

As Introduced

134th General Assembly

Regular Session

2021-2022

H. B. No. 270

Representatives Manchester, Upchurch

A BILL

To amend sections 1753.28, 3727.09, 3923.65, and 1
4765.01 of the Revised Code to regulate the 2
practice of reducing benefits related to 3
emergency services if a condition is determined, 4
after the fact, to not be an emergency. 5

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

Section 1. That sections 1753.28, 3727.09, 3923.65, and 6
4765.01 of the Revised Code be amended to read as follows: 7

Sec. 1753.28. (A) As used in this section: 8

(1) "Emergency facility" means a hospital emergency 9
department or any other facility that provides emergency medical 10
services. 11

(2) "Emergency medical condition" means a ~~medical-physical~~ 12
or mental health condition that manifests itself by such acute 13
symptoms of sufficient severity, including severe pain, that, 14
regardless of final or presumptive diagnosis, a prudent 15
layperson with an average knowledge of health and medicine could 16
reasonably expect either of the following: 17

(a) That the absence of immediate medical attention to 18

could result in any of the following: 19

~~(a) (i) Placing the health of the individual or, with~~ 20
respect to a pregnant woman, the health of the woman or her 21
unborn child, in serious jeopardy; 22

~~(b) (ii) Serious impairment to bodily functions;~~ 23

~~(c) (iii) Serious dysfunction of any bodily organ or part.~~ 24

(b) With respect to a pregnant woman who is having or is 25
believed to be having contractions, that there is: 26

(i) Inadequate time to effect a safe transport of the 27
woman to another hospital before delivery; 28

(ii) A threat to the health or safety of the woman or 29
unborn child if the woman does not have access to immediate 30
medical attention. 31

~~(2) (3) "Emergency services" means the following:~~ 32

~~(a) A medical screening examination, as required by~~ 33
~~federal law, that is within the capability of the emergency-~~ 34
~~department of a hospital, including ancillary services routinely~~ 35
~~available to the emergency department, to evaluate an emergency-~~ 36
~~medical condition;~~ 37

~~(b) Such further medical examination and treatment that~~ 38
~~are required by federal law to stabilize an emergency medical-~~ 39
~~condition and are within the capabilities of the staff and~~ 40
~~facilities available at the hospital, including any trauma and~~ 41
~~burn center of the hospital.~~ 42

~~(3) (a) "Stabilize" means the provision of such medical-~~ 43
~~treatment as may be necessary to assure, within reasonable~~ 44
~~medical probability, that no material deterioration of an~~ 45

~~individual's medical condition is likely to result from or occur~~ 46
~~during a transfer, if the medical condition could result in any~~ 47
~~of the following:~~ 48

~~(i) Placing the health of the individual or, with respect~~ 49
~~to a pregnant woman, the health of the woman or her unborn~~ 50
~~child, in serious jeopardy;~~ 51

~~(ii) Serious impairment to bodily functions;~~ 52

~~(iii) Serious dysfunction of any bodily organ or part.~~ 53

~~(b) In the case of a woman having contractions,~~ 54
~~"stabilize" means such medical treatment as may be necessary to~~ 55
~~deliver, including the placenta.~~ 56

~~(4) "Transfer" has the same meaning as in section 1867 of~~ 57
~~the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.~~ 58
~~1395dd, as amended any health care service furnished or required~~ 59
~~in order to determine whether an emergency medical condition~~ 60
~~exists and the appropriate care to treat, stabilize, or treat~~ 61
~~and stabilize the emergency condition in an emergency facility~~ 62
~~or emergency setting.~~ 63

~~(4) "Emergency services utilization review" means a review~~ 64
~~of a claim related to emergency services for the purpose of~~ 65
~~determining whether the claim relates to an emergency condition.~~ 66
~~"Emergency services utilization review" includes a determination~~ 67
~~as to whether or not there was medical necessity for the level~~ 68
~~of services required for the evaluation, treatment, or both of~~ 69
~~the emergency condition.~~ 70

~~(5) "Independent emergency physician review" means a~~ 71
~~utilization review conducted by a physician in good standing~~ 72
~~with the state medical board who is board certified by the~~ 73
~~American board of emergency medicine or American osteopathic~~ 74

board of emergency medicine and is not otherwise directly or 75
indirectly hired by the health insuring corporation except for 76
the purpose of utilization review. 77

(B) A health insuring corporation policy, contract, or 78
agreement providing coverage of basic health care services shall 79
cover emergency services for enrollees with emergency medical 80
conditions without regard to the day or time the emergency 81
services are rendered or to whether the enrollee, the hospital's 82
emergency department where the services are rendered, or an 83
emergency physician treating the enrollee, obtained prior 84
authorization for the emergency services. 85

(C) A health insuring corporation policy, contract, or 86
agreement providing coverage of basic health care services shall 87
cover both of the following: 88

(1) Emergency services provided to an enrollee at a 89
participating hospital's emergency department if the enrollee 90
presents self with an emergency medical condition; 91

(2) Emergency services provided to an enrollee at a 92
nonparticipating hospital's emergency department if the enrollee 93
presents self with an emergency medical condition and one of the 94
following circumstances applies: 95

(a) Due to circumstances beyond the enrollee's control, 96
the enrollee was unable to utilize a participating hospital's 97
emergency department without serious threat to life or health. 98

(b) A prudent layperson with an average knowledge of 99
health and medicine would have reasonably believed that, under 100
the circumstances, the time required to travel to a 101
participating hospital's emergency department could result in 102
one or more of the adverse health consequences described in 103

division (A) (1) of this section.	104
(c) A person authorized by the health insuring corporation	105
refers the enrollee to an emergency department and does not	106
specify a participating hospital's emergency department.	107
(d) An ambulance takes the enrollee to a nonparticipating	108
hospital other than at the direction of the enrollee.	109
(e) The enrollee is unconscious.	110
(f) A natural disaster precluded the use of a	111
participating emergency department.	112
(g) The status of a hospital changed from participating to	113
nonparticipating with respect to emergency services during a	114
contract year and no good faith effort was made by the health	115
insuring corporation to inform enrollees of this change.	116
(D) A health insuring corporation that provides coverage	117
for emergency services shall inform enrollees of all of the	118
following:	119
(1) The scope of coverage for emergency services;	120
(2) The appropriate use of emergency services, including	121
the use of the 9-1-1 system and any other telephone access	122
systems utilized to access prehospital emergency services;	123
(3) Any cost sharing provisions for emergency services;	124
(4) The procedures for obtaining emergency services and	125
other medical services, so that enrollees are familiar with the	126
location of the emergency departments of participating hospitals	127
and with the location and availability of other participating	128
facilities or settings at which they could receive medical	129
services.	130

(E) A physician shall not be eligible to provide independent emergency physician reviews unless that physician has substantial professional experience providing emergency medical services, within the two years previous, in an acute care hospital emergency department. 131
132
133
134
135

(F) (1) Utilization review of emergency services shall include a review of the entire medical record of the patient, including all of the following: 136
137
138

(a) The complaint in question; 139

(b) The patient's medical history; 140

(c) The patient's diagnostic testing; 141

(d) The medical decision making history of the physician in question. 142
143

(2) For utilization reviewers operating in this state, the process of providing utilization review shall be considered the practice of medicine and shall be subject to the oversight and review of the state medical board of this state. 144
145
146
147

(G) A claim for reimbursement for emergency services shall not be reduced or denied based solely on a final diagnosis or impression, the ICD code, or select procedure codes. 148
149
150

(H) (1) Before a health insuring corporation does any of the following, the health insuring corporation shall obtain an independent emergency physician review that includes, at minimum, the items described in division (H) (2) of this section: 151
152
153
154

(a) Deny benefits; 155

(b) Select a CPT evaluation and management or procedure code of lesser acuity than what was billed by the emergency 156
157

<u>services provider;</u>	158
<u>(c) Reduce reimbursement for an emergency service based on</u>	159
<u>a determination of the absence of an emergency medical</u>	160
<u>condition;</u>	161
<u>(d) Make a determination that medical necessity was not</u>	162
<u>present and therefore reimbursement will be for a lower level of</u>	163
<u>care or as a nonemergency service.</u>	164
<u>(2) The independent emergency physician review required</u>	165
<u>pursuant to division (H) (1) of this section shall include, at</u>	166
<u>minimum, a review of the following related to the emergency</u>	167
<u>service:</u>	168
<u>(a) The enrollee's medical record, including the nature of</u>	169
<u>the presenting problems or symptoms;</u>	170
<u>(b) The enrollee's patient history;</u>	171
<u>(c) The exam and medical decision making.</u>	172
<u>(3) Division (H) of this section does not apply when a</u>	173
<u>reduction in reimbursement is made by a health insuring</u>	174
<u>corporation based on a contractually agreed upon adjustment for</u>	175
<u>health care services.</u>	176
<u>(I) If a health insuring corporation requests records</u>	177
<u>related to a potential denial of or reimbursement reduction for</u>	178
<u>an enrollee's benefits when emergency services were furnished to</u>	179
<u>an enrollee, a provider of emergency services has a duty to</u>	180
<u>respond to the health insuring corporation in a timely manner.</u>	181
<u>(J) If an independent emergency physician reviewer</u>	182
<u>determines that the reimbursement or any part of the claim</u>	183
<u>should be denied, reduced or paid at a lower level of emergency</u>	184
<u>service, or as a nonemergency service, or otherwise, the</u>	185

independent emergency physician reviewer shall explain in 186
writing the reason for the reduction or denial of reimbursement. 187
The written explanation for the reduction or denial and the 188
reviewer's name, date, signature, and supporting evidence shall 189
be provided in writing to the enrollee and provider. 190

(K) Nothing in this section shall be construed as 191
exempting a health insuring corporation from the prompt payment 192
requirements prescribed in sections 3901.381 to 3901.3814 of the 193
Revised Code. 194

(L) (1) A health insuring corporation shall inform its 195
enrollees at the time of enrollment, and not less than annually 196
thereafter, that emergency care is a covered benefit and provide 197
the enrollee with the legal definition of an "emergency medical 198
condition," as provided in this section. 199

(2) A health insuring corporation shall clearly educate 200
their enrollees on the fact that, if an enrollee believes they 201
may have an emergency medical condition as defined in this 202
section, the health insuring corporation will cover the 203
emergency services, even if after emergency evaluation, no 204
emergency is found. 205

(3) A health insuring corporation shall disclose to 206
enrollees that they are not required to self-diagnose. 207

(M) All information provided to enrollees, including 208
advertisements, web sites, enrollee advice, enrollee 209
correspondence, and language in the explanation of benefits, 210
shall be consistent with this section and shall not be false or 211
misleading. A health insuring corporation shall not discourage 212
appropriate use of the emergency department. Health insuring 213
corporations shall educate enrollees as to the appropriate site 214

<u>of service based upon symptoms and availability of alternative</u>	215
<u>sites of care.</u>	216
<u>(N) Repeated violations of this section shall be</u>	217
<u>considered an unfair and deceptive practice in the business of</u>	218
<u>insurance under sections 3901.19 to 3901.26 of the Revised Code.</u>	219
Sec. 3727.09. (A) As used in this section and sections	220
3727.10 and 3727.101 of the Revised Code:	221
(1) "Trauma," "trauma care," "trauma center," "trauma	222
patient," "pediatric," and "adult" have the same meanings as in	223
section 4765.01 of the Revised Code.	224
(2) (a) "Stabilize" and "transfer" have the same meanings	225
as in section 1753.28 of the Revised Code. <u>means the provision</u>	226
<u>of such medical treatment as may be necessary to assure, within</u>	227
<u>reasonable medical probability, that no material deterioration</u>	228
<u>of an individual's medical condition is likely to result from or</u>	229
<u>occur during a transfer, if the medical condition could result</u>	230
<u>in any of the following:</u>	231
<u>(i) Placing the health of the individual or, with respect</u>	232
<u>to a pregnant woman, the health of the woman or her unborn</u>	233
<u>child, in serious jeopardy;</u>	234
<u>(ii) Serious impairment to bodily functions;</u>	235
<u>(iii) Serious dysfunction of any bodily organ or part.</u>	236
<u>(b) In the case of a woman having contractions,</u>	237
<u>"stabilize" means such medical treatment as may be necessary to</u>	238
<u>deliver, including the placenta.</u>	239
<u>(3) "Transfer" has the same meaning as in 42 U.S.C.</u>	240
<u>1395dd.</u>	241

(B) On and after November 3, 2002, each hospital in this state that is not a trauma center shall adopt protocols for adult and pediatric trauma care provided in or by that hospital; each hospital in this state that is an adult trauma center and not a level I or level II pediatric trauma center shall adopt protocols for pediatric trauma care provided in or by that hospital; each hospital in this state that is a pediatric trauma center and not a level I and II adult trauma center shall adopt protocols for adult trauma care provided in or by that hospital. In developing its trauma care protocols, each hospital shall consider the guidelines for trauma care established by the American college of surgeons, the American college of emergency physicians, and the American academy of pediatrics. Trauma care protocols shall be written, comply with applicable federal and state laws, and include policies and procedures with respect to all of the following:

(1) Evaluation of trauma patients, including criteria for prompt identification of trauma patients who require a level of adult or pediatric trauma care that exceeds the hospital's capabilities;

(2) Emergency treatment and stabilization of trauma patients prior to transfer to an appropriate adult or pediatric trauma center;

(3) Timely transfer of trauma patients to appropriate adult or pediatric trauma centers based on a patient's medical needs. Trauma patient transfer protocols shall specify all of the following:

(a) Confirmation of the ability of the receiving trauma center to provide prompt adult or pediatric trauma care appropriate to a patient's medical needs;

(b) Procedures for selecting an appropriate alternative adult or pediatric trauma center to receive a patient when it is not feasible or safe to transport the patient to a particular trauma center;	272 273 274 275
(c) Advance notification and appropriate medical consultation with the trauma center to which a trauma patient is being, or will be, transferred;	276 277 278
(d) Procedures for selecting an appropriate method of transportation and the hospital responsible for arranging or providing the transportation;	279 280 281
(e) Confirmation of the ability of the persons and vehicle that will transport a trauma patient to provide appropriate adult or pediatric trauma care;	282 283 284
(f) Assured communication with, and appropriate medical direction of, the persons transporting a trauma patient to a trauma center;	285 286 287
(g) Identification and timely transfer of appropriate medical records of the trauma patient being transferred;	288 289
(h) The hospital responsible for care of a patient in transit;	290 291
(i) The responsibilities of the physician attending a patient and, if different, the physician who authorizes a transfer of the patient;	292 293 294
(j) Procedures for determining, in consultation with an appropriate adult or pediatric trauma center and the persons who will transport a trauma patient, when transportation of the patient to a trauma center may be delayed for either of the following reasons:	295 296 297 298 299

(i) Immediate transfer of the patient is unsafe due to adverse weather or ground conditions.	300 301
(ii) No trauma center is able to provide appropriate adult or pediatric trauma care to the patient without undue delay.	302 303
(4) Peer review and quality assurance procedures for adult and pediatric trauma care provided in or by the hospital.	304 305
(C) (1) On and after November 3, 2002, each hospital shall enter into all of the following written agreements unless otherwise provided in division (C) (2) of this section:	306 307 308
(a) An agreement with one or more adult trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of adult trauma patients from the hospital to those trauma centers;	309 310 311 312
(b) An agreement with one or more pediatric trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of pediatric trauma patients from the hospital to those trauma centers.	313 314 315 316
(2) A level I or level II adult trauma center is not required to enter into an adult trauma patient transfer agreement with another hospital. A level I or level II pediatric trauma center is not required to enter into a pediatric trauma patient transfer agreement with another hospital. A hospital is not required to enter into an adult trauma patient transfer agreement with a level III or level IV adult trauma center, or enter into a pediatric trauma patient transfer agreement with a level III or level IV pediatric trauma center, if no trauma center of that type is reasonably available to receive trauma patients transferred from the hospital.	317 318 319 320 321 322 323 324 325 326 327
(3) A trauma patient transfer agreement entered into by a	328

hospital under division (C) (1) of this section shall comply with 329
applicable federal and state laws and contain provisions 330
conforming to the requirements for trauma care protocols set 331
forth in division (B) of this section. 332

(D) A hospital shall make trauma care protocols it adopts 333
under division (B) of this section and trauma patient transfer 334
agreements it adopts under division (C) of this section 335
available for public inspection during normal working hours. A 336
hospital shall furnish a copy of such documents upon request and 337
may charge a reasonable and necessary fee for doing so, provided 338
that upon request it shall furnish a copy of such documents to 339
the director of health free of charge. 340

(E) A hospital that ceases to operate as an adult or 341
pediatric trauma center under provisional status is not in 342
violation of divisions (B) and (C) of this section during the 343
time it develops different trauma care protocols and enters into 344
different patient transfer agreements pursuant to division (D) 345
(2) (c) of section 3727.101 of the Revised Code. 346

Sec. 3923.65. (A) As used in this section: 347

~~(1) "Emergency, "emergency facility," "emergency medical 348
condition," means a medical condition that manifests itself by 349
such acute symptoms of sufficient severity, including severe 350
pain, that a prudent layperson with average knowledge of health 351
and medicine could reasonably expect the absence of immediate 352
medical attention to result in any of the following: 353~~

~~(a) Placing the health of the individual or, with respect 354
to a pregnant woman, the health of the woman or her unborn 355
child, in serious jeopardy; 356~~

~~(b) Serious impairment to bodily functions; 357~~

~~(c) Serious dysfunction of any bodily organ or part.~~ 358

~~(2) "Emergency services" means the following:~~ 359

~~(a) A medical screening examination, as required by~~ 360
~~federal law, that is within the capability of the emergency~~ 361
~~department of a hospital, including ancillary services routinely~~ 362
~~available to the emergency department, to evaluate an emergency~~ 363
~~medical condition;~~ 364

~~(b) Such further medical examination and treatment that~~ 365
~~are required by federal law to stabilize an emergency medical~~ 366
~~condition and are within the capabilities of the staff and~~ 367
~~facilities available at the hospital, including any trauma and~~ 368
~~burn center of the hospital. "emergency services," "emergency~~ 369
~~services utilization review," and "independent emergency~~ 370
~~physician review" have the same meanings as in section 1753.28~~ 371
~~of the Revised Code.~~ 372

(B) Every individual or group policy of sickness and 373
accident insurance that provides hospital, surgical, or medical 374
expense coverage shall cover emergency services without regard 375
to the day or time the emergency services are rendered or to 376
whether the policyholder, the hospital's emergency department 377
where the services are rendered, or an emergency physician 378
treating the policyholder, obtained prior authorization for the 379
emergency services. 380

(C) Every individual policy or certificate furnished by an 381
insurer in connection with any sickness and accident insurance 382
policy shall provide information regarding the following: 383

(1) The scope of coverage for emergency services; 384

(2) The appropriate use of emergency services, including 385
the use of the 9-1-1 system and any other telephone access 386

systems utilized to access prehospital emergency services; 387

(3) Any copayments for emergency services. 388

(D) This section does not apply to any individual or group 389
policy of sickness and accident insurance covering only 390
accident, credit, dental, disability income, long-term care, 391
hospital indemnity, medicare supplement, medicare, tricare, 392
specified disease, or vision care; coverage under a one-time- 393
limited-duration policy that is less than twelve months; 394
coverage issued as a supplement to liability insurance; 395
insurance arising out of workers' compensation or similar law; 396
automobile medical payment insurance; or insurance under which 397
benefits are payable with or without regard to fault and which 398
is statutorily required to be contained in any liability 399
insurance policy or equivalent self-insurance. 400

(E) A physician shall not be eligible to provide 401
independent emergency physician reviews unless that physician 402
has substantial professional experience providing emergency 403
medical services, within the two years previous, in an acute 404
care hospital emergency department. 405

(F) (1) Utilization review of emergency services shall 406
include a review of the entire medical record of the patient, 407
including all of the following: 408

(a) The complaint in question; 409

(b) The patient's medical history; 410

(c) The patient's diagnostic testing; 411

(d) The medical decision making history of the physician 412
in question. 413

(2) For utilization reviewers operating in this state, the 414

process of providing utilization review shall be considered the 415
practice of medicine and shall be subject to the oversight and 416
review of the state medical board of this state. 417

(G) A claim for reimbursement for emergency services shall 418
not be reduced or denied based solely on a final diagnosis or 419
impression, the ICD code, or select procedure codes. 420

(H) (1) Before a sickness and accident insurer does any of 421
the following, the insurer shall obtain an independent emergency 422
physician review that includes, at minimum, the items described 423
in division (H) (2) of this section: 424

(a) Deny benefits; 425

(b) Select a CPT evaluation and management or procedure 426
code of lesser acuity than what was billed by the emergency 427
services provider; 428

(c) Reduce reimbursement for an emergency service based on 429
a determination of the absence of an emergency medical 430
condition; 431

(d) Make a determination that medical necessity was not 432
present and therefore reimbursement will be for a lower level of 433
care or as a nonemergency service. 434

(2) The independent emergency physician review required 435
pursuant to division (H) (1) of this section shall include, at 436
minimum, a review of the following related to the emergency 437
service: 438

(a) The covered person's medical record, including the 439
nature of the presenting problems or symptoms; 440

(b) The covered person's patient history; 441

<u>(c) The exam and medical decision making.</u>	442
<u>(3) Division (H) of this section does not apply when a</u>	443
<u>reduction in reimbursement is made by a sickness and accident</u>	444
<u>insurer based on a contractually agreed upon adjustment for</u>	445
<u>health care services.</u>	446
<u>(I) If a sickness and accident insurer requests records</u>	447
<u>related to a potential denial of or reimbursement reduction for</u>	448
<u>a covered person's benefits when emergency services were</u>	449
<u>furnished to a covered person, a provider of emergency services</u>	450
<u>has a duty to respond to the sickness and accident insurer in a</u>	451
<u>timely manner.</u>	452
<u>(J) If an independent emergency physician reviewer</u>	453
<u>determines that the reimbursement or any part of the claim</u>	454
<u>should be denied, reduced or paid at a lower level of emergency</u>	455
<u>service, or as a nonemergency service, or otherwise, the</u>	456
<u>independent emergency physician reviewer shall explain in</u>	457
<u>writing the reason for the reduction or denial of reimbursement.</u>	458
<u>The written explanation for the reduction or denial and the</u>	459
<u>reviewer's name, date, signature, and supporting evidence shall</u>	460
<u>be provided in writing to the covered person and provider.</u>	461
<u>(K) Nothing in this section shall be construed as</u>	462
<u>exempting a sickness and accident insurer from the prompt</u>	463
<u>payment requirements prescribed in sections 3901.381 to</u>	464
<u>3901.3814 of the Revised Code.</u>	465
<u>(L) (1) A sickness and accident insurer shall inform</u>	466
<u>persons covered under its policies at the time of enrollment,</u>	467
<u>and not less than annually thereafter, that emergency care is a</u>	468
<u>covered benefit and provide the covered person with the legal</u>	469
<u>definition of an "emergency medical condition," as provided in</u>	470

this section. 471

(2) A sickness and accident insurer shall clearly educate persons covered under its policies on the fact that, if a covered person believes they may have an emergency medical condition as defined in this section, the sickness and accident insurer will cover the emergency services, even if after emergency evaluation, no emergency is found. 472
473
474
475
476
477

(3) A sickness and accident insurer shall disclose to persons covered under the insurer's policies that they are not required to self-diagnose. 478
479
480

(M) All information provided to covered persons, including advertisements, web sites, covered person advice, covered person correspondence, and language in the explanation of benefits, shall be consistent with this section and shall not be false or misleading. A sickness and accident insurer shall not discourage appropriate use of the emergency department. A sickness and accident insurer shall educate persons covered by the insurer's policies as to the appropriate site of service based upon symptoms and availability of alternative sites of care. 481
482
483
484
485
486
487
488
489

(N) Repeated violations of this section shall be considered an unfair and deceptive practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. 490
491
492

Sec. 4765.01. As used in this chapter: 493

(A) "First responder" means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as a first responder. 494
495
496

(B) "Emergency medical technician-basic" or "EMT-basic" means an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code to practice as 497
498
499

an emergency medical technician-basic. 500

(C) "Emergency medical technician-intermediate" or "EMT-I" 501
means an individual who holds a current, valid certificate 502
issued under section 4765.30 of the Revised Code to practice as 503
an emergency medical technician-intermediate. 504

(D) "Emergency medical technician-paramedic" or 505
"paramedic" means an individual who holds a current, valid 506
certificate issued under section 4765.30 of the Revised Code to 507
practice as an emergency medical technician-paramedic. 508

(E) "Ambulance" means any motor vehicle that is used, or 509
is intended to be used, for the purpose of responding to 510
emergency medical situations, transporting emergency patients, 511
and administering emergency medical service to patients before, 512
during, or after transportation. 513

(F) "Cardiac monitoring" means a procedure used for the 514
purpose of observing and documenting the rate and rhythm of a 515
patient's heart by attaching electrical leads from an 516
electrocardiograph monitor to certain points on the patient's 517
body surface. 518

(G) "Emergency medical service" means any of the services 519
described in sections 4765.35, 4765.37, 4765.38, and 4765.39 of 520
the Revised Code that are performed by first responders, 521
emergency medical technicians-basic, emergency medical 522
technicians-intermediate, and paramedics. "Emergency medical 523
service" includes such services performed before or during any 524
transport of a patient, including transports between hospitals 525
and transports to and from helicopters. 526

(H) "Emergency medical service organization" means a 527
public or private organization using first responders, EMTs- 528

basic, EMTs-I, or paramedics, or a combination of first 529
responders, EMTs-basic, EMTs-I, and paramedics, to provide 530
emergency medical services. 531

(I) "Physician" means an individual who holds a current, 532
valid license issued under Chapter 4731. of the Revised Code 533
authorizing the practice of medicine and surgery or osteopathic 534
medicine and surgery. 535

(J) "Registered nurse" means an individual who holds a 536
current, valid license issued under Chapter 4723. of the Revised 537
Code authorizing the practice of nursing as a registered nurse. 538

(K) "Volunteer" means a person who provides services 539
either for no compensation or for compensation that does not 540
exceed the actual expenses incurred in providing the services or 541
in training to provide the services. 542

(L) "Emergency medical service personnel" means first 543
responders, emergency medical technicians-basic, emergency 544
medical technicians-intermediate, emergency medical technicians- 545
paramedic, and persons who provide medical direction to such 546
persons. 547

(M) "Hospital" has the same meaning as in section 3727.01 548
of the Revised Code. 549

(N) "Trauma" or "traumatic injury" means severe damage to 550
or destruction of tissue that satisfies both of the following 551
conditions: 552

(1) It creates a significant risk of any of the following: 553

(a) Loss of life; 554

(b) Loss of a limb; 555

(c) Significant, permanent disfigurement;	556
(d) Significant, permanent disability.	557
(2) It is caused by any of the following:	558
(a) Blunt or penetrating injury;	559
(b) Exposure to electromagnetic, chemical, or radioactive energy;	560 561
(c) Drowning, suffocation, or strangulation;	562
(d) A deficit or excess of heat.	563
(O) "Trauma victim" or "trauma patient" means a person who has sustained a traumatic injury.	564 565
(P) "Trauma care" means the assessment, diagnosis, transportation, treatment, or rehabilitation of a trauma victim by emergency medical service personnel or by a physician, nurse, physician assistant, respiratory therapist, physical therapist, chiropractor, occupational therapist, speech-language pathologist, audiologist, or psychologist licensed to practice as such in this state or another jurisdiction.	566 567 568 569 570 571 572
(Q) "Trauma center" means all of the following:	573
(1) Any hospital that is verified by the American college of surgeons as an adult or pediatric trauma center;	574 575
(2) Any hospital that is operating as an adult or pediatric trauma center under provisional status pursuant to section 3727.101 of the Revised Code;	576 577 578
(3) Until December 31, 2004, any hospital in this state that is designated by the director of health as a level II pediatric trauma center under section 3727.081 of the Revised Code;	579 580 581 582

(4) Any hospital in another state that is licensed or designated under the laws of that state as capable of providing specialized trauma care appropriate to the medical needs of the trauma patient.	583 584 585 586
(R) "Pediatric" means involving a patient who is less than sixteen years of age.	587 588
(S) "Adult" means involving a patient who is not a pediatric patient.	589 590
(T) "Geriatric" means involving a patient who is at least seventy years old or exhibits significant anatomical or physiological characteristics associated with advanced aging.	591 592 593
(U) "Air medical organization" means an organization that provides emergency medical services, or transports emergency victims, by means of fixed or rotary wing aircraft.	594 595 596
(V) "Emergency care" and "emergency facility" have the same meanings as in section 3727.01 of the Revised Code.	597 598
(W) "Stabilize," except as it is used in division (B) of section 4765.35 of the Revised Code with respect to the manual stabilization of fractures, has the same meaning as in section 1753.28 <u>3727.09</u> of the Revised Code.	599 600 601 602
(X) "Transfer" has the same meaning as in section 1753.28 <u>3727.09</u> of the Revised Code.	603 604
(Y) "Firefighter" means any member of a fire department as defined in section 742.01 of the Revised Code.	605 606
(Z) "Volunteer firefighter" has the same meaning as in section 146.01 of the Revised Code.	607 608
(AA) "Part-time paid firefighter" means a person who	609

provides firefighting services on less than a full-time basis, 610
is routinely scheduled to be present on site at a fire station 611
or other designated location for purposes of responding to a 612
fire or other emergency, and receives more than nominal 613
compensation for the provision of firefighting services. 614

(BB) "Physician assistant" means an individual who holds a 615
valid license to practice as a physician assistant issued under 616
Chapter 4730. of the Revised Code. 617

Section 2. That existing sections 1753.28, 3727.09, 618
3923.65, and 4765.01 of the Revised Code are hereby repealed. 619