Introduced: 6/28/2013 **Current Status:** Agenda Ready

Version: 1 **Matter Type:** BoS Agreement

a) Authorize the Purchasing Manager for Natividad Medical Center (NMC) to execute the Second Amendment to the Professional Services Agreement with Salinas Valley Plastic Surgery Associates to provide plastic surgery services at NMC, extending the Agreement to June 30, 2015 and adding $400,000 for a revised total Agreement amount not to exceed $800,000 in the aggregate; and
b) Authorize the Purchasing Manager for NMC to execute to sign up to three (3) amendments to this agreement where the total amendments do not exceed 10% of the original contract amount, and do not significantly change the scope of work.

RECOMMENDATION:

It is recommended that the Board of Supervisors:

a) Authorize the Purchasing Manager for Natividad Medical Center (NMC) to execute the Second Amendment to the Professional Services Agreement with Salinas Valley Plastic Surgery Associates to provide plastic surgery services at NMC, extending the Agreement to June 30, 2015 and adding $400,000 for a revised total Agreement amount not to exceed $800,000 in the aggregate; and
b) Authorize the Purchasing Manager for NMC to execute to sign up to three (3) amendments to this agreement where the total amendments do not exceed 10% of the original contract amount, and do not significantly change the scope of work.

SUMMARY/DISCUSSION:

NMC currently has an agreement with Salinas Valley Plastic Surgery Associates to provide emergency department call coverage as well as plastic surgery services in the outpatient specialty clinic. NMC wishes to amend the agreement with Salinas Valley Plastic Surgery Associates to extend the term an additional twenty three (23) months and to expand the services to include surgeries in the operating room.

The maximum liability of the agreement for the period August 1, 2011 to June 30, 2015 is $800,000. Salinas Valley Plastic Surgery Associates is paid according to the terms of this agreement for the actual number of call coverage, surgeries and clinic services provided, which may increase due to patient volume and the need for coverage, but will not increase the rate of pay or exceed the aggregate maximum liability. NMC has obtained an independent opinion of fair market value supporting the payment terms of this Agreement.

OTHER AGENCY INVOLVEMENT:

County Counsel has reviewed and approved this Amendment/Agreement as to legal form and risk provisions. Auditor-Controller has reviewed and approved this Amendment/Agreement as to fiscal provisions. The Amendment/Agreement has also been reviewed and approved by

Natividad Medical Center's Board of Trustees.

FINANCING:

The cost for this Amendment/Agreement is $800,000. $97,776 was disbursed in Fiscal Year 2011/2012; $119,932 was disbursed in Fiscal Year 2012/2013; $291,146 is included in the Fiscal Year 2013/14 Recommended Budget; the remaining $291,146 will be budgeted in subsequent years. There is no impact to the General Fund.

Prepared by: Jeanne-Ann Balza, Management Analyst, 783.2506
Approved by: Harry Weis, Chief Executive Officer, 783.2553

Attachments: Agreement; First-Second Amendment

Originals on file at the Clerk of the Board

Harry Weis, CEO

7/3/13
Date

File ID A 13-159 No. 26

Monterey County

168 West Alisal Street,
1st Floor
Salinas, CA 93901
831.755.5066

Board Order

Agreement No.: A-11850

Upon motion of Supervisor Potter, seconded by Supervisor Parker and carried by those members present, the Board of Supervisors hereby:

a. Authorized the Purchasing Manager for Natividad Medical Center (NMC) to execute the Second Amendment to the Professional Services Agreement with Salinas Valley Plastic Surgery Associates to provide plastic surgery services at NMC, extending the Agreement to June 30, 2015 and adding $400,000 for a revised total Agreement amount not to exceed $800,000 in the aggregate; and
b. Authorized the Purchasing Manager for NMC to execute to sign up to three (3) amendments to this agreement where the total amendments do not exceed 10% of the original contract amount, and do not significantly change the scope of work.

PASSED AND ADOPTED on this 16th day of July 2013, by the following vote, to wit:

AYES: Supervisors Armenta, Calcagno, Salinas, Parker and Potter
NOES: None
ABSENT: None

I, Gail T. Borkowski, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 76 for the meeting on July 16, 2013.

Dated: July 16, 2013
File Number: A 13-159

Gail T. Borkowski, Clerk of the Board of Supervisors
County of Monterey, State of California

By _____
Deputy

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 August 1, 2013, by and between COUNTY OF MONTEREY (**"County"**) on behalf of NATIVIDAD MEDICAL CENTER (**"Hospital"**), and SALINAS VALLEY PLASTIC SURGERY ASSOCIATES, A MEDICAL CORPORATION, a California professional corporation ("**Contractor**") with respect to the following:

RECITALS

A. County owns and operates Hospital, a general acute care teaching hospital facility located in Salinas, California under its acute care license.

B. Contractor and Hospital have entered into that certain Professional and Call Coverage Services Agreement dated effective as of August 1, 2011 and amended effective as of August 1, 2012 (collectively, the **"Agreement"**), pursuant to which Contractor provides professional services in the Specialty to Non-Clinic and Clinic Patients.

C. Hospital and Contractor desire to amend the Agreement to add Non-Clinic Services, increase the amount payable to Contractor by $400,000 for services provided during the extended term of 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. **Section 1.14(d)**. Section 1.14(d) to the Agreement is hereby amended to read in its entirety as follows:

> "(d) any Group Physician voluntarily or involuntarily retires from the practice of medicine."

3. **Section 2.1**. Section 2.1 to the Agreement is hereby amended to read in its entirety as follows:

> **"2.1 Compensation.** Hospital shall pay to Contractor the amount determined in accordance with **Exhibit 2.1** (the **"Compensation"**), upon the terms and conditions set forth therein. The total amount payable by Hospital to Contractor under this Agreement shall not exceed the sum of Eight Hundred Thousand Dollars ($800,000) for the full term of this Agreement."

4. **Exhibit 2.1**. **Exhibit 2.1** to the Agreement is hereby amended to read in its entirety as attached hereto as Exhibit 2.1.

5. **Section 2.2**. Section 2.2 to the Agreement is hereby amended to read in its entirety as follows:

"2.2 Intentionally left blank."

6. **Section 2.3**. Section 2.3 to the Agreement is hereby amended to read in its entirety as follows:

"2.3 Billing and Collection. Hospital shall have the sole and exclusive right to bill and collect for any and all Professional Services rendered to Clinic and Non-Clinic Patients by Contractor or any Group Physician under this Agreement (the **"NMC Services"**). Hospital shall have the sole and exclusive right, title and interest in and to accounts receivable with respect to such NMC Services.

(a) **Assignment of Claims.** Contractor hereby assigns (or reassigns, as the case may be) to Hospital all claims, demands and rights of Contractor for any and all NMC Services rendered by Contractor pursuant to this Agreement. Contractor shall take such action and execute such documents (e.g., CMS Forms 855R and 855I), as may be reasonably necessary or appropriate to effectuate the assignment (or reassignment, as the case may be) to Hospital of all claims, demands and rights of Contractor for any and all NMC Services rendered by Contractor pursuant to this Agreement.

(b) **Fees and Rates.** Hospital shall have the right to determine, after consultation with Contractor, all rates and charges for NMC Services rendered by Contractor pursuant to this Agreement, including fee-for-service rates.

(c) **Cooperation with Billing and Collections.** Contractor shall cooperate with Hospital in the billing and collection of fees with respect to NMC Services rendered by Contractor. Without limiting the generality of the foregoing, Contractor shall cooperate with Hospital in completing such claim forms with respect to NMC Services rendered by Contractor pursuant to this Agreement as may be required by insurance carriers, health care service plans, governmental agencies, or other third party payors.

(d) **Hospital as Exclusive Source for Compensation for NMC Services.** Contractor shall seek and obtain compensation for the performance of NMC Services only from Hospital. Contractor shall not, bill, assess or charge any fee, assessment or charge of any type against any Hospital patient or any other person or entity for NMC Services rendered by Contractor pursuant to this Agreement. Contractor shall promptly deliver to Hospital any and all compensation, in whatever form, that is received by Contractor or any Group Physician for NMC Services rendered by Contractor or any Group Physician pursuant to this Agreement, including any amount received from any Managed Care Organization (as defined below) for NMC Services rendered by Contractor or any Group Physician pursuant to this Agreement.

(e) **Indemnification for Billing Information.** Contractor hereby agrees to indemnify County, Hospital, its officers, supervisors, trustees, employees and agents, from and against any and all liability, cost, loss, penalty or expense (including, without limitation, attorneys' fees and court costs) incurred by Hospital resulting from negligent acts or negligent omissions of Contractor which result in inaccurate and/or improper billing information furnished by Contractor and relied on by Hospital regarding Professional Services rendered by Contractor to Clinic Patients, to the extent such liability, cost, loss, penalty or expense exceeds the amount of payment or reimbursement actually received by Hospital for such services."

7. **Section 5.1**. Section 5.1 to the Agreement is hereby amended to read in its entirety as follows:

"**5.1 Term.** This Agreement shall become effective on August 1, 2011 (the **"Effective Date"**), and shall continue until June 30, 2015 (the **"Expiration Date"**), subject to the termination provisions of this Agreement."

8. **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.

9. **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.

10. **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

SALINAS VALLEY PLASTIC SURGERY ASSOCIATES, A MEDICAL CORPORATION, a California professional corporation

Date: 7/1, 2013

By: _____
Its President

By: _____
Its Treasurer

NATIVIDAD MEDICAL CENTER

_____
Purchase Order Number

By: _____
Contracts /Purchasing Manager

Date: 7-19, 2013

By: _____
Natividad Medical Center Representative

Date: 7/3, 2013

APPROVED AS TO LEGAL FORM:
CHARLES J. McKEE, County Counsel

_____
Stacy Saetta, Deputy County Counsel

Date: 7/3, 2013

Reviewed as to fiscal provisions

_____
Auditor-Controller
County of Monterey 7-3-13

Exhibit 2.1

COMPENSATION

1. **Professional Services.** Hospital shall pay to Contractor the amount of Seven Hundred Twenty-Eight Dollars ($728) per four (4) hour period (each, a **"Half-Day Clinic"**) for Professional Services provided to Clinic Patients (**"Clinic Services"**); provided, however, that Contractor is in compliance with the terms and conditions of this Agreement. Contractor shall provide Clinic Services a minimum of two (2) Half-Day Clinics per month during the term of this Agreement.

2. **Coverage Stipend.** Hospital shall pay to Contractor an amount equal to Three Hundred Fifty Dollars ($350) per twenty-four (24) hour period for Coverage Services provided pursuant to this Agreement.

3. **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".

4. **Non-Clinic Services.** Hospital shall pay to Contractor for Professional Services provided by Contractor to Non-Clinic Patients, who are not inpatient consults, ED patients or Uninsured/MIA Patients (as defined below) at NMC (**"Non-Clinic Services"**), an amount equal to ninety-five percent (95%) of the actual reimbursement received by Hospital for such services (the **"Non-Clinic Compensation"**). Hospital shall calculate the Non-Clinic Compensation on a monthly basis and be subject to bi-annual reconciliation in accordance with this Section 4.

(a) **Monthly Advances**. Hospital shall advance to Contractor, each month during the term of this Agreement, an amount equal the estimated amount of the Non-Clinic Compensation payable to Contractor, as determined in good faith by the Hospital (the **"Advance(s)"**).

(b) **Monthly Reconciliation.** Within thirty (30) days after the end of each month during the term of the Agreement (each, a **"Compensation Period"**), Hospital shall compare the aggregate Advances during such Compensation Period to the aggregate Non-Clinic Compensation for such Compensation Period. In the event the aggregate Advances during such Compensation Period exceed the aggregate Non-Clinic Compensation for such Compensation Period, Hospital shall withhold from each of the next Advance(s) otherwise payable to Contractor an amount equal to the difference between the aggregate Advances during such Compensation Period and the aggregate Non-Clinic Compensation for such Compensation Period. In the event the aggregate Non-Clinic Compensation during any such Compensation Period exceeds the aggregate Advances during such Compensation Period, Hospital shall pay to Contractor, in addition to the next Advance payable to Contractor, an amount equal to the

difference between the aggregate Non-Clinic Compensation for such Compensation Period and the aggregate Advances during such Compensation Period. Hospital shall conduct the first reconciliation pursuant to this Section 4(b) ninety (90) days after the Effective Date.

(c) **Non-Clinic Compensation Reports**. Hospital shall provide Contractor with a monthly report (each, a **"Report"**) that demonstrates the calculation of the Non-Clinic Compensation payable under this Agreement. If Contractor disagrees with any aspect of any such Report, Contractor shall, thirty (30) days after receipt of such Report, prepare and deliver to Hospital a written statement setting forth in reasonable detail Contractor's objections to the times stated in the Report. If Hospital does not receive such a written statement within such thirty (30) day period, Contractor shall be deemed to have agreed with each and every aspect of such Report.

5. **Non-Clinic Uninsured/MIA Services**. Hospital shall pay to Contractor an amount equal to then-current (as of the date of service), hospital-based, Medicare Physician Fee Schedule for the service or procedure (the **"Uninsured/MIA Compensation"**). The Uninsured/MIA Compensation shall be Contractor's sole and exclusive compensation for Uninsured/MIA Services (defined below) 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.

(a) For purposes of this Agreement, **"Uninsured/MIA Services"** shall mean medically necessary professional medical services that are rendered to patients at Hospital, other than Clinic patients, who: (i) have been identified by Hospital as patients who are designated as Medically Indigent Adults (**"MIA"**); or (ii) are not insured for medical care by any third-party payor (collectively, the **"Uninsured/MIA Patients"**).

(b) 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 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 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.

(c) The Parties intend that Hospital will pay for Uninsured/MIA Services only if the Uninsured/MIA 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/MIA Patient or a third-party payor will pay for the Uninsured/MIA 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/MIA 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/MIA Services. In the event that Contractor receives any payment from third-party payors for Uninsured/MIA 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/MIA 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 this Section 5. 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.

6. **Encounter Submissions.** For Non-Clinic Services and Uninsured/MIA Services, Hospital shall pay to Contractor the Monthly Advances and Uninsured/MIA Compensation, respectively, so long as Contractor submits information relating to its patient encounters as follows:

(i) Contractor will complete an encounter charge form at the time a service is provided, or within twenty-four (24) hours of that service.

(ii) After Contractor completes an encounter charge form, the Contractor will keep one copy and deposit a copy of the encounter charge form in a Hospital charge collection box.

(iii) Hospital physician billing staff will pick up encounter charge forms daily (Monday – Friday) from the Hospital charge collection box.

(iv) Hospital will check both the diagnosis and the documentation to verify coding on encounter forms for one hundred percent (100%) of encounters. This review will require Contractor to dictate patient visit notes into the Hospital dictation system within twenty-four (24) hours of completion of an encounter so that documentation available is for review of the encounter charge form. Any encounter charge form for which there is not an accompanying dictated patient visit note shall not be reviewed by Hospital until the patient visit note is submitted to the Hospital Physician Billing Manager. The sole exception to the dictation requirement shall be when Contractor is using CPT code 99024 for post operative visits and is not expecting payment for the visit, in which case the Contractor physician can hand write the visit note.

(v) Hospital will sign off on "clean" coded charges and forward for data entry.

(vi) Hospital's Physician Billing Manager will notify of disputed coding within five (5) business days of the daily pick-up of the encounter charge form, and will work with Contractor to resolve the dispute so that the claim may be filed within the filing deadlines established by the applicable payor. Hospital's Physician Billing Manager will also notify Contractor of any encounter charge forms for which there is no correlating dictated note within two (2) business days of the daily pick-up of the encounter charge form.

(vii) Contractor will return corrected charges within five (5) business days of receipt from Hospital's Physician Billing Manger.

(viii) For undisputed charges, charges will be entered by Hospital within five (5) business days. Hospital will make every effort during the last week of the month to get as many charges as possible entered into the system for that month's invoice. Contractor will be notified if an issue arises which prevents timely entry of charges. Disputed charges will be entered within five (5) business days of the final date of dispute resolution between Contractor and Hospital, and paid only after entry of the charges following resolution of the dispute.

(ix) In the event of a dispute regarding the appropriateness of a code or modifier, or similar technical billing issue, which cannot be resolved informally by the parties, the parties shall jointly designate an independent third party billing expert to review and make a recommendation regarding the issue. The cost of such expert shall be shared equally by the parties, Hospital shall give such recommendation great weight but, as the billing entity, shall have ultimate discretion in resolving such issue.

(x) Charges entered through the last day of the month will be the charges considered for payment for that month's invoice. Charges appearing on a given month's invoice may be for dates of service provided in a different month.

(xi) Hospital's Physician Services staff will generate the encounter report necessary to create the invoice. The encounter report will be based on the Hospital information system (currently MediTech) generated date/stamp for all charges entered by the Hospital physician billing staff as of the last day of the prior month, in accordance with Section 6(x) of this Exhibit.

(xii) The Hospital Physician Services staff will create and send the following documents to the Contractor on or before the twelfth (12^{th}) day of the month: (i) an "Encounter Summary Sheet" detailing worked performed by Contractor for the previous month, and (ii) a single invoice for all the work performed by Contractor during that month.

(xiii) Within three (3) business days of receiving it, Contractor will review the encounter report and invoice, discuss any disputes with the Hospital Physician Billing Manager and/or the Hospital Physician Services, accept and sign off on the invoice and return all documents to the Hospital Physician Services.

(xiv) Upon receipt of the accepted and signed invoice, the Hospital Physician Services will review the encounter charge forms and invoices, approve them, and initiate routing process to be completed within fifteen (15) days.

(xv) Once Contractor approves the monthly invoice and submits it to Hospital, Hospital will have forty-five (45) days to pay the invoice, resulting in a maximum of fifteen (15) days from submission of the invoice by Contractor to Hospital for Hospital to submit a certified invoice to the County Auditor Controller's office for payment; the Auditor Controller shall issue payment within thirty (30) days upon receipt in the Auditor Controller's Office.

7. **Excluded Patients**.

(a) This Agreement, including the compensation provisions set forth in this Exhibit 2.1, shall apply only to Professional Services provided by Contractor to patients who present to the Hospital or Clinic as Hospital patients (inpatient, outpatient and/or ED patient). This Agreement shall not apply to patients referred to the Hospital or Clinic from any Contractor office or private practice (**"Excluded Patients"**).

(b) Contractor shall be solely responsible for billing and collecting the professional component with respect to all Professional Services provided to Excluded Patients at Hospital or Clinic (**"Excluded Services"**). Contractor shall bill Excluded Patients and third party payors for the professional component with respect to the Excluded Services at its own expense and under its own provider number, except where direct patient billing is otherwise prohibited. In the event that Contractor receives any payment for Excluded Services from County, Contractor shall promptly return such payment to County.

(c) Contractor shall identify Excluded Patients by writing "Excluded Patient" on the encounter charge form at the time the Excluded Service is provided, or within twenty-four (24) hours of that service, and provide a copy to Hospital.

(d) Contractor shall, to the extent permitted by law and permitted by any third party payor agreements with Hospital or Clinic, and permitted by the terms of this Agreement, look exclusively to Excluded Patients, or those third party payors responsible for the payment of the professional component, as the sole source of its compensation for the Excluded Services provided at Hospital. In no case shall Hospital pay any amount to Contractor with respect to the Excluded Services.

(e) Contractor shall follow government program regulations on patient billing for patients covered by Medicare, Medicaid and other such programs. Contractor shall cease any billing practices which violates these regulations, and shall indemnify County for all damages, costs, expenses, and losses incurred by County, including but not limited to attorneys' fees, as a result of any violation.

(f) County shall have the right to disapprove the use by Contractor of any collection agency which engages in conduct which results in the unreasonable annoyance or harassment of patients. Contractor shall either cure this problem or discharge the collection agency within thirty days following written notice of disapproval by County. Contractor shall, if this problem occurs a second time, discharge the collection agency within thirty (30) days following written notice of disapproval by County."