APPLECARE
MEDICAL GROUP
Part of OptumCare

July 22, 2019

35379

Provider: The City of Long Beach
Address: 2525 Grand Avenue, #115
Long Beach, CA 90815
Phone: (562) 570-4000
Fax: (562) 570-4049

Dear Provider:

This letter shall serve as a Letter of Agreement for provision of service to be provided by **The City of Long Beach** (hereafter referred to as "Provider") to AppleCare Medical Group, Inc. and AppleCare Medical Group St. Francis, Inc. (hereafter referred to as "Group") enrollees to provide **HIV Medicine** Services. Enrollees will have their own Primary Care Provider within the Health Plan. Hospital admissions will be through Health Plan Hospitalists.

1. Provider understands the requirements for enrollee protection, which prohibit Provider from recovering, or seeking to recover from Enrollees any monies owed Provider by Group, except for authorized co-payments or deductibles.

2. Provider shall provide the following service to Group enrollee with prior authorization. Claim may be denied if authorization is not obtained. Provider agrees that in no event, including but not limited to nonpayment by Group, insolvency of the Managed Care Organization or Group or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an Enrollee or persons (other than Group) acting on his/their behalf for services provided pursuant to this Agreement.

*Payment Terms/CPT Codes:

- Group will reimburse at the lesser of billed charges or 100% of current year RBRVS.

- Any authorized procedure, which is unlisted under Medicare guidelines, but considered Medicare allowable charges, shall be reimbursed at thirty (30) percent of Provider's billed charges. Group will not pay Medicare non-allowable charges.

- SPECIALTY CARE REIMBURSEMENT/MEDI-CAL: Reimbursement for Medi-Cal plan members will be paid at the lesser of the Medi-Cal fee schedule or the rate above. Group will not pay Medi-Cal non-allowable charges.

- E&M CODING: All services will be billed at the following codes for all products:

Office Visit New:	99201-99205
Office Visit Established:	99211-99215
Initial Hospital Care:	99221-99222
Subsequent Hospital Care:	99231-99232
Inpatient Discharge Visit:	99238

  If services warrant payment at a higher level, appeals must be submitted in writing.

3. Provider agrees to bill Group within ninety (90) days from the date of service, for services to enrollees of Group and that Enrollee will not be liable to Provider for payment of monies owed by Group except for authorized co-payments, and deductibles, and Provider will not bill, collect from or charge Enrollees of Group for services rendered. Submit claims with a copy of this Letter of Agreement to the following address:

AppleCare Medical Group, Inc.	AppleCare Medical Group St. Francis, Inc.
P.O. BOX NUMBER 6014	P.O. BOX NUMBER 6016
Artesia CA 90702-6014	Artesia CA 90702-6016

4. Group agrees to remit payment to Provider within forty-five (45) working days from the date of claims receipt for professional services performed.

5. This agreement shall be effective immediately for authorized services provided and shall continue until a formal contract is finalized. After the initial consult it is requested that your medical summary be provided to the Primary Care Physician to review and to decipher if ongoing treatment is necessary.

6. Provider may terminate this Agreement without cause, by giving one hundred twenty (120) days prior written notice to IPA. This Agreement may be terminated by IPA, at any time, without cause, by giving ninety (90) days written notice to Provider.

7. IPA shall have the right to terminate this Agreement immediately with cause upon written notice should the following occur:

(1) IPA determines the health, safety, or welfare of Enrollees is jeopardized;

(2) Provider's license to practice medicine (or the license to practice medicine of any employee, contractor or owner of Provider, if Provider is a corporation or partnership) in any jurisdiction within the United States is suspended, placed on probation or revoked, without regard to whether such suspension, probation or revocation has been finally adjudicated;

(3) Provider (or any employee, contractor or owner of Provider, if Provider is a corporation or partnership) is excluded from participation in the Medicare program or suspended from participation in the Medi-Cal program, without regard to whether such exclusion or suspension has been finally adjudicated;

(4) The DEA number of Provider (or any employee, contractor or owner of Provider, if Provider is a corporation or partnership) is suspended, restricted, or revoked, without regard to whether such suspension, restriction or revocation has been finally adjudicated; or

(5) Provider (or any employee, contractor or owner of Provider, if Provider is a corporation or partnership) is convicted of any felony.

8. Either party shall have the right to terminate this Agreement immediately upon written notice if the other party breaches a material term, covenant or condition of this Agreement; provided, the party in breach of a material term, covenant or condition of this Agreement shall have thirty (30) days, beginning on the day of receipt of written notice of the breach from the non-breaching party, to cure such breach subject to the reasonable satisfaction of the non-breaching party. If the breaching party fails to cure the breach to the reasonable satisfaction of the non-breaching party within such thirty (30)-day period, this Agreement shall be terminated automatically on the thirtieth day after said notice of breach.

Please indicate your acceptance of these terms by signing below and completing the attached W-9 form. Please fax the signed agreement and completed W-9 back to the attention of Amanda Piane, Contract Specialist, at **1-714-276-1400**.

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If you have any questions concerning this Agreement, contact me at **1-714-452-5044.**
Thank you again for your willingness to provide these services to our patients.

PROVIDER INFORMATION

Provider Name	**License**	**NPI**
Mauro Torno, MD	A52189	1144222803

Sincerely,

Amanda Piane — 8/8/19

Amanda Piane
Contract Specialist

Date

I understand and accept the terms of this agreement.
I understand a complete copy of this LOA must be attached to any and all claims submitted under this LOA.

Signed — 8/5/19

Date

Print Name: **Tom Modica**

Title: **Assistant City Manager**

License Number

Individual NPI Billing Number: 1023116811

Group NPI Billing Number (if applicable)

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER

APPROVED AS TO FORM
August 1, 2019
CHARLES PARKIN, City Attorney
By
TAYLOR M. ANDERSON
DEPUTY CITY ATTORNEY