THIRD AMENDMENT TO PROFESSIONAL AND CALL COVERAGE SERVICES AGREEMENT

THIS THIRD AMENDMENT TO PROFESSIONAL AND CALL COVERAGE SERVICES AGREEMENT (the **"Amendment"**) is made and entered into as of October 1, 2018, by and between COUNTY OF MONTEREY (**"County"**) on behalf of NATIVIDAD MEDICAL CENTER (**"Hospital"**), and MONTEREY SPINE AND JOINT, PC, 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 and various outpatient clinics (collectively, the **"Clinics"**) under its acute care license.

B. Contractor and Hospital have entered into that certain Professional and Call Coverage Services Agreement, effective as of October 1, 2014, and amended as of October 1, 2015 and October 1, 2017 (collectively, the **"Agreement"**) pursuant to which Contractor provides Specialty services to Clinic and Hospital Patients.

C. Hospital and Contractor desire to amend the Agreement to extend the term for one additional year and increase the Coverage Services Stipend and aggregate amount payable to Contractor.

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 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 Two Million Nine Hundred Fifty Thousand Dollars ($2,950,000) during the term of this Agreement.**"**

3. **Exhibit 2.1**. Exhibit 2.1 to the Agreement is hereby replaced in its entirety with the attached **Exhibit 2.1.**

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

> **"5.1 Term. This Agreement shall become effective on October 1, 2014 (the "Effective Date"), and shall continue until September 30, 2019 (the "Expiration Date"), subject to the termination provisions of this Agreement."**

5. **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.

6. **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.

7. **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

MONTEREY SPINE AND JOINT, PC, a
California professional corporation

By:_____ Date: _____, 2018
Its_____

NATIVIDAD MEDICAL CENTER

_____ Date: _____, 2018
Deputy Purchasing Agent

APPROVED AS TO LEGAL PROVISIONS:

_____ Date:_____, 2018
Stacy Saetta, Deputy County Counsel

APPROVED AS TO FISCAL PROVISIONS:

_____ Date: _____, 2018
Deputy Auditor/Controller

Exhibit 2.1

COMPENSATION

1. **Coverage Services.** Hospital shall pay to Contractor an amount equal to Two Thousand Seven Hundred Thirty Dollars ($2,730) per unrestricted twenty-four (24) hour period of Coverage Services provided pursuant to this Agreement (the **"Coverage Services Compensation"**), provided, however, that Contractor is in compliance with the terms and conditions of this Agreement and applicable Laws.

2. **Backup Call Services**. Hospital shall pay to Contractor an amount equal to Two Hundred Thirty Dollars ($230) per unrestricted twenty-four (24) hour period of coverage services provided by Contactor when Contractor is not providing primary call and receiving the Coverage Services Compensation as set forth in Section 1 of this Exhibit 2.1 for the same twenty-four (24) hour period ("Backup Call Services"). Contractor shall only be required to provide Backup Call Services upon mutual agreement by the Parties.

3. **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 **"Uninsured Patient Compensation"**). The Uninsured Patient Compensation shall be Contractor's sole and exclusive compensation for Uninsured Services provided by Group Physician 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, **"Uninsured Services"** shall mean medically necessary, professional medical services that are rendered to Non-Clinic 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 or any Group Physician 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 this Section 2. 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. **Clinic Services.** Contractor shall provide Professional Services in the Clinics (**"Clinic Services"**) a minimum of one (1) Half Day Clinic per week. For purposes of this Agreement, a **"Half-Day Clinic"** shall mean a minimum of four (4) hours per day in the Clinic providing Clinic Services and not simultaneously providing Coverage Services. Hospital shall pay to Contractor an amount equal to Three Hundred Twenty-Five Dollars ($325) per hour (**"Clinic Hourly Rate"**) for those Professional Services rendered by Group Physician under this Agreement; provided, however, that Contractor is in compliance with the terms and conditions of this Agreement.

(a) Hospital shall bill and collect for all Professional Services provided by Group Physician in the Clinic as set forth in Section 2.3; and

(b) If the Group Physician providing Clinic Services is simultaneously providing Coverage Services at Hospital, the Coverage Services Compensation shall be decreased by an amount equal to the Clinic Hourly Rate for each hour spent by such Group Physician in the Clinic providing Clinic Services.

5. **Director Services.** Hospital shall pay to Contractor the amount equal to three Two Hundred Fifty Dollars ($250) per hour for the provision of Director Services.

6. **Professional Liability Reimbursement.** In the event that Contractor does not purchase the professional liability insurance set forth in Article III of the Agreement, Hospital has the right to deduct a minimum of $16,198 annual premium contribution (e.g., calculated at Forty-Four Dollars and Thirty-Eight Cents ($44.38) per provider/per day worked), to reimburse Hospital for Hospital's payment of professional liability insurance premiums on behalf of Contractor; these amounts may also increase at a liquidated rate of 15% should Contractor and/or its' physicians fail to timely submit applications (e.g., including physicians FTEs and medical specialties), at the current quoted Beta Healthcare Group rates.

7. **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".