Reviewed As To Form By
Legislative Service Commission

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134th General Assembly
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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;

(b) Serious impairment to bodily functions;

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

(2) "Emergency services" means the following:

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

(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

(3)(a) "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

(i) 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;

(ii) Serious impairment to bodily functions;

(iii) Serious dysfunction of any bodily organ or part.

(b) In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

(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 emergency department without serious threat to life or health.

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

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

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

(e) The enrollee is unconscious.

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

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

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

(1) The scope of coverage for emergency services;

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

(3) Any cost sharing provisions for emergency services;

(4) The procedures for obtaining emergency services and other medical services, so that enrollees are familiar with the location of the emergency departments of participating hospitals and with the location and availability of other participating facilities or settings at which they could receive medical services;

(5) That enrollees are not required to self-diagnose.

(E) A health insuring corporation shall not reduce or deny a claim for reimbursement for emergency services based solely on a diagnosis code or impression, current ICD code, or select procedure code relating to the enrollee's condition included on a form submitted to the health insuring corporation by a provider for reimbursement of a claim. Reimbursement for an emergency services claim shall not be reduced or denied based on the absence of an emergency medical condition if a prudent layperson with an average knowledge of health and medicine would have reasonably expected the presence of an emergency medical condition. Before reducing or denying a claim for emergency services, a health insuring corporation shall perform an emergency services utilization review of the claim.

(F)(1) An emergency services utilization review shall be conducted by a physician in good standing with the state medical board who is board-certified by the American board of emergency medicine or American osteopathic board of emergency medicine and is not otherwise directly or indirectly hired by the health insuring corporation except for the purpose of utilization review.

(2) A physician shall not be eligible to provide emergency

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

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

(1) The complaint in question including presenting symptoms;

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

(3) The patient's diagnostic testing;

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

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

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

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

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

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

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

~~(1) "Emergency~~, "emergency medical condition~~,~~" ~~means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with 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;~~

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

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

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

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

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

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

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

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

(1) The scope of coverage for emergency services;

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

(3) Any copayments for emergency services;

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

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

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

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

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

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

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

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

(1) The complaint in question including presenting symptoms;

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

(3) The patient's diagnostic testing;

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

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

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

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

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

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

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