Ohio Revised Code

Section 3923.53 Public employee benefit plans - breast cancer and cervical cancer screening.

Effective: March 22, 2005
Legislation: House Bill 331 - 125th General Assembly

(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) 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 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.

(3) The benefit paid in accordance with division (C)(1) of this section shall constitute full payment. No provider, hospital, or other health care 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.