As Introduced

134th General Assembly Regular Session 2021-2022

H. B. No. 270

Representatives Manchester, Upchurch

A BILL

То	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

<pre>could result in any of the following:</pre>	19
$\frac{(a)}{(i)}$ 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
<pre>medical condition;</pre>	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

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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
presents sell 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	131
independent emergency physician reviews unless that physician	132
has substantial professional experience providing emergency	133
medical services, within the two years previous, in an acute	134
<pre>care hospital emergency department.</pre>	135
(F)(1) Utilization review of emergency services shall	136
include a review of the entire medical record of the patient,	137
<pre>including all of the following:</pre>	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	142
in question.	143
(2) For utilization reviewers operating in this state, the	144
process of providing utilization review shall be considered the	145
practice of medicine and shall be subject to the oversight and	146
review of the state medical board of this state.	147
(G) A claim for reimbursement for emergency services shall	148
not be reduced or denied based solely on a final diagnosis or	149
impression, the ICD code, or select procedure codes.	150
(H)(1) Before a health insuring corporation does any of	151
the following, the health insuring corporation shall obtain an	152
independent emergency physician review that includes, at	153
minimum, the items described in division (H)(2) of this section:	154
(a) Deny benefits;	155
(b) Select a CPT evaluation and management or procedure	156
code of lesser acuity than what was billed by the emergency	157

services provider;	158
(c) Reduce reimbursement for an emergency service based on	159
a determination of the absence of an emergency medical	160
<pre>condition;</pre>	161
(d) Make a determination that medical necessity was not	162
present and therefore reimbursement will be for a lower level of	163
care or as a nonemergency service.	164
(2) The independent emergency physician review required	165
pursuant to division (H)(1) of this section shall include, at	166
minimum, a review of the following related to the emergency	167
service:	168
(a) The enrollee's medical record, including the nature of	169
the presenting problems or symptoms;	170
(b) The enrollee's patient history;	171
(c) The exam and medical decision making.	172
(3) Division (H) of this section does not apply when a	173
reduction in reimbursement is made by a health insuring	174
corporation based on a contractually agreed upon adjustment for	175
health care services.	176
(I) If a health insuring corporation requests records	177
related to a potential denial of or reimbursement reduction for	178
an enrollee's benefits when emergency services were furnished to	179
an enrollee, a provider of emergency services has a duty to	180
respond to the health insuring corporation in a timely manner.	181
(J) If an independent emergency physician reviewer	182
determines that the reimbursement or any part of the claim	183
should be denied, reduced or paid at a lower level of emergency	184
service, or as a nonemergency service, or otherwise, the	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
<pre>condition," as provided in this section.</pre>	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
<pre>emergency services, even if after emergency evaluation, no_</pre>	204
<pre>emergency is found.</pre>	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

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

(B) On and after November 3, 2002, each hospital in this	242
state that is not a trauma center shall adopt protocols for	243
adult and pediatric trauma care provided in or by that hospital;	244
each hospital in this state that is an adult trauma center and	245
not a level I or level II pediatric trauma center shall adopt	246
protocols for pediatric trauma care provided in or by that	247
hospital; each hospital in this state that is a pediatric trauma	248
center and not a level I and II adult trauma center shall adopt	249
protocols for adult trauma care provided in or by that hospital.	250
In developing its trauma care protocols, each hospital shall	251
consider the guidelines for trauma care established by the	252
American college of surgeons, the American college of emergency	253
physicians, and the American academy of pediatrics. Trauma care	254
protocols shall be written, comply with applicable federal and	255
state laws, and include policies and procedures with respect to	256
all of the following:	257
(1) Evaluation of trauma patients, including criteria for	258
prompt identification of trauma patients who require a level of	259
adult or pediatric trauma care that exceeds the hospital's	260
capabilities;	261
(2) Emergency treatment and stabilization of trauma	262
patients prior to transfer to an appropriate adult or pediatric	263
trauma center;	264
(3) Timely transfer of trauma patients to appropriate	265
adult or pediatric trauma centers based on a patient's medical	266
needs. Trauma patient transfer protocols shall specify all of	267
the following:	268
(a) Confirmation of the ability of the receiving trauma	269
center to provide prompt adult or pediatric trauma care	270

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appropriate to a patient's medical needs;

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

(i) Immediate transfer of the patient is unsafe due to	300
adverse weather or ground conditions.	301
(ii) No trauma center is able to provide appropriate adult	302
or pediatric trauma care to the patient without undue delay.	303
(4) Peer review and quality assurance procedures for adult	304
and pediatric trauma care provided in or by the hospital.	305
(C)(1) On and after November 3, 2002, each hospital shall	306
enter into all of the following written agreements unless	307
otherwise provided in division (C)(2) of this section:	308
(a) An agreement with one or more adult trauma centers in	309
each level of categorization as a trauma center higher than the	310
hospital that governs the transfer of adult trauma patients from	311
the hospital to those trauma centers;	312
(b) An agreement with one or more pediatric trauma centers	313
in each level of categorization as a trauma center higher than	314
the hospital that governs the transfer of pediatric trauma	315
patients from the hospital to those trauma centers.	316
(2) A level I or level II adult trauma center is not	317
required to enter into an adult trauma patient transfer	318
agreement with another hospital. A level I or level II pediatric	319
trauma center is not required to enter into a pediatric trauma	320
patient transfer agreement with another hospital. A hospital is	321
not required to enter into an adult trauma patient transfer	322
agreement with a level III or level IV adult trauma center, or	323
enter into a pediatric trauma patient transfer agreement with a	324
level III or level IV pediatric trauma center, if no trauma	325
center of that type is reasonably available to receive trauma	326
patients transferred from the hospital.	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
<pre>medical condition;</pre>	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
<pre>care hospital emergency department.</pre>	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
<pre>code of lesser acuity than what was billed by the emergency</pre>	427
services provider;	428
(c) Reduce reimbursement for an emergency service based on	429
a determination of the absence of an emergency medical	430
<pre>condition;</pre>	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
<pre>service:</pre>	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

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

this section.	471
(2) A sickness and accident insurer shall clearly educate	472
persons covered under its policies on the fact that, if a	473
covered person believes they may have an emergency medical	474
condition as defined in this section, the sickness and accident	475
insurer will cover the emergency services, even if after	476
emergency evaluation, no emergency is found.	477
(3) A sickness and accident insurer shall disclose to	478
persons covered under the insurer's policies that they are not	479
required to self-diagnose.	480
(M) All information provided to covered persons, including	481
advertisements, web sites, covered person advice, covered person	482
correspondence, and language in the explanation of benefits,	483
shall be consistent with this section and shall not be false or	484
misleading. A sickness and accident insurer shall not discourage	485
appropriate use of the emergency department. A sickness and	486
accident insurer shall educate persons covered by the insurer's	487
policies as to the appropriate site of service based upon	488
symptoms and availability of alternative sites of care.	489
(N) Repeated violations of this section shall be	490
considered an unfair and deceptive practice in the business of	491
insurance under sections 3901.19 to 3901.26 of the Revised Code.	492
Sec. 4765.01. As used in this chapter:	493
(A) "First responder" means an individual who holds a	494
current, valid certificate issued under section 4765.30 of the	495
Revised Code to practice as a first responder.	496
(B) "Emergency medical technician-basic" or "EMT-basic"	497
means an individual who holds a current, valid certificate	498
issued under section 4765.30 of the Revised Code to practice as	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

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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

(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	560
energy;	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	564
has sustained a traumatic injury.	565
(P) "Trauma care" means the assessment, diagnosis,	566
transportation, treatment, or rehabilitation of a trauma victim	567
by emergency medical service personnel or by a physician, nurse,	568
physician assistant, respiratory therapist, physical therapist,	569
chiropractor, occupational therapist, speech-language	570
pathologist, audiologist, or psychologist licensed to practice	571
as such in this state or another jurisdiction.	572
(Q) "Trauma center" means all of the following:	573
(1) Any hospital that is verified by the American college	574
of surgeons as an adult or pediatric trauma center;	575
(2) Any hospital that is operating as an adult or	576
pediatric trauma center under provisional status pursuant to	577
section 3727.101 of the Revised Code;	578
(3) Until December 31, 2004, any hospital in this state	579
that is designated by the director of health as a level II	580
pediatric trauma center under section 3727.081 of the Revised	581
Code;	582

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

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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