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 4765.01 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, 3727.09, 3923.65, and 4765.01 of the Revised Code be amended to read as follows:

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

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

(2) "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, regardless of final or presumptive diagnosis, a prudent layperson with an average knowledge of health and medicine could reasonably expect either of the following:

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

could result in any of the following:

~~(a)~~ (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;

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

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

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

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

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

~~(2)~~ (3) "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~~ any health care service furnished or required in order to determine whether an emergency medical condition exists and the appropriate care to treat, stabilize, or treat and stabilize the emergency condition in an emergency facility or emergency setting.

(4) "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 condition. "Emergency services utilization review" includes a determination as to whether or not there was medical necessity for the level of services required for the evaluation, treatment, or both of the emergency condition.

(5) "Independent emergency physician review" means a utilization review 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.

(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.

(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.

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

(a) The complaint in question;

(b) The patient's medical history;

(c) The patient's diagnostic testing;

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

(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.

(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.

(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:

(a) Deny benefits;

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

services provider;

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

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

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

(a) The enrollee's medical record, including the nature of the presenting problems or symptoms;

(b) The enrollee's patient history;

(c) The exam and medical decision making.

(3) Division (H) of this section does not apply when a reduction in reimbursement is made by a health insuring corporation based on a contractually agreed upon adjustment for health care services.

(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 independent emergency physician 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

independent emergency physician 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.

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

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

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

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

of service based upon symptoms and availability of alternative sites of care.

(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.

Sec. 3727.09. (A) As used in this section and sections 3727.10 and 3727.101 of the Revised Code:

(1) "Trauma," "trauma care," "trauma center," "trauma patient," "pediatric," and "adult" have the same meanings as in section 4765.01 of the Revised Code.

(2)(a) "Stabilize" ~~and "transfer" have the same meanings as in section 1753.28 of the Revised Code.~~ 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.

(3) "Transfer" has the same meaning as in 42 U.S.C. 1395dd.

(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;

(c) Advance notification and appropriate medical consultation with the trauma center to which a trauma patient is being, or will be, transferred;

(d) Procedures for selecting an appropriate method of transportation and the hospital responsible for arranging or providing the transportation;

(e) Confirmation of the ability of the persons and vehicle that will transport a trauma patient to provide appropriate adult or pediatric trauma care;

(f) Assured communication with, and appropriate medical direction of, the persons transporting a trauma patient to a trauma center;

(g) Identification and timely transfer of appropriate medical records of the trauma patient being transferred;

(h) The hospital responsible for care of a patient in transit;

(i) The responsibilities of the physician attending a patient and, if different, the physician who authorizes a transfer of the patient;

(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:

(i) Immediate transfer of the patient is unsafe due to adverse weather or ground conditions.

(ii) No trauma center is able to provide appropriate adult or pediatric trauma care to the patient without undue delay.

(4) Peer review and quality assurance procedures for adult and pediatric trauma care provided in or by the hospital.

(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:

(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;

(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.

(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.

(3) A trauma patient transfer agreement entered into by a

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

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

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

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

~~(1) "Emergency~~, "emergency facility," "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," "emergency services utilization review," and "independent emergency physician 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.

(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 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.

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

(a) The complaint in question;

(b) The patient's medical history;

(c) The patient's diagnostic testing;

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

(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.

(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.

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

(a) Deny benefits;

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

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

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

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

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

(b) The covered person's patient history;

(c) The exam and medical decision making.

(3) Division (H) 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 adjustment for health care services.

(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 independent emergency physician 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 independent emergency physician 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.

(L)(1) A sickness and accident insurer shall inform persons covered under its policies at the time of enrollment, and not less than annually thereafter, that emergency care is a covered benefit and provide the covered person with the legal definition of an "emergency medical condition," as provided in

this section.

(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.

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

(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.

(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.

Sec. 4765.01. As used in this chapter:

(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.

(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

an emergency medical technician-basic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Loss of life;

(b) Loss of a limb;

(c) Significant, permanent disfigurement;

(d) Significant, permanent disability.

(2) It is caused by any of the following:

(a) Blunt or penetrating injury;

(b) Exposure to electromagnetic, chemical, or radioactive energy;

(c) Drowning, suffocation, or strangulation;

(d) A deficit or excess of heat.

(O) "Trauma victim" or "trauma patient" means a person who has sustained a traumatic injury.

(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.

(Q) "Trauma center" means all of the following:

(1) Any hospital that is verified by the American college of surgeons as an adult or pediatric trauma center;

(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;

(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;

(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.

(R) "Pediatric" means involving a patient who is less than sixteen years of age.

(S) "Adult" means involving a patient who is not a pediatric patient.

(T) "Geriatric" means involving a patient who is at least seventy years old or exhibits significant anatomical or physiological characteristics associated with advanced aging.

(U) "Air medical organization" means an organization that provides emergency medical services, or transports emergency victims, by means of fixed or rotary wing aircraft.

(V) "Emergency care" and "emergency facility" have the same meanings as in section 3727.01 of the Revised Code.

(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~~ 3727.09 of the Revised Code.

(X) "Transfer" has the same meaning as in section ~~1753.28~~ 3727.09 of the Revised Code.

(Y) "Firefighter" means any member of a fire department as defined in section 742.01 of the Revised Code.

(Z) "Volunteer firefighter" has the same meaning as in section 146.01 of the Revised Code.

(AA) "Part-time paid firefighter" means a person who

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

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

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