SECOND AMENDMENT TO PROFESSIONAL AND CALL COVERAGE SERVICES AGREEMENT

THIS SECOND AMENDMENT TO PROFESSIONAL AND CALL COVERAGE SERVICES AGREEMENT (the **"Amendment"**) is made and entered into as of January 1, 2023, by and between COUNTY OF MONTEREY (**"County"**) on behalf of NATIVIDAD MEDICAL CENTER (**"Hospital"**), and Thai Lan N Tran MD Inc, a California professional corporation (**"Contractor"**) with respect to the following:

RECITALS

A. County owns and operates Hospital, a general acute care teaching hospital facility and Level II Trauma Center located in Salinas, California and various outpatient clinics (collectively, the **"Clinic"**) under its acute care license.

B. Contractor and Hospital have entered into that certain Professional and Call Coverage Services Agreement dated effective as of June 1, 2019, and amended effective as of July 1, 2021 (collectively, the **"Agreement"**) pursuant to which Contractor provides Specialty services to Hospital's Patients.

C. Hospital and Contractor desire to amend the Agreement to modify the compensation arrangements in the compensation Exhibit to the Agreement.

AGREEMENT

IN CONSIDERATION of the foregoing recitals and the mutual promises and covenants contained herein, Hospital and Contractor agree as follows:

1. **Defined Terms**. Capitalized terms not otherwise defined herein shall have the meaning ascribed to them in the Agreement.

2. **Exhibit 2.1**. Exhibit 2.1 is hereby deleted and replaced in its entirety and incorporated by reference as attached **Exhibit 2.1**.

3. **Counterparts**. This Amendment may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

4. **Continuing Effect of Agreement**. Except as herein provided, all of the terms and conditions of the Agreement remain in full force and effect from the Effective Date of the Agreement.

5. **Reference**. After the date of this Amendment, any reference to the Agreement shall mean the Agreement as amended by this Amendment.

[signature page follows]

IN WITNESS WHEREOF, Hospital and Contractor have executed this Amendment as of the day and year first written above.

CONTRACTOR

Thai Lan N Tran MD Inc, a California professional corporation

DocuSigned by:
By: Thai Lan Tran Date: 12/16/2022 | 6:59 PM PST
4D42E9CAA4834FE...
Its

By: _____
Its _____

NATIVIDAD MEDICAL CENTER

_____ Date: 12/23/22
Deputy Purchasing Agent

APPROVED AS TO LEGAL PROVISIONS:

DocuSigned by:
Stacy Saetta Date: 12/19/2022 | 10:31 AM PST
C0ECE1B99F444A9...
Stacy Saetta, Deputy County Counsel

APPROVED AS TO FISCAL PROVISIONS:

DocuSigned by:
Jennifer Forsyth Date: 12/19/2022 | 3:16 PM PST
4E7E057875454AE...
Deputy Auditor/Controller

Exhibit 2.1

COMPENSATION

1. **Coverage Services Compensation.**

(a) Hospital shall pay to Contractor an amount equal to Three Thousand Five Hundred Dollars ($3,500) per Shift of **Trauma Coverage Services**;

(b) Hospital shall pay to Contractor an amount equal to Two Thousand Dollars ($2,000) per Shift of **General Surgery Coverage Services** provided pursuant to this Agreement; provided, however, that Contractor is in compliance with the terms and conditions of this Agreement. For the avoidance of doubt, Contractor shall not simultaneously provide Trauma Coverage Services and General Surgery Coverage Services during the same Shift.

(c) If Contractor is asked to provide trauma back-up call coverage separate of General Surgery Coverage Services, Contractor shall be paid an amount equal to Five Hundred Dollars ($500) per twenty-four (24) hour period (**"Back-up Call Coverage Compensation"**), plus One Hundred Forty-Five Dollars and Eighty-Three Cents ($145.83) per each hour that Contractor is required to be physically present at Hospital, not to exceed Three Thousand Five Hundred Dollars ($3,500) per day in the aggregate.

2. **Associate Medical Director Services.** Hospital shall pay to Contractor the amount equal to Two Hundred Dollars ($200) per hour for the provision of Associate Medical Director Services, not to exceed Two Thousand Dollars ($2,000) per month.

3. **Clinic Services.** In recognition of the mutual obligations of the Parties hereunder, Hospital and Contractor acknowledge that there shall be no monetary compensation to Contractor for the Clinic Services furnished by Contractor hereunder.

4. **Non Clinic Uninsured Patient Services.**

(a) Hospital shall pay to Contractor an amount equal to then-current (as of the date of service), facility-based, Medicare Physician Fee Schedule amount for Uninsured Services (as defined below) provided by Group Physician (the **"Non Clinic Uninsured Patient Compensation"**). The Uninsured Patient Compensation shall be Contractor's sole and exclusive compensation for Uninsured Services provided by Contractor pursuant to this Agreement and Contractor shall not seek further compensation from any other source. Contractor shall be paid on the CPT codes submitted and verified by Hospital professional billing office coders.

(b) For purposes of this Agreement, **"Non Clinic Uninsured Services"** shall mean medically necessary, professional medical services that are rendered to Patients at Hospital who are not insured for medical care by any third-party payor and ineligible for federal or state medical assistance under the Medicare or Medicaid programs (collectively, the **"Uninsured Patients"**). Contractor understands and agrees that the determination of whether a patient is uninsured may not be made until sometime after the date of service. Uninsured Services do not include any Professional Services provided by Contractor to Excluded Patients.

(c) Procedures with the following modifiers will be reimbursed at the Medicare allowable rate using the current established Medicare guidelines for reimbursement when using the modifier:

(i) Procedures that are or could be billed with the modifier 22 (unusual procedural services) will not be considered for additional reimbursement to be paid to Contractor; rather the procedure will be reimbursed at the Medicare allowable rate and if other modifiers are used, the procedure will be paid at the current established Medicare reimbursement rate applying Medicare guidelines for those modifiers.

(ii) If modifier 52 (reduced services) and/or 53 (discontinued services) is/are needed for billing, the percentage of the Medicare allowable rate to be paid to Contractor will be determined by the Hospital physician billing manager and the Hospital Chief Medical Officer (CMO).

(iii) Unless a code is specifically designated as an add-on code, the Medicare rules for multiple procedure guidelines shall apply (*i.e.,* the main procedure will be paid at one hundred percent (100%) and subsequent procedures will be paid at fifty percent (50%)), consistent with Medicare reimbursement guidelines for modifiers.

(d) The Parties intend that Hospital will pay for Uninsured Services only if the Uninsured Patient has no means of paying for those services (*e.g.,* independent wealth, third-party payor, etc.). If it is later determined that an Uninsured Patient or a third-party payor will pay for the Uninsured Services the following shall apply:

(i) Hospital shall have the sole and exclusive right to bill, collect and own any and all fees that might be collected for Uninsured Services provided by Contractor pursuant to this Agreement. Contractor hereby grants Hospital the right to retain any and all collections received by Hospital for Contractor's Uninsured Services. In the event that Contractor receives any payment from third-party payors for Uninsured Services that Contractor furnishes pursuant to this Agreement, Contractor shall promptly turn over such payments to Hospital. Contractor shall designate Hospital as Contractor's

attorney-in-fact for billing for Uninsured Services provided by Contractor pursuant to this Agreement.

(ii) For any procedure without an established RVU value and/or not listed procedure (*e.g.,* x stop), Hospital will reimburse Contractor based upon Hospital's reimbursement from a payor if Hospital has received payment from a payor. In the event no payment is received from a payor, no reimbursement will be made to Contractor.

(iii) The Parties agree to resolve any and all billing, collection and reimbursement disputes as expeditiously as possible, up to and including the dispute resolution procedure outlined in the Agreement. If a claim is disputed by a payor, Contractor will make every effort to assist the Hospital billing manager to resolve the claim, If the claim is denied by the payor, and no payment is received within twelve (12) months of the service date, the amount of the disputed claim will be adjusted (recouped) from future payments due to Contractor after the twelve (12) month period.

(iv) Hospital will adjust future invoices if Hospital is unable to recover payment for surgery/treatment due to a procedure being classified by a payor as non-payable (*e.g.,* it is considered experimental, represents non-covered services, is categorized as medically unnecessary, or is otherwise excluded from coverage), or if Contractor is found to have breached a necessary reimbursement procedure (*e.g.,* scheduling a procedure from its office and not obtaining the authorization for the procedure to be performed at Hospital). No payment will be allowed to Contractor in these circumstances. At its discretion and at its sole cost and expense, Contractor may appeal to the payor any determination that a procedure is non-payable.

(e) Hospital shall pay to Contractor the Uninsured Patient Compensation, so long as Contractor submits a **"Non-Clinic Uninsured Patient Compensation Claim"**, attached hereto as **Attachment B**, with information relating to its patient encounters as follows:

(i) It has been 90 - 180 days since the date of service(s);

(ii) Contractor has made a reasonable effort to collect payment and has been rejected for payment by the responsible third party(ies) and/or patient(s) for the patient(s) listed below;

(iii) Contractor has received notification from the third party(ies) and/or patient(s) that no payment will be made. Copies of denials from all payor sources are attached to this form;

(iv) Contractor has verified that patient has not become eligible for a government sponsored program; and

(v) Contractor has completed a 1500 billing form.

4. **Professional Liability Reimbursement.** In the event that Contractor does not purchase the professional liability insurance set forth in the Agreement, Hospital will deduct Eight Hundred Fifty-Four Dollars and Ninety One Cents ($854.91) per month to compensate for Hospital's payment of professional liability insurance premiums on behalf of Contractor. This amount reflects the then-current rate, rates are subject to change.

5. **Timing.** Hospital shall pay the compensation due for Services performed by Contractor after Contractor's submission of the monthly invoice of preceding month's activity and time report in accordance with this Agreement; provided, however, that if Contractor does not submit an invoice and time sheet within sixty (60) days of the end of the month during which Services were performed, Hospital shall not be obligated to pay Contractor for Services performed during that month. The County of Monterey Standard Payment Terms for contracts/PSAs and paying invoices is "30 days after receipt of the certified invoice in the Auditor-Controller's Office".