Ohio Revised Code

Section 3923.52 Screening mammography and cytologic screening benefits.

Effective: September 23, 2022
Legislation: House Bill 371

(A) As used in this section and section 3923.53 of the Revised Code:

(1) "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 digital breast tomosynthesis. "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) "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

(B) Notwithstanding section 3901.71 of the Revised Code, every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of all of the following:

(1) To detect the presence of breast cancer in adult women, screening mammography;

(2) To detect the presence of breast cancer in adult women meeting either of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;

(3) To detect the presence of cervical cancer, cytologic screening.

(C)(1) The benefits provided under division (B)(1) of this section shall cover expenses for one screening mammography every year, including digital breast tomosynthesis.

(2) The benefits provided under division (B)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult woman who meets either of the following conditions:

(a) The woman's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue;

(b) The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.

(D) 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 or a component of the supplemental breast cancer screening benefit in division (B)(2) 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) or (2) of this section, the total benefit for a screening mammography or supplemental breast cancer screening shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography or supplemental breast cancer screening. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography or supplemental breast cancer screening or a component of supplemental breast cancer screening, 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 (D)(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 (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) or (2) of this section shall be provided only for screening mammographies or supplemental breast cancer screenings 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)(3) 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.