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**Sub. H. B. No. 331**

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Miller, Mumper, Nein, Padgett, Prentiss, Randy Gardner, Robert Gardner,  
Roberts, Schuring, Spada, Wachtmann, White, Zurz**

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**A B I L L**

To amend sections 1751.62, 3701.74, 3701.741, 1  
3701.742, 3923.52, 3923.53, and 3923.54 of the 2  
Revised Code to cap the benefits health care plans 3  
provide for the expense of screening 4  
mammographies, an examination that the plans are 5  
required to cover, at 130% of the Medicare 6  
reimbursement rate, to continue and adjust fee 7  
schedules for copies of medical records, and to 8  
declare an emergency. 9

**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. 69

~~(2)~~(3) The benefit paid in accordance with division (D)(1) of 70  
this section shall constitute full payment. No ~~institutional or~~ 71  
~~professional provider, hospital, or other~~ health care ~~provider~~ 72  
~~facility~~ shall seek or receive remuneration in excess of the 73  
payment made in accordance with division (D)(1) of this section, 74  
except for approved deductibles and copayments. 75

(E) The benefits provided under division (B)(1) of this 76  
section shall be provided only for screening mammographies that 77  
are performed in a health care facility or mobile mammography 78  
screening unit that is accredited under the American college of 79  
radiology mammography accreditation program or in a hospital as 80  
defined in section 3727.01 of the Revised Code. 81

(F) The benefits provided under divisions (B)(1) and (2) of 82  
this section shall be provided according to the terms of the 83  
subscriber contract. 84

(G) The benefits provided under division (B)(2) of this 85  
section shall be provided only for cytologic screenings that are 86  
processed and interpreted in a laboratory certified by the college 87  
of American pathologists or in a hospital as defined in section 88  
3727.01 of the Revised Code. 89

**Sec. 3701.74.** (A) As used in this section and section 90  
3701.741 of the Revised Code: 91

(1) "Ambulatory care facility" means a facility that provides 92  
medical, diagnostic, or surgical treatment to patients who do not 93  
require hospitalization, including a dialysis center, ambulatory 94  
surgical facility, cardiac catheterization facility, diagnostic 95  
imaging center, extracorporeal shock wave lithotripsy center, home 96  
health agency, inpatient hospice, birthing center, radiation 97  
therapy center, emergency facility, and an urgent care center. 98

"Ambulatory care facility" does not include the private office of a physician or dentist, whether the office is for an individual or group practice.	99 100 101
(2) "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic.	102 103
(3) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.	104 105 106
(4) "Health care practitioner" means all of the following:	107
(a) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;	108 109
(b) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;	110 111
(c) An optometrist licensed under Chapter 4725. of the Revised Code;	112 113
(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;	114 115 116 117
(e) A pharmacist licensed under Chapter 4729. of the Revised Code;	118 119
(f) A physician;	120
(g) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;	121 122
(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;	123 124
(i) A psychologist licensed under Chapter 4732. of the Revised Code;	125 126
(j) A chiropractor;	127

(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;	128 129
(l) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;	130 131
(m) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;	132 133
(n) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;	134 135
(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;	136 137 138 139
(p) A dietitian licensed under Chapter 4759. of the Revised Code;	140 141
(q) A respiratory care professional licensed under Chapter 4761. of the Revised Code;	142 143
(r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.	144 145 146
(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.	147 148 149
(6) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.	150 151
(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	152 153 154 155 156 157

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 189  
in this division. 190

(12) "Pharmacy" has the same meaning as in section 4729.01 of 191  
the Revised Code. 192

(13) "Physician" means a person authorized under Chapter 193  
4731. of the Revised Code to practice medicine and surgery, 194  
osteopathic medicine and surgery, or podiatric medicine and 195  
surgery. 196

(14) "Authorized person" means a person to whom a patient has 197  
given written authorization to act on the patient's behalf 198  
regarding the patient's medical record. 199

(B) A patient ~~or, a patient's~~ personal representative or an 200  
authorized person who wishes to examine or obtain a copy of part 201  
or all of a medical record shall submit to the health care 202  
provider a written request signed by the patient, personal 203  
representative, or authorized person dated not more than sixty 204  
days before the date on which it is submitted. The ~~patient or~~ 205  
~~patient's representative who wishes to obtain a copy of the record~~ 206  
~~shall indicate in the request~~ shall indicate whether the copy is 207  
to be sent to the ~~patient's residence~~ requestor, physician or 208  
chiropractor, ~~or representative,~~ or held for the ~~patient~~ requestor 209  
at the office of the health care provider. Within a reasonable 210  
time after receiving a request that meets the requirements of this 211  
division and includes sufficient information to identify the 212  
record requested, a health care provider that has the patient's 213  
medical records shall permit the patient to examine the record 214  
during regular business hours without charge or, on request, shall 215  
provide a copy of the record in accordance with section 3701.741 216  
of the Revised Code, except that if a physician or chiropractor 217  
who has treated the patient determines for clearly stated 218  
treatment reasons that disclosure of the requested record is 219  
likely to have an adverse effect on the patient, the health care 220

provider shall provide the record to a physician or chiropractor 221  
designated by the patient. The health care provider shall take 222  
reasonable steps to establish the identity of the person making 223  
the request to examine or obtain a copy of the patient's record. 224

(C) If a health care provider fails to furnish a medical 225  
record as required by division (B) of this section, the patient ~~or~~ 226  
~~patient's, personal~~ representative, or authorized person who 227  
requested the record may bring a civil action to enforce the 228  
patient's right of access to the record. 229

(D)(1) This section does not apply to medical records whose 230  
release is covered by section 173.20 or 3721.13 of the Revised 231  
Code, by Chapter 1347. or 5122. of the Revised Code, by 42 C.F.R. 232  
part 2, "Confidentiality of Alcohol and Drug Abuse Patient 233  
Records," or by 42 C.F.R. 483.10. 234

(2) Nothing in this section is intended to supersede the 235  
confidentiality provisions of sections 2305.24, 2305.25, 2305.251, 236  
and 2305.252 of the Revised Code. 237

**Sec. 3701.741.** (A) Through December 31, ~~2004~~ 2008, each 238  
health care provider and medical records company shall provide 239  
copies of medical records in accordance with this section. 240

(B) Except as provided in divisions (C) and (E) of this 241  
section, a health care provider or medical records company that 242  
receives a request for a copy of a patient's medical record ~~may~~ 243  
shall charge not more than the amounts set forth in this section. 244  
~~Total~~ 245

(1) If the request is made by the patient or the patient's 246  
personal representative, total costs for copies and all services 247  
related to those copies shall not exceed the sum of the following: 248

(1)(a) With respect to data recorded on paper, the following 249  
amounts: 250

<u>(i) Two dollars and fifty cents per page for the first ten pages;</u>	251
	252
<u>(ii) Fifty-one cents per page for pages eleven through fifty;</u>	253
<u>(iii) Twenty cents per page for pages fifty-one and higher;</u>	254
<u>(b) With respect to data recorded other than on paper, one dollar and seventy cents per page;</u>	255
	256
<u>(c) The actual cost of any related postage incurred by the health care provider or medical records company.</u>	257
	258
<u>(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:</u>	259
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<u>(a) An initial fee of fifteen dollars and thirty-five cents, which shall compensate for the records search;</u>	263
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<del>(2)</del> <u>(b) With respect to data recorded on paper, the following amounts:</u>	265
	266
<del>(a)</del> <u>(i) One dollar and two cents per page for the first ten pages;</u>	267
	268
<del>(b)</del> <u>(ii) Fifty-one cents per page for pages eleven through fifty;</u>	269
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<del>(c)</del> <u>(iii) Twenty cents per page for pages fifty-one and higher.</u>	271
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<del>(3)</del> <u>(c) With respect to data recorded other than on paper, the actual cost of making the copy one dollar and seventy cents per page;</u>	273
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<del>(4)</del> <u>(d) The actual cost of any related postage incurred by the health care provider or medical records company.</u>	276
	277
<u>(C)(1) A health care provider or medical records company shall provide one copy without charge to the following:</u>	278
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+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;	280 281 282
+2+(b) The industrial commission, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;	283 284 285
+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;	286 287 288
+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;	289 290 291
+5+(e) A patient or patient's <u>personal</u> 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.	292 293 294 295 296
<u>(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.</u>	297 298 299 300
(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.	301 302 303 304
(E) A health care provider or medical records company may enter into a contract with <del>a patient, a patient's representative, or an insurer</del> <u>either of the following</u> for the copying of medical records at a fee other than as provided in division (B) of this section:	305 306 307 308 309

(1) A patient, a patient's personal representative, or an authorized person; 310  
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(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. 312  
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(F) This section does not apply to ~~either of the following:~~ 316

~~(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;~~ 317  
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~~(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.~~ 322  
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~~(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.~~ 324  
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**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,~~ 330  
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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 333  
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statistics, for the twelve-calendar-month period prior to the 340  
immediately preceding first day of January over the immediately 341  
preceding twelve-calendar-month period, as reported by the bureau. 342  
The director of health shall make this determination and adjust 343  
the amounts accordingly. The director shall provide a list of the 344  
adjusted amounts to any party upon request and the department of 345  
health shall make the list available to the public on its internet 346  
web site. 347

**Sec. 3923.52.** (A) As used in this section and section 3923.53 348  
of the Revised Code, "screening mammography" means a radiologic 349  
examination utilized to detect unsuspected breast cancer at an 350  
early stage in asymptomatic women and includes the x-ray 351  
examination of the breast using equipment that is dedicated 352  
specifically for mammography, including, but not limited to, the 353  
x-ray tube, filter, compression device, screens, film, and 354  
cassettes, and that has an average radiation exposure delivery of 355  
less than one rad mid-breast. "Screening mammography" includes two 356  
views for each breast. The term also includes the professional 357  
interpretation of the film. 358

"Screening mammography" does not include diagnostic 359  
mammography. 360

(B) Every policy of individual or group sickness and accident 361  
insurance that is delivered, issued for delivery, or renewed in 362  
this state shall ~~offer to~~ provide benefits for the expenses of 363  
both of the following: 364

(1) Screening mammography to detect the presence of breast 365  
cancer in adult women; 366

(2) Cytologic screening for the presence of cervical cancer. 367

(C) The benefits provided under division (B)(1) of this 368  
section shall cover expenses in accordance with all of the 369

following: 370

(1) If a woman is at least thirty-five years of age but under 371  
forty years of age, one screening mammography; 372

(2) If a woman is at least forty years of age but under fifty 373  
years of age, either of the following: 374

(a) One screening mammography every two years; 375

(b) If a licensed physician has determined that the woman has 376  
risk factors to breast cancer, one screening mammography every 377  
year. 378

(3) If a woman is at least fifty years of age but under 379  
sixty-five years of age, one screening mammography every year. 380

(D)~~(1)~~ The benefits As used in this division, "medicare 381  
reimbursement rate" means the reimbursement rate paid in this 382  
state under the medicare program for screening mammography that 383  
does not include digitization or computer-aided detection, 384  
regardless of whether the actual benefit includes digitization or 385  
computer-aided detection. 386

(1) Subject to divisions (D)(2) and (3) of this section, if a 387  
provider, hospital, or other health care facility provides a 388  
service that is a component of the screening mammography benefit 389  
in division (B)(1) of this section and submits a separate claim 390  
for that component, a separate payment shall be made to the 391  
provider, hospital, or other health care facility in an amount 392  
that corresponds to the ratio paid by medicare in this state for 393  
that component. 394

(2) Regardless of whether separate payments are made for the 395  
benefit provided under division (B)(1) of this section, the total 396  
benefit for a screening mammography shall not exceed ~~eighty five~~ 397  
~~dollars per year unless a lower amount is established pursuant to~~ 398  
~~a provider contract~~ one hundred thirty per cent of the medicare 399

reimbursement rate in this state for screening mammography. If 400  
there is more than one medicare reimbursement rate in this state 401  
for screening mammography or a component of a screening 402  
mammography, the reimbursement limit shall be one hundred thirty 403  
per cent of the lowest medicare reimbursement rate in this state. 404

~~(2)~~(3) The benefit paid in accordance with division (D)(1) of 405  
this section shall constitute full payment. No ~~institutional or~~ 406  
~~professional provider, hospital, or other health care provider~~ 407  
~~facility~~ shall seek or receive compensation in excess of the 408  
payment made in accordance with division (D)(1) of this section, 409  
except for approved deductibles and copayments. 410

(E) The benefits provided under division (B)(1) of this 411  
section shall be provided only for screening mammographies that 412  
are performed in a facility or mobile mammography screening unit 413  
that is accredited under the American college of radiology 414  
mammography accreditation program or in a hospital as defined in 415  
section 3727.01 of the Revised Code. 416

(F) The benefits provided under division (B)(2) of this 417  
section shall be provided only for cytologic screenings that are 418  
processed and interpreted in a laboratory certified by the college 419  
of American pathologists or in a hospital as defined in section 420  
3727.01 of the Revised Code. 421

(G) This section does not apply to any policy that provides 422  
coverage for specific diseases or accidents only, or to any 423  
hospital indemnity, medicare supplement, or other policy that 424  
offers only supplemental benefits. 425

**Sec. 3923.53.** (A) Every public employee benefit plan that is 426  
established or modified in this state shall provide benefits for 427  
the expenses of both of the following: 428

(1) Screening mammography to detect the presence of breast 429

cancer in adult women; 430

(2) Cytologic screening for the presence of cervical cancer. 431

(B) The benefits provided under division (A)(1) of this 432  
section shall cover expenses in accordance with all of the 433  
following: 434

(1) If a woman is at least thirty-five years of age but under 435  
forty years of age, one screening mammography; 436

(2) If a woman is at least forty years of age but under fifty 437  
years of age, either of the following: 438

(a) One screening mammography every two years; 439

(b) If a licensed physician has determined that the woman has 440  
risk factors to breast cancer, one screening mammography every 441  
year. 442

(3) If a woman is at least fifty years of age but under 443  
sixty-five years of age, one screening mammography every year. 444

~~(C)(1) The benefits As used in this division, "medicare~~ 445  
~~reimbursement rate" means the reimbursement rate paid in this~~ 446  
~~state under the medicare program for screening mammography that~~ 447  
~~does not include digitization or computer-aided detection,~~ 448  
~~regardless of whether the actual benefit includes digitization or~~ 449  
~~computer-aided detection.~~ 450

(1) Subject to divisions (C)(2) and (3) of this section, if a 451  
provider, hospital, or other health care facility provides a 452  
service that is a component of the screening mammography benefit 453  
in division (B)(1) of this section and submits a separate claim 454  
for that component, a separate payment shall be made to the 455  
provider, hospital, or other health care facility in an amount 456  
that corresponds to the ratio paid by medicare in this state for 457  
that component. 458

(2) Regardless of whether separate payments are made for the 459

benefit provided under division (A)(1) of this section, the total 460  
benefit for a screening mammography shall not exceed eighty five 461  
dollars per year unless a lower amount is established pursuant to 462  
a provider contract one hundred thirty per cent of the medicare 463  
reimbursement rate in this state for screening mammography. If 464  
there is more than one medicare reimbursement rate in this state 465  
for screening mammography or a component of a screening 466  
mammography, the reimbursement limit shall be one hundred thirty 467  
per cent of the lowest medicare reimbursement rate in this state. 468

~~(2)~~(3) The benefit paid in accordance with division (C)(1) of 469  
this section shall constitute full payment. No ~~institutional or~~ 470  
~~professional~~ provider, hospital, or other healthcare ~~provider~~ 471  
facility shall seek or receive compensation in excess of the 472  
payment made in accordance with division (C)(1) of this section, 473  
except for approved deductibles and copayments. 474

(D) The benefits provided under division (A)(1) of this 475  
section shall be provided only for screening mammographies that 476  
are performed in a facility or mobile mammography screening unit 477  
that is accredited under the American college of radiology 478  
mammography accreditation program or in a hospital as defined in 479  
section 3727.01 of the Revised Code. 480

(E) The benefits provided under division (A)(2) of this 481  
section shall be provided only for cytologic screenings that are 482  
processed and interpreted in a laboratory certified by the college 483  
of American pathologists or in a hospital as defined in section 484  
3727.01 of the Revised Code. 485

**Sec. 3923.54.** (A) As used in this section, "screening 486  
mammography" means a radiologic examination utilized to detect 487  
unsuspected breast cancer at an early stage in asymptomatic women 488  
and includes the x-ray examination of the breast using equipment 489  
that is dedicated specifically for mammography including, but not 490

limited to, the x-ray tube, filter, compression device, screens, 491  
film, and cassettes, and that has an average radiation exposure 492  
delivery of less than one rad mid-breast. "Screening mammography" 493  
includes two views for each breast. The term also includes the 494  
professional interpretation of the film. 495

"Screening mammography" does not include diagnostic 496  
mammography. 497

(B) Each employer in this state that provides, in whole or in 498  
part, health care benefits for its employees under a policy of 499  
sickness and accident insurance issued in accordance with Chapter 500  
3923. of the Revised Code shall also provide to its employees 501  
benefits for the expenses of both of the following: 502

(1) Screening mammography to detect the presence of breast 503  
cancer in adult women; 504

(2) Cytologic screening for the presence of cervical cancer. 505

(C) An employer may comply with division (B) of this section 506  
in any of the following ways: 507

(1) By providing the benefits under a health insuring 508  
corporation contract issued in accordance with Chapter 1751. of 509  
the Revised Code or a policy of sickness and accident insurance 510  
issued in accordance with Chapter 3923. of the Revised Code; 511

(2) By reimbursing the employee for the direct health care 512  
provider charges associated with receipt of the covered service; 513

(3) By making any other arrangement that provides the 514  
benefits described in division (B) of this section. 515

(D) The benefits provided under division (B)(1) of this 516  
section shall cover expenses in accordance with all of the 517  
following: 518

(1) If a woman is at least thirty-five years of age but under 519  
forty years of age, one screening mammography; 520

(2) If a woman is at least forty years of age but under fifty years of age, either of the following: 521  
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(a) One screening mammography every two years; 523

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year. 524  
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(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year. 527  
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~~(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. 529  
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(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. 535  
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(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~~ 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. 543  
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~~(2)~~(3) The benefit paid in accordance with division (E)(1) of 552  
this section shall constitute full payment. No ~~institutional or~~ 553  
~~professional provider, hospital, or other~~ health care ~~provider~~ 554  
~~facility~~ shall seek or receive compensation in excess of the 555  
payment made in accordance with division (E)(1) of this section, 556  
except for approved deductibles and copayments. 557

(F) The benefits provided under division (B)(1) of this 558  
section shall be provided only for screening mammographies that 559  
are performed in a facility or mobile mammography screening unit 560  
that is accredited under the American college of radiology 561  
mammography accreditation program or in a hospital as defined in 562  
section 3727.01 of the Revised Code. 563

(G) The benefits provided under division (B)(2) of this 564  
section shall be provided only for cytologic screenings that are 565  
processed and interpreted in a laboratory certified by the college 566  
of American pathologists or in a hospital as defined in section 567  
3727.01 of the Revised Code. 568

**Section 2.** That existing sections 1751.62, 3701.74, 3701.741, 569  
3701.742, 3923.52, 3923.53, and 3923.54 of the Revised Code are 570  
hereby repealed. 571

**Section 3.** Sections 1751.62, 3923.52, 3923.53, and 3923.54 of 572  
the Revised Code, as amended by this act, shall take effect on the 573  
ninety-first day after the effective date of this act. 574

**Section 4.** This act is hereby declared to be an emergency 575  
measure necessary for the immediate preservation of the public 576  
peace, health, and safety. The reason for this necessity is that 577  
the current fee schedule for copies of medical records ceases to 578  
be effective on January 1, 2005, and a new fee schedule is needed 579  
to ensure that Ohioans can obtain medical records efficiently. 580  
Therefore, this act shall go into immediate effect. 581