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Representatives Schmidt, Schneider, Hughes, Clancy, Raga, Schlichter, Webster, T. Patton, Grendell, Flowers, Barrett, J. Stewart, Miller, Allen, DeBose, McGregor, Latta, S. Patton, Key, Kearns, Brown, Jerse, Beatty, Harwood, Kilbane, Walcher, Price, G. Smith, S. Smith, Cirelli, Hollister, Reidelbach, Aslanides, Boccieri, Book, Buehrer, Callender, Carano, Carmichael, Cates, Chandler, Collier, Daniels, DeGeeter, Distel, Domenick, C. Evans, D. Evans, Faber, Gilb, Hagan, Hartnett, Hoops, Koziura, Martin, Mason, Oelslager, Olman, Otterman, Schaffer, Seaver, Setzer, Sferra, Skindell, Slaby, D. Stewart, Strahorn, Sykes, Taylor, Ujvagi, Widener, Widowfield, Willamowski, Wilson, Woodard, Yates
Senators Hagan, Amstutz, Austria, Blessing, Brady, Carey, Coughlin, Dann, Fedor, Fingerhut, Goodman, Harris, Hottinger, Jacobson, Jordan, Mallory, Miller, Mumper, Nein, Padgett, Prentiss, Randy Gardner, Robert Gardner, Roberts, Schuring, Spada, Wachtmann, White, Zurz

A B I L L

To amend sections 1751.62, 3701.74, 3701.741, 3701.742, 3923.52, 3923.53, and 3923.54 of the Revised Code to cap the benefits health care plans provide for the expense of screening mammographies, an examination that the plans are required to cover, at 130% of the Medicare reimbursement rate, to continue and adjust fee schedules for copies of medical records, and to declare an emergency.

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

Section 1. That sections 1751.62, 3701.74, 3701.741, 3701.742, 3923.52, 3923.53, and 3923.54 of the Revised Code be amended to read as follows:

Sec. 1751.62. (A) As used in this section~~, "screening~~:

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(2) "Medicare reimbursement rate" means the reimbursement rate paid in Ohio under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(B) Every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D)(1) ~~The benefits~~ Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed ~~eighty-five dollars per year unless a lower amount is established pursuant to a provider contract~~ one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty

per cent of the lowest medicare reimbursement rate in this state.

~~(2)~~(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No ~~institutional or professional~~ provider, hospital, or other health care ~~provider~~ facility shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3701.74. (A) As used in this section and section 3701.741 of the Revised Code:

(1) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center.

"Ambulatory care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.

(2) "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic.

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

(4) "Health care practitioner" means all of the following:

(a) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(b) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(c) An optometrist licensed under Chapter 4725. of the Revised Code;

(d) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

(e) A pharmacist licensed under Chapter 4729. of the Revised Code;

(f) A physician;

(g) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;

(i) A psychologist licensed under Chapter 4732. of the Revised Code;

(j) A chiropractor;

(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;

(l) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(m) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(n) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(o) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;

(p) A dietitian licensed under Chapter 4759. of the Revised Code;

(q) A respiratory care professional licensed under Chapter 4761. of the Revised Code;

(r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

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

(7) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; an adult care facility, as defined in section 3722.01 of the Revised Code; a nursing facility or intermediate care facility for the mentally retarded, as those terms are defined in section 5111.20 of the

Revised Code; a facility or portion of a facility certified as a skilled nursing facility under Title XVIII of the "Social Security Act," 49 Stat. 286 (1965), 42 U.S.C.A. 1395, as amended.

(8) "Medical record" means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment.

(9) "Medical records company" means a person who stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative.

(10) "Patient" means either of the following:

(a) An individual who received health care treatment from a health care provider;

(b) A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section.

(11) "Patient's personal representative" means a ~~person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical records, except that if the patient is deceased, "patient's representative" means the~~ minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate~~,~~ or the person responsible for the patient's estate if it is not to be probated. "Patient's personal representative" does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state ~~or,~~ a health insuring corporation holding a certificate of authority under

Chapter 1751. of the Revised Code, or any other person not named in this division.

(12) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(13) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(14) "Authorized person" means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record.

(B) A patient ~~or~~, a patient's personal representative or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than sixty days before the date on which it is submitted. The ~~patient or patient's representative who wishes to obtain a copy of the record shall indicate in the~~ request shall indicate whether the copy is to be sent to the ~~patient's residence~~ requestor, physician or chiropractor, ~~or representative~~, or held for the ~~patient~~ requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care

provider shall provide the record to a physician or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient ~~or patient's~~, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

(D)(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347. or 5122. of the Revised Code, by 42 C.F.R. part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," or by 42 C.F.R. 483.10.

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25, 2305.251, and 2305.252 of the Revised Code.

Sec. 3701.741. (A) Through December 31, ~~2004~~ 2008, each health care provider and medical records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record ~~may~~ shall charge not more than the amounts set forth in this section. ~~Total~~

(1) If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

~~(1)~~(a) With respect to data recorded on paper, the following amounts:

(i) Two dollars and fifty cents per page for the first ten pages;

(ii) Fifty-one cents per page for pages eleven through fifty;

(iii) Twenty cents per page for pages fifty-one and higher;

(b) With respect to data recorded other than on paper, one dollar and seventy cents per page;

(c) The actual cost of any related postage incurred by the health care provider or medical records company.

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of fifteen dollars and thirty-five cents, which shall compensate for the records search;

~~(2)~~(b) With respect to data recorded on paper, the following amounts:

~~(a)~~(i) One dollar and two cents per page for the first ten pages;

~~(b)~~(ii) Fifty-one cents per page for pages eleven through fifty;

~~(c)~~(iii) Twenty cents per page for pages fifty-one and higher.

~~(3)~~(c) With respect to data recorded other than on paper, ~~the actual cost of making the copy~~ one dollar and seventy cents per page;

~~(4)~~(d) The actual cost of any related postage incurred by the health care provider or medical records company.

(C)(1) A health care provider or medical records company shall provide one copy without charge to the following:

~~(1)~~(a) The bureau of workers' compensation, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

~~(2)~~(b) The industrial commission, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

~~(3)~~(c) The department of job and family services, in accordance with Chapter 5101. of the Revised Code and the rules adopted under those chapters;

~~(4)~~(d) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;

~~(5)~~(e) A patient or patient's personal representative if the medical record is necessary to support a claim under Title II or Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of job and family services.

(E) A health care provider or medical records company may enter into a contract with ~~a patient, a patient's representative, or an insurer~~ either of the following for the copying of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) This section does not apply to ~~either of the following:~~

~~(1) Copies of medical records provided to insurers authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code;~~

~~(2) Medical~~ medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

~~(G) Nothing in this section requires or precludes the distribution of medical records at any particular cost or fee to insurers authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code.~~

Sec. 3701.742. ~~If the date specified in section 3701.741 of the Revised Code is amended to reflect a date that occurs after December 31, 2004, then not~~ Not later than January 31, ~~2005~~ 2006, the amounts specified in division (B) of section 3701.741 of the Revised Code and, not later than the first day of January of each year thereafter, any amounts computed by adjustments made under this section, shall be increased or decreased by the average percentage of increase or decrease in the consumer price index for all urban consumers (United States city average, all items), prepared by the United States department of labor, bureau of labor

statistics, for the twelve-calendar-month period prior to the immediately preceding first day of January over the immediately preceding twelve-calendar-month period, as reported by the bureau. The director of health shall make this determination and adjust the amounts accordingly. The director shall provide a list of the adjusted amounts to any party upon request and the department of health shall make the list available to the public on its internet web site.

Sec. 3923.52. (A) As used in this section and section 3923.53 of the Revised Code, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall ~~offer to~~ provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the

following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D)~~(1) The benefits~~ As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed ~~eighty-five dollars per year unless a lower amount is established pursuant to a provider contract~~ one hundred thirty per cent of the medicare

reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

~~(2)~~(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No ~~institutional or professional~~ provider, hospital, or other health care ~~provider~~ facility shall seek or receive compensation in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

(G) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy that offers only supplemental benefits.

Sec. 3923.53. (A) Every public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast

cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(B) The benefits provided under division (A)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(C)~~(1) The benefits~~ As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (C)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the

benefit provided under division (A)(1) of this section, the total benefit for a screening mammography shall not exceed ~~eighty-five dollars per year unless a lower amount is established pursuant to a provider contract~~ one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

~~(2)~~(3) The benefit paid in accordance with division (C)(1) of this section shall constitute full payment. No ~~institutional or professional~~ provider, hospital, or other health care ~~provider~~ facility shall seek or receive compensation in excess of the payment made in accordance with division (C)(1) of this section, except for approved deductibles and copayments.

(D) The benefits provided under division (A)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The benefits provided under division (A)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3923.54. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography including, but not

limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Each employer in this state that provides, in whole or in part, health care benefits for its employees under a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code shall also provide to its employees benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) An employer may comply with division (B) of this section in any of the following ways:

(1) By providing the benefits under a health insuring corporation contract issued in accordance with Chapter 1751. of the Revised Code or a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code;

(2) By reimbursing the employee for the direct health care provider charges associated with receipt of the covered service;

(3) By making any other arrangement that provides the benefits described in division (B) of this section.

(D) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(E)~~(1) The benefits~~ As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (E)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography need not exceed ~~eighty-five dollars per year~~ one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

~~(2)~~(3) The benefit paid in accordance with division (E)(1) of this section shall constitute full payment. No ~~institutional or professional~~ provider, hospital, or other health care ~~provider~~ facility shall seek or receive compensation in excess of the payment made in accordance with division (E)(1) of this section, except for approved deductibles and copayments.

(F) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Section 2. That existing sections 1751.62, 3701.74, 3701.741, 3701.742, 3923.52, 3923.53, and 3923.54 of the Revised Code are hereby repealed.

Section 3. Sections 1751.62, 3923.52, 3923.53, and 3923.54 of the Revised Code, as amended by this act, shall take effect on the ninety-first day after the effective date of this act.

Section 4. This act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, and safety. The reason for this necessity is that the current fee schedule for copies of medical records ceases to be effective on January 1, 2005, and a new fee schedule is needed to ensure that Ohioans can obtain medical records efficiently. Therefore, this act shall go into immediate effect.