



State of California Emergency Medical Services Law

**Health & Safety Code Division 2.5
Statutes in Effect as of January 1, 2015**

**Emergency Medical Services Authority
Health and Human Services Agency**





Medal of Valor
EMS Cross
Distinguished Service Medal
Meritorious Service Medal
Lifesaving Medal
Community Service Award
Interservice EMS Recognition
Civilian Award for EMS
EMT of the Year
EMS Educator of the Year
EMS Medical Director of the Year
EMS Administrator of the Year

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Updated January 2015
www.emsa.ca.gov

The attached compilation of EMS Statutes (Division 2.5 of the Health and Safety Code) has been updated for your convenience to include changes made during the second half of the 2013-14 Legislative Session. Although every effort has been made to ensure that this document is accurate and complete, no guarantee is being made or implied.

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A quick look at the

California EMS Authority

State Emergency Medical Services

The Emergency Medical Services Authority (EMSA) was created in 1980 to provide leadership in developing EMS systems throughout California and to develop standards for training and scope of practice for EMS personnel. Prior to 1980, California did not have a central state agency responsible for ensuring the development and coordination of EMS services and programs statewide.

Although the many stakeholders in EMS, including local administrators, fire agencies, ambulance companies, hospitals, physicians, nurses, and other health care providers did not agree on all issues, there was a consensus that a more unified approach was needed to emergency and disaster medical services.

After several years of effort by the EMS constituents to establish a state lead agency, in 1980 Governor Jerry Brown signed into law the Emergency Medical Services System and Prehospital Emergency Care Personnel Act (SB 125) creating the Emergency Medical Services Authority and adding Division 2.5 to the Health and Safety Code (Sections 1797-1799).

EMSA's mission is to ensure quality patient care by administering an effective statewide system of coordinated emergency medical care, injury prevention and disaster medical response.

Our vision encompasses strong internal and external working relationships that promote public trust and quality patient care. Emergency and disaster medical services in California are rooted in the skills and commitment of the first responders, EMTs, nurses, physicians, and administrators who deliver care to the public and operate the system. In order for high quality services to be delivered efficiently, all aspects of EMS systems must work together, mutually reinforcing and supporting each other for the benefit of the patient. The California EMS Authority plays a central role in improving the quality of emergency medical services available for all Californians by setting standards, building consensus, and providing leadership. EMSA is organized into three divisions:

- The EMS Personnel Standards Division develops and implements regulations for training, certification, licensing and scope of practice for emergency medical personnel, including emergency medical technician (EMT), advanced EMT, paramedic, firefighter, peace officer and lifeguard. They license, investigate and discipline

paramedics statewide for civil and criminal violations of the California Health and Safety Code. They also approve first aid and CPR training programs that are required for child care providers and school bus drivers.

- The EMS Systems Division coordinates the local EMS systems, the statewide trauma system, and the California Poison Control system. They establish regulations and guidelines and review local EMS plans to ensure they meet minimum standards. This division also manages EMS data collection, quality assurance, dispatch and communication standards and EMS for Children efforts.
- The Disaster Medical Services Division fulfills EMSA's role as the lead agency responsible for coordinating California's medical response to disasters. The Division organizes a statewide network to provide medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies and personnel from unaffected regions of the State to meet the needs of disaster victims.

While day-to-day management of California's EMS system is the statutory responsibility of the counties, through the local EMS agencies, EMSA's job is to coordinate the system statewide. In addition to establishing standards through regulation, here are a few examples of the work we do on behalf of Californians to support the EMS system:

✓ **Paramedic Licensure:** EMSA licenses approximately 20,000 paramedics statewide. We also investigate actions by paramedics that may be violations of the professional and ethical standards for paramedics in the Health and Safety Code and take licensure action when necessary to protect the public.



✓ **EMS Personnel Registry:** EMSA operates the statewide EMS Personnel Central Registry - an online database containing certification/licensure status of every EMT, Advanced EMT and Paramedic in the State. The system has enabled certification in one county to be verified throughout the State. The website receives more than 2,300 inquiries about individual providers each week.

✓ **First Aid, CPR and AED Regulations and Training:** EMSA oversees first aid and CPR training for 80,000 child care providers and school bus

drivers. In addition, EMSA writes regulations for use of automated external defibrillator.

- ✓ **Mobile Medical Assets:** EMSA has 42 Disaster Medical Support Units filled with medical supplies and equipment strategically placed throughout the State that are ready to re-supply ambulance strike teams in the event that the local EMS resources are overwhelmed. EMSA also coordinates California Medical Assistance Teams.
- ✓ **California Poison Control System:** EMSA supports and oversees the statewide system that provides free, immediate answers to poisoning questions over the phone. The California Poison Control System receives more than three hundred thousand calls per year.
- ✓ **Emergency Medical Services for Children:** EMSA worked with subject matter experts to develop a comprehensive model for the EMS for Children program that has been adopted for use by many local EMS agencies.
- ✓ **California Emergency Medical Services Information System (CEMSIS):** In cooperation with the National EMS Information System, EMSA administers a statewide system to collect pre-hospital and trauma center data. The information is used to support local quality improvement and participate in national data collection efforts.
- ✓ **Disaster Healthcare Personnel:** More than 21,000 healthcare professionals from dozens of medical specialties have registered with California's Disaster Healthcare Volunteers Program (DHV) so that when disaster strikes, they can be mobilized to help. The DHV system allows EMSA to automatically verify credentials for 48 different professions. In addition, EMSA coordinates 44 Medical Reserve Corps units which are local teams of trained volunteers that are integrated into the DHV Program.
- ✓ **Stroke and STEMI:** EMSA works with subject matter experts to develop regional systems of specialized care that address the medical needs of patients who suffer stroke and heart attacks. The workgroup is writing regulations to ensure they receive specialized prehospital and hospital emergency care that will increase their chances of survival and recovery.



- ✓ **Scope of Practice:** EMSA approves the scope of practice for EMS providers and designates training and care for specialized paramedics who serve on a tactical law enforcement team, on a helicopter or fixed-wing aircraft, or on a search and rescue team.



- ✓ **Local EMS Agency Systems Plans Review:** EMSA reviews EMS plans from local EMS agencies to ensure they meet the requirements of the Health and Safety Code and provide a coordinated system of emergency medical care. This includes evaluation of the ambulance zones.

EMSA Phone Directory by Subject

ALL NUMBERS ARE IN THE 916 AREA CODE

EMSA Main Number	322-4336
Air Transport	431-3677
Alternate Base/Receiving Hospital Information	431-3685
Ambulance Service Areas	431-3677
Ambulance Strike Team (AST)	431-3681
Automated External Defibrillator	431-3707
Base Hospital Information	431-3685
California Public Health & Medical Emergency Operations Manual	431-3681
California Health Alert Network (CAHAN)	431-3698
California Medical Assistance Teams (CAL-MATs)	431-3676
California Medical Assistance Teams - Specialized	255-4171
California Public Health & Medical Emergency Ops. Manual	255-4728
CBRNE Preparedness for Healthcare Providers	384-0906
Child Day Care Health & Safety Training	431-3678
Commission on EMS	431-3701
Communications Systems (Access)	431-3667
Director's Office	431-3701
Disaster Healthcare Volunteers (DHV)	431-3683
Disaster Medical Assistance Teams (DMATs)	431-3676
Disaster Medical Communications	384-1445
Disaster Medical Supplies/Equipment	255-4171
Disaster Medical Support Units (DMSUs)	384-1443
Disaster Response Exercises	255-4728

Dispatcher Guidelines	431-3677
Do Not Resuscitate (DNR) Forms	431-3727
EMS Awards	431-3700
EMS Data (CA EMS Information System)	431-3742
EMS for Children	431-3696
Field Treatment Sites	255-4728
EMS Plan Review	431-3688
EMS Standards & Guidelines	431-3695
EMT & AEMT	431-3717
EMT 2010 Enforcement Liaison	431-3692
Enforcement - Investigations	431-3703
Enforcement - Probation/Case Management	431-3668
External Affairs	431-3700
First Responder/Bystander Care	431-3717
Health Information Exchange (HIE)	431-3695
Hospital Administrative Support Unit (HASU)	431-3676
Hospital Diversion Policies	431-3685
Hospital Downgrade/Closure	431-3695
Hospital Incident Command System (HICS)	431-3676
Human Resources	431-3669
Injury Prevention/Public Education	431-3685
Interfacility Transport and Transfer Guidelines	431-3677
Legal Office - Counsel	431-3693
Legislative Affairs	431-3700
Medical Mutual Aid	255-4728

Medical Reserve Corps (MRC)	431-3691
Mission Support Team (MST)	431-3676
Mobile Field Hospital	255-4171
Mobile Intensive Care Nurses (MICNs)	431-3649
National Incident Management System (NIMS)	431-3676
Patient Movement Project	255-4702
Paramedic Licensure Information	323-9875
Paramedic Licensure Renewal	431-3652
Paramedic Licensure Audit Renewal	323-9875
Paramedic Local Optional Scope of Practice	431-3689
Paramedic National Registry Exams	431-3741
Paramedic Regulations and Trial Studies	431-3689
Pandemic Influenza	431-3676
Poison Control Centers	431-3695
Public Information/Media	431-3700
Public Safety, First Aid, CPR, and AED	431-3717
Quality Improvement	431-3659
Regional Disaster Medical/Health Specialists	255-1826
Regional/Multi-County EMS Agencies	431-3688
Rural EMS	431-3695
School Bus Driver First Aid/CPR	431-3678
Small Business Liaison/Advocate	431-3653
So. Cal. Catastrophic Earthquake Response Plan	255-4702
Specialty Care Centers (STEMI, Stroke)	431-3685
Standardized Emergency Management Systems	431-3676

State Agency Terrorism Awareness Group	431-3676
State Emergency Plan (SEP)	255-1766
Statewide Disaster Medical/Health Exercises	255-1826
Trauma Regulations and Plan Review	431-3649
Weapons of Mass Destruction	255-4728

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CHAPTER 1. General Provisions [1797 - 1797.9] (Chapter 1 added by Stats. 1980, Ch. 1260.)

1797.0 (Title)

This division shall be known and may be cited as the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act. (Amended by Stats. 1986, Ch. 248, Sec. 121.)

1797.1. (Legislative Intent: Statewide System)

The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services. (Amended by Stats. 1983, Ch. 1246, Sec. 6.)

1797.2. (Legislative Intent: EMT-P v. EMT II Programs)

It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible. (Added by Stats. 1980, Ch. 1260.)

1797.3. (Additional Local Training Standards)

The provisions of this division do not preclude the adoption of additional training standards for EMT-II and EMT-P personnel by local EMS agencies, consistent with standards adopted pursuant to Sections 1797.171, 1797.172, and 1797.214. (Amended by Stats. 1989, Ch. 1362, Sec. 1. Effective October 2, 1989.)

1797.4. (Wedsworth-Townsend Reference Clarification)

Any reference in any provision of law to mobile intensive care paramedics subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid certificates under this division as an EMT-I, EMT-II, or EMT-P. Any reference in any provision of law to mobile intensive care nurses subject to former Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 shall be deemed to be a reference to persons holding valid authorization under this division as an MICN. (Added by Stats. 1988, Ch. 260, Sec. 1.)

1797.5. (Legislative Intent: Encourage Assisting Others)

It is the intent of the Legislature to promote the development, accessibility, and provision of emergency medical services to the people of the State of California.

Further, it is the policy of the State of California that people shall be encouraged and trained to assist others at the scene of a medical emergency. Local governments, agencies, and other organizations shall be encouraged to offer training in cardiopulmonary resuscitation and lifesaving first aid techniques so that people may be adequately trained, prepared, and encouraged to assist others immediately. (Added by Stats. 1983, Ch. 1246, Sec. 8.)

1797.6. (Legislative Intent: Antitrust Immunity)

(a) It is the policy of the State of California to ensure the provision of effective and efficient emergency medical care. The Legislature finds and declares that achieving this policy has been hindered by the confusion and concern in the 58 counties resulting from the United States Supreme Court's holding in *Community Communications Company, Inc. v. City of Boulder, Colorado*, 455 U.S. 40, 70 L. Ed. 2d 810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust laws.

(b) It is the intent of the Legislature in enacting this section and Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state direction and supervision over emergency medical services as will provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this division. (Added by Stats. 1984, Ch. 1349, Sec. 1.)

1797.7. (Legislative Intent: Statewide Recognition of Prehospital Personnel)

(a) The Legislature finds and declares that the ability of some prehospital emergency medical care personnel to move from the jurisdiction of one local EMS agency which issued certification and authorization to the jurisdiction of another local EMS agency which utilizes the same level of emergency medical care personnel will be unreasonably hindered if those personnel are required to be retested and recertified by each local EMS agency.

(b) It is the intent of the Legislature in enacting this section and Section 1797.185 to ensure that EMT-P personnel who have met state competency standards for their basic scope of practice, as defined in Chapter 4 (commencing with Section 100135) of Division 9 of Title 22 of the California Code of Regulations, and are currently certified are recognized statewide without having to repeat testing or certification for that same basic scope of practice.

(c) It is the intent of the Legislature that local EMS agencies may require prehospital emergency medical care personnel who were certified in another jurisdiction to be oriented to the local EMS system and receive training and demonstrate competency in any optional skills for which they have not received accreditation. It is also the intent of the Legislature that no individual who possesses a valid California EMT-P certificate shall be prevented from beginning working within the standard statewide scope of practice of an EMT-P if he or she is accompanied by a EMT-P who is currently certified in California and is accredited by the local EMS agency. It is further the intent of the Legislature that the local EMS agency provide, or arrange for the provision of, training and accreditation testing in local EMS operational policies and procedures and any optional skills utilized in the local EMS system within 30 days of application for accreditation as an EMT-P by the local EMS agency.

(d) It is the intent of the Legislature that subdivisions (a), (b), and (c) not be construed to hinder the ability of local EMS agencies to maintain medical control within their EMS system in accordance with the requirements of this division. (Amended by Stats. 1989, Ch. 1362, Sec. 2. Effective October 2, 1989.)

1797.8. (Administration of Naloxone Hydrochloride)

(a) For purposes of this section, the following definitions apply:

(1) "EMT-I" means any person who has training and a valid certificate as prescribed by Section 1797.80.

(2) "EMT certifying authority" means the medical director of the local emergency medical services agency.

(b) Any county may, at the discretion of the county or regional medical director of emergency medical services, develop a program to certify an EMT-I to administer naloxone hydrochloride by means other than intravenous injection.

(c) Any county that chooses to implement a program to certify an EMT-I to administer naloxone hydrochloride, as specified in subdivision (b), shall approve and administer a training and testing program leading to certification consistent with guidelines established by the state Emergency Medical Services Authority.

(d) On or before July 1, 2003, the state Emergency Medical Services Authority shall develop guidelines relating to the county certification programs authorized pursuant to subdivision (b).

(e) An EMT-I may be authorized by the EMT certifying authority to administer naloxone hydrochloride by means other than intravenous injection only if the EMT-I has completed training and passed an examination administered or approved by the EMT certifying authority in the area.

(f) This section shall be operative only until the operative date of regulations that revise the regulations set forth in Chapter 3 (commencing with Section 100101) of Division 9 of Title 22 of the California Code of Regulations and that authorize an EMT-I to receive EMT-II training in administering naloxone hydrochloride without having to complete the entire EMT-II certification course. (Added by Stats. 2002, Ch. 678, Sec. 2. Effective January 1, 2003. Conditionally inoperative as provided in subd. (f).)

1797.9. (Public Aircraft - Uses & Regulation)

(a) This division shall not be construed to regulate or authorize state or local regulation of any nonmedical aspects of the following:

- (1) Public aircraft certification or configuration.
- (2) Public aircraft maintenance procedures and documentation.
- (3) Piloting techniques and methods of piloting public aircraft.
- (4) Public aircraft crewmember qualifications.
- (5) Pilot certification or qualifications for public aircraft.

(b) For purposes of this section, "public aircraft" has the same meaning as in Section 1.1 of Title 14 of the Code of Federal Regulations. (Added by Stats. 2008, Ch. 289, Sec. 2. Effective January 1, 2009.)

CHAPTER 2. Definitions [1797.50 - 1797.97] (Chapter 2 added by Stats. 1980, Ch. 1260.)

1797.50. (Effect of Definitions)

Unless the context otherwise requires, the definitions contained in this chapter shall govern the provisions of this division. (Amended by Stats. 1986, Ch. 248, Sec. 123.)

1797.52. (Advanced Life Support)

“Advanced life support” means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. (Amended by Stats. 1984, Ch. 1391, Sec. 4.)

1797.53. (Alternative Base Station)

“Alternative base station” means a facility or service operated and directly supervised by, or directly supervised by, a physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel, which has been approved by the medical director of the local EMS agency to provide medical direction to advanced life support or limited advanced life support personnel responding to a medical emergency as part of the local EMS system, when no qualified hospital is available to provide that medical direction. (Added by Stats. 1988, Ch. 1390, Sec. 1.)

1797.54. (Authority)

“Authority” means the Emergency Medical Services Authority established by this division. (Amended by Stats. 1986, Ch. 248, Sec. 124.)

1797.56. (Authorized Registered Nurse)

“Authorized registered nurse,” “mobile intensive care nurse,” or “MICN” means a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been authorized by the medical director of the local EMS agency as qualified to provide prehospital advanced life support or to issue instructions to prehospital emergency medical care personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide

guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a registered nurse or mobile intensive care nurse as otherwise provided by law. (Amended by Stats. 1984, Ch. 1391, Sec. 5.)

1797.58. (Base Hospital)

“Base hospital” means one of a limited number of hospitals which, upon designation by the local EMS agency and upon the completion of a written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system and prehospital care system assigned to it by the local EMS agency. (Amended by Stats. 1984, Ch. 1391, Sec. 6.)

1797.59. (Base Hospital Physician)

“Base hospital physician” or “BHP” means a physician and surgeon who is currently licensed in California, who is assigned to the emergency department of a base hospital, and who has been trained to issue advice and instructions to prehospital emergency medical care personnel consistent with statewide guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a physician and surgeon as otherwise provided by law. (Added by Stats. 1984, Ch. 1391, Sec. 7.)

1797.60. (Basic Life Support)

“Basic life support” means emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available. (Added by Stats. 1980, Ch. 1260.)

1797.61. (Certificate or License)

(a) “Certificate” or “license” means a specific document issued to an individual denoting competence in the named area of prehospital service.

(b) “Certificate status” or “license status” means the active, expired, denied, suspended, revoked, or placed on probation designation applied to a certificate or license issued pursuant to this division.

(Added by Stats. 2008, Ch. 274, Sec. 2. Effective January 1, 2009.)

1797.62. (Certifying Entity)

“Certifying entity” means a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT-I personnel that is approved pursuant to the standards developed pursuant to Section

1797.109, or the medical director of a local EMS agency. (Repealed and added by Stats. 2008, Ch. 274, Sec. 4. Effective January 1, 2009.)

1797.63. (Certifying Examination)

“Certifying examination” or “examination for certification” means an examination designated by the authority for a specific level of prehospital emergency medical care personnel that must be satisfactorily passed prior to certification or recertification at the specific level and may include any examination or examinations designated by the authority, including, but not limited to, any of the following options determined appropriate by the authority:

(a) An examination developed either by the authority or under the auspices of the authority or approved by the authority and administered by the authority or any entity designated by the authority to administer the examination.

(b) An examination developed and administered by the National Registry of Emergency Medical Technicians.

(c) An examination developed administered, or approved by a certifying agency pursuant to standards adopted by the authority for the certification examination. (Added by Stats. 1989, Ch. 1362, Sec. 3. Effective October 2, 1989.)

1797.64. (Commission)

“Commission” means the Commission on Emergency Medical Services created pursuant to the provisions of Section 1799. (Added by Stats. 1980, Ch. 1260.)

1797.66. (Competency Based Curriculum)

“Competency based curriculum” means a curriculum in which specific objectives are defined for each of the separate skills taught in training programs with integrated didactic and practical instruction and successful completion of an examination demonstrating mastery of every skill. (Added by Stats. 1980, Ch. 1260.)

1797.67. (Designated Facility)

“Designated facility” means a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority. (Added by Stats. 1983, Ch. 1246, Sec. 12.)

1797.68. (Director)

“Director” means the Director of the Emergency Medical Services Authority. (Amended by Stats. 1983, Ch. 1246, Sec. 13.)

1797.70. (Emergency)

“Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency. (Added by Stats. 1980, Ch. 1260.)

1797.72. (Emergency Medical Services)

“Emergency medical services” means the services utilized in responding to a medical emergency. (Added by Stats. 1980, Ch. 1260.)

1797.74. (EMS Area)

“Emergency medical services area” or “EMS area” means the geographical area within the jurisdiction of the designated local EMS agency. (Amended by Stats. 1984, Ch. 1391, Sec. 8.)

1797.76. (EMS Plan)

“Emergency medical services plan” means a plan for the delivery of emergency medical services consistent with state guidelines addressing the components listed in Section 1797.103. (Amended by Stats. 1983, Ch. 1246, Sec. 14.)

1797.78. (EMS System)

“Emergency medical services system” or “system” means a specially organized arrangement which provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions. (Added by Stats. 1980, Ch. 1260.)

1797.80. (Emergency Medical Technician)

“Emergency Medical Technician-I” or “EMT-I” means an individual trained in all facets of basic life support according to standards prescribed by this part and who has a valid certificate issued pursuant to this part. This definition shall include, but not be limited to, EMT-I (FS) and EMT-I-A. (Added by Stats. 1980, Ch. 1260.)

1797.82. (Emergency Medical Technician-II)

“Emergency Medical Technician-II,” “EMT-II,” “Advanced Emergency Medical Technician,” or “Advanced EMT” means an EMT-I with additional training in limited advanced life support according to standards prescribed

by this part and who has a valid certificate issued pursuant to this part. (Amended by Stats. 2008, Ch. 275, Sec. 2. Effective January 1, 2009.)

1797.84. (Emergency Medical Technician-Paramedic)

“Emergency Medical Technician-Paramedic,” “EMT-P,” “paramedic” or “mobile intensive care paramedic” means an individual whose scope of practice to provide advanced life support is according to standards prescribed by this division and who has a valid certificate issued pursuant to this division. (Amended by Stats. 1986, Ch. 248, Sec. 125.)

1797.85. (Exclusive Operating Area)

“Exclusive operating area” means an EMS area or subarea defined by the emergency medical services plan for which a local EMS agency, upon the recommendation of a county, restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. (Added by Stats. 1984, Ch. 1349, Sec. 2.)

1797.86. (Health Systems Agency)

“Health systems agency” means a health systems agency as defined in subsection (a) of Section 300(l)-1 of Title 42 of the United States Code. (Added by Stats. 1980, Ch. 1260.)

1797.88. (Hospital)

“Hospital” means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of-state acute care hospital which substantially meets the requirements of Chapter 2 (commencing with Section 1250) of Division 2, as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located. (Amended by Stats. 1986, Ch. 1162, Sec. 1. Effective September 26, 1986.)

1797.90. (Medical Control)

“Medical control” means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798). (Added by Stats. 1980, Ch. 1260.)

1797.92. (Limited Advanced Life Support)

“Limited advanced life support” means special service designed to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support and are those procedures specified pursuant to Section 1797.171. (Added by Stats. 1980, Ch. 1260.)

1797.94. (Local EMS Agency)

“Local EMS agency” means the agency, department, or office having primary responsibility for administration of emergency medical services in a county and which is designated pursuant to Chapter 4 (commencing with Section 1797.200). (Added by Stats. 1980, Ch. 1260.)

1797.97. (Poison Control Center)

“Poison control center” or “PCC” means a hospital-based facility or other facility which, as a minimum, provides information and advice regarding the management of individuals who have or may have ingested or otherwise been exposed to poisonous or possibly toxic substances, and which has been designated by the Emergency Medical Services Authority according to the standards prescribed by this division. (Amended by Stats. 1987, Ch. 972, Sec. 1.)

CHAPTER 2.5. The Maddy Emergency Medical Services Fund [1797.98a - 1797.98g] (Heading of Chapter 2.5 amended by Stats. 1998, Ch. 58, Sec. 2.)

1797.98a. (Fund Administration)

(a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund in an amount that does not exceed the actual administrative costs or 10 percent of the amount of the fund, whichever amount is lower.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic, comprehensive, or standby emergency services pursuant to paragraph (3) or (5) of subdivision (f) of Section 1797.98e up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

(e) Of the money deposited into the fund pursuant to Section 76000.5 of the Government Code, 15 percent shall be utilized to provide funding for all pediatric trauma centers throughout the county, both publicly and privately owned and operated. The expenditure of money shall be limited to reimbursement to physicians and surgeons, and to hospitals for patients who do not make payment for emergency care services in hospitals up to the point of stabilization, or to hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment. Local emergency medical services (EMS) agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures. Counties that do not maintain a pediatric trauma center shall utilize the money deposited into the fund pursuant to Section 76000.5 of the Government Code to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children. Funds spent for the purposes of this section, shall be known as Richie's Fund. This subdivision shall remain in effect until January 1, 2017, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2017, deletes or extends that date.

(f) Costs of administering money deposited into the fund pursuant to Section 76000.5 of the Government Code shall be reimbursed from the money collected in an amount that does not exceed the actual administrative costs or 10 percent of the money collected, whichever amount is lower. This subdivision shall remain in effect until January 1, 2017, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before January 1, 2017, deletes or extends that date. (Amended by Stats. 2013, Ch. 600, Sec. 2. Effective January 1, 2014.)

1797.98b. (Legislative Fund Report)

(a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the authority on the implementation and status of the Emergency Medical Services Fund. Notwithstanding Section 10231.5 of the Government Code, the authority shall compile and forward a summary of each county's report to the appropriate policy and fiscal committees of the Legislature. Each county report, and the summary compiled by the authority, shall cover the immediately preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund, or, if no moneys were deposited into the fund, the reason or reasons for the lack of deposits. The total amounts of penalty assessments shall be listed on the basis of each statute that provides the authority for the penalty assessment, including Sections 76000, 76000.5, and 76104 of the Government Code, and Section 42007 of the Vehicle Code.

(2) The amount of penalty assessment funds collected under Section 76000.5 of the Government Code that are used for the purposes of subdivision (e) of Section 1797.98a.

(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.

(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment

methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contacted to review claims payment methodologies.

(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.

(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98c.

(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.

(B) The amount of moneys available to be disbursed to hospitals.

(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.

(11) The name and contact information of the entity responsible for each of the following:

(A) Collection of fines, forfeitures, and penalties.

(B) Distribution of penalty assessments into the Emergency Medical Services Fund.

(C) Distribution of moneys to physicians and surgeons.

(b) (1) Each county, upon request, shall make available to any member of the public the report provided to the authority under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis. (Amended by Stats. 2014, Ch. 442, Sec. 5. Effective September 18, 2014.)

1797.98c. (Physician Reimbursement Requirements)

(a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations. Amended by Stats. 2005, Ch. 671, Sec. 3. Effective January 1, 2006.)

1797.98e. (Administrative Procedures)

(a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that

claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991–92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(5) A standby emergency room in existence on January 1, 2007, in a hospital located in Los Angeles County that meets all of the following requirements:

(A) The requirements of subdivision (m) of Section 70413 and Sections 70415 and 70417 of Title 22 of the California Code of Regulations.

(B) Reported at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in 2007 and continues to report at least 18,000 emergency department patient encounters to the Office of Statewide Health Planning and Development in each year thereafter.

(C) A hospital with a standby emergency department meeting the requirements of this paragraph shall do both of the following:

(i) Annually provide the State Department of Public Health and the local emergency medical services agency with certification that it meets the requirements of subparagraph (A). The department shall confirm the hospital's compliance with subparagraph (A).

(ii) Annually provide to the State Department of Public Health and the local emergency medical services agency the emergency department patient encounters it reports to the Office of Statewide Health Planning and Development to establish that it meets the requirement of subparagraph (B).

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(l) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California. (Amended by Stats. 2008, Ch. 288, Sec. 2. Effective January 1, 2009.)

1797.98f. (Gross Billings Arrangement)

Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

- (a) The services are provided in a basic or comprehensive general acute care hospital emergency department, or in a standby emergency department in a small and rural hospital as defined in Section 124840.
- (b) The physician and surgeon is not an employee of the hospital.
- (c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.
- (d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients. (Amended by Stats. 1998, Ch. 1016, Sec. 3. Effective January 1, 1999.)

1797.98g. (Moneys Not Subject to Article 3.5)

The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code. (Added by Stats. 1991, Ch. 1169, Sec. 4.)

CHAPTER 3. State Administration [1797.100 - 1797.197] (Chapter 3 added by Stats. 1980, Ch. 1260.)

ARTICLE 1. The Emergency Medical Services Authority [1797.100 - 1797.118] (Article 1 added by Stats. 1980, Ch. 1260.)

1797.100. (Creation)

There is in the state government in the Health and Welfare Agency, the Emergency Medical Services Authority. (Amended by Stats. 1983, Ch. 1246, Sec. 16.)

1797.101. (Director)

The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services. The director shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine. (Amended by Stats. 2008, Ch. 274, Sec. 5. Effective January 1, 2009.)

1797.102. (Assessment of Service Area)

The authority, utilizing regional and local information, shall assess each EMS area or the system's service area for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services. (Added by Stats. 1980, Ch. 1260.)

1797.103. (System Guidelines)

The authority shall develop planning and implementation guidelines for emergency medical services systems which address the following components:

- (a) Manpower and training.
- (b) Communications.
- (c) Transportation.
- (d) Assessment of hospitals and critical care centers.
- (e) System organization and management.
- (f) Data collection and evaluation.

(g) Public information and education.

(h) Disaster response.

(Added by Stats. 1980, Ch. 1260.)

1797.104. (Technical Assistance)

The authority shall provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems. (Added by Stats. 1980, Ch. 1260.)

1797.105. (Local EMS Plan Approval)

(a) The authority shall receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.

(b) After the applicable guidelines or regulations are established by the authority, a local EMS agency may implement a local plan developed pursuant to Section 1797.250, 1797.254, 1797.257, or 1797.258 unless the authority determines that the plan does not effectively meet the needs of the persons served and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority.

(c) A local EMS agency may appeal a determination of the authority pursuant to subdivision (b) to the commission.

(d) In an appeal pursuant to subdivision (c), the commission may sustain the determination of the authority or overrule and permit local implementation of a plan, and the decision of the commission is final. (Amended by Stats. 1984, Ch. 1735, Sec. 1. Effective September 30, 1984.)

1797.106. (Group Practice Prepayment Health Plans)

(a) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall not prohibit hospitals which contract with group practice prepayment health care service plans from providing necessary medical services for the members of those plans.

(b) Regulations, standards, and guidelines adopted by the authority and by local EMS agencies pursuant to the provisions of this division shall provide for the transport and transfer of a member of a group practice prepayment health care service plan to a hospital that contracts with the plan when the base hospital determines that the condition of the member permits the transport or when the condition of the member permits the transfer, except

that when the dispatching agency determines that the transport by a transport unit would unreasonably remove the transport unit from the area, the member may be transported to the nearest hospital capable of treating the member. (Amended by Stats. 1986, Ch. 248, Sec. 127.)

1797.107. (Adoption of Rules & Regulations)

The authority shall adopt, amend, or repeal, after approval by the commission and in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division and to enable the authority to exercise the powers and perform the duties conferred upon it by this division not inconsistent with any of the provisions of any statute of this state. (Amended by Stats. 1986, Ch. 248, Sec. 128.)

1797.108. (Funding Assistance to Local EMS Agencies)

Subject to the availability of funds appropriated therefor, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

In addition, the authority may provide special funding to multicounty EMS agencies which serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

Each local or multicounty EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation. (Added by Stats. 1983, Ch. 191, Sec. 3. Effective July 11, 1983.)

1797.109. (Public Safety Personnel EMT Training)

(a) The director may develop, or prescribe standards for and approve, an emergency medical technician training and testing program for the Department of the California Highway Patrol, Department of Forestry and Fire Protection, California Fire Fighter Joint Apprenticeship Committee, and other public safety agency personnel, upon the request of, and as deemed appropriate by, the director for the particular agency.

(b) The director may, with the concurrence of the Department of the California Highway Patrol, designate the California Highway Patrol Academy as a site where the training and testing may be offered.

(c) The director may prescribe that each person, upon successful completion of the training course and upon passing a written and a practical examination, be certified as an emergency medical technician of an appropriate classification. A suitable identification card may be issued to each certified person to designate that person's emergency medical skill level.

(d) The director may prescribe standards for refresher training to be given to persons trained and certified under this section.

(e) The Department of the California Highway Patrol shall, subject to the availability of federal funds, provide for the initial training of its uniformed personnel in the rendering of emergency medical technician services to the public in specified areas of the state as designated by the Commissioner of the California Highway Patrol. (Amended by Stats. 2000, Ch. 157, Sec. 1. Effective January 1, 2001.)

1797.110. (Advance Payments to Local EMS Agencies)