Emergency Room Coverage: What Every Neurosurgeon Should Know

Section on Neurotrauma and Critical Care
Dear Colleague:

Recent changes have taken place in federal regulations governing the delivery of trauma and emergency care. One in five neurosurgeons in the United States now receives stipends ranging from $500 to $1,500 per night for providing emergency room coverage at trauma centers.

The purpose of this mailing is to provide neurosurgeons with background information to facilitate the negotiation of such stipends with their hospitals.

In this packet, we include the following items:

1. Overview of neurosurgical contracts for trauma coverage.
2. Position statement from the American Association of Neurological Surgeons and Congress of Neurological Surgeons concerning emergency room coverage.
3. Background information regarding EMTALA.
4. Sample contracts.
5. Abbreviated list of CPT and ICD-9 codes for neurotrauma procedures.

The Trauma Section hopes this informational packet will make it easier for all neurosurgeons to provide the best possible care to neurotrauma patients.

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NEUROSURGICAL CONTRACTS WITH TRAUMA HOSPITALS
John McVicker, M.D.

In many communities, neurosurgeons are expected to take call as a condition of medical staff membership. Emergency Medical Treatment and Active Labor Act (EMTALA) regulations dictate that specialty availability on a hospital call schedule must extend to the hospital Emergency Department (ED), obligating medical staff to trauma call. As hospital systems expand, market, and in many cases profit from participation in trauma care delivery, the neurosurgeon's available time for reliably compensated elective activities diminishes. This situation is disproportionately worsened by there being comparatively fewer available neurosurgeons relative to other high-demand trauma specialists, such as orthopedic surgeons. Even though neurosurgery is a small specialty, 57% of all high-acuity trauma patients have some neurologic injury, and half of the 150,000 injury-related deaths that occur annually in the United States involve a serious brain injury that is primarily responsible for the patient’s demise [1]. Obviously, neurosurgical availability is key to the success of a trauma program. However, many neurosurgeons now opt out of taking ED call because they simply cannot afford the loss of time and revenue such a service entails [2].

Maintaining enthusiastic support for a trauma program by a medical staff is not an easy assignment for the average community hospital. Contractually agreed-upon call stipends are a reasonable way to assure adequate neurosurgical coverage by an institution that has made such a commitment. Contracts between trauma hospitals and neurosurgeons can guarantee neurosurgical call availability, as well as mandate neurosurgical participation in quality assurance, education, and protocol and program development, including trauma program outreach. Contracts improve the institution’s ability to meet EMTALA obligations, help assure the institution meets standards required for trauma center verification, and improve coordination among trauma specialists. In addition, the pending Balanced Budget Reform Act of 2000 includes a section (§204) that may allow hospitals to include on-call stipends in their hospital cost reports, which will provide the hospitals direct means of obtaining Medicare reimbursement for these expenses. Such contracts may provide the funds necessary to bring needed neurosurgical workforce to a community and may be the only way some neurosurgeons can afford to remain on a medical staff that requires participation in trauma.

Typical neurotrauma contracts include several sections. Hospital obligations should be spelled out regarding equipment requirements (CT, MRI, microscope, etc.), staffing requirements (ED, intensive care unit, operating room, 24-hour radiology, etc.), and transfer agreements with other hospitals. Transfer agreements are ideally worked out in the context of a state or regional trauma...
system and should include predefined criteria to avoid EMTALA violations. Unavoidable unavailability of the surgeon and any back-up call requirements, if necessary, should be addressed. Trauma Program requirements (trauma coordinator, secretarial support, etc.) are the hospital's responsibility. The contract should define neurosurgeon or neurosurgical group responsibilities such as frequency and duration of call and back-up availability, negotiated appropriate to trauma level, average acuity, trauma volume, and available workforce; no neurosurgeon should be expected to cover a trauma service beyond the limits of a safe and reasonable workload. The contract should spell out required committee involvement, anticipated protocol development and updating, and expectations for participation in medical and nursing staff education and trauma outreach programs. Reimbursement type, amount and methodology and whether the contract is with individuals or groups should be decided. Defining peer review and quality assurance parameters is of significant importance.

Most of the problems that a hospital may face if it enters into a contract for neurotrauma coverage and program development are more perceived than real. For example, the “snowball” effect of various other trauma specialties lining up for costly stipends has not materialized in hospitals that have instituted this practice for neurosurgery, with the exception of trauma surgeons or trauma anesthesiologists who are required to provide coverage in-house. On the other hand, specifically dangerous to the institution is any implication that a neurosurgeon who contracts for trauma coverage is compelled to bring elective work to the hospital. Major regulatory concerns have arisen over these anti-kickback “payment for referral” issues, and hospital systems have been made to pay considerable fines and have undergone substantial federal scrutiny for such schemes. Nevertheless, legal analysis suggests that physicians could expect fair market compensation for services that go beyond usual medical staff obligations. When limited workforce and high reliance on neurosurgical trauma services are factored in, it is apparent that neurotrauma coverage commonly demands more from the neurosurgeon than general emergency coverage does of the average medical staff member and is thus worthy of additional compensation at fair market value [1].

Estimating fair market value then becomes critical in structuring a fair neurotrauma contract. The best yardstick of this value in a community may be local or regional data as long as demographics, average Injury Severity Scores, and the like are comparable. These figures are difficult to come by, and large regional and demographic variability is likely to exist. National figures will reflect reimbursement methodology for similar institutions more broadly, but such data compilations are likewise not widely available. The Council of State Neurosurgical Societies (CSNS) has recently completed a national Internet survey on key socioeconomic parameters of emergency neurosurgery and neurotrauma. The survey was to address the national spectrum of contractual and practical agreements between neurosurgeons and the hospitals and systems in which they practice. Of the 263 respondents, 91% actively participated in
trauma, about half urban and half suburban or rural. Sixty-two percent of respondents were in private practice, 28% in academics, and 10% were salaried. Level 1 trauma centers accounted for 40% of the institutions, with Level 2 about 30%, and Level 3 and undesignated about 30%. About one in three respondents had a formal contract for neurotrauma coverage with their institution.

Compared to limited prior surveys [3,4], contractual arrangements with hospitals for the provision of neurotrauma care appear to be growing more prevalent. Nineteen percent of respondents in the CSNS survey were directly reimbursed for trauma call availability, and over 31% received some form of financial incentive to participate (see following paragraph). Call stipends were about twice as frequent in private and salaried practices (21%) as in academic practices (11%) and tended to be in a lower range (mode $500-1000) in academics and salaried positions than in private practice (mode $1000-1500). As a general rule, call coverage was more frequent, less likely to be reimbursed (or reimbursed at a lower rate), and more likely to be mandatory at Level 3 and undesignated trauma centers than at Level 1 or 2 centers. Over 75% of all respondents reported call coverage to be mandatory at their institution. Half the unreimbursed respondents reported trauma call to be disruptive to their practices “most of the time,” while about a third reported the same level of disruption if stipends were in place. Hence, stipends appear to allow a practice to adjust in part to the additional time and resources required to participate in trauma call.

Neurosurgeons and their hospitals have developed a variety of creative arrangements for making trauma coverage both fiscally and physically responsible. Smaller community hospitals with a limited number of neurosurgeons have worked out cross-coverage arrangements, periodic locum tenens, or temporary transfer agreements to shield their neurosurgeons from the burden of excessive call requirements. Hospitals may bill patients directly and reimburse a guaranteed percentage of the neurosurgeon’s trauma receivables or simply provide billing services for the neurosurgeon. Hospitals may supply on-campus office space to allow for ready neurosurgical availability. Since neurotrauma coverage is widely perceived as increasing exposure to medicolegal liability, some institutions have agreed to pay for additional malpractice coverage and, in some cases, cover the entire amount. "Neurotrauma Director" positions may be created for neurosurgeons most involved in program development, along with a negotiated annual consulting fee.

In summary, neurotrauma contracts can be a win-win situation for the neurosurgeon and the hospital. The hospital can reduce its EMTALA exposure, improve its performance in the trauma center verification process, and ensure neurosurgical participation in quality assurance and program development by supporting the concept of voluntary trauma contracts. For the neurosurgeon, these contracts help alleviate the double burden of providing mandatory uncompensated care even as reliably compensated elective practice is negatively impacted. Everyone negotiates for and knows what their agreed-upon responsibilities in the provision of trauma care will be, and excessive and
potentially unsafe workload on the neurosurgeon can be avoided. These legal agreements appear to be increasingly prevalent nationwide. Contractual relationships between neurotrauma centers and trauma neurosurgeons that include reimbursement for guaranteed availability will greatly facilitate neurosurgical participation in trauma care as they become common practice.

References:


POSITION STATEMENT

of the

American Association of Neurological Surgeons

and

Congress of Neurological Surgeons

IMPROVING ACCESS TO EMERGENCY NEUROSURGICAL SERVICES

BACKGROUND

The Emergency Medical Services (EMS) system is in the midst of a growing crisis because of a recognized shortage of on-call specialists. This problem extends to the provision of emergency neurosurgical care. Since neurosurgeons are a vital component of the EMS system, their active participation is essential. Reimbursing neurosurgeons for serving on-call to hospital emergency departments is therefore appropriate.

JUSTIFICATION

1. Within their capabilities, hospitals have a legal obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to provide screening and stabilization services to patients who come to emergency departments. As part of this obligation, hospitals are required to maintain a list of physicians who are on-call to treat patients in the emergency room and to ensure that on-call physicians respond when called.

2. Neurosurgeons have a variety of financial and contractual problems with managed care plans. In many instances, these contracts have no on-call arrangement, or require on-call availability without reimbursement, or have reimbursement rates that are extremely low. Because of these and other economic pressures, neurosurgeons are finding it increasingly difficult to subsidize emergency medical care through internal "cost-shifting," thus limiting their ability to subsidize their own on-call activities.

3. Neurosurgeons are faced with increased risks and liability when providing emergency care. Because of the seriousness of cases in the emergency medical setting and because of the lack of a pre-existing physician/patient relationship, neurosurgeons have a greater potential to be part of a medical malpractice action. In addition, neurosurgeons who provide on-call services must also comply with the mandates of EMTALA, subjecting them to potential fines of $50,000 for any violations of this complex law and regulations.

POSITION STATEMENT

To facilitate the availability of neurosurgeons for on-call services to hospital emergency departments, hospitals may provide neurosurgeons with reasonable compensation for serving on the on-call panel. This compensation should supplement any reimbursement the neurosurgeon receives for services rendered while serving on-call.
Neurosurgical Issues Regarding ED Call and EMTALA

Date: 3/26/01

To: Washington Committee

From: John A. Kusske, M.D.

Re: Neurosurgery Emergency Department Coverage

This report will summarize some of the issues that might be considered when the problem of emergency room coverage provided by neurosurgeons is discussed. A part of this discussion must relate to the emergency transfer laws as they apply specifically to the medical staff and physicians who serve on-call to the emergency department. Further, the lack of adequate neurosurgery coverage or back-up coverage in some hospital emergency departments (EDs) is also integrated into the theme of this statement, as well as payment of stipends for emergency neurosurgical care.

Medical Staff Obligations

1. **What are the obligations of medical staffs under the emergency transfer laws?**

   In most states medical staffs have a duty to consult with their hospitals in developing policies and transfer protocols. Medical staffs should work with their hospitals if they do not have these policies and transfer protocols. Also, in some states the protocols are to be submitted to the state agency regulating the hospitals.

   With respect to federal law, the Interpretive Guidelines set forth in Appendix V to the HCFA State Operations Manual (HSOM) provide that:¹

   > The medical staff bylaws or policies and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions. Interpretive Guidelines at Tag Number A404.

   In addition, the hospital (through the medical staff) must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. ²

   The AMA recommends that the medical staff should have a primary role in the development of educational materials and review sessions for physicians and hospital personnel to assure that they understand the on-call procedures and emergency transfer laws.

¹These guidelines do not have the force of law but are important because when HCFA surveyors investigate alleged violations of law, they use the Guidelines to decide whether an actual violation occurred.

²While the Interpretive Guidelines technically impose this requirement upon the hospital, given the fact that the self-governing medical staff is responsible for assuring patient care, active medical staff involvement is warranted here.
Physician Obligations to Serve On-Call

2. What are medical staff members’ obligations with respect to on-call coverage?

Neither federal nor any state law I know of affirmatively requires an individual physician to serve “on-call”. Rather, the responsibility to provide specialty medical coverage rests with the facility that offers emergency services. However, it is obviously the physicians on the medical staff who must provide the professional services. Thus, if the hospital and medical staff agree to maintain the emergency department, medical staff members, either voluntarily or through some other mechanism, will have to serve on-call.

Assuming that emergency services will continue to be provided, medical staffs and governing boards have considerable latitude to come up with creative and cooperative solutions to emergency coverage. Different medical staffs, different communities, even different departments within the same medical staff may address the issue in unique ways to deal with the unique characteristics of their situation. These might include, but are not limited to: (a) voluntary on-call coverage, (b) mandatory on-call coverage as a condition of medical staff membership, (c) contracting for on-call services (e.g., payment of stipends), (d) insurance coverage for on-call physicians, (e) compensation for some portion of the uncompensated care rendered by on-call physicians, and (f) “call sharing” arrangements with other hospitals. There is no need that the policy be uniform across all departments if such uniformity would result in unfair burdens to some specialists. Indeed, exceptions may be made even within a department or within the staff as a whole where that exception is reasonable.

3. What obligations does a physician have when he/she agrees to serve on-call?

Once a physician accepts on-call responsibilities, the physician must comply with the emergency transfer laws and may be liable for failure to do so. The laws prohibit an on-call physician from refusing to respond for any nonmedical reason.

Federal law is not as specific as some state laws regarding on-call responsibilities. However, federal law does require the hospital to maintain a list of physicians who are on call to provide stabilizing treatment to patients after the initial screening examination. (42 U.S.C. §1395cc(a)(1)(I).) The Interpretive Guidelines make it clear, however, that physicians, including specialists and subspecialists, are not required to be on-call at all times. Tag Number A4040. Nonetheless, the Guidelines continue:

The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. Id.

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4The Interpretive Guidelines provide that the purpose of this on-call list is to ensure that the emergency department is prospectively aware of which physicians are available to provide treatment necessary to stabilize individuals with emergency medical conditions. Tag Number A404.
Again, given the medical staff’s role in patient care, the medical staff should approve and be involved in the development of these policies.

HCFA’s Interpretive Guidelines provide additional information concerning on-call physicians’ rights and responsibilities. For example, according to HCFA:

- Physicians are not required to be on-call in their specialty or subspecialty for emergencies when they are visiting their own patients in a hospital.

- If a physician is on-call to provide emergency services or to consult with an emergency room physician in an area of his or her expertise, that physician would be considered to be available at the hospital.

- Where a physician is on-call in an office, it is not acceptable to refer emergency cases to the physician’s office for examination or treatment. The physician must come to the hospital to examine the patient unless the physician is in a hospital-owned facility on contiguous land or on the hospital campus.

- If a physician demonstrates a pattern of not arriving at the hospital while on call, but directs the patient to be transferred to another hospital where that physician can treat the patient, this may be a violation.

Tag Number A404

4. **What can physicians do to limit their risk of liability?**

It is essential that physicians who serve on-call take steps to protect themselves from the risk of liability. For example, it may be advisable to institute some sort of date- and time-specific roster of on-call coverage, such that there is no question as to which staff members are on-call and when. Because federal law requires a hospital to maintain a list of physicians who are on-call and to report physicians who do not respond when called, informal or ad hoc arrangements are no longer viable. Hospitals and medical staffs that are unable to provide this coverage may be forced to establish arrangements with other hospital(s) to share call, seek a reduction in scope of services, or eliminate their EDs.

**Mandatory On-Call Policies**

5. **Can a hospital medical staff with no particular on-call provisions in its bylaws force a physician to serve on a mandatory call list?**

Under most medical staff bylaws, a medical staff member agrees to be bound not only by the medical staff bylaws, rules and regulations, but also by all duly adopted policies of the medical staff. Therefore, if the medical staff adopts a policy calling for mandatory on-call service, a medical staff member will be bound by the policy. Policies that concern matters of controversy should be adopted by the medical staff acting as a whole, rather than solely by a committee, such as the Medical Executive Committee. If a medical staff committee adopts and attempts to enforce a mandatory on-call policy on its own, under most bylaws, any medical staff member (acting with others) may call for a special medical staff meeting, at which any policy may be revoked and/or a new policy may be considered for adoption by the entire medical staff.
6. Can a hospital medical staff include in its bylaws provisions that require a physician to serve on a mandatory call list?

Yes. If the bylaws are approved through the prescribed channels (generally through a vote of the medical staff membership and subject to governing body approval), then all medical staff members will be bound by the terms of the bylaws.

Other Coverage Options

7. Are there alternatives to a mandatory on-call policy?

Yes. Rather than attempt to institute unilaterally a mandatory on-call policy, the hospital should work with the medical staff toward a mutually acceptable solution. Careful consideration by both the medical staff and hospital should be given to all possible options, some of which were listed earlier in this document.

8. Recommendations Regarding Potential Lack of ED Backup

Recommendation 1—Hospital and Medical Staff Policies and Procedures. Hospitals and their medical staffs should have policies and procedures to assure that they fulfill their shared ethical responsibility for the provision of emergency care. These policies and procedures should be clearly delineated as part of the medical staff bylaws, or rules and regulations, and should contain appropriate mechanisms to assure performance. Policies should also assure that all participating physicians understand the medical screening, stabilization and transfer requirements of EMTALA, in order to improve compliance and minimize medical-legal risks. Medical staffs should be required to maintain a grievance system, e.g., the medical staff peer review or corrective action process, for resolution of disputes between EDs and on-call specialists over on-call specialty coverage. Medical staffs should adopt and enforce policies and procedures which delineate the circumstances under which a failure to respond or to come to the ED is justified, and alternatively, when and whether penalties are justified.

Recommendation 2—Contracting for On-Call Services. Hospitals and interested members of their medical staffs should be encouraged to develop, in compliance with applicable law, emergency service IPAs and consolidated billing and coding arrangements in communities where such arrangements may create economies of scale that are beneficial for the provision of ED on-call coverage. Consideration should be given to supporting legislation that would facilitate these arrangements.

Recommendation 3—Payment of Stipends and Other Incentives. Hospitals and their medical staffs should work together to develop incentives and compensation mechanisms that adequately reward physicians, both for the provision of emergency care and for their service in providing standby coverage for the community. Hospitals should pay stipends to on-call physicians who are required to provide care for a disproportionate number of Medicaid and uninsured patients. In addition, such stipends should be considered for certain specialties that are disproportionately burdened due to a scarcity of the specialty in the geographic area or due to excessive caseloads or intensity of services required. The medical staff should be actively involved in all decisions regarding stipends.
Recommendation 4—Payment Mandates for and Responsibility by Managed Care Plans and Insurers. All HMOs, IPAs, PPOs, and indemnity insurers should be required to pay directly for provision of emergency care, in accordance with the contracted rate with respect to emergency services provided by contracted physicians, or on a uniform RBRVS-based fee schedule for services provided by noncontracted physicians. A similar methodology should be used for the reimbursement of facility services. Each managed care and insurance entity should be required to set aside an emergency services reserve fund for these payment purposes. Funds could be maintained through withholds of total insurance premiums paid to plans by employers.

All interested parties should support ongoing legislative efforts to require payors to pay treble damages for unpaid or inappropriately paid claims, plus a 30% interest penalty for late payment. Moreover, physicians who provide emergency services should be educated as to their legal right to compensation for emergency care and should be empowered to obtain redress through civil and regulatory means.
Enclosed are two sample contracts. Comparing their similarities and differences is very interesting. As you can see, each contract has been tailored to address the specific concerns of the neurosurgeons at that particular facility. Also note that separate contracts exist: one for the group to provide neurotrauma services, and another for an individual neurosurgeon to be the “Neurotrauma Director”.

Please keep in mind that a contract which demands more of a neurosurgeon’s time and effort should stipulate more reimbursement than a contract that requires a smaller commitment.

These examples are provided only as educational and informational items. The AANS/CNS Section on Neurotrauma and Critical Care recommends that any neurosurgeons who are considering entering into similar agreements with their hospitals seek professional legal advice.
SAMPLE CONTRACT #1
This agreement is attached to, made a part of and executed simultaneously with that certain Professional Services Agreement between the undersigned, dated ................

EXCLUSIVE 24-hour neurosurgery coverage for the Facility Emergency Department and Trauma Program shall be provided by Contractor on a 24-hour-per-day, 7-day-per-week basis, in accordance with such schedules as may be determined by the Neurosurgery Program Medical Director or his designee from time to time. This 24-hour neurosurgery coverage shall be for neurosurgery services required by Facility, its Emergency Department, Trauma Program (appropriate for Facility’s Trauma designation) and inpatient and outpatient patient care needs.

Contractor agrees to the following criteria:

1. In conjunction with the Facility’s Medical Staff Office and Administration, Contractor shall have exclusive and sole duty to establish and manage a monthly neurosurgery call schedule for the Facility’s Emergency Department and Trauma Program (appropriate to Facility’s Trauma designation). Contractor, in addition to a reliable call schedule, shall have a formally arranged contingency plan in the event the capability of the neurosurgeon, Facility or system to care for neurotrauma is overwhelmed.

2. **24-hour Neurosurgery Coverage**- Contractor will guarantee 100% 24-hour neurosurgery coverage of the Facility’s Emergency Department and Trauma Program appropriate to Facility’s Trauma designation and assume any call coverage should scheduled physicians fail to meet their obligations. Contractor’s failure to provide 100% neurosurgery coverage to the Facility’s Emergency Department and Trauma Program (appropriate to Facility’s Trauma designation) will be considered a material breach of this agreement and at Facility’s sole discretion may result in default of this agreement.

3. **One-Institution Requirement**- Contractor agrees that physicians on-call may cover only one (1) institution and, at a minimum, must be of commensurate experience and training as those on staff.

4. **Neurosurgery Qualifications**- Contractor shall provide physicians Board-certified or eligible in the American Board of Neurological Surgery or other equivalent board as determined by the Facility Medical Staff credentialling process.

   a. Education- Contractor shall provide neurosurgeons that have an interest in and a commitment to emergency medicine and trauma care.
5. **Clinical Care Parameters**: Contractor agrees that neurosurgeons taking neurotrauma and neurosurgical call shall recognize and adhere to the protocols of FACILITY and the standards of the community. Further, neurosurgeons will participate as appropriate in the organization of trauma protocols, trauma teams, and trauma rounds.

6. **Medical Staff Policies and Procedures**: Contractor agrees to meet all appropriate Medical Staff Policies and Procedures, including timely response to the Emergency Department as outlined in the Medical Staff Emergency Department Call Lists, Policies and Procedures.

7. **Regulatory Requirements and American College of Surgeons Committee on Trauma (ACS COT) Guidelines**: Contractor agrees to meet all appropriate State Trauma Regulations and American College of Surgeons Committee on Trauma Guidelines appropriate to neurotrauma patients, including timely response to the Facility. Contractor agrees to meet requirements outlined in the ACS COT’s *Resources for Optimal Care of the Injured Patient*.

8. **Follow-up Visits**: Contractor agrees to provide the requisite number of follow-up visits required post-hospitalization to Emergency Department and Trauma program patients.

**Call Availability**
Contractor shall require neurosurgeons meet the *On-Call and Promptly Available on Short Notice* requirements of the State and ACS COT. A neurosurgeon must be promptly and continuously available to provide neurotrauma care for severe head and spinal cord injuries, as well as less severe head and spinal cord injuries. **See Neurosurgery Timeliness Response Requirements (PART C).**

**Call Schedule Notification Requirements**

- **Month=s Call Schedule Advance Notice**: Contractor shall provide a Monthly Call schedule to the Facility=s Administration, Medical Staff Office, Emergency Department, and Trauma Service Coordinator prior to the beginning of each month.

- **Revisions & Changes**: Contractor shall contact the Medical Staff Office and Emergency Department with any revisions or changes during the month as required by the facility=s Medical Staff Rules & Regulations and Policies and Procedures.

- **Final Revised Call Schedule**: Contractor shall provide at the end of each month a revised copy of the Call Schedule including all revisions and changes made during the month for Facility=s records for regulatory compliance.
**Neurotrauma Patient Protocol Development**

1. Contractor shall **advise and consult** Facility in developing appropriate protocols to assist in the care of the neurotrauma patient throughout the continuum of care.

2. Contractor shall actively set and monitor the triage criteria for head and spinal cord injury.

**Trauma Program Development**

1. Contractor shall **reasonably advise and consult** in developing and enhancing ............. image as a Trauma Designated Facility with a Neurotrauma program.

2. Contractor shall **reasonably advise and consult** in establishing an integrated credible Neurotrauma Program with Facility Medical Staff in Metro........

3. Contractor shall **reasonably advise and consult** Facility Administration and Facility Trauma Service in developing its trauma center status and image to its full potential.

4. Contractor shall **reasonably advise and consult** Facility Administration and Facility Trauma Service in developing a comprehensive and Integrated Trauma Service that serves the needs of the community.

5. Contractor shall oversee the management of neurotrauma care at ..... This includes meeting with the appropriate Medical Directors, Nursing Directors and other Directors as necessary.

6. Marketing Commitment- Work with staff to conduct a **reasonable amount of** trauma patient outreach and marketing.

7. Contractor shall **reasonably advise and consult** Facility Administration and Facility Trauma Service in developing and participating in an effective and collaborative injury prevention program.

**Verification/Consultation Program Involvement**

1. Contractor shall assist Facility in any verification/consultation process to evaluate and improve the Trauma Care Program and its designation.

2. Contractor shall be involved in the preparation for and the actual on-site visit of consultants to review Facility=s capability in trauma and the care of patients.

3. Contractor shall be involved in any COT consultation, including but not limited to, pre-review meetings and on-site review.

**Public Education and Professional Education**

1. **Public Education**- Contractor, as reasonably requested, shall assist Facility in educating the public about injury as a significant disease and public health problem.

2. **Professional Education/Inservices**- Contractor shall, as reasonably requested by Facility, participate and assist in neurotrauma educational in-service training activities associated with Facility=s Medical Staff, nursing staff and emergency medical services staff.

**Quality Improvement**- Contractor shall participate in quality improvement activities and other neurosurgery service activities as appropriate.
Committee Participation - Contractor and representatives shall, as reasonably requested by Facility Administration or designee, participate in various Facility committees. This shall include at a minimum the Facility Trauma Multidisciplinary Committee and any appropriate Peer Review Committee.

Additional Duties
1. Act as a liaison between Medical Staff, nursing staff, and Facility Administration in matters regarding the Neurosurgery Section.
2. Ensure that any contract, corporation or association internal policies or disgruntlement, etc., within the Contractor group shall not interfere with Contractors’ performance of its obligations under this Agreement.
3. **Do that which is reasonable to assist in creating a positive reputation and relationship between the Facility and the community with a sensitivity to patient satisfaction and public relations of Contractor services.**
4. Contractor shall cooperate with other Contractors and with physicians from all other specialties, including anesthesia, trauma surgery, the Emergency Department, contracting physicians, as well as Facility nursing and ancillary staff to provide a cohesive and coordinated neurosurgery and trauma team to maintain the Level II or Level III designation or such other designations as determined by Facility.

CONTRACTOR:  
FACILITY/Hospital:  
LLC d/b/a/ The Medical Center.

________________________________________   By:
Chief Executive Officer, as VP of Facility

________________________________________   By:
Facility Ethics & Compliance Officer
PART B

FACILITY OBLIGATIONS TO NEUROTRAUMA AND NEUROSURGERY CALL COVERAGE

Facility is obligated to provide the following items to assist Contractor in meeting obligations to care for neurotrauma and neurosurgical patients in the Facility.

Facility commits to meeting or exceeding State regulatory and ACS COT requirements appropriate for the Facility’s Trauma designation. Further, Facility commits to attaining the optimal patient outcome and the timely availability of healthcare professionals who are dedicated to providing medical care to the injured patient. Specifically, Facility commits to the following items:

Radiology/Diagnostic Imaging

CT Availability - Facility is obligated to make available 24-hour in-house CT personnel.

MRI Availability - Facility is obligated to provide 24-hour On-Call availability of MRI personnel.

Interventional Radiology Availability - Facility is obligated to provide 24-hour On-Call availability of interventional radiology personnel.

Radiologist Availability - Facility is obligated at a minimum to have 24-hour On-Call availability.

Operating Room

OR Trauma Team Availability - Facility is obligated to make available 24-hour in-house OR Surgical Team personnel. This team shall consist of a minimum of one (1) RN, one (1) scrub tech, one (1) Nursing Assistant. Facility is obligated to provide for an additional On-Call OR Surgical Team. Facility shall also make available Evoked Potential technicians.

Neurosurgery & Trauma Surgery OR Clinical Coordinator - Facility is obligated to provide one (1) RN designated as the Neurosurgery & Trauma Surgery OR Clinical Coordinator. Such individual shall be selected with the input of Contractor and Facility’s trauma surgeons, administration and administration’s designees.

Equipment - Facility is obligated to provide such equipment that may be reasonably expected to be available at a community-based neurosurgical program. Contractor shall assist Facility in assessing its present situation and recommending appropriate additions. Such equipment shall include but is not limited to:

- Craniotomy sets and appropriate drills
- Microscopes based upon utilization
- Appropriate surgical tables based upon utilization
Additional Personnel

Neurosurgery Clinical Educator- Facility is obligated to provide one (1) RN designated as the Neurosurgery Clinical Specialist in addition to its present Clinical Educator complement. Such individual shall be selected with the input of Contractor and Facility's trauma surgeons, administration and administration designees. This Neurosurgery Clinical Specialist works to promote the optimal care for the neurotrauma and neurosurgical patient through the entire continuum of care including the clinical program, administrative functions and professional and public education. This Clinical educator shall also assist in acting as a liaison between the Contractor and the Facility where appropriate.

Additional Equipment

Intracranial Pressure Monitors- Facility is obligated to provide a minimum of three ICP monitors and more as appropriate.
PART C
NEUROSURGERY TIMELINESS GUIDELINES

On-Call Response
Contractor shall be obligated, but not limited, to meet the following guidelines as a definition of timely response:

Contractor and its subcontractors are required to meet the timeliness requirements of the Facility Medical Staff Rules & Regulations and Policies and Procedures, the State Trauma Regulations and the American College of Surgeons Committee on Trauma (ACS COT).

In providing call for 24-hour Neurosurgery Coverage, Contractor must respond within 10 minutes to all calls or pages concerning neurosurgery patients and be present within a mutually acceptable time frame that shall be decided by the Trauma Surgeon (or the Emergency Department physician) and by the covering neurosurgeon.

Additional appropriate time frames for presentment may be determined by Facility Medical Staff Rules & Regulations and Policies and Procedures, State Trauma Regulations or ACS COT or as mutually agreed upon by Facility and Contractor.

The On-Call Neurosurgeon shall actively participate in the ongoing resuscitation, monitoring and treatment of the neurotrauma patient.

Additional guidelines may be amended to these requirements as changes are implemented to the Medical Staff Rules & Regulations and Policies and Procedures, the State Trauma Regulations, and the ACS COT requirements.

Operative Procedure Timeliness- The time from ED arrival to operative procedure shall be determined by Trauma Service Protocols.

CONTRACTOR: FACILITY/Hospital:
LLC d/b/a/ The Medical Center..

______________________________  By:____________________________________
Chief Executive Officer, as VP of Facility

By:_____________________________________
Facility Ethics & Compliance Officer
PART D
NEUROSURGERY PROGRAM DEVELOPMENT

Program Goal- Develop a well established Neurosurgery Program as a business unit to meet the needs of the Facility and the community it serves in a cost-effective manner. Contractor shall participate in implementing and developing a community-based neurosurgery program. Functions shall include participating in, but are not limited to:

$ directing and overseeing the delivery of patient care services to the Facility=s neurotrauma and neurosurgical patient population.
$ establishing policies and procedures.
$ reviewing process issues.
$ developing, with Facility Quality Management Department and Medical Staff committees, innovative care management programs for the neurotrauma and neurosurgical patient population.
$ developing a cost-effective program that is in line with the Facility=s overall objectives and goals.
$ developing and enhancing Facility=s image as a Facility with a Neurosurgery program.
$ reviewing and analyzing neurosurgery data for program evaluation and utilization.

Clinical Leadership
1. Contractor shall provide clinical leadership to the Facility=s Neurosurgery Program and work with Facility medical staff, Administration and management team to meet the needs of its community and organization goals and objectives.

Community-based Neurosurgery Program
1. Develop a group practice organization that will support long-term participation by well qualified neurosurgeons and establish an integrated and credible Neurosurgery Program with the Facility Medical Staff, ..... Health System and metro-healthcare community.
2. Develop a core group of neurosurgeons who provide care in a collaborative manner at Facility and in the community.
3. Scope of Program- Enhance the breadth and scope of patient care provided to meet the needs of both the Neurosurgery Program and the Trauma Center and support an appropriate number of neurosurgeons in the community of......
4. On-Site Availability- Contractor shall make available on-site in a practice setting in (city) two (2) neurosurgery physicians every business day during normal business hours. Business hours shall be reasonably defined by Contractor. (On-site shall be defined as any of Facility=s campuses or property contiguous to Facility=s campuses.)
$ Contractor shall specifically make available to The Medical Center of.... development and implementation of a Neurosurgery Program for year ONE of the contract.
**Marketing Commitment**
1. Contractor shall work with Facility Administration and Trauma Program to market Neurosurgery Program to Medical Staff and community.

**Neurosurgical Patient Care Protocol Development and Clinical Involvement**
1. Contractor shall advise and consult with Facility in developing appropriate protocols to assist in the care of the neurosurgical patient through the continuum of care.
2. Reasonably advise and consult in developing protocols, treatment plans and tools to assess patients and patient care goals and to identify outcomes.

**Personnel and Resources**
1. Contractor shall assist Facility in identifying personnel and resources as needed to provide for care of the neurosurgical patient through the continuum of care.

**Professional Education**
1. **Professional Education/Inservices**—Contractor shall, as reasonably requested by Facility, participate and assist in neurosurgery educational in-service training activities associated with Facility’s Medical Staff, nursing staff and emergency medical services staff.

**Committee Participation**
1. Contractor and representatives shall participate in various Facility committees as reasonably requested by Facility Administration or designee. This shall include at a minimum the Facility Peer Review Committee and the Medical Records Review Committee as requested by Facility Administration.

**Additional Responsibilities**
1. **Situational Assessment—Participates, advises and consults** in the development of a plan of care for the neurosurgical patient through an interdisciplinary team process in conjunction with the patient and family in internal and external settings.
   $ On a concurrent basis, assess the appropriateness of the level of neurosurgical care; diagnostic testing and clinical procedures; quality and clinical risk issues and documentation of medical record completeness.
2. **Reasonably advise and consult** in systematically implementing and evaluating opportunities for program improvement, including clinical pathways, protocols, and other mechanisms to improve patient outcomes.
3. **Reasonably advise and consult** in assessing, identifying and communicating cost-effective alternative delivery methods based on the neurotrauma and neurosurgical patient population and individual patient’s clinical and functional status.
4. **Reasonably advise and consult** in designing and reviewing quality monitoring activities in association with the Emergency Department, Trauma Program, Perioperative Services and the Quality Management Department.
5. **Reasonably advise and consult** in identifying and addressing suspected problems of over- or underutilization or inappropriate scheduling of services and bringing issues to the attention of the appropriate Facility designee such as Director of Quality Management, Director of Perioperative Services, or Trauma Medical Director.

6. Advise and consult with Facility Administration regarding staffing needs, assignment of personnel, and scheduling of personnel in the appropriate departments.

7. **Reasonably advise and consult** in the budgeting process and control of resources of the appropriate departments in accordance with Facility policy.

8. Act as a liaison between Medical Staff, nursing staff, and Facility Administration in matters regarding the Neurosurgery Section.

9. **Reasonably ensure a positive reputation and relationship between the Facility and the community with a sensitivity to patient satisfaction and public relations of Contractor services.**

10. Contractor shall, **as reasonably requested by Facility**, participate in **Facility-designated** community programs to promote patient care at the Facility.

**CONTRACTOR:**

**FACILITY/Hospital:**

LLC d/b/a/ The Medical Center.

____________________________

By:__________________________

Chief Executive Officer, as VP of Facility

By:__________________________

Facility Ethics & Compliance Officer
PART E
NEUROSURGICAL COVERAGE

$...... a day not to exceed $....... a year for 24-hour neurosurgical coverage as outlined in PART A.

Additionally, in Year ONE Facility shall pay contractor $.... a month not to exceed $.... a year for the maintenance of the Neurosurgical Call schedule.

Initial Fee of $..... shall be paid in the first month of the agreement for the initial development of the Neurosurgical Call schedule.

CONTRACTOR: FACILITY/Hospital:
LLC d/b/a/ The Medical Center..

____________________________  By:____________________________________
Chief Executive Officer, as VP of Facility

By:____________________________
Facility Ethics & Compliance Officer
PART F
REIMBURSEMENT FOR NEUROTRAUMA OR TRAUMA

Trauma-Related Continuing Medical Education: The Employer will pay and/or reimburse the Contractor \textbf{up to $... per year per Physician} expended in connection with the physician attending medical conventions and/or reasonable continuing medical education seminars, including travel, lodging and meals.

CONTRACTOR: FACILITY/Hospital:

____________________________  By:____________________________________

Chief Executive Officer, as VP of Facility

____________________________

Facility Ethics & Compliance Officer
This addendum is attached to, made a part of and executed simultaneously with that certain Professional Services Agreement between the undersigned, dated the ...... day of ...., .....  

NOW, THEREFORE, in consideration of the agreement herein contained and for the good and valuable consideration, the parties hereto agree as follows: 

Role Summary

The Role of the Medical Director is to assist in designing, implementing, and enhancing systems that support the development of a complete, comprehensive community-based neurosurgery program. 

The Medical Center of ........ Neurosurgery Medical Director is responsible for the medical management of the Neurosurgery program at ...... He/she must support the philosophy of the system by maintaining the dignity of the individual, enhancing the quality of human life, and providing our patients with the best medical care possible. 

.... Neurosurgery Medical Director represents the Neurosurgery Section at departmental meetings and reports to the Surgery Committees on programmatic issues. ..... Neurosurgery Medical Director works with .... Trauma Medical Director and closely with the Medical Directors of Emergency Medical Services. 

Participation in the clinical activities of the Neurosurgery Services is integral to the successful completion of the responsibilities listed below. 

Responsibilities

Clinical Operations

1. Oversees daily operations of Neurosurgery-related activity at ..., including the OR, ICU, ED, EMS, and Radiology. 

2. Serves as facility Neurosurgery Medical Director at .... 

3. Takes Neurosurgery call in scheduled rotation. 

4. Provides relief Neurosurgery coverage for Neurosurgeons during weekday hours as mutually established with Administration and the Neurosurgery Surgeons. 

5. Organizes teams of physicians from appropriate medical and surgical specialties at ..... to provide the necessary clinical services for Neurosurgery patients.
6. Participates in Neurosurgery-related clinical rounds within the System.

7. Assists in the coordination with appropriate heads of nursing and ancillary departments in defining the necessary nursing and support services required for the Neurosurgery program, and works with system administration and medical/nursing staff to implement these services.

8. Works with the department of Emergency Medical Services and Trauma to ensure appropriate communication of Neurosurgery education, policy, and protocol to all hospital departments and EMS agencies.

**Service Operations**

1. Evaluates participation, contributions and performance of attending Neurosurgeons.

2. Assigns responsibilities to other Neurosurgeons as appropriate.

3. Appoints appropriate designees and collaborates in the completion of Neurosurgery rotation and call schedules.

4. Recommends policies governing the operation of the Neurosurgery Service.

5. Directs and collaborates in the preparation of patient cases for Neurosurgery morbidity and mortality conferences.

6. Provides feedback to outreach hospitals/physicians as appropriate.

**Maintenance of Trauma Center Status**

1. Assists in directing ...... Neurosurgery administrative staff in organizing, directing, and maintaining the Neurosurgery program to meet criteria for Trauma designations as outlined by the American College of Surgeons and the State Trauma Committee. The services must also meet requirements of the Joint Commission on Accreditation of Healthcare Organizations.

2. Assists in the preparation of the application for the ...... Trauma Center verification process through ...... or whatever means the state has in place at time of reverification of Trauma Center Designation.

3. Participates in the design and implementation of future programs relating to Neurosurgery activities including but not limited to:
   a. Outreach programs
   b. Upgrading Trauma Center designations
   c. Networking with affiliated hospitals
Committee Responsibilities

1. Represents Neurosurgery at the Trauma Committee, which has the responsibility for patient care protocols, quality assurance, morbidity and mortality, peer review, and evaluation of performance of the Neurosurgeons in compliance with the policies of the Neurosurgery Section.

2. Serves on the following committees and attends the following meetings as appropriate:
   a. Trauma and/or Neurosurgery Service Conferences
   b. Trauma and/or Neurosurgeon’s Education Conference
   c. Trauma Quality Assurance Committees
   d. Morbidity and Mortality Conferences
   e. Critical Care Committees
   f. Trauma and/or Neurosurgery Systems Meetings
   g. Surgery Committees
   h. Medical Executive Committee as appropriate
   i. Department of Surgery Meetings

Hospital Operations

1. Assists and participates with the Trauma Clinical Coordinator and Neurosurgery Clinical Specialist and other hospital personnel in conducting the necessary quality assurance activities to ensure the proper functioning of the ..... program. Participates in initial QA review as requested by the Trauma Clinical Coordinator and Neurosurgery Clinical Specialist.

2. Assists the Trauma Clinical Coordinator and Neurosurgery Clinical Specialist in complying with and maintaining Trauma registry reporting requirements.

3. Provides input to Administration for the operating and capital budget needs of the Neurosurgery section.

4. Provides input to Administration in the selection of Neurosurgery OR staff members.

5. Provides input to Administration for the annual performance appraisal for Neurosurgery OR staff members.

6. Meets with the Trauma Clinical Coordinator and Neurosurgery Clinical Specialist to update the status of the service activities, agendas, QA review, registry, etc.

7. Meets at least biweekly with the Trauma Medical Director to discuss the status of the service activities, issues, solutions, etc.

8. Assists in the preparation of reports as requested by Administration.
Community and Liaison

1. Maintains and supports inservice and community outreach programs related to care of the Neurosurgery patient for medical, nursing, and EMS communities, as well as nonmedical personnel.

2. Provides consultation on Neurosurgery care and Neurosurgery Service development to outreach areas as requested by Administration.

3. Maintains liaison with local EMS agencies through appropriate committee participation.

4. Maintains liaison with other Neurosurgery Centers in the State through participation in the ..... Trauma Institute, conferences and meetings.

Education and Research

1. Assists in the review of data through the Trauma Registry program in accordance with national and local standards. Where appropriate, participates in recognized statistical analysis programs.

2. Assesses desirability/need for formal or informal research program. Supports requests for data acquisition and analysis.

3. Directs program development for...... Neurosurgery Team member education.

4. Participates in other education programs.

Qualifications

1. Licensed to practice medicine in the State of ..... 

2. Board certified by the American Board of Neurological Surgery.

3. Training in accredited Neurosurgery program and/or extensive documented experience in the care of Neurosurgery patients.

4. ACS membership, experience in management, research and teaching desirable.

5. Member of the Medical Staff of the system hospitals.
IN WITNESS WHEREOF, the duly authorized offices of the parties have executed this AMENDMENT, as of the respective dates written below.

**CONTRACTOR:**

By: ______________________________

Chief Executive Officer, as VP of Facility

By: ______________________________

Facility Ethics & Compliance Officer

**FACILITY/Hospital:**

LLC d/b/a/ The Medical Center..
SAMPLE CONTRACT #2
PROFESSIONAL NEUROSURGICAL TRAUMA SERVICES AGREEMENT

THIS PROFESSIONAL NEUROSURGICAL TRAUMA SERVICES AGREEMENT (this “Agreement”) is entered into and effective ........... 20... (the “Effective Date”), by and between ......................................... and .......... NEUROSURGERY ASSOCIATES, P.A., a (state) professional corporation (“Group”).

Background Statement

Hospital’s constant objectives are to improve the quality of patient care; to utilize Hospital’s facilities, equipment and employees efficiently and effectively; and to minimize the costs of medical care. In pursuit of these objectives in the area of neurosurgical trauma services, Hospital desires to secure the services of a group of qualified physicians to provide certain professional services and medical supervision and direction for Hospital’s Trauma Service (the “Trauma Service”). Group employs physicians who are qualified by virtue of background, education, training and experience to provide professional neurosurgical trauma services and medical supervision and direction for the Trauma Service (the “Specialists”).

Statement of Agreement

NOW, THEREFORE, in consideration of the mutual promises contained in this Agreement, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. Term and Renewal. The initial term of this Agreement shall begin on ......, 20.., and shall end at midnight on ........., 20.. (the “Initial Term”). After the Initial Term, this Agreement shall automatically renew for successive two (2) year terms (each, a “Renewal Term”), unless either party gives the other party at least twelve (12) months written notice prior to the end of the Initial Term, or the then current Renewal Term, of its intention not to renew this Agreement. Any such written notice shall specify the reason for nonrenewal. The Initial Term and the Renewal Terms, if any, shall be referred to herein as the “Term”.

2. Services of Group. Group agrees to assume the following responsibilities and perform the following duties:

   (a) Provide Specialists who are employees of Group and are listed on Exhibit A attached hereto as neurosurgery attending physicians to Hospital to provide the following professional neurosurgical trauma services (the “Neurosurgical Trauma Services”) to patients of the Trauma Service:

   (i) Consultation, evaluation, admission, treatment and neurosurgery services for any Trauma Service patient during such patient’s initial hospitalization;

   (ii) Neurosurgery for any patient originally admitted to Hospital as a Trauma Service patient who is readmitted to Hospital within the post-operative global fee period;

   (iii) Neurosurgical outpatient follow-up care provided to Trauma Service patients upon discharge from Hospital; and
(iv) Other neurosurgical inpatient or outpatient treatment related to the traumatic injury of a Trauma Service patient.

As used herein, Neurosurgical Trauma Services means those services customarily provided by neurosurgeons in tertiary care institutions in the United States, and includes without limitation the application and insertion of any invasive cranial monitoring. The Trauma Service attending physician (the “Trauma Attending”) or the Trauma Service chief resident shall notify Specialists when a patient of the Trauma Service requires Neurosurgical Trauma Services. If at any time Group or any Specialist determines in good faith that the Trauma Attending has requested Neurosurgical Trauma Services inappropriately or has failed to request Neurosurgical Trauma Services when necessary, then upon Group’s request, the Hospital’s Trauma Services Director shall work cooperatively with Group to assure that Group’s services are appropriately utilized under this Agreement.

(b) Provide Neurosurgical Trauma Services twenty-four (24) hours a day, seven (7) days per week, and provide to Hospital a back-up call schedule at all times.

(c) Cause Specialist(s) to be present for any neurosurgery performed on Trauma Service patients and to attend in the operating room and in the perioperative period when neurosurgical care is being provided to patients requiring neurosurgical care.

(d) Cause Specialists to adhere to all policies and procedures required to maintain Hospital’s accreditation as a Level I Trauma Center by the State of ............ as specified in this Agreement and in the criteria of the American College of Surgeons, including Specialist response within thirty (30) minutes of notification by the Trauma Service attending physician, or such physician’s designee, as required by the ..... Administrative Code for Level I Trauma Center Criteria.

(e) Cause Specialists to cooperate with the Trauma Service attending physician to coordinate all calls regarding the acceptance and transfer of patients meeting multiple trauma criteria.

(f) Cause Specialists to respond promptly in writing to all requests from Hospital’s Trauma Outcomes Committees, both pediatric and adult, which are responsible for Trauma Service Quality Assurance; and cause at least one (1) Specialist to be in attendance at not less than seventy-five percent (75%) of the meetings of such Trauma Outcomes Committees.

(g) Require the Specialists, while providing Neurosurgical Trauma Services hereunder, (i) to permit physician residents from the Hospital’s Residency Training Programs to observe and receive instruction from Specialists within the normal course of Specialists’ provision of clinical care; and (ii) to participate in clinical research studies mutually agreed upon by Hospital and Group and, if required, approved by Hospital’s Institutional Review Board. Group recognizes and acknowledges that the treatment of patients admitted to the Trauma Service is an integral aspect of Hospital’s Residency Training Programs and clinical research activities.

(h) Require each Specialist to maintain continuing medical education (“CME”) in trauma surgery, which CME shall include the equivalent of sixteen (16) CME credits each year in trauma-related topics. Each year Group shall submit to Hospital documentation evidencing each Specialist’s CME credits for such year. Group shall cause at
least one (1) Specialist to be in attendance at not less than fifty percent (50%) of the monthly multidisciplinary trauma conferences offered each year by Hospital and to report to the other Specialists regarding each such conference that a Specialist attends.

(i) Instruct and cause the Specialists to comply with the following: (i) Medical Staff (as defined below) rules, regulations and policies; (ii) rules, regulations and policies of various accreditation and governmental agencies applicable to Hospital or to the Trauma Service; (iii) and applicable state and federal laws and regulations, as they may be amended from time to time in providing Neurosurgical Trauma Services hereunder. Group shall also ensure that each of its employees providing services under this Agreement to or at Hospital complies with the professional ethics and standards of conduct required by relevant State Licensing Boards and of his or her professional organization.

(j) Cooperate with the Hospital’s Trauma Services Director, or his designee, and provide input to such Trauma Services Director with respect to the clinical management and triage of patients requiring Neurosurgical Trauma Services. Through such cooperation, Hospital and Group desire to achieve an allocation of available beds, services and resources that most effectively utilizes the facilities available to Hospital.

3. Additional Agreements and Covenants of Group. Group shall neither hire any person to provide services under this Agreement or to work on Hospital’s premises nor hire any person as a Hospital employee without the prior written approval of the Senior Vice President/Chief Operating Officer of Hospital. Notwithstanding the foregoing, nothing in this Agreement shall be construed to restrict Group’s right or ability to hire Group employees. Group hereby represents, warrants, covenants and agrees that no individual provided at any time to Hospital under this Agreement shall have been (i) convicted of a criminal offense related to healthcare; or (ii) debarred or excluded from Federal program participation.

4. Qualifications of Specialists. Each Specialist assigned by Group to provide services pursuant to this Agreement shall at all times:

(a) have a valid and unrestricted license to practice medicine in the State of .......

(b) be certified by the American Board of Neurological Surgery (the “Board”), or be eligible for certification by the Board at the time Specialist begins providing services hereunder and within three (3) years of such time and at all times thereafter be certified by the Board; provided, however, that if the Board delays administering the examination for certification for any reason unrelated to the qualifications of Specialist, and as a result Specialist is not certified within the three (3) year period required hereunder, then such time period shall be extended for the same period of time as the delay by the Board;

(c) maintain in good standing active membership and clinical privileges on Hospital’s Medical and Dental Staff (the “Medical Staff”) and Hospital’s Department of Neurosurgery (the “Department”) in accordance with the Medical Staff Bylaws;

(d) comply with the bylaws, rules and regulations, policies, procedures and directives of Hospital and the Medical Staff; and
(e) have a current narcotics license and number issued by the appropriate governmental agency or agencies.

If at any time any Specialist fails to meet any of the above requirements, Hospital shall provide written notice to Group of such failure, specifying the requirement(s) that the Specialist failed to meet. Group shall, upon receipt of such notice, promptly, and in any event within a period of five (5) business days following receipt of such notice, suspend such Specialist from all duties on the Trauma Service pursuant to this Agreement and provide an interim Specialist who meets the above requirements as soon as reasonably possible, or impose such other restrictions as may be reasonably approved by Hospital.

5. **Duties of the Hospital**

(a) Hospital shall make available to Group such space, facilities, supplies, materials, equipment and utilities as are reasonably available or attainable, adequate and appropriate to enable Group and the Specialists to perform those services required under this Agreement. Commencing January 1, 200..., Hospital shall make available to Group a Neurosurgical Trauma Services operating room daily between the hours of 1:00 P.M. and 8:00 P.M. standard time; provided, however, that Group assist Hospital to recruit and retain adequate and appropriate personnel, not currently employed at Hospital or any other hospital owned or operated by..., to staff such operating room during such time period. If at any time Group determines in good faith that the Hospital is failing to satisfy the requirements of the foregoing sentences, then upon Group’s request, the Senior Vice President/Chief Operating Officer of Hospital shall meet with Group to discuss Hospital’s performance under this Agreement.

(b) Hospital shall provide Group adequate and timely documentation of Hospital’s services provided to patients of the Trauma Service necessary to enable Group to conduct its billing and collection operations for professional fees. Hospital agrees to provide the Specialists with access to Hospital’s dictation system.

(c) The Hospital’s Trauma Services Director, or his designee, shall cooperate with Group while providing, and shall solicit Group’s input regarding, the clinical management and triage of patients requiring Neurosurgical Trauma Services. Through such cooperation, Hospital and Group desire to achieve an efficient allocation of available beds, services and resources that most effectively utilizes the facilities available to Hospital. The parties hereto anticipate that Group will designate Specialist(s) to serve in the yet-to-be-defined role of Neurosurgical Trauma Services Triage Director. Hospital, Group and the Hospital’s Trauma Services Director will initiate immediate efforts to define and implement this role during the Term of this Agreement.

6. **Compensation.** As consideration for the services of Group provided hereunder, Hospital shall pay Group the compensation described in Exhibit B attached hereto. Group shall have the sole responsibility for compensating Specialists and other employees of the Group.

7. **Medical Records**

(a) Group shall, and shall require each Specialist to, maintain complete medical records relating to its responsibilities under this Agreement in compliance with the
applicable requirements of the Medical Staff Bylaws and any federal or State licensing entity with jurisdiction and shall afford the Hospital reasonable access thereto.

(b) All medical records pertaining to the provision of Neurosurgical Trauma Services at Hospital shall be the property of Hospital and shall at all times be freely available for the use of Group and the Specialists; provided, however, that the original of such records may not be removed from Hospital premises without Hospital’s consent. Upon the expiration or termination of this Agreement, Hospital will retain custody and control of such patient medical records.

8. **Billing, Documentation and Reimbursement Requirements**

(a) Group shall bill each patient of the Trauma Service, or such patient’s insurer or representative, for Neurosurgical Trauma Services provided by Specialists to each such patient pursuant to this Agreement.

(b) Group shall record, maintain and provide to Hospital all reasonable information and documentation that Hospital may require in order to secure reimbursement from federal or State agencies, intermediaries, carriers or other third-party reimbursers or patients for services provided to inpatients and outpatients hereunder. This information and documentation shall include the recording and maintenance by the Specialists and other Group professional employees, if any, of records of Neurosurgical Trauma Services provided, of time spent providing Neurosurgical Trauma Services, and such other information as may be requested by Hospital or such third-party payors. If (i) Hospital loses income from any third-party reimbursers as a direct result of Group’s failure to maintain and provide the records required under this Agreement by Hospital; (ii) Hospital provides written notice to Group of Group’s specific failure causing such loss of income and the amount of such lost income; and (iii) Group fails or refuses to correct such failure within thirty (30) days of receipt of such notice, then Group shall reimburse Hospital for any such lost income, and Hospital may reduce its payment to Group for services provided to Hospital by an amount equal to the amount of such lost income. Hospital shall record, maintain and provide to Group all reasonable information and documentation that Group may require in order to secure reimbursement from federal or State agencies, intermediaries, carriers or other third-party reimbursers or patients for services provided to inpatients or outpatients by Hospital hereunder.

(c) The Group shall require each Specialist to comply with federal documentation guidelines when supplying supporting documentation for Neurosurgical Trauma Services.

(d) Until the expiration of four (4) years following the furnishing of goods or services pursuant to this Agreement, Group shall, and shall require each Specialist to, make available, upon written request, to the Secretary of the Department of Health and Human Services or, upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, the contract, books, documents, and records of the Specialists that are necessary to certify the nature and extent of Group’s costs under this Agreement. If Group carries out any of the duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of goods or services pursuant to such subcontract, the related organization shall make available, upon written request, to the Secretary of the Department of Health and Human Services, or, upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, the subcontract and books,
documents, and records of such related organization that are necessary to verify the nature and extent of the subcontractor’s costs.

(e) If (i) Group loses income from any third-party-reimburser as a direct result of Hospital’s failure to maintain and provide to Group the documentation required in Section 5(b) of this Agreement; (ii) group provides written notice to Hospital of Hospital’s specific failure causing such loss of income and the amount of such lost income; and (iii) Hospital fails or refuses to correct such failure within thirty (30) days of receipt of such notice, then Hospital shall reimburse Group for any such income.

9. Insurance

(a) Group shall obtain and maintain in force throughout the duration of this Agreement professional liability insurance providing general and physician’s professional liability malpractice insurance coverage for at least $1,000,000 for any one occurrence and $3,000,000 annual aggregate. The Group’s professional liability insurance shall cover each Specialist and all other personnel of Group assigned by the Group to provide services under this Agreement. Group shall supply Hospital with a certificate of insurance evidencing such coverage. This insurance shall cover each Specialist in the event of a claim or lawsuit for professional negligence for any action or omission committed by a Specialist pursuant to this Agreement. Group shall immediately notify Hospital in writing if it receives notice of cancellation, termination, reduction or nonrenewal of the insurance required in this Section. If such insurance is canceled or terminated and if for any reason Group is unable to secure or maintain the insurance coverage required by this Section, Hospital shall have the option, upon ten (10) days’ written notice, to declare this Agreement temporarily suspended and, in the event of such suspension, Group shall temporarily discontinue services, in which case the parties shall be relieved of their respective obligations under this Agreement, except that Hospital may require the Group to continue to meet the emergency needs of Trauma Service patients for which the services of other qualified physicians cannot reasonably be obtained. Should this Agreement be temporarily suspended, it shall be immediately reinstated, together with the respective obligations of the parties, at the time Group provides Hospital satisfactory evidence of insurance coverage required by this Section. Group agrees to save and hold harmless the Hospital from any liability for any negligent act or omission of Group or any Specialist.

(b) ....... shall, at its own expense, through self-insurance or through insurance contracts, maintain at all times during the Term of this Agreement professional liability insurance for its employees in a minimum amount of $1,000,000 per occurrence, $5,000,00 in the aggregate, and comprehensive general public liability insurance, with respect to the business carried on, in or from Hospital’s facilities in such amounts as ....... deems appropriate. Upon Group’s request, ....... shall supply Group with evidence of such coverage. ....... shall immediately notify Group in writing upon the cancellation, termination, reduction or nonrenewal of the insurance required in this Section.

10. Independent Contractors. The sole relationship between the parties hereto is that of independent contractors. This Agreement is not intended, nor shall it be construed, to create any partnership, employment, agency or joint venture relationship between Hospital or Group or the employees of Group. Group is independent and expressly disclaims, both for itself and its employees, any entitlement to Hospital’s employee benefits. Hospital is neither practicing medicine nor does it intend to control or direct the practice of medicine by Group’s employees.
11. **Responsibility for Taxes.** Group shall be solely responsible for and shall hold Hospital harmless from the payment of any and all taxes, penalties, assessments and interest of whatever kind that may be due or assessed by any governmental entity or agency arising out of any monies earned by Group or benefits received by and paid to Group for services rendered by Group to Hospital pursuant to this Agreement. Hospital shall be solely responsible and shall hold Group harmless from payment of any and all taxes, penalties, assessments and interest of whatever kind that may be due or assessed by any governmental entity or agency arising out of any monies earned by Hospital or benefits received by Hospital pursuant to this Agreement. The obligations of the parties pursuant to this Section shall survive termination of this Agreement.

12. **Termination.** In the event of a breach of the terms of this Agreement by either party which is not corrected within thirty (30) days following written notice thereof by the other party (the “Nonbreaching Party”), this Agreement may be terminated immediately by the Nonbreaching Party. In addition, Hospital shall have the right to terminate this Agreement immediately upon the occurrence of any of the following: (i) any restrictions or limitations are imposed by any governmental authority having jurisdiction over Group to such an extent that Group cannot engage in the professional practice of neurosurgery as required hereunder; or (ii) any Specialist (A) ceases to be qualified as required under Section 4 of this Agreement and the Group fails to remove such Specialist within the time period provided in Section 4; (B) is found guilty of unprofessional or unethical conduct by any Board, institution, organization or professional society having any privilege or right to pass upon such conduct; (C) commits a felony; or (D) commits any offense involving moral turpitude, including but not limited to fraud, theft or embezzlement. Notwithstanding the foregoing, if a specific Specialist or other professional employee of the Group is responsible for an event of default set forth in subsections (ii) (B), (C) or (D) above, then Group may cure such default by removing such Specialist from all duties at the Trauma Service pursuant to this Agreement and providing, as soon as reasonably possible, a replacement Specialist who satisfies the requirements of this Agreement, or imposing such other restrictions as may be reasonably approved by Hospital for purposes of curing such defaults.

13. **Changes in Law**

   (a) **Legal Event: Consequences.** Notwithstanding any other provision of this Agreement, if the governmental agencies that administer the Medicare, Medicaid, or other federal programs (or their representatives or agents), or any other federal, State or local governmental or nongovernmental agency, or any court or administrative tribunal passes, issues or promulgates any law, rule, regulation, standard, interpretation, order, decision or judgment, including but not limited to those relating to any regulations pursuant to State or federal anti-kickback or self-referral statutes (collectively or individually, a “Legal Event”), which, in the good-faith judgment of one party (the “Noticing Party”), materially and adversely affects either party’s licensure, accreditation, certification, or ability to refer, to accept any referral, to bill, to claim, to present a bill or claim, or to receive payment or reimbursement from any federal, state or local governmental or non-governmental payor, or which subjects the Noticing Party to a risk of prosecution or civil monetary penalty, or which, in the good faith of the Noticing Party, indicates a rule or regulation with which the Noticing Party desires further compliance, or if in the good faith opinion of legal counsel to either party any term or provision of this Agreement could trigger a Legal Event, then the Noticing Party may give the other party notice of intent to amend or terminate this Agreement in accordance with the following subsections.
(b) Notice Requirements. The Noticing Party shall give notice to the other party together with an opinion of legal counsel setting forth the following information:

(i) The Legal Event(s) giving rise to the notice;
(ii) The consequences of the Legal Event(s) as to the Noticing Party;
(iii) The Noticing Party’s intention to either:

(A) Terminate this Agreement due to unacceptable risk of prosecution or civil monetary penalty; or
(B) Amend this Agreement, together with a statement that the purpose thereof is one or more of the following:

1. To further comply with any statutory provisions or rules or regulations created or affected by Legal Event(s); and/or
2. To satisfy any licensure, accreditation or certification requirements created or affected by the Legal Event(s); and/or
3. To eliminate or minimize the risk of prosecution or civil monetary penalty.

(iv) The Noticing Party’s proposed amendment(s); and
(v) The Noticing Party’s request for commencement of the Renegotiation Period (as defined below).

(c) Renegotiation Period: Termination. In the event of notice under either subsection (b)(iii)(A) or (b)(iii)(B) above, the parties shall have thirty (30) days from the giving of such notice (the “Renegotiation Period”) within which to attempt to amend this Agreement in accordance with the Noticing Party’s proposal (if any) or otherwise as the parties may agree. If this Agreement is not so amended within the Renegotiation Period, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given. Except as otherwise required by applicable law, any amounts owing to either party hereunder shall be paid, on a pro rata basis, up to the date of such termination, and any obligation hereunder that is to continue beyond expiration or termination shall so continue pursuant to its terms. All opinions of legal counsel presented by the Noticing Party hereunder, and any corresponding opinions given by the other party in response, shall be deemed confidential and given solely for the purposes of renegotiation and settlement of a potential dispute, and shall not be deemed disclosed so as to waive any privileges otherwise applicable to said opinions.

14. Confidentiality. Except as required by law or as necessary to perform its obligations hereunder, Group agrees not to disclose the terms of this Agreement or any information relating to Hospital’s operations without the express written consent of Hospital. In performing duties and obligations under this Agreement, each member of Group and Hospital shall comply with, and each shall cause its employees to comply with, applicable state and federal laws and regulations relating to the security and protection of health information, including without limitation the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, as they may be amended from time to time.
15. **No Referrals.** The parties agree that this Agreement shall not be interpreted in any manner so as to require the referral of patients by Group or Specialists to Hospital, or by Hospital to Group or Specialists, in contravention of any applicable law or regulation.

16. **Miscellaneous Provisions**

   (a) All section and item headings are inserted for convenience only and do not expressly or by implication limit, define, or extend the specific terms of the section so designated.

   (b) This Agreement and all Exhibits incorporated by reference contain the entire understanding of the parties relating to the matters referred to herein, and shall be amended only by written instrument signed by the parties to this Agreement.

   (c) If any provision of this Agreement shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein, unless the invalidity of any such provision substantially deprives either party of the practical benefits intended to be conferred by this Agreement.

   (d) This Agreement shall be construed in accordance with and governed by the laws of the State of .........., without giving effect to the conflict-of-laws provisions thereof.

   (e) Whenever a notice is required to be given in writing under this Agreement, such notice shall be given in person or by certified mail, return receipt requested.

   (f) Group may not assign any of Group’s rights or obligations hereunder without the prior written consent of Hospital.

   (g) The failure of either party to promptly exercise a right hereunder, or to seek a remedy available hereunder because of a breach of this Agreement, shall not be construed as a waiver of that right or a waiver of any remedy for that breach or any future breach of this Agreement.

   (h) Nothing in this Agreement shall be construed as creating or giving rise to any rights in any third parties or any persons other than the parties hereto.

   (i) Whenever used herein, the masculine pronoun shall include the feminine and neuter pronouns, and the singular shall include the plural, and the plural the singular.
IN WITNESS WHEREOF, the parties have executed this Agreement the day and year first written above.

(Hospital)

By: ____________________________________________
Name: __________________________________________
Title: _________________________________________

......... NEUROSURGERY ASSOCIATES, P.A.

By: ____________________________________________
Name: __________________________________________
Title: _________________________________________

The Specialists below hereby execute this Agreement:

John Doe, M.D.                                   John Doe, M.D.

John Doe, M.D.                                   John Doe, M.D.

John Doe, M.D.                                   John Doe, M.D.

John Doe, M.D.                                   John Doe, M.D.

John Doe, M.D.                                   John Doe, M.D.
EXHIBIT A

Specialists

John Doe, M.D.

John Doe, M.D.

John Doe, M.D.

John Doe, M.D.

John Doe, M.D.

John Doe, M.D.

EXHIBIT B

Compensation

(Attach agreement between hospital and group)
PROFESSIONAL MEDICAL DIRECTOR SERVICES AGREEMENT

THIS PROFESSIONAL MEDICAL DIRECTOR SERVICES AGREEMENT (this “Agreement”) is entered into as of the 1st day of ........, 20.., by and between........ HOSPITAL AUTHORITY (the “Hospital”) and ...... NEUROSURGERY ASSOCIATES, P.A., a (state) professional corporation (“Group”).

Background Statement

The Hospital desires to engage the services of a physician to provide professional direction and supervision with respect to neurosurgical trauma to the Hospital’s Trauma Service. Group employs physicians who are qualified by virtue of background, education, training and experience to provide such services (the “Physicians”), and Group desires to provide such services to Hospital pursuant to the terms and conditions of this Agreement. The neurosurgical trauma section of the Hospital’s Trauma Service shall be referred to herein as the “Neurosurgical Trauma Section”.

Hospital and Group entered into a Professional Neurosurgical Trauma Services Agreement as of ..........., 20.. (the “Trauma Services Agreement”), pursuant to which Group provides neurosurgical trauma services to Hospital.

Statement of Agreement

NOW, THEREFORE, in consideration of the mutual promises of the parties hereto and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Term. The initial term of this Agreement shall be for a period of one (1) year, beginning on ......., 20.., and ending at midnight on ......, 20... This Agreement may be renewed for additional one-year terms upon written amendment signed by the parties.

2. Services of Group. Group agrees to provide a Physician satisfactory to Hospital who is an employee of Group to assume the responsibilities and perform the duties described in Exhibit B attached hereto and incorporated herein by reference. The parties estimate that Physician shall devote approximately five (5) to six (6) hours per month to the performance of such duties. Group shall cause Physician to deliver to Hospital each month a Service Documentation Report in the form attached hereto as Attachment B-1 (the “Service Documentation Report”). Group shall cause Physician to deliver Service Documentation Report to Hospital within ten (10) days of the end of each month that Physician provides services hereunder.

3. Qualifications of Physician. At all times during the term of this Agreement, the Physician assigned by Group to provide services pursuant to this Agreement shall: (a) hold a license to practice medicine in the State of ....; (b) maintain active medical staff privileges and membership in good standing on the Hospital’s Medical Staff (“Medical Staff”) and Hospital’s Department of Neurosurgery (“Department of Neurosurgery”); (c) have a current narcotics license and number issued by the appropriate governmental agency or agencies; and (d) be certified by the American Board of Neurological Surgery (the “Board”) and remain current with that certification through periodic continuing medical education and examination as required by the Board.
4. **Compensation.** As consideration for the services of Group provided to Hospital hereunder, Hospital shall pay Group compensation according to Exhibit A attached hereto and incorporated herein by reference.

5. **Hospital Obligations.** The Hospital shall provide the facilities, equipment, support personnel and supplies reasonably necessary for Physician to provide the services required of Physician under this Agreement. Hospital is neither practicing medicine nor does it intend to control or direct the practice of medicine by Physician.

6. **Policies and Procedures: Personnel Matters.** Group agrees, and shall require Physician to, abide by the rules, policies and procedures of Hospital and the Department of Neurosurgery, all as may be amended from time to time, and the requirements of various governmental or accrediting agencies applicable to Hospital or the Department of Neurosurgery. These rules, policies, and procedures may include, among other things, standards of care and professional protocols applicable to ......... and Hospital outpatient facilities. All such rules, policies and procedures are hereby incorporated by reference and made a part of this Agreement. Notwithstanding the foregoing, a revision or amendment to a rule, policy or procedure of ....... or Hospital that would result in a material change in the business arrangement agreed to by Group herein shall not be incorporated and made a part of this Agreement without the consent of Group. Group acknowledges and agrees that nothing in this Agreement shall be construed to authorize Group or Physician to hire any person on behalf of Hospital as a Hospital employee.

7. **Confidentiality of Information.** Group agrees not to disclose, and to require Physician not to disclose, any information relating to Hospital or Neurosurgical Trauma Section operations to persons other than: (a) members of the Medical Staff; (b) any state licensing board; (c) the Joint Commission on Accreditation of Healthcare Organizations; or (d) any third-party reimbursement entity having the right and need to know, without the express written consent of Hospital, unless otherwise ordered by a court of law. This Section 7 shall survive the expiration or termination of this Agreement for any reason.

8. **Billing.** Group agrees that neither Group nor Physician will bill for any physician services provided pursuant to this Agreement, and that Group’s sole compensation for services provided pursuant to this Agreement shall be as provided in Exhibit A.

9. **Termination.** This Agreement may be terminated as follows:

   a. A party hereto may terminate this Agreement immediately in the event of a material breach of any term of this Agreement by the other party that is not corrected within ten (10) days following written notice thereof.

   b. A party hereto may terminate this Agreement upon ninety (90) days written notice to the other party.

   c. The Hospital shall have the right to terminate this Agreement immediately “for cause” if Physician: (i) ceases to be qualified as required in Section 3 or has Physician’s Medical Staff or Department of Neurosurgery membership or privileges suspended or reduced to an extent that Physician is thereby unable to provide the services described in Exhibit B; (ii) commits any felony; (iii) commits any offense involving moral turpitude, including but not limited to fraud, theft or embezzlement; (iv) commits professional malpractice sufficient to indicate that Physician is not competent to practice medicine; or (v) exhibits significant misconduct or willful inattention to the economic or ethical welfare of the Neurosurgical Trauma Section, the Hospital, or .......
d. The parties agree that if this Agreement is terminated by either party for cause under this Section during the first year of this Agreement, then the parties shall not do either of the following until at least one (1) year from the date of the beginning of the initial term: (i) enter into a services agreement with each other for services similar to those provided hereunder; or (ii) negotiate with each other the terms of a services agreement for services similar to those provided hereunder.

10. **Professional Liability Insurance.** Group shall maintain professional liability insurance with a limit of not less than $1,000,000.00 per occurrence and with $3,000,000.00 aggregate limit. Group shall furnish Hospital a certificate of insurance as proof of this coverage. This insurance shall cover Physician in the event of a claim or lawsuit for professional negligence for any action or omission committed by Physician pursuant to this Agreement. Group shall immediately notify the Hospital in writing if Group receives notice of cancellation, termination, reduction or nonrenewal of the insurance required in this Section. If such insurance is canceled or terminated and if for any reason Group is unable to secure or maintain the insurance coverage required by this Section, the Hospital shall have the option, upon ten (10) days' written notice, to declare this Agreement temporarily suspended and, in the event of such suspension, Group shall temporarily discontinue services, in which case the parties shall be relieved of their respective obligations under this Agreement. Should this Agreement be temporarily suspended, it shall be immediately reinstated, together with the respective obligations of the parties, at the time Group provides the Hospital satisfactory evidence of insurance coverage required by this Section. Group agrees to save and hold harmless the Hospital from any liability for any negligent act or omission of Group or Physician. Hospital agrees to save and hold harmless the Group and Physician from any liability for any negligent act or omission of the Hospital.

11. **Records Access.** Until the expiration of four (4) years after the furnishing of any services by Group hereunder, Group shall make available, upon written request, to the Secretary of the Department of Health and Human Services or, upon request, to the Comptroller General, or their duly authorized representatives, this Agreement and the books, documents, and records of Group that are necessary to certify the nature and extent of the costs of this Agreement. If Group carries out any of the duties of this Agreement through a subcontract (with a value or cost of $10,000 or more over a twelve-month period) with a related organization, such subcontract shall contain a provision substantially identical to this Section, requiring such subcontractor to make similar agreements, books, documents, and records available to the same parties as must Group for the same time period for the purpose of verifying the nature and extent of such costs.

12. **Independent Contractor.** The sole relationship between the parties hereto is that of independent contractors. This Agreement is not intended, nor shall it be construed, to create any partnership, employment, agency or joint venture relationship between the Hospital and Group. Group is independent and expressly disclaims, both for itself and for its employees, any entitlement to the Hospital’s employee benefits. The Hospital is neither practicing medicine nor does it intend to control or direct the practice of medicine by Physician.
13. **Responsibility for Taxes.** Group shall be solely responsible for and shall hold the Hospital harmless from the payment of any and all taxes, penalties, assessments and interest of whatever kind that may be due or assessed by any governmental entity or agency arising out of any monies earned by Group or benefits received by and paid to Group for services rendered by Group to the Hospital pursuant to this Agreement. The Hospital shall be solely responsible and shall hold Group harmless from the payment of any and all taxes, penalties, assessments and interest of whatever kind that may be due or assessed by any governmental entity or agency arising out of any monies earned by the Hospital or benefits received by the Hospital pursuant to this Agreement. These obligations shall survive termination of this Agreement.

14. **Changes in Law**

(a) **Legal Event: Consequences.** Notwithstanding any other provision of this Agreement, if the governmental agencies that administer the Medicare, Medicaid or other federal programs (or their representative or agents), or any other federal, state or local governmental or nongovernmental agency, or any court or administrative tribunal passes, issues or promulgates any law, rule, regulation, standard, interpretation, order, decision or judgment, including but not limited to those relating to any regulations pursuant to state or federal anti-kickback or self-referral statutes (collectively or individually, “Legal Event”), which, in the reasonable and good-faith judgment of one party (the “Noticing Party”) (and supported by the written opinion of independent legal counsel as required in (b) below), draws into question the terms of this Agreement in a manner that may materially and adversely affect either party’s licensure, accreditation, certification, or ability to refer, to accept any referral, to bill, to claim, to present a bill or claim, or to receive payment or reimbursement from any federal, state or local governmental or non-governmental payor, or that may subject the Noticing Party to a substantial risk of prosecution or civil monetary penalty, then the Noticing Party may give the other party notice of intent to amend or terminate this Agreement in accordance with the next subparagraph.

(b) **Notice Requirements.** The Noticing Party shall give notice to the other party together with the following information:

(i) A description of the Legal Event(s) giving rise to the notice;
(ii) The written opinion of independent legal counsel with expertise in the area of healthcare law and a national practice specializing in healthcare law, describing the Legal Event and the consequences or potential consequences of the Legal Event(s) as to the Noticing Party;
(iii) the Noticing Party’s intention to either:

(A) amend this Agreement, together with a description of the terms of such amendment and the purposes thereof; or
(B) if the documentation from legal counsel referred to in item (ii) above states that no amendment to this Agreement can reasonably avoid the material and adverse consequences of the Legal Event(s), terminate this Agreement.

(c) **Renegotiation Period: Termination.** Upon the giving of a notice pursuant to subsection (b) above, the parties shall have sixty (60) days from the giving of such notice to attempt to amend this Agreement in accordance with the Noticing Party’s proposal (if any) or otherwise as the parties may agree. If this Agreement is not so amended within such 60-day period, this Agreement shall terminate as of midnight on the 60th day after said notice was given. Except as otherwise required by applicable law, any amounts owing to either party hereunder shall be paid, on a pro rata basis, up to the date of such termination,
and any obligation hereunder that is to continue beyond expiration or termination shall so continue pursuant to its terms. All communications presented by the Noticing Party hereunder, and any communications given by the other in response, shall be deemed confidential and given solely for the purposes of renegotiation and settlement of a potential dispute, and shall not be deemed disclosed so as to make any admission or waive any privileges otherwise applicable thereto.

15. **Miscellaneous Provisions**

A. All section and item headings are inserted for convenience only and do not expressly or by implication limit, define or extend the specific terms of the section so designated.

B. This Agreement and all Exhibits incorporated by reference contain the entire understanding of the parties relating to the matters referred to herein, and shall be amended only by written instrument signed by the parties to this Agreement.

C. If any provision of this Agreement shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein, unless the invalidity of any such provision substantially deprives either party of the practical benefits intended to be conferred by this Agreement.

D. This Agreement shall be construed in accordance with and governed by the laws of the State of ......., without giving effect to the conflict-of-laws provisions thereof.

E. Whenever a notice is required to be given in writing under this Agreement, such notice shall be given in person or by certified mail, return receipt requested.

F. Neither party may assign any of its rights or obligations hereunder without the prior written consent of the other party.

G. The failure by either party to promptly exercise a right hereunder, or to seek a remedy available hereunder because of a breach of this Agreement, shall not be construed as a waiver of that right or a waiver of any remedy for that breach or any future breach of this Agreement.

H. Nothing in this Agreement shall be construed as creating or giving rise to any rights to any third parties or any persons other than the parties hereto.

I. Whenever used herein, the masculine pronoun shall include the feminine and neuter pronouns, and the singular shall include the plural, and the plural the singular.
IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed the day and year first above written at (City, State).

......NEUROSURGERY ASSOCIATES, P.A.

By: ________________________________________
    John Doe, M.D.
Its:    President
EXHIBIT A
COMPENSATION

As consideration for the services provided hereunder, Hospital shall pay Group at the rate of ........ ($0.00) per hour for services provided by the Physician; provided, however, that the total annual compensation paid to Group hereunder shall not exceed ........ ($0.00). Hospital shall pay Group on a monthly basis within ten (10) days of receiving a completed Service Documentation Report for services rendered in the prior month.

Notwithstanding the foregoing, Physician must submit the Service Documentation Report each month in order to receive monthly compensation payments hereunder. If Physician fails to deliver the Service Documentation Report in any month, then Group shall not be entitled to receive compensation hereunder, and Hospital shall make no compensation payments to Group until Physician delivers such Service Documentation Report (and all other Service Documentation Reports then due) to Hospital. Upon delivery to Hospital of all Service Documentation Reports then due, Group shall be entitled to receive, and Hospital shall pay to Group, any monthly compensation payments that Hospital withheld pursuant to the foregoing sentence.
EXHIBIT B
PHYSICIAN SERVICES

Physician shall:

A. Serve as Medical Director of Neurosurgical Trauma for the Neurosurgical Trauma Section. Responsibilities of the Medical Director include:

1. Serving as the point person and communication liaison with the Hospital for all issues related to the management of neurosurgical trauma, including preparing memoranda, organizing meetings and relaying Group issues and suggestions.

2. Monitoring existing Neurosurgical Trauma Section policies and procedures and preparing and recommending changes to such policies and procedures as necessary for the efficient operation of the Neurosurgical Trauma Section.

3. Assisting Hospital in the review of treatment protocols and clinical pathways related to neurosurgical trauma.

4. Assisting Hospital in the development of regional trauma systems and triage of neurosurgical trauma cases during high census time.

5. Assisting Hospital in verifying that physicians providing services to Hospital pursuant to the Trauma Services Agreement attend Hospital meetings in satisfaction of attendance requirements of the American College of Surgeons for Level 1 Trauma Centers.

6. Attending or requiring a designee who is a neurosurgeon or a physician’s assistant to attend Hospital’s weekly multidisciplinary trauma management meeting (currently held on ....... mornings) to ensure appropriate continuity of patient care.

7. Assisting Hospital in allocating operating rooms for neurosurgical trauma services, participating in day-to-day use of operating rooms utilized for Neurosurgical Trauma, utilization review of neurosurgical trauma cases, reviewing appropriateness of scheduling of neurosurgical trauma cases, assisting Hospital in triaging neurological cases and utilizing regional trauma systems during high census times.

8. Assisting Hospital in recruiting and retaining qualified staff for Hospital’s operating rooms used for Trauma Services, interviewing applicants for employment, advising Hospital with respect to such applicants and attending recruiting functions.

B. Documentation of Time. Each month, Physician shall provide a Service Documentation Report in the form attached hereto as Attachment B-1 documenting the approximate time Physician devoted to the provision of service hereunder to the Administrative Director of Trauma Services or such other Hospital administrator as the President of the Hospital shall designate.
# ATTACHMENT B-1
## FORM OF SERVICE DOCUMENTATION REPORT

### MEDICAL DIRECTOR

**SERVICE DOCUMENTATION REPORT**

**DATE:** ________________ to ________________  
**NAME:** __________________________________________, M.D.  
**DEPARTMENT:** _________________________________________

<table>
<thead>
<tr>
<th>DESCRIPTION OF SERVICES</th>
<th>TOTAL HOURS FOR PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monitoring and reviewing Neurosurgical Trauma Section policies and procedures. Specifically:</td>
<td></td>
</tr>
<tr>
<td>2. Assisting in review of treatment protocols and clinical pathways. Specifically:</td>
<td></td>
</tr>
<tr>
<td>3. Assisting Hospital in the development of regional trauma systems and triage of neurosurgical trauma cases during high census times. Specifically:</td>
<td></td>
</tr>
<tr>
<td>4. Assisting Hospital in verifying that physicians providing services to Hospital pursuant to the Trauma Services Agreement attend Hospital meetings in satisfaction of the requirements of the American College of Surgeons for Level 1 Trauma Centers. Specifically:</td>
<td></td>
</tr>
<tr>
<td>5. Attending or requiring a designee who is a neurosurgeon to attend Hospital's weekly multidisciplinary trauma management meeting to ensure appropriate continuity of patient care. Specifically:</td>
<td></td>
</tr>
<tr>
<td>6. Assisting Hospital in allocating operating rooms for neurosurgical trauma services, participating in utilization review of neurosurgical trauma cases, reviewing appropriateness of scheduling of neurosurgical trauma cases, assisting Hospital in triaging neurosurgical cases and utilizing regional trauma systems during high census times. Specifically:</td>
<td></td>
</tr>
<tr>
<td>7. Assisting Hospital in recruiting and retaining qualified staff for Hospital's operating rooms used for Trauma Services, interviewing applicants for employment, advising Hospital with respect to such applicants and attending recruiting functions. Specifically:</td>
<td></td>
</tr>
</tbody>
</table>

**I CERTIFY THAT THE ABOVE NUMBER OF HOURS IS AN ACCURATE REFLECTION OF THE TIME SPENT ON MY MEDICAL DIRECTOR DUTIES.**

**Signature:** __________________________________________  
________________________________________, M.D.
**ABSCESS** - Intracranial (cerebellar) 324.0  
Burr hole 61150  
Crani/supratent 61320  
Crani/supratent 61514  
Crani/infratent 61522  
Scalp 682.8  
Spinal, epidural 324.1  
Lungs 513.0  
Unspecified 324.9  
Cervical 63265  
Thoracic 63266  

Arterial catheterization (A-Line) 36620

Brachial Plexus Palsy 353.0  
Injury 953.4

Cardiac Arrest 427.5  
CPR 92950

Catheter, central venous 36489  
Pulmonary - Swan Ganz 93503

Causalgia, upper limb 354.4

Central Venous Catheter 36489

Cerebral edema 348.5

Cerebral laceration/contusion 851.++  
Twist drill catheter 61107  
Crani intracerebral 61313

Closed Head Injury 854.0+  
Post-concussion syndrome 310.2  
w/open intracranial wound 854.1+  
Twist hole for cath/Ventric 61107  
Crani w/penet brain wound 61571

Compression—Brain 348.4  
Nerve Root 724.9  
Spinal Cord 336.9  
Elevation DSF, simple 63200

Concussion 850.+  
Contusion 851.++  
Craniotomy for ICH 61313  
w/ tx of penetra wound 61571

CPR 92950

CSF Leak 349.81

Craniotomy for repair 62100  
Lumbar drain 62272

Dislocation, occipitoatlantal 839.01

Echoencephalography 76506

Edema, cerebral 348.5  
Cranial decomp 61340  
Skull/abdominal 29026

Empyema, brain 324.0

Fluoroscopy (1 hour) 76000  
(1+ hour) 76001

**FRACTURES**

Skull, closed 800.1+  
Skull, depres, open 800.6+  
Elevation/simple 62000  
GSW, repair 62010

Base of skull/sinus 801.++  
Supratent/evac hema 61312  
Crani/extradural/elevation 61582  
Elev/compo/extradural 62005  
Crani/repair dura/elevation 62010  
Sinus/obliterative/ablation 31081  
Obliterative, w/flap/coronal 31085

Cervical, closed 805.0+  
Corpectomy/single 63081  
Arthro/ant 22554  
Arthro/post C1-2 22595  
Arthro/posterlat/below C2 22600  
Additional segment 22614  
Wiring 22841  
Anterior Instr 22845

“ ” 4-7 segments 22846  
Post inst/segmental 22842

Cervical, closed, no cord inj 805.4+  
Lumbar, closed, no cord inj 806.4  
Lumbar, open 805.5  
Lumbar, open, cord inj 806.5  
Allograft/morselized 20930  
Allograft/structural 20931  
Graft/morselized 20937  
Autograft 20938  
Arthrodesis/anterior 22554  
Arthrodesis/thoracic 22556  
Arthrodesis 22590  
Arthro/lumbar/post 22612  
Post arthro/single 22630
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<tbody>
<tr>
<td>Pedicle screws</td>
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<tr>
<td>Wiring/instr/post</td>
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<tr>
<td>Post instr 3-6 seg.</td>
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<tr>
<td>Ant instr</td>
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<td>Open reduction</td>
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<td>w/ grafting</td>
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<td>Reduct/posterior</td>
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<td>Arthrodesis</td>
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<td>Post/nonseg/instrum (Harrington Rod)</td>
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<td>Application of screw/cage</td>
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<td>Screw fixation</td>
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<td>Thoracic fracture, closed</td>
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<td>Bone graft/major</td>
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<td>Allograft/morselized</td>
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<td>Wiring</td>
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<td>Ant arthro/below C2</td>
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<td>Arthro/anterior</td>
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<td>Lateral plating/post</td>
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<tr>
<td>Post instr 3-6 seg.</td>
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<tr>
<td>Ant instr 2-3 segments</td>
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<td>Appl prosthetic device</td>
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<td>Lamin, thoracic</td>
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<td>Vertebral corpect</td>
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<td>Each add seg</td>
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<tr>
<td>Verteb corp/thorocolum</td>
<td>63087</td>
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<tr>
<td>Corpectomy/lower/single</td>
<td>63090</td>
</tr>
</tbody>
</table>

| GSW to the head, vault                                                          | 800.6+ |
| Skull base                                                                      | 801.6+ |
| Complicated open                                                                | 851.3+ |
| SDH                                                                             | 852.+  |
| General complicated                                                             | 873.9  |
| Intracran/major vasc                                                            | 900.89 |
| Assault by firearm, purposely inf                                              | E965.4 |
| Unspecified firearm/ accident??                                                 | E985.4 |
| Self-Inflicted                                                                  | E955.4 |
| Repair 7.6-12.5cm                                                               | 12034  |
| Subdural, craniotomy                                                            | 61312  |
| Crani/extradural/subdural                                                       | 61314  |
| Crani w/penetrating wound                                                       | 61571  |
| Elevat/comp/extradural                                                          | 62005  |
| w/repair dura/debride brain                                                     | 62010  |
| Echoencephalography                                                             | 76506  |
| Head, deformity, acquired                                                       | 738.10 |
| Crani for defect: 5cm                                                           | 62140  |
| Replace bone flap                                                               | 62143  |
| (usually requires -58 modifier)                                                |        |
| Head injury, unspecified                                                        | 959.01 |

| HEMATOMA, epidural, fx                                                          | 800.2+ |
| Contusion                                                                       | 851.++ |
| Intracranial (inj)                                                              | 853.0+ |
| Epidural                                                                        | 852.4+ |
| Subdural (injury)                                                               | 852.2+ |
| Complication from surg                                                          | 998.1+ |
| Sinus/oblit/coronal inc                                                         | 31085  |
| Burr hole/ventric punct                                                         | 61105  |
| Twist drill inc                                                                 | 61108  |
| " + another surgery                                                             | 61130  |
| Burr hole, chronic/extra/subdural                                               | 61154  |
| Crani/suprat/extral/subdural                                                    | 61312  |
| Crani/intracerebral                                                             | 61313  |
| Elevat/simple/extradural                                                        | 62000  |
| Elevat/comp/extradural                                                          | 62005  |
| " + repair dura/debride brain                                                   | 62010  |
| Spinal (cord inj)                                                                | 336.9  |
| Thoracic excision                                                               | 63271  |
| Spinal punct for drainage CSF                                                    | 62272  |
| Hemorrhage, p injury                                                            | 852.0+ |
| " traumatic                                                                     | 853.04 |
| Crani, suprat, extra/subdural                                                   | 61312  |
| Crani, intracerebral                                                            | 61313  |
| Posterior fossa                                                                 | 61315  |
| Echoencephalography                                                             | 76506  |
Hydrocephalus, comm 331.3
  Acquired, obstructive 331.4
    w/ spina bifida 741.0+
  Congenital 742.3
  Burr hole 61107
  Endoscopic/third ventricle 62200
  VPS 62223
  Spinal 63740
  Paraplegia 344.1
  Paraparesis 344.9
    Repair of dural/CSF leak 63707
  Paresthesias 782.0
  Post concussion syndrome 310.2
  Postoperative infection 998.5
    I&D 10180
  Quadriplegia 344.0+
  Radiculopathy, cervical 722.0
  Lumbar/thoracic 724.4
  Cerv w/ decompression 63020
  Ray cages 22630
  Autograft 20936
  Lumbar lam 63047
  Ant diskectomy 63075
  Reflex sympathetic dystrophy 337.20
  Respiratory failure 518.81
    Chronic 518.83
  Tracheostomy 31600

Infection, local, unspecified 686.9
  Cranial/bone 730.9
  Spine 730.08
  Debrid skin/subcut tiss/muscle 11043
  Craniotomy 61501
  Repair of dural/CSF leak 63707

Intracranial injuries 850-854
  Implant catheter/ICP 61107
    w/ radiculopathy 724.2
  Laceration, scalp 873.0
    Repair (20-30 cm) 12036
  Seroma 998.13
    Wound revision 12035
  Sciatica 724.3
    w/ radiculopathy 724.2
  Seizure, grand mal 345.3
    Petit 345.2
    Convulsion 780.3
  Laceration, scalp 873.0
    Layer closure 7.6-12.5 cm 12034
  MVA E812.++
  Shunt malfunction 996.2
    w/ infection 996.63
  Creation of shunt 62223
  Neck Injury 959.0
    Revision 62230
  Otorrhea, spinal 388.61
    Removal 62256
    Remove/replace 62258
  Paralysis/Paraparesis 344.9
    Sinusotomy, frontal/obliterative 31085
  Paraplegia 344.1
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
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<tbody>
<tr>
<td>Skull defect, acquired</td>
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<tr>
<td>Cranioplasty</td>
<td>62140</td>
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<tr>
<td>Skull base repair</td>
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<tr>
<td>Spondylolisthesis (acq), lumbar</td>
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<td>Lumbosacral (cong)</td>
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<td>Allograft</td>
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<td>Morselized/harvest</td>
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<tr>
<td>Each add level</td>
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<td>PLIF</td>
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<td>Spondyloysis: acquired</td>
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<td>Lumbosacral</td>
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<td>Spondylosis, acquired</td>
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<tr>
<td>Cervical</td>
<td>721.1 or 756.19</td>
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<td>w/o myelopathy</td>
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<td>Arthro/ant/cerv</td>
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<td>Cervical lam, 1-2 levels</td>
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<td>Cervical lam, 2+ levels</td>
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<td>Ant disk, cerv</td>
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<td>Hemilam w/decomp,1 lev</td>
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<td>Each add space, cerv/lum</td>
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<tr>
<td>Sprain/strain, cervical</td>
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<td>Subluxation, cervical, closed</td>
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<td>Syringomyelia</td>
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<td>Tracheostomy</td>
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<td>Sinus</td>
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<td>Ventricle</td>
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<td>Ventricul/twist drill</td>
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<td>After craniotomy</td>
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<td>Burr hole/fiberoptic dev</td>
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<td>Ommaya Reservoir</td>
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<tr>
<td>Third Ventricle</td>
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<td>Whiplash, neck</td>
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<td>Wound infection</td>
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<td>Postop</td>
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<td>Incision &amp; drainage</td>
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**Critical Care**

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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>99232/99233</td>
<td>&lt; 30 minutes</td>
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<tr>
<td>99291</td>
<td>First 30-74 minutes</td>
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<tr>
<td>99292</td>
<td>Each additional 30 minutes</td>
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</table>

**Modifiers:**

- GC= Supervision of residents
- 22= Unusual services/greater than usual (see 60)
- 25= E&M on day of surgery (see 57)
- 32= Mandated Service
- 50= Bilateral
- 51= Multiple procedures
- 57= E&M on day of surgery (see 25)
- 58= Staged procedure during postop period
- 59= Same Day, different surgery or site/injury/lesion
- 60= Altered surgical field anatomy/infection/trauma
- 62= Two surgeons (co-surgeons)
- 66= More than one surgeon using the same code (surgical team)
- 76= Repeat procedure, same surgeon
- 78= Second surgery, related to 1st surg, during postop period
- 79= Surgery (within 90 days) unrelated to previous surgery
- 80= Assistant surgeon

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(There is a fee for this service.)