensure as 7922
a category III terminal distributor of dangerous drugs with a 7923
pain management clinic classification unless the facility is 7924
licensed with the classification; 7925

~~(47)~~(46) Failure to comply with the requirement regarding 7926
maintaining notes described in division (B) of section 2919.191 7927
of the Revised Code or failure to satisfy the requirements of 7928
section 2919.191 of the Revised Code prior to performing or 7929
inducing an abortion upon a pregnant woman; 7930

~~(48)~~(47) Failure to comply with the requirements in 7931
section 3719.061 of the Revised Code before issuing to a minor a 7932
prescription for a controlled substance containing an opioid. 7933

(C) Disciplinary actions taken by the state medical board 7934
under divisions (A) and (B) of this section shall be taken 7935
pursuant to an adjudication under Chapter 119. of the Revised 7936
Code, except that in lieu of an adjudication, the board may 7937
enter into a consent agreement with an individual to resolve an 7938
allegation of a violation of this chapter or any rule adopted 7939
under it. A consent agreement, when ratified by an affirmative 7940
vote of not fewer than six members of the board, shall 7941

constitute the findings and order of the board with respect to 7942
the matter addressed in the agreement. If the board refuses to 7943
ratify a consent agreement, the admissions and findings 7944
contained in the consent agreement shall be of no force or 7945
effect. 7946

A telephone conference call may be utilized for 7947
ratification of a consent agreement that revokes or suspends an 7948
individual's certificate to practice. The telephone conference 7949
call shall be considered a special meeting under division (F) of 7950
section 121.22 of the Revised Code. 7951

If the state medical board takes disciplinary action 7952
against an individual under division (B) of this section for a 7953
second or subsequent plea of guilty to, or judicial finding of 7954
guilt of, a violation of section 2919.123 of the Revised Code, 7955
the disciplinary action shall consist of a suspension of the 7956
individual's certificate to practice for a period of at least 7957
one year or, if determined appropriate by the board, a more 7958
serious sanction involving the individual's certificate to 7959
practice. Any consent agreement entered into under this division 7960
with an individual that pertains to a second or subsequent plea 7961
of guilty to, or judicial finding of guilt of, a violation of 7962
that section shall provide for a suspension of the individual's 7963
certificate to practice for a period of at least one year or, if 7964
determined appropriate by the board, a more serious sanction 7965
involving the individual's certificate to practice. 7966

(D) For purposes of divisions (B) (10), (12), and (14) of 7967
this section, the commission of the act may be established by a 7968
finding by the state medical board, pursuant to an adjudication 7969
under Chapter 119. of the Revised Code, that the individual 7970
committed the act. The board does not have jurisdiction under 7971

those divisions if the trial court renders a final judgment in 7972
the individual's favor and that judgment is based upon an 7973
adjudication on the merits. The board has jurisdiction under 7974
those divisions if the trial court issues an order of dismissal 7975
upon technical or procedural grounds. 7976

(E) The sealing of conviction records by any court shall 7977
have no effect upon a prior state medical board order entered 7978
under this section or upon the board's jurisdiction to take 7979
action under this section if, based upon a plea of guilty, a 7980
judicial finding of guilt, or a judicial finding of eligibility 7981
for intervention in lieu of conviction, the board issued a 7982
notice of opportunity for a hearing prior to the court's order 7983
to seal the records. The board shall not be required to seal, 7984
destroy, redact, or otherwise modify its records to reflect the 7985
court's sealing of conviction records. 7986

(F) (1) The state medical board shall investigate evidence 7987
that appears to show that a person has violated any provision of 7988
this chapter or any rule adopted under it. Any person may report 7989
to the board in a signed writing any information that the person 7990
may have that appears to show a violation of any provision of 7991
this chapter or any rule adopted under it. In the absence of bad 7992
faith, any person who reports information of that nature or who 7993
testifies before the board in any adjudication conducted under 7994
Chapter 119. of the Revised Code shall not be liable in damages 7995
in a civil action as a result of the report or testimony. Each 7996
complaint or allegation of a violation received by the board 7997
shall be assigned a case number and shall be recorded by the 7998
board. 7999

(2) Investigations of alleged violations of this chapter 8000
or any rule adopted under it shall be supervised by the 8001

supervising member elected by the state medical board in 8002
accordance with section 4731.02 of the Revised Code and by the 8003
secretary as provided in section 4731.39 of the Revised Code. 8004
The president may designate another member of the board to 8005
supervise the investigation in place of the supervising member. 8006
No member of the board who supervises the investigation of a 8007
case shall participate in further adjudication of the case. 8008

(3) In investigating a possible violation of this chapter 8009
or any rule adopted under this chapter, or in conducting an 8010
inspection under division (E) of section 4731.054 of the Revised 8011
Code, the state medical board may question witnesses, conduct 8012
interviews, administer oaths, order the taking of depositions, 8013
inspect and copy any books, accounts, papers, records, or 8014
documents, issue subpoenas, and compel the attendance of 8015
witnesses and production of books, accounts, papers, records, 8016
documents, and testimony, except that a subpoena for patient 8017
record information shall not be issued without consultation with 8018
the attorney general's office and approval of the secretary and 8019
supervising member of the board. 8020

(a) Before issuance of a subpoena for patient record 8021
information, the secretary and supervising member shall 8022
determine whether there is probable cause to believe that the 8023
complaint filed alleges a violation of this chapter or any rule 8024
adopted under it and that the records sought are relevant to the 8025
alleged violation and material to the investigation. The 8026
subpoena may apply only to records that cover a reasonable 8027
period of time surrounding the alleged violation. 8028

(b) On failure to comply with any subpoena issued by the 8029
state medical board and after reasonable notice to the person 8030
being subpoenaed, the board may move for an order compelling the 8031

production of persons or records pursuant to the Rules of Civil Procedure. 8032
8033

(c) A subpoena issued by the state medical board may be 8034
served by a sheriff, the sheriff's deputy, or a board employee 8035
designated by the board. Service of a subpoena issued by the 8036
board may be made by delivering a copy of the subpoena to the 8037
person named therein, reading it to the person, or leaving it at 8038
the person's usual place of residence, usual place of business, 8039
or address on file with the board. When serving a subpoena to an 8040
applicant for or the holder of a certificate issued under this 8041
chapter, service of the subpoena may be made by certified mail, 8042
return receipt requested, and the subpoena shall be deemed 8043
served on the date delivery is made or the date the person 8044
refuses to accept delivery. If the person being served refuses 8045
to accept the subpoena or is not located, service may be made to 8046
an attorney who notifies the board that the attorney is 8047
representing the person. 8048

(d) A sheriff's deputy who serves a subpoena shall receive 8049
the same fees as a sheriff. Each witness who appears before the 8050
board in obedience to a subpoena shall receive the fees and 8051
mileage provided for under section 119.094 of the Revised Code. 8052

(4) All hearings, investigations, and inspections of the 8053
state medical board shall be considered civil actions for the 8054
purposes of section 2305.252 of the Revised Code. 8055

(5) A report required to be submitted to the state medical 8056
board under this chapter, a complaint, or information received 8057
by the board pursuant to an investigation or pursuant to an 8058
inspection under division (E) of section 4731.054 of the Revised 8059
Code is confidential and not subject to discovery in any civil 8060
action. 8061

The state medical board shall conduct all investigations 8062
or inspections and proceedings in a manner that protects the 8063
confidentiality of patients and persons who file complaints with 8064
the board. The board shall not make public the names or any 8065
other identifying information about patients or complainants 8066
unless proper consent is given or, in the case of a patient, a 8067
waiver of the patient privilege exists under division (B) of 8068
section 2317.02 of the Revised Code, except that consent or a 8069
waiver of that nature is not required if the board possesses 8070
reliable and substantial evidence that no bona fide physician- 8071
patient relationship exists. 8072

The state medical board may share any information it 8073
receives pursuant to an investigation or inspection, including 8074
patient records and patient record information, with law 8075
enforcement agencies, other licensing boards, and other 8076
governmental agencies that are prosecuting, adjudicating, or 8077
investigating alleged violations of statutes or administrative 8078
rules. An agency or board that receives the information shall 8079
comply with the same requirements regarding confidentiality as 8080
those with which the state medical board must comply, 8081
notwithstanding any conflicting provision of the Revised Code or 8082
procedure of the agency or board that applies when it is dealing 8083
with other information in its possession. In a judicial 8084
proceeding, the information may be admitted into evidence only 8085
in accordance with the Rules of Evidence, but the court shall 8086
require that appropriate measures are taken to ensure that 8087
confidentiality is maintained with respect to any part of the 8088
information that contains names or other identifying information 8089
about patients or complainants whose confidentiality was 8090
protected by the state medical board when the information was in 8091
the board's possession. Measures to ensure confidentiality that 8092

may be taken by the court include sealing its records or 8093
deleting specific information from its records. 8094

(6) On a quarterly basis, the state medical board shall 8095
prepare a report that documents the disposition of all cases 8096
during the preceding three months. The report shall contain the 8097
following information for each case with which the board has 8098
completed its activities: 8099

(a) The case number assigned to the complaint or alleged 8100
violation; 8101

(b) The type of certificate to practice, if any, held by 8102
the individual against whom the complaint is directed; 8103

(c) A description of the allegations contained in the 8104
complaint; 8105

(d) The disposition of the case. 8106

The report shall state how many cases are still pending 8107
and shall be prepared in a manner that protects the identity of 8108
each person involved in each case. The report shall be a public 8109
record under section 149.43 of the Revised Code. 8110

(G) If the secretary and supervising member determine both 8111
of the following, they may recommend that the state medical 8112
board suspend an individual's certificate to practice without a 8113
prior hearing: 8114

(1) That there is clear and convincing evidence that an 8115
individual has violated division (B) of this section; 8116

(2) That the individual's continued practice presents a 8117
danger of immediate and serious harm to the public. 8118

Written allegations shall be prepared for consideration by 8119

the state medical board. The board, upon review of those 8120
allegations and by an affirmative vote of not fewer than six of 8121
its members, excluding the secretary and supervising member, may 8122
suspend a certificate without a prior hearing. A telephone 8123
conference call may be utilized for reviewing the allegations 8124
and taking the vote on the summary suspension. 8125

The state medical board shall issue a written order of 8126
suspension by certified mail or in person in accordance with 8127
section 119.07 of the Revised Code. The order shall not be 8128
subject to suspension by the court during pendency of any appeal 8129
filed under section 119.12 of the Revised Code. If the 8130
individual subject to the summary suspension requests an 8131
adjudicatory hearing by the board, the date set for the hearing 8132
shall be within fifteen days, but not earlier than seven days, 8133
after the individual requests the hearing, unless otherwise 8134
agreed to by both the board and the individual. 8135

Any summary suspension imposed under this division shall 8136
remain in effect, unless reversed on appeal, until a final 8137
adjudicative order issued by the state medical board pursuant to 8138
this section and Chapter 119. of the Revised Code becomes 8139
effective. The board shall issue its final adjudicative order 8140
within seventy-five days after completion of its hearing. A 8141
failure to issue the order within seventy-five days shall result 8142
in dissolution of the summary suspension order but shall not 8143
invalidate any subsequent, final adjudicative order. 8144

(H) If the state medical board takes action under division 8145
(B) (9), (11), or (13) of this section and the judicial finding 8146
of guilt, guilty plea, or judicial finding of eligibility for 8147
intervention in lieu of conviction is overturned on appeal, upon 8148
exhaustion of the criminal appeal, a petition for 8149

reconsideration of the order may be filed with the board along 8150
with appropriate court documents. Upon receipt of a petition of 8151
that nature and supporting court documents, the board shall 8152
reinstate the individual's certificate to practice. The board 8153
may then hold an adjudication under Chapter 119. of the Revised 8154
Code to determine whether the individual committed the act in 8155
question. Notice of an opportunity for a hearing shall be given 8156
in accordance with Chapter 119. of the Revised Code. If the 8157
board finds, pursuant to an adjudication held under this 8158
division, that the individual committed the act or if no hearing 8159
is requested, the board may order any of the sanctions 8160
identified under division (B) of this section. 8161

(I) The certificate to practice issued to an individual 8162
under this chapter and the individual's practice in this state 8163
are automatically suspended as of the date of the individual's 8164
second or subsequent plea of guilty to, or judicial finding of 8165
guilt of, a violation of section 2919.123 of the Revised Code, 8166
or the date the individual pleads guilty to, is found by a judge 8167
or jury to be guilty of, or is subject to a judicial finding of 8168
eligibility for intervention in lieu of conviction in this state 8169
or treatment or intervention in lieu of conviction in another 8170
jurisdiction for any of the following criminal offenses in this 8171
state or a substantially equivalent criminal offense in another 8172
jurisdiction: aggravated murder, murder, voluntary manslaughter, 8173
felonious assault, kidnapping, rape, sexual battery, gross 8174
sexual imposition, aggravated arson, aggravated robbery, or 8175
aggravated burglary. Continued practice after suspension shall 8176
be considered practicing without a certificate. 8177

The state medical board shall notify the individual 8178
subject to the suspension by certified mail or in person in 8179
accordance with section 119.07 of the Revised Code. If an 8180

individual whose certificate is automatically suspended under 8181
this division fails to make a timely request for an adjudication 8182
under Chapter 119. of the Revised Code, the board shall do 8183
whichever of the following is applicable: 8184

(1) If the automatic suspension under this division is for 8185
a second or subsequent plea of guilty to, or judicial finding of 8186
guilt of, a violation of section 2919.123 of the Revised Code, 8187
the state medical board shall enter an order suspending the 8188
individual's certificate to practice for a period of at least 8189
one year or, if determined appropriate by the board, imposing a 8190
more serious sanction involving the individual's certificate to 8191
practice. 8192

(2) In all circumstances in which division (I)(1) of this 8193
section does not apply, enter a final order permanently revoking 8194
the individual's certificate to practice. 8195

(J) If the state medical board is required by Chapter 119. 8196
of the Revised Code to give notice of an opportunity for a 8197
hearing and if the individual subject to the notice does not 8198
timely request a hearing in accordance with section 119.07 of 8199
the Revised Code, the board is not required to hold a hearing, 8200
but may adopt, by an affirmative vote of not fewer than six of 8201
its members, a final order that contains the board's findings. 8202
In that final order, the board may order any of the sanctions 8203
identified under division (A) or (B) of this section. 8204

(K) Any action taken by the state medical board under 8205
division (B) of this section resulting in a suspension from 8206
practice shall be accompanied by a written statement of the 8207
conditions under which the individual's certificate to practice 8208
may be reinstated. The board shall adopt rules governing 8209
conditions to be imposed for reinstatement. Reinstatement of a 8210

certificate suspended pursuant to division (B) of this section 8211
requires an affirmative vote of not fewer than six members of 8212
the board. 8213

(L) When the state medical board refuses to grant a 8214
certificate to an applicant, revokes an individual's certificate 8215
to practice, refuses to register an applicant, or refuses to 8216
reinstate an individual's certificate to practice, the board may 8217
specify that its action is permanent. An individual subject to a 8218
permanent action taken by the board is forever thereafter 8219
ineligible to hold a certificate to practice and the board shall 8220
not accept an application for reinstatement of the certificate 8221
or for issuance of a new certificate. 8222

(M) Notwithstanding any other provision of the Revised 8223
Code, all of the following apply: 8224

(1) The surrender of a certificate issued under this 8225
chapter shall not be effective unless or until accepted by the 8226
state medical board. A telephone conference call may be utilized 8227
for acceptance of the surrender of an individual's certificate 8228
to practice. The telephone conference call shall be considered a 8229
special meeting under division (F) of section 121.22 of the 8230
Revised Code. Reinstatement of a certificate surrendered to the 8231
board requires an affirmative vote of not fewer than six members 8232
of the board. 8233

(2) An application for a certificate made under the 8234
provisions of this chapter may not be withdrawn without approval 8235
of the state medical board. 8236

(3) Failure by an individual to renew a certificate of 8237
registration in accordance with this chapter shall not remove or 8238
limit the state medical board's jurisdiction to take any 8239

disciplinary action under this section against the individual. 8240

(4) At the request of the state medical board, a 8241
certificate holder shall immediately surrender to the board a 8242
certificate that the board has suspended, revoked, or 8243
permanently revoked. 8244

(N) Sanctions shall not be imposed under division (B) (28) 8245
of this section against any person who waives deductibles and 8246
copayments as follows: 8247

(1) In compliance with the health benefit plan that 8248
expressly allows such a practice. Waiver of the deductibles or 8249
copayments shall be made only with the full knowledge and 8250
consent of the plan purchaser, payer, and third-party 8251
administrator. Documentation of the consent shall be made 8252
available to the state medical board upon request. 8253

(2) For professional services rendered to any other person 8254
authorized to practice pursuant to this chapter, to the extent 8255
allowed by this chapter and rules adopted by the state medical 8256
board. 8257

(O) Under the state medical board's investigative duties 8258
described in this section and subject to division (F) of this 8259
section, the board shall develop and implement a quality 8260
intervention program designed to improve through remedial 8261
education the clinical and communication skills of individuals 8262
authorized under this chapter to practice medicine and surgery, 8263
osteopathic medicine and surgery, and podiatric medicine and 8264
surgery. In developing and implementing the quality intervention 8265
program, the board may do all of the following: 8266

(1) Offer in appropriate cases as determined by the board 8267
an educational and assessment program pursuant to an 8268

investigation the board conducts under this section; 8269

(2) Select providers of educational and assessment 8270
services, including a quality intervention program panel of case 8271
reviewers; 8272

(3) Make referrals to educational and assessment service 8273
providers and approve individual educational programs 8274
recommended by those providers. The board shall monitor the 8275
progress of each individual undertaking a recommended individual 8276
educational program. 8277

(4) Determine what constitutes successful completion of an 8278
individual educational program and require further monitoring of 8279
the individual who completed the program or other action that 8280
the board determines to be appropriate; 8281

(5) Adopt rules in accordance with Chapter 119. of the 8282
Revised Code to further implement the quality intervention 8283
program. 8284

An individual who participates in an individual 8285
educational program pursuant to this division shall pay the 8286
financial obligations arising from that educational program. 8287

(P) If an individual who holds a certificate issued under 8288
this chapter is listed in a claim filed under Chapter 3965. of 8289
the Revised Code, the state medical board shall suspend any 8290
investigation and shall not take disciplinary action under this 8291
section against that individual for conduct relating to that 8292
claim unless otherwise required by the health care professional 8293
standards board or until the health care professional standards 8294
board has concluded its investigation under Chapter 4746. of the 8295
Revised Code. 8296

The state medical board shall take any disciplinary action 8297

required by the health care professional standards board against 8298
a certificate holder under this chapter pursuant to section 8299
4746.05 of the Revised Code. If the health care professional 8300
standards board imposes discipline on a certificate holder, the 8301
state medical board shall not take disciplinary action for the 8302
same conduct that is the subject of the disciplinary action 8303
ordered by the health care professional standards board. 8304
However, the state medical board may account for that 8305
disciplinary action in any future disciplinary action taken 8306
against the certificate holder. 8307

Sec. 4731.224. (A) Within sixty days after the imposition 8308
of any formal disciplinary action taken by any health care 8309
facility, including a hospital, health care facility operated by 8310
a health insuring corporation, ambulatory surgical center, or 8311
similar facility, against any individual holding a valid 8312
certificate to practice issued pursuant to this chapter, the 8313
chief administrator or executive officer of the facility shall 8314
report to the state medical board and the health care 8315
professional standards board the name of the individual, the 8316
action taken by the facility, and a summary of the underlying 8317
facts leading to the action taken. Upon request, the requesting 8318
board shall be provided certified copies of the patient records 8319
that were the basis for the facility's action. Prior to release 8320
to the board, the summary shall be approved by the peer review 8321
committee that reviewed the case or by the governing board of 8322
the facility. As used in this division, "formal disciplinary 8323
action" means any action resulting in the revocation, 8324
restriction, reduction, or termination of clinical privileges 8325
for violations of professional ethics, or for reasons of medical 8326
incompetence, medical malpractice, or drug or alcohol abuse. 8327
"Formal disciplinary action" includes a summary action, an 8328

action that takes effect notwithstanding any appeal rights that 8329
may exist, and an action that results in an individual 8330
surrendering clinical privileges while under investigation and 8331
during proceedings regarding the action being taken or in return 8332
for not being investigated or having proceedings held. "Formal 8333
disciplinary action" does not include any action taken for the 8334
sole reason of failure to maintain records on a timely basis or 8335
failure to attend staff or section meetings. 8336

The filing or nonfiling of a report with ~~the either~~ board, 8337
investigation by ~~the either~~ board, or any disciplinary action 8338
taken by ~~the either~~ board, shall not preclude any action by a 8339
health care facility to suspend, restrict, or revoke the 8340
individual's clinical privileges. 8341

In the absence of fraud or bad faith, no individual or 8342
entity that provides patient records to ~~the either~~ board shall 8343
be liable in damages to any person as a result of providing the 8344
records. 8345

(B) If any individual authorized to practice under this 8346
chapter or any professional association or society of such 8347
individuals believes that a violation of any provision of this 8348
chapter, Chapter 4730., 4760., 4762., 4774., or 4778. of the 8349
Revised Code, or any rule of the board has occurred, the 8350
individual, association, or society shall report to the state 8351
medical board and the health care professional standards board 8352
the information upon which the belief is based. This division 8353
does not require any treatment provider approved by the state 8354
medical board under section 4731.25 of the Revised Code or any 8355
employee, agent, or representative of such a provider to make 8356
reports with respect to an impaired practitioner participating 8357
in treatment or aftercare for substance abuse as long as the 8358

practitioner maintains participation in accordance with the 8359
requirements of section 4731.25 of the Revised Code, and as long 8360
as the treatment provider or employee, agent, or representative 8361
of the provider has no reason to believe that the practitioner 8362
has violated any provision of this chapter or any rule adopted 8363
under it, other than the provisions of division (B) (26) of 8364
section 4731.22 of the Revised Code. This division does not 8365
require reporting by any member of an impaired practitioner 8366
committee established by a health care facility or by any 8367
representative or agent of a committee or program sponsored by a 8368
professional association or society of individuals authorized to 8369
practice under this chapter to provide peer assistance to 8370
practitioners with substance abuse problems with respect to a 8371
practitioner who has been referred for examination to a 8372
treatment program approved by the state medical board under 8373
section 4731.25 of the Revised Code if the practitioner 8374
cooperates with the referral for examination and with any 8375
determination that the practitioner should enter treatment and 8376
as long as the committee member, representative, or agent has no 8377
reason to believe that the practitioner has ceased to 8378
participate in the treatment program in accordance with section 8379
4731.25 of the Revised Code or has violated any provision of 8380
this chapter or any rule adopted under it, other than the 8381
provisions of division (B) (26) of section 4731.22 of the Revised 8382
Code. 8383

(C) Any professional association or society composed 8384
primarily of doctors of medicine and surgery, doctors of 8385
osteopathic medicine and surgery, doctors of podiatric medicine 8386
and surgery, or practitioners of limited branches of medicine 8387
that suspends or revokes an individual's membership for 8388
violations of professional ethics, or for reasons of 8389

professional incompetence or professional malpractice, within 8390
sixty days after a final decision shall report to the state 8391
medical board and the health care professional standards board, 8392
on forms prescribed and provided by the state medical board, the 8393
name of the individual, the action taken by the professional 8394
organization, and a summary of the underlying facts leading to 8395
the action taken. 8396

The filing of a report with ~~the either~~ board or decision 8397
not to file a report, investigation by ~~the either~~ board, or any 8398
disciplinary action taken by ~~the either~~ board, does not preclude 8399
a professional organization from taking disciplinary action 8400
against an individual. 8401

(D) Any insurer providing professional liability insurance 8402
to an individual authorized to practice under this chapter, or 8403
any other entity that seeks to indemnify the professional 8404
liability of such an individual, shall notify the state medical 8405
board within thirty days after the final disposition of any 8406
written claim for damages where such disposition results in a 8407
payment exceeding twenty-five thousand dollars. The notice shall 8408
contain the following information: 8409

(1) The name and address of the person submitting the 8410
notification; 8411

(2) The name and address of the insured who is the subject 8412
of the claim; 8413

(3) The name of the person filing the written claim; 8414

(4) The date of final disposition; 8415

(5) If applicable, the identity of the court in which the 8416
final disposition of the claim took place. 8417

(E) ~~The Either~~ board may investigate possible violations 8418
of this chapter or the rules adopted under it that are brought 8419
to its attention as a result of the reporting requirements of 8420
this section, except that the state medical board shall conduct 8421
an investigation if a possible violation involves repeated 8422
malpractice. As used in this division, "repeated malpractice" 8423
means three or more claims for medical malpractice within the 8424
previous five-year period, each resulting in a judgment or 8425
settlement in excess of twenty-five thousand dollars in favor of 8426
the claimant, and each involving negligent conduct by the 8427
practicing individual. 8428

(F) All summaries, reports, and records received and 8429
maintained by the state medical board and the health care 8430
professional standards board pursuant to this section shall be 8431
held in confidence and shall not be subject to discovery or 8432
introduction in evidence in any federal or state civil action 8433
involving a health care professional or facility arising out of 8434
matters that are the subject of the reporting required by this 8435
section. ~~The Either~~ board may use the information obtained only 8436
as the basis for an investigation, as evidence in a disciplinary 8437
hearing against an individual whose practice is regulated under 8438
this chapter, or in any subsequent trial or appeal of a board 8439
action or order. 8440

~~The Either~~ board may disclose the summaries and reports it 8441
receives under this section only to health care facility 8442
committees within or outside this state that are involved in 8443
credentialing or recredentialing the individual or in reviewing 8444
the individual's clinical privileges. The state medical board 8445
shall indicate whether or not the information has been verified. 8446
Information transmitted by the board shall be subject to the 8447
same confidentiality provisions as when maintained by the board. 8448

(G) Except for reports filed by an individual pursuant to 8449
division (B) of this section, the state medical board shall send 8450
a copy of any reports or summaries it receives pursuant to this 8451
section to the individual who is the subject of the reports or 8452
summaries. The individual shall have the right to file a 8453
statement with the board concerning the correctness or relevance 8454
of the information. The statement shall at all times accompany 8455
that part of the record in contention. 8456

(H) An individual or entity that, pursuant to this 8457
section, reports to ~~the either~~ board or refers an impaired 8458
practitioner to a treatment provider approved by the state 8459
medical board under section 4731.25 of the Revised Code shall 8460
not be subject to suit for civil damages as a result of the 8461
report, referral, or provision of the information. 8462

(I) In the absence of fraud or bad faith, no professional 8463
association or society of individuals authorized to practice 8464
under this chapter that sponsors a committee or program to 8465
provide peer assistance to practitioners with substance abuse 8466
problems, no representative or agent of such a committee or 8467
program, and no member of the state medical board shall be held 8468
liable in damages to any person by reason of actions taken to 8469
refer a practitioner to a treatment provider approved under 8470
section 4731.25 of the Revised Code for examination or 8471
treatment. 8472

Sec. 4731.281. (A) On or before the deadline established 8473
under division (B) of this section for applying for renewal of a 8474
certificate of registration, each person holding a certificate 8475
under this chapter to practice medicine and surgery, osteopathic 8476
medicine and surgery, or podiatric medicine and surgery shall 8477
certify to the state medical board that in the preceding two 8478

years the person has completed one hundred hours of continuing 8479
medical education. The certification shall be made upon the 8480
application for biennial registration submitted pursuant to 8481
division (B) of this section. The board shall adopt rules 8482
providing for pro rata reductions by month of the number of 8483
hours of continuing education required for persons who are in 8484
their first registration period, who have been disabled due to 8485
illness or accident, or who have been absent from the country. 8486

In determining whether a course, program, or activity 8487
qualifies for credit as continuing medical education, the board 8488
shall approve all continuing medical education taken by persons 8489
holding a certificate to practice medicine and surgery that is 8490
certified by the Ohio state medical association, all continuing 8491
medical education taken by persons holding a certificate to 8492
practice osteopathic medicine and surgery that is certified by 8493
the Ohio osteopathic association, and all continuing medical 8494
education taken by persons holding a certificate to practice 8495
podiatric medicine and surgery that is certified by the Ohio 8496
podiatric medical association. Each person holding a certificate 8497
to practice under this chapter shall be given sufficient choice 8498
of continuing education programs to ensure that the person has 8499
had a reasonable opportunity to participate in continuing 8500
education programs that are relevant to the person's medical 8501
practice in terms of subject matter and level. 8502

The board may require a random sample of persons holding a 8503
certificate to practice under this chapter to submit materials 8504
documenting completion of the continuing medical education 8505
requirement during the preceding registration period, but this 8506
provision shall not limit the board's authority to investigate 8507
pursuant to section 4731.22 of the Revised Code. 8508

(B) (1) Every person holding a certificate under this 8509
chapter to practice medicine and surgery, osteopathic medicine 8510
and surgery, or podiatric medicine and surgery wishing to renew 8511
that certificate shall apply to the board for a certificate of 8512
registration upon an application furnished by the board, and pay 8513
to the board at the time of application a fee of three hundred 8514
five dollars, according to the following schedule: 8515

(a) Persons whose last name begins with the letters "A" 8516
through "B," on or before April 1, 2001, and the first day of 8517
April of every odd-numbered year thereafter; 8518

(b) Persons whose last name begins with the letters "C" 8519
through "D," on or before January 1, 2001, and the first day of 8520
January of every odd-numbered year thereafter; 8521

(c) Persons whose last name begins with the letters "E" 8522
through "G," on or before October 1, 2000, and the first day of 8523
October of every even-numbered year thereafter; 8524

(d) Persons whose last name begins with the letters "H" 8525
through "K," on or before July 1, 2000, and the first day of 8526
July of every even-numbered year thereafter; 8527

(e) Persons whose last name begins with the letters "L" 8528
through "M," on or before April 1, 2000, and the first day of 8529
April of every even-numbered year thereafter; 8530

(f) Persons whose last name begins with the letters "N" 8531
through "R," on or before January 1, 2000, and the first day of 8532
January of every even-numbered year thereafter; 8533

(g) Persons whose last name begins with the letter "S," on 8534
or before October 1, 1999, and the first day of October of every 8535
odd-numbered year thereafter; 8536

(h) Persons whose last name begins with the letters "T" 8537
through "Z," on or before July 1, 1999, and the first day of 8538
July of every odd-numbered year thereafter. 8539

The board shall deposit the fee in accordance with section 8540
4731.24 of the Revised Code, except that the board shall deposit 8541
twenty dollars of the fee into the state treasury to the credit 8542
of the physician loan repayment fund created by section 3702.78 8543
of the Revised Code. 8544

(2) The board shall mail or cause to be mailed to every 8545
person registered to practice medicine and surgery, osteopathic 8546
medicine and surgery, or podiatric medicine and surgery, a 8547
notice of registration renewal addressed to the person's last 8548
known address or may cause the notice to be sent to the person 8549
through the secretary of any recognized medical, osteopathic, or 8550
podiatric society, according to the following schedule: 8551

(a) To persons whose last name begins with the letters "A" 8552
through "B," on or before January 1, 2001, and the first day of 8553
January of every odd-numbered year thereafter; 8554

(b) To persons whose last name begins with the letters "C" 8555
through "D," on or before October 1, 2000, and the first day of 8556
October of every even-numbered year thereafter; 8557

(c) To persons whose last name begins with the letters "E" 8558
through "G," on or before July 1, 2000, and the first day of 8559
July of every even-numbered year thereafter; 8560

(d) To persons whose last name begins with the letters "H" 8561
through "K," on or before April 1, 2000, and the first day of 8562
April of every even-numbered year thereafter; 8563

(e) To persons whose last name begins with the letters "L" 8564
through "M," on or before January 1, 2000, and the first day of 8565

January of every even-numbered year thereafter; 8566

(f) To persons whose last name begins with the letters "N" 8567
through "R," on or before October 1, 1999, and the first day of 8568
October of every odd-numbered year thereafter; 8569

(g) To persons whose last name begins with the letter "S," 8570
on or before July 1, 1999, and the first day of July of every 8571
odd-numbered year thereafter; 8572

(h) To persons whose last name begins with the letters "T" 8573
through "Z," on or before April 1, 1999, and the first day of 8574
April of every odd-numbered year thereafter. 8575

(3) Failure of any person to receive a notice of renewal 8576
from the board shall not excuse the person from the requirements 8577
contained in this section. 8578

(4) The board's notice shall inform the applicant of the 8579
renewal procedure. The board shall provide the application for 8580
registration renewal in a form determined by the board. 8581

(5) The applicant shall provide in the application the 8582
applicant's full name, principal practice address and residence 8583
address, the number of the applicant's certificate to practice, 8584
and any other information required by the board. 8585

(6) (a) Except as provided in division (B) (6) (b) of this 8586
section, in the case of an applicant who prescribes or 8587
personally furnishes opioid analgesics or benzodiazepines, the 8588
applicant shall certify to the board whether the applicant has 8589
been granted access to the drug database established and 8590
maintained by the state board of pharmacy pursuant to section 8591
4729.75 of the Revised Code. 8592

(b) The requirement in division (B) (6) (a) of this section 8593

does not apply if either of the following is the case: 8594

(i) The state board of pharmacy notifies the state medical 8595
board pursuant to section 4729.861 of the Revised Code that the 8596
applicant has been restricted from obtaining further information 8597
from the drug database. 8598

(ii) The state board of pharmacy no longer maintains the 8599
drug database. 8600

(c) If an applicant certifies to the state medical board 8601
that the applicant has been granted access to the drug database 8602
and the board finds through an audit or other means that the 8603
applicant has not been granted access, the board may take action 8604
under section 4731.22 of the Revised Code. 8605

(7) The applicant shall include with the application a 8606
list of the names and addresses of any clinical nurse 8607
specialists, certified nurse-midwives, or certified nurse 8608
practitioners with whom the applicant is currently 8609
collaborating, as defined in section 4723.01 of the Revised 8610
Code. Every person registered under this section shall give 8611
written notice to the state medical board of any change of 8612
principal practice address or residence address or in the list 8613
within thirty days of the change. 8614

(8) The applicant shall report any criminal offense to 8615
which the applicant has pleaded guilty, of which the applicant 8616
has been found guilty, or for which the applicant has been found 8617
eligible for intervention in lieu of conviction, since last 8618
filing an application for a certificate of registration. 8619

(9) The applicant shall execute and deliver the 8620
application to the board in a manner prescribed by the board. 8621

(C) The board shall issue to any person holding a 8622

certificate under this chapter to practice medicine and surgery, 8623
osteopathic medicine and surgery, or podiatric medicine and 8624
surgery, upon application and qualification therefor in 8625
accordance with this section, a certificate of registration 8626
under the seal of the board. A certificate of registration shall 8627
be valid for a two-year period. 8628

(D) Failure of any certificate holder to register and 8629
comply with this section shall operate automatically to suspend 8630
the holder's certificate to practice. Continued practice after 8631
the suspension of the certificate to practice shall be 8632
considered as practicing in violation of section 4731.41, 8633
4731.43, or 4731.60 of the Revised Code. If the certificate has 8634
been suspended pursuant to this division for two years or less, 8635
it may be reinstated. The board shall reinstate a certificate to 8636
practice suspended for failure to register upon an applicant's 8637
submission of a renewal application, the biennial registration 8638
fee, and the applicable monetary penalty. The penalty for 8639
reinstatement shall be fifty dollars. If the certificate has 8640
been suspended pursuant to this division for more than two 8641
years, it may be restored. Subject to section 4731.222 of the 8642
Revised Code, the board may restore a certificate to practice 8643
suspended for failure to register upon an applicant's submission 8644
of a restoration application, the biennial registration fee, and 8645
the applicable monetary penalty and compliance with sections 8646
4776.01 to 4776.04 of the Revised Code. The board shall not 8647
restore to an applicant a certificate to practice unless the 8648
board, in its discretion, decides that the results of the 8649
criminal records check do not make the applicant ineligible for 8650
a certificate issued pursuant to section 4731.14, 4731.56, or 8651
4731.57 of the Revised Code. The penalty for restoration shall 8652
be one hundred dollars. The board shall deposit the penalties in 8653

accordance with section 4731.24 of the Revised Code. 8654

(E) If an individual certifies completion of the number of 8655
hours and type of continuing medical education required to 8656
receive a certificate of registration or reinstatement of a 8657
certificate to practice, and the board finds through the random 8658
samples it conducts under this section or through any other 8659
means that the individual did not complete the requisite 8660
continuing medical education, the board may impose a civil 8661
penalty of not more than five thousand dollars. The board's 8662
finding shall be made pursuant to an adjudication under Chapter 8663
119. of the Revised Code and by an affirmative vote of not fewer 8664
than six members. 8665

A civil penalty imposed under this division may be in 8666
addition to or in lieu of any other action the board may take 8667
under section 4731.22 of the Revised Code. The board shall 8668
deposit civil penalties in accordance with section 4731.24 of 8669
the Revised Code. 8670

(F) The state medical board and the health care 8671
professional standards board may obtain information not 8672
protected by statutory or common law privilege from courts and 8673
other sources concerning malpractice claims against any person 8674
holding a certificate to practice under this chapter or 8675
practicing as provided in section 4731.36 of the Revised Code. 8676

(G) Each mailing sent by the state medical board under 8677
division (B)(2) of this section to a person registered to 8678
practice medicine and surgery or osteopathic medicine and 8679
surgery shall inform the applicant of the reporting requirement 8680
established by division (H) of section 3701.79 of the Revised 8681
Code. At the discretion of the board, the information may be 8682
included on the application for registration or on an 8683

accompanying page. 8684

Sec. 4731.74. Implementation of this section is subject to 8685
section 5166.50 of the Revised Code. 8686

For purposes of section 3727.61 of the Revised Code, the 8687
state medical board shall establish a list of nonemergency 8688
medical conditions. A condition on the list may not be an 8689
"emergency medical condition" as defined in 42 C.F.R. 489.24. 8690
For each condition on the list, the board shall identify 8691
symptoms that are associated with the condition. 8692

Sec. 4734.31. (A) The state chiropractic board may take 8693
any of the actions specified in division (B) of this section 8694
against an individual who has applied for or holds a license to 8695
practice chiropractic in this state if any of the reasons 8696
specified in division (C) of this section for taking action 8697
against an individual are applicable. Except as provided in 8698
division (D) of this section, actions taken against an 8699
individual shall be taken in accordance with Chapter 119. of the 8700
Revised Code. The board may specify that any action it takes is 8701
a permanent action. The board's authority to take action against 8702
an individual is not removed or limited by the individual's 8703
failure to renew a license. 8704

(B) In its imposition of sanctions against an individual, 8705
the state chiropractic board may do any of the following: 8706

(1) Refuse to issue, renew, restore, or reinstate a 8707
license to practice chiropractic or a certificate to practice 8708
acupuncture; 8709

(2) Reprimand or censure a license holder; 8710

(3) Place limits, restrictions, or probationary conditions 8711
on a license holder's practice; 8712

(4) Impose a civil fine of not more than five thousand 8713
dollars according to a schedule of fines specified in rules that 8714
the state chiropractic board shall adopt in accordance with 8715
Chapter 119. of the Revised Code; 8716

(5) Suspend a license to practice chiropractic or a 8717
certificate to practice acupuncture for a limited or indefinite 8718
period; 8719

(6) Revoke a license to practice chiropractic or a 8720
certificate to practice acupuncture. 8721

(C) The state chiropractic board may take the actions 8722
specified in division (B) of this section for any of the 8723
following reasons: 8724

(1) A plea of guilty to, a judicial finding of guilt of, 8725
or a judicial finding of eligibility for intervention in lieu of 8726
conviction for, a felony in any jurisdiction, in which case a 8727
certified copy of the court record shall be conclusive evidence 8728
of the conviction; 8729

(2) Commission of an act that constitutes a felony in this 8730
state, regardless of the jurisdiction in which the act was 8731
committed; 8732

(3) A plea of guilty to, a judicial finding of guilt of, 8733
or a judicial finding of eligibility for intervention in lieu of 8734
conviction for, a misdemeanor involving moral turpitude, as 8735
determined by the board, in which case a certified copy of the 8736
court record shall be conclusive evidence of the matter; 8737

(4) Commission of an act involving moral turpitude that 8738
constitutes a misdemeanor in this state, regardless of the 8739
jurisdiction in which the act was committed; 8740

(5) A plea of guilty to, a judicial finding of guilt of, 8741
or a judicial finding of eligibility for intervention in lieu of 8742
conviction for, a misdemeanor committed in the course of 8743
practice, in which case a certified copy of the court record 8744
shall be conclusive evidence of the matter; 8745

(6) Commission of an act in the course of practice that 8746
constitutes a misdemeanor in this state, regardless of the 8747
jurisdiction in which the act was committed; 8748

(7) A violation or attempted violation of this chapter or 8749
the rules adopted under it governing the practice of 8750
chiropractic and the practice of acupuncture by a chiropractor 8751
licensed under this chapter; 8752

(8) Failure to cooperate in an investigation conducted by 8753
the state chiropractic board or the health care professional 8754
standards board, including failure to comply with a subpoena or 8755
order issued by ~~the either~~ board or failure to answer truthfully 8756
a question presented by ~~the either~~ board at a deposition or in 8757
written interrogatories, except that failure to cooperate with 8758
an investigation shall not constitute grounds for discipline 8759
under this section if the board or a court of competent 8760
jurisdiction has issued an order that either quashes a subpoena 8761
or permits the individual to withhold the testimony or evidence 8762
in issue; 8763

(9) Engaging in an ongoing professional relationship with 8764
a person or entity that violates any provision of this chapter 8765
or the rules adopted under it, unless the chiropractor makes a 8766
good faith effort to have the person or entity comply with the 8767
provisions; 8768

(10) Retaliating against a chiropractor for the 8769

chiropractor's reporting to the state chiropractic board or any 8770
other agency with jurisdiction any violation of the law or for 8771
cooperating with the board of another agency in the 8772
investigation of any violation of the law; 8773

(11) Aiding, abetting, assisting, counseling, or 8774
conspiring with any person in that person's violation of any 8775
provision of this chapter or the rules adopted under it, 8776
including the practice of chiropractic without a license, the 8777
practice of acupuncture without a certificate, or aiding, 8778
abetting, assisting, counseling, or conspiring with any person 8779
in that person's unlicensed practice of any other health care 8780
profession that has licensing requirements; 8781

(12) With respect to a report or record that is made, 8782
filed, or signed in connection with the practice of chiropractic 8783
or acupuncture, knowingly making or filing a report or record 8784
that is false, intentionally or negligently failing to file a 8785
report or record required by federal, state, or local law or 8786
willfully impeding or obstructing the required filing, or 8787
inducing another person to engage in any such acts; 8788

(13) Making a false, fraudulent, or deceitful statement to 8789
the state chiropractic board or the health care professional 8790
standards board or any agent of ~~the either~~ board during any 8791
investigation or other official proceeding conducted by ~~the~~ 8792
either board under this chapter or Chapter 4746. of the Revised 8793
Code or in any filing that must be submitted to ~~the either~~ 8794
board; 8795

(14) Attempting to secure a license to practice 8796
chiropractic or certificate to practice acupuncture or to 8797
corrupt the outcome of an official state chiropractic board 8798
proceeding through bribery or any other improper means; 8799

- (15) Willfully obstructing or hindering the state 8800
chiropractic board or any agent of the board in the discharge of 8801
the board's duties; 8802
- (16) Habitually using drugs or intoxicants to the extent 8803
that the person is rendered unfit for the practice of 8804
chiropractic or acupuncture; 8805
- (17) Inability to practice chiropractic or acupuncture 8806
according to acceptable and prevailing standards of care by 8807
reason of chemical dependency, mental illness, or physical 8808
illness, including conditions in which physical deterioration 8809
has adversely affected the person's cognitive, motor, or 8810
perceptive skills and conditions in which a chiropractor's 8811
continued practice may pose a danger to the chiropractor or the 8812
public; 8813
- (18) Any act constituting gross immorality relative to the 8814
person's practice of chiropractic or acupuncture, including acts 8815
involving sexual abuse, sexual misconduct, or sexual 8816
exploitation; 8817
- (19) Exploiting a patient for personal or financial gain; 8818
- (20) Failing to maintain proper, accurate, and legible 8819
records in the English language documenting each patient's care, 8820
including, as appropriate, records of the following: dates of 8821
treatment, services rendered, examinations, tests, x-ray 8822
reports, referrals, and the diagnosis or clinical impression and 8823
clinical treatment plan provided to the patient; 8824
- (21) Except as otherwise required by the state 8825
chiropractic board or by law, disclosing patient information 8826
gained during the chiropractor's professional relationship with 8827
a patient without obtaining the patient's authorization for the 8828

disclosure;	8829
(22) Commission of willful or gross malpractice, or	8830
willful or gross neglect, in the practice of chiropractic or	8831
acupuncture;	8832
(23) Failing to perform or negligently performing an act	8833
recognized by the board as a general duty or the exercise of due	8834
care in the practice of chiropractic or acupuncture, regardless	8835
of whether injury results to a patient from the failure to	8836
perform or negligent performance of the act;	8837
(24) Engaging in any conduct or practice that impairs or	8838
may impair the ability to practice chiropractic or acupuncture	8839
safely and skillfully;	8840
(25) Practicing, or claiming to be capable of practicing,	8841
beyond the scope of the practice of chiropractic or acupuncture	8842
as established under this chapter and the rules adopted under	8843
this chapter;	8844
(26) Accepting and performing professional	8845
responsibilities as a chiropractor or chiropractor with a	8846
certificate to practice acupuncture when not qualified to	8847
perform those responsibilities, if the person knew or had reason	8848
to know that the person was not qualified to perform them;	8849
(27) Delegating any of the professional responsibilities	8850
of a chiropractor or chiropractor with a certificate to practice	8851
acupuncture to an employee or other individual when the	8852
delegating chiropractor knows or had reason to know that the	8853
employee or other individual is not qualified by training,	8854
experience, or professional licensure to perform the	8855
responsibilities;	8856
(28) Delegating any of the professional responsibilities	8857

of a chiropractor or chiropractor with a certificate to practice	8858
acupuncture to an employee or other individual in a negligent	8859
manner or failing to provide proper supervision of the employee	8860
or other individual to whom the responsibilities are delegated;	8861
(29) Failing to refer a patient to another health care	8862
practitioner for consultation or treatment when the chiropractor	8863
knows or has reason to know that the referral is in the best	8864
interest of the patient;	8865
(30) Obtaining or attempting to obtain any fee or other	8866
advantage by fraud or misrepresentation;	8867
(31) Making misleading, deceptive, false, or fraudulent	8868
representations in the practice of chiropractic or acupuncture;	8869
(32) Being guilty of false, fraudulent, deceptive, or	8870
misleading advertising or other solicitations for patients or	8871
knowingly having professional connection with any person that	8872
advertises or solicits for patients in such a manner;	8873
(33) Violation of a provision of any code of ethics	8874
established or adopted by the board under section 4734.16 of the	8875
Revised Code;	8876
(34) Failing to meet the examination requirements for	8877
receipt of a license specified under section 4734.20 of the	8878
Revised Code;	8879
(35) Actions taken for any reason, other than nonpayment	8880
of fees, by the chiropractic or acupuncture licensing authority	8881
of another state or country;	8882
(36) Failing to maintain clean and sanitary conditions at	8883
the clinic, office, or other place in which chiropractic	8884
services or acupuncture services are provided;	8885

(37) Except as provided in division (G) of this section:	8886
(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;	8887 8888 8889 8890 8891 8892
(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.	8893 8894 8895 8896 8897
(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.	8898 8899 8900 8901
(D) The adjudication requirements of Chapter 119. of the Revised Code apply to the <u>state chiropractic board</u> when taking actions against an individual under this section, except as follows:	8902 8903 8904 8905
(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.	8906 8907 8908 8909 8910
(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.	8911 8912 8913
(3) In lieu of an adjudication, the board may accept the	8914

surrender of a license to practice chiropractic or certificate 8915
to practice acupuncture from a chiropractor. 8916

(4) In lieu of an adjudication, the board may enter into a 8917
consent agreement with an individual to resolve an allegation of 8918
a violation of this chapter or any rule adopted under it. A 8919
consent agreement, when ratified by the board, shall constitute 8920
the findings and order of the board with respect to the matter 8921
addressed in the agreement. If the board refuses to ratify a 8922
consent agreement, the admissions and findings contained in the 8923
consent agreement shall be of no force or effect. 8924

(E) This section does not require the state chiropractic 8925
board to hire, contract with, or retain the services of an 8926
expert witness when the board takes action against a 8927
chiropractor concerning compliance with acceptable and 8928
prevailing standards of care in the practice of chiropractic or 8929
acupuncture. As part of an action taken concerning compliance 8930
with acceptable and prevailing standards of care, the board may 8931
rely on the knowledge of its members for purposes of making a 8932
determination of compliance, notwithstanding any expert 8933
testimony presented by the chiropractor that contradicts the 8934
knowledge and opinions of the members of the board. 8935

(F) The sealing of conviction records by a court shall 8936
have no effect on a prior state chiropractic board order entered 8937
under this section or on the board's jurisdiction to take action 8938
under this section if, based on a plea of guilty, a judicial 8939
finding of guilt, or a judicial finding of eligibility for 8940
intervention in lieu of conviction, the board issued a notice of 8941
opportunity for a hearing prior to the court's order to seal the 8942
records. The board shall not be required to seal, destroy, 8943
redact, or otherwise modify its records to reflect the court's 8944

sealing of conviction records. 8945

(G) Actions shall not be taken pursuant to division (C) 8946
(37) of this section against any chiropractor who waives 8947
deductibles and copayments as follows: 8948

(1) In compliance with the health benefit plan that 8949
expressly allows a practice of that nature. Waiver of the 8950
deductibles or copayments shall be made only with the full 8951
knowledge and consent of the plan purchaser, payer, and third- 8952
party administrator. Documentation of the consent shall be made 8953
available to the state chiropractic board upon request. 8954

(2) For professional services rendered to any other person 8955
licensed pursuant to this chapter, to the extent allowed by this 8956
chapter and the rules of the state chiropractic board. 8957

(H) If an individual who holds a certificate or license 8958
issued under this chapter is listed in a claim filed under 8959
Chapter 3965. of the Revised Code, the state chiropractic board 8960
shall suspend any investigation and shall not take disciplinary 8961
action under this section against that individual for conduct 8962
relating to that claim unless otherwise required by the health 8963
care professional standards board or until the health care 8964
professional standards board has concluded its investigation 8965
under Chapter 4746. of the Revised Code. 8966

The state chiropractic board shall take any disciplinary 8967
action required by the health care professional standards board 8968
against a certificate or license holder under this chapter 8969
pursuant to section 4746.05 of the Revised Code. If the health 8970
care professional standards board imposes discipline on a 8971
certificate or license holder, the state chiropractic board 8972
shall not take disciplinary action for the same conduct that is 8973

the subject of the disciplinary action ordered by the health 8974
care professional standards board. However, the state 8975
chiropractic board may account for that disciplinary action in 8976
any future disciplinary action taken against the certificate or 8977
license holder. 8978

Sec. 4734.32. (A) (1) Except as provided in division (A) (2) 8979
of this section, if formal disciplinary action is taken against 8980
a chiropractor by any health care facility, including a clinic, 8981
hospital, or similar facility, the chief administrator or 8982
executive officer of the facility shall file a report with the 8983
state chiropractic board and the health care professional 8984
standards board not later than sixty days after the disciplinary 8985
action is imposed. The report shall include the name of the 8986
individual, the action taken by the facility, and a summary of 8987
the underlying facts leading to the action taken. On request, 8988
the state chiropractic board shall be provided certified copies 8989
of the patient records that were the basis for the facility's 8990
action. Prior to release to ~~the either~~ board, the summary shall 8991
be approved by the peer review committee that reviewed the case 8992
or by the governing board of the facility. 8993

The filing of a report with ~~the either~~ board, a decision 8994
not to file a report with ~~the either~~ board, an investigation by 8995
~~the either~~ board, or any disciplinary action taken by ~~the either~~ 8996
board, does not preclude a health care facility from taking 8997
disciplinary action against a chiropractor. 8998

In the absence of fraud or bad faith, no individual or 8999
entity that provides patient records to ~~the either~~ board shall 9000
be liable in damages to any person as a result of providing the 9001
records. 9002

(2) Disciplinary action taken against a chiropractor by a 9003

chiropractic clinic need not be reported to the state 9004
chiropractic board or the health care professional standards 9005
board in either of the following circumstances: 9006

(a) The clinic takes the disciplinary action for reasons 9007
that do not involve clinical or patient care issues. 9008

(b) The clinic employs fewer than five chiropractors and 9009
the disciplinary action taken does not rise above the level of a 9010
written reprimand. 9011

(B) A chiropractor or professional association or society 9012
of chiropractors that believes a violation of any provision of 9013
this chapter or rule of the state chiropractic board has 9014
occurred shall report to the state chiropractic board and the 9015
health care professional standards board the information upon 9016
which the belief is based. This division does not require any 9017
treatment provider approved by the state chiropractic board 9018
under section 4734.40 of the Revised Code or any employee, 9019
agent, or representative of such a provider to make reports with 9020
respect to a chiropractor participating in treatment or 9021
aftercare for substance abuse as long as the chiropractor 9022
maintains participation in accordance with the requirements of 9023
section 4734.40 of the Revised Code and the treatment provider 9024
or employee, agent, or representative of the provider has no 9025
reason to believe that the chiropractor has violated any 9026
provision of this chapter or rule adopted under it, other than 9027
being impaired by alcohol, drugs, or other substances. This 9028
division does not require reporting by any member of an impaired 9029
practitioner committee established by a health care facility or 9030
by any representative or agent of a committee or program 9031
sponsored by a professional association or society of 9032
chiropractors to provide peer assistance to chiropractors with 9033

substance abuse problems with respect to a chiropractor who has 9034
been referred for examination to a treatment program approved by 9035
the state chiropractic board under section 4734.40 of the 9036
Revised Code if the chiropractor cooperates with the referral 9037
for examination and with any determination that the chiropractor 9038
should enter treatment and as long as the committee member, 9039
representative, or agent has no reason to believe that the 9040
chiropractor has ceased to participate in the treatment program 9041
in accordance with section 4734.40 of the Revised Code or has 9042
violated any provision of this chapter or rule adopted under it, 9043
other than being impaired by alcohol, drugs, or other 9044
substances. 9045

(C) Any professional association or society composed 9046
primarily of chiropractors that suspends or revokes an 9047
individual's membership for violations of professional ethics, 9048
or for reasons of professional incompetence or professional 9049
malpractice, within sixty days after a final decision, shall 9050
report to the state chiropractic board and the health care 9051
professional standards board, on forms prescribed and provided 9052
by the state chiropractic board, the name of the individual, the 9053
action taken by the professional organization, and a summary of 9054
the underlying facts leading to the action taken. 9055

The filing of a report with ~~the either~~ board, a decision 9056
not to file a report with ~~the either~~ board, an investigation by 9057
~~the either~~ board, or any disciplinary action taken by ~~the either~~ 9058
board, shall not preclude a professional organization from 9059
taking disciplinary action against a chiropractor. 9060

(D) Any insurer providing professional liability insurance 9061
to any person holding a valid license as a chiropractor or any 9062
other entity that seeks to indemnify the professional liability 9063

of a chiropractor shall notify the state chiropractic board 9064
within thirty days after the final disposition of any written 9065
claim for damages where such disposition results in a payment 9066
exceeding ten thousand dollars. The notice shall contain the 9067
following information: 9068

(1) The name and address of the person submitting the 9069
notification; 9070

(2) The name and address of the insured who is the subject 9071
of the claim; 9072

(3) The name of the person filing the written claim; 9073

(4) The date of final disposition; 9074

(5) If applicable, the identity of the court in which the 9075
final disposition of the claim took place. 9076

(E) ~~The~~ Either board may investigate possible violations 9077
of this chapter or the rules adopted under it that are brought 9078
to its attention as a result of the reporting requirements of 9079
this section, except that the state chiropractic board shall 9080
conduct an investigation if a possible violation involves 9081
repeated malpractice. As used in this division, "repeated 9082
malpractice" means three or more claims for malpractice within 9083
the previous five-year period, each resulting in a judgment or 9084
settlement in excess of ten thousand dollars in favor of the 9085
claimant, and each involving tortious conduct by the 9086
chiropractor. 9087

(F) All summaries, reports, and records received and 9088
maintained by the state chiropractic board and the health care 9089
professional standards board pursuant to this section shall be 9090
held in confidence and shall not be subject to discovery or 9091
introduction in evidence in any federal or state civil action 9092

involving a chiropractor or health care facility arising out of 9093
matters that are the subject of the reporting required by this 9094
section. The ~~board~~ boards may use the information obtained only 9095
as the basis for an investigation, as evidence in a disciplinary 9096
hearing against a chiropractor, or in any subsequent trial or 9097
appeal of a board action or order. 9098

The state chiropractic board may disclose the summaries 9099
and reports it receives under this section only to health care 9100
facility committees within or outside this state that are 9101
involved in credentialing or recredentialing a chiropractor or 9102
reviewing the chiropractor's privilege to practice within a 9103
particular facility. The board shall indicate whether or not the 9104
information has been verified. Information transmitted by the 9105
board shall be subject to the same confidentiality provisions as 9106
when maintained by the board. 9107

(G) Except for reports filed by an individual pursuant to 9108
division (B) of this section, the state chiropractic board shall 9109
send a copy of any reports or summaries it receives pursuant to 9110
this section to the chiropractor. The chiropractor shall have 9111
the right to file a statement with ~~the board~~ both boards 9112
concerning the correctness or relevance of the information. The 9113
statement shall at all times accompany that part of the record 9114
in contention. 9115

(H) An individual or entity that reports to ~~the either~~ 9116
board or refers an impaired chiropractor to a treatment provider 9117
approved by the board under section 4734.40 of the Revised Code 9118
shall not be subject to suit for civil damages as a result of 9119
the report, referral, or provision of the information. 9120

(I) In the absence of fraud or bad faith, a professional 9121
association or society of chiropractors that sponsors a 9122

committee or program to provide peer assistance to a 9123
chiropractor with substance abuse problems, a representative or 9124
agent of such a committee or program, and a member of the state 9125
chiropractic board shall not be held liable in damages to any 9126
person by reason of actions taken to refer a chiropractor to a 9127
treatment provider approved under section 4734.40 of the Revised 9128
Code for examination or treatment. 9129

Sec. 4743.08. (A) As used in this section and in section 9130
4743.09 of the Revised Code: 9131

(1) "Dangerous drug" has the same meaning as in section 9132
4729.01 of the Revised Code. 9133

(2) "Health care provider" or "provider" means an 9134
individual who is licensed, certified, or registered by a board, 9135
commission, or agency that is created under or by virtue of 9136
Title XLVII of the Revised Code and provides health-related 9137
diagnostic, evaluative, or treatment services. In accordance 9138
with Chapter 119. of the Revised Code, the director of health 9139
may adopt rules further defining "health care provider." 9140

(3) "Insurer" means any person that is authorized to 9141
engage in the business of insurance in this state under Title 9142
XXXIX of the Revised Code, the Ohio fair plan underwriting 9143
association created under section 3929.43 of the Revised Code, 9144
any health insuring corporation, or any legal entity that is 9145
self-insured and provides benefits to its employees or members. 9146

(B) (1) Except as provided in division (D) of this section, 9147
before a health care provider dispenses a dangerous drug or 9148
provides a medical product or service to a patient, the provider 9149
shall notify the patient or the patient's representative of all 9150
of the following: 9151

(a) The provider's usual and customary charge for the drug 9152
or medical product or service; 9153

(b) The portion of the charge described in division (B)(1) 9154
(a) of this section that the patient's insurer will pay for the 9155
drug, medical product, or service or, if the patient is a 9156
medicaid recipient, the portion the medicaid program will pay 9157
for the medicaid service; 9158

(c) Any out-of-pocket amount the patient will be charged 9159
for the drug, medical product, or service. 9160

(2) The notifications required by division (B)(1) of this 9161
section shall be provided in writing unless the patient and the 9162
provider are in different locations. Under those circumstances, 9163
the notifications may be given verbally. 9164

To assist in providing the notification in writing, a 9165
health care provider may create forms that contain lists of 9166
commonly provided services and that identify for each of the 9167
services the information described in divisions (B)(1)(a) to (c) 9168
of this section. As necessary, separate forms may be created for 9169
different insurers and the medicaid program. Any form created 9170
shall be not more than eight and one-half inches by five and 9171
one-half inches in size. The list of services and the 9172
associated information shall be presented on one side of the 9173
form and shall be printed in not less than twelve-point type. 9174

(C) Except as provided in division (D) of this section, a 9175
health care provider shall not dispense a dangerous drug or 9176
provide a medical product or service to a patient unless the 9177
patient or the patient's representative consents to being 9178
charged the out-of-pocket amount for the item. Consent shall be 9179
given in writing unless the patient and the provider are in 9180

different locations. Under those circumstances, consent may be 9181
given verbally if the verbal consent is recorded by the 9182
provider. 9183

(D) The requirements of divisions (B) and (C) of this 9184
section do not apply in emergency situations. The director of 9185
health may adopt rules specifying which situations are emergency 9186
situations. Application of the requirement of division (C) of 9187
this section is subject to section 5166.50 of the Revised Code 9188
when the patient is a medicaid recipient. 9189

Sec. 4743.09. Notwithstanding any provision of the Revised 9190
Code to the contrary, a health care provider may advertise the 9191
provider's usual and customary charge for any product, 9192
procedure, or service that is provided, performed, or rendered 9193
by the provider. Any provision in a contract that prohibits this 9194
practice is void. 9195

Sec. 4746.01. As used in this chapter: 9196

(A) "Chiropractic claim," "dental claim," "medical claim," 9197
"optometric claim," "derivative claim," and "provider" have the 9198
same meanings as in section 3965.01 of the Revised Code. 9199

(B) "Claim" means a chiropractic, dental, medical, 9200
optometric, or derivative claim filed under Chapter 3965. or 9201
3967. of the Revised Code. 9202

(C) "License" means an authorization evidenced by a 9203
license, certificate, registration, permit, card, or other 9204
authority that is issued or conferred by a regulatory authority 9205
to a provider or to an applicant for an initial license by which 9206
the provider or initial license applicant has or claims the 9207
privilege to engage in a profession, occupation, or occupational 9208
activity. 9209

(D) "Regulatory authority" means the state medical board, 9210
state dental board, state nursing board, state board of 9211
optometry, state chiropractic board, state board of pharmacy, 9212
Ohio occupational therapy, physical therapy, and athletic 9213
trainers board, and the state board of emergency medical, fire, 9214
and transportation services. 9215

Sec. 4746.02. (A) (1) There is hereby created the health 9216
care professional standards board consisting of nine members 9217
appointed as follows, within ninety days after the effective 9218
date of this section: 9219

(a) Three members appointed by the state medical board, 9220
one for a term ending one year after the effective date of this 9221
section, one for a term ending two years after the effective 9222
date of this section, and one for a term ending three years 9223
after the effective date of this section; 9224

(b) One member appointed by the state dental board, for a 9225
term ending four years after the effective date of this section; 9226

(c) One member appointed by the state chiropractic board, 9227
for a term ending five years after the effective date of this 9228
section; 9229

(d) One member appointed by the state board of pharmacy, 9230
for a term ending five years after the effective date of this 9231
section; 9232

(e) Two members appointed by the state board of nursing, 9233
one for a term ending three years after the effective date of 9234
this section, and one for a term ending four years after the 9235
effective date of this section; 9236

(f) One member appointed by the state board of optometry, 9237
for a term ending two years after the effective date of this 9238

section. 9239

(2) Members shall be appointed in consultation with the 9240
Ohio board of regents and shall either be the members of the 9241
respective boards who are responsible for developing, 9242
evaluating, or revising the applicable examinations for 9243
licensure of the respective occupation or profession or be 9244
members of the national organization responsible for creating 9245
such examinations. 9246

(B) Except as otherwise provided in this division, after 9247
initial appointment, terms of office shall be for five years, 9248
each term ending on the same day of the same month as did the 9249
term that it succeeds. 9250

A member appointed under division (A) (1) (f) of this 9251
section shall be appointed for a period of two years. Upon 9252
expiration of the term of the initial member appointed under 9253
that division, the Ohio occupational therapy, physical therapy, 9254
and athletic trainers board shall appoint the succeeding member. 9255
Upon expiration of the term of the member appointed by the Ohio 9256
occupational therapy, physical therapy, and athletic trainers 9257
board, the state board of emergency medical, fire, and 9258
transportation services shall appoint the succeeding member. 9259
Thereafter, the three boards shall rotate appointing that member 9260
in the order described in this division. 9261

Each member shall hold office from the date of appointment 9262
until the end of the term for which the member was appointed. A 9263
vacancy shall be filled in the same manner prescribed for 9264
filling the position in which the vacancy occurs. Any member 9265
appointed to fill a vacancy occurring prior to the expiration of 9266
the term for which the member's predecessor was appointed shall 9267
hold office for the remainder of the term. Any member shall 9268

continue in office subsequent to the expiration date of the 9269
member's term until a successor takes office, or until a period 9270
of sixty days has elapsed, whichever occurs first. 9271

(C) Each member of the board shall receive an amount fixed 9272
pursuant to division (J) of section 124.15 of the Revised Code 9273
for each day, or portion thereof, actually engaged in the 9274
discharge of official duties. Each member also shall be 9275
reimbursed for actual and necessary expenses incurred in the 9276
performance of those duties. 9277

Sec. 4746.03. (A) The health care professional standards 9278
board shall do all of the following: 9279

(1) Determine, pursuant to section 4746.04 of the Revised 9280
Code and in accordance with the appropriate standard of care of 9281
the occupation or profession, whether an action or omission by a 9282
provider in a claim constitutes gross negligence or whether a 9283
provider has engaged in a pattern of negligent behavior; 9284

(2) Impose discipline in accordance with section 4746.05 9285
of the Revised Code, or designate the appropriate regulatory 9286
authority to impose the disciplinary action recommended by the 9287
board; 9288

(3) Create and maintain the database required under 9289
section 4746.06 of the Revised Code; 9290

(4) Prepare and submit to the office of budget and 9291
management a budget for each biennium; 9292

(5) Create and maintain a public web site; 9293

(6) Coordinate and cooperate with the appropriate 9294
regulatory authority in conducting investigations and imposing 9295
discipline under this chapter; 9296

(7) Perform any other duties as prescribed under this 9297
chapter; 9298

(8) Adopt rules in accordance with Chapter 119. of the 9299
Revised Code as the board considers necessary to administer this 9300
chapter. 9301

(B) The board may employ staff as the board determines 9302
necessary in carrying out the duties of the board under this 9303
chapter. 9304

Sec. 4746.04. Within thirty days after a claim is filed 9305
under Chapter 3965. of the Revised Code, the administrator of 9306
medical injury compensation shall provide a copy of the claim to 9307
the health care professional standards board. The board shall 9308
investigate the claim to determine whether an action or omission 9309
by a provider listed in the claim was filed constitutes gross 9310
negligence or whether such a provider has engaged in a pattern 9311
of negligent behavior over a short period of time, as defined in 9312
rules adopted by the board. In conducting an investigation, the 9313
board may issue subpoenas, examine witnesses, and administer 9314
oaths. The board may request the appropriate regulatory 9315
authority to conduct the investigation. Neither the board nor 9316
the appropriate regulatory authority shall review or consider a 9317
determination of liability made under Chapter 3965. or 3967. of 9318
the Revised Code when conducting an investigation or making a 9319
determination under this section as to whether a provider's acts 9320
or omissions constitute gross negligence. If, after an 9321
investigation, the board determines that a provider's act or 9322
omission constitutes gross negligence or that a provider has 9323
engaged in a pattern of negligent behavior over a short period 9324
of time, the board shall send the provider a written notice of 9325
that determination in accordance with section 119.07 of the 9326

Revised Code. If a provider requests a hearing in accordance 9327
with that section, the board shall conduct a hearing in 9328
accordance with Chapter 119. of the Revised Code. If, after a 9329
hearing, the board determines that a provider's act or omission 9330
constitutes gross negligence or that a provider has engaged in a 9331
pattern of negligent behavior over a short period of time, or if 9332
a provider fails to request a hearing as provided in that 9333
section, discipline shall be imposed against the provider in 9334
accordance with section 4746.05 of the Revised Code. 9335

Sec. 4746.05. (A) The health care professional standards 9336
board may take any of the following actions against a provider's 9337
license if the board determines under section 4746.04 of the 9338
Revised Code that the provider's act or omission in a claim 9339
constitutes gross negligence or that the provider has engaged in 9340
a pattern of negligent behavior over a short period of time with 9341
respect to claims: 9342

(1) A public reprimand; 9343

(2) A license suspension for a definite period of time 9344
that is not less than two months nor more than two years; 9345

(3) An indefinite license suspension, or a license 9346
suspension for an indefinite period of time that is at least two 9347
years; 9348

(4) Permanent revocation of a license. 9349

(B) In lieu of the board imposing a disciplinary action as 9350
described in division (A) of this section, the board may require 9351
the appropriate regulatory authority to impose the discipline. 9352

(C) If the board disciplines a provider under this section 9353
or directs a regulatory authority to discipline a provider, the 9354
board shall do all of the following: 9355

(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; 9356
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(2) Notify the appropriate authority in each state other than this state that regulates the profession in which the provider is engaged; 9360
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9362

(3) Publish the board's decision on the web site created and maintained by the board. 9363
9364

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. 9365
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(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. 9371
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(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. 9378
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(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 9381
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feasible, the board shall adopt rules in accordance with Chapter 9385
119. of the Revised Code to implement the reporting program. 9386

Sec. 4755.47. (A) In accordance with Chapter 119. of the 9387
Revised Code, the physical therapy section of the Ohio 9388
occupational therapy, physical therapy, and athletic trainers 9389
board may refuse to grant a license to an applicant for an 9390
initial or renewed license as a physical therapist or physical 9391
therapist assistant or, by an affirmative vote of not less than 9392
five members, may limit, suspend, or revoke the license of a 9393
physical therapist or physical therapist assistant or reprimand, 9394
fine, place a license holder on probation, or require the 9395
license holder to take corrective action courses, on any of the 9396
following grounds: 9397

(1) Habitual indulgence in the use of controlled 9398
substances, other habit-forming drugs, or alcohol to an extent 9399
that affects the individual's professional competency; 9400

(2) Conviction of a felony or a crime involving moral 9401
turpitude, regardless of the state or country in which the 9402
conviction occurred; 9403

(3) Obtaining or attempting to obtain a license issued by 9404
the physical therapy section by fraud or deception, including 9405
the making of a false, fraudulent, deceptive, or misleading 9406
statement; 9407

(4) An adjudication by a court, as provided in section 9408
5122.301 of the Revised Code, that the applicant or licensee is 9409
incompetent for the purpose of holding the license and has not 9410
thereafter been restored to legal capacity for that purpose; 9411

(5) Subject to section 4755.471 of the Revised Code, 9412
violation of the code of ethics adopted by the physical therapy 9413

section;	9414
(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;	9415 9416 9417 9418
(7) Failure of one or both of the examinations required under section 4755.43 or 4755.431 of the Revised Code;	9419 9420
(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;	9421 9422 9423
(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;	9424 9425 9426 9427
(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;	9428 9429 9430 9431 9432 9433
(11) Willful betrayal of a professional confidence;	9434
(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;	9435 9436 9437
(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;	9438 9439 9440 9441

(14) Obtaining, or attempting to obtain, money or anything	9442
of value by fraudulent misrepresentations in the course of	9443
practice;	9444
(15) Violation of the conditions of limitation or	9445
agreements placed by the physical therapy section on a license	9446
to practice;	9447
(16) Failure to renew a license in accordance with section	9448
4755.46 of the Revised Code;	9449
(17) Except as provided in section 4755.471 of the Revised	9450
Code, engaging in the division of fees for referral of patients	9451
or receiving anything of value in return for a specific referral	9452
of a patient to utilize a particular service or business;	9453
(18) Inability to practice according to acceptable and	9454
prevailing standards of care because of mental illness or	9455
physical illness, including physical deterioration that	9456
adversely affects cognitive, motor, or perception skills;	9457
(19) The revocation, suspension, restriction, or	9458
termination of clinical privileges by the United States	9459
department of defense or department of veterans affairs;	9460
(20) Termination or suspension from participation in the	9461
medicare or medicaid program established under Title XVIII and	9462
Title XIX, respectively, of the "Social Security Act," 49 Stat.	9463
620 (1935), 42 U.S.C. 301, as amended, for an act or acts that	9464
constitute a violation of sections 4755.40 to 4755.56 of the	9465
Revised Code;	9466
(21) Failure of a physical therapist to maintain	9467
supervision of a student, physical therapist assistant,	9468
unlicensed support personnel, other assistant personnel, or a	9469
license applicant in accordance with the requirements of	9470

sections 4755.40 to 4755.56 of the Revised Code and rules 9471
adopted under those sections; 9472

(22) Failure to complete continuing education requirements 9473
as prescribed in section 4755.51 or 4755.511 of the Revised Code 9474
or to satisfy any rules applicable to continuing education 9475
requirements that are adopted by the physical therapy section; 9476

(23) Conviction of a misdemeanor when the act that 9477
constitutes the misdemeanor occurs during the practice of 9478
physical therapy; 9479

(24) (a) Except as provided in division (A) (24) (b) of this 9480
section, failure to cooperate with an investigation conducted by 9481
the physical therapy section or the health care professional 9482
standards board, including failure to comply with a subpoena or 9483
orders issued by the section or the board or failure to answer 9484
truthfully a question presented by the section or the board at a 9485
deposition or in written interrogatories. 9486

(b) Failure to cooperate with an investigation does not 9487
constitute grounds for discipline under this section if a court 9488
of competent jurisdiction issues an order that either quashes a 9489
subpoena or permits the individual to withhold the testimony or 9490
evidence at issue. 9491

(25) Regardless of whether the contact or verbal behavior 9492
is consensual, engaging with a patient other than the spouse of 9493
the physical therapist or physical therapist assistant, in any 9494
of the following: 9495

(a) Sexual contact, as defined in section 2907.01 of the 9496
Revised Code; 9497

(b) Verbal behavior that is sexually demeaning to the 9498
patient or may be reasonably interpreted by the patient as 9499

sexually demeaning. 9500

(26) Failure to notify the physical therapy section of a 9501
change in name, business address, or home address within thirty 9502
days after the date of change; 9503

(27) Except as provided in division (B) of this section: 9504

(a) Waiving the payment of all or any part of a deductible 9505
or copayment that a patient, pursuant to a health insurance or 9506
health care policy, contract, or plan that covers physical 9507
therapy, would otherwise be required to pay if the waiver is 9508
used as an enticement to a patient or group of patients to 9509
receive health care services from that provider; 9510

(b) Advertising that the individual will waive the payment 9511
of all or any part of a deductible or copayment that a patient, 9512
pursuant to a health insurance or health care policy, contract, 9513
or plan that covers physical therapy, would otherwise be 9514
required to pay. 9515

(28) Violation of any section of this chapter or rule 9516
adopted under it. 9517

(B) Sanctions shall not be imposed under division (A) (27) 9518
of this section against any individual who waives deductibles 9519
and copayments as follows: 9520

(1) In compliance with the health benefit plan that 9521
expressly allows such a practice. Waiver of the deductibles or 9522
copayments shall be made only with the full knowledge and 9523
consent of the plan purchaser, payer, and third-party 9524
administrator. Documentation of the consent shall be made 9525
available to the physical therapy section upon request. 9526

(2) For professional services rendered to any other person 9527

licensed pursuant to sections 4755.40 to 4755.56 of the Revised 9528
Code to the extent allowed by those sections and the rules of 9529
the physical therapy section. 9530

(C) When a license is revoked under this section, 9531
application for reinstatement may not be made sooner than one 9532
year after the date of revocation. The physical therapy section 9533
may accept or refuse an application for reinstatement and may 9534
require that the applicant pass an examination as a condition 9535
for reinstatement. 9536

When a license holder is placed on probation under this 9537
section, the physical therapy section's order for placement on 9538
probation shall be accompanied by a statement of the conditions 9539
under which the individual may be removed from probation and 9540
restored to unrestricted practice. 9541

(D) When an application for an initial or renewed license 9542
is refused under this section, the physical therapy section 9543
shall notify the applicant in writing of the section's decision 9544
to refuse issuance of a license and the reason for its decision. 9545

(E) On receipt of a complaint that a person licensed by 9546
the physical therapy section has committed any of the actions 9547
listed in division (A) of this section, the physical therapy 9548
section may immediately suspend the license of the physical 9549
therapist or physical therapist assistant prior to holding a 9550
hearing in accordance with Chapter 119. of the Revised Code if 9551
it determines, based on the complaint, that the person poses an 9552
immediate threat to the public. The physical therapy section may 9553
review the allegations and vote on the suspension by telephone 9554
conference call. If the physical therapy section votes to 9555
suspend a license under this division, the physical therapy 9556
section shall issue a written order of summary suspension to the 9557

person in accordance with section 119.07 of the Revised Code. If 9558
the person fails to make a timely request for an adjudication 9559
under Chapter 119. of the Revised Code, the physical therapy 9560
section shall enter a final order permanently revoking the 9561
person's license. Notwithstanding section 119.12 of the Revised 9562
Code, a court of common pleas shall not grant a suspension of 9563
the physical therapy section's order of summary suspension 9564
pending the determination of an appeal filed under that section. 9565
Any order of summary suspension issued under this division shall 9566
remain in effect, unless reversed on appeal, until a final 9567
adjudication order issued by the physical therapy section 9568
pursuant to division (A) of this section becomes effective. The 9569
physical therapy section shall issue its final adjudication 9570
order regarding an order of summary suspension issued under this 9571
division not later than ninety days after completion of its 9572
hearing. Failure to issue the order within ninety days shall 9573
result in immediate dissolution of the suspension order, but 9574
shall not invalidate any subsequent, final adjudication order. 9575

(F) If an individual who holds a license issued under 9576
sections 4755.40 to 4755.56 of the Revised Code is listed in a 9577
claim filed under Chapter 3965. of the Revised Code, the 9578
physical therapy section shall suspend any investigation and 9579
shall not take disciplinary action under this section against 9580
that individual for conduct relating to that claim unless 9581
otherwise required by the health care professional standards 9582
board or until the health care professional standards board has 9583
concluded its investigation under Chapter 4746. of the Revised 9584
Code. 9585

The physical therapy section shall take any disciplinary 9586
action required by the health care professional standards board 9587
against a license holder under sections 4755.40 to 4755.56 of 9588

the Revised Code pursuant to section 4746.05 of the Revised 9589
Code. If the health care professional standards board imposes 9590
discipline on a license holder, the physical therapy section 9591
shall not take disciplinary action for the same conduct that is 9592
the subject of the disciplinary action ordered by the health 9593
care professional standards board. However, the physical therapy 9594
section may account for that disciplinary action in any future 9595
disciplinary action taken against the license holder. 9596

Sec. 4765.11. (A) The state board of emergency medical, 9597
fire, and transportation services shall adopt, and may amend and 9598
rescind, rules in accordance with Chapter 119. of the Revised 9599
Code and division (C) of this section that establish all of the 9600
following: 9601

(1) Procedures for its governance and the control of its 9602
actions and business affairs; 9603

(2) Standards for the performance of emergency medical 9604
services by first responders, emergency medical technicians- 9605
basic, emergency medical technicians-intermediate, and emergency 9606
medical technicians-paramedic; 9607

(3) Application fees for certificates of accreditation, 9608
certificates of approval, certificates to teach, and 9609
certificates to practice, which shall be deposited into the 9610
trauma and emergency medical services fund created in section 9611
4513.263 of the Revised Code; 9612

(4) Criteria for determining when the application or 9613
renewal fee for a certificate to practice may be waived because 9614
an applicant cannot afford to pay the fee; 9615

(5) Procedures for issuance and renewal of certificates of 9616
accreditation, certificates of approval, certificates to teach, 9617

and certificates to practice, including any procedures necessary	9618
to ensure that adequate notice of renewal is provided in	9619
accordance with division (D) of section 4765.30 of the Revised	9620
Code;	9621
(6) Procedures for suspending or revoking certificates of	9622
accreditation, certificates of approval, certificates to teach,	9623
and certificates to practice;	9624
(7) Grounds for suspension or revocation of a certificate	9625
to practice issued under section 4765.30 of the Revised Code and	9626
for taking any other disciplinary action against a first	9627
responder, EMT-basic, EMT-I, or paramedic;	9628
(8) Procedures for taking disciplinary action against a	9629
first responder, EMT-basic, EMT-I, or paramedic;	9630
(9) Standards for certificates of accreditation and	9631
certificates of approval;	9632
(10) Qualifications for certificates to teach;	9633
(11) Requirements for a certificate to practice;	9634
(12) The curricula, number of hours of instruction and	9635
training, and instructional materials to be used in adult and	9636
pediatric emergency medical services training programs and adult	9637
and pediatric emergency medical services continuing education	9638
programs;	9639
(13) Procedures for conducting courses in recognizing	9640
symptoms of life-threatening allergic reactions and in	9641
calculating proper dosage levels and administering injections of	9642
epinephrine to adult and pediatric patients who suffer life-	9643
threatening allergic reactions;	9644
(14) Examinations for certificates to practice;	9645

(15) Procedures for administering examinations for certificates to practice;	9646 9647
(16) Procedures for approving examinations that demonstrate competence to have a certificate to practice renewed without completing an emergency medical services continuing education program;	9648 9649 9650 9651
(17) Procedures for granting extensions and exemptions of emergency medical services continuing education requirements;	9652 9653
(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;	9654 9655 9656 9657 9658 9659 9660 9661
(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;	9662 9663 9664 9665 9666
(20) Procedures for administering the emergency medical services grant program established under section 4765.07 of the Revised Code;	9667 9668 9669
(21) Procedures consistent with Chapter 119. of the Revised Code for appealing decisions of the board;	9670 9671
(22) Minimum qualifications and peer review and quality improvement requirements for persons who provide medical direction to emergency medical service personnel;	9672 9673 9674

(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. 9734

The state board of emergency medical, fire, and 9735
transportation services shall take any disciplinary action 9736
required by the health care professional standards board against 9737
a certificate holder under this chapter pursuant to section 9738
4746.05 of the Revised Code. If the health care professional 9739
standards board imposes discipline on a certificate holder, the 9740
state board of emergency medical, fire, and transportation 9741
services shall not take disciplinary action for the same conduct 9742
that is the subject of the disciplinary action ordered by the 9743
health care professional standards board. However, the state 9744
board of emergency medical, fire, and transportation services 9745
may account for that disciplinary action in any future 9746
disciplinary action taken against the certificate holder. 9747

Sec. 5162.63. The medicaid director shall seek government 9748
and nongovernment grants and donations to help fund the medicaid 9749
components authorized by section 5166.53 of the Revised Code. 9750
All such grants and donations shall be deposited into the 9751
medicaid donations fund, which is hereby created in the state 9752
treasury. All money in the fund shall be used for the medicaid 9753
components authorized by section 5166.53 of the Revised Code. 9754

Sec. 5164.01. As used in this chapter: 9755

(A) "DRG" means diagnosis-related group. 9756

(B) "Early and periodic screening, diagnostic, and 9757
treatment services" has the same meaning as in the "Social 9758
Security Act," section 1905(r), 42 U.S.C. 1396d(r). 9759

~~(B)~~ (C) "Federal financial participation" has the same 9760
meaning as in section 5160.01 of the Revised Code. 9761

~~(C)~~ (D) "Healthcheck" means the component of the medicaid 9762

program that provides early and periodic screening, diagnostic, 9763
and treatment services. 9764

~~(D)~~ (E) "Home and community-based services medicaid waiver 9765
component" has the same meaning as in section 5166.01 of the 9766
Revised Code. 9767

~~(E)~~ (F) "Hospital" has the same meaning as in section 9768
3727.01 of the Revised Code. 9769

~~(F)~~ (G) "ICDS participant" means a dual eligible 9770
individual who participates in the integrated care delivery 9771
system. 9772

~~(G)~~ (H) "ICF/IID" has the same meaning as in section 9773
5124.01 of the Revised Code. 9774

~~(H)~~ (I) "Integrated care delivery system" and "ICDS" mean 9775
the demonstration project authorized by section 5164.91 of the 9776
Revised Code. 9777

~~(I)~~ (J) "Mandatory services" means the health care 9778
services and items that must be covered by the medicaid state 9779
plan as a condition of the state receiving federal financial 9780
participation for the medicaid program. 9781

~~(J)~~ (K) "Medicaid managed care organization" has the same 9782
meaning as in section 5167.01 of the Revised Code. 9783

~~(K)~~ (L) "Medicaid provider" means a person or government 9784
entity with a valid provider agreement to provide medicaid 9785
services to medicaid recipients. To the extent appropriate in 9786
the context, "medicaid provider" includes a person or government 9787
entity applying for a provider agreement, a former medicaid 9788
provider, or both. 9789

~~(L)~~ (M) "Medicaid services" means either or both of the 9790

following: 9791

(1) Mandatory services; 9792

(2) Optional services that the medicaid program covers. 9793

~~(M)~~ (N) "Noninstitutional provider" means any medicaid 9794
provider other than a hospital, nursing facility, or ICF/IID. 9795

(O) "Nursing facility" has the same meaning as in section 9796
5165.01 of the Revised Code. 9797

~~(N)~~ (P) "Optional services" means the health care services 9798
and items that may be covered by the medicaid state plan or a 9799
federal medicaid waiver and for which the medicaid program 9800
receives federal financial participation. 9801

~~(O)~~ (Q) "Prescribed drug" has the same meaning as in 42 9802
C.F.R. 440.120. 9803

~~(P)~~ (R) "Provider agreement" means an agreement to which 9804
all of the following apply: 9805

(1) It is between a medicaid provider and the department 9806
of medicaid; 9807

(2) It provides for the medicaid provider to provide 9808
medicaid services to medicaid recipients; 9809

(3) It complies with 42 C.F.R. 431.107(b). 9810

~~(Q)~~ (S) "Terminal distributor of dangerous drugs" has the 9811
same meaning as in section 4729.01 of the Revised Code. 9812

Sec. 5164.07. (A) The medicaid program shall include 9813
coverage of inpatient care and follow-up care for a mother and 9814
her newborn as follows: 9815

(1) The medicaid program shall cover a minimum of forty- 9816

eight hours of inpatient care following a normal vaginal 9817
delivery and a minimum of ninety-six hours of inpatient care 9818
following a cesarean delivery. Services covered as inpatient 9819
care shall include medical, educational, and any other services 9820
that are consistent with the inpatient care recommended in the 9821
protocols and guidelines developed by national organizations 9822
that represent pediatric, obstetric, and nursing professionals. 9823

(2) The medicaid program shall cover a physician-directed 9824
source of follow-up care. Services covered as follow-up care 9825
shall include physical assessment of the mother and newborn, 9826
parent education, assistance and training in breast or bottle 9827
feeding, assessment of the home support system, performance of 9828
any medically necessary and appropriate clinical tests, and any 9829
other services that are consistent with the follow-up care 9830
recommended in the protocols and guidelines developed by 9831
national organizations that represent pediatric, obstetric, and 9832
nursing professionals. The coverage shall apply to services 9833
provided in a medical setting or through home health care 9834
visits. The coverage shall apply to a home health care visit 9835
only if the health care professional who conducts the visit is 9836
knowledgeable and experienced in maternity and newborn care. 9837

When a decision is made in accordance with division (B) of 9838
this section to discharge a mother or newborn prior to the 9839
expiration of the applicable number of hours of inpatient care 9840
required to be covered, the coverage of follow-up care shall 9841
apply to all follow-up care that is provided within forty-eight 9842
hours after discharge. When a mother or newborn receives at 9843
least the number of hours of inpatient care required to be 9844
covered, the coverage of follow-up care shall apply to follow-up 9845
care that is determined to be medically necessary by the health 9846
care professionals responsible for discharging the mother or 9847

newborn. 9848

(B) Any decision to shorten the length of inpatient stay 9849
to less than that specified under division (A)(1) of this 9850
section shall be made by the physician attending the mother or 9851
newborn, except that if a nurse-midwife is attending the mother 9852
in collaboration with a physician, the decision may be made by 9853
the nurse-midwife. Decisions regarding early discharge shall be 9854
made only after conferring with the mother or a person 9855
responsible for the mother or newborn. For purposes of this 9856
division, a person responsible for the mother or newborn may 9857
include a parent, guardian, or any other person with authority 9858
to make medical decisions for the mother or newborn. 9859

(C) The department of medicaid, in administering the 9860
medicaid program, may not do either of the following: 9861

(1) Terminate the provider agreement of a health care 9862
professional or health care facility solely for making 9863
recommendations for inpatient or follow-up care for a particular 9864
mother or newborn that are consistent with the care required to 9865
be covered by this section; 9866

(2) Establish or offer monetary or other financial 9867
incentives for the purpose of encouraging a person to decline 9868
the inpatient or follow-up care required to be covered by this 9869
section. 9870

(D) This section does not do any of the following: 9871

(1) Require the medicaid program to cover inpatient or 9872
follow-up care that is not received in accordance with the 9873
program's terms pertaining to the health care professionals and 9874
facilities from which a medicaid recipient is authorized to 9875
receive health care services. 9876

(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 9906
hospital emergency department provides to the recipient to 9907
diagnose and treat the nonemergency medical condition shall not 9908
be billed to the medicaid program as an emergency room visit 9909
claim, as that term is defined in rules adopted under section 9910
5164.02 of the Revised Code. 9911

(B) Division (A) of this section does not apply in the 9912
case of medicaid services provided by a hospital emergency 9913
department to diagnose and treat a medicaid recipient who was 9914
determined under section 3727.61 of the Revised Code to have a 9915
nonemergency medical condition if both of the following are the 9916
case: 9917

(1) The recipient was referred, pursuant to section 9918
3727.61 of the Revised Code, to receive services at the space 9919
within or adjacent to the hospital that is described in division 9920
(C) (1) or (2) of that section. 9921

(2) A determination was made while services were being 9922
provided at the space to which the recipient was referred that 9923
the recipient had an emergency medical condition, the recipient 9924
was returned to the hospital emergency department for treatment 9925
of the emergency medical condition, and the hospital emergency 9926
department treated the recipient's emergency medical condition. 9927

Sec. 5165.15. (A) Except as otherwise provided by sections 9928
5165.151 to 5165.157 and 5165.34 of the Revised Code, the total 9929
per medicaid day payment rate that the department of medicaid 9930
shall pay a nursing facility provider for nursing facility 9931
services the provider's nursing facility provides during a 9932
fiscal year shall ~~equal~~ be determined as follows: 9933

(1) Determine the sum of all of the following: 9934

(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;	9935 9936 9937
(2) (b) The per medicaid day payment rate for capital costs determined for the nursing facility under section 5165.17 of the Revised Code;	9938 9939 9940
(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;	9941 9942 9943
(4) (d) The per medicaid day payment rate for tax costs determined for the nursing facility under section 5165.21 of the Revised Code;	9944 9945 9946
(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 + .	9947 9948 9949 9950
(6) <u>The (2) Reduce the sum determined under division (A) (1) of this section by the following:</u>	9951 9952
<u>(a) For fiscal year 2016, two per cent;</u>	9953
<u>(b) For fiscal year 2017, four per cent;</u>	9954
<u>(c) For fiscal year 2018 and each fiscal year thereafter, six per cent.</u>	9955 9956
<u>(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;</u>	9957 9958 9959 9960
<u>(4) Add the per medicaid day quality incentive payment</u>	9961

~~paid to~~ determined for the nursing facility under section 9962
5165.25 of the Revised Code to the amount determined under 9963
division (A) (3) of this section. 9964

(B) In addition to paying a nursing facility provider the 9965
nursing facility's total rate determined under division (A) of 9966
this section for a fiscal year, the department shall pay the 9967
provider a quality bonus under section 5165.26 of the Revised 9968
Code for that fiscal year if the provider's nursing facility is 9969
a qualifying nursing facility, as defined in that section, for 9970
that fiscal year. The quality bonus shall not be part of the 9971
total rate. 9972

Sec. 5165.23. (A) Each fiscal year, the department of 9973
medicaid shall determine the critical access incentive payment 9974
for each nursing facility that qualifies as a critical access 9975
nursing facility. To qualify as a critical access nursing 9976
facility for a fiscal year, a nursing facility must meet all of 9977
the following requirements: 9978

(1) The nursing facility must be located in an area that, 9979
on December 31, 2011, was designated an empowerment zone under 9980
the "Internal Revenue Code of 1986," section 1391, 26 U.S.C. 9981
1391. 9982

(2) The nursing facility must have an occupancy rate of at 9983
least eighty-five per cent as of the last day of the calendar 9984
year immediately preceding the fiscal year. 9985

(3) The nursing facility must have a medicaid utilization 9986
rate of at least sixty-five per cent as of the last day of the 9987
calendar year immediately preceding the fiscal year. 9988

(4) The nursing facility must have been awarded at least 9989
five points for meeting accountability measures under section 9990

5165.25 of the Revised Code for the fiscal year and at least one 9991
of the five points must have been awarded for meeting the 9992
accountability measures identified in divisions (C) (9), (10), 9993
(11), (12), and (14) of section 5165.25 of the Revised Code. 9994

(B) A critical access nursing facility's critical access 9995
incentive payment for a fiscal year shall equal five per cent of 9996
~~the portion of the~~ nursing facility's total rate for the fiscal 9997
~~year that is the sum of the rates and payment identified in~~ 9998
~~divisions (A) (1) to (4) and (6) of~~, as determined under 9999
division (A) of section 5165.15 of the Revised Code, excluding 10000
the portions of the rate that represent the critical access 10001
payment and the value based purchasing payment. 10002

Sec. 5165.24. (A) As used in this section: 10003

(1) "Electronic medication administration record system" 10004
means technology that automatically documents the administration 10005
of medication into electronic health record technology by using 10006
electronic tracking sensors. 10007

(2) "Long-stay resident" means an individual who has 10008
resided in a nursing facility for at least one hundred one days. 10009

(3) "Measurement period" means the following: 10010

(a) For fiscal year 2016, the period beginning July 1, 10011
2014, and ending December 31, 2014; 10012

(b) For each subsequent fiscal year, the calendar year 10013
immediately preceding the fiscal year. 10014

(4) "Nurse aide" has the same meaning as in section 10015
3721.21 of the Revised Code. 10016

(5) "Preferences for everyday living inventory" means a 10017
tool used to document the lifestyle preferences of older persons 10018

and to provide information to caregivers to assist in 10019
customizing care delivery. 10020

(6) "Short-stay resident" means a nursing facility 10021
resident who is not a long-stay resident. 10022

(B) Using the funds made available for a fiscal year by 10023
the rate reductions made under division (A) (2) of section 10024
5165.15 of the Revised Code, the department of medicaid shall 10025
determine each nursing facility's value based purchasing payment 10026
for that fiscal year. A nursing facility's value based 10027
purchasing payment shall be based on its ranking under division 10028
(C) of this section. The largest value based purchasing payment 10029
shall be made to nursing facilities with the highest ranking. 10030

(C) (1) For each fiscal year, the department shall rank 10031
each nursing facility based on the number of the following 10032
quality indicators that the nursing facility meets for the 10033
measurement period: 10034

(a) The nursing facility's residents received an average 10035
of at least two and eight-tenths hours of direct care per 10036
inpatient day from nurse aides and an average of at least one 10037
and three-tenths hours of nursing care per inpatient day from 10038
registered nurses, other than the nursing facility's director of 10039
nursing, and from licensed practical nurses. 10040

(b) At least eighty-five per cent of the nursing 10041
facility's long-stay residents received direct care from not 10042
more than twelve different nurse aides during any thirty-day 10043
period. 10044

(c) Not more than the target percentage of the nursing 10045
facility's short-stay residents had new or worsened pressure 10046
ulcers and not more than the target percentage of long-stay 10047

residents at high risk for pressure ulcers had pressure ulcers. 10048

(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. 10049
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(e) The number of the nursing facility's residents who had avoidable inpatient hospital admissions did not exceed the target rate. 10054
10055
10056

(f) The nursing facility uses the preferences for everyday living inventory. 10057
10058

(g) The nursing facility uses the electronic medication administration record system. 10059
10060

(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. 10061
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Sec. 5165.98. This section is subject to section 5166.50 of the Revised Code. 10069
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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. 10071
10072
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10075

Sec. 5166.01. As used in this chapter:	10076
"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.	10077 10078 10079 10080 10081 10082
<u>"Care management system" means the system established under section 5167.03 of the Revised Code.</u>	10083 10084
"Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	10085 10086
<u>"Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.</u>	10087 10088
<u>"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.</u>	10089 10090
"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.	10091 10092 10093 10094 10095
"Hospital" has the same meaning as in section 3727.01 of the Revised Code.	10096 10097
"Hospital long-term care unit" has the same meaning as in section 5168.40 of the Revised Code.	10098 10099
"ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.	10100 10101
"ICF/IID" and "ICF/IID services" have the same meanings as	10102

in section 5124.01 of the Revised Code. 10103

"Integrated care delivery system" and "ICDS" have the same 10104
meanings as in section 5164.01 of the Revised Code. 10105

"Level of care determination" means a determination of 10106
whether an individual needs the level of care provided by a 10107
hospital, nursing facility, or ICF/IID and whether the 10108
individual, if determined to need that level of care, would 10109
receive hospital services, nursing facility services, or ICF/IID 10110
services if not for a home and community-based services medicaid 10111
waiver component. 10112

"Medicaid buy-in for workers with disabilities program" 10113
has the same meaning as in section 5163.01 of the Revised Code. 10114

"Medicaid services" has the same meaning as in section 10115
5164.01 of the Revised Code. 10116

"Medicaid waiver component" means a component of the 10117
medicaid program authorized by a waiver granted by the United 10118
States department of health and human services under the "Social 10119
Security Act," section 1115 or 1915, 42 U.S.C. 1315 or 1396n. 10120
"Medicaid waiver component" does not include a care management 10121
system established under section 5167.03 of the Revised Code. 10122

"Nursing facility" and "nursing facility services" have 10123
the same meanings as in section 5165.01 of the Revised Code. 10124

"Ohio home care waiver program" means the home and 10125
community-based services medicaid waiver component that is known 10126
as Ohio home care and was created pursuant to section 5166.11 of 10127
the Revised Code. 10128

"Ohio transitions II aging carve-out program" means the 10129
home and community-based services medicaid waiver component that 10130

is known as Ohio transitions II aging carve-out and was created 10131
pursuant to section 5166.11 of the Revised Code. 10132

"Provider agreement" has the same meaning as in section 10133
5164.01 of the Revised Code. 10134

"Residential treatment facility" means a residential 10135
facility licensed by the department of mental health and 10136
addiction services under section 5119.34 of the Revised Code, or 10137
an institution certified by the department of job and family 10138
services under section 5103.03 of the Revised Code, that serves 10139
children and either has more than sixteen beds or is part of a 10140
campus of multiple facilities or institutions that, combined, 10141
have a total of more than sixteen beds. 10142

"Skilled nursing facility" has the same meaning as in 10143
section 5165.01 of the Revised Code. 10144

"Unified long-term services and support medicaid waiver 10145
component" means the medicaid waiver component authorized by 10146
section 5166.14 of the Revised Code. 10147

Sec. 5166.50. (A) The medicaid director shall request that 10148
the United States secretary of health and human services enter 10149
into an enforceable agreement with the director that provides 10150
for at least all of the following: 10151

(1) The implementation of Chapter 195. of the Revised 10152
Code; 10153

(2) Hospitals to be able to implement section 3727.61 of 10154
the Revised Code despite federal requirements; 10155

(3) Health care providers to be able to comply with 10156
division (C) of section 4743.08 of the Revised Code when a 10157
patient is a medicaid recipient; 10158

(4) No federal financial participation to be withheld due 10159
to any of the following: 10160

(a) Implementation of Chapter 195. or sections 3727.61, 10161
4731.74, 5164.78, 5165.98, 5166.52 to 5166.5210, 5166.53, 10162
5167.16, 5167.32, and 5167.33 of the Revised Code; 10163

(b) Application of division (C) of section 4743.08 of the 10164
Revised Code when a patient is a medicaid recipient; 10165

(c) For the purpose of section 5167.04 of the Revised 10166
Code, enrollment of individuals designated for participation in 10167
the care management system pursuant to divisions (B) (1) and (2) 10168
of section 5167.03 of the Revised Code in medicaid managed care 10169
organizations that are regional networks consisting of 10170
hospitals. 10171

(5) The federal government to pay the state a penalty for 10172
failure to comply in full with any provision of the agreement. 10173

(B) Unless the agreement specified in division (A) of this 10174
section is in effect: 10175

(1) Chapter 195. and sections 3727.61, 4731.74, 5164.78, 10176
5165.98, 5166.52 to 5166.5210, 5166.53, 5167.16, 5167.32, and 10177
5167.33 of the Revised Code shall not be implemented. 10178

(2) Division (C) of section 4743.08 of the Revised Code 10179
shall not apply when a patient is a medicaid recipient. 10180

(3) For the purpose of section 5167.04 of the Revised 10181
Code, the department shall not enroll individuals designated for 10182
participation in the care management system pursuant to 10183
divisions (B) (1) and (2) of section 5167.03 of the Revised Code 10184
in medicaid managed care organizations that are regional 10185
networks consisting of hospitals. 10186

<u>Sec. 5166.52. (A) As used in sections 5166.52 to 5166.5210</u>	10187
<u>of the Revised Code:</u>	10188
<u>(1) "Adult" means an individual who is at least eighteen</u>	10189
<u>years of age.</u>	10190
<u>(2) "Buckeye account" means a modified health savings</u>	10191
<u>account established under section 5166.522 of the Revised Code.</u>	10192
<u>(3) "Contribution" means the amounts that an individual</u>	10193
<u>contributes to the individual's buckeye account and are</u>	10194
<u>contributed to the account on the individual's behalf under</u>	10195
<u>divisions (C) and (D) of section 5166.522 of the Revised Code.</u>	10196
<u>"Contribution" does not mean the portion of an individual's</u>	10197
<u>buckeye account that consists of medicaid funds deposited under</u>	10198
<u>division (B) of section 5166.522 of the Revised Code or section</u>	10199
<u>5166.524 of the Revised Code.</u>	10200
<u>(4) "Core portion" means the portion of a healthy Ohio</u>	10201
<u>program participant's buckeye account that consists of the</u>	10202
<u>following:</u>	10203
<u>(a) The amount of contributions to the account;</u>	10204
<u>(b) The amounts awarded to the account under divisions (C)</u>	10205
<u>and (D) of section 5166.524 of the Revised Code.</u>	10206
<u>(5) "Eligible employer-sponsored health plan" has the same</u>	10207
<u>meaning as in section 5000A(f) (2) of the "Internal Revenue Code</u>	10208
<u>of 1986," 26 U.S.C. 5000A(f) (2).</u>	10209
<u>(6) "Healthy Ohio program" means the medicaid waiver</u>	10210
<u>component established under sections 5166.52 to 5166.5210 of the</u>	10211
<u>Revised Code under which medicaid recipients specified in</u>	10212
<u>division (B) (2) of this section enroll in comprehensive health</u>	10213
<u>plans and contribute to buckeye accounts.</u>	10214

(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. 10215
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(8) "Minor" means an individual who is less than eighteen
years of age. 10219
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(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). 10221
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(10) "Ward of the state" means both of the following: 10225

(a) An individual who is a ward, as defined in section
2111.01 of the Revised Code; 10226
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(b) A minor who is in the temporary or permanent custody
of a public children services agency or private child placing
agency. 10228
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(11) "Workforce development activity" and "workforce
development agency" have the same meanings as in section 6301.01
of the Revised Code. 10231
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(B) Subject to section 5166.50 of the Revised Code, all of
the following apply: 10234
10235

(1) The medicaid director shall establish a medicaid
waiver component to be known as the healthy Ohio program. 10236
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(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: 10238
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(a) The individual is determined to be eligible for 10241

medicaid on the basis of being included in the category 10242
identified by the department of medicaid as covered families and 10243
children. 10244

(b) If, pursuant to section 5166.53 of the Revised Code, 10245
the medicaid program covers the group described in division (C) 10246
(4) (d) of that section or, pursuant to the priorities specified 10247
in division (D) of that section, a portion of that group, the 10248
individual is determined to be eligible for medicaid on the 10249
basis of being included in that group or portion of that group. 10250

(3) A healthy Ohio program participant shall not receive 10251
medicaid services under the fee-for-service component of 10252
medicaid or participate in the care management system. 10253

(4) Notwithstanding any other state statute, only medicaid 10254
recipients not required to participate in the healthy Ohio 10255
program shall receive medicaid services under the fee-for- 10256
service component of medicaid or participate in the care 10257
management system. 10258

Sec. 5166.521. A healthy Ohio program participant shall 10259
enroll in a comprehensive health plan offered by a managed care 10260
organization under contract with the department of medicaid. All 10261
of the following apply to the health plan: 10262

(A) It shall cover physician, hospital inpatient, hospital 10263
outpatient, pregnancy-related, mental health, pharmaceutical, 10264
laboratory, and other health care services the medicaid director 10265
determines necessary. 10266

(B) In the case of a health professional service also 10267
covered by the medicare program, it shall have the same payment 10268
rate as the medicare payment rate for the health professional 10269
service. 10270

(C) It shall not begin to pay for any services it covers 10271
until the amount of the noncore portion of the participant's 10272
buckeye account is zero. 10273

(D) It shall require copayments for services covered by 10274
the health plan, except that a participant's copayments shall be 10275
waived whenever the amount of the core portion of the 10276
participant's buckeye account is zero. 10277

(E) It shall have the following payout limits: 10278

(1) Three hundred thousand dollars per year; 10279

(2) One million dollars for a participant's lifetime. 10280

Sec. 5166.522. (A) (1) A buckeye account shall be 10281
established for each individual who is determined to be eligible 10282
for the healthy Ohio program. Subject to division (A) (2) of this 10283
section, an individual's buckeye account shall consist of both 10284
of the following: 10285

(a) The medicaid funds deposited into the account under 10286
division (B) of this section and division (A) of section 10287
5166.524 of the Revised Code; 10288

(b) Contributions made by the individual and on the 10289
individual's behalf under divisions (C) and (D) of this section. 10290

(2) A buckeye account shall not have more than ten 10291
thousand dollars in it at one time. 10292

(B) (1) Subject to division (A) (2) of this section, the 10293
following amount of medicaid funds shall be deposited each year 10294
into the buckeye account of an individual participating in the 10295
healthy Ohio program: 10296

(a) If the individual is an adult, one thousand dollars; 10297

<u>(b) If the individual is a minor, five hundred dollars.</u>	10298
<u>(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.</u>	10299 10300 10301 10302 10303 10304
<u>(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:</u>	10305 10306 10307 10308 10309
<u>(1) One dollar;</u>	10310
<u>(2) The lesser of the following:</u>	10311
<u>(a) Two per cent of the individual's annual countable family income;</u>	10312 10313
<u>(b) The following amount:</u>	10314
<u>(i) If the individual is an adult who is not a smoker, ninety-nine dollars;</u>	10315 10316
<u>(ii) If the individual is a minor who is not a smoker, forty-nine dollars;</u>	10317 10318
<u>(iii) If the individual is a smoker, regardless of age, one hundred forty-nine dollars.</u>	10319 10320
<u>(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:</u>	10321 10322 10323
<u>(a) If the individual is a minor, the individual's parent</u>	10324

or caretaker relative; 10325

(b) The individual's employer, but only up to fifty per cent of the contributions the individual is required to make; 10326
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(c) A not-for-profit organization, but only up to seventy-five per cent of the contributions the individual is required to make; 10328
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(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: 10331
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(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. 10334
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(ii) They cannot reduce the amount the individual is required to contribute. 10338
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(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. 10340
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(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. 10346
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(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: 10354
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(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; 10357
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(b) If division (F) (1) (a) of this section does not apply, the core portion of the account. 10360
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(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. 10362
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(G) A buckeye account shall be used only for the following: 10369
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(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; 10371
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(2) Other purposes authorized by rules adopted under section 5166.5210 of the Revised Code. 10374
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(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 10376
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provided in an electronic format. 10383

Sec. 5166.523. (A) A managed care organization that offers 10384
the health plan in which a healthy Ohio program participant 10385
enrolls shall issue a debit swipe card to be used to pay only 10386
for the following: 10387

(1) Until the amount of the noncore portion of the 10388
participant's buckeye account is zero, the costs of health care 10389
services that are covered by the health plan and provided to the 10390
participant by a provider participating in the health plan; 10391

(2) The participant's copayments under division (A) (4) of 10392
section 5166.521 of the Revised Code; 10393

(3) Subject to rules authorized by section 5166.5210 of 10394
the Revised Code, the costs of health care services, including 10395
dental and vision services, that are medically necessary for the 10396
participant but not covered by the health plan. 10397

(B) (1) A healthy Ohio program participant's debit swipe 10398
card shall be credited with one point for each of the following: 10399

(a) Each dollar of medicaid funds deposited into the 10400
participant's buckeye account under division (B) of section 10401
5166.522 of the Revised Code; 10402

(b) Each dollar contributed to the participant's buckeye 10403
account under divisions (C) and (D) of section 5166.522 of the 10404
Revised Code; 10405

(c) Each point awarded to the participant under section 10406
5166.524 of the Revised Code. 10407

(2) Each time a healthy Ohio program participant uses the 10408
participant's debit swipe card, the amount for which the card is 10409
used shall be deducted from the number of points on the card as 10410

follows: 10411

(a) If the card is used for the purpose specified in 10412
division (A)(1) of this section, the deduction shall come from 10413
the points representing the noncore portion of the participant's 10414
buckeye account. 10415

(b) If the card is used for the purpose specified in 10416
division (A)(2) or (3) of this section, the deduction shall come 10417
from the points representing the core portion of the 10418
participant's buckeye account. 10419

(C) A healthy Ohio program participant's debit swipe card 10420
shall do all of the following: 10421

(1) Verify the participant's eligibility for the healthy 10422
Ohio program; 10423

(2) Determine whether the service the participant seeks is 10424
covered under the health plan; 10425

(3) Determine whether the provider from which the 10426
participant seeks the service is a participating provider under 10427
the health plan; 10428

(4) Be linked to the participant's buckeye account in a 10429
manner that enables the participant to know at the point of 10430
service what will be deducted from the noncore portion and core 10431
portion of the participant's buckeye account for the service and 10432
how much will remain in each portion of the account after the 10433
deduction. 10434

Sec. 5166.524. (A) The medicaid director shall establish a 10435
system under which points are awarded in accordance with this 10436
section to healthy Ohio program debit swipe cards. One dollar of 10437
medicaid funds shall be deposited into a healthy Ohio program 10438

participant's buckeye account for each point awarded to the 10439
participant under this section. 10440

(B) The director shall provide a one-time award of twenty 10441
points to a healthy Ohio program participant who provides for 10442
the participant's contributions under division (C) of section 10443
5166.522 of the Revised Code to be made by electronic funds 10444
transfers from the participant's checking or savings account. 10445
Twenty points shall be deducted from the participant's card if 10446
the participant terminates the electronic funds transfers. 10447

(C) The director may award up to two hundred points 10448
annually to a healthy Ohio program participant who achieves 10449
health care goals. The points shall be awarded in accordance 10450
with the rules authorized by section 5166.5210 of the Revised 10451
Code. A participant shall not be awarded more than two hundred 10452
points per year under this division regardless of the number of 10453
health care goals the participant achieves that year. 10454

(D) Up to one hundred points may be awarded annually to a 10455
healthy Ohio program participant by one or more primary care 10456
physicians who verify that the participant has satisfied health 10457
care benchmarks set by the physicians. A participant shall not 10458
be awarded more than one hundred points per year under this 10459
division regardless of how many primary care physicians award 10460
points to the participant that year and the number of points the 10461
primary care physicians award the participant that year. 10462

Sec. 5166.525. An individual's participation in the 10463
healthy Ohio program shall be suspended if the individual 10464
exhausts the individual's annual payout limit specified in 10465
division (A) (5) (a) of section 5166.521 of the Revised Code. The 10466
suspension shall end on the first day of the following year. 10467

Sec. 5166.526. (A) An individual's participation in the 10468
healthy Ohio program shall cease if any of the following 10469
applies: 10470

(1) A monthly installment payment to the individual's 10471
buckeye account is sixty days late. 10472

(2) The individual, or if the individual is a minor, the 10473
individual's parent or caretaker relative, fails to submit 10474
documentation needed for a redetermination of the individual's 10475
eligibility for medicaid before the sixty-first day after the 10476
documentation is requested. 10477

(3) The individual becomes eligible for medicaid on a 10478
basis other than being included in the category identified by 10479
the department of medicaid as covered families and children or 10480
being included in the eligibility group described in section 10481
1902(a)(10)(A)(i)(VIII) of the "Social Security Act," 42 U.S.C. 10482
1396a(a)(10)(A)(i)(VIII). 10483

(4) The individual becomes a ward of the state. 10484

(5) The individual ceases to be eligible for medicaid. 10485

(6) The individual exhausts the individual's lifetime 10486
payout limit specified in division (A)(5)(b) of section 5166.521 10487
of the Revised Code. 10488

(7) The individual, or if the individual is a minor, the 10489
individual's parent or caretaker relative, requests that the 10490
individual's participation be terminated. 10491

(B) An individual who ceases to participate in the healthy 10492
Ohio program under division (A)(1) or (2) of this section may 10493
not resume participation earlier than twelve months after the 10494
participation ceases. 10495

(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. 10496
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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. 10503
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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: 10511
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(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; 10519
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(2) If the former participant has obtained health care coverage under an eligible employer-sponsored health plan, the 10524
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former participant's out-of-pocket expenses under the plan for 10526
health care services and prescription drugs covered by the plan. 10527

(B) Only the amount remaining in a former healthy Ohio 10528
program participant's buckeye account at the time the former 10529
participant ceased to participate in the healthy Ohio program 10530
shall be deposited into the bridge account. The bridge account 10531
shall be closed once the amount transferred to it under division 10532
(A) of this section is exhausted. 10533

(C) The medicaid director shall notify a former healthy 10534
Ohio program participant when a bridge account is established 10535
for the former participant under this section. 10536

(D) The medicaid director shall provide for a former 10537
healthy Ohio program participant to be able to use either of the 10538
following to access, for the purposes specified in division (A) 10539
of this section, the amount transferred to the former 10540
participant's bridge account: 10541

(1) To the extent possible, the former participant's 10542
healthy Ohio program debit card; 10543

(2) Another debit swipe card issued to the former 10544
participant. 10545

Sec. 5166.529. Each county department of job and family 10546
services shall offer to refer to a workforce development agency 10547
each healthy Ohio program participant who resides in the county 10548
served by the county department, is an adult, and is either 10549
unemployed or employed for less than an average of twenty hours 10550
per week. The referral shall include information about the 10551
workforce development activities available from the workforce 10552
development agency. A participant may refuse to accept the 10553
referral and to participate in the workforce development 10554

activities without any affect on the participant's eligibility 10555
for, or participation in, the healthy Ohio program. 10556

Sec. 5166.5210. The medicaid director shall adopt rules 10557
under section 5166.02 of the Revised Code to do all of the 10558
following: 10559

(A) For the purpose of division (F) (1) (a) of section 10560
5166.522 of the Revised Code, establish requirements regarding 10561
preventative health services for healthy Ohio program 10562
participants. The requirements may differ for participants of 10563
different ages and genders. 10564

(B) For the purpose of division (G) (2) of section 5166.522 10565
of the Revised Code, authorize additional uses of a buckeye 10566
account and establish the means for using the account for those 10567
purposes. 10568

(C) For the purpose of division (A) (3) of section 5166.523 10569
of the Revised Code, establish requirements for the use of a 10570
healthy Ohio program debit swipe card to pay for the costs of 10571
medically necessary health care services not covered by the 10572
health plan in which a healthy Ohio program participant enrolls. 10573

(D) For the purpose of division (C) of section 5166.524 of 10574
the Revised Code, establish a system under which the director 10575
may award points to healthy Ohio program participants who 10576
achieve health care goals. The rules shall specify the goals 10577
that qualify for points and the number of points each goal is 10578
worth. The number of points may vary for different goals. 10579

(E) For the purpose of section 5166.527 of the Revised 10580
Code, establish a catastrophic health care plan for healthy Ohio 10581
program participants who exhaust the annual or lifetime payout 10582
limit specified in division (A) (5) of section 5166.521 of the 10583

Revised Code. 10584

(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. 10585
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Sec. 5166.53. (A) As used in this section: 10589

"Disproportionate share hospital" has the same meaning as in section 5168.01 of the Revised Code. 10590
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"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. 10592
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"Hospital care assurance program" means the program established under sections 5168.01 to 5168.14 of the Revised Code. 10596
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"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. 10599
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"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. 10603
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(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: 10607
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(1) Determine the total amount of the actual expenditures for the medicaid program for fiscal year 2016; 10610
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(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; 10612
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(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. 10619
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(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: 10624
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(1) Annual payments to each disproportionate share hospital in the amount of the difference between the following: 10630
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(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); 10632
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(b) The amount the disproportionate share hospital is paid under the hospital care assurance program for that year. 10639
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<u>(2) Department of developmental disabilities-administered</u>	10641
<u>home and community-based services;</u>	10642
<u>(3) Community behavioral health services covered by the</u>	10643
<u>medicaid program;</u>	10644
<u>(4) The costs of having the medicaid program cover all of</u>	10645
<u>the following:</u>	10646
<u>(a) Veterans who do not otherwise qualify for medicaid and</u>	10647
<u>are either ineligible for medical benefits from the United</u>	10648
<u>States department of veterans affairs or reside more than one</u>	10649
<u>hundred miles away from a veterans affairs medical facility;</u>	10650
<u>(b) Individuals who are considered to have serious mental</u>	10651
<u>illnesses under 42 C.F.R. 483.102(b) and do not otherwise</u>	10652
<u>qualify for medicaid;</u>	10653
<u>(c) Individuals who would qualify for medicaid if the</u>	10654
<u>income eligibility threshold specified in section 5163.07 of the</u>	10655
<u>Revised Code were one hundred, rather than ninety, per cent of</u>	10656
<u>the federal poverty line;</u>	10657
<u>(d) Subject to division (D) of this section, individuals</u>	10658
<u>to whom all of the following apply:</u>	10659
<u>(i) They are under sixty-five years of age.</u>	10660
<u>(ii) They are not pregnant.</u>	10661
<u>(iii) They are not entitled to or enrolled for benefits</u>	10662
<u>under medicare part A.</u>	10663
<u>(iv) They are not enrolled for benefits under medicare</u>	10664
<u>part B.</u>	10665
<u>(v) They are not otherwise eligible for medicaid.</u>	10666
<u>(vi) They have family countable incomes equal to at least</u>	10667

fifty but not more than one hundred per cent of the federal 10668
poverty line. 10669

(5) The costs of providing under the medicaid program 10670
maintenance therapies for chronic conditions specified in rules 10671
adopted under section 5166.02 of the Revised Code to individuals 10672
to whom all of the following apply: 10673

(a) They have one or more of the chronic conditions 10674
specified in the rules. 10675

(b) They are not entitled to or enrolled for benefits 10676
under medicare part A. 10677

(c) They are not enrolled for benefits under medicare part 10678
B. 10679

(d) They are not otherwise eligible for medicaid. 10680

(D) If the medicaid director determines that the amount 10681
available for this section for a fiscal year is insufficient to 10682
pay the costs of having the medicaid program cover the 10683
individuals described in division (C)(4)(d) of this section, the 10684
director shall limit medicaid coverage of those individuals to 10685
the extent necessary. In limiting medicaid coverage, the 10686
director shall prioritize coverage as follows: 10687

(1) First priority shall be given to the individuals who 10688
have family countable incomes equal to at least ninety but not 10689
more than one hundred per cent of the federal poverty line. 10690

(2) Second priority shall be given to the individuals who 10691
have family countable incomes equal to at least eighty but less 10692
than ninety per cent of the federal poverty line. 10693

(3) Third priority shall be given to the individuals who 10694
have family countable incomes equal to at least seventy but less 10695

than eighty per cent of the federal poverty line. 10696

(4) Fourth priority shall be given to the individuals who 10697
have family countable incomes equal to at least sixty but less 10698
than seventy per cent of the federal poverty line. 10699

(5) Fifth priority shall be given to the individuals who 10700
have family countable incomes equal to at least fifty but less 10701
than sixty per cent of the federal poverty line. 10702

Sec. 5167.01. As used in this chapter: 10703

(A) "Controlled substance" has the same meaning as in 10704
section 3719.01 of the Revised Code. 10705

(B) "CPI-U medical inflation rate" means the percentage 10706
increase in the prices for medical care as specified in the 10707
consumer price index for all urban consumers for the midwest 10708
region published by the United States bureau of labor 10709
statistics. 10710

(C) "DRG" means diagnosis-related group. 10711

(D) "Dual eligible individual" has the same meaning as in 10712
section 5160.01 of the Revised Code. 10713

~~(C)~~ (E) "Emergency services" has the same meaning as in 10714
the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u- 10715
2(b)(2). 10716

~~(D)~~ (F) "Home and community-based services medicaid waiver 10717
component" has the same meaning as in section 5166.01 of the 10718
Revised Code. 10719

~~(E)~~ (G) "ICF/IID" has the same meaning as in section 10720
5124.01 of the Revised Code. 10721

(H) "Medicaid managed care organization" means a managed 10722

care organization under contract with the department of medicaid 10723
pursuant to section 5167.10 of the Revised Code. 10724

~~(F)~~ (I) "Medicaid waiver component" has the same meaning 10725
as in section 5166.01 of the Revised Code. 10726

~~(G)~~ (J) "Noninstitutional provider" means any provider 10727
other than a hospital, nursing facility, or ICF/IID. 10728

(K) "Nursing facility" has the same meaning as in section 10729
5165.01 of the Revised Code. 10730

~~(H)~~ (L) "Prescribed drug" has the same meaning as in 10731
section 5164.01 of the Revised Code. 10732

~~(I)~~ (M) "Provider" means any person or government entity 10733
that furnishes services to a medicaid recipient enrolled in a 10734
medicaid managed care organization, regardless of whether the 10735
person or entity has a provider agreement. 10736

~~(J)~~ (N) "Provider agreement" has the same meaning as in 10737
section 5164.01 of the Revised Code. 10738

Sec. 5167.03. (A) As part of the medicaid program, the 10739
department of medicaid shall establish a care management system. 10740

(B) The department shall implement the care management 10741
system in some or all counties and, subject to division (B) (4) 10742
of section 5166.52 of the Revised Code, shall designate the 10743
medicaid recipients who are required or permitted to participate 10744
in the system. In the department's implementation of the system 10745
and designation of participants, all of the following apply: 10746

(1) In the case of individuals who receive medicaid on the 10747
basis of being included in the category identified by the 10748
department as covered families and children, the department 10749
shall implement the care management system in all counties. ~~All~~ 10750

Except as provided in division (C) of this section, all 10751
individuals included in the category shall be designated for 10752
participation, ~~except for individuals included in one or more of~~ 10753
~~the medicaid recipient groups specified in 42 C.F.R. 438.50(d).~~ 10754
~~The department shall ensure that all participants are enrolled~~ 10755
~~in medicaid managed care organizations that are health insuring~~ 10756
~~corporations.~~ 10757

(2) In the case of individuals who receive medicaid on the 10758
basis of being aged, blind, or disabled, the department shall 10759
implement the care management system in all counties. Except as 10760
provided in division (C) of this section, all individuals 10761
included in the category shall be designated for participation. 10762
~~The department shall ensure that all participants are enrolled~~ 10763
~~in medicaid managed care organizations that are health insuring~~ 10764
~~corporations.~~ 10765

(3) Alcohol, drug addiction, and mental health services 10766
covered by medicaid shall not be included in any component of 10767
the care management system when the nonfederal share of the cost 10768
of those services is provided by a board of alcohol, drug 10769
addiction, and mental health services or a state agency other 10770
than the department of medicaid, but, subject to division (B)(4) 10771
of section 5166.52 of the Revised Code, the recipients of those 10772
services may otherwise be designated for participation in the 10773
system. 10774

(C) (1) In designating participants who receive medicaid on 10775
the basis of being included in the category identified by the 10776
department as covered families and children, the department 10777
shall do both of the following: 10778

(a) Exclude individuals included in one or more of the 10779
medicaid recipient groups specified in 42 C.F.R. 438.50(d); 10780

(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. 10781
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(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: 10785
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(a) Individuals who are under twenty-one years of age; 10789

(b) Individuals who are institutionalized; 10790

(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; 10791
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(d) Dual eligible individuals; 10794

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component. 10795
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~~(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: 10797
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(a) Individuals who are under twenty-one years of age; 10801

(b) Individuals who reside in a nursing facility; 10802

(c) Individuals who, as an alternative to receiving nursing facility services, are participating in a home and community-based services medicaid waiver component; 10803
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(d) Dual eligible individuals. 10806

(D) Subject to division (B) of this section, the 10807

department may do both of the following under the care 10808
management system: 10809

(1) Require or permit participants in the system to obtain 10810
health care services from providers designated by the 10811
department; 10812

(2) Require or permit participants in the system to obtain 10813
health care services through medicaid managed care 10814
organizations. 10815

Sec. 5167.04. The department of medicaid shall ensure that 10816
each individual designated for participation in the care 10817
management system pursuant to division (B) (1) or (2) of section 10818
5167.03 of the Revised Code is enrolled in a medicaid managed 10819
care organization that is either of the following: 10820

(A) A health insuring corporation; 10821

(B) Subject to section 5166.50 of the Revised Code, a 10822
regional network consisting of hospitals that accepts a 10823
capitated payment from the department that is not more than 10824
ninety per cent of the lowest capitated payment made to a 10825
medicaid managed care organization that is a health insuring 10826
corporation. 10827

Sec. 5167.10. (A) The department of medicaid may enter 10828
into contracts with managed care organizations, ~~including health-~~ 10829
~~insuring corporations,~~ under which the organizations are 10830
authorized to provide, or arrange for the provision of, health 10831
care services to medicaid recipients who are required or 10832
permitted to obtain health care services through managed care 10833
organizations as part of the care management system established 10834
under section 5167.03 of the Revised Code. The managed care 10835
organizations with which the department may enter into contract 10836

include health insuring corporations and, pursuant to division 10837
(B) of section 5167.04 of the Revised Code, regional networks 10838
consisting of hospitals. 10839

(B) (1) Subject to division (B) (2) (a) of this section, the 10840
department or its actuary shall base the hospital inpatient 10841
capital payment portion of the payment made to managed care 10842
organizations on data for services provided to all recipients 10843
enrolled in managed care organizations with which the department 10844
contracts, as reported by hospitals on relevant cost reports 10845
submitted pursuant to rules adopted under section 5167.02 of the 10846
Revised Code. 10847

(2) (a) The hospital inpatient capital payment portion of 10848
the payment made to medicaid managed care organizations shall 10849
not exceed any maximum rate established by the department 10850
pursuant to rules adopted under this section. 10851

(b) If a maximum rate is established, a medicaid managed 10852
care organization shall not compensate hospitals for inpatient 10853
capital costs in an amount that exceeds that rate. 10854

(C) The department of medicaid shall allow a medicaid 10855
managed care organization to use providers to render care upon 10856
completion of the medicaid managed care organization's 10857
credentialing process. 10858

Sec. 5167.16. (A) As used in this section: 10859

(1) "Applicable percentage" means the following: 10860

(a) For the first year that incentive payments are made 10861
under this section, two per cent; 10862

(b) For the second year that the incentive payments are 10863
made, four per cent; 10864

(c) For the third and subsequent years that the incentive payments are made, six per cent. 10865
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(2) "Base operating DRG payment amount" has the meaning specified in rules authorized by this section. 10867
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(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). 10869
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(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. 10873
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(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. 10877
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(C) Subject to section 5166.50 of the Revised Code, each 10893

medicaid managed care organization shall reduce each 10894
participating hospital's base operating DRG payment amount for 10895
each discharge in a year by an amount equal to the applicable 10896
percentage of the participating hospital's base operating DRG 10897
payment amount for the discharge for that year. The reduction 10898
shall be made for all participating hospitals each year 10899
regardless of whether a participating hospital has earned an 10900
incentive payment under this section for that year. 10901

(D) The medicaid director shall adopt rules under section 10902
5167.02 of the Revised Code as necessary to implement this 10903
section, including rules that define the term "base operating 10904
DRG payment amount." 10905

Sec. 5167.30. (A) ~~(1)~~— The department of medicaid shall 10906
establish a managed care performance payment program. Under the 10907
program, the department ~~may~~ shall provide payments to medicaid 10908
managed care organizations that meet performance standards 10909
established by the department. 10910

~~(2)~~—(B) In establishing performance standards, the 10911
department may consult any of the following: 10912

~~(a)~~—(1) Any quality measurements developed under the 10913
pediatric quality measures program established pursuant to 10914
section 1139A of the "Social Security Act," ~~section 1139A,~~ 42 10915
U.S.C. 1320b-9a; 10916

~~(b)~~—(2) Any core set of adult health quality measures for 10917
medicaid eligible adults used for purposes of section 1139A of 10918
the "Social Security Act," ~~section 1139A,~~ 42 U.S.C. 1320b-9b, 10919
and any adult health quality used for purposes of the medicaid 10920
quality measurement program when the program is established 10921
under that section of the "Social Security Act"; 10922

~~(e)~~ (3) The most recent healthcare effectiveness data and information set and quality measurement tool established by the national committee for quality assurance. 10923
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~~(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. 10926
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~~(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~~ 10930
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(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. 10934
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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. 10942
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~~(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 10949
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department makes to a medicaid managed care organization during 10952
a fiscal year: 10953

(a) For fiscal year 2016, two per cent of the payment; 10954

(b) For fiscal year 2017, four per cent of the payment; 10955

(c) For fiscal year 2018 and each fiscal year thereafter, 10956
six per cent of the payment. The amount shall be established as 10957
a percentage of each premium payment. The percentage shall be 10958
the same for all medicaid managed care organizations. The sum of 10959
all withholdings under this division shall not exceed two per 10960
cent of the total of all premium payments made to all medicaid 10961
managed care organizations. 10962

(2) Each medicaid managed care organization shall agree to 10963
the withholding as a condition of receiving or maintaining its 10964
provider agreement with the department. 10965

~~When the amount is established and each time the amount is~~ 10966
~~modified thereafter, the~~ (3) The department shall certify the 10967
~~amount to the director of budget and management and begin~~ 10968
~~withholding the amount from each premium the department pays to~~ 10969
~~a medicaid managed care organization the total amount of the~~ 10970
withholdings made under division (E)(1) of this section for each 10971
fiscal year. 10972

Sec. 5167.32. (A) As used in this section, " specified 10973
states" means the following states: Illinois, Indiana, Michigan, 10974
Ohio, Pennsylvania, and West Virginia. 10975

(B) This section is subject to section 5166.50 of the 10976
Revised Code. 10977

(C) The department of medicaid shall determine both of the 10978
following before the beginning of each fiscal year: 10979

(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; 10980
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(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. 10984
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(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. 10990
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(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. 11001
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Sec. 5167.33. Subject to section 5166.50 of the Revised Code, the department of medicaid shall penalize a medicaid 11008
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managed care organization if the organization pays a rate for a 11010
hospital outpatient service provided to a medicaid recipient 11011
enrolled in the organization that is more than ten per cent 11012
higher than the rate it pays for the same service when provided 11013
by a noninstitutional provider. 11014

Section 2. That existing sections 1751.67, 2117.06, 11015
2125.01, 2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 11016
2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 11017
2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 11018
2711.22, 2711.23, 2711.24, 2743.02, 2743.43, 2919.171, 3923.63, 11019
3923.64, 3929.302, 3929.62, 3929.67, 3931.01, 3937.25, 3937.28, 11020
3937.29, 3955.05, 4715.30, 4723.28, 4723.341, 4725.19, 4729.16, 11021
4730.25, 4730.32, 4731.22, 4731.224, 4731.281, 4734.31, 4734.32, 11022
4755.47, 4765.11, 5164.01, 5164.07, 5165.15, 5165.23, 5166.01, 11023
5167.01, 5167.03, 5167.10, and 5167.30 and section 4731.143 of 11024
the Revised Code are hereby repealed. 11025

Section 3. Thirty days after the effective date of this 11026
act, or as soon as possible thereafter, the Director of Budget 11027
and Management shall transfer cash from the GRF to the 11028
Nonstandard Multiple Employer Welfare Arrangement Reinsurance 11029
Fund and the Nonstandard Multiple Employer Welfare Arrangement 11030
Guarantee Fund in an amount determined by the Superintendent of 11031
Insurance sufficient to fund the reinsurance and guarantee 11032
portions of the Nonstandard Multiple Employer Welfare 11033
Arrangement Program, as prescribed in sections 1739.32 and 11034
1739.33 of the Revised Code. 11035

Section 4. That sections 1739.30, 1739.31, 1739.32, and 11036
1739.33 of the Revised Code are hereby repealed. 11037

Section 5. Section 4 of this act shall take effect five 11038
years after the effective date of this act. 11039

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. 11069

(B) Notwithstanding sections 3965.30, 3965.31, 3965.32, 11070
3965.33, 3965.50, and 3965.51 of the Revised Code, as enacted by 11071
this act, no claim shall be filed with the Medical Injury 11072
Compensation Center for a period beginning on the effective date 11073
of this act and ending one year after the effective date of this 11074
act. Any chiropractic claim, dental claim, medical claim, 11075
optometric claim, or derivative claim that accrues prior to one 11076
year after the effective date of this act may be brought in a 11077
court of competent jurisdiction in accordance with the 11078
applicable laws as those laws existed immediately prior to the 11079
effective date of this act. 11080

(C) Notwithstanding sections 1751.67, 2117.06, 2125.01, 11081
2125.02, 2305.11, 2305.113, 2305.15, 2305.23, 2305.231, 11082
2305.234, 2305.25, 2307.24, 2307.26, 2315.21, 2315.32, 2317.02, 11083
2323.41, 2323.42, 2323.421, 2323.43, 2323.45, 2323.55, 2711.21, 11084
2711.22, 2743.02, 2743.43, 2919.171, 3923.63, 3923.64, 3929.302, 11085
3929.62, 3929.67, 3931.01, 3937.25, 3937.29, 3955.05, and 11086
5164.07 of the Revised Code, as amended by this act, and 11087
sections 3965.30, 3965.31, 3965.32, 3965.33, 3965.50, and 11088
3965.51 of the Revised Code, as enacted by this act, if a 11089
chiropractic claim, dental claim, medical claim, optometric 11090
claim, or derivative claim accrues during the time period 11091
beginning one year after the effective date of this act and 11092
ending the date that is two years after the effective date of 11093
this act, a claimant may elect to file a claim with the Medical 11094
Injury Compensation Center or may elect to bring a cause of 11095
action in a court of competent jurisdiction in accordance with 11096
the applicable laws as those laws existed immediately prior to 11097
the effective date of this act. A claimant may not file with 11098
both a court and the Center. 11099

(D) A chiropractic claim, dental claim, medical claim, 11100
optometric claim, or derivative claim that accrues more than two 11101
years after the effective date of this act shall be filed in 11102
accordance with sections 3965.30, 3965.31, 3965.32, 3965.33, 11103
3965.50, and 3965.51 of the Revised Code, as enacted by this 11104
act. 11105

Section 10. (A) As used in this section: 11106

(1) "Addiction services" has the same meaning as in 11107
section 5119.01 of the Revised Code. 11108

(2) "Child care" has the same meaning as in section 11109
5104.01 of the Revised Code. 11110

(3) "Ex-offender reentry services" means the services 11111
available under reentry programs identified in the reports that 11112
the Ex-Offender Reentry Coalition is required by section 5120.07 11113
of the Revised Code to prepare. 11114

(4) "Housing services" means services or activities 11115
designed to assist individuals or families in locating, 11116
obtaining, or retaining suitable housing. 11117

(5) "Medicaid managed care organization" has the same 11118
meaning as in section 5167.01 of the Revised Code. 11119

(6) "Mental health services" has the same meaning as in 11120
section 5119.01 of the Revised Code. 11121

(7) "Provider agreement" has the same meaning as in 11122
section 5164.01 of the Revised Code. 11123

(8) "Publicly funded child care" has the same meaning as 11124
in section 5104.01 of the Revised Code. 11125

(9) "Supplemental Nutrition Assistance Program" means the 11126

program administered by the Director of Job and Family Services	11127
pursuant to section 5101.54 of the Revised Code.	11128
(10) "WIC program" has the same meaning as in section	11129
3701.132 of the Revised Code.	11130
(11) "Workforce development activity" has the same meaning	11131
as in section 6301.01 of the Revised Code.	11132
(B) The Department of Medicaid shall establish, and	11133
operate for two years, a pilot program under which one or more	11134
Medicaid managed care organizations help coordinate all of the	11135
following services that Medicaid recipients enrolled in the	11136
organizations receive:	11137
(1) The health care services that the Medicaid managed	11138
care organizations, pursuant to their provider agreements,	11139
provide to, or arrange for, the recipients;	11140
(2) Addiction services;	11141
(3) Mental health services;	11142
(4) Support services for children, including child care	11143
and publicly funded child care;	11144
(5) Services made available under Chapters 5123. and 5126.	11145
of the Revised Code for individuals with mental retardation and	11146
other developmental disabilities;	11147
(6) Services made available under Chapter 173. of the	11148
Revised Code for individuals sixty years of age or older;	11149
(7) Housing services;	11150
(8) Workforce development activities;	11151
(9) Food assistance, including the Supplemental Nutrition	11152
Assistance Program and the WIC program;	11153

(10) Ex-offender reentry services.	11154
(C) All of the following shall assist the Department of Medicaid in establishing the pilot program:	11155
	11156
(1) The Department of Aging;	11157
(2) The Department of Developmental Disabilities;	11158
(3) The Development Services Agency;	11159
(4) The Department of Health;	11160
(5) The Department of Job and Family Services;	11161
(6) The Department of Mental Health and Addiction Services;	11162
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(7) The Department of Rehabilitation and Correction.	11164
(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.	11165
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(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.	11168
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(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	11175
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eligible to receive. 11181

(G) All persons and state and local government entities 11182
overseeing or operating a program offering any of the services 11183
specified in division (B) of this section, or providing the 11184
services, shall cooperate with the Medicaid managed care 11185
organizations participating in the pilot program for the purpose 11186
of coordinating the services. 11187

(H) Not later than ninety days after the pilot program 11188
ends, the Department of Medicaid shall complete a report 11189
regarding the pilot program. The report shall specify the pilot 11190
program's successes and problems and include the Department's 11191
recommendations for resolving the problems. The Department shall 11192
submit copies of the report to the Governor and, in accordance 11193
with section 101.68 of the Revised Code, the General Assembly. 11194

Section 11. The General Assembly, applying the principle 11195
stated in division (B) of section 1.52 of the Revised Code that 11196
amendments are to be harmonized if reasonably capable of 11197
simultaneous operation, finds that the following sections, 11198
presented in this act as composites of the sections as amended 11199
by the acts indicated, are the resulting versions of the 11200
sections in effect prior to the effective date of the sections 11201
as presented in this act: 11202

Section 109.572 of the Revised Code as amended by both Am. 11203
Sub. H.B. 483 and Am. Sub. S.B. 143 of the 130th General 11204
Assembly. 11205

Section 4715.30 of the Revised Code as amended by Sub. 11206
H.B. 314, Am. Sub. H.B. 341, and Am. Sub. H.B. 483, all of the 11207
130th General Assembly. 11208

Section 4723.28 of the Revised Code as amended by both Am. 11209

Sub. H.B. 341 and Am Sub. H.B. 483 of the 130th General Assembly.	11210 11211
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.	11212 11213 11214
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.	11215 11216 11217
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.	11218 11219 11220