

As Introduced

135th General Assembly

Regular Session

2023-2024

H. B. No. 99

Representative Manchester

A BILL

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

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

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

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

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

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

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part. 19

(2) "Emergency services" means the following: 20

(a) A medical screening examination, as required by 21
federal law, that is within the capability of the emergency 22
department of a hospital, including ancillary services routinely 23
available to the emergency department, to evaluate an emergency 24
medical condition; 25

(b) Such further medical examination and treatment that 26
are required by federal law to stabilize an emergency medical 27
condition and are within the capabilities of the staff and 28
facilities available at the hospital, including any trauma and 29
burn center of the hospital. 30

(3) (a) "Stabilize" means the provision of such medical 31
treatment as may be necessary to assure, within reasonable 32
medical probability, that no material deterioration of an 33
individual's medical condition is likely to result from or occur 34
during a transfer, if the medical condition could result in any 35
of the following: 36

(i) Placing the health of the individual or, with respect 37
to a pregnant woman, the health of the woman or her unborn 38
child, in serious jeopardy; 39

(ii) Serious impairment to bodily functions; 40

(iii) Serious dysfunction of any bodily organ or part. 41

(b) In the case of a woman having contractions, 42
"stabilize" means such medical treatment as may be necessary to 43
deliver, including the placenta. 44

(4) "Transfer" has the same meaning as in section 1867 of 45
the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 46

1395dd, as amended.

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

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

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

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

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

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

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

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

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

(e) The enrollee is unconscious. 87

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

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

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

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

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

(3) Any cost sharing provisions for emergency services; 101

(4) The procedures for obtaining emergency services and 102

other medical services, so that enrollees are familiar with the 103
location of the emergency departments of participating hospitals 104
and with the location and availability of other participating 105
facilities or settings at which they could receive medical 106
services; 107

(5) That enrollees are not required to self-diagnose. 108

(E) (1) A health insuring corporation shall not reduce or 109
deny a claim for reimbursement for emergency services based 110
solely on a diagnosis code or impression, current ICD code, or 111
select procedure code relating to the enrollee's condition 112
included on a form submitted to the health insuring corporation 113
by a provider for reimbursement of a claim. 114

(2) Reimbursement for an emergency services claim shall 115
not be reduced or denied based on the absence of an emergency 116
medical condition if a prudent layperson with an average 117
knowledge of health and medicine would have reasonably expected 118
the presence of an emergency medical condition. 119

(3) Before reducing or denying a claim for emergency 120
services, a health insuring corporation shall perform an 121
emergency services utilization review of the claim. 122

(F) (1) An emergency services utilization review shall be 123
conducted by a physician in good standing with the state medical 124
board who is board-certified by the American board of emergency 125
medicine or American osteopathic board of emergency medicine and 126
is not otherwise directly or indirectly hired by the health 127
insuring corporation except for the purpose of utilization 128
review. 129

(2) A physician shall not be eligible to provide emergency 130
services utilization reviews unless that physician has 131

substantial professional experience providing emergency medical 132
services, within the two years previous, in an acute care 133
hospital emergency department. 134

(G) An emergency services utilization review shall include 135
a review of the entire medical record of the patient, including 136
all of the following: 137

(1) The complaint in question including presenting 138
symptoms; 139

(2) The patient's medical history. Repeated utilization of 140
the emergency department may be considered. 141

(3) The patient's diagnostic testing; 142

(4) Whether a prudent layperson would reasonably presume 143
the presence of an emergency medical condition. 144

(H) Division (E) of this section does not apply when a 145
reduction in reimbursement is made by a health insuring 146
corporation based on a contractually agreed upon reimbursement 147
rate. 148

(I) If a health insuring corporation requests records 149
related to a potential denial of or reimbursement reduction for 150
an enrollee's benefits when emergency services were furnished to 151
an enrollee, a provider of emergency services has a duty to 152
respond to the health insuring corporation in a timely manner. 153

(J) If an emergency services utilization reviewer 154
determines that the reimbursement or any part of the claim 155
should be denied, reduced, or paid at a lower level of emergency 156
service, or as a nonemergency service, or otherwise, the 157
reviewer shall explain in writing the reason for the reduction 158
or denial of reimbursement. The written explanation for the 159

reduction or denial and the reviewer's name, date, signature, 160
and supporting evidence shall be provided in writing to the 161
enrollee and provider. 162

(K) Nothing in this section shall be construed as 163
exempting a health insuring corporation from the prompt payment 164
requirements prescribed in sections 3901.381 to 3901.3814 of the 165
Revised Code. 166

Sec. 3923.65. (A) As used in this section: 167

~~(1) "Emergency, emergency medical condition," means a~~ 168
~~medical condition that manifests itself by such acute symptoms~~ 169
~~of sufficient severity, including severe pain, that a prudent~~ 170
~~layperson with average knowledge of health and medicine could~~ 171
~~reasonably expect the absence of immediate medical attention to~~ 172
~~result in any of the following:~~ 173

~~(a) Placing the health of the individual or, with respect~~ 174
~~to a pregnant woman, the health of the woman or her unborn~~ 175
~~child, in serious jeopardy;~~ 176

~~(b) Serious impairment to bodily functions;~~ 177

~~(c) Serious dysfunction of any bodily organ or part.~~ 178

~~(2) "Emergency services" means the following:~~ 179

~~(a) A medical screening examination, as required by~~ 180
~~federal law, that is within the capability of the emergency~~ 181
~~department of a hospital, including ancillary services routinely~~ 182
~~available to the emergency department, to evaluate an emergency~~ 183
~~medical condition;~~ 184

~~(b) Such further medical examination and treatment that~~ 185
~~are required by federal law to stabilize an emergency medical~~ 186
~~condition and are within the capabilities of the staff and~~ 187

~~facilities available at the hospital, including any trauma and~~ 188
~~burn center of the hospital. "emergency services," and "emergency~~ 189
~~services utilization review" have the same meanings as in~~ 190
~~section 1753.28 of the Revised Code.~~ 191

(B) Every individual or group policy of sickness and 192
accident insurance that provides hospital, surgical, or medical 193
expense coverage shall cover emergency services without regard 194
to the day or time the emergency services are rendered or to 195
whether the policyholder, the hospital's emergency department 196
where the services are rendered, or an emergency physician 197
treating the policyholder, obtained prior authorization for the 198
emergency services. 199

(C) Every individual policy or certificate furnished by an 200
insurer in connection with any sickness and accident insurance 201
policy shall provide information regarding the following: 202

(1) The scope of coverage for emergency services; 203

(2) The appropriate use of emergency services, including 204
the use of the 9-1-1 system and any other telephone access 205
systems utilized to access prehospital emergency services; 206

(3) Any copayments for emergency services; 207

(4) That the covered person is not required to self- 208
diagnose. 209

(D) This section does not apply to any individual or group 210
policy of sickness and accident insurance covering only 211
accident, credit, dental, disability income, long-term care, 212
hospital indemnity, medicare supplement, medicare, tricare, 213
specified disease, or vision care; coverage under a one-time- 214
limited-duration policy that is less than twelve months; 215
coverage issued as a supplement to liability insurance; 216

insurance arising out of workers' compensation or similar law; 217
automobile medical payment insurance; or insurance under which 218
benefits are payable with or without regard to fault and which 219
is statutorily required to be contained in any liability 220
insurance policy or equivalent self-insurance. 221

(E) (1) A sickness and accident insurer shall not reduce or 222
deny a claim for reimbursement for emergency services based 223
solely on a diagnosis code or impression, current ICD code, or 224
select procedure code relating to the covered person's condition 225
included on a form submitted to the sickness and accident 226
insurer by a provider for reimbursement of a claim. 227

(2) Reimbursement for an emergency services claim shall 228
not be reduced or denied based on the absence of an emergency 229
medical condition if a prudent layperson with an average 230
knowledge of health and medicine would have reasonably expected 231
the presence of an emergency medical condition. 232

(3) Before reducing or denying a claim for emergency 233
services, a sickness and accident insurer shall perform an 234
emergency services utilization review of the claim. 235

(F) (1) An emergency services utilization review shall be 236
conducted by a physician in good standing with the state medical 237
board who is board-certified by the American board of emergency 238
medicine or American osteopathic board of emergency medicine and 239
is not otherwise directly or indirectly hired by the sickness 240
and accident insurer except for the purpose of utilization 241
review. 242

(2) A physician shall not be eligible to provide emergency 243
services utilization reviews unless that physician has 244
substantial professional experience providing emergency medical 245

services, within the two years previous, in an acute care 246
hospital emergency department. 247

(G) An emergency services utilization review shall include 248
a review of the entire medical record of the patient, including 249
all of the following: 250

(1) The complaint in question including presenting 251
symptoms; 252

(2) The patient's medical history. Repeated utilization of 253
the emergency department may be considered. 254

(3) The patient's diagnostic testing; 255

(4) Whether a prudent layperson would reasonably presume 256
the presence of an emergency medical condition. 257

(H) Division (E) of this section does not apply when a 258
reduction in reimbursement is made by a sickness and accident 259
insurer based on a contractually agreed upon reimbursement rate. 260

(I) If a sickness and accident insurer requests records 261
related to a potential denial of or reimbursement reduction for 262
a covered person's benefits when emergency services were 263
furnished to a covered person, a provider of emergency services 264
has a duty to respond to the sickness and accident insurer in a 265
timely manner. 266

(J) If an emergency services utilization reviewer 267
determines that the reimbursement or any part of the claim 268
should be denied, reduced, or paid at a lower level of emergency 269
service, or as a nonemergency service, or otherwise, the 270
reviewer shall explain in writing the reason for the reduction 271
or denial of reimbursement. The written explanation for the 272
reduction or denial and the reviewer's name, date, signature, 273

and supporting evidence shall be provided in writing to the 274
covered person and provider. 275

(K) Nothing in this section shall be construed as 276
exempting a sickness and accident insurer from the prompt 277
payment requirements prescribed in sections 3901.381 to 278
3901.3814 of the Revised Code. 279

Section 2. That existing sections 1753.28 and 3923.65 of 280
the Revised Code are hereby repealed. 281