

I_134_1078-4

134th General Assembly
Regular Session
2021-2022

. B. No.

A BILL

To amend sections 1753.28 and 3923.65 of the
Revised Code to regulate the practice of
reducing benefits related to emergency services
if a condition is determined, after the fact, to
not be an emergency.

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

Section 1. That sections 1753.28 and 3923.65 of the
Revised Code be amended to read as follows:

Sec. 1753.28. (A) As used in this section:

(1) "Emergency medical condition" means a ~~medical-physical~~
or mental health condition that manifests itself by such acute
symptoms of sufficient severity, including severe pain, that a
prudent layperson with an average knowledge of health and
medicine could reasonably expect the absence of immediate
medical attention to result in any of the following:

(a) Placing the health of the individual or, with respect
to a pregnant woman, the health of the woman or her unborn
child, in serious jeopardy;



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(b) Serious impairment to bodily functions;	18
(c) Serious dysfunction of any bodily organ or part.	19
(2) "Emergency services" means the following:	20
(a) A medical screening examination, as required by	21
federal law, that is within the capability of the emergency	22
department of a hospital, including ancillary services routinely	23
available to the emergency department, to evaluate an emergency	24
medical condition;	25
(b) Such further medical examination and treatment that	26
are required by federal law to stabilize an emergency medical	27
condition and are within the capabilities of the staff and	28
facilities available at the hospital, including any trauma and	29
burn center of the hospital.	30
(3) (a) "Stabilize" means the provision of such medical	31
treatment as may be necessary to assure, within reasonable	32
medical probability, that no material deterioration of an	33
individual's medical condition is likely to result from or occur	34
during a transfer, if the medical condition could result in any	35
of the following:	36
(i) Placing the health of the individual or, with respect	37
to a pregnant woman, the health of the woman or her unborn	38
child, in serious jeopardy;	39
(ii) Serious impairment to bodily functions;	40
(iii) Serious dysfunction of any bodily organ or part.	41
(b) In the case of a woman having contractions,	42
"stabilize" means such medical treatment as may be necessary to	43
deliver, including the placenta.	44

(4) "Transfer" has the same meaning as in section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

(5) "Emergency services utilization review" means a review of a claim related to emergency services for the purpose of determining whether the claim relates to an emergency medical condition. "Emergency services utilization review" includes a determination as to whether or not a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of an emergency medical condition.

(B) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover emergency services for enrollees with emergency medical conditions without regard to the day or time the emergency services are rendered or to whether the enrollee, the hospital's emergency department where the services are rendered, or an emergency physician treating the enrollee, obtained prior authorization for the emergency services.

(C) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover both of the following:

(1) Emergency services provided to an enrollee at a participating hospital's emergency department if the enrollee presents self with an emergency medical condition;

(2) Emergency services provided to an enrollee at a nonparticipating hospital's emergency department if the enrollee presents self with an emergency medical condition and one of the following circumstances applies:

(a) Due to circumstances beyond the enrollee's control,

the enrollee was unable to utilize a participating hospital's 74
emergency department without serious threat to life or health. 75

(b) A prudent layperson with an average knowledge of 76
health and medicine would have reasonably believed that, under 77
the circumstances, the time required to travel to a 78
participating hospital's emergency department could result in 79
one or more of the adverse health consequences described in 80
division (A) (1) of this section. 81

(c) A person authorized by the health insuring corporation 82
refers the enrollee to an emergency department and does not 83
specify a participating hospital's emergency department. 84

(d) An ambulance takes the enrollee to a nonparticipating 85
hospital other than at the direction of the enrollee. 86

(e) The enrollee is unconscious. 87

(f) A natural disaster precluded the use of a 88
participating emergency department. 89

(g) The status of a hospital changed from participating to 90
nonparticipating with respect to emergency services during a 91
contract year and no good faith effort was made by the health 92
insuring corporation to inform enrollees of this change. 93

(D) A health insuring corporation that provides coverage 94
for emergency services shall inform enrollees of all of the 95
following: 96

(1) The scope of coverage for emergency services; 97

(2) The appropriate use of emergency services, including 98
the use of the 9-1-1 system and any other telephone access 99
systems utilized to access prehospital emergency services; 100

- (3) Any cost sharing provisions for emergency services; 101
- (4) The procedures for obtaining emergency services and 102
other medical services, so that enrollees are familiar with the 103
location of the emergency departments of participating hospitals 104
and with the location and availability of other participating 105
facilities or settings at which they could receive medical 106
services; 107
- (5) That enrollees are not required to self-diagnose. 108
- (E) A health insuring corporation shall not reduce or deny 109
a claim for reimbursement for emergency services based solely on 110
a diagnosis code or impression, current ICD code, or select 111
procedure code relating to the enrollee's condition included on 112
a form submitted to the health insuring corporation by a 113
provider for reimbursement of a claim. Reimbursement for an 114
emergency services claim shall not be reduced or denied based on 115
the absence of an emergency medical condition if a prudent 116
layperson with an average knowledge of health and medicine would 117
have reasonably expected the presence of an emergency medical 118
condition. Before reducing or denying a claim for emergency 119
services, a health insuring corporation shall perform an 120
emergency services utilization review of the claim. 121
- (F) (1) An emergency services utilization review shall be 122
conducted by a physician in good standing with the state medical 123
board who is board-certified by the American board of emergency 124
medicine or American osteopathic board of emergency medicine and 125
is not otherwise directly or indirectly hired by the health 126
insuring corporation except for the purpose of utilization 127
review. 128
- (2) A physician shall not be eligible to provide emergency 129

services utilization reviews unless that physician has 130
substantial professional experience providing emergency medical 131
services, within the two years previous, in an acute care 132
hospital emergency department. 133

(G) An emergency services utilization review shall include 134
a review of the entire medical record of the patient, including 135
all of the following: 136

(1) The complaint in question including presenting 137
symptoms; 138

(2) The patient's medical history. Repeated utilization of 139
the emergency department may be considered. 140

(3) The patient's diagnostic testing; 141

(4) Whether a prudent layperson would reasonably presume 142
the presence of an emergency medical condition. 143

(H) Division (E) of this section does not apply when a 144
reduction in reimbursement is made by a health insuring 145
corporation based on a contractually agreed upon reimbursement 146
rate. 147

(I) If a health insuring corporation requests records 148
related to a potential denial of or reimbursement reduction for 149
an enrollee's benefits when emergency services were furnished to 150
an enrollee, a provider of emergency services has a duty to 151
respond to the health insuring corporation in a timely manner. 152

(J) If an emergency services utilization reviewer 153
determines that the reimbursement or any part of the claim 154
should be denied, reduced, or paid at a lower level of emergency 155
service, or as a nonemergency service, or otherwise, the 156
reviewer shall explain in writing the reason for the reduction 157

or denial of reimbursement. The written explanation for the 158
reduction or denial and the reviewer's name, date, signature, 159
and supporting evidence shall be provided in writing to the 160
enrollee and provider. 161

(K) Nothing in this section shall be construed as 162
exempting a health insuring corporation from the prompt payment 163
requirements prescribed in sections 3901.381 to 3901.3814 of the 164
Revised Code. 165

Sec. 3923.65. (A) As used in this section: 166

~~(1) "Emergency, "emergency medical condition," means a~~ 167
~~medical condition that manifests itself by such acute symptoms~~ 168
~~of sufficient severity, including severe pain, that a prudent~~ 169
~~layperson with average knowledge of health and medicine could~~ 170
~~reasonably expect the absence of immediate medical attention to~~ 171
~~result in any of the following:~~ 172

~~(a) Placing the health of the individual or, with respect~~ 173
~~to a pregnant woman, the health of the woman or her unborn~~ 174
~~child, in serious jeopardy;~~ 175

~~(b) Serious impairment to bodily functions;~~ 176

~~(c) Serious dysfunction of any bodily organ or part.~~ 177

~~(2) "Emergency services" means the following:~~ 178

~~(a) A medical screening examination, as required by~~ 179
~~federal law, that is within the capability of the emergency~~ 180
~~department of a hospital, including ancillary services routinely~~ 181
~~available to the emergency department, to evaluate an emergency~~ 182
~~medical condition;~~ 183

~~(b) Such further medical examination and treatment that~~ 184
~~are required by federal law to stabilize an emergency medical~~ 185

~~condition and are within the capabilities of the staff and~~ 186
~~facilities available at the hospital, including any trauma and~~ 187
~~burn center of the hospital. "emergency services," and "emergency~~ 188
services utilization review" have the same meanings as in 189
section 1753.28 of the Revised Code. 190

(B) Every individual or group policy of sickness and 191
accident insurance that provides hospital, surgical, or medical 192
expense coverage shall cover emergency services without regard 193
to the day or time the emergency services are rendered or to 194
whether the policyholder, the hospital's emergency department 195
where the services are rendered, or an emergency physician 196
treating the policyholder, obtained prior authorization for the 197
emergency services. 198

(C) Every individual policy or certificate furnished by an 199
insurer in connection with any sickness and accident insurance 200
policy shall provide information regarding the following: 201

(1) The scope of coverage for emergency services; 202

(2) The appropriate use of emergency services, including 203
the use of the 9-1-1 system and any other telephone access 204
systems utilized to access prehospital emergency services; 205

(3) Any copayments for emergency services; 206

(4) That the covered person is not required to self- 207
diagnose. 208

(D) This section does not apply to any individual or group 209
policy of sickness and accident insurance covering only 210
accident, credit, dental, disability income, long-term care, 211
hospital indemnity, medicare supplement, medicare, tricare, 212
specified disease, or vision care; coverage under a one-time- 213
limited-duration policy that is less than twelve months; 214

coverage issued as a supplement to liability insurance; 215
insurance arising out of workers' compensation or similar law; 216
automobile medical payment insurance; or insurance under which 217
benefits are payable with or without regard to fault and which 218
is statutorily required to be contained in any liability 219
insurance policy or equivalent self-insurance. 220

(E) A sickness and accident insurer shall not reduce or 221
deny a claim for reimbursement for emergency services based 222
solely on a diagnosis code or impression, current ICD code, or 223
select procedure code relating to the covered person's condition 224
included on a form submitted to the sickness and accident 225
insurer by a provider for reimbursement of a claim. 226
Reimbursement for an emergency services claim shall not be 227
reduced or denied based on the absence of an emergency medical 228
condition if a prudent layperson with an average knowledge of 229
health and medicine would have reasonably expected the presence 230
of an emergency medical condition. Before reducing or denying a 231
claim for emergency services, a sickness and accident insurer 232
shall perform an emergency services utilization review of the 233
claim. 234

(F) (1) An emergency services utilization review shall be 235
conducted by a physician in good standing with the state medical 236
board who is board-certified by the American board of emergency 237
medicine or American osteopathic board of emergency medicine and 238
is not otherwise directly or indirectly hired by the sickness 239
and accident insurer except for the purpose of utilization 240
review. 241

(2) A physician shall not be eligible to provide emergency 242
services utilization reviews unless that physician has 243
substantial professional experience providing emergency medical 244

services, within the two years previous, in an acute care 245
hospital emergency department. 246

(G) An emergency services utilization review shall include 247
a review of the entire medical record of the patient, including 248
all of the following: 249

(1) The complaint in question including presenting 250
symptoms; 251

(2) The patient's medical history. Repeated utilization of 252
the emergency department may be considered. 253

(3) The patient's diagnostic testing; 254

(4) Whether a prudent layperson would reasonably presume 255
the presence of an emergency medical condition. 256

(H) Division (E) of this section does not apply when a 257
reduction in reimbursement is made by a sickness and accident 258
insurer based on a contractually agreed upon reimbursement rate. 259

(I) If a sickness and accident insurer requests records 260
related to a potential denial of or reimbursement reduction for 261
a covered person's benefits when emergency services were 262
furnished to a covered person, a provider of emergency services 263
has a duty to respond to the sickness and accident insurer in a 264
timely manner. 265

(J) If an emergency services utilization reviewer 266
determines that the reimbursement or any part of the claim 267
should be denied, reduced, or paid at a lower level of emergency 268
service, or as a nonemergency service, or otherwise, the 269
reviewer shall explain in writing the reason for the reduction 270
or denial of reimbursement. The written explanation for the 271
reduction or denial and the reviewer's name, date, signature, 272

and supporting evidence shall be provided in writing to the 273
covered person and provider. 274

(K) Nothing in this section shall be construed as 275
exempting a sickness and accident insurer from the prompt 276
payment requirements prescribed in sections 3901.381 to 277
3901.3814 of the Revised Code. 278

Section 2. That existing sections 1753.28 and 3923.65 of 279
the Revised Code are hereby repealed. 280