As Introduced

134th General Assembly Regular Session 2021-2022

H. B. No. 270

Representatives Manchester, Upchurch

A BILL

To amend sec	tions 1753.28, 3727.09, 3923.65, and	1
4765.01 0:	f the Revised Code to regulate the	2
practice of	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) <u>"Emergency facility" means a hospital emergency</u>	9
department or any other facility that provides emergency medical	10
services.	11
(2) UTwannen medienlenen dition Urmannen ernedienlenkunisel	10
<u>(2)</u> "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:	
(a) That the absence of immediate medical attention to	18

<u>could</u> result in any of the following:	
$\frac{1}{(a)}$ Placing the health of the individual or, with	20
respect to a pregnant woman, the health of the woman or her	
unborn child, in serious jeopardy;	22
(b) (ii) Serious impairment to bodily functions;	23
(c) <u>(</u>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
<u>(ii) A threat to the health or safety of the woman or </u>	29
unborn child if the woman does not have access to immediate	30
medical attention.	31
(2) (3) "Emergency services" means the following:	32
(2) (3) "Emergency services" means the following:	32 33
	-
(a) A medical screening examination, as required by	33
(a) A medical screening examination, as required by federal law, that is within the capability of the emergency	33 34
(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-	33 34 35
(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;	33 34 35 36 37
(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	33 34 35 36 37 38
<pre>(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;</pre>	33 34 35 36 37 38 39
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 (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. 	 33 34 35 36 37 38 39 40 41 42 43
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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

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 84 emergency physician treating the enrollee, obtained prior 85 authorization for the emergency services. (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 96 (a) Due to circumstances beyond the enrollee's control, the enrollee was unable to utilize a participating hospital's 97 emergency department without serious threat to life or health. 98 99 (b) A prudent layperson with an average knowledge of 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

board of emergency medicine and is not otherwise directly or

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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

(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
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(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
care hospital emergency department.	135
(F)(1) Utilization review of emergency services shall	136
include a review of the entire medical record of the patient,	137
including all of the following:	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	144
practice of medicine and shall be subject to the oversight and	145
review of the state medical board of this state.	140
Teview of the state medical board of this state.	141
(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

condition;

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

162 (d) Make a determination that medical necessity was not present and therefore reimbursement will be for a lower level of 163 164 care or as a nonemergency service.

(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 167 168 service:

(a) The enrollee's medical record, including the nature of 169 the presenting problems or symptoms; 170

(b) The enrollee's patient history;

(c) The exam and medical decision making.

(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 175 176 health care services.

(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

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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

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
<u>child, in serious jeopardy;</u>	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 quidelines 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 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
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needs. Trauma patient transfer protocols shall specify all of
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the following:

(a) Confirmation of the ability of the receiving trauma
(b) center to provide prompt adult or pediatric trauma care
(c) 270
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following reasons:

(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 274 275 trauma center; (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; 291 292 (i) The responsibilities of the physician attending a 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

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(i) Immediate transfer of the patient is unsafe due to 300adverse weather or ground conditions. 301

(ii) No trauma center is able to provide appropriate adult302or pediatric trauma care to the patient without undue delay.303

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

(a) An agreement with one or more adult trauma centers in
ach 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 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 with329applicable federal and state laws and contain provisions330conforming to the requirements for trauma care protocols set331forth 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
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pediatric trauma center under provisional status is not in
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violation of divisions (B) and (C) of this section during the
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time it develops different trauma care protocols and enters into
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different patient transfer agreements pursuant to division (D)
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(2) (c) of section 3727.101 of the Revised Code.

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

(1) "Emergency, "emergency facility," "emergency medical348condition_" means a medical condition that manifests itself by349such acute symptoms of sufficient severity, including severe350pain, that a prudent layperson with average knowledge of health351and medicine could reasonably expect the absence of immediate352medical attention to result in any of the following:353

(a) Placing the health of the individual or, with respect354to a pregnant woman, the health of the woman or her unborn355child, 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

(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-393 394 limited_duration policy that is less than twelve months; 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 eliqible 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 406 407

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 414

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(3) Any copayments for emergency services.(D) This section does not apply to any individual or gro

systems utilized to access prehospital emergency services;

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
(C) A claim for reimburgement for emergency corvices shall	418
(G) A claim for reimbursement for emergency services shall	-
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
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(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

(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

body surface.

an emergency medical technician-basic.

(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 509 510 is intended to be used, for the purpose of responding to 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

(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 527public or private organization using first responders, EMTs- 528

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basic, EMTs-I, or paramedics, or a combination of first529responders, EMTs-basic, EMTs-I, and paramedics, to provide530emergency medical services.531

(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
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 medicine and surgery.
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(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.
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(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
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in training to provide the services.
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(L) "Emergency medical service personnel" means first
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 responders, emergency medical technicians-basic, emergency
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 medical technicians-intermediate, emergency medical technicians 545
 paramedic, and persons who provide medical direction to such
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 persons.

(M) "Hospital" has the same meaning as in section 3727.01 548of 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

(a) Loss of life;

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

(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	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 585 586 trauma patient. (R) "Pediatric" means involving a patient who is less than 587 588 sixteen years of age. (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 3727.09 of the Revised Code. 602 603 (X) "Transfer" has the same meaning as in section 1753.28-3727.09 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

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
valid license to practice as a physician assistant issued under Chapter 4730. of the Revised Code.	616 617