Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
1	81193	12/18/21-12/20/21	12/16/2022	$ 180.00	**Initial, PR-2 ($180 each)**	$ 180.00	**100%**	Accident Fund
2	80250	11/11/21-11/18/21	10/27/2022	$ 180.00	**2 F/u acup ($180 each)**	$ 180.00	**100%**	AIG/ Chartis
3		12/20/2021	12/12/2022	$ 90.00	**F/u physio therapy ($180)**	$ 90.00	**100%**	
4	80452	04/08/21-5/13/21	10/25/2022	$ 360.00	**PR-2, initial chiro, f/u chiro, initial physio ($180 each)**	$ 360.00	**100%**	AIG/ Chartis
5	80489	11/11/2021	10/31/2022	$ 90.00	**Shockwave ($180)**	$ 90.00	**100%**	AIG/ Chartis
6	80555	9/30/2021	8/23/2022	$ 90.00	**F/u physio therapy ($180)**	$ 90.00	**100%**	AIG/ Chartis
7	81806	11/12/2021	10/27/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	AIG/ Chartis
8	76951	3/16/21-4/13/21	1/6/2022	$ 270.00	**3 F/u chiro ($180 each)**	$ 270.00	**100%**	Amtrust
9		04/27/21&5/11/21	1/27/2022	$ 180.00	**2 F/u physio ($180 each)**	$ 180.00	**100%**	
10		5/19/2021	2/23/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
11	77272	12/10/19-12/27/19	1/24/2022	$ 270.00	**3 F/u acup ($180 each)**	$ 270.00	**100%**	Amtrust
12		11/21/19-12/03/19	1/25/2022	$ 280.00	**Initial, initial acup ($230 each)**	$ 280.00	**100%**	Amtrust
13	78174	5/11/2021	1/27/2022	$ 90.00	**Initial psych ($180)**	$ 90.00	**100%**	Amtrust

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
14		04/13/21-4/16/21	1/10/2022	$ 270.00	**F/u acup, 2 f/u chiro ($180 each)**	$ 270.00	**100%**	
15		5/1/2021	1/25/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	
16	78296	5/17/2021	2/11/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	Amtrust
17		09/14/21-9/20/21	8/24/2022	$ 180.00	**F/u acup, f/u physio ($180 each)**	$ 180.00	**100%**	
18		9/22/2021	8/30/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
19	78518	03/12/21-4/23/21	1/6/2022	$ 180.00	**2 PR-2s ($180 each)**	$ 180.00	**100%**	Amtrust
20	78566	03/17/2021-04/22/21	1/4/2022	$ 1,080.00	**Initial, PR-2, 3 f/u acup, 5 f/u physio, shockwave ($180 each)**	$ 1,080.00	**100%**	Amtrust
21	78575	5/3/2021	1/27/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Amtrust
22		10/11/21 - 10/18/21	10/3/2022	$ 180.00	**F/u acup, PR-2 ($180 each)**	$ 180.00		
23	78777	9/8/2021	8/22/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	Amtrust
24	79007	10/4/2021	10/7/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Amtrust
25	79060	06/28/21-06/30/21	5/3/2022	$ 180.00	**PR-2, f/u physio ($180 each)**	$ 180.00	**100%**	Amtrust
26		9/23/2021	8/23/2022	$ 90.00	**F/u acup ($180)**	$ 90.00		
27	79308	04/26/21-05/05/21	2/2/2022	$ 360.00	**4 F/u acup ($180 each)**	$ 360.00	**100%**	Amtrust
28	79846	02/03/21-10/04/21	9/27/2022	$ 900.00	**Initial, initial chiro, initial acup, 3 PR-2s, 4 f/u acup, P&S ($180 each)**	$ 900.00	**100%**	Amtrust

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
29	80501	9/29/2021	9/14/2022	$ 90.00	**Shockwave ($180)**	$ 90.00	**100%**	Amtrust
30	80710	04/06/21-07/06/21	11/10/2022	$ 1,080.00	**2 F/u chiro, 5 F/u acup, 2 PR-2s, 3 f/u physio ($180 each)**	$ 1,080.00	**100%**	Amtrust
31	81166	4/28/2021	1/27/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Amtrust
32	81645	01/14/20-04/02/20	5/11/2022	$ 450.00	**Initial, initial acup, 6 f/u acup, PR-2 ($180 each)**	$ 450.00	**100%**	Applied Risk
33	79542	7/29/2021	4/29/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Athens
34	77986	03/03/21-3/29/21	1/24/2022	$ 547.50	**4 F/u acup ($180 each)**	$ 547.50	**100%**	Berkshire
35	79417	4/06/21-4/13/21	1/6/2022	$ 305.00	**2 F/u physio ($180 each)**	$ 305.00	**100%**	Berkshire
36	81294	06/08/21-11/19/21	11/1/2022	$ 2,699.10	**Initial, 2 PR-2s, EMG, 18 f/u acup ($180 each)**	$ 2,699.10	**100%**	Broadspire
37	77710	5/6/2021	1/28/2022	$ 90.00	**Initial acup ($180)**	$ 90.00	**100%**	Cannon Cochran
38		5/27/2021	6/1/2022	$ 90.00	**Initial exam ($180)**	$ 90.00		
39		6/7/2021	3/3/2022	$ 90.00	**PR-2 ($180)**	$ 90.00		
40		8/17/2021	6/7/2022	$ 90.00	**Chiro ($180)**	$ 90.00		

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
41	78354	7/28/2021	5/19/2022	$ 90.00	**F/u acup ($180)**	$ 90.00		Cannon Cochran
42		05/19/21-05/26/21	6/2/2022	$ 180.00	**2 F/u acup ($180 each)**	$ 180.00	**100%**	
43		9/15/2021	7/13/2022	$ 90.00	**F/u acup ($180)**	$ 90.00		
44	80377	11/18/2021-11/22/21	12/5/2022	$ 180.00	**F/u acup, PR-2 ($180 each)**	$ 180.00	**100%**	Cannon Cochran
45	81113	11/20/2021	12/2/2022	$ 90.00	**Physiotherapy ($180)**	$ 90.00	**100%**	Cannon Cochran
46	81859	08/10/21-12/06/21	12/28/2022	$ 1,260.00	**Initial, 6 f/u acup, 2 f/u physio, 2 PR-2s, initial chiro ($180 each)**	$ 1,260.00	**100%**	Cannon Cochran
47	77612	4/15/2021	1/25/2022	$ 90.00	**F/u chiro ($180)**	$ 90.00	**100%**	Compwest
48		09/08/21-09/15/21	7/7/2022	$ 180.00	**F/u chiro, f/u physio ($180 each)**	$ 180.00		
49	79376	8/10/2021	5/11/2022	$ 90.00	**Initial acup ($180)**	$ 90.00	**100%**	Compwest
50	79392	10/8/2021	8/22/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Compwest
51	79855	8/30/2021	6/17/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Compwest
52	80663	8/19/21 & 9/7/21	6/6/2022	$ 270.00	**F/u acup, PR-2, f/u physio ($180 each)**	$ 270.00	**100%**	Compwest
53		9/24/2021	8/9/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
54		10/1/2021	8/22/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
55	81219	12/13/21-12/20/21	12/9/2022	$ 270.00	**2 F/u physio, f/u acup ($180 each)**	$ 270.00	**100%**	Compwest
56	82004	08/12/21-11/16/21	12/13/2021	$ 1,530.00	**2 Initials, initial acup, 12 f/u acup, FCE test, PR-2 ($180 each)**	$ 1,530.00	**100%**	Compwest

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
57	82188	12/14/2021	12/16/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	Compwest
58	81558	6/28/21-9/16/21	12/28/2022	$ 1,620.00	**Initial, initial acup, 7 f/u physio, 7 f/u acup,EMG, PR-2 ($180 each)**	$ 1,620.00	**100%**	Crum & Forster
59	78358	2/15/2021	3/8/2022	$ 90.00	**F/u acup ($180)**	$ 270.00	**100%**	Farmers
60	79266	3/22/2021	2/2/2022	$ 90.00	**PR-2 ($180)**	$ 270.00	**100%**	Farmers
61	79438	12/18/2021	11/28/2022	$ 162.00	**PR-2 ($180)**	$ 162.00	**100%**	Ins Co Of the West
62	82950	3/9/2022	10/31/2022	$ 305.00	**PR-2 ($485) Exotic Language**	$ 305.00	**100%**	Ins Co Of the West
63	78124	7/31/2021	5/25/2022	$ 90.00	**F/u chiro ($180)**	$ 90.00	**100%**	Liberty Mutual
64		9/25/2021	8/22/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
65	78574	8/31/2021	7/1/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Liberty Mutual
66	78805	10/19/2021	9/14/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	Liberty Mutual
67	81137	05/26/21-07/01/21	10/14/2022	$ 630.00	**Initial, initial acup, 5 F/u acup ($180 each)**	$ 630.00	**100%**	Liberty Mutual
68	81305	12/14/2021	12/1/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	Liberty Mutual

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
69	81375	06/15/21-11/17/21	10/19/2022	$ 1,530.00	**Initial, 11 f/u chiro, 4 PR-2s, initial acup ($180 each)**	$ 1,530.00	**100%**	Liberty Mutual
70		11/22/21-12/15/21	11/9/2022	$ 270.00	**3 F/u acup ($180 each)**	$ 270.00	**100%**	
71		11/29/2021	11/21/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
72	82182	8/31/21-12/17/21	12/5/2022	$ 1,080.00	**Initial, initial acup, initial physio, 3 f/u physio, 2 PR-2s, 4 f/u acup ($180 each)**	$ 1,080.00	**100%**	Liberty Mutual
73	82789	10/27/21-12/8/21	12/2/2022	$ 540.00	**Initial, initial chiro, 3 f/u chiro, PR-2 ($180 each)**	$ 540.00	**100%**	Liberty Mutual
74	79170	12/3/2021	12/2/2022	$ 90.00	**P&S ($180)**	$ 90.00	**100%**	Nationwide
75	81413	12/17/2021	12/2/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Omaha
76	80623	12/07/21-12/09/21	11/21/2022	$ 180.00	**PR-2, f/u acup ($180 each)**	$ 360.00	**100%**	Pacific Comp
77		12/22/2021	12/8/2022	$ 90.00	**F/u acup ($180)**	$ 270.00	**100%**	
78	81292	11/9/21-11/30/21	12/14/2022	$ 270.00	**2 F/u acup, PR-2 ($180 each)**	$ 270.00	**100%**	Pacific Comp
79		12/17/21-1/11/22	12/8/2022	$ 270.00	**2 F/u physio, PR-2 ($180 each)**	$ 270.00	**100%**	
80	81653	11/30/21-12/9/21	11/30/2022	$ 270.00	**PR-2, 2 f/u physio ($180 each)**	$ 270.00	**100%**	Pacific Comp
81	82412	09/23/21-12/01/21	12/14/2022	$ 270.00	**Initial, 4 f/u acup, PR-2 ($180 each)**	$ 270.00	**100%**	Pacific Comp

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
82	82608	11/10/2021	12/1/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Pacific Comp
83	77667	08/03/20-9/18/20	1/10/2022	$ 180.00	**PR-2, P&S ($180 each)**	$ 180.00	**100%**	Scif
84	79149	5/5/2021	6/9/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	Scif
85	77410	3/17/2021	1/21/2022	$ 90.00	**F/u chiro ($180)**	$ 90.00	**100%**	Sedgwick
86		4/13/2021	1/25/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
87	77699	9/18/2020	4/22/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	Sedgwick
88	78167	5/13/2021	2/11/2022	$ 90.00	**Shockwave ($180)**	$ 90.00	**100%**	Sedgwick
89		6/10/21-6/19/21	7/7/2022	$ 270.00	**2 Shockwave, PR-2 ($180 each)**	$ 270.00	**100%**	
90	74055	5/4/2021	1/19/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	The Hartford
91		5/25/2021-5/26/2021	2/23/2022	$ 180.00	**PR-2, initial exam ($180 each)**	$ 180.00	**100%**	
92		8/19/2021	5/17/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	
93		8/27/2021	7/28/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
94		9/2/2021	6/24/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
95		10/11/2021	9/8/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
96	77020	2/6/20-2/11/20	3/22/2022	$ 180.00	**F/u acup ($180)**	$ 180.00	**100%**	The Hartford

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
97	78936	4/14/2021	1/6/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	The Hartford
98		7/30/2021	4/22/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	
99		9/28/2021	8/9/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
100		10/12/2021	8/26/2022	$ 90.00	**F/u physio ($180)**	$ 90.00	**100%**	
101	79598	10/12/21-10/26/2021	9/28/2022	$ 270.00	**3 F/u physio ($180 each)**	$ 270.00	**100%**	The Hartford
102		10/6/2021	9/30/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
103		11/04/21-11/16/21	10/20/2022	$ 450.00	**3 F/u physio, 2 PR-2s ($180 each)**	$ 450.00	**100%**	
104	79767	10/26/2021	9/27/2022	$ 90.00	**F/u chiro ($180)**	$ 90.00	**100%**	The Hartford
105		12/6/2021	11/21/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	
106	79854	9/30/2021	8/22/2022	$ 90.00	**Shockwave ($180)**	$ 90.00	**100%**	The Hartford
107		12/9/2021	11/21/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	
108	80242	11/08/21-11/10/21	10/4/2022	$ 180.00	**Initial acup, f/u acup ($180 each)**	$ 180.00	**100%**	The Hartford
109		11/15/2021	10/21/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	
110		11/22/21-12/13/21	11/7/2022	$ 450.00	**3 F/u acup, 2 PR-2s ($180 each)**	$ 450.00	**100%**	
111		12/29/2021	11/30/2022	$ 180.00	**F/u acup ($180)**	$ 180.00	**100%**	
112		1/10/22-1/19/22	12/22/2022	$ 360.00	**3 f/u acup, P&S ($180 each)**	$ 360.00	**100%**	
113		4/29/21-10/19/21	12/29/2022	$ 1,080.00	**10 F/u chiro, PR-2, P&S ($180 each)**	$ 1,080.00	**100%**	

Maximus IBR Determinations Market Rate Summary Graph 2022

	Invoice	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addt'l Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
114	80639	1/10/2022	12/22/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	The Hartford
115	81101	9/28/2021	8/17/2022	$ 90.00	**PR-2 ($180)**	$ 90.00	**100%**	The Hartford
116	82312	12/9/2021	11/28/2022	$ 90.00	**F/u acup ($180)**	$ 90.00	**100%**	The Hartford
117		1/11/2022-1/17/2022	12/22/2022	$ 180.00	**Shockwave, f/u acup ($180 each)**	$ 180.00	**100%**	
118	82519	9/27/21-1/7/22	12/28/2022	$ 1,170.00	**Initial, 5 f/u acup, 4 f/u physio, PR-2, EMG, f/u chiro ($180 each)**	$ 1,170.00	**100%**	The Hartford
119	75998	5/7/2021	1/27/2022	$ 90.00	**F/u chiro ($180)**	$ 90.00	**100%**	York

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81193

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000068 December 16, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 20 2022

IBR Case Number	CB22-0002471
Claim Number	
Assignment Date	11/04/2022
Claims Administrator	Accident Fund
Date(s) of service	12/18/2021 - 12/20/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 2
Date of Injury	04/12/2021
Application Received	09/30/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Accident Fund
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 2 submitted for dates of service 12/18/2021 – 12/20/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/19/2022. Response received 11/04/2022. Claims Administrator provided copies of the IBR documents.
- Itemized invoices
    - 12/18/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 12/20/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 12/18/2021 and 12/20/2021. Charge exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 12/18/2021 and 12/20/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Service x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 2
Date of Service: 12/18/2021 – 12/20/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Accident Fund
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Security features included. Details on back.

AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102412208

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 05/22/2022

Pay This Amount

Pay the Sum of *One hundred eighty and 00/100 Dollars*

$180.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102412208⑈ ⑆044115443⑆ 268937353⑈

AF Group

PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 05/22/2022
CHECK NUMBER : 102412208

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	01/04/2022	01/04/2022	5022-5843406		$90.00
	12/18/2021	12/18/2021	4022-75134		$90.00
				TOTAL	$180.00

PAID
JUN 01 2022
BY. .....

RECEIVED
MAY 31 2022
81193

Questions may be directed to us at : 866-206-5851
Check Number : 102412208

UnitedHeartland

United Heartland - California 4022

Process Date: 05/19/2022
Control Number: 75134
EOR Page 1 of 2
Rev/Aud: AA/SN

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 81193 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN: XXX-XX-8729
Date Of Injury: 04/12/2021
Claims Received Date: 05/09/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/18/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

UnitedHeartland
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
UnitedHeartland.com

CHECK DATE : 05/13/2022
CHECK NUMBER : 102403365

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

	EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
		12/20/2021	12/20/2021	4022-74952		$90.00
					TOTAL	$90.00

PAID
MAY 24 2022

MAY 23 2022
BY: 81193

Questions may be directed to us at : 800-258-2667
Check Number : 102403365

UnitedHeartland
Part of the AF Group

United Heartland - California 4022

Process Date: 05/12/2022
Control Number: 74952
EOR Page 1 of 2
Rev/Aud: AA/SN

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 81193 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 04/12/2021
Claims Received Date: 05/05/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/20/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: HASSANIN, MOHAMED
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80250

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000089 October 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 3 1 2022

IBR Case Number	CB22-0001967
Claim Number	
Assignment Date	09/15/2022
Claims Administrator	Chartis (AIG)
Date(s) of service	11/11/2021 - 11/18/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	07/15/2020
Application Received	08/19/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis (AIG)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 11/11/2021 – 11/18/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/30/2022. Response not yet received.
- Itemized invoices
    - 11/11/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/18/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/11/2021 and 11/18/2021. The charge exceeds the OMFS allowance, the charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/11/2021 and 11/18/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks. and Explanation of Payments.
- Based on the documentation, interpreter verification form, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 11/11/2021 – 11/18/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis (AIG)
PO Box 25977
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202204190129

Electronic Service Requested

ALL FOR AADC 926
33048 0.7130 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 515
PO BOX 4165
TUSTIN, CA 92781-4165

1 OF 3 F

ENV 33048

Check No.: 35453563
RFP No.: 139013
Check Date: 04/19/2022
Check Amount: 90.00
Insured: CAITAC GARMENT PROCESSING INC
Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

APR 25 2022

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000014022293		001	07/15/2020	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 80250 111121-111121

Use File # 572/00083102 on all correspondence for prompt processing.
For check information call: 877-802-5246

646586 (PC6)

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210101111
Control #: 26221040021900

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

ENV 33048 2 OF 3 F

ALL FOR AADC 926
33048 0.7130 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 515
PO BOX 4165
TUSTIN, CA 92781-4165

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 07/15/2020
Claimant SSN:

State Claim #: ADJ14330481
Patient Acct #: 80250
Service Dates: 11/11/2021-11/11/2021

Policy #: 000014022293
Employer: CAITAC GARMENT PROCESSING INC
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 04/05/2022
Date Reviewed: 04/14/2022
Date Processed: 04/18/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
11/11/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
		Totals		180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210101111
Control #: 26221040021900

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

2 OF 3 B
ENV 33048

* -Request for Independent Bill Review. After a health care provider, health care facility, or billing agent, assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent, assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of the service of the EOR. The Request for Independent Bill Review must conform to the requirements of the title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent, assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer ha
s contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final. (ZD49)
* -This claim has been processed on a policy underwritten by AMERICAN HOME ASSURANCE COMPANY

Negotiated/ PPO Savings:	0.00
Recommended Amount:	90.00
Previously Paid:	0.00
Payment:	90.00

Check #:	35453563
Check Date:	04/19/2022
Method of Payment:	Check
Payment Status Code:	1

Medical bill EOR and payment status information is now available online at www.aig.com/epbi.
Click "Provider Sign Up" on the Sign in screen.

If you have questions about this review please call AIG at: 877-802-5246

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202204260127

Electronic Service Requested

ALL FOR AADC 926
17329 0.7648 AB 0.458
JOYCE ALTMAN INTERPRETERS INC 224
PO BOX 4165
TUSTIN, CA 92781-4165

1 OF 3 F

ENV 17329

BY

Check No.: 35461635
RFP No.: 143695
Check Date: 04/26/2022
Check Amount: 90.00
Insured: CAITAC GARMENT PROCESSING INC
Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000014022293		001	07/15/2020	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 80250 111821-111821

Use File # 572/00083102 on all correspondence for prompt processing
For check information call: 877-802-5246

646586 (PC6)

Control #: 26221110024500

P.O. BOX 25978
SHAWNEE MISSION KS 66225

ALL FOR AADC 926
17329 0.7648 AB 0.458
JOYCE ALTMAN INTERPRETERS INC 224
PO BOX 4165
TUSTIN, CA 92781-4165

2 OF 3 F

ENV 17329

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Claim #:
Claimant:
Date of Injury: 07/15/2020
Claimant SSN:

P4000028003

AIG

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

EXPLANATION OF BILL REVIEW

Invoice #: 2210800658
Control #: 26221110024500

* -Request for Independent Bill Review. After a health care provider, health care facility, or billing agent, assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent, assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of the service of the EOR. The Request for Independent Bill Review must conform to the requirements of the title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent, assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer ha
s contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final. (ZD49)

* This claim has been processed on a policy underwritten by AMERICAN HOME ASSURANCE COMPANY

ENV 17329 2 OF 3 B

P4000028003

20220426012 7

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210800658
Control #: 26221110024500

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

ENV 17329 2 OF 3 F

ALL FOR AADC 926
17329 0.7648 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 224
PO BOX 4165
TUSTIN, CA 92781-4165

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 07/15/2020
Claimant SSN:

State Claim #: ADJ14330481
Patient Acct #: 80250
Service Dates: 11/18/2021-11/18/2021

Policy #: 000014022293
Employer: CAITAC GARMENT PROCESSING INC
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 04/12/2022
Date Reviewed: 04/21/2022
Date Processed: 04/25/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
11/18/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
			Totals	180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210800658
Control #: 26221110024500

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

ENV 17329 2 OF 3 B

* -Request for Independent Bill Review. After a health care provider, health care facility, or billing agent, assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent, assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of the service of the EOR. The Request for Independent Bill Review must conform to the requirements of the title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent, assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer ha
s contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final. (ZD49)
* -This claim has been processed on a policy underwritten by AMERICAN HOME ASSURANCE COMPANY

Negotiated/ PPO Savings:	0.00
Recommended Amount:	90.00
Previously Paid:	0.00
Payment:	90.00

Check #:	35461635
Check Date:	04/26/2022
Method of Payment:	Check
Payment Status Code:	1

Medical bill EOR and payment status information is now available online at www.aig.com/epbi.
Click "Provider Sign Up" on the Sign in screen.

If you have questions about this review please call AIG at: 877-802-5246

AIG WEST WC
P O BOX 2934
CLINTON IA 52733-2934

0102732 01 RE 0.515 **AUTO T6 2 1742 92781-416565 -P02734 C01

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN CA 92781-4165

ALTM
DEC 2 1 2022

DIRECT INQUIRIES TO:

PHONE: 1-315-234-2600
AIG WEST WC
P. O. BOX 2934
CLINTON IA 52733-2934

NATIONAL UNION FIRE INSURANCE CO. OF P

CLAIM NO.

CLAIMANT:

DESCRIPTION: IBR

DATE OF SERVICE: 11-Nov-2021 TO 18-Nov-2021

BRANCH NO 269

ACC. DATE 15-Jul-2020

PAYMENT AMOUNT: $180.00

CHECK NO. 0184322966

VN. 0000660411

DATE: 14-Dec-2022

RE0102732-0001_of_0002 1742-0002875 (G26D)

DETACH AND RETAIN THIS STUB FOR YOUR RECORDS

CHECK NO. 0184322966 ATTACHED BELOW

AIG WEST WC
P O BOX 2934
CLINTON IA 52733-2934

0102646 01 RE 0.515 **AUTO T6 1 1748 92781-416565 -P02648 C01

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN CA 92781-4165

DIRECT INQUIRIES TO:

PHONE: 1-315-234-2600
AIG WEST WC
P. O. BOX 2934
CLINTON IA 52733-2934

NATIONAL UNION FIRE INSURANCE CO. OF P

CLAIM NO.

BRANCH NO. 269

CHECK NO. 0184549714

CLAIMANT:

ACC. DATE 15-Jul-2020

VN. 0000917234

DESCRIPTION: OUSTANDING BALANCE

DATE 22-Dec-2022

DATE OF SERVICE: 02-Apr-2021 TO 24-May-2022

PAYMENT AMOUNT: $2,070.00

RE0102646-0001_of_0001 1748-0002786 (326U)

DETACH AND RETAIN THIS STUB FOR YOUR RECORDS

CHECK NO. 0184549714 ATTACHED BELOW

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80250

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000041 December 12, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 19 2022

IBR Case Number	CB22-0002406
Claim Number	
Assignment Date	10/31/2022
Claims Administrator	Chartis (AIG)
Date(s) of service	12/20/2021 - 12/20/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	07/15/2020
Application Received	09/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis (AIG)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/20/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/13/2022. Response not yet received.
- Itemized invoice
    - 12/20/2021 Interpreting for physiotherapy (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the amount indicated in the fee schedule.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/20/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/20/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis (AIG)
PO Box 25977
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

202205190128

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

Electronic Service Requested

ALL FOR AADC 926
33486 0.9555 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 530
PO BOX 4165
TUSTIN, CA 92781-4165

RECEIVED
MAY 25 2022

RECEIVED
MAY 24 2022

3 OF 4 F

ENV 33486

Check No.: 35489084
RFP No.: 157424
Check Date: 05/19/2022
Check Amount: 90.00
Insured: CAITAC GARMENT PROCESSING INC
Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000014022293		001	07/15/2020	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 80250 122021-122021

Use File # 572/00083102 on all correspondence for prompt processing.
For check information call: 877-802-5246

646586 (PC6)

P4000028003

202205190128

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2213201223
Control #: 26221360066000

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

4 OF 4 F

ENV 33486

ALL FOR AADC 926
33486 0.9555 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 530
PO BOX 4165
TUSTIN, CA 92781-4165

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 07/15/2020
Claimant SSN:

State Claim #: ADJ14330481
Patient Acct #: 80250
Service Dates: 12/20/2021-12/20/2021

Policy #: 000014022293
Employer: CAITAC GARMENT PROCESSING INC
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 05/06/2022
Date Reviewed: 05/16/2022
Date Processed: 05/18/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
12/20/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
		Totals		180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

AIG WEST WC
P O BOX 2934
CLINTON IA 52733-2934

0102646 01 RE 0.515 **AUTO T6 1 1748 92781-416565 -P02648 C01

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX 4165
TUSTIN CA 92781-4165

DIRECT INQUIRIES TO:

PHONE: 1-315-234-2600
AIG WEST WC
P. O. BOX 2934
CLINTON IA 52733-2934

NATIONAL UNION FIRE INSURANCE CO. OF P

CLAIM NO.

BRANCH NO. 269

CHECK NO. 0184549714

CLAIMANT:

ACC. DATE 15-Jul-2020

VN. 0000917234

DESCRIPTION: OUSTANDING BALANCE

DATE 22-Dec-2022

DATE OF SERVICE: 02-Apr-2021 TO 24-May-2022

PAYMENT AMOUNT: $2,070.00

RE0102646-0001_of_0001 1748-0002786 (326U)

DETACH AND RETAIN THIS STUB FOR YOUR RECORDS

CHECK NO. 0184549714 ATTACHED BELOW

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80452

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000076 October 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 3 1 2022

IBR Case Number	CB22-0001764
Claim Number	
Assignment Date	09/12/2022
Claims Administrator	Chartis (AIG)
Date(s) of service	04/08/2021 - 05/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 4
Date of Injury	03/11/2020
Application Received	07/27/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $360.00 in additional reimbursement for a total of $540.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$540.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis (AIG)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 4 submitted for dates of service 04/08/2021 – 05/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/24/2022. Response not yet received.
- Itemized invoices
    - 04/08/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 04/23/2021 Interpreting for Initial Chiro $180.00 (Billed at a minimum of 2 hours)
    - 05/06/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 05/13/2021 Interpreting for Initial physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 04/08/2021 – 05/13/2021. Charges exceed the OMFS allowance; charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks. and Explanation of Payments.
- Based on the documentation, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 4 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 4.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 4
Date of Service: 04/08/2021 – 05/13/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis (AIG)
PO Box 25987
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202203280130

Electronic Service Requested

ENV 20130 1 OF 4 F

ALL FOR AADC 926
20130 0.9028 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 337
PO BOX 4165
TUSTIN, CA 92781-4165

Check No.: 35427076
RFP No.: 127307
Check Date: 03/26/2022
Check Amount: 360.00
Insured: DECISIONHR I, INC.

Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

PAID
APR 05 2022
BY:

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000023540579		001	03/11/2020	MED	O	360.00
					Total Amount	360.00

Reason for Payment ✓
ORG: 720.00 ACT: 80452 040821-051321

Use File # 572/00073064 on all correspondence for prompt processing.
For check information call: 877-802-5246

RECEIVED
APR 04 2022

646586 (PC6)

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2207601072
Control #: 26220810065500

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

ALL FOR AADC 926
20130 0.9028 AB 0.458

JOYCE ALTMAN INTERPRETERS INC 337
PO BOX 4165
TUSTIN, CA 92781-4165

2 OF 4 F
ENV 20130

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 03/11/2020
Claimant SSN:

State Claim #: ADJ13389157
Patient Acct #: 80452
Service Dates: 04/08/2021-05/13/2021

Policy #: 000023540579
Employer: DECISIONHR I, INC.
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 03/14/2022
Date Reviewed: 03/22/2022
Date Processed: 03/25/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
04/08/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
04/23/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
05/06/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
05/13/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
			Totals	720.00	360.00	0.00	360.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2207601072
Control #: 26220810065500

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

2022032801301 2 OF 4 B ENV 20130

* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)
* -Request for Independent Bill Review. After a health care provider, health care facility, or billing agent, assignee submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, a health care provider, health care facility, or billing agent, assignee that still disputes the amount paid may submit a request for independent bill review within 30 days of the service of the EOR. The Request for Independent Bill Review must conform to the requirements of the title 8, California Code of Regulations section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent, assignee fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer ha s contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final. (ZD49)
* -This claim has been processed on a policy underwritten by AMERICAN HOME ASSURANCE COMPANY

Negotiated/ PPO Savings:	0.00
Recommended Amount:	360.00
Previously Paid:	0.00
Payment:	360.00

Check #:	35427076
Check Date:	03/26/2022
Method of Payment:	Check
Payment Status Code:	1

Medical bill EOR and payment status information is now available online at www.aig.com/epbi.
Click "Provider Sign Up" on the Sign in screen.

If you have questions about this review please call AIG at: 877-802-5246

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80489

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 31, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002014
Claim Number	
Assignment Date	09/20/2022
Claims Administrator	Chartis (AIG)
Date(s) of service	11/11/2021 - 11/11/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/16/2020
Application Received	08/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis (AIG)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/11/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/02/2022. Response not yet received.
- Itemized invoice
    - 11/11/2021 Interpreting for shockwave therapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the OMFS allowance; charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/11/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/11/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis (AIG)
PO Box 25977
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202204253915

Electronic Service Requested

ALL FOR AADC 926
5185 2.2355 AB 0.458
JOYCE ALTMAN INTERPRETERS INC 35
PO BOX 4165
TUSTIN, CA 92781-4165

ENV 5185 1 OF 11 F

Check No.: 35460082
RFP No.: 142814
Check Date: 04/23/2022
Check Amount: 90.00
Insured: DECISIONHR I, INC.

Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

PAID
MAY 03 2022
BY.....

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000023540503		001	02/16/2020	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 80489 111121-111121

Use File # 572/00068435 on all correspondence for prompt processing.
For check information call: 877-802-5246

PAYMENT
BY.....

646586 (PC6)

P4000028003

202204253915

AIG

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

EXPLANATION OF BILL REVIEW

Invoice #: 2210401033
Control #: 26221090014400

ALL FOR AADC 926
5185 2.2355 AB 0.458
JOYCE ALTMAN INTERPRETERS INC 35
PO BOX 4165
TUSTIN, CA 92781-4165

ENV 5185 2 OF 11 F

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210401033
Control #: 26221090014400

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

ALL FOR AADC 926
5185 2.2355 AB 0.458
JOYCE ALTMAN INTERPRETERS INC 35
PO BOX 4165
TUSTIN, CA 92781-4165

2 OF 11 F
ENV 5185

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 02/16/2020
Claimant SSN:

State Claim #: ADJ13399520
Patient Acct #: 80489
Service Dates: 11/11/2021-11/11/2021

Policy #: 000023540503
Employer: DECISIONHR I, INC.
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 04/05/2022
Date Reviewed: 04/19/2022
Date Processed: 04/22/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
11/11/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
			Totals	180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

AIG WEST WC
P O BOX 2934
CLINTON IA 52733-2934

M

0102287 01 RE 0.515 **AUTO T5 0 1722 92781-416565 -P02289 C01

JOYCE ALTMAN INTERPRETERS, INC.
P O. BOX 4165
TUSTIN CA 92781-4165

NOV 2 3 2022

DIRECT INQUIRIES TO:

PHONE: 1-315-234-2600
AIG WEST WC
P. O. BOX 2934
CLINTON IA 52733-2934

NATIONAL UNION FIRE INSURANCE CO. OF P

CLAIM NO.

CLAIMANT:

DESCRIPTION: CB22-0002014

DATE OF SERVICE: 11-Nov-2021 TO 11-Nov-2021

BRANCH NO. 269

ACC. DATE 16-Feb-2020

PAYMENT AMOUNT: $270.00

CHECK NO. 0183597665

VN. 0000185731

DATE: 15-Nov-2022

RE0102287-0001_of_0001 1722-0002395 (G26D)

DETACH AND RETAIN THIS STUB FOR YOUR RECORDS

CHECK NO. 0183597665 ATTACHED BELOW

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80555

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000056 August 23, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

AUG 3 0 2022

IBR Case Number	CB22-0001367
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	Chartis
Date(s) of service	09/30/2021 - 09/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	07/24/2019
Application Received	06/10/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for dates of service 09/30/2021 .**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response not yet received.
- Itemized Invoices
    - 09/30/2021 Interpreting FU physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: this charge exceeds the OMFS allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/30/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis
P. O. Box 25977
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202202151619

Electronic Service Requested

SINGLE PIECE
2242 0.5486 SP 0.560

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781-4165

1 OF 2 F
ENV 2242

Check No.: 35378303
RFP No.: 103079
Check Date: 02/15/2022
Check Amount: 90.00
Insured: ZODIAC US CORPORATION

Claimant:

Claim Office: 572
Insuring Company: AMERICAN HOME ASSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

FEB 24

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000012717061		001	07/24/2019	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 80555 093021-093021

Use File # 572/00055952 on all correspondence for prompt processing
For check information call: 877-802-5246

RECEIVED
FEB 22

BY:

646586 (PC6)

AIG

EXPLANATION OF BILL REVIEW

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

Invoice #: 2203501349
Control #: 26220410012600

SINGLE PIECE
2242 0.5486 SP 0.560

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781-4165

ENV 2242 2 OF 2 F

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 07/24/2019
Claimant SSN:

State Claim #:
Patient Acct #: 80555
Service Dates: 09/30/2021-09/30/2021

Policy #: 000012717061
Employer: ZODIAC US CORPORATION
Insurer: AMERICAN HOME ASSURANCE CO

Date Received: 01/24/2022
Date Reviewed: 02/10/2022
Date Processed: 02/14/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
09/30/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2 ,3 ,4
			Totals	180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -This charge was adjusted for the reasons set forth in the attached letter.
2 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
3 -The reduction was made for reasons indicated in note below or on the attached note or letter.
4 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81806

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000090 October 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 3 1 2022

IBR Case Number	CB22-0001968
Claim Number	
Assignment Date	09/15/2022
Claims Administrator	Chartis (AIG)
Date(s) of service	11/12/2021 - 11/12/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/15/2021
Application Received	08/19/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Chartis (AIG)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/12/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/30/2022. Response not yet received.
- Itemized invoice
    - 11/12/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the OMFS allowance; charge was adjusted to the scheduled allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/12/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/12/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Chartis (AIG)
PO Box 25977
Shawnee Mission, KS 66225

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

P4000028000

American International Group, Inc.
PO Box 25565
Shawnee Mission, KS 66225

202204201617

Electronic Service Requested

SINGLE PIECE
912 0.5486 SP 0.560

JOYCE ALTMAN INTERPRETERS INC 3
PO BOX 4165
TUSTIN, CA 92781-4165

1 OF 2 F
ENV 912

Check No.: 35454933
RFP No.: 139970
Check Date: 04/20/2022
Check Amount: 90.00
Insured: DMSI HOLDINGS INC

Claimant:

Claim Office: 572
Insuring Company: AIU INSURANCE COMPANY

Payee Name: JOYCE ALTMAN INTERPRETERS

RECEIVED
APR 26 2022

Policy No.	Claim No.	Symbol	Date of Loss	Type	Status	Amount
000048426040		001	05/15/2021	MED	O	90.00
					Total Amount	90.00

Reason for Payment
ORG: 180.00 ACT: 81806 111221-111221

Use File # 572/00086540 on all correspondence for prompt processing.
For check information call: 877-802-5246

RECEIVED
APR 2 [illegible]

DE: 81806

646586 (PC6)

AIG

EXPLANATION OF BILL REVIEW

Invoice #: 2210201179
Control #: 26221050025300

AIG CLAIMS, INC.
P.O. BOX 25978
SHAWNEE MISSION KS 66225

SINGLE PIECE
912 0.5486 SP 0.560

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781-4165

3

2 OF 2 F
ENV 912

Billing Provider:
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Tax ID: 330956713
State License #:
NPI #: 9999999999

Rendering Provider:

Tax ID/NPI #:

Claim #:
Claimant:
Date of Injury: 05/15/2021
Claimant SSN:

State Claim #: ADJ14803773
Patient Acct #: 81806
Service Dates: 11/12/2021-11/12/2021

Policy #: 000048426040
Employer: DMSI HOLDINGS INC
Insurer: AM INTL UNDRWRTRS & AIU INS CO

Date Received: 04/06/2022
Date Reviewed: 04/15/2022
Date Processed: 04/19/2022

Jurisdiction: CA

Dates of Service	Billed Proc Code	Paid Proc Code	Units	Billed Charges	Fee Schedule or Customary	PPO Savings	Recommended Allowance	Codes
11/12/2021	T1013	T1013	8.00	180.00	90.00	0.00	90.00	1 ,2
		Totals		180.00	90.00	0.00	90.00	

Diagnosis:
T1490 INJURY, UNSPECIFIED

1 -The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
2 -The charge for the procedure exceeds the amount indicated in the fee schedule.
* -In accordance with section 9789.12.2(a) of the California Official Medical Fee Schedule, reimbursement is based on the non-facility site of service calculation. (PNFC)
* -California is a jurisdictional state. This review has been conducted based on the Official Medical Fee Schedule (OMFS) or other criteria that apply to your bill within California jurisdiction. (Z005)
* -California Labor Code Section 4600.2 allows a carrier to enter into a contractual agreement with a pharmacy network . AIG and AIG Claims, Inc. have entered into a contractual agreement with TMESYS a Pharmacy Benefit Network. As of March 1, 2011 all pharmacy transactions should be processed through TMESYS. For questions regarding how to process transactions through TMESYS please call 1-800-682-4491. (Z356)
* -Request for Second Review. After an EOR is received on an original bill submission, a healthcare provider, healthcare facility, or billing agent, assignee that disputes the amount paid may submit an appeal, reconsideration, Request for Second Review to the claims administrator within 90 days of the service of the explanation or review. The Request for Second Review must conform to the requirements of the Division of Workers' Compensation Medical Billing Guide, and regulations at title 8. California Code of Regulations section 9792.5.4 et seq. If the dispute is the amount of payment and the health care provider, health care facility, or billing agent, assignee does not request a second review within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. (Z400)
* -Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)
* -Medical bills and reconsideration requests should be directed to P.O. Box 25978, Shawnee Mission, KS 66225. (Z657)
* -The Payment Status Code reflects the recommended allowance as a result of our Bill Review analysis. The actual payment will be determined by the Payor. (ZCA1)

If you have questions about this review please call AIG at: 877-802-5246

CONTINUED

76951

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 10 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000073 January 6, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002555
Claim Number	
Assignment Date	11/16/2021
Claims Administrator	AmTrust
Date(s) of service	03/16/2021 - 04/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	08/23/2019
Application Received	10/15/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed expianation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 03/16/2021 – 04/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/29/2021. Response not yet received.
- Itemized Invoices
    - 03/16/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
    - 04/06/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
    - 04/13/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 03/16/2021 – 04/13/2021. The OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 03/16/2021 – 04/13/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 03/16/2021 – 04/13/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/16/2021** $90.00 (Market Rate for One hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/06/2021** $90.00 (Market Rate for One hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/13/2021** $90.00 (Market Rate for One hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

VOID VOID VOID

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00237912
3153527-1
QWC1071438

DATE	AMOUNT
6/10/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈00237912⑈ ⑆021000021⑆ 226733883⑈

RECEIVED
JUN 17 2021

Explanation Of Bill Review

Check Number	00237912
Claim Number:	
Regulatory ID:	
Bill Number:	16502044
Invoice Number:	FP1-MJCA-1437186
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	8/23/2019 FP1-MJCA-1437186
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

RECEIVED
JUN 15 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/6/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00237913
3153527-1
QWC1071438

DATE	AMOUNT
6/10/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈00237913⑈ ⑆021000021⑆ 226733883⑈

JUN 17 2021

Explanation Of Bill Review

Check Number	00237913
Claim Number:	
Regulatory ID:	
Bill Number:	16502046
Invoice Number:	FP1-MJCA-1437210
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	8/23/2019 FP1-MJCA-1437210
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/13/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.	
00262987	
3153527-1	
QWC1071438	
DATE	AMOUNT
1/26/2022	$450.00

Four Hundred Fifty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈00262987⑈ ⑆021000021⑆ 226733883⑈

Check Number	00262987
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	8/23/2019
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372

PAID
FEB 01 2022

BY: .....

Amount:	$450.00
Dates of Service:	3/16/2021-4/13/2021
Explanation:	Per IBR Final Determination
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

76951

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000032 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002756
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	AmTrust
Date(s) of service	04/27/2021 - 05/11/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	08/23/2019
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 04/27/2021 - 05/11/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized Invoices
    - 04/27/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 05/11/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/27/2021 and 05/11/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 04/27/2021 – 05/11/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78174

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000029 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002753
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	AmTrust
Date(s) of service	05/11/2021 - 05/11/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/20/2018
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/11/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized Invoice
    - 05/11/2021 Interpreting for initial psych visit $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/11/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/11/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00240763
3153527-1
QWC1071438

DATE	AMOUNT
7/12/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈00240763⑈ ⑆021000021⑆ 226733883⑈

JUL 15 2021

Explanation Of Bill Review

Check Number	00240763	SEQUOIA INSURANCE COMPANY
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16584089	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1461953	858-385-4040
Policy / Insured:	OWC1071438/Murat Group LLC	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	8/23/2019 FP1-MJCA-1461953	
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -	
Examiner Code:	30372	
Network/PPO Network:		

76951

JUL 15 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/27/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amoun recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLI AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amou of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request f Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 day of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00242077
3153527-1
QWC1071438

DATE	AMOUNT
7/22/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈00242077⑈ ⑆021000021⑆ 226733883⑈

PAID
JUL 26 2021

Explanation Of Bill Review

Check Number	00242077
Claim Number:	
Regulatory ID:	
Bill Number:	16618046
Invoice Number:	FP1-MJCA-1467846
Policy / Insured:	OWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	8/23/2019 FP1-MJCA-1467846
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

76951
RECEIVED
JUL 26 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/11/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00265781
3153527-1
QWC1071438

DATE	AMOUNT
2/18/2022	$360.00

Three Hundred Sixty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈00265781⑈ ⑆021000021⑆ 226733883⑈

Check Number	00265781
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	8/23/2019
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372

Amount:	$360.00
Dates of Service:	4/27/2021-5/11/2021
Explanation:	DOS 04 27 2021 05 11 2021 Cirilo
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239.3909

76951

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

FEB 2 8 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000111 February 23, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002992
Claim Number	
Assignment Date	01/05/2022
Claims Administrator	AmTrust
Date(s) of service	05/19/2021 - 05/19/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/23/2019
Application Received	12/02/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/19/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/20/2021. Response not yet received.
- Itemized invoice
    - 05/19/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/19/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 hours = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS DOCUMENT HAS AN ARTIFICIAL BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00242614
3153527-1
QWC1071438

DATE	AMOUNT
7/28/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈00242614⑈ ⑆021000021⑆ 226733883⑈

Explanation Of Bill Review

AUG 02 2021

Check Number	00242614
Claim Number:	
Regulatory ID:	
Bill Number:	16636093
Invoice Number:	FP1-MJCA-1486840
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	8/23/2019 FP1-MJCA-1486840
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

76981

AUG 02 2021 by

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/19/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00267699
3153527-1
QWC1071438

DATE	AMOUNT
3/4/2022	$270.00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈00267699⑈ ⑆021000021⑆ 226733883⑈

Check Number	00267699
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	QWC1071438/Murat Group LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	8/23/2019
Location:	2019 E ARTESIA BLVD LONG BEACH CA 90805 -
Examiner Code:	30372

Amount:	$270.00
Dates of Service:	5/19/2021-5/19/2021
Explanation:	Interpreter Reimbursement
Category:	M13 - Settlement
Placement:	2 - Medical
Transaction Type:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

PAID
MAR 10 2022

BY: .....

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77272

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000042 January 24, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002684
Claim Number	
Assignment Date	12/01/2021
Claims Administrator	AmTrust
Date(s) of service	12/10/2019 - 12/27/2019
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	07/01/2019
Application Received	10/29/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 12/10/2019 – 12/27/2019.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/15/2021. Response not yet received.
- Itemized Invoices
    - 12/10/2019 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/17/2019 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/27/2019 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 12/10/2019 – 12/27/2019. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 12/10/2019 – 12/27/2019 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 12/10/2019 – 12/27/2019
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/10/2019** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/17/2019** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/27/2019** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03816768
3199527-1
SWC1205877

DATE	AMOUNT
7/7/2021	$540.00

Five Hundred Forty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03816768⑈ ⑆021309379⑆ 790262463⑈

PAID
JUL 13 2021

BY: .....

Explanation Of Bill Review

Check Number	03816768
Claim Number:	
Regulatory ID:	
Bill Number:	16570799
Invoice Number:	FP1-MJCA-1456873
Policy / Insured:	SWC1205877/Pasadena Car Wash Inc. A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	7/1/2019 FP1-MJCA-1456873
Location:	310 S vincent Ave West Covina CA 91790 -
Examiner Code:	32999
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

77272
RECEIVED
JUL 12 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
11/21/2019	Q00014	INTERPRETER OTHER 15	120.00	230.00	140.00	0.00	90.00	G2, 402
12/3/2019	Q00014	INTERPRETER OTHER 15	120.00	230.00	140.00	0.00	90.00	G2, 402
12/10/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
12/17/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
12/27/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/18/2021	Q00014	INTERPRETER OTHER 15	120.00	150.00	60.00	0.00	90.00	G2, 402
				1150.00	610.00	0.00	540.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04040937
3199527-1
SWC1205877

DATE	AMOUNT
1/25/2022	$500.00

Five Hundred and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈04040937⑈ ⑆021309379⑆ 790262463⑈

Check Number	04040937
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1205877/Pasadena Car Wash Inc. A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	7/1/2019
Location:	310 S vincent Ave West Covina CA 91790 -
Examiner Code:	33608

Amount:	$500.00
Dates of Service:	1/24/2022-1/24/2022
Explanation:	Lien Settlement Agreement Full Final
Category:	M27 - Settlement / multi bills / claim was denied
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101

888.239.3909

FEB 0 [illegible] 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77272

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000022 January 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 3 1 2022

IBR Case Number	CB21-0002685
Claim Number	
Assignment Date	12/02/2021
Claims Administrator	AmTrust
Date(s) of service	11/21/2019 - 12/03/2019
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	07/01/2019
Application Received	10/29/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $280.00 in additional reimbursement for a total of $460.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$460.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for date of service 11/21/2019 - 12/03/2019.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/16/2021. Response not yet received.
- Itemized invoice
    - 11/21/2019 Interpreting for Initial Exam $230.00 (Billed at a minimum of 2 hours)
    - 12/03/2019 Interpreting for Initial acupuncture $230.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for interpreting services for both dates of service 11/21/2019 – 12/03/2019. The OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $230.00 ($115.00 per hour) for initial exam and acupuncture as reflected on invoices and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 11/21/2019 - 12/03/2019
Interpreter

Service Code	Interpreter Services
Provider Billed	$230.00
Plan Allowed	$90.00
Dispute Amount	$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$230.00
Notes	**Overturn DOS 11/21/2019** $115.00 (Market Rate for One Hour) * 2 (hours) = $230.00 - $90.00 (Plan Allowed) = **$140.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$230.00
Plan Allowed	$90.00
Dispute Amount	$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$230.00
Notes	**Overturn DOS 12/03/2019** $115.00 (Market Rate for One Hour) * 2 (hours) = $230.00 - $90.00 (Plan Allowed) = **$140.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03816768
3199527-1
SWC1205877

DATE	AMOUNT
7/7/2021	$540.00

Five Hundred Forty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03816768⑈ ⑆021309379⑆ 790262463⑈

PAID
JUL 13 2021

Explanation Of Bill Review

BY: .....

Check Number	03816768
Claim Number:	
Regulatory ID:	
Bill Number:	16570799
Invoice Number:	FP1-MJCA-1456873
Policy / Insured:	SWC1205877/Pasadena Car Wash Inc. A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	7/1/2019 FP1-MJCA-1456873
Location:	310 S vincent Ave West Covina CA 91790 -
Examiner Code:	32999
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

77272
RECEIVED
JUL 12 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
11/21/2019	Q00014	INTERPRETER OTHER 15	120.00	230.00	140.00	0.00	90.00	G2, 402
12/3/2019	Q00014	INTERPRETER OTHER 15	120.00	230.00	140.00	0.00	90.00	G2, 402
12/10/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
12/17/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
12/27/2019	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/18/2021	Q00014	INTERPRETER OTHER 15	120.00	150.00	60.00	0.00	90.00	G2, 402
				1150.00	610.00	0.00	540.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04040937
3199527-1
SWC1205877

DATE	AMOUNT
1/25/2022	$500.00

Five Hundred and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈04040937⑈ ⑆021309379⑆ 790262463⑈

Check Number	04040937
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1205877/Pasadena Car Wash Inc. A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	7/1/2019
Location:	310 S vincent Ave West Covina CA 91790 -
Examiner Code:	33608

Amount:	$500.00
Dates of Service:	1/24/2022-1/24/2022
Explanation:	Lien Settlement Agreement Full Final
Category:	M27 - Settlement / multi bills / claim was denied
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101

888.239.3909

FEB 0[illegible] 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78174

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000029 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002753
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	AmTrust
Date(s) of service	05/11/2021 - 05/11/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/20/2018
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/11/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized Invoice
    - 05/11/2021 Interpreting for initial psych visit $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/11/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/11/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03826174
3002330-1
SWC1157220

DATE	AMOUNT
7/14/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 927814165

⑈03826174⑈ ⑆021309379⑆ 790262463⑈

JUL 19 2021

Explanation Of Bill Review

Check Number	03826174
Claim Number:	3002330-1
Regulatory ID:	
Bill Number:	16593495
Invoice Number:	FP1-MJCA-1468473
Policy / Insured:	SWC1157220/My Trim Inc. a Corp
Claimant Name:	Nasaria Sanchez
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	5/20/2018 FP1-MJCA-1468473
Location:	732 Corporate Center Drive Pomona CA 91768 -
Examiner Code:	33504
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

78174
RECEIVED
JUL 19 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/11/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

78296

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 13 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000080 January 10, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002486
Claim Number	
Assignment Date	11/22/2021
Claims Administrator	AmTrust
Date(s) of service •	04/13/2021 - 04/16/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	10/20/2019
Application Received	10/08/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 04/13/2021 - 04/16/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/04/2021. Response not yet received.
- Itemized invoices
    - 04/13/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
    - 04/14/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 04/16/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 04/13/2021 - 04/16/2021. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/13/2021 - 04/16/2021 signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 04/13/2021 - 04/16/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03790745
SWC1225080

DATE	AMOUNT
6/11/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03790745⑈ ⑆021309379⑆ 790262463⑈

JUN 18 2021

Explanation Of Bill Review

Check Number	03790745	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16506245	Cleveland, OH 44101
Invoice Number:	FP1-MQCA-107222	858-385-4040
Policy / Insured:	SWC1225080/SDP Investments A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	10/20/2019 FP1-MQCA-107222	
Location:	4922 w. Century Blvd Los Angeles CA 90250 -	
Examiner Code:	ochanthalangsy	
Network/PPO Network:		

JUN 18 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/13/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03790744
SWC1225080

DATE	AMOUNT
6/11/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03790744⑈ ⑆021309379⑆ 790262463⑈

JUN 18 2021

Explanation Of Bill Review

Check Number	03790744	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16506244	Cleveland, OH 44101
Invoice Number:	FP1-MQCA-107220	858-385-4040
Policy / Insured:	SWC1225080/SDP Investments A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	10/20/2019 FP1-MQCA-107220	
Location:	4922 w. Century Blvd Los Angeles CA 90250 -	
Examiner Code:	ochanthalangsy	
Network/PPO Network:		

7892/6

JUN 18 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/14/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03790746
SWC1225080

DATE	AMOUNT
6/11/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781

⑈03790746⑈ ⑆021309379⑆ 79026246 3⑈

JUN 18 2021

Explanation Of Bill Review

Check Number	03790746
Claim Number:	
Regulatory ID:	
Bill Number:	16506247
Invoice Number:	FP1-MQCA-107224
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	10/20/2019 FP1-MQCA-107224
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/16/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	402, G2
				180.00	90.00	0.00	90.00	

402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307; G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04038581
SWC1225080

DATE	AMOUNT
1/21/2022	$450.00

Four Hundred Fifty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈04038581⑈ ⑆021309379⑆ 790262463⑈

PAID
JAN 26 2022
BY:

Check Number	04038581
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	10/20/2019
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy

PAID
JAN 2[illegible] 2022
BY:

Amount:	$450.00
Dates of Service:	4/13/2021-4/16/2021
Explanation:	DOS 04 13 21-04 16 21
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78296

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000024 January 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 3 1 2022

IBR Case Number	CB21-0002687
Claim Number	
Assignment Date	12/02/2021
Claims Administrator	AmTrust
Date(s) of service	05/01/2021 - 05/01/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/20/2019
Application Received	10/29/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/01/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/16/2021. Response not yet received.
- Itemized invoice
    - 05/01/2021 Interpreting for PR2 / ReEvaluation $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/01/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/01/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

VOID VOID VOID VOID VOID VOID

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03824674
SWC1225080

DATE	AMOUNT
7/13/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03824674⑈ ⑆021309379⑆ 790262463⑈

Explanation Of Bill Review

Check Number	03824674	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16589650	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1470364	858-385-4040
Policy / Insured:	SWC1225080/SDP Investments A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	10/20/2019 FP1-MJCA-1470364	
Location:	4922 w. Century Blvd Los Angeles CA 90250 -	
Examiner Code:	ochanthalangsy	
Network/PPO Network:		

78296

RECEIVED
JUL 19 2021

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/1/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402, 877
				180.00	90.00	0.00	90.00	

JUL 19 2021

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307; 877 - PAYMENT BASED ON A 2 HOUR MINIMUM. IF THE SERVICES EXCEEDED 2 HOURS, PLEASE RESUBMIT BILL WITH DOCUMENTATION TO SUPPORT TIME SPENT.;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

VOID VOID VOID

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04082284
SWC1225080

DATE	AMOUNT
3/1/2022	$270.00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04082284⑈ ⑆021309379⑆ 790262463⑈

MAR 09 2022

Explanation Of Bill Review

Check Number	04082284	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17272121	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1735373	888.239.3909
Policy / Insured:	SWC1225080/SDP Investments A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	10/20/2019 FP1-MJCA-1735373	
Location:	4922 w. Century Blvd Los Angeles CA 90250 -	
Examiner Code:	ochanthalangsy	
Network/PPO Network:		

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
2/8/2022	MDS21	SETTLEMENT FOR DISPUTE	1.00	270.00	0.00	0.00	270.00	
				270.00	0.00	0.00	270.00	

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

78296

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000053 February 11, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 1 4 2022

IBR Case Number	CB21-0002925
Claim Number	
Assignment Date	12/28/2021
Claims Administrator	AmTrust
Date(s) of service	05/17/2021 - 05/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/20/2019
Application Received	11/24/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/09/2021. Response not yet received.
- Itemized invoice
    - 05/17/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/17/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/17/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 hours = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03839369
SWC1225080

DATE	AMOUNT
7/23/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03839369⑈ ⑆021309379⑆ 790262463⑈

JUL 30 2021

Explanation Of Bill Review

Check Number	03839369
Claim Number:	
Regulatory ID:	
Bill Number:	16622601
Invoice Number:	FP1-MJCA-1482841
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	10/20/2019 FP1-MJCA-1482841
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101
858-385-4040

78296

RECEIVED
JUL 30 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/17/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04087405
SWC1225080

DATE	AMOUNT
3/7/2022	$270.00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈04087405⑈ ⑆021309379⑆ 79026263⑈

Check Number	04087405
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	10/20/2019
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy

PAID
MAR 15 2022
BY

Amount:	$270.00
Dates of Service:	5/17/2021-5/17/2021
Explanation:	IBR Final Determination Overturn DOS 5 17 2021
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239.3909

W

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78296

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 24, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001371
Claim Number	
Assignment Date	07/11/2022
Claims Administrator	AmTrust
Date(s) of service	09/14/2021 - 09/20/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	10/20/2019
Application Received	06/10/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 09/14/2021 – 09/20/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/23/2022. Response not yet received.
- Itemized invoice
    - 09/14/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/20/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 09/14/2021 and 09/20/2021 with the rationale: the OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 09/14/2021 and 09/20/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 09/14/2021 – 09/20/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04020528
SWC1225080

DATE	AMOUNT
1/4/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04020528⑈ ⑆021309379⑆ 790262463⑈

PAID
JAN 11 2022

Explanation Of Bill Review

Check Number	04020528	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17101771	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1668375	888.239.3909
Policy / Insured:	SWC1225080/SDP Investments A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	10/20/2019 FP1-MJCA-1668375	
Location:	4922 w. Century Blvd Los Angeles CA 90250 -	
Examiner Code:	ochanthalangsy	
Network/PPO Network:		

78296

RECEIVED
JAN 10 2022
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/14/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04029411
SWC1225080

DATE	AMOUNT
1/12/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04029411⑈ ⑆021309379⑆ 79026246 3⑈

RECEIVED
JAN 19 2022

Explanation Of Bill Review

BY:

Check Number	04029411
Claim Number:	
Regulatory ID:	
Bill Number:	17129170
Invoice Number:	FP1-MJCA-1668332
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	10/20/2019 FP1-MJCA-1668332
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

RECEIVED
JAN 18 2022
BY: 78296

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/20/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04306258
SWC1225080

DATE	AMOUNT
9/1/2022	$360 00

Three Hundred Sixty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈04306258⑈ ⑆021309379⑆ 790262463⑈

RECEIVED
SEP 07 2022
BY:

Check Number	04306258
Claim Number	
Bill Number	
Invoice Number	
Policy / Insured	SWC1225080/SDP Investments A Corp
Claimant Name	
Payee ID Name	JOYCE ALTMAN INTERPRETERS
Loss Date	10/20/2019
Location	4922 w Century Blvd Los Angeles CA 90250 -
Examiner Code	ochanthalangsy

RECEIVED
SEP 06 2022
BY: 78296

Amount	$360 00
Dates of Service	9/14/2021-9/20/2021
Explanation	
Category	M23 - Medical Interpreter
Placement	2 - Medical
Transaction Type	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888 239 3909

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78296

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 30, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001462
Claim Number	
Assignment Date	07/15/2022
Claims Administrator	AmTrust
Date(s) of service	09/22/2021 - 09/22/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/20/2019
Application Received	06/23/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/22/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/29/2022. Response not yet received.
- Itemized invoice
    - 09/22/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: the OMFS does not list this code, an allowance has been made for a comparable service
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/22/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/22/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
P.O. Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04038170
SWC1225080

DATE	AMOUNT
1/20/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04038170⑈ ⑆021309379⑆ 790262463⑈

RECEIVED
JAN 25 2022

Explanation Of Bill Review

Check Number	04038170
Claim Number:	
Regulatory ID:	
Bill Number:	17152084
Invoice Number:	FP1-MJCA-1685213
Policy / Insured:	SWC1225080/SDP Investments A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	10/20/2019 FP1-MJCA-1685213
Location:	4922 w. Century Blvd Los Angeles CA 90250 -
Examiner Code:	ochanthalangsy
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

BY: .....

RECEIVED
JAN 25 2022

BY. 78296

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/22/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04314800
SWC1225080

DATE	AMOUNT
9/9/2022	$270 00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc

⑈04314800⑈ ⑆021309379⑆ 790262463⑈

78296

Check Number	04314800
Claim Number	
Bill Number	
Invoice Number	
Policy Insured	SWC1225080/SDP Investments A Corp
Claimant Name	
Payee ID / Name	JOYCE ALTMAN INTERPRETERS
Loss Date	10/20/2019
Location	4922 w Century Blvd Los Angeles CA 90250 -
Examiner Code	ochanthalangsy

PAID
SEP 20 2022
BY

Amount	$270 00	ANA UBI Claims
Dates of Service	9/22/2021-9/22/2021	AmTrust North America
Explanation		PO Box 89404
Category	M23 - Medical Interpreter	Cleveland, OH 44101
Placement	2 - Medical	888 239 3909
Transaction Type		

78518

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 1 0 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000053 January 6, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002554
Claim Number	
Assignment Date	11/16/2021
Claims Administrator	AmTrust
Date(s) of service	03/12/2021 - 04/23/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	11/26/2018
Application Received	10/15/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 03/12/2021 – 04/23/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/29/2021. Response not yet received.
- Itemized invoices
    - 03/12/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 04/23/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 03/12/2021 and 04/23/2021. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 03/12/2021 and 04/23/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 03/12/2021 – 04/23/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04859579
TWC3741900

DATE	AMOUNT
5/21/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈04859579⑈ ⑆021309379⑆ 6018775331⑈

MAY 25 2021

Explanation Of Bill Review

Check Number	04859579
Claim Number:	
Regulatory ID:	
Bill Number:	16442923
Invoice Number:	FP1-MJCA-1407969
Policy / Insured:	TWC3741900/Paris Baguette USA Inc
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	11/26/2018 FP1-MJCA-1407969
Location:	6100 S Malt Ave Commerce. CA 90040 -
Examiner Code:	33200
Network/PPO Network:	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

78518
MAY 25 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/12/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04904932
TWC3741900

DATE	AMOUNT
6/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04904932⑈ ⑆021309379⑆ 6018775331⑈

PAID
JUL 03 2021

Explanation Of Bill Review

Check Number	04904932
Claim Number:	
Regulatory ID:	
Bill Number:	16542497
Invoice Number:	FP1-MJCA-1448074
Policy / Insured:	TWC3741900/Paris Baguette USA Inc
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	11/26/2018 FP1-MJCA-1448074
Location:	6100 S Malt Ave Commerce. CA 90040 -
Examiner Code:	33200
Network/PPO Network:	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

98518

JUL 01 2021

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/23/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

785666

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000061 January 4, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 11 2022

IBR Case Number	CB21-0002481
Claim Number	
Assignment Date	11/15/2021
Claims Administrator	AmTrust
Date(s) of service	03/17/2021 - 04/22/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 12
Date of Injury	09/01/2019
Application Received	10/08/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,080.00 in additional reimbursement for a total of $1,260.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,260.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 12 submitted for dates of service 03/17/2021 - 04/22/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/27/2021. Response not yet received.
- Itemized invoices
    - 03/17/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/18/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 03/20/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 03/24/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/25/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 03/26/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/30/2021 Interpreting for shock wave therapy $180.00 (Billed at a minimum of 2 hours)
    - 03/31/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 04/01/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 04/08/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 04/13/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 04/22/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 03/17/2021 - 04/22/2021. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.

- Interpretation Confirmation Affidavits dated 03/17/2021 - 04/22/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 12 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 12.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 12
Date of Service: 03/17/2021 - 04/22/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/31/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03756697
SWC1231697

DATE	AMOUNT
5/13/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03756697⑈ ⑆021309379⑆ 790262463⑈

MAY 18 2021

Explanation Of Bill Review

Check Number	03756697
Claim Number:	
Regulatory ID:	
Bill Number:	16418238
Invoice Number:	FP1-MJCA-1398311
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	9/1/2019 FP1-MJCA-1398311
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

RECEIVED MAY 17 2021

78566

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/17/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03773064
SWC1231697

DATE	AMOUNT
5/27/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03773064⑈ ⑆021309379⑆ 790262463⑈

RECEIVED
JUN 02 2021
BY:

Explanation Of Bill Review

Check Number	03773064	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16460334	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1413554	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	9/1/2019 FP1-MJCA-1413554	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

RECEIVED
JUN 01 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/20/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03780789
SWC1231697

DATE	AMOUNT
6/3/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03780789⑈ ⑆021309379⑆ 790262463⑈

JUN 09 2021

Explanation Of Bill Review 78566

Check Number	03780789	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16480688	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1421365	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	9/1/2019 FP1-MJCA-1421365	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/24/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	877, G2, 402
				180.00	90.00	0.00	90.00	

877 - PAYMENT BASED ON A 2 HOUR MINIMUM. IF THE SERVICES EXCEEDED 2 HOURS, PLEASE RESUBMIT BILL WITH DOCUMENTATION TO SUPPORT TIME SPENT.; G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03784041
SWC1231697

DATE	AMOUNT
6/7/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03784041⑈ ⑆021309379⑆ 790262463⑈

JUN 15 2021

JUN 14 2021

BY:.....

Explanation Of Bill Review

Check Number	03784041	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16488021	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1425956	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	9/1/2019 FP1-MJCA-1425956	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

JUN 14 2021

BY:.....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/25/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03785848
SWC1231697

DATE	AMOUNT
6/8/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03785848⑈ ⑆021309379⑆ 790262463⑈

JUN 14 2021

Explanation Of Bill Review

Check Number	03785848
Claim Number:	
Regulatory ID:	
Bill Number:	16492818
Invoice Number:	FP1-MJCA-1421364
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	9/1/2019 FP1-MJCA-1421364
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

78566

RECEIVED
JUN 14 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/26/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03784039
SWC1231697

DATE	AMOUNT
6/7/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03784039⑈ ⑆021309379⑆ 790262463⑈

JUN 15 2021

Explanation Of Bill Review

Check Number	03784039
Claim Number:	
Regulatory ID:	
Bill Number:	16488019
Invoice Number:	FP1-MJCA-1425943
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	9/1/2019 FP1-MJCA-1425943
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

JUN 14 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/30/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03784042
SWC1231697

DATE	AMOUNT
6/7/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03784042⑈ ⑆021309379⑆ 79026246 3⑈

JUN 15 2021

Explanation Of Bill Review

BY:

Check Number	03784042	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16488022	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1425958	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	9/1/2019 FP1-MJCA-1425958	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

28566

RECEIVED

JUN 14 2021

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
3/31/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03780790
SWC1231697

DATE	AMOUNT
6/3/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781

JUN 09 2021

⑈03780790⑈ ⑆021309379⑆ 790262463⑈

Explanation Of Bill Review

Check Number	03780790
Claim Number:	
Regulatory ID:	
Bill Number:	16480689
Invoice Number:	FP1-MJCA-1421366
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	9/1/2019 FP1-MJCA-1421366
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/1/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03785851
SWC1231697

DATE	AMOUNT
6/8/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03785851⑈ ⑆021309379⑆ 790262463⑈

JUN 1 4 2021

Explanation Of Bill Review

Check Number	03785851	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16494466	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1436065	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	9/1/2019 FP1-MJCA-1436065	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

79566

JUN 1 4 2021

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/8/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03785850
SWC1231697

DATE	AMOUNT
6/8/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03785850⑈ ⑆021309379⑆ 790262463⑈

JUN 14 2021

Explanation Of Bill Review

Check Number	03785850	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		P O Box 89404
Bill Number:	16494142	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1435524	212-655-2000
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	9/1/2019 FP1-MJCA-1435524	
Location:	15905 CANARY AVE LA MIRADA CA 90638 -	
Examiner Code:	23657	
Network/PPO Network:		

78566

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/13/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03799836
3263227-1
SWC1231697

DATE	AMOUNT
6/22/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03799836⑈ ⑆021309379⑆ 790262463⑈

PAID
JUN 29 2021

Explanation Of Bill Review

Check Number	03799836
Claim Number:	3263227-1
Regulatory ID:	
Bill Number:	16532052
Invoice Number:	FP1-MJCA-1448349
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	Juan Bantun
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	9/1/2019 FP1-MJCA-1448349
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

18566

RECEIVED
JUN 28 2021

BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/22/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

VOID VOID VOID

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938519
3263227-1
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938519⑈ ⑆021309379⑆ 79026246 3⑈

M

Check Number	03938519
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	Juan Bantun
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 202
BY:.....

Amount:	$90.00
Dates of Service:	3/17/2021-3/17/2021
Explanation:	FP1-MJCA-1589474 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021

BY. .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938516
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938516⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938516
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	Juan Bantun
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/18/2021-3/18/2021
Explanation:	FP1-MJCA-1589471 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938517
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938517⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938517
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/20/2021-3/20/2021
Explanation:	FP1-MJCA-1589472 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: .....

VOID VOID VOID VOID VOID VOID

THIS DOCUMENT HAS A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938514
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

M

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938514⑈ ⑆021309379⑆ 79026246 3⑈

Check Number	03938514
Claim Number:	
Bill Number:	U
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/24/2021-3/24/2021
Explanation:	FP1-MJCA-1589468 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938502
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938502⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938502
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/25/2021-3/25/2021
Explanation:	FP1-MJCA-1589459 Patient Acct 78566 Recon
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY. .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938505
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938505⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938505
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/26/2021-3/26/2021
Explanation:	FP1-MJCA-1589460 Patient Acct 78566 Recon
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938510
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938510⑈ ⑆021309379⑆ 79026246 3⑈

Check Number	03938510
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	3/30/2021-3/30/2021
Explanation:	FP1-MJCA-1589463 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938508
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938508⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938508
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 202
BY:

Amount:	$90.00
Dates of Service:	3/31/2021-3/31/2021
Explanation:	FP1-MJCA-1589462 Patient Acct 78566 Recon
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY:

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938515
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938515⑈ ⑆021309379⑆ 79026246 3⑈

Check Number	03938515
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: _____

Amount:	$90.00
Dates of Service:	4/1/2021-4/1/2021
Explanation:	FP1-MJCA-1589469 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938511
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938511⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938511
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 202

BY: .....

Amount:	$90.00
Dates of Service:	4/8/2021-4/8/2021
Explanation:	FP1-MJCA-1589464 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021

BY: .....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938513
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

M

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938513⑈ ⑆021309379⑆ 79026246 3⑈

Check Number	03938513
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY:.....

Amount:	$90.00
Dates of Service:	4/13/2021-4/13/2021
Explanation:	FP1-MJCA-1589466 PATIENT ACCOUNT 78566 RECONSIDERATION
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY:.....

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03938512
SWC1231697

DATE	AMOUNT
10/25/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03938512⑈ ⑆021309379⑆ 790262463⑈

Check Number	03938512
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1231697/ENK CUSTOM DISPLAY INC. A CORP.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	9/1/2019
Location:	15905 CANARY AVE LA MIRADA CA 90638 -
Examiner Code:	23657

RECEIVED
NOV 0 1 2021
BY: .....

Amount:	$90.00
Dates of Service:	4/22/2021-4/22/2021
Explanation:	FP1-MJCA-1589455 Patient Acct 78566 Recon
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
866.450.0620

PAID
NOV 0 2 2021
BY: ...

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78575

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000031 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002755
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	AmTrust
Date(s) of service	05/03/2021 - 05/03/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	07/13/2020
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/03/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized Invoices
    - 05/03/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/03/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/03/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03826172
SWC1286314

DATE	AMOUNT
7/14/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈03826172⑈ ⑆021309379⑆ 790262463⑈

RECEIVED
JUL 19 2021
BY:

Explanation Of Bill Review

JUL 19 2021

Check Number	03826172
Claim Number:	
Regulatory ID:	
Bill Number:	16593329
Invoice Number:	FP1-MJCA-1465591
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	7/13/2020 FP1-MJCA-1465591
Location:	732 Corporate Center Dr Pomona CA 91768 -
Examiner Code:	23657
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
P O Box 89404
Cleveland, OH 44101
212-655-2000

78575

RECEIVED
JUL 19 2021
BY:

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/3/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03960784
3260113-1
SWC1286314

DATE	AMOUNT
11/12/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈03960784⑈ ⑆021309379⑆ 79026263⑈

Check Number	03960784
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	7/13/2020
Location:	732 Corporate Center Dr Pomona CA 91768 -
Examiner Code:	23657

Amount:	$90.00	ANA UBI Claims
Dates of Service:	5/3/2021-5/3/2021	AmTrust North America
Explanation:	FP1-MJCA-1605714 Patient Acct 78575 Recon	PO Box 89404
Category:	M23 - Medical Interpreter	Cleveland, OH 44101
Placement:	2 - Medical	888.239.3909
Transaction Type:		

REC'D NOV 1 0 2021

BY:.....

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04490352
3260113-1
SWC1286314

DATE	AMOUNT
2/2/2023	$292.50

Two Hundred Ninety-Two and 50/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781

AmTrust Financial Services, Inc.

⑈04490352⑈ ⑆021309379⑆ 790262463⑈

FEB 13 2023

Explanation Of Bill Review

Check Number	04490352
Claim Number:	
Regulatory ID:	
Bill Number:	18515250
Invoice Number:	FP1-MJCA-2182246
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	7/13/2020 FP1-MJCA-2182246
Location:	732 Corporate Center Dr Pomona CA 91768 -
Examiner Code:	36856
Network/PPO Network:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
1/26/2023	MDS10	SETTLEMENT FOR DISPUTE	1.00	292.50	0.00	0.00	292.50	
				292.50	0.00	0.00	292.50	

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5 If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR) If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78575

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 03, 2022

OCT 17 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001796
Claim Number	
Assignment Date	08/23/2022
Claims Administrator	AmTrust
Date(s) of service	10/11/2021 - 10/18/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 2
Date of Injury	07/13/2020
Application Received	07/29/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 10/11/2021 – 10/18/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/05/2022. Response not yet received.
- Itemized Invoices
    - 10/11/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/18/2021 Interpreting for PR2 ReEval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 10/11/2021 – 10/18/2021. The OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 10/11/2021 – 10/18/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 10/11/2021 – 10/18/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04075806
SWC1286314

DATE	AMOUNT
2/23/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

MAR 0 2 2022

⑈04075806⑈ ⑆021309379⑆ 790262463⑈

Explanation Of Bill Review

Check Number	04075806	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17253756	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1722645	888.239.3909
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	7/13/2020 FP1-MJCA-1722645	
Location:	732 Corporate Center Dr Pomona CA 91768 -	
Examiner Code:	23657	
Network/PPO Network:		

RECEIVED FEB 28 2022 BY: 78575

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
10/11/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

VOID VOID VOID

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04095242
SWC1286314

DATE	AMOUNT
3/14/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 927814165

⑈04095242⑈ ⑆021309379⑆ 790262463⑈

PAID
MAR 2 1 2022

BY: .....

Explanation Of Bill Review

Check Number	04095242	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17308783	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1744096	888.239.3909
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	7/13/2020 FP1-MJCA-1744096	
Location:	732 Corporate Center Dr Pomona CA 91768 -	
Examiner Code:	23657	
Network/PPO Network:		

MAR 2 1 2022
BY: 78575

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
10/18/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04353625
SWC1286314

DATE	AMOUNT
10/12/2022	$360.00

Three Hundred Sixty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈04353625⑈ ⑆021309379⑆ 790262463⑈

OCT 20 2022

OCT 20 2022

Check Number	04353625
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	SWC1286314/World Service West LA Inflight Service Company LLC
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	7/13/2020
Location:	732 Corporate Center Dr Pomona CA 91768 -
Examiner Code:	23657

OCT 17 20[illegible]

BY: .....

Amount:	$360.00
Dates of Service:	10/11/2021-10/18/2021
Explanation:	IBR CASE CB22-0001796
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

78777

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

RECEIVED SEP 78777

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001370
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	AmTrust
Date(s) of service	09/08/2021 - 09/08/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services
Date of Injury	07/22/2020
Application Received	06/10/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/08/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response not yet received.
- Itemized invoice
    - 09/08/2021 Interpreting for follow-up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. OMFS does not list this code; an allowance was made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/08/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/08/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
P. O. Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

VOID VOID VOID VOID

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00260644
QWC1111685

DATE	AMOUNT
1/5/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈00260644⑈ ⑆021000021⑆ 226733883⑈

JAN 12 2022

Explanation Of Bill Review

BY: .....

Check Number	00260644
Claim Number:	
Regulatory ID:	
Bill Number:	17108088
Invoice Number:	FP1-MJCA-1665947
Policy / Insured:	QWC1111685/Precision Investment Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	7/22/2020 FP1-MJCA-1665947
Location:	441 E Carson St Carson CA 90745 -
Examiner Code:	24894
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

RECEIVED
JAN 12 2022
78777
BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/8/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

SEQUOIA INSURANCE COMPANY
P.O BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.	
00296417	
QWC1111685	
DATE	AMOUNT
9/19/2022	$270.00

M

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈00296417⑈ ⑆021000021⑆ 226733883⑈

PAID
SEP 28 2022

Check Number	00296417
Claim Number	
Bill Number	0
Invoice Number	
Policy / Insured	QWC1111685/Precision Investment Inc
Claimant Name	
Payee ID / Name	JOYCE ALTMAN INTERPRETERS
Loss Date	7/22/2020
Location	441 E Carson St Carson CA 90745 -
Examiner Code	35636

BY. [redacted]

[redacted]

SEP 26 2022

Amount	$270 00
Dates of Service	9/8/2021-9/8/2021
Explanation	IBR Case CB22-0001370 IBR Final Determination Overturn DOS 9 8 21
Category	M23 - Medical Interpreter
Placement	2 - Medical
Transaction Type	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239 3909

MAXIMUS Federal Services

79507

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000038 October 7, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 11 2022

IBR Case Number	CB22-0001813
Claim Number	
Assignment Date	08/25/2022
Claims Administrator	AmTrust
Date(s) of service	10/04/2021 - 10/04/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/01/2019
Application Received	08/03/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/04/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/09/2022. Response not yet received.
- Itemized invoice
    - 10/04/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/04/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/04/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
05210293
TWC3797678

DATE	AMOUNT
2/7/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈05210293⑈ ⑆021309379⑆ 601877533⑈

PAID
FEB 11 2022

Explanation Of Bill Review

Check Number	05210293
Claim Number:	
Regulatory ID:	
Bill Number:	17202769
Invoice Number:	FP1-MJCA-1703086
Policy / Insured:	TWC3797678/Sushi Boy Inc A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC
Loss Date:	10/1/2019 FP1-MJCA-1703086
Location:	21605 S WESTERN AVE #G TORRANCE CA 90501 - LOS ANGELES
Examiner Code:	33119
Network/PPO Network:	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

RECEIVED
FEB 14 2022
79007

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
10/4/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79060

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000023 May 3, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0000414
Claim Number	
Assignment Date	04/01/2022
Claims Administrator	AmTrust
Date(s) of service	06/28/2021 - 06/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	08/19/2020
Application Received	02/25/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 06/28/2021 – 06/30/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/15/2022. Response not yet received.
- Itemized invoices
    - 06/28/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 06/30/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 06/28/2021-06/30/2021. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 06/28/2021 and 06/30/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 an hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 06/28/2021 – 06/30/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
P.O. Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03919488
SWC1269778

DATE	AMOUNT
10/5/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03919488⑈ ⑆021309379⑆ 790262463⑈

PAID
OCT 12 2021

Explanation Of Bill Review

Check Number	03919488	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	16831696	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1559460	866.450.0620
Policy / Insured:	SWC1269778/World Class Valet Inc.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	8/19/2020 FP1-MJCA-1559460	
Location:	1975 Zonal Ave Los Angeles CA 90033 -	
Examiner Code:	33052	
Network/PPO Network:		

79060

OCT 11 2021

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
6/28/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
03919489
SWC1269778

DATE	AMOUNT
10/5/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈03919489⑈ ⑆021309379⑆ 790262463⑈

PAID
OCT 12 2021

BY: .....

Explanation Of Bill Review

Check Number	03919489	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	16831700	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1559519	866.450.0620
Policy / Insured:	SWC1269778/World Class Valet Inc.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	8/19/2020 FP1-MJCA-1559519	
Location:	1975 Zonal Ave Los Angeles CA 90033 -	
Examiner Code:	33052	
Network/PPO Network:		

PAID
OCT 11 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
6/30/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

...SECURITY FEATURES INCLUDED. DETAILS ON BACK. ...REMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04165256
SWC1269778

DATE	AMOUNT
5/12/2022	$270.00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc

⑈04165256⑈ ⑆021309379⑆ 790262463⑈

Check Number	04165256
Claim Number:	
Bill Number:	
Invoice Number:	
Policy / Insured:	SWC1269778/World Class Valet Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	8/19/2020
Location:	1975 Zonal Ave Los Angeles CA 90033 -
Examiner Code:	34988

MAY 16 2022
BY: .....

Amount:	$270.00
Dates of Service:	6/30/2021-5/3/2022
Explanation:	FP1-MJCA-1818342 Reconsideration Patient acct 79060
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239.3909

MAY 23 2022
BY: .....

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04165255
3263763-1
SWC1269778

DATE	AMOUNT
5/12/2022	$270.00

Two Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈04165255⑈ ⑆021309379⑆ 790262463⑈

Check Number	04165255
Claim Number:	
Bill Number:	U
Invoice Number:	
Policy / Insured:	/World Class Valet Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	8/19/2020
Location:	1975 Zonal Ave Los Angeles CA 90033 -
Examiner Code:	34988

RECEIVED
MAY 16 2022
BY: ...

Amount:	$270.00	ANA UBI Claims
Dates of Service:	6/28/2021-5/3/2022	AmTrust North America
Explanation:	FP1-MJCA-1818341 Reconsideration Patient acct 79060	PO Box 89404
Category:	M23 - Medical Interpreter	Cleveland, OH 44101
Placement:	2 - Medical	888.239.3909
Transaction Type:		

RECEIVED
MAY 23 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

74060

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 23, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001369
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	AmTrust
Date(s) of service	09/23/2021 - 09/23/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/19/2020
Application Received	06/10/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for dates of service 09/23/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response not yet received.
- Itemized Invoices
    - 09/23/2021 Interpreting FU acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: the OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/23/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
P.O. Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04041717
SWC1269778

DATE	AMOUNT
1/25/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04041717⑈ ⑆021309379⑆ 790262463⑈

PAID
JAN 31 2022

Explanation Of Bill Review

Check Number	04041717	ANA UBI Claims
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17164529	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1690736	888.239.3909
Policy / Insured:	SWC1269778/World Class Valet Inc.	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	8/19/2020 FP1-MJCA-1690736	
Location:	1975 Zonal Ave Los Angeles CA 90033 -	
Examiner Code:	33052	
Network/PPO Network:		

RECEIVED
JAN 31 2022
79060

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/23/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

ANA UBI Claims
PO BOX 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04320051
SWC1269778

DATE	AMOUNT
9/14/2022	$180 00

One Hundred Eighty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈04320051⑈ ⑆021309379⑆ 79026 2463⑈

Check Number	04320051
Claim Number	
Bill Number	0
Invoice Number	
Policy / Insured	SWC1269778/World Class Valet Inc
Claimant Name	
Payee ID / Name	JOYCE ALTMAN INTERPRETERS
Loss Date	8/19/2020
Location	1975 Zonal Ave Los Angeles CA 90033 -
Examiner Code	34988

PAID
SEP 2 2 2022

Amount	$180 00
Dates of Service	9/23/2021-9/23/2021
Explanation	FP1-MICA-1985522 PAT ACCT 79060 Reconsideration
Category	M23 - Medical Interpreter
Placement	2 - Medical
Transaction Type	

ANA UBI Claims
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888 239 3909

79308

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000051 February 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 07 2022

IBR Case Number	CB21-0002815
Claim Number	
Assignment Date	12/09/2021
Claims Administrator	AmTrust
Date(s) of service	04/26/2021 - 05/05/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 4
Date of Injury	03/05/2020
Application Received	11/12/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $360.00 in additional reimbursement for a total of $540.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$540.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 4 submitted for dates of service 04/26/2021 – 05/05/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/23/2021. Response not yet received.
- Itemized invoices
    - 04/26/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 04/28/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 05/03/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 05/05/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 04/26/2021 – 05/05/2021. The OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/26/2021 – 05/05/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 4 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 4.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 4
Date of Service: 04/26/2021 – 05/05/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/05/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
P.O. Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04933544
TWC3851105

DATE	AMOUNT
7/16/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04933544⑈ ⑆021309379⑆ 601877533⑈

JUL 21 2021

Explanation Of Bill Review

Check Number	04933544	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16601222	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1466622	858-385-4040
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	3/5/2020 FP1-MJCA-1466622	
Location:	820 N. Central Glendale CA 91203 -	
Examiner Code:	25242	
Network/PPO Network:		

RECEIVED JUL 21 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/26/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID THROUGH 180 DAYS FROM ISSUE DATE. VOID AFTER 180 DAYS

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04933542
TWC3851105

DATE	AMOUNT
7/16/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04933542⑈ ⑆021309379⑆ 601877533⑈

JUL 21 2021

Explanation Of Bill Review

Check Number	04933542	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16601201	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1465641	858-385-4040
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	3/5/2020 FP1-MJCA-1465641	
Location:	820 N. Central Glendale CA 91203 -	
Examiner Code:	25242	
Network/PPO Network:		

RECEIVED JUL 21 2021

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/28/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04933541
TWC3851105

DATE	AMOUNT
7/16/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈04933541⑈ ⑆021309379⑆ 601877533⑈

JUL 21 2021

Explanation Of Bill Review

Check Number	04933541	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16601128	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1460653	858-385-4040
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	3/5/2020 FP1-MJCA-1460653	
Location:	820 N. Central Glendale CA 91203 -	
Examiner Code:	25242	
Network/PPO Network:		

79508

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/3/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04933543
TWC3851105

DATE	AMOUNT
7/16/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈04933543⑈ ⑆021309379⑆ 6018775 33⑈

JUL 21 2021

Explanation Of Bill Review

Check Number	04933543	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16601202	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1465643	858-385-4040
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	3/5/2020 FP1-MJCA-1465643	
Location:	820 N. Central Glendale CA 91203 -	
Examiner Code:	25242	
Network/PPO Network:		

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
5/5/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
05231441
TWC3851105

DATE	AMOUNT
2/22/2022	$540.00

Five Hundred Forty and 0/100s Dollars**********

M

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

⑈05231441⑈ ⑆021309379⑆ 6018775338

RECEIVED
MAR 03 2022
By

Check Number	05231441
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	3/5/2020
Location:	820 N. Central Glendale CA 91203 -
Examiner Code:	25242

Amount:	$540.00
Dates of Service:	4/26/2021-5/5/2021
Explanation:	IBR Final Determination Case CB21-0002815
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239.3909

#79846

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001669
Claim Number	
Assignment Date	08/19/2022
Claims Administrator	AmTrust
Date(s) of service	02/03/2021 - 10/04/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 10
Date of Injury	01/18/2021
Application Received	07/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $900.00 in additional reimbursement for a total of $1,080.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,080.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 10 submitted for dates of service 02/03/2021 – 10/04/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/03/2022. Response not yet received.
- Itemized invoices
    - 02/03/2021 Interpreting for Initial exam $180.00 (Billed at a minimum of 2 hours)
    - 02/08/2021 Interpreting for Initial chiropractic $180.00 (Billed at a minimum of 2 hours)
    - 02/24/2021 Interpreting for Initial acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/22/2021 Interpreting for PR2/ReEval $180.00 (Billed at a minimum of 2 hours)
    - 05/10/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 05/26/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/09/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/06/2021 Interpreting for PR2/ReEval $180.00 (Billed at a minimum of 2 hours)
    - 08/25/2021 Interpreting for PR2/ReEval with follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/04/2021 Interpreting for P&S $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 02/03/2021 – 10/04/2021. OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 02/03/2021 – 10/04/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 10 Overturned.**

- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 10.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 10
Date of Service: 02/03/2021 – 10/04/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/04/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
05234837
TWC3878041

DATE	AMOUNT
2/23/2022	$900.00

Nine Hundred and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈05234837⑈ ⑆021309379⑆ 601877533⑈

MAR 0 2 2022

Explanation Of Bill Review

Check Number	05234837	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		PO Box 89404
Bill Number:	17253485	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1718297	888.239.3909
Policy / Insured:	TWC3878041/RED BRICK CORPORATION	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	1/18/2021 FP1-MJCA-1718297	
Location:	5362-5364 VENICE BLVD LOS ANGELES CA 90019 -	
Examiner Code:	lderry	
Network/PPO Network:		

BY: 79846

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
2/3/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
2/8/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
2/24/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
3/22/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
5/10/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
5/26/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/9/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
8/6/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
8/25/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
10/4/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				1800.00	900.00	0.00	900.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
05627461
TWC3878041

DATE	AMOUNT
10/7/2022	$1,080 00

One Thousand Eighty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈05627461⑈ ⑆021309379⑆ 6018775330⑈

Check Number	05627461
Claim Number	
Bill Number	U
Invoice Number	
Policy / Insured	TWC3878041/RED BRICK CORPORATION
Claimant Name	
Payee ID / Name	JOYCE ALTMAN INTERPRETERS
Loss Date	1/18/2021
Location	5362-5364 VENICE BLVD LOS ANGELES CA 90019 -
Examiner Code	Iderry

RECEIVED
OCT 18 2022

Amount	$1,080 00
Dates of Service	2/3/2021-10/4/2021
Explanation	IBR Fee
Category	E19 - CA Only - IBR Fee/Cost
Placement	4 - Expense
Transaction Type	

TECHNOLOGY INSURANCE CO (Claims Funding) 1085
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888 239 3909

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

86501

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000057 September 14, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

SEP 19 2022

IBR Case Number	CB22-0001577
Claim Number	
Assignment Date	08/05/2022
Claims Administrator	AmTrust
Date(s) of service	09/29/2021 - 09/29/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/30/2020
Application Received	07/08/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/29/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 07/20/2022. Response not yet received.
- Itemized invoice
    - 09/29/2021 Interpreting for shockwave therapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: the OMFS does not list this code. An allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/29/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/29/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00264915
QWC1103479

DATE	AMOUNT
2/10/2022	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈00264915⑈ ⑆021000021⑆ 226733883⑈

PAID
FEB 15 2022

Explanation Of Bill Review

Check Number	00264915
Claim Number:	
Regulatory ID:	
Bill Number:	17215522
Invoice Number:	FP1-MJCA-1694854
Policy / Insured:	QWC1103479/K and F Navi Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	10/30/2020 FP1-MJCA-1694854
Location:	1501 Washington Blvd Montebello CA 90640 -
Examiner Code:	32019
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

RECEIVED
FEB 14 2022
BY: 8050

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
9/29/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80710

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 10, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002104
Claim Number	
Assignment Date	10/03/2022
Claims Administrator	AmTrust
Date(s) of service	04/06/2021 - 07/06/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 12
Date of Injury	03/26/2020
Application Received	09/02/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,080.00 in additional reimbursement for a total of $1,260.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,260.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 12 submitted for dates of service 04/06/2021 – 07/06/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/15/2022. Response not yet received.
- Itemized invoices
    - 04/06/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 04/15/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 04/27/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 05/03/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 06/04/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/07/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/11/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/14/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/15/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 06/22/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 06/28/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 07/06/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,170.00 ($90.00 for each date of service 04/06/2021 – 07/06/2021). The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/06/2021 – 07/06/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 12 Overturned.**

- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 12.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 12
Date of Service: 04/06/2021 – 07/06/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/04/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 89404

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00269260
QWC1101055

DATE	AMOUNT
3/17/2022	$1,170.00

One Thousand One Hundred Seventy and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN , CA 92781-

⑈00269260⑈ ⑆021000021⑆ 226733883⑈

PAID
MAR 23 2022

Explanation Of Bill Review

Check Number	00269260
Claim Number:	
Regulatory ID:	
Bill Number:	17327675
Invoice Number:	FP1-MJCA-1749777
Policy / Insured:	QWC1101055/DenWest Restaurants Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC
Loss Date:	3/26/2020 FP1-MJCA-1749777
Location:	5811 E. Firestone Blvd South Gate CA 90280 -
Examiner Code:	33296
Network/PPO Network:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

PAID
MAR 22 2022
BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/6/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
4/15/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
4/27/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
5/3/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/4/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/7/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/11/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/14/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/15/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/22/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
6/28/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
7/6/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402
2/10/2022	Q00014	INTERPRETER OTHER 15	120.00	150.00	60.00	0.00	90.00	G2, 402
				2310.00	1140.00	0.00	1170.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

SEQUOIA INSURANCE COMPANY
P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
00306613
QWC1101055

DATE	AMOUNT
11/22/2022	$1,260.00

One Thousand Two Hundred Sixty and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS
P O BOX 4165
TUSTIN, CA 92781-4165

AmTrust Financial Services, Inc.

⑈00306613⑈ ⑆021000021⑆ 226733883⑈

PAID
NOV 2 9 2022

M

Check Number	00306613
Claim Number:	
Bill Number:	0
Invoice Number:	
Policy / Insured:	QWC1101055/DenWest Restaurants Inc.
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS
Loss Date:	3/26/2020
Location:	5811 E. Firestone Blvd South Gate CA 90280 -
Examiner Code:	21764

Amount:	$1,260.00
Dates of Service:	4/6/2021-7/6/2021
Explanation:	Interpreters Fee Payment for IBR Determination DOS 04 06 2021-07 06 2021
Category:	M23 - Medical Interpreter
Placement:	2 - Medical
Transaction Type:	

SEQUOIA INSURANCE COMPANY
AmTrust North America
PO Box 89404

Cleveland, OH 44101
888.239.3909

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81166

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000033 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002757
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	AmTrust
Date(s) of service	04/28/2021 - 04/28/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/20/2020
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: AmTrust
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 04/28/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized Invoice
    - 04/28/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. The OMFS does not list this code, an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 04/28/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 04/28/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

AmTrust
PO Box 89404
Cleveland, OH 44101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND AN ARTIFICIAL WATERMARK ON THE BACK - HOLD AT AN ANGLE TO VIEW

TECHNOLOGY INSURANCE CO (Claims Funding)
PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
04931678
TWC3851105

DATE	AMOUNT
7/15/2021	$90.00

Ninety and 0/100s Dollars**********

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC

VOID AFTER 180 DAYS

Mail To
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX # 4165
TUSTIN , CA 92781-4165

⑈04931678⑈ ⑆021309379⑆ 6018775 33⑈

Explanation Of Bill Review

Check Number	04931678	TECHNOLOGY INSURANCE CO (Claims Funding) 1085
Claim Number:		AmTrust North America
Regulatory ID:		P.O. Box 89404
Bill Number:	16597058	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-1463191	858-385-4040
Policy / Insured:	TWC3851105/Conrad s Restaurant Inc. A Corp	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	2/20/2020 FP1-MJCA-1463191	
Location:	CA -	
Examiner Code:	31964	
Network/PPO Network:		

JUL 21 2021

BY: .....

DATES of SERVICE	CPT Code	DESCRIPTION	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/28/2021	Q00014	INTERPRETER OTHER 15	120.00	180.00	90.00	0.00	90.00	G2, 402, 877
				180.00	90.00	0.00	90.00	

G2 - THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.; 402 - PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307; 877 - PAYMENT BASED ON A 2 HOUR MINIMUM. IF THE SERVICES EXCEEDED 2 HOURS, PLEASE RESUBMIT BILL WITH DOCUMENTATION TO SUPPORT TIME SPENT.;

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual providers agreement with the preferred provider organization. TIME LIMITS TO DISPUTE PAYMENT AMOUNT FOR HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES OR BILLING AGENT/ASSIGNEE (HEREIN AFTER PROVIDER) FOR SERVICES ON/AFTER 1/1/2013. Request for Second Bill Review (SBR): After an Explanation of Review (EOR) is received on an original bill submission, a provider that disputes the amount paid may submit a Request for SBR to the claims administrator within 90 days of service of the EOR. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and CA Code of Regulations, Title 8 sections 9792.5.4 and 9792.5.5. If the only dispute is the amount of payment and the provider does not request a SBR within the 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): If the only dispute is the amount of payment and the second bill review does not resolve the payment dispute, a provider may submit a Request for IBR within 30 days of service of the SBR, pursuant to Section 4603.2 or 4622. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.7. Failure to request an IBR within 30 days will deem the bill satisfied and neither the employer nor employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. PURSUANT TO CA LABOR CODE SECTION 9792.5.1 - YOU MAY REGISTER FOR ELECTRONIC BILL SUBMISSION BY REGISTERING AT WWW.AVAILITY.COM AND CHOOSE THE 'REGISTER' TAB.

Amtrust North America, PO Box 94574, Cleveland, OH 44101, (800) 732-0153, is designated to receive by certified mail requests for petition of reimbursement.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81645

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000090 May 11, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAY 16 2022

IBR Case Number	CB22-0000479
Claim Number	
Assignment Date	04/07/2022
Claims Administrator	Applied Risk Services
Date(s) of service	01/14/2020 - 04/02/2020
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 9
Date of Injury	01/01/2018
Application Received	03/04/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $450.00 in additional reimbursement for a total of $630.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$630.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Applied Risk Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 9 submitted for dates of service 01/14/2020 – 04/02/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/22/2022. Response not yet received.
- Itemized Invoices
    - 01/14/2020 Interpreting for Initial Exam $180.00 (Billed at a minimum of 2 hours)
    - 01/20/2020 Interpreting for Initial Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 01/27/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 01/31/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 02/03/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 02/12/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/12/2020 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 03/19/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 04/02/2020 Interpreting for Follow up Acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $130.00 for each date of service 01/14/2020 – 04/02/2020. Charge exceeds guidelines set by CCR Section 9795.3.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 01/14/2020 – 04/02/2020 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.

- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 9 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 9.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 9
Date of Service: 01/14/2020 – 04/02/2020
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/14/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/20/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/27/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/31/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/03/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/12/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/12/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/19/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$130.00
Dispute Amount	$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/02/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $130.00 (Plan Allowed) = **$50.00** **Due Provider** Refer to Analysis

Copy to:

Applied Risk Services
PO Box 3804
Omaha, NE 68103

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

California Insurance Company
P.O. Box 3804
Omaha, NE 68103

Medical Payment

Check Date:	10/29/21
Service Begining:	01/14/20
Service Ending:	04/02/20

Claimant Name	Date Of Birth	Date Of Injury	Claim #
		01/01/18	

Bill #	Dates Of Service	Billed Amt.	Allowed Amt.	Discount Amt.	Net Amt.
81645	01/14/20-04/02/20	1,620.00	1,170.00	0.00	1,170.00

Messages

RECEIVED
NOV 01 2021
BY: .....

PAID
NOV 02 2021
BY: .....

Total	1,170.00

REMOVE DOCUMENT ALONG THIS PERFORATION

THIS DOCUMENT IS PRINTED IN TWO COLORS. DO NOT ACCEPT UNLESS BLUE AND GREEN ARE PRESENT.

0001373547

Union Bank of California, N.A.
716 Santa Cruz Ave , Menlo Park, CA 94025
11-491220

California Insurance Company
P.O. Box 3804 Omaha, NE 68103

Date: 10/29/21

Pay ONE THOUSAND ONE HUNDRED SEVENTY AND .00 DOLLARS********** $ 1,170.00

VOID AFTER 60 DAYS

to the order of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 92781-4165

Amy C Robb

⑈0001373547⑈ ⑆122000496⑆ 7000168038⑈

RRD SECURITY MARK™ ★ RRD SECURITY

RRD SECURITY MARK™ ★ RRD SECURITY

Applied Risk Services
PO Box 3804
Omaha, NE - 68103
Phone: (877)234-4420
Fax: (877)234-4425

California Insurance Company

Explanation of Review

Administrator:	Applied Risk Services, Inc.	**Bill Id:**		**Print Date:**	10/29/21
Address:	P. O. Box 3804	**Review Type:**		**FDOS / EDOS:**	01/14/20 - 04/02/20
City/State:	Omaha, NE - 68103-0804	**Ins. Type:**	Workers Compensation	**Invoice Date:**	09/28/21
Phone:	(877)234-4420	**Review Date:**	10/27/21	**Bill Recd. Date:**	10/04/21
Carrier Name:	California Insurance Company	**NAIC:**	38865-4962	**Adjuster:**	MAKAYLA BIEGLER
Address:	P. O. Box 3804	**Self-Insured #:**		**State Jurisdn.:**	CA
City/State:	Omaha, NE - 68103-0804	**Service Co:**		**Jurisdn. ID:**	201808211432352291748 2
Patient:		**SSN #:**		**Claim #:**	
Address:		**Patient Acct. #:**		**DOI:**	01/01/18
City/State:		**Employer ID:**	14-9420	**Employer:**	MR. BUILD HOME

Billing Provider:
Tax Id: 330956713 **Suffix:**
Name: JOYCE ALTMAN INTERPRETERS INC
Address: PO Box 4165
City/State: Tustin, CA - 92781-4165
Phone: (714)838-0950

Service Provider:
Tax Id or NPI:
Name:
License:
Phone:

DRG:
ICD: A
Bill Freq: B
Adm. Diag.:

Item No.	Service Date	Billed Procedure	Reviewed Procedure	Billed Modifier	Orig Qty	Rev Qty	DX.PT.	POS	TOS	Billed Amount	Allowed Amount	PPO Discount	Net Due Provider
1	01/14/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. MAGGIE PEZESHKIAN							**Reason Code:**		V02, V03			
2	01/20/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	TED PRIEBE							**Reason Code:**		V02, V03			
3	01/27/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. TED PREIBE							**Reason Code:**		V02, V03			
4	01/31/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. TED PREIBE							**Reason Code:**		V02, V03			
5	02/03/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. TED PREIBE							**Reason Code:**		V02, V03			
6	02/12/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. TED PREIBE							**Reason Code:**		V02, V03			
7	03/12/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	DR. MOHAMED HASSANIN							**Reason Code:**		V02, V03			
8	03/19/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	HWANG							**Reason Code:**		V02, V03			
9	04/02/20	T1013	T1013		1.00	1.00		11		180.00	130.00	0.00	130.00
	HWANG							**Reason Code:**		V02, V03			

CALIFORNIA INSURANCE COMPANY
P.O. Box 3804
Omaha, NE 68103

Medical Payment

Check Date:	04/06/22
Service Begining:	01/14/20
Service Ending:	04/02/20

Claimant Name	Date Of Birth	Date Of Injury	Claim #
		01/01/18	

Bill #	Dates Of Service	Billed Amt.	Allowed Amt.	Discount Amt.	Net Amt.
81645(A)	01/14/20-04/02/20	450.00	450.00	0.00	450.00

Messages

APR 1 1 2022

PAID

Total	450.00

REMOVE DOCUMENT ALONG THIS PERFORATION

THIS DOCUMENT IS PRINTED IN TWO COLORS. DO NOT ACCEPT UNLESS BLUE AND GREEN ARE PRESENT.

CALIFORNIA INSURANCE COMPANY
P.O. Box 3804 Omaha, NE 68103

Union Bank of California, N.A.
716 Santa Cruz Ave , Menlo Park, CA 94025
11-491220

0001384339

Date: 04/06/22

Pay FOUR HUNDRED FIFTY AND .00 DOLLARS********** $ 450.00

to the order of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 92781-4165

VOID AFTER 60 DAYS

Amy Robb

RRD SECURITY MARK™ ★ RRD SECURITY

⑈0001384339⑈ ⑆122000496⑆ 7000168038⑈

CALIFORNIA INSURANCE COMPANY
P.O. Box 3804
Omaha, NE 68103

Expense Payment

Check Date:	05/20/22
Service Begining:	05/11/22
Service Ending:	05/11/22

Claimant Name	Date Of Birth	Date Of Injury	Claim #
	N/A		

Bill #	Dates Of Service	Billed Amt.	Allowed Amt.	Discount Amt.	Net Amt.
CB22-0000479	05/11/22-05/11/22	180.00	N/A	N/A	180.00

Messages

PAID
MAY 24 2022

REMOVE DOCUMENT ALONG THIS PERFORATION

THIS DOCUMENT IS PRINTED IN TWO COLORS. DO NOT ACCEPT UNLESS BLUE AND GREEN ARE PRESENT.

CALIFORNIA INSURANCE COMPANY
P.O. Box 3804 Omaha, NE 68103

Union Bank of California, N.A.
716 Santa Cruz Ave , Menlo Park, CA 94025
11-491220

0001387228

Date: 05/20/22

Pay ONE HUNDRED EIGHTY AND .00 DOLLARS********** $ 180.00

to the order of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 92781-4165

VOID AFTER 60 DAYS

Amy Robb

⑈0001387228⑈ ⑆122000496⑆ 7000168038⑈

79542

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000039 April 29, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAY 0 2 2022

IBR Case Number	CB22-0000413
Claim Number	
Assignment Date	04/01/2022
Claims Administrator	Athens Administrators
Date(s) of service	07/29/2021 - 07/29/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/18/2020
Application Received	02/25/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Athens Administrators
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 07/29/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/15/2022. Response not yet received.
- Itemized Invoices
    - 07/29/2021 Interpreting follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 07/29/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 07/29/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Athens Administrators
P.O. Box 696
Concord, CA 94522

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

WELLS FARGO BANK, N.A.

Arch-NSM Staffing Program WC

11-24/121
1210(8)

CHECK NO: 5320

DATE: 10/26/2021

WORKERS' COMPENSATION PROGRAM
ADMINISTERED BY: ATHENS ADMINISTRATORS
P.O. BOX 696, CONCORD, CALIFORNIA 94522

THIS CHECK IS VOID AFTER 180 DAYS

AMOUNT

**********$90.00

CLAIMANT:
CLAIM NO:
PAY *Ninety And 00/100 US Dollars*

PAYABLE TO Joyce Altman Interpreters Inc
PO Box 4165
Tustin CA 92781

AUTHORIZED SIGNATURE

TWO SIGNATURES ARE REQUIRED

SIGNATURE HAS A COLORED BACKGROUND • BORDER CONTAINS MICROPRINTING

⑈00005320⑈ ⑆121000248⑆ 4126037126⑈

Provider Bill Detail

Payer: Blue Lake Recruiting
Provider Patient Account #: 79542/5097

Check Number: 5320
Check Date: 10/26/2021

Claim Number:
Claimant Name:
SSN:
Date of Birth: no valid date
State of Jurisdiction: California

Date Received: 10/19/2021
Date Reviewed: 10/25/2021
Date of Injury: 8/18/2020
Document Number: SC4103_5097
Employer: Blue Lake Recruiting

Examiner: aterkeurst
Bill Type:
Pay Code: 10392
From: 7/29/2021
Through: 7/29/2021

ICD9 Codes:

Date	Code	Mod	Description	Qty	Billed	BR Red	PPO Red	Other	Allowed	Reason
7/29/2021	T1013		SIGN LANGUAGE/ORAL INTEPR SERVICES PER 15 MIN	1.00	180.00	90.00	0.00	0.00	90.00	G1 601 P12
			Totals:		180.00	90.00	0.00	0.00	90.00	

Reduction Reason Codes:

Code:	Description:
601	CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
P12	WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

PAID
NOV 01 2021
BY: .....

Notices:

For reconsideration of denied or reduced payment, please respond in writing to the contact information below and include 1) What specifically you wish to reconsider, 2) a copy of this Review Analysis, and 3) supporting documentation. Should you have further questions, you may contact:

Athens Administrators
PO Box 696, Concord, CA 94522
Phone:
Fax: 925-609-5306
Email:

79542
RECEIVED
OCT 29 2021
BY: .....

THIS CHECK IS VOID WITHOUT A WATERMARK • HOLD AT ANGLE TO VIEW • BORDER CONTAINS MICROPRINTING • SEE BACK FOR ENDORSEMENT • SEE DETACHABLE CLAIMANT VOUCHER

Arch-NSM Staffing Program WC

WELLS FARGO BANK, N.A.

11-24/121
1210(8)

CHECK NO: 6089

DATE: 5/4/2022

WORKERS' COMPENSATION PROGRAM
ADMINISTERED BY: ATHENS ADMINISTRATORS
P.O. BOX 696, CONCORD, CALIFORNIA 94522

THIS CHECK IS VOID AFTER 180 DAYS

AMOUNT

**********$90.00

CLAIMANT:
CLAIM NO:
PAY *Ninety And 00/100 US Dollars*

PAYABLE TO Joyce Altman Interpreters Inc
PO Box 4165
Tustin CA 92781

AUTHORIZED SIGNATURE

TWO SIGNATURES ARE REQUIRED

SIGNATURE HAS A COLORED BACKGROUND • BORDER CONTAINS MICROPRINTING

⑈00006089⑈ ⑆121000248⑆ 4126037126⑈

M

Provider Bill Detail

Payer: Blue Lake Recruiting
Provider Patient Account #: 79542/9000184

Check Number: 6089
Check Date: 5/4/2022

Claim Number:
Claimant Name:
SSN:
Date of Birth: no valid date
State of Jurisdiction: California

Date Received: 5/3/2022
Date Reviewed: 5/3/2022
Date of Injury: 8/18/2020
Document Number: SC4103_9000184
Employer: Blue Lake Recruiting

Examiner: mtorres
Bill Type:
Pay Code: 10392
From: 7/29/2021
Through: 7/29/2021

ICD9 Codes:

Date	Code	Mod	Description	Qty	Billed	BR Red	PPO Red	Other	Allowed	Reason
7/29/2021	T1013		SIGN LANGUAGE/ORAL INTEPR SERVICES PER 15 MIN	1.00	0.00	-90.00	0.00	0.00	90.00	G1 G5 1001 4535 P1 P12
			Totals:		0.00	-90.00	0.00	0.00	90.00	

Reduction Reason Codes:

Code:	Description:
1001	Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
4535	ADDITIONAL ALLOWANCE IS RECOMMENDED PER FINAL RULING FROM IBR.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G5	THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.
P1	STATE-MANDATED REQUIREMENT FOR PROPERTY AND CASUALTY, SEE CLAIM PAYMENT REMARKS CODE FOR SPECIFIC EXPLANATION.
P12	WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

RECEIVED
MAY 11 2022

RECEIVED
MAY 06 2022
BY:

THIS CHECK IS VOID WITHOUT A WATERMARK - HOLD TO LIGHT TO VIEW - RUB HEAT SENSITIVE CHECKMARK TO SEE COLOR DISAPPEAR AND REAPPEAR

WELLS FARGO BANK, N.A.

Arch-NSM Staffing Program WC

11-24/121
1210(8)

CHECK NO: 6087

DATE: 5/3/2022

WORKERS' COMPENSATION PROGRAM
ADMINISTERED BY: ATHENS ADMINISTRATORS
P.O. BOX 696, CONCORD, CALIFORNIA 94522

THIS CHECK IS VOID AFTER 180 DAYS

AMOUNT

*********$180.00

CLAIMANT:
CLAIM NO:
AMOUNT *One Hundred And Eighty And 00/100 US Dollars*

PAY JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781

AUTHORIZED SIGNATURE

TWO SIGNATURES ARE REQUIRED

SIGNATURE HAS A COLORED BACKGROUND • BORDER CONTAINS MICROPRINTING

⑈0000608 7⑈ ⑆121000248⑆ 4126037126⑈

Payee: JOYCE ALTMAN **TIN/SSN:** XX-XXX6713

Check Number: 6087

Check Amount: 180.00

Check Date: 5/3/2022

Claim Number	Employer	Claimant Name	Loss Date	Payment Transaction	From	Through	Invoice Date	Invoice #	Amount
20014964	Blue Lake Recruiting		8/18/2020	Misc Med/Other	7/29/2021	7/29/2021	1/1/1900		180.00

Comments: IBR Fee

PAID
MAY 05 2022

77986

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000035 January 24, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 2 8 2022

IBR Case Number	CB21-0002066
Claim Number	
Assignment Date	12/01/2021
Claims Administrator	Berkshire Hathaway
Date(s) of service	03/03/2021 - 03/29/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 4
Date of Injury	09/05/2019
Application Received	09/03/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $547.50 in additional reimbursement for a total of $727.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$727.50** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Berkshire Hathaway
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 4 submitted for dates of service 03/03/2021 - 03/29/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/15/2021. Response not yet received.
- Itemized invoices
    - 03/03/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/08/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/22/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 03/29/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for 03/29/2021 with the rationale: paid according to contracted pre negotiated rates and $27.50 for each date of service 03/03/2021 - 03/22/2021. With the rationale an allowance for this procedure was made at the usual and customary amount for this geographical area.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 03/03/2021 - 03/29/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 4 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 4.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 4
Date of Service: 03/03/2021 - 03/29/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$27.50
Dispute Amount	$152.50
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $27.50 (Plan Allowed) = **$152.50 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$27.50
Dispute Amount	$152.50
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $27.50 (Plan Allowed) = **$152.50 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$27.50
Dispute Amount	$152.50
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $27.50 (Plan Allowed) = **$152.50 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 03/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Berkshire Hathaway
PO Box 1368
Wilkes-Barre, PA 18703

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

009640208

MAY 10 2021

77986

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

GDN73773A05A0AA.000775.01.02.000000

Please see attached documentation.

PAID

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
1210

009640208

DATE 05/06/2021

AMOUNT *********$27.50

NOT VALID AFTER 180 DAYS

⇨⇨⇨⇨⇨PAY ONLY $27.50
DOLLAR TWO SEVEN PERIOD FIVE ZERO

TWENTY-SEVEN DOLLARS AND 50 CENTS**********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $27.50

⑈009640208⑈ ⑆121000248⑆ 2000519407927⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

MAY 10 2021

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1147091

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986 ✔
Invoice Date: 04-13-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-03-2021
Post Date: 05-04-2021

Reviewer: SI/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-03-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G1, 360, G4, 975, G57, U00
				180.00	152.50				27.50

Totals

Total Charges:	180.00
Bill Review Reductions:	152.50
Recommended Allowance:	**27.50**

Messages

360	ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA. LABOR CODE 5307.1
975	THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210419GUAGUCA71523

GDN73773A05A0AA.000775.02.02.000000

009641115

MAY 1 3 2021

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

GDN74672A05A0AA.000806.01.02.000000

77986

Please see attached documentation.

PAID

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
1210

009641115

DATE
05/10/2021

AMOUNT
*********$27.50

⇨⇨⇨⇨⇨PAY ONLY $27.50
DOLLAR TWO SEVEN PERIOD FIVE ZERO

NOT VALID AFTER 180 DAYS

■ TWENTY-SEVEN DOLLARS AND 50 CENTS**********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $27.50

⑈009641115⑈ ⑆121000248⑆ 2000519407927⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

MAY 13 2021

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1148825

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A99999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 04-16-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-08-2021
Post Date: 05-06-2021

Reviewer: S1/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-08-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G1, 360, G4, 975, G57, U00
				180.00	152.50				27.50

Totals

Total Charges:	180.00	
Bill Review Reductions:		152.50
Recommended Allowance:		**27.50**

Messages

360	ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA. LABOR CODE 5307.1
975	THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210421GUAGUCA70669

CDN74672A05A0AA.000806.02.02.000000

009647850

22986

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

GDN25150A05A0AA.000945.01.02.000000

Please see attached documentation.

JUN 04 2021

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
T210

009647850

DATE 06/01/2021

AMOUNT *********$27.50

NOT VALID AFTER 180 DAYS

⇨⇨⇨⇨⇨PAY ONLY $27.50
DOLLAR TWO SEVEN PERIOD FIVE ZERO

■ TWENTY-SEVEN DOLLARS AND 50 CENTS**********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $27.50

⑈009647850⑈ ⑆121000248⑆ 2000519407927⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1159428

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 05-10-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-22-2021
Post Date: 05-27-2021
Reviewer: S1/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-22-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G1, 360, G4, 975, G57, U00
				180.00	152.50				27.50

Totals

Total Charges:	180.00
Bill Review Reductions:	152.50
Recommended Allowance:	**27.50**

Messages

360	ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA. LABOR CODE 5307.1
975	THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210513GUAGUCA70716

GDN25150A05A0AA.000945.02.02.000000

009648635

77986

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

JUN 07 2021

BY: .....

GDN93314A05A0AA.001190.01.03.000000

Please see attached documentation.

JUN 08 2021

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
T210

009648635

DATE 06/03/2021

AMOUNT ********$180.00

NOT VALID AFTER 180 DAYS

⇨⇨⇨⇨⇨PAY ONLY $180.00
DOLLAR ONE EIGHT ZERO PERIOD ZERO ZERO

■ ONE HUNDRED EIGHTY DOLLARS AND 00 CENTS**********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $180.00

⑈009648635⑈ ⑆121000248⑆ 2000519407927⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1161643

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 05-13-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-29-2021
Post Date: 06-01-2021
Reviewer: G2/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-29-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G67, D28
				180.00				90.00	90.00

Totals

Total Charges:	180.00	
Bill Review Allowance:	180.00	
Other Reductions:		90.00
Recommended Allowance:		**90.00**

Messages

D28 PAID ACCORDING TO CONTRACTED/PRE-NEGOTIATED RATES
G67 PAYMENT BASED ON INDIVIDUAL PRE- NEGOTIATED AGREEMENT FOR THIS SPECIFIC SERVICE.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210517GUAGUCA71875

GDN93314A05A0AA.001190.02.03.000000

009702622

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

GDN1035A05A0AAA.001191.01.05.000000

Please see attached documentation.

RECEIVED
DEC 07 2021
BY:.....

PAID
DEC 08 2021
BY:.....

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
T210

009702622

VOID

DATE 12/03/2021

AMOUNT ********$610.00

⇨⇨⇨⇨⇨PAY ONLY $610.00
DOLLAR SIX ONE ZERO PERIOD ZERO ZERO

NOT VALID AFTER 180 DAYS

■ SIX HUNDRED TEN DOLLARS AND 00 CENTS**********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $610.00

⑈009702622⑈ ⑆121000248⑆ 2000519407977⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

GDN1035A05A0AAA.001191.02.05.000000

Original Bill ID: GUA-GUCA-1213114 **Bill:** GUA-GUCA-1242966 **Re-evaluation**

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 04-13-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-03-2021
Post Date: 12-01-2021
Reviewer: DH/DH
Pay Auth: 14
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-03-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G1, P12, 790, 197, G57, U00
				180.00					180.00

Totals

Total Charges:	180.00
Recommended Allowance:	**180.00**
Previous Recommended Allowance:	27.50
Add'l Recommendation For This Review:	152.50

Messages

197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
790	WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
P12	WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210913GUAGUCA60038

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Original Bill ID: GUA-GUCA-1213117 **Bill:** GUA-GUCA-1242967 **Re-evaluation**

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A99999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 04-16-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-08-2021
Post Date: 12-01-2021
Reviewer: DH/DH
Pay Auth: 14
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	Network	ONR	Other	Explanation Code(s)	Allow.
1	03-08-2021	11	T1013	A	180.00	1		SIGN LANG/ORAL INTERPRET				G1, P12, 790, 197, G57, U00	180.00

Totals

Total Charges:	180.00
Recommended Allowance:	**180.00**
Previous Recommended Allowance:	27.50
Add'l Recommendation For This Review:	152.50

Messages

197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
790	WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
P12	WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210913GUAGUCA60039

GDN1035A05A0AAA.001191.03.05.000000

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: AMGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Original Bill ID: GUA-GUCA-1213121 **Bill:** GUA-GUCA-1242970 **Re-evaluation**

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 09-05-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** VA082093001
Invoice No: 77986
Invoice Date: 05-10-2021
Patient Account: 77986

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 03-22-2021
Post Date: 12-01-2021
Reviewer: DH/DH
Pay Auth: 14
Client Type of Bill: LANG
Adjuster: MSCHUBAC

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description			Explanation Code(s)
				Charges	BR	Network	ONR	Other	Allow.
1	03-22-2021	11	T1013	A	1	SIGN LANG/ORAL INTERPRET			G1, P12, 790, 197, G57, U00
				180.00					180.00

Totals

Total Charges:	180.00
Recommended Allowance:	**180.00**
Previous Recommended Allowance:	27.50
Add'l Recommendation For This Review:	152.50

Messages

197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
790	WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
P12	WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210913GUAGUCA60040

GDN1035A05A0AAA.001191.05.05.000000

79417 97090
79413

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 1 0 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000055 January 6, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002557
Claim Number	
Assignment Date	11/18/2021
Claims Administrator	Berkshire Hathaway
Date(s) of service •	04/06/2021 - 04/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	03/14/2019
Application Received	10/15/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $305.00 in additional reimbursement for a total of $485.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$485.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Berkshire Hathaway
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 04/06/2021 - 04/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/02/2021. Response not yet received.
- Itemized invoices
    - 04/06/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 04/13/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $27.50 for each date of service 04/06/2021 - 04/13/2021. An allowance for this procedure was made at the usual and customary amount for this geographical area.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/06/2021 - 04/13/2021were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 04/06/2021 - 04/13/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$27.50
Dispute Amount	$152.50
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $27.50 (Plan Allowed) = **$152.50** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$27.50
Dispute Amount	$152.50
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $27.50 (Plan Allowed) = **$152.50** **Due Provider** Refer to Analysis

Copy to:

Berkshire Hathaway
PO Box 1368
Wilkes-Barre, PA 18703

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: NORGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1179514

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI:
Tax ID: 33-0956713
License: A9999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386
Invoice No: 79417
Invoice Date: 05-21-2021
Patient Account: 79417

Rendering NPI:
Type: OT **Specialty (1):** AO
Specialty (2): AO

Claim Number:
DOI/DOL: 03-14-2019

External Claim Number: EL974920021

Region: 26 **Payment Status Code:** 1

RECEIVED JUL 19 2021 BY: .....

Bill Details

Dates of Service: 04-06-2021
Post Date: 07-13-2021

Reviewer: MD/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: PALCALA

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	Network	ONR	Other	Explanation Code(s)	Allow.
1	04-06-2021	11	T1013	A	180.00	1	152.50	SIGN LANG/ORAL INTERPRET				G1, 360, G4, 975	27.50

Totals

Total Charges:	180.00
Bill Review Reductions:	152.50
Recommended Allowance:	27.50

Messages

360	ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA. LABOR CODE 5307.1
975	THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210624GUAGUCA70942

GDN01716A05A0AA.001058.03.03.000000

009979026

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

JUN 2 4 2021

GDN38461A05A0AA.001112.01.02.000000

Please see attached documentation.

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

NorGUARD Insurance Company

P.O. Box AH
Wilkes-Barre, PA 18703-0020

Wells Fargo Bank, N.A.

11-24
1210

009979026

DATE
06/21/2021

AMOUNT
*********$27.50

NOT VALID AFTER 180 DAYS

⇨⇨⇨⇨⇨PAY ONLY $27.50
DOLLAR TWO SEVEN PERIOD FIVE ZERO

■ TWENTY-SEVEN DOLLARS AND 50 CENTS*********

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER $27.50

⑈009979026⑈ ⑆121000248⑆ 2000519409116⑈

Explanation of Review

BERKSHIRE HATHAWAY GUARD INSURANCE COMPANIES

Carrier

Carrier No:
Carrier: NORGUARD INSURANCE COMPANY
P.O. BOX A-H / 16 S. RIVER STREET
WILKES-BARRE, PA 18703-0020

Bill: GUA-GUCA-1169940

Provider

JOYCE ALTMAN INTERPRETERS INC
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Claimant

NPI: **Rendering NPI:**
Tax ID: 33-0956713 **Type:** OT **Specialty (1):** AO **Claim Number:**
License: A9999999 **Specialty (2):** AO **DOI/DOL:** 03-14-2019
Rendering Provider: JOYCE ALTMAN INTERPRETERS
External ID: 5386 **External Claim Number:** EL974920021
Invoice No: 79417
Invoice Date: 05-28-2021
Patient Account: 79417

Region: 26 **Payment Status Code:** 1

Bill Details

Dates of Service: 04-13-2021
Post Date: 06-17-2021

Reviewer: SI/
Pay Auth: 0
Client Type of Bill: LANG
Adjuster: MESPARZA

Bill ICD Version: 10
Dx A: T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BR	Description	Network	ONR	Other	Explanation Code(s)	Allow.
1	04-13-2021	11	T1013	A	180.00	1	152.50	SIGN LANG/ORAL INTERPRET				G1, 360, G4, 975	27.50

Totals

Total Charges:	180.00
Bill Review Reductions:	152.50
Recommended Allowance:	**27.50**

Messages

360	ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE USUAL AND CUSTOMARY AMOUNT FOR THIS GEOGRAPHICAL AREA. LABOR CODE 5307.1
975	THIS LINE ITEM WAS REVIEWED USING THE FAIR HEALTH CHARGE BENCHMARK DATABASE MODULE BASED ON THE PROVIDER GEOGRAPHIC AREA.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS, PLEASE SEND THE BILL AND THE ANALYSIS TO:

GUARD INSURANCE GROUP, PO BOX 1368, WILKES-BARRE, PA 18703, (800) 673 - 2465

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 210603GUAGUCA70336

GDN38461A05A0AA.001112.02.02.000000

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81294

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000091 November 1, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 07 2022

IBR Case Number	CB22-0002016
Claim Number	
Assignment Date	09/20/2022
Claims Administrator	Broadspire Insurance
Date(s) of service	06/08/2021 - 11/19/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 30
Date of Injury	03/12/2021
Application Received	08/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $2,699.10 in additional reimbursement for a total of $2,879.10. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$2,879.10** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Broadspire Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 30 submitted for dates of service 06/08/2021 – 11/19/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/02/2022. Response not yet received.
- Itemized invoices
    - 06/08/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 06/23/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/25/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/02/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/07/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/09/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/14/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/16/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/20/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 07/21/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/23/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/13/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/18/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/19/2021 Interpreting for EMG $180.00 (Billed at a minimum of 2 hours)
    - 08/20/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/25/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/01/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 09/10/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/17/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/06/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/08/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)

- 10/20/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 10/22/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 10/26/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- 10/29/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 11/05/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 11/12/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 11/17/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- 11/19/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)

- EORs reflect reimbursement of $90.00 for each date of service 06/08/2021 – 08/25/2021, 09/07/2021 – 11/19/2021 and $90.90 for date of service 09/01/2021 for a total reimbursement of $2,700.90. Workers compensation fee schedule adjustment.
- **CCR § 9795.3. Fees for Interpreter Services.**
  - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
    - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
    - A medical treatment appointment;
  - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
    2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 30 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 30.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 30
Date of Service: 06/08/2021 – 11/19/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/02/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/21/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn 07/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn 08/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.90
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.90 (Plan Allowed) = **$89.10** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/05/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Broadspire Insurance
PO Box 14645
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Broadspire Services, Inc.
PO Box 189080
Plantation, FL 33318-9080

0000064-0000648 S0716 001 411071 BSP

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781-0000

Broadspire®
A CRAWFORD COMPANY

RECEIVED
BY: 81294

The document you are holding is a payment for services provided. The attached check and Explanation of Payment(s) is sent to you for services rendered on behalf of Broadspire Services, Inc. who has partnered with VPay® to process their payments. If you have questions regarding the payment, please contact us at 1-855-388-8371. If you have questions regarding the payment amount or benefit calculation, please contact Broadspire Services, Inc. at 1-800-800-7885.

Claim ID:	
Client Reference ID:	9152024701
VP Trans ID:	1357320559 BSP0001002
Date:	04/29/2022
Amount:	$2,700.90
Check Number:	5625345

PAID
MAY 04 2022
BY:

Get Paid Faster
When you sign up for
VCard or ACH
Email
support@vpayusa.com
today to find out how.

Notice of Confidentiality - The information contained in this communication is confidential and is intended solely for the addressee. The information may also be legally privileged. This communication is sent in trust, for the sole purpose of delivery to the intended recipient. If you have received this document in error, any use, reproduction or dissemination of this communication is strictly prohibited. If you are not the intended recipient, please immediately notify VPay® at (877) 399-5917 and provide the VP Trans ID shown above and destroy this communication and its attachments, if any.

Broadspire
A CRAWFORD COMPANY

Bill Id: BRS-BSCA-3353299

Carrier
XL INSURANCE AMERICA, INC.
70 SEAVIEW AVE
STAMFORD, CT 06902

Provider
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781-0000

Tax ID: 33-0956713
License: 999999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.
Invoice Date: 04/11/2022
Patient Account: 81294
Region: 26
Payment Status Code: 1

Claimant

Claim Number
DOI/DOL: 03/12/2021
CR Date / BR Date: 04/18/2022 / 04/18/2022
External Claim Number: 20210421113904344253 97
Social Security Number:
Employer/Insured: EMPLOYBRIDGE, LLC
Employer/Insured Address: REAL TIME STAFFING SERVICES
1640 SOUTH GROVE
ONTARIO, CA 91761
Policy Admin Information: 023363
Branch ID: BRE

Bill Details

Dates of Service: 06/08/2021 to 11/19/2021
Post Date: 04/27/2022
Client Type of Bill: 74
Adjuster: MJVOSS

Bill ICD Version: 10
Dx A:T14.90 INJURY, UNSPECIFIED

Broadspire
A CRAWFORD COMPANY

Explanation of Review

Bill Id: BRS-BSCA-3353299

Carrier

XL INSURANCE AMERICA, INC.
70 SEAVIEW AVE
STAMFORD, CT 06902

Provider

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781-0000

Claimant

Tax ID: 33-0956713
License: 999999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.
Invoice Date: 04/11/2022
Patient Account: 81294
Region: 26
Payment Status Code: 1

Claim Number:
DOI/DOL: 03/12/2021
CR Date / BR Date: 04/18/2022 / 04/18/2022
External Claim Number: 202104121139043442539 7
Social Security Number:
Employer/Insured: EMPLOYBRIDGE, LLC
Employer/Insured Address: REAL TIME STAFFING SERVICES
1640 SOUTH GROVE
ONTARIO, CA 91761
Policy Admin Information: 023363
Branch ID: BRE

Bill Details

Dates of Service: 06/08/2021 to 11/19/2021
Post Date: 04/27/2022
Client Type of Bill: 74
Adjuster: MJVOSS

Bill ICD Version: 10

Dx A:T14.90 INJURY, UNSPECIFIED

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description	Charges	Review	Network	Explanation Code(s) Misc.	Allowance
1	06/08/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
2	06/23/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
3	06/25/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
4	07/02/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
5	07/07/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
6	07/09/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
7	07/14/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
8	07/16/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
9	07/20/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
10	07/21/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
11	07/23/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
12	08/13/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
13	08/18/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
14	08/19/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
15	08/20/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
16	08/25/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
17	09/01/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	89.10	0.00	W1,885 0.00	90.90
18	09/07/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
19	09/10/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	885,W1 0.00	90.00
20	09/17/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00

Broadspire
A CRAWFORD COMPANY

Explanation of Review

Bill Id: BRS-BSCA-3353299

Carrier

XL INSURANCE AMERICA, INC.
70 SEAVIEW AVE
STAMFORD, CT 06902

Provider

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781-0000

Claimant

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description	Charges	Review	Network	Explanation Code(s) Misc.	Allowance
21	10/06/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
22	10/08/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
23	10/20/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
24	10/22/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
25	10/26/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
26	10/29/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
27	11/05/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
28	11/12/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
29	11/17/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00
30	11/19/2021	99	00014	A	8	INTERPRETER OTHER 15	180.00	90.00	0.00	W1,885 0.00	90.00

Totals

Total Charges:	5,400.00			
Bill Review Reductions:		2,699.10		
Network Reductions:			0.00	
Miscellaneous Reductions:				0.00
Recommended Allowance:				2,700.90

Messages

W1 WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
885 REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT



1357320559

Broadspire
A CRAWFORD COMPANY

Explanation of Review

Bill Id: BRS-BSCA-3353299

Carrier	XL INSURANCE AMERICA, INC. 70 SEAVIEW AVE STAMFORD, CT 06902

Provider	JOYCE ALTMAN INTERPRETERS, INC. P.O. BOX # 4165 TUSTIN, CA 92781-0000	Claimant	

Notes

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

For Reconsiderations, please send your bill and a copy of this EOR to Broadspire at PO Box 14645, Lexington, KY 40512 or contact Customer Assistance at 800-800-7885 or Provider24@choosebroadspire.com

Broadspire offers a Provider Portal where you can view the status of your medical bills anytime, anywhere. Visit MyMBRStatus.choosebroadspire.com to get started today.

1357320559

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77710

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000034 January 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002817
Claim Number	
Assignment Date	12/09/2021
Claims Administrator	Cannon Cochran
Date(s) of service	05/06/2021 - 05/06/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/16/2019
Application Received	11/12/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/06/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/23/2021. Response received 12/03/2021. Claims Administrator provided copies of the IBR documents. No position statement was provided
- Itemized invoice
    - 05/06/2021 Interpreting for Initial acupuncture visit $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/06/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/06/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran
1800 Sutter Street, Suite 460
Concord, CA 94520

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN. DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161680317

Date: 07/08/2021

Batch#: 304635432

Amount: NINETY AND 00 / 100*****

Amount

$****90.00

Void After 180 Days

PAY TO THE ORDER OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161680317⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	77710	ACHAN
10/16/2019			STRATACARE		133011 DS 05/06/21	Concord

77710

RECEIVED
JUL 12 2021

BY:.....

PAID
JUL 13 2021

Batch#: 304635432

Loc: 80-CARSON, CA-LYNEER

Check# 161680317

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 07/06/2021
Control Number: 133011
EOR Page 1 of 2
Rev/Aud: SS/AW

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 77710 Geo Zip: 90744
Provider License: CA99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/16/2019
Claims Received Date: 06/28/2021

Adjuster Name: Chan Amy
ICD-DX1: T14.90 Injury, unspecified

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/06/21	11	T1013		SIGN LANGUAGE/(	120.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name:
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161695073

Date: 03/10/2022

Batch#: 305302320

Amount: TWO HUNDRED SEVENTY AND 00/100*****

Amount

$****270.00

Void After 180 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX #4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161695073⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		270.00	0.00	270.00		ACHAN
10/16/2019					$270 payment per IBR Determination dated	CONCORD

PAID
MAR 17 2022
BY: .....

Batch#: 305302320

Loc: 80-CARSON, CA-LYNEER

Check# 161695073

Check Amount: $**270.00**

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77710

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000096 June 1, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUN 0 6 2022

IBR Case Number	CB21-0002994
Claim Number	
Assignment Date	04/26/2022
Claims Administrator	Cannon Cochran
Date(s) of service	05/27/2021 - 05/27/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/16/2019
Application Received	12/02/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 05/27/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/08/2022. Response received 04/14/2022 and 05/09/2022. Claims Administrator supplied copies of IBR documents.
- Itemized invoice
    - 05/27/2021 Initial Exam $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/27/2021 was signed by the patient and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 05/27/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran
1800 Sutter St. Ste. 460
Concord, CA 94520

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161682214

Date: 08/06/2021

Batch#: 304721137

Amount

$****270.00

Void After 180 Days

Amount: TWO HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161682214⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	78354	CWATTS
11/19/2019			STRATACARE		134541 DS 05/26/21	LAS VEGAS
		180.00	90.00	90.00	78354	CWATTS
11/19/2019			STRATACARE		134584 DS 05/19/21	LAS VEGAS
		180.00	90.00	90.00	77710	ACHAN
10/16/2019			STRATACARE		134347 DS 05/27/21	Concord

PAID
AUG 1 1 2021

BY: .....

AUG 1 1 2021

BY: .....

Batch#: 304721137

Loc: 150-RIVERSIDE, CA-LYNEER

Check# 161682214

Check Amount: $**270.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 08/04/2021
Control Number: 134347
EOR Page 1 of 2
Rev/Aud: SS/SR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 77710 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 10/16/2019
Claims Received Date: 07/22/2021

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/27/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	50,G1,601, 601
				TOTALS:		**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
				TOTAL RECOMMENDED ALLOWANCE:						**90.00**	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1	-THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

50	-THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
601	-CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
601	-TREATMENT IS NOT REASONABLE, NECESSARY OR CAUSALLY RELATED TO THE WORK INJURY

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID PATTERN - DOES NOT SHOW

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161697557

Date: 04/29/2022

Batch#: 305444646

Amount

$****5,370.00

Void After 180 Days

Two Signatures Required for Amounts over $5000.00

Amount: FIVE THOUSAND THREE HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden
John E Kluth II

⑈0161697557⑈ ⑆071000039⑆ 866662264 2⑈

m

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		5,370.00	0.00	5,370.00		ACHAN
10/16/2019					pay in full and final for all DOS per agreement	CONCORD

MAY 05 2022

BY: .....

Batch#: 305444646

Check# 161697557

Check Amount: $****5,370.00

Loc: 80-CARSON, CA-LYNEER

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

37710

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000028 March 3, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAR 0 7 2022

IBR Case Number	CB21-0003151
Claim Number	
Assignment Date	01/19/2022
Claims Administrator	Cannon Cochran
Date(s) of service	06/07/2021 - 06/07/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/16/2019
Application Received	12/23/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 06/07/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/03/2022. Response received 02/01/2022. Claims Administrator supplied copies of IBR documents.
- Itemized invoice
    - 06/07/2021 Interpreting for PR2/ReEval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 06/07/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 06/07/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran
1800 Sutter St. Ste. 460
Concord, CA 94520

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161683087

Date: 08/18/2021

Batch#: 304755717

Amount

$****90.00

Void After 180 Days

Amount: NINETY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161683087⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	77710	ACHAN
10/16/2019		STRATACARE			135803 DS 06/07/21	Concord

PAID
AUG 23 2021
BY: .....

PAID
AUG 23 2021
BY: .....

Batch#: 304755717

Loc: 80-CARSON, CA-LYNEER

Check# 161683087

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 08/16/2021
Control Number: 135803
EOR Page 1 of 2
Rev/Aud: SS/AW

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 77710 Geo Zip: 90744
Provider License: CA99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/16/2019
Claims Received Date: 08/10/2021

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
06/07/21	11	T1013		SIGN LANGUAGE/(	120.000	180.00	90.00	0.00	0.00	90.00	G1,601
		99919 Changed to T1013 Better Defining Services Performed									
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: FMR CARSON
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID PATTERN - DOES NOT SHOW

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161697557

Date: 04/29/2022

Batch#: 305444646

Amount

$****5,370.00

Void After 180 Days

Two Signatures Required for Amounts over $5000.00

Amount: FIVE THOUSAND THREE HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden
John E Kluth II

⑈0161697557⑈ ⑆071000039⑆ 866662264 2⑈

m

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		5,370.00	0.00	5,370.00		ACHAN
10/16/2019					pay in full and final for all DOS per agreement	CONCORD

MAY 05 2022

BY: .....

Batch#: 305444646

Check# 161697557

Check Amount: $****5,370.00

Loc: 80-CARSON, CA-LYNEER

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JUN 10 2022

77710

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000072 June 7, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0000765
Claim Number	
Assignment Date	04/28/2022
Claims Administrator	Cannon Cochran Mgmt Svcs
Date(s) of service	08/17/2021 - 08/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/16/2019
Application Received	04/01/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Mgmt Svcs
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 08/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/12/2022. Response received 04/25/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoice
    - 08/17/2021 Interpreting for chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/17/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 08/17/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Mgmt Svcs
1800 Sutter St., Ste 460
Concord, CA 94520

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161688867

Date: 11/15/2021

Batch#: 305000487

Amount: NINETY AND 00 / 100*****

Amount
$****90.00

Void After 180 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161688867⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	77710	ACHAN
10/16/2019		STRATACARE			141671 DS 08/17/21	Concord

PAID
NOV 18 2021
BY: .....

RECEIVED
NOV 18 2021
BY: 77710

Batch#: 305000487

Loc: 80-CARSON, CA-LYNEER

Check# 161688867

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 11/11/2021
Control Number: 141671
EOR Page 1 of 2
Rev/Aud: SS/HD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 77710 Geo Zip: 90744
Provider License: CA99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/16/2019
Claims Received Date: 11/02/2021

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/17/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name:
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID PATTERN - DOES NOT SHOW

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161697557

Date: 04/29/2022

Batch#: 305444646

Amount

$****5,370.00

Void After 180 Days

Two Signatures Required for Amounts over $5000.00

Amount: FIVE THOUSAND THREE HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden
John E Kluth II

⑈0161697557⑈ ⑆071000039⑆ 866662264 2⑈

m

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		5,370.00	0.00	5,370.00		ACHAN
10/16/2019					pay in full and final for all DOS per agreement	CONCORD

MAY 05 2022

BY: .....

Batch#: 305444646

Check# 161697557

Check Amount: $****5,370.00

Loc: 80-CARSON, CA-LYNEER

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78354

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000022 May 19, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAY 23 2022

IBR Case Number	CB22-0000617
Claim Number	
Assignment Date	04/14/2022
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	07/28/2021 - 07/28/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/19/2019
Application Received	03/18/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Management Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 07/28/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/29/2022. Response not yet received.
- Itemized Invoice
    - 07/28/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 07/28/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 07/28/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 35350
Las Vegas, NV 89133

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161688227

Date: 11/04/2021

Batch#: 304972993

Amount: NINETY AND 00 / 100*****

Amount

$****90.00

Void After 180 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161688227⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	78354	CWATTS
11/19/2019		STRATACARE			141359 DS 07/28/21	LAS VEGAS

RECEIVED
NOV 08 2021
BY: 78354

PAID
NOV 09 2021
BY:

Batch#: 304972993

Loc: 150-RIVERSIDE, CA-LYNEER

Check# 161688227

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 11/02/2021
Control Number: 141359
EOR Page 1 of 2
Rev/Aud: SS/GT

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 78354 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 11/19/2019
Claims Received Date: 10/08/2021

Adjuster Name: Watts Chelsea

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
07/28/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name:
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No **0161600838**

Date 07/14/2022

Batch# 305655301

Amount

$****290 00

Void After 180 Days

Amount TWO HUNDRED NINETY AND 00 / 100*****

- 290
290

Rodney J. Golden

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

⑈0161600838⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOL	Claimant	Inv Amt	Disc Amt	Net Paid	Inv #\Comment	Adjuster\Office
		290 00	0 00	290 00		PSMOLKA
11/19/2019					Inv 78354 - IBR - C B22 0000617	LAS VEGAS

PAID
AUG 0 6 2022
BY: .....

Batch# 305655301

Loc 150 RIVERSIDE C A

Check# 161600838

Check Amount $****290 00

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78354

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000053 June 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUN 0 6 2022

IBR Case Number	CB21-0002993
Claim Number	
Assignment Date	04/26/2022
Claims Administrator	Cannon Cochran
Date(s) of service	05/19/2021 - 05/26/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	11/19/2019
Application Received	12/02/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 05/19/2021 - 05/26/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/08/2022. Response not yet received.
- Itemized invoice
    - 05/19/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 05/26/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 05/19/2021 and 05/26/2021. These are non-covered services because this is not deemed a medical necessity by the payer.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 05/19/2021 and 05/26/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 05/19/2021 – 05/26/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran
PO Box 35350
Las Vegas, NV 89133

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND. PATENT NO. NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161682214

Date: 08/06/2021

Batch#: 304721137

Amount

$****270.00

Void After 180 Days

Amount: TWO HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161682214⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	78354	CWATTS
11/19/2019			STRATACARE		134541 DS 05/26/21	LAS VEGAS
		180.00	90.00	90.00	78354	CWATTS
11/19/2019			STRATACARE		134584 DS 05/19/21	LAS VEGAS
		180.00	90.00	90.00	77710	ACHAN
10/16/2019			STRATACARE		134347 DS 05/27/21	Concord

RECEIVED
AUG 11 2021
BY:

RECEIVED
AUG 11 2021
BY:

Batch#: 304721137

Loc: 150-RIVERSIDE, CA-LYNEER

Check# 161682214

Check Amount: $**270.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 08/04/2021
Control Number: 134584
EOR Page 1 of 2
Rev/Aud: SS/SR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 78354 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 11/19/2019
Claims Received Date: 07/12/2021

Adjuster Name: Watts Chelsea

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/19/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	50,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI: 9999999999

CARRIER EXPLANATION REASON CODE

50	-THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
601	-TREATMENT IS NOT REASONABLE, NECESSARY OR CAUSALLY RELATED TO THE WORK INJURY

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 08/04/2021
Control Number: 134541
EOR Page 1 of 2
Rev/Aud: SS/SR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 78354 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/19/2019
Claims Received Date: 07/20/2021

Adjuster Name: Watts Chelsea

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/26/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	50,G1,601, 601
				TOTALS:		**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
				TOTAL RECOMMENDED ALLOWANCE:						**90.00**	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

50 -THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
601 -TREATMENT IS NOT REASONABLE, NECESSARY OR CAUSALLY RELATED TO THE WORK INJURY

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3 710 IL

Check No 0161600837

Date 07/14/2022

Batch# 305655301

Amount

$****360 00

Void After 180 Days

Amount THREE HUNDRED SIXTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX #4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161600837⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOI	Claimant	Inv Amt	Disc Amt	Net Paid	Inv #\Comment	Adjuster\Office
		360 00	0 00	360 00		PSMOLKA
11 19 2019					IBRC Inc # CB21-0002993	LAS VEGAS

PAID
AUG 06 2022
BY: .....

Batch# 305655301

Check# 161600837

Check Amount $****360 00

Loc 150 RIVERSIDE CA

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78354

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000029 July 13, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUL 18 2022

IBR Case Number	CB22-0001034
Claim Number	
Assignment Date	06/02/2022
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	09/15/2021 - 09/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/19/2019
Application Received	05/06/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Management Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/17/2022. Response not yet received.
- Itemized invoice
    - 09/15/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/15/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/15/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 35350
Las Vegas, NV 89133

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN. DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161691577

Date: 01/03/2022

Batch#: 305123008

Amount

$****180.00

Void After 180 Days

Amount: ONE HUNDRED EIGHTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161691577⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	78354	CWATTS
11/19/2019			STRATACARE		145418 DS 09/15/21	LAS VEGAS
		180.00	90.00	90.00	77710	ACHAN
10/16/2019			STRATACARE		145430 DS 09/13/21	Concord

PAID
JAN 06 2022

BY: .....

RECEIVED
JAN 06 2022

BY: .....

Batch#: 305123008

Check# 161691577

Check Amount: $****180.00

Loc: 150-RIVERSIDE, CA-LYNEER

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 12/29/2021
Control Number: 145418
EOR Page 1 of 2
Rev/Aud: SS/AJ

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 78354 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 11/19/2019
Claims Received Date: 12/15/2021

Adjuster Name: Watts Chelsea

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name:
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161601815

Date. 08/08/2022

Batch#. 305723749

Amount: TWO HUNDRED SEVENTY AND 00 / 100*****

Amount

$****270.00

Void After 180 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX #4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161601815⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		270.00	0.00	270.00		PSMOLKA
11/19/2019					CB22-0001034 09-15-2021 - IBR overturn	LAS VEGAS

AUG 12 2022

BY: .....

PAID

AUG 16 2022

BY: .....

Batch#. 305723749

Check# 161601815

Check Amount: $**270.00**

Loc: 150 RIVERSIDE, CA

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80377

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000068 December 5, 2022

DEC 1 2 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002321
Claim Number	
Assignment Date	10/21/2022
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	11/18/2021 - 11/22/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 2
Date of Injury	09/10/2019
Application Received	09/21/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Management Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 2 submitted for dates of service 11/18/2021 – 11/22/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/05/2022. Response received 10/17/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoices
    - 11/18/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/22/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/18/2021 and 11/22/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/18/2021 and 11/22/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Service x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 2
Date of Service: 11/18/2021 – 11/22/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 35350
Las Vegas, NV 89133

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF "VOID" IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161697772

Date: 05/04/2022

Batch#: 305456905

Amount

$****90.00

Void After 180 Days

Amount: NINETY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161697772⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	80377 ✓	ACHAN
09/10/2019		STRATACARE			152992 DS 11/18/21	CONCORD

RECEIVED
MAY 09 2022
BY:

MAY 12 2022

Batch#: 305456905

Loc: WORKFORCE ENTERPRISES WFE INC - COMMERCE BRANCH

Check# 161697772

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 05/02/2022
Control Number: 152992
EOR Page 1 of 2
Rev/Aud: SS/MA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 80377 Geo Zip: 90240
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 09/10/2019
Claims Received Date: 04/18/2022

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/18/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: KANG, SUSANNAH
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161697915

Date: 05/06/2022

Batch#: 305464546

Amount

$****90.00

Void After 180 Days

Amount: NINETY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161697915⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	80377	ACHAN
09/10/2019			STRATACARE		152994 DS 11/22/21	CONCORD

MAY 12 2022

MAY 09 2022

BY: .....

Batch#: 305464546

Loc: WORKFORCE ENTERPRISES WFE INC - COMMERCE BRANCH

Check# 161697915

Check Amount: $**90.00**

Comp MC

EMPLOYER HR, LLC 2303

Process Date: 05/04/2022
Control Number: 152994

Rev/Aud: SS/MA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 80377 Geo Zip: 90240
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 09/10/2019
Claims Received Date: 04/18/2022

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BP/Red	PPO/Red	Other/Red	Allowance	Reasons
11/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: HASSANIN, MOHAMED
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161606745

Date: 12/21/2022

Batch#: 306136826

Amount: THREE HUNDRED SIXTY AND 00 / 100*****

Amount

$****360.00

Void After 90 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161606745⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	0.00	180.00	80377	ACHAN
09/10/2019					80377 5/24/22	CONCORD
		180.00	0.00	180.00	81570	TSOARES
03/10/2021					81570 DS 5/18/22	LAS VEGAS

PAID
DEC 30 2022
BY. .....

Batch#: 306136826

Check# 161606745

Check Amount: $****360.00

Loc: WORKFORCE ENTERPRISES WFE INC - COMMERCE BRANCH

MAXIMUS
Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81113

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000040 December 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 5 2022

IBR Case Number	CB22-0002301
Claim Number	
Assignment Date	10/19/2022
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	11/20/2021 - 11/20/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/12/2021
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Management Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/20/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/03/2022. Response received 10/11/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoice
    - 11/20/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/20/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is due **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/20/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 53550
Irvine, CA 92619

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY V[illegible] BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0161698036

Date: 05/10/2022

Batch#: 305473530

Amount: NINETY AND 00 / 100*****

Amount

$****90.00

Void After 180 Days

PAY TO THE ORDER OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161698036⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		180.00	90.00	90.00	81113	ACHAN
02/12/2021		STRATACARE		153306 DS 11/20/21		CONCORD

MAY 16 2022

BY: 81113

MAY 17 2022

BY: .....

Batch#: 305473530

Check# 161698036

Check Amount: $****90.00

Loc: 80-CARSON, CA-LYNEER

CompMC

EMPLOYER HR, LLC 2303

Process Date: 05/06/2022
Control Number: 153306

Rev/Aud: SS/HC

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 81113 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 02/12/2021
Claims Received Date: 04/20/2022

Adjuster Name: Chan Amy

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/20/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: FMR CARSON
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Employer Name: 80-CARSON, CA-LYNEER, Employer ID: AMW0300098003, Employer Address: 637 E. ALBERTONI ST. SUITE 101, CARSON, CA 90746

Payer Name: State National Insurance Company, Inc., Payer Address: Po Box 24622 Fort Worth, TX 76124, Payer ID Number: 751980552

Claimant Address: 141 E 120th St Apt 2 Los Angeles, CA 900612486, Claimant D.O.B.: 07/14/1976

Payment Information: Payment Status Code:

TIME LIMITS TO DISPUTE PAYMENT AMOUNT
REQUEST FOR SECOND REVIEW
After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

REQUEST FOR INDEPENDENT BILL REVIEW
After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual provider's agreement with the preferred provider organization.

PLEASE REMIT ALL REFUNDS AND/OR OVERPAYMENTS DIRECTLY TO THE INSURANCE CARRIER.

For questions regarding this analysis, you may respond in writing to CareSolutions Service Center, Attn: Provider Relations, PO Box 19600, Irvine, CA. 92623-9600. Please include 1) Reason for inquiry, 2) A copy of the bill and this analysis, and 3) Supporting documentation. Should you prefer, you may contact us at (833) 444-5112 or you may email any billing inquiries to WorkCompCallCenter@Conduent.com.

STRATACARE IS NEITHER THE EMPLOYER NOR THE INSURANCE CARRIER, NOR IS IT RESPONSIBLE FOR PAYMENT OF THE MEDICAL SERVICES CONTAINED IN THIS EXPLANATION OF BENEFITS.

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. **0161606485**

Date: 12/13/2022

Batch#: 306106245

Amount

$****270.00

Void After 90 Days

Amount: TWO HUNDRED SEVENTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX #4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0161606485⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		270.00	0.00	270.00		ACHAN
02/12/2021					Full & Finaly Pymt per IBR final determination CB22-0002301	CONCORD

PAID
DEC 21 2022

Batch#: 306106245

Check# 161606485

Check Amount: $**270.00**

Loc: 80-CARSON, CA-LYNEER

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81859

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000098 December 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 0 3 2023

IBR Case Number	CB22-0002587
Claim Number	
Assignment Date	11/15/2022
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	08/10/2021 - 12/06/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 14
Date of Injury	06/08/2021
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,260.00 in additional reimbursement for a total of $1,440.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,440.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Cannon Cochran Management Services
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 14 submitted for dates of service 08/10/2021 – 12/06/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/28/2022. Response received 11/11/2022. Claims Administrator provided copies of IBR documents.
- Itemized Invoices
    - 08/10/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 08/26/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/02/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/20/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 09/23/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 09/30/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 10/11/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/18/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/20/2021 Interpreting for initial chiro $180.00 (Billed at a minimum of 2 hours)
    - 10/25/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/08/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 11/15/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 11/30/2022 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 12/06/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,260.00 ($90.00 for each date of service 08/10/2021 – 12/06/2021). Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Service x 14 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 14.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 14
Date of Service: 08/10/2021 – 12/06/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/02/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 53550
Irvine, CA 92619

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE SECURITY VOID BACKGROUND PATTERN - DO NOT CASH IF VOID IS VISIBLE.

CCMSI OBO NIXER COMP, INC
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0176005350

Date: 06/06/2022

Batch#: 305545643

Amount: ONE THOUSAND TWO HUNDRED SIXTY AND 00 / 100*****

Amount

$****1,260.00

Void After 180 Days

PAY TO THE ORDER OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0176005350⑈ ⑆071000039⑆ 866662264 2⑈

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
		2,520.00	1,260.00	1,260.00	81859	RDEARMORE
06/08/2021		STRATACARE			67222 DS 08/10/21~12/06/21	CONCORD

RECEIVED
JUN 10 2022
PY. 81859

PAID
JUN 13 2022
PY. .....

Batch#: 305545643
Check# 176005350

Check Amount: $****1,260.00

Loc: OSI STAFFING, INC.

Comp MC

NIXER COMP, INC. 7710

Process Date: 05/27/2022
Control Number: 67222
EOR Page 1 of 2
Rev/Aud: SS/AV

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 230833
Provider Ref: 81859 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/08/2021
Claims Received Date: 05/19/2022

Adjuster Name: Dearmore Ruthann

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/10/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/26/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/02/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/20/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/23/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/30/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/11/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/18/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/20/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/25/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/08/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/15/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/30/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
12/06/21	11	T1013		SIGN LANGUAGE/	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**2,520.00**	**1,260.00**	**0.00**	**0.00**	**1,260.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**1,260.00**	

Rendering Provider Name:
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE FACE OF THIS CHECK CONTAINS A MICROPRINT BORDER AND A BLUE-GREEN TO GOLD BACKGROUND. AN ERROR IS NOT CASH IF VOID IS VISIBLE

CCMSI OBO NIXER COMP, INC
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

2-3/710 IL

Check No. 0176009189

Date: 01/13/2023

Batch#: 306207061

Amount

$****1,440.00

Void After 90 Days

Amount: ONE THOUSAND FOUR HUNDRED FORTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Rodney J. Golden

⑈0176009189⑈ ⑆071000039⑆ 866662264 2⑈

M

Claim#\DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #\Comment	Adjuster\Office
21G71J932819	Ayala, Roger	1,440.00	0.00	1,440.00	AYALA , ROGER	RDEARMORE
06/08/2021					DS 08.10.21-12.06.21	CONCORD

61809

PAID
JAN 23 2023
BY: .....

Batch#: 306207061

Check# 176009189

Check Amount: $**1,440.00**

Loc: OSI STAFFING, INC

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77612

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000023 January 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 3 1 2022

IBR Case Number	CB21-0002686
Claim Number	
Assignment Date	12/02/2021
Claims Administrator	CompWest
Date(s) of service	04/15/2021 - 04/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/28/2019
Application Received	10/29/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 04/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/16/2021. Response received 12/01/2021. Claims Administrator provided copies of IBR documents, no position statement found.
- Itemized Invoices
    - 04/15/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 04/15/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 04/15/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 06/17/2021
CHECK NUMBER : 101982955

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	04/15/2021	04/15/2021	5022-5713736		$90.00
				TOTAL	$90.00

77612 —

PAID
JUN 30 2021

BY: .....

Questions may be directed to us at : 888-266-7937
Check Number : 101982955

CompWest

CompWest - California 5022

Process Date: 06/16/2021
Control Number: 5713736
EOR Page 1 of 2
Rev/Aud: AA/KN

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 77612 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/28/2019
Claims Received Date: 06/07/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name:
Rendering Provider NPI:
INV# 77612

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

m

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 02/10/2022
CHECK NUMBER : 102283808

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME CLAIM NO.	FROM DATE COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	04/15/2021	04/15/2021	5022-9054331		$90.00
				TOTAL	$90.00

PAID
FEB 21 2022
BY: .....

Questions may be directed to us at : 888-266-7937
Check Number : 102283808

CompWest

CompWest - California 5022

RE-EVALUATION
Process Date: 02/09/2022
Re-Evaluation Control Number: 9054331
Original Control Number: 5713736

Rev/Aud: JW/KN

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 77612 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/28/2019
Claims Received Date: 01/31/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/15/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G5,4535
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				0.00	-90.00	0.00	0.00	90.00	
		TOTAL RECOMMENDED ALLOWANCE:								90.00	

Rendering Provider Name:
Rendering Provider NPI:

DWC CODE DESCRIPTION

G5 -THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.

CARRIER EXPLANATION REASON CODE

4535 -ADDITIONAL ALLOWANCE IS RECOMMENDED PER FINAL RULING FROM IBR.

Thank you, Provider Relations

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77612

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000031 July 7, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUL 12 2022

IBR Case Number	CB22-0000975
Claim Number	
Assignment Date	05/27/2022
Claims Administrator	CompWest Insurance
Date(s) of service	09/08/2021 - 09/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	08/28/2019
Application Received	04/29/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 09/08/2021 – 09/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/11/2022. Response not yet received.
- Itemized invoices
    - 09/08/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 09/15/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 09/08/2021 and 09/15/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 09/08/2021 and 09/15/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is due. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 09/08/2021 – 09/15/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102219940

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 12/16/2021

Pay This Amount

Pay the Sum of *One hundred eighty and 00/100 Dollars*

$180.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102219940⑈ ⑆044115443⑆ 268937353⑈

AF Group | PO Box 40790 Lansing, MI 48901-7990 AFGroupInsurance.com

CHECK DATE : 12/16/2021
CHECK NUMBER : 102219940

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

	EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
		09/09/2021	09/09/2021	5022-5787063		$90.00
77612		09/08/2021	09/08/2021	5022-5786313		$90.00
					TOTAL	$180.00

PAID
JAN 04 2022
BY .....

Questions may be directed to us at : 866-206-5851
Check Number : 102219940

CompWest

Part of the AF Group

CompWest - California 5022

Process Date: 12/15/2021
Control Number: 5786313

Rev/Aud: AA/KN

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 77612 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/28/2019
Claims Received Date: 12/08/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	5422,5423, 601,G1
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: DR COOK FMR
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.



AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102229669

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 12/27/2021

Pay This Amount

Pay the Sum of *Five hundred forty and 00/100 Dollars*

$540.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102229669⑈ ⑆044115443⑆ 268937353⑈

AF Group | PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 12/27/2021
CHECK NUMBER : 102229669

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

77612

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	01/25/2019	11/09/2020	5022-5789369		$450.00
	09/15/2021	09/15/2021	5022-5789664		$90.00
				TOTAL	$540.00

PAID
JAN 05 2022
BY: .....

REC'D
JAN 05 2022
BY: .....

Questions may be directed to us at : 866-206-5851
Check Number : 102229669

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79376

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000070 May 11, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0000480
Claim Number	
Assignment Date	04/07/2022
Claims Administrator	CompWest Insurance
Date(s) of service	08/10/2021 - 08/10/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	03/20/2020
Application Received	03/04/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 08/10/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/22/2022. Response not yet received.
- Itemized Invoices
    - 08/10/2021 Interpreting initial acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/10/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 08/10/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
P.O. Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Security features included. Details on back.

AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102166208

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 11/03/2021

Pay This Amount

Pay the Sum of *One hundred ninety and 00/100 Dollars*

$190.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102166208⑈ ⑆044115443⑆ 268937353⑈

AF Group

PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 11/03/2021
CHECK NUMBER : 102166208

PAID
NOV 09 2021
BY

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	07/07/2017	06/26/2018		Full & Final	$100.00
79376	08/10/2021	08/10/2021	5022-5766591		$90.00
				TOTAL	$190.00

Questions may be directed to us at : 866-206-5851
Check Number : 102166208

CompWest

CompWest - California 5022

Process Date: 11/02/2021
Control Number: 5766591

Rev/Aud: AA/CS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 79376 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 03/20/2020
Claims Received Date: 10/25/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/10/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
				TOTALS:		180.00	90.00	0.00	0.00	90.00	
				TOTAL RECOMMENDED ALLOWANCE:						90.00	

Rendering Provider Name: GOFNUNG CHIRO
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.



MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79392

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001349
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	CompWest Insurance
Date(s) of service	10/08/2021 - 10/08/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/07/2020
Application Received	06/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/08/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response received 07/15/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoice
    - 10/08/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/08/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/08/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Security features included. Details on back.

AF Group PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102287325

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 02/14/2022

Pay This Amount

Pay the Sum of *One thousand eight hundred and 00/100 Dollars*

****$1,800.00****

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102287325⑈ ⑆044115443⑆ 268937353⑈

AF Group

PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 02/14/2022
CHECK NUMBER : 102287325

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME ~~CLAIM NO.~~	FROM DATE COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
79392	10/08/2021	10/08/2021	5022-5808255		$90.00
	04/08/2021	09/03/2021			$1,710.00
				TOTAL	$1,800.00

PAID
FEB 2[illegible] 2022
BY: .....

Questions may be directed to us at : 866-206-5851
Check Number : 102287325

Security features included Details on back

AF Group

VOID AFTER 180 DAYS

Check Number 102527648

JPMorgan Chase Bank, N A
Columbus, OH
56-1544/441

Check Date 09/08/2022 **Pay This Amount**

Pay the Sum of *Ninety and 00/100 Dollars*

$90 00

Pay To The Order Of

Joyce Altman Interpreters, Inc
P O Box 4165
Tustin, CA 92781-4165

⑈102527648⑈ ⑆044115443⑆ 268937353⑈

CompWest

PO Box 10790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 09/08/2022
CHECK NUMBER : 102527648

PAID
SEP 20 2022
BY

Payable To **Joyce Altman Interpreters, Inc**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO	FROM DATE / COMMENT	THRU DATE	M8R NUMBER	INVOICE NUMBER	AMOUNT
	10/08/2021	10/08/2021	5022-202209070268300		$90 00
				TOTAL	$90 00

RECEIVED SEP 16 2022

Questions may be directed to us at 888-266-7937
Check Number 102527648

AF Group

CHECK DATE : 09/06/2022
CHECK NUMBER 102524639

RECEIVED
SEP 14 2022
BY:

Payable To **Joyce Altman Interpreters, Inc**
P O Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME ~~CLAIM NO.~~	FROM DATE COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	10/08/2021	10/08/2021		IBR - Case# CB22-0001349	$180 00
	03/15/2022	03/15/2022	5022-202209050194800		$90 00
				TOTAL	$270 00

RECEIVED
SEP 12 2022
BY:

Questions may be directed to us at 866-206-5851
Check Number 102524639

JUN 2 1 2022

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79855

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000067 June 17, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0000835
Claim Number	
Assignment Date	05/05/2022
Claims Administrator	CompWest Insurance
Date(s) of service	08/30/2021 - 08/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	06/14/2019
Application Received	04/08/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 08/30/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/19/2022. Response not yet received.
- Itemized invoice
    - 08/30/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/30/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 08/30/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
P.O. Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 12/03/2021
CHECK NUMBER : 102203689

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	08/30/2021	08/30/2021	5022-5780042		$90.00
				TOTAL	$90.00

PAID
DEC 13 2021
BY: .....

DEC 13 2021
BY: 79855

Questions may be directed to us at : 888-266-7937
Check Number : 102203689

CompWest

Process Date: 12/02/2021
Control Number: 5780042

Rev/Aud: AA/KA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 79855 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/14/2019
Claims Received Date: 11/19/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/30/21	11	T1013		SIGN LANGUAGE/(	2.000	180.00	90.00	0.00	0.00	90.00	5422,5423, 601,G1
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name:
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND.

Security features included
Details on back

AF Group

PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102466118

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 07/15/2022

Pay This Amount

Pay the Sum of *Ninety and 00/100 Dollars*

$90.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102466118⑈ ⑆044115443⑆ 268937353⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80663

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000037 June 6, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUN 0 9 2022

IBR Case Number	CB22-0000764
Claim Number	
Assignment Date	04/28/2022
Claims Administrator	Compwest Insurance
Date(s) of service	08/19/2021 - 09/07/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	02/11/2021
Application Received	04/01/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Compwest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 08/19/2021 – 09/07/201.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/12/2022. Response not yet received.
- Itemized Invoices
    - 08/19/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/23/2021 Interpreting for PR2/ReEval $180.00 (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 08/19/2021 – 09/07/201 with the rationale: charges exceed maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 08/19/2021 – 09/07/201 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 08/19/2021 – 09/07/201
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/201** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestinsurance.com

CHECK DATE : 11/21/2021
CHECK NUMBER : 102187722

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME CLAIM NO.	FROM DATE COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	08/19/2021	08/19/2021	5022-5775206		$90.00
				TOTAL	$90.00

RECEIVED
DEC 07 2021
BY: .....

PAID
DEC 09 2021
BY: .....

Questions may be directed to us at : 888-266-7937
Check Number : 102187722

CompWest

CompWest - California 5022

Process Date: 11/18/2021
Control Number: 5775206
EOR Page 1 of 2
Rev/Aud: AA/CS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 80663 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 02/11/2021
Claims Received Date: 11/08/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/19/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	5422,5423, 601,G1
				TOTALS:		180.00	90.00	0.00	0.00	90.00	
				TOTAL RECOMMENDED ALLOWANCE:						90.00	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 11/29/2021
CHECK NUMBER : 102195805

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

PAID
DEC 09 2021

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	08/23/2021	08/23/2021	5022-5776598		$90.00
				TOTAL	$90.00

80463
DEC 07 2021
BY:

Questions may be directed to us at : 888-266-7937
Check Number : 102195805

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 80663 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 02/11/2021
Claims Received Date: 11/11/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/23/21	11	T1013		SIGN LANGUAGE/(	2.000	180.00	90.00	0.00	0.00	90.00	5422,5423, 601,G1
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: FMR
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

AF Group

PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 12/14/2021
CHECK NUMBER : 102216368

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
906663	09/07/2021	09/07/2021	5022-5785306		$90.00
	08/21/2019	12/14/2020			$9,500.00
	02/16/2021	02/16/2021	5022-9051864		$90.00
	09/07/2021	09/07/2021	5022-5785735		$90.00
	09/03/2021	09/03/2021	5022-5785492		$90.00
				TOTAL	$9,860.00

PAID
DEC 22 2021

Questions may be directed to us at : 866-206-5851
Check Number : 102216368

CompWest
Part of the AF Group

CompWest - California 5022

Process Date: 12/13/2021
Control Number: 5785306

Rev/Aud: AA/CS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 80663 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 02/11/2021
Claims Received Date: 12/06/2021

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

RECEIVED
DEC 21 2021
BY:

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	5422,5423, 601,G1
				TOTALS:		180.00	90.00	0.00	0.00	90.00	
				TOTAL RECOMMENDED ALLOWANCE:						90.00	

Rendering Provider Name: FMR
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 9, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001230
Claim Number	CWC230389478
Assignment Date	06/27/2022
Claims Administrator	CompWest Insurance
Date(s) of service	09/24/2021 - 09/24/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	Landeros, Julio
Disputed Codes	Interpreter Service
Date of Injury	02/11/2021
Application Received	05/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/24/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/09/2022. Response received 06/21/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoice
    - 09/24/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/24/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/24/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 01/21/2022
CHECK NUMBER : 102259599

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	09/24/2021	09/24/2021			$90.00
				TOTAL	$90.00

PAID
JAN 3 1 2022
BY: .....

RECEIVED
JAN 3 1 2022
BY: 80663

Questions may be directed to us at : 888-266-7937
Check Number : 102259599

M

CompWest

CHECK DATE 08/24/2022
CHECK NUMBER : 102511051

Payable To **Joyce Altman Interpreters, Inc.**
P.O Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	09/24/2021	09/24/2021	5022-202208240151600		$90 00
				TOTAL	$90 00

PAID
AUG 3 1 2022

AUG 3 0 2022

BY: 80663

Questions may be directed to us at 888-266-7937
Check Number 102511051

AF Group

VOID AFTER 180 DAYS

Check Number 102508151

JPMorgan Chase Bank, N A
Columbus, OH
56-1544/441

Check Date 08/22/2022

Pay This Amount

Pay the Sum of *Four thousand three hundred sixty and 00/100 Dollars*

$4,360 00

Pay To The Order Of

Joyce Altman Interpreters, Inc
P O Box 4165
Tustin, CA 92781-4165

⑈102508151⑈ ⑆044115443⑆ 268937353⑈

AF Group

CHECK DATE 08/22/2022
CHECK NUMBER : 102508151

RECEIVED
AUG 30 2022

Payable To **Joyce Altman Interpreters, Inc.**
P O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	08/17/2020 full and final settlement of lien	05/26/2021			$4,000 00
	03/08/2022	03/08/2022	5022-202208220145300		$90 00
	03/10/2022	03/10/2022	5022-202208220154000		$90 00
	09/24/2021	09/24/2021		CBCC-0001230	$180 00
				TOTAL	$4,360 00

Questions may be directed to us at 866-206-5851
Check Number 102508151

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80663

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001352
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	CompWest Insurance
Date(s) of service	10/01/2021 - 10/01/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/11/2021
Application Received	06/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

AF LANSING 09292022

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

AF LANSING 08292022

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

AF LANSING 08292022

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/01/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response not yet received.
- Itemized invoice
    - 10/01/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/01/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

AF LANSING 08292022

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/01/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

AF LANSING 08292022

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 01/31/2022
CHECK NUMBER : 102269887

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	10/01/2021	10/01/2021	5022-5801415		$90.00
				TOTAL	$90.00

FEB 08 2022
BY:

RECEIVED
BY: 80663

Questions may be directed to us at : 888-266-7937
Check Number : 102269887

CompWest

CompWest - California 5022

Process Date: 01/28/2022
Control Number: 5801415

Rev/Aud: AA/CS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 80663 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 02/11/2021
Claims Received Date: 01/24/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/01/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: FMR INTERVENTIONAL QMP
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

CompWest

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 09/20/2022
CHECK NUMBER : 102539480

Payable To **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	10/01/2021	10/01/2021		CBCC-0001352	$180 00
				TOTAL	$180 00

PAID
SEP 2 9 2022

Questions may be directed to us at 888-266-7937
Check Number 102539480

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81219

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000081 December 9, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 12 2022

IBR Case Number	CB22-0002405
Claim Number	
Assignment Date	10/28/2022
Claims Administrator	CompWest Insurance Company
Date(s) of service	12/13/2021 - 12/20/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	05/13/2021
Application Received	09/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 12/13/2021 – 12/20/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/12/2022. Response received 11/03/2022. Claims Administrator provided copies of IBR documents.
- Itemized invoices
    - 12/13/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 12/17/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 12/20/2021 Interpreting for physiotherapy (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 12/13/2021 – 12/20/2021. Charge exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 12/13/2021 – 12/20/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 12/13/2021 – 12/20/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 05/16/2022
CHECK NUMBER : 102405236

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME ~~CLAIM NO.~~	FROM DATE COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	12/20/2021	12/20/2021	5022-5841335		$90.00
	12/13/2021	12/13/2021	5022-5839794		$90.00
	12/17/2021	12/17/2021	5022-5840228		$90.00
	12/14/2021	12/14/2021	5022-5840271		$90.00
	08/12/2021	11/16/2021	5022-5835899		$1,530.00
				TOTAL	$1,890.00

PAID
MAY 24 2022
BY: .....

RECEIVED
MAY 23 2022
BY: .....

Questions may be directed to us at : 866-206-5851
Check Number : 102405236

CompWest

CompWest - California 5022

Process Date: 05/13/2022
Control Number: 5839794
EOR Page 1 of 2
Rev/Aud: AA/KY

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 81219 -93165 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 05/13/2021
Claims Received Date: 05/02/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/13/21	11	T1013		SIGN LANGUAGE/(	2.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
				TOTALS:		180.00	90.00	0.00	0.00	90.00	
				TOTAL RECOMMENDED ALLOWANCE:						90.00	

Rendering Provider Name: FMR
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

CompWest

CompWest - California 5022

Process Date: 05/13/2022
Control Number: 5840228

Rev/Aud: AA/KY

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 81219 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 05/13/2021
Claims Received Date: 05/02/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/17/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
				TOTALS:		180.00	90.00	0.00	0.00	90.00	
				TOTAL RECOMMENDED ALLOWANCE:						90.00	

Rendering Provider Name: FMR
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

CompWest

CompWest - California 5022

Process Date: 05/13/2022
Control Number: 5841335

Rev/Aud: AA/KY

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 81219 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/13/2021
Claims Received Date: 05/05/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/20/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: PEZESHKIAN
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

$2004

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000108 December 13, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 16 2022

IBR Case Number	CB22-0002477
Claim Number	CWC230301446
Assignment Date	10/31/2022
Claims Administrator	CompWest Insurance
Date(s) of service	08/12/2021 - 11/16/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	Cisneros, Maria
Disputed Codes	Interpreter Service x 17
Date of Injury	04/01/2020
Application Received	09/30/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,530.00 in additional reimbursement for a total of $1,710.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,710.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 17 submitted for dates of service 08/12/2021 – 11/16/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/13/2022. Response not yet received.
- Itemized invoices
    - 08/12/2021 Interpreting for initial exam (Billed at a minimum of 2 hours)
    - 08/17/2021 Interpreting for initial acupuncture (Billed at a minimum of 2 hours)
    - 08/19/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 08/24/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 08/26/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 08/31/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 09/02/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 10/12/2021 Interpreting for FCE Test (Billed at a minimum of 2 hours)
    - 10/20/2021 Interpreting for PR2/Reeval (Billed at a minimum of 2 hours)
    - 10/26/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 10/27/2021 Interpreting for initial exam (Billed at a minimum of 2 hours)
    - 11/02/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 11/04/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 11/09/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 11/11/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
    - 11/16/2021 Interpreting for acupuncture (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,530.00 ($90.00 for each date of service 08/12/2021 – 11/16/2021). Charge exceeds maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.

- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Service x 17 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 17.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 17
Date of Service: 08/12/2021 – 11/16/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/31/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/02/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/02/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/04/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Security features included. Details on back.

AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102405236

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 05/16/2022

Pay This Amount

Pay the Sum of *One thousand eight hundred ninety and 00/100 Dollars*

****$1,890.00****

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102405236⑈ ⑆044115443⑆ 268937353⑈

AF Group | PO Box 40790 Lansing, MI 48901-7990 AFGroupInsurance.com

CHECK DATE : 05/16/2022
CHECK NUMBER : 102405236

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
Edi Osoy CWC230426271	12/20/2021	12/20/2021	5022-5841335		$90.00
Edi Osoy CWC230426271	12/13/2021	12/13/2021	5022-5839794		$90.00
Edi Osoy CWC230426271	12/17/2021	12/17/2021	5022-5840228		$90.00
Jose Castro CWC230373869	12/14/2021	12/14/2021	5022-5840271		$90.00
Maria Cisneros CWC230301446	08/12/2021	11/16/2021	5022-5835899		$1,530.00
				TOTAL	$1,890.00

PAID
MAY 24 2022
BY: .....

RECEIVED
MAY 23 2022
BY: .....

Questions may be directed to us at : 866-206-5851
Check Number : 102405236

CompWest

CompWest - California 5022

Process Date: 05/13/2022
Control Number: 5835899
EOR Page 1 of 2
Rev/Aud: AA/JL

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 82004 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 04/01/2020
Claims Received Date: 04/25/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MAY 23 2022

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/12/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
08/17/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
08/19/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
08/24/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
08/26/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
08/31/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
09/02/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
09/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
10/12/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
10/20/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
10/26/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
10/27/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
11/02/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
11/04/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
11/09/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
11/11/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
11/16/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
				TOTALS:		3,060.00	1,530.00	0.00	0.00	1,530.00	
				TOTAL RECOMMENDED ALLOWANCE:						1,530.00	

Rendering Provider Name: MOGHARABI, FARDAD
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND

CompWest
Part of the AF Group

PO Box 40790
Lansing, MI 48901-7990
CompWestInsurance.com

CHECK DATE : 01/20/2023
CHECK NUMBER : 102676466

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	08/12/2021	11/16/2021		Per IMR Determination dated 12/13/2022 for DOS 08/12/2021 - 11/16/2021	$1,710.00
				TOTAL	$1,710.00

PAID
JAN 30 2023
BY: .....

Questions may be directed to us at : 888-266-7937
Check Number : 102676466

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82188

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000069 December 16, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 20 2022

IBR Case Number	CB22-0002472
Claim Number	
Assignment Date	11/04/2022
Claims Administrator	CompWest Insurance
Date(s) of service	12/14/2021 - 12/14/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	09/27/2017
Application Received	09/30/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: CompWest Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/14/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/19/2022. Response received 11/04/2022. Claims Administrator provided copies of the IBR documents.
- Itemized invoice
    - 12/14/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/14/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/14/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

CompWest Insurance
PO Box 40790
Lansing, MI 48901

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Security features included. Details on back.

AF Group | PO Box 40790 Lansing, MI 48901-7990

on behalf of
Accident Fund Insurance Company of America

VOID AFTER 180 DAYS

Check Number 102405236

JPMorgan Chase Bank, N.A.
Columbus, OH
56-1544/441

Check Date 05/16/2022 **Pay This Amount**

Pay the Sum of *One thousand eight hundred ninety and 00/100 Dollars*

$1,890.00

Pay To The Order Of:

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

⑈102405236⑈ ⑆044115443⑆ 268937353⑈

AF Group | PO Box 40790 Lansing, MI 48901-7990 AFGroupInsurance.com

CHECK DATE : 05/16/2022
CHECK NUMBER : 102405236

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	12/20/2021	12/20/2021	5022-5841335		$90.00
	12/13/2021	12/13/2021	5022-5839794		$90.00
	12/17/2021	12/17/2021	5022-5840228		$90.00
	12/14/2021	12/14/2021	5022-5840271		$90.00
	08/12/2021	11/16/2021	5022-5835899		$1,530.00
				TOTAL	$1,890.00

PAID
MAY 24 2022
BY:

RECEIVED
MAY 23 2022
BY:

Questions may be directed to us at : 866-206-5851
Check Number : 102405236

CompWest

CompWest - California 5022

Process Date: 05/13/2022
Control Number: 5840271
EOR Page 1 of 2
Rev/Aud: AA/JL

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 1313
Provider Ref: 82188 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number: 9999999999
Claimant SSN:
Date Of Injury: 09/27/2017
Claims Received Date: 05/02/2022

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/14/21	11	T1013		SIGN LANGUAGE/(	2.000	180.00	90.00	0.00	0.00	90.00	G1,601,5422, 5423
			TOTALS:			180.00	90.00	0.00	0.00	90.00	
			TOTAL RECOMMENDED ALLOWANCE:							90.00	

Rendering Provider Name: FMR INTERVENTIONAL QPM CARSON
Rendering Provider NPI: 9999999999

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

5422 -THE INTERPRETERS BILL IS, PURSUANT TO ADMINISTRATIVE DIRECTORS RULES 9795.3, EXCESSIVE AND UNREASONABLE. WE HAVE PAID WHAT WE DETERMINED AS REASONABLE AND ARE OBJECTING TO THE REMAINING BALANCE.

5423 -ACCORDING TO THE ADMINISTRATIVE DIRECTORS RULES SECTION 9795.3, INTERPRETER FEES SHALL BE BILLED AND PAID AT THE RATE OF $11.25 PER QUARTER HOUR OR PORTION THEREOF, WITH A MINIMUM PAYMENT OF TWO HOURS, OR THE MARKET RATE, WHICHEVER IS GREATER. THE INTERPRETER SHALL ESTABLISH THE MARKET RATE FOR THE INTERPRETERS SERVICES BY SUBMITTING DOCUMENTATION TO THE CLAIMS ADMINISTRATOR, INCLUDING A LIST OF RECENT SIMILAR SERVICES PERFORMED AND THE AMOUNTS PAID FOR THOSE SERVICES.

MAY 23 2022

BY:

M

AF Group

PO Box 40790
Lansing, MI 48901-7990
AFGroupInsurance.com

CHECK DATE : 01/03/2023
CHECK NUMBER : 102654885

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	12/14/2021	12/14/2021	5022-202209080036302		$90.00
	05/26/2022	05/26/2022	5022-202301010290700		$90.00
				TOTAL	$180.00

JAN 1 1 2023
BY.

PAID
JAN 1 2 2023
BY.

Questions may be directed to us at : 866-206-5851
Check Number : 102654885

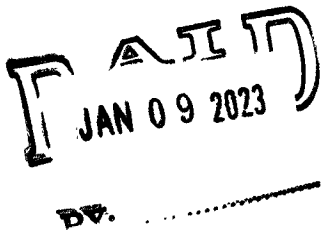
CompWest

PO Box 40790
Lansing, MI 48901-7990
CompWest Insurance.com

CHECK DATE : 12/28/2022
CHECK NUMBER : 102651004

Payable To: **Joyce Altman Interpreters, Inc.**
P.O. Box 4165
Tustin, CA 92781-4165

EMPLOYEE NAME / CLAIM NO.	FROM DATE / COMMENT	THRU DATE	MBR NUMBER	INVOICE NUMBER	AMOUNT
	12/16/2022	12/16/2022		IBR CB22-0002472	$180.00
				TOTAL	$180.00



Questions may be directed to us at : 888-266-7937
Check Number : 102651004

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81558

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002583
Claim Number	
Assignment Date	11/15/2022
Claims Administrator	Crum and Forster
Date(s) of service	06/28/2021 - 09/16/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 18
Date of Injury	05/21/2021
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,620.00 in additional reimbursement for a total of $1,800.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,800.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Crum and Forster
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 18 submitted for dates of service 06/28/2021 – 09/16/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/27/2022. Response not yet received.
- Itemized Invoices
    - 06/28/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 07/07/2021 Interpreting for initial acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/08/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 07/14/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/14/2021 Interpreting for EMG testing $180.00 (Billed at a minimum of 2 hours)
    - 07/15/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 07/19/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/22/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 07/28/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/29/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 08/04/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/05/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 08/11/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 08/12/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 08/30/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 09/08/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/15/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/16/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,620.00 ($90.00 for each date of service 06/28/2021 – 09/16/2021). Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Services x 18 Overturned.**

- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 18.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 18
Date of Service: 06/28/2021 – 09/16/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/04/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/05/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Crum and Forster
PO Box 14139
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

zelis payments

PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

RECEIVED
JUN 07 2022
BY: 81558

Forwarding Service Requested

**********MIXED AADC 926
PB-STL_UNSORTED-MACH-ENV 7620 18
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN CA 92781-4165

PAID
JUN 03 2022

[-CC]

Customer Service:	
Check #:	15000776
Check Date:	05/24/22
Check Amount:	$1,620.00
Payment ID:	244868191
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

Did you know there is an estimated $760 billion in healthcare waste each year?

Go green and minimize your impact on the environment today with our paperless options!

With Zelis Payments providers can:

ACCELERATE ACCESS TO CASH AND CLAIMS

Providers choose the payment option that works best for their organization

Zelis ACH
With paperless payments, access your funds without unnecessary printing and mailing.

Zelis Virtual Card
Simply enter the card number into your terminal to receive payments. Access all card numbers on the portal instantly.

OPTIMIZE PRODUCTIVITY

Add enhanced visibility into your payments and claims information all in one location

Zelis Payments Portal
Remotely access payments and claims data from one easy-to-use, secure platform at any time.

Ready to go paperless? Call 855.496.1571 and mention code PL260 to save time, money, and paper.

zelis payments

PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB Financial Corporation
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER
15000776
36-1901/10

ISSUE DATE
Date 05/24/2022

AMOUNT
****$1,620.00

Void if presented after 180 days.

One Thousand Six Hundred Twenty Dollars and No Cents

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781

Authorized Signature

⑈15000776⑈ ⑆101219017⑆ 500823204⑈

CRUM & FORSTER
A FAIRFAX COMPANY

Crum & Forster PZC 53004

[-CC]

Process Date: 05/20/2022
Control Number: 40060843
EOR Page 1 of 2
Rev/Aud: SS/KR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 330956713-0005
Provider Ref: 81558 Geo Zip: 92781
Provider License: 999999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/21/2021
Claims Received Date: 05/11/2022
Payment Code : TRANS - Translation
Insurere Number:
Adjuster Name : Kimberlee Rucker

JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781-4165

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
06/28/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/14/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,863
07/14/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,863
07/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/19/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/28/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/29/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/04/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/05/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/11/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/12/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/16/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
09/23/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
09/29/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
09/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/06/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/11/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/13/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/14/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/21/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
10/25/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
11/03/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
11/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
11/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
11/29/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
12/01/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
12/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G1,863,5586
		TOTALS:				**6,300.00**	**4,680.00**	**0.00**	**0.00**	**1,620.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**1,620.00**	

Rendering Provider Name: JOYCE ALTMAN INTERPRETERS INC
Rendering Provider NPI:

000 0000155 00000000 001 001 00155 INS: 0 0

United States Fire Insurance Company
Attn: Claims Payables
P.O. Box 1973
Morristown, NJ 07962

Mail To:
Joyce Altman Interpreters, Inc
PO Box 4165
Tustin, CA 92781-4165

Payee: IRS: 0330956713
Joyce Altman Interpreters, Inc
PO Box 4165
Tustin CA 92781-4165

Insured: Islands Restaurants, Lp Cfbc, Llc
Policy No: 406733479

Check Number: 0003909108
Check Date: 02/01/2023

Claimant	Claim #	Feature #	Invoice#	Date of Loss	Amount
		EXP-Payment Dates From 12/28/2022 To 12/28/2022		05/21/2021	$180.00

FEB 07 2023

TOTAL:	$180.00

WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty may be jail or prison, a fine, and loss of benefits.

ADVERTENCIA: Es necesario que usted le avise a su patron o a su compania de seguro todo dinero que usted ha ganado por trabajar, durante el tiempo cubierto por este cheque, y antes de cambiar este cheque. Si usted no sigue estos reglamentos, Usted puede estar en violacion de la ley y el castigo podria ser carcel o prision, una multa, y perdida de beneficios.

NOTICE

Making a false or fraudulent workers' compensation claim is a felony subject to up to 5 years in prison or a fine of up to $50,000 or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

Send Inquiries To:
By Phone: **(800) 690-5520**
By Email: **Claims.Payables@cfins.com**
By Mail: **United States Fire Insurance Company**
Attn: Claims Payables
P.O. Box 1973
Morristown, NJ 07962

WARNING: THIS DOCUMENT CONTAINS SEVERAL DOCUMENT SECURITY FEATURES - DO NOT CASH IF THE WORD VOID IS VISIBLE - SEE REVERSE SIDE FOR LIST OF SECURITY FEATURES

Please Detach Before Depositing

CRUM&FORSTER

THE NORTH RIVER INSURANCE COMPANY

50-937/213

Check Number: 0003909108
Claim Number
Date of Loss: 05/21/2021

NOT VALID SIX MONTHS AFTER ISSUE

DATE	AMOUNT
02/01/2023	$ 180.00

VOID VOID

One Hundred Eighty And 0/100 Dollars

PAY TO THE ORDER OF
Joyce Altman Interpreters, Inc

Payment Explanation:
CB22-0002583

JPMorgan Chase Bank, N.A.
Syracuse, NY

AUTHORIZED SIGNATURE
SIGNATURE HAS A BLUE-GREEN BACKGROUND - BORDER CONTAINS MICROPRINTING

⑈0003909108⑈ ⑆021309379⑆ 8871301697⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78358

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000025 March 8, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAR 14 2022

IBR Case Number	CB21-0002317
Claim Number	
Assignment Date	01/20/2022
Claims Administrator	Farmers Insurance
Date(s) of service	02/15/2021 - 02/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	04/13/2020
Application Received	09/24/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Farmers Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 02/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/04/2022. Response not yet received.
- Itemized invoice
    - 02/15/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the OMFS allowance, charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 02/15/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 02/15/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Farmers Insurance
PO Box 108843
Oklahoma City, OK 73101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Farmers Workers' Compensation Claims

Check Number: 8817645434
Date: 04/12/2021

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE $90.00*******

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:	
Insured:	Truck Depot (dba) Truck Depot, Inc
Date of Loss:	04/13/2020
Claim Number:	
Invoice Number:	FRM-FWCA-197301
Check Number:	8817645434
Payment Under Insured's:	N/A
Correspondence Reference:	P1JFHD34W
Print Date	04/12/2021 08:42 AM
Requested By	Abigail L Echanique

78358
RECEIVED
APR 19 2021
BY:.....

APR 19 2021

PLEASE FOLD AND DETACH CHECK ON RED LINE BELOW

01 01 000558 P1JFHD34W1 CE0413P1 04 [ ] 000857

FARMERS INSURANCE

Explanation of Review

03 02 000857 P1JFHD34W1 CE0413P1 04 [ ] 000857

Carrier

FARMERS
Carrier No:
Carrier: Mid-Century Insurance Company
PO Box 108843
Oklahoma City, OK 73101

Bill: FRM-FWCA-197301

Provider

JOYCE ALTMAN INTERPRETERS,INC
JOYCE ALTMAN INTERPRETERS,INC
PO BOX # 4165
TUSTIN, CA 92781-4165

Claimant

NPI:
Rendering NPI: 1477186625
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 99999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.

Invoice No: 78358
Invoice Date: 03-30-2021
Patient Account: 78358

Region: 26 **Payment Status Code:** 1

Claim Number:
DOI/DOL: 04-13-2020
CR Date / BR Date: 04-05-2021 / 04-06-2021
External Claim Number: 7001337355-1
Social Security Number:
Policy Number: A0949682000
Employer/Insured: (DBA) TRUCK DEPOT, INC, TRUCK DEPOT

Policy Admin Information: A0949682000

Bill Details

Dates of Service: 02-15-2021
Post Date: 04-12-2021

Reviewer: MT/b©
Pay Auth: 1
Client Type of Bill: 370 **CR Seq:** CC8085A3780100C05BB034EC4FB48D
Adjuster: ABIGAIL.ECHANIQUE

Bill ICD Version: 10
Dx A: T14.90XA INJURY, UNSPECIFIED, INITIAL E NCOUNTER

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description				Explanation Code(s)	
				Charges	BRV	CBR	PPO	ONR	OTH	ADJ	Allow.
1	02-15-2021	11	Q00014	A	120	INTERPRETER OTHER 15				877, G1, 790, G57, U00	
				180.00	90.00						90.00

Totals

Total Charges:	180.00
Bill Review Reductions:	90.00
Recommended Allowance:	**90.00**

Messages

790	WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. LABOR CODES 5307.1 - 5307.9
877	SERVICES PAID BASED ON THE 2 HOUR MINIMUM. IF SERVICES WENT BEYOND THE 2 HOURS, PLEASE RESUBMIT WITH DOCUMENTATION SUPPORTING TIME SPENT.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (877) 401-1411 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 20210406_CCP_178924324_0000382

Farmers Workers' Compensation Claims

Check Number: 1632543405
Date: 03/21/2022

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE $90.00*******

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:	
Insured:	Truck Depot (dba) Truck Depot, Inc
Date of Loss:	04/13/2020
Claim Number:	
Invoice Number:	FRM-FWCA-343981
Check Number:	1632543405
Payment Under Insured's:	Workers Compensation
Correspondence Reference:	014RTZ1WW
Print Date	03/21/2022 09:10 AM
Requested By	Abigail L Echanique

PAID
MAR 28 2022
BY.....

PAID
MAR 28 2022
BY.....

FARMERS INSURANCE

62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
7001337355-1

Check No. 1632543405
Date: 03/21/2022

PAY Ninety Dollars And No Cents $90.00*******

NOT GOOD AFTER SIX MONTHS

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Thomas S. Toh

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK — HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT

⑈1632543405⑈ ⑆031100209⑆ 3872438 9⑈

Explanation of Review

FARMERS INSURANCE

Carrier

FARMERS
Carrier No:
Carrier: Mid-Century Insurance Company
PO Box 108843
Oklahoma City, OK 73101

Bill: FRM-FWCA-343981 **Re-evaluation**

Provider

JOYCE ALTMAN INTERPRETERS,INC
JOYCE ALTMAN INTERPRETERS,INC
PO BOX # 4165
TUSTIN, CA 92781-4165

Claimant

NPI: **Rendering NPI:** 1477186625
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 999999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.

Invoice No: 78358
Invoice Date: 06-30-2021
Patient Account: 78358

Region: 26 **Payment Status Code:** 1

Claim Number:
DOI/DOL: 04-13-2020
CR Date / BR Date: 03-18-2022 / 03-18-2022
External Claim Number: 7001337355-1
Social Security Number:
Policy Number: A0949682000
Employer/Insured: (DBA) TRUCK DEPOT, INC, TRUCK DEPOT

Policy Admin Information: A0949682000

Bill Details

Dates of Service: 02-15-2021
Post Date: 03-21-2022

Reviewer: TD/b©
Pay Auth: 1
Client Type of Bill: 370 **CR Seq:** CC8085A3780100C05BB034EC4FB48D
Adjuster: ABIGAIL.ECHANIQUE

Bill ICD Version: 10
Dx A: T14.90XA INJURY, UNSPECIFIED, INITIAL E NCOUNTER

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units BRV	Description CBR	PPO	ONR	OTH	Explanation Code(s) ADJ	Allow.
1	02-15-2021	11		A	180.00	120	INTERPRETER OTHER 15				877, 197, G57, U00	180.00

Totals

Total Charges:	180.00
Recommended Allowance:	**180.00**
Previous Recommended Allowance:	90.00
Add'l Recommendation For This Review:	90.00

Messages

197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
877	SERVICES PAID BASED ON THE 2 HOUR MINIMUM. IF SERVICES WENT BEYOND THE 2 HOURS, PLEASE RESUBMIT WITH DOCUMENTATION SUPPORTING TIME SPENT.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IBR Overturn CB21-0002317

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (877) 401-1411 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

CPT Copyright 1995-2021 American Medical Association. All rights reserved.

03 02 000597 014RTZ1WW1 CE0322P1 04 [1] 000597

MID-CENTURY INSURANCE COMPANY

Check Number: 1632530422
Date: 03/18/2022

Amount: $180.00******

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE
NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:		Primary Adjuster:	Abigail Echanique
Insured:	Truck Depot (dba) Truck Depot, Inc	Toll Free Number:	8884861451
Date of Loss:	04/13/2020	Applicable Coverage:	Workers Compensation
Claim Number:			
Correspondence Reference:	ZB4WR7QRW		

Additional Information:
Review Cost for IBR submisson
If there are questions regarding the cashing of this check, please contact the Primary Adjuster at their toll free telephone number or claims office at the address on the check.

Service From/To	Payment For	Paid Amount
03/08/2022 to 03/08/2022	Other Treatment	$180.00

PAID
MAR 28 2022
BY .....

FARMERS INSURANCE

62-20/311

CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim #: 7001337355-1 Check No. 1632530422
Date: 03/18/2022

Payable, if desired, at any Citibank

PAY One Hundred Eighty Dollars And No Cents $180.00******
NOT GOOD AFTER SIX MONTHS

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Thomas S. Noh

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT

⑈1632530422⑈ ⑆031100209⑆ 38724389⑈

79266

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000034 February 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 07 2022

IBR Case Number	CB21-0002146
Claim Number	
Assignment Date	12/16/2021
Claims Administrator	Farmers
Date(s) of service	03/22/2021 - 03/22/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/08/2010
Application Received	09/10/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Farmers
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 03/22/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/30/2021. Response received 12/27/2021. Claims Administrator upheld their determination.
- Itemized Invoice
    - 03/22/2021 Interpreting for PR2 / ReEvaluation $180.00 (Billed at a minimum of two hours)
- EORs reflect reimbursement of $90.00. Services paid based on the 2 hour minimum. If services went beyond the 2 hours, please resubmit with documentation supporting time spent.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 03/22/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 03/22/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Farmers
PO Box 108843
Oklahoma City, OK 73101

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Farmers Workers' Compensation Claims

Check Number: 8817660934
Date: 05/18/2021

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE $90.00*******

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:	
Insured:	Transparent Products Inc
Date of Loss:	11/08/2010
Claim Number:	
Invoice Number:	FRM-FWCA-222545
Check Number:	8817660934
Payment Under Insured's:	Workers Comp Medical
Correspondence Reference:	BFQFMZFSW
Print Date	05/18/2021 10:16 AM
Requested By	Allison Miller

79266

BY: .....

MAY 24 2021

PLEASE FOLD AND DETACH CHECK ON RED LINE BELOW

Explanation of Review

FARMERS INSURANCE

Carrier

FARMERS
Carrier No:
Carrier: Mid-Century Insurance Company
PO Box 108843
Oklahoma City, OK 73101

Bill: FRM-FWCA-222545

Provider

JOYCE ALTMAN INTERPRETERS,INC
JOYCE ALTMAN INTERPRETERS,INC
PO BOX # 4165
TUSTIN, CA 92781-4165

Claimant

NPI: **Rendering NPI:** 1477186625
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 99999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.

Invoice No: 79266
Invoice Date: 05-06-2021
Patient Account: 79266

Claim Number:
DOI/DOL: 11-08-2010
CR Date / BR Date: 05-11-2021 / 05-12-2021
External Claim Number: WC10024190
Social Security Number:
Policy Number: A0476876010
Employer/Insured: TRANSPARENT PRODUCTS INC

Region: 26 **Payment Status Code:** 1

Policy Admin Information: A0476876010

Bill Details

Dates of Service: 03-22-2021
Post Date: 05-17-2021

Reviewer: MT/b©
Pay Auth: 1
Client Type of Bill: 370 **CR Seq:** CC50EF61790000C9119DA3C58D4940
Adjuster: ALLISON.MILLER1

Bill ICD Version: 10
Dx A: T14.90XA INJURY, UNSPECIFIED, INITIAL E NCOUNTER

Line	Date	POS	Rev./Proc. Code	Dx.	Units	Description				Explanation Code(s)	
				Charges	BRV	CBR	PPO	ONR	OTH	ADJ	Allow.
1	03-22-2021	11	Q00014	A	120	INTERPRETER OTHER 15				877, G1, 790, G57, U00	
				180.00	90.00						90.00

Totals

Total Charges:	180.00
Bill Review Reductions:	90.00
Recommended Allowance:	**90.00**

Messages

790	WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. LABOR CODES 5307.1 - 5307.9
877	SERVICES PAID BASED ON THE 2 HOUR MINIMUM. IF SERVICES WENT BEYOND THE 2 HOURS, PLEASE RESUBMIT WITH DOCUMENTATION SUPPORTING TIME SPENT.
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (877) 401-1411 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

CPT Copyright 1995-2020 American Medical Association. All rights reserved.

DCN Number: 20210512_CCP_184109320_0000682

03 02 000792 BFQFMZFSW1 CE0519P1 04 [ ] 000792

Farmers Workers' Compensation Claims

Check Number: 1632221686
Date: 02/11/2022

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE $90.00*******

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:	
Insured:	Transparent Products Inc
Date of Loss:	11/08/2010
Claim Number:	
Invoice Number:	FRM-FWCA-332110
Check Number:	1632221686
Payment Under Insured's:	Workers Compensation
Correspondence Reference:	YDAFVP90W
Print Date	02/11/2022 10:49 AM
Requested By	Amy V Babel

additional owed per IBR Overturn

PAID
FEB 21 2022
BY: .....

FARMERS INSURANCE

62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
WC10024190

Check No. 1632221686
Date: 02/11/2022

PAY Ninety Dollars And No Cents

$90.00*******

NOT GOOD AFTER SIX MONTHS

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Thomas S. Toh

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A BLUE/GREEN PAPER BACK. VOID AT AN ANGLE TO VIEW WHITE OR DOUBLE IMAGE.

⑈1632221686⑈ ⑆031100209⑆ 38724389⑈

FARMERS INSURANCE

Explanation of Review

Carrier

FARMERS
Carrier No:
Carrier: Mid-Century Insurance Company
PO Box 108843
Oklahoma City, OK 73101

Bill: FRM-FWCA-332110 **Re-evaluation**

Provider

JOYCE ALTMAN INTERPRETERS,INC
JOYCE ALTMAN INTERPRETERS,INC
PO BOX # 4165
TUSTIN, CA 92781-4165

Claimant

NPI: **Rendering NPI:** 1477186625
Tax ID: 330956713 **Type:** OT **Specialty (1):** AO
License: 99999999
Rendering Provider: JOYCE ALTMAN INTERPRETERS, INC.

Invoice No: 79266
Invoice Date: 07-30-2021
Patient Account: 79266

Region: 26 **Payment Status Code:** 1

Claim Number:
DOI/DOL: 11-08-2010
CR Date / BR Date: 02-11-2022 / 02-11-2022
External Claim Number: WC10024190
Social Security Number:
Policy Number: A0476876010
Employer/Insured: TRANSPARENT PRODUCTS INC

Policy Admin Information: A0476876010

Bill Details

Dates of Service: 03-22-2021
Post Date: 02-11-2022

Reviewer: TD/b©
Pay Auth: 1
Client Type of Bill: 370 **CR Seq:** CC50EF61790000C9119DA3C58D4940
Adjuster: AMY.BABEL

Bill ICD Version: 10
Dx A: T14.90XA INJURY, UNSPECIFIED, INITIAL E NCOUNTER

Line	Date	POS	Rev./Proc. Code	Dx.	Charges	Units	BRV	Description CBR	PPO	ONR	OTH	Explanation Code(s) ADJ	Allow.
1	03-22-2021	11		A	180.00	120		INTERPRETER OTHER 15				877, 197, G57, U00	180.00

Totals

Total Charges:	180.00
Recommended Allowance:	**180.00**
Previous Recommended Allowance:	90.00
Add'l Recommendation For This Review:	90.00

Messages

197	PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
877	SERVICES PAID BASED ON THE 2 HOUR MINIMUM. IF SERVICES WENT BEYOND THE 2 HOURS, PLEASE RESUBMIT WITH DOCUMENTATION SUPPORTING TIME SPENT.
G57	THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.
U00	THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.

IBR Overturn case # CB21-0002146 letter dated 2/2/2022

IF YOU HAVE ANY QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL MITCHELL INTERNATIONAL, INC. AT (877) 401-1411 OR SEND YOUR BILL AND ANALYSIS TO:

FARMERS, PO BOX 108843, OKLAHOMA CITY, OK 73101-8843

CPT Copyright 1995-2021 American Medical Association. All rights reserved.

03 02 000784 YDAFVP90W1 CE0214P1 04 [ ] 000784

014247

THE TRAVELERS - WORKERS' COMPENSATI
WORKERS' COMPENSATION UNIT
P O BOX 660055
DALLAS TX 75266-0055

SA07049

896D 97160983

M

TRAVELERS

DATE: 01/11/23
LOSS DATE: 07/25/17
FILE NUMBER: 152 CB E9R7220 M

JOYCE ALTMAN INTERPRETERS INC
P O BOX 4165
TUSTIN, CA 92781

EMPLOYEE
ARACELI CASTILLO

ACCOUNT NAME:

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

THIS BILL HAS BEEN REPRICED. THE EXPLANATION FOR THE REPRICING HAS BEEN SENT UNDER SEPARATE COVER.

DATE OF SERVICE: 01/10/23

Per agreement
TOTAL PAID: $1525.17

PAID
JAN 2 3 2023
BY.

FOR ADDITIONAL INFORMATION, CONTACT: VIENNIA K GOOREY AT (909)612-3510

011007131
DETACH CHECK

UNSUMM -111311
OVRPUNS2-121295
DETACH CHECK

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79438

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000051 November 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 30 2022

IBR Case Number	CB22-0002278
Claim Number	
Assignment Date	10/13/2022
Claims Administrator	Insurance Company of the West
Date(s) of service	12/18/2021 - 12/18/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/28/2018
Application Received	09/16/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $162.00 in additional reimbursement for a total of $342.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$342.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Insurance Company of the West
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/18/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/27/2022. Response not yet received.
- Itemized invoice
    - 12/18/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $18.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/18/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/18/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$18.00
Dispute Amount	$162.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $18.00 (Plan Allowed) = **$162.00** **Due Provider** Refer to Analysis

Copy to:

Insurance Company of the West
PO Box 509039
San Diego, CA 92150

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 06/23/2022
Check Number: 4194177
Check Amount: $18.00

Sign up today for Electronic Funds Transfer (EFT). Insurance Company of the West now uses JopariPay to speed payments directly to your bank account. Visit https://rg.jopari.net and sign up by entering your registration code,WDDDV6

WDDDV6

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED
JUL 05 2022
79438

PAID
JUL 07 2022
BY.

Payment Summary

Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
	11/28/2018	$180.00	$162.00	$18.00

Category	Stub Notes	Stub Amount
180	The charges have been paid per ICW s usual and cus	$0.00

See attached page(s) for Explanations of Review

Explanation of Bill Review

Payer: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128
Provider: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781
TIN: 330956713
Payee ID: 49459

Check Number: 4194177
Check Date: 06/23/2022

Carrier: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128
Carrier ID:

Claim #:
Bill Type: PROF **Jurisdiction:** CA **Payment Type:** MED
From: 12/18/2021 **Through:** 12/18/2021 **Adjuster:** Capewell, Debbie
Claimant:
SS#:
Date of Injury: 11/28/2018
Reviewed By: I8 **Date Received:** 05/16/2022 **Date Reviewed:** 05/17/2022 **Bill Review #:** FIC-IWCA-4546847
Patient Acct #: 79438 **Bill Control #:** FIC-IWCA-4546847 **State Claim #:** 201811301757099293207O
Employer: INNOVATIVE STAMPING INC
Rendering: JOYCE ALTMAN **NPI:** **State Lic.#:** 999999999
PPO: **PPO Phone:**
PPO Subnet: **PPO/MPN ID:**

Diagnosis Codes: T14.90

Date of Service	Line	TOS	POS	Procedure Code/Mod	Qty	Charged	Fee Schedule	--- Reductions --- PPO	Prior Paid	Other	Allowed	Explanation Codes
12/18/2021	001	9	11	T1013	8	180.00	162.00	0.00	0.00	0.00	18.00	402, 375
				Alert: Additional information/explanation will be sent separately. This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.								
				Totals:		180.00	162.00	0.00	0.00	0.00	18.00	

Comments:

The charges have been paid per ICW s usual and customary rates, the recommended allowances are reasonable for the services provided.

Bill Review Claim Adjustment Reason Codes with Cross Reference to State/ANSI Codes:

BR	State	ANSI	BR Description
375	G5	P1	PLEASE SEE SPECIAL *NOTE* BELOW.
402	G2	P12	PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307

Explanation of State/ANSI Reduction Codes:

Code	Description
G2	THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
G5	THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.

ANSI Claim Adjustment Reason Codes:

Code	Description
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment.

Procedure Code Guide:

Code	Description
T1013	Sign language or oral interpretive services, per 15 minutes

Notices:

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

If you have any questions regarding this analysis, please call Mitchell International, Inc. at (800) 732-0153 or send your bill and analysis to:
ICW Group,PO BOX 2965 Clinton, IA 52733-2965 or FAX to (858)586-2446

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 12/07/2022
Check Number: 4441044
Check Amount: $342.00

Sign up today for Electronic Funds Transfer (EFT). Insurance Company of the West now uses JopariPay to speed payments directly to your bank account. Visit https://rg.jopari.net and sign up by entering your registration code,5CRUXH

5CRUXH

4/6/22 11 54 AM 3 0000875 20221208 SL3GM101 JOP-FEC 1 oz DOM SL3GM10000* 161281 CK

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

PAID
DEC 19 2022
BY

Payment Summary

Claim #	Claimant	Date of Injury	Invoice #	Payment Type	From	Through	Total Amount
		11/28/2018		180	12/18/2021	12/18/2021	$342.00

Category	Stub Notes	Stub Amount
180	Paying per IBR determination	$0.00

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82950

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000073 October 31, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 0 3 2022

IBR Case Number	CB22-0002018
Claim Number	
Assignment Date	09/20/2022
Claims Administrator	Insurance Company of the West
Date(s) of service	03/09/2022 - 03/09/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	12/02/2021
Application Received	08/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $305.00 in additional reimbursement for a total of $485.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$485.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Insurance Company of the West
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 03/09/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/02/2022. Response not yet received.
- Itemized invoice
    - 03/09/2022 Interpreting for exotic language (Russian) $485.00 (Billed at a minimum of 2 hours)
- EORs reimbursement of $180.00. The OMFS does not list this code; an allowance has been made for a comparable service.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 03/09/2022 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $242.50 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 03/09/2022
Interpreter

Service Code	Interpreter Service
Provider Billed	$485.00
Plan Allowed	$180.00
Dispute Amount	$305.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$485.00
Notes	**Overturn** $242.50 (Market Rate for One Hour) * 2 (hours) = $485.00 - $180.00 (Plan Allowed) = **$305.00** **Due Provider** Refer to Analysis

Copy to:

Insurance Company of the West
PO Box 2965
Clinton, IA 52733

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

4/6/22 11:54 AM 3 0001412 20220418 SD5LM101 JOP-FEC 1 oz DOM SD5LM10000 161281 CK

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 04/15/2022
Check Number: 4091123
Check Amount: $180.00

Sign up today for Electronic Funds Transfer (EFT). Insurance Company of the West now uses JopariPay to speed payments directly to your bank account. Visit https://rg.jopari.net and sign up by entering your registration code,A7HDUK

A7HDUK

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED
APR 26 2022
BY:

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
		12/02/2021	$485.00	$305.00	$180.00

Category	Stub Notes	Stub Amount
180	The charges have been paid per ICW s usual and cus	$0.00

RECEIVED
APR 25 2022
BY: 82950

See attached page(s) for Explanations of Review

Explanation of Bill Review

Payer: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128
Provider: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781
TIN: 330956713
Payee ID: 49459

Check Number: 4091123
Check Date: 04/15/2022

Carrier: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128
Carrier ID:

Claim #:
Bill Type: PROF **Jurisdiction:** CA **Payment Type:** MED
From: 03/09/2022 **Through:** 03/09/2022 **Adjuster:** Phakitthong, Manisone
Claimant:
SS#: **Date of Birth:** **Date of Injury:** 12/02/2021
Reviewed By: OA **Date Received:** 04/02/2022 **Date Reviewed:** 04/04/2022 **Bill Review #:** FIC-IWCA-4496155
Patient Acct #: 82950 **Bill Control #:** FIC-IWCA-4496155 **State Claim #:** 202112171214327919817 6
Employer: LEE'S COLLISION CENTERS, LLC
Rendering: JOYCE ALTMAN **NPI:** **State Lic.#:** 999999999
PPO: **PPO Phone:**
PPO Subnet: **PPO/MPN ID:**

Diagnosis Codes: T14.90

Date of Service	Line	TOS	POS	Procedure Code/Mod	Qty	Charged	Fee Schedule	--- Reductions --- PPO	Prior Paid	Other	Allowed	Explanation Codes
03/09/2022	001	9	11	T1013	8	485.00	305.00	0.00	0.00	0.00	180.00	402, 375
				This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Alert: Additional information/explanation will be sent separately.								
				Totals:		485.00	305.00	0.00	0.00	0.00	180.00	

Comments:

The charges have been paid per ICW s usual and customary rates, the recommended allowances are reasonable for the services provided.

Bill Review Claim Adjustment Reason Codes with Cross Reference to State/ANSI Codes:

BR	State	ANSI	BR Description
375	G5	P1	PLEASE SEE SPECIAL *NOTE* BELOW.
402	G2	P12	PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307

Explanation of State/ANSI Reduction Codes:

Code	Description
G2	THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
G5	THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.

ANSI Claim Adjustment Reason Codes:

Code	Description
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment.

Procedure Code Guide:

Code	Description
T1013	Sign language or oral interpretive services, per 15 minutes

Notices:

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 11/15/2022
Check Number: 4410984
Check Amount: $305.00

Sign up today for Electronic Funds Transfer (EFT). Insurance Company of the West now uses JopariPay to speed payments directly to your bank account. Visit https://rg.jopari.net and sign up by entering your registration code,86FGXJ

86FGXJ

4/6/22 11 54 AM 3 0000912 20221116 SK61K101 JOP-FEC 1 oz DOM SK61K10000* 161281 CK

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
		12/02/2021	$485.00	$180.00	$305.00

Category	Stub Notes	Stub Amount
180	IBR OVERTURNED - ADDITIONAL ALLOWANCE\nThe charges	$0.00

NOV 23 2022

See attached page(s) for Explanations of Review

Explanation of Bill Review

Payer: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Provider: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

TIN: 330956713

Payee ID: 49459

Check Number: 4410984

Check Date: 11/15/2022

Carrier: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Carrier ID:

Claim #:

Bill Type: PROF **Jurisdiction:** CA **Payment Type:** MED

From: 03/09/2022 **Through:** 03/09/2022 **Adjuster:** Phakitthong, Manisone

Claimant: PO BOX 290633, Phelan, CA 92329

SS#: **Date of Birth:** **Date of Injury:** 12/02/2021

Reviewed By: J3 **Date Received:** 11/09/2022 **Date Reviewed:** 11/14/2022 **Bill Review #:** FIC-IWCA-4748709

Patient Acct #: 82950 **Bill Control #:** FIC-IWCA-4748709 **State Claim #:** 202112171214327919817 6

Employer: LEE'S COLLISION CENTERS, LLC

Rendering: JOYCE ALTMAN **NPI:** **State Lic.#:** 999999999

PPO: **PPO Phone:**

PPO Subnet: **PPO/MPN ID:**

Diagnosis Codes: T14.90

Date of Service	Line	TOS	POS	Procedure Code/Mod	Qty	Charged	Fee Schedule	--- Reductions --- PPO	Prior Paid	Other	Allowed	Explanation Codes
03/09/2022	001	9	11	T1013	8	485.00	0.00	0.00	0.00	180.00	305.00	402, C21, 375
				Alert: Additional information/explanation will be sent separately. This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.								
				Totals:		485.00	0.00	0.00	0.00	180.00	305.00	

Comments:

IBR OVERTURNED - ADDITIONAL ALLOWANCE
The charges have been paid per ICW s usual and customary rates, the recommended allowances are reasonable for the services provided.

Bill Review Claim Adjustment Reason Codes with Cross Reference to State/ANSI Codes:

BR	State	ANSI	BR Description
375		P1	PLEASE SEE SPECIAL *NOTE* BELOW.
402	G2	P12	PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307
C21	G5		OVERRIDES PPO'S

Explanation of State/ANSI Reduction Codes:

Code	Description
G2	THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
G5	THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.

ANSI Claim Adjustment Reason Codes:

Code	Description
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment.

Procedure Code Guide:

Code	Description
T1013	Sign language or oral interpretive services, per 15 minutes

Notices:

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

Explanation of Bill Review

Payer: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Provider: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

TIN: 330956713

Payee ID: 49459

Check Number: 4410984

Check Date: 11/15/2022

Carrier: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Carrier ID:

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 11/15/2022
Check Number: 4410984
Check Amount: $305.00

Sign up today for Electronic Funds Transfer (EFT). Insurance Company of the West now uses JopariPay to speed payments directly to your bank account. Visit https://rg.jopari.net and sign up by entering your registration code,86FGXJ

86FGXJ

4/6/22 11 54 AM 3 0000912 20221116 SK61K101 JOP-FEC 1 oz DOM SK61K10000* 161281 CK

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
		12/02/2021	$485.00	$180.00	$305.00

Category	Stub Notes	Stub Amount
180	IBR OVERTURNED - ADDITIONAL ALLOWANCE\nThe charges	$0.00

NOV 23 2022

See attached page(s) for Explanations of Review

Explanation of Bill Review

Payer: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Provider: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

TIN: 330956713

Payee ID: 49459

Check Number: 4410984

Check Date: 11/15/2022

Carrier: Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Carrier ID:

Claim #:

Bill Type: PROF **Jurisdiction:** CA **Payment Type:** MED

From: 03/09/2022 **Through:** 03/09/2022 **Adjuster:** Phakitthong, Manisone

Claimant: PO BOX 290633, Phelan, CA 92329

SS#: **Date of Birth:** 03/16/1997 **Date of Injury:** 12/02/2021

Reviewed By: J3 **Date Received:** 11/09/2022 **Date Reviewed:** 11/14/2022 **Bill Review #:** FIC-IWCA-4748709

Patient Acct #: 82950 **Bill Control #:** FIC-IWCA-4748709 **State Claim #:**

Employer: LEE'S COLLISION CENTERS, LLC

Rendering: JOYCE ALTMAN **NPI:** **State Lic.#:** 999999999

PPO: **PPO Phone:**

PPO Subnet: **PPO/MPN ID:**

Diagnosis Codes: T14.90

Date of Service	Line	TOS	POS	Procedure Code/Mod	Qty	Charged	Fee Schedule	--- Reductions --- PPO	Prior Paid	Other	Allowed	Explanation Codes
03/09/2022	001	9	11	T1013	8	485.00	0.00	0.00	0.00	180.00	305.00	402, C21, 375
				Alert: Additional information/explanation will be sent separately. This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.								
				Totals:		485.00	0.00	0.00	0.00	180.00	305.00	

Comments:

IBR OVERTURNED - ADDITIONAL ALLOWANCE
The charges have been paid per ICW s usual and customary rates, the recommended allowances are reasonable for the services provided.

Bill Review Claim Adjustment Reason Codes with Cross Reference to State/ANSI Codes:

BR	State	ANSI	BR Description
375		P1	PLEASE SEE SPECIAL *NOTE* BELOW.
402	G2	P12	PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307
C21	G5		OVERRIDES PPO'S

Explanation of State/ANSI Reduction Codes:

Code	Description
G2	THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
G5	THIS CHARGE WAS ADJUSTED FOR THE REASONS SET FORTH IN THE ATTACHED LETTER.

ANSI Claim Adjustment Reason Codes:

Code	Description
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P12	Workers' compensation jurisdictional fee schedule adjustment.

Procedure Code Guide:

Code	Description
T1013	Sign language or oral interpretive services, per 15 minutes

Notices:

Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

If you have any questions regarding this analysis, please call Mitchell International, Inc. at (800) 732-0153 or send your bill and analysis to:
ICW Group,PO BOX 2965 Clinton, IA 52733-2965 or FAX to (858)586-2446

MAY 3 1 2022

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78124

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000059 May 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0000618
Claim Number	
Assignment Date	04/14/2022
Claims Administrator	Liberty Mutual
Date(s) of service	07/31/2021 - 07/31/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	04/26/2017
Application Received	03/18/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 07/31/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/29/2022. Response received 04/11/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 07/31/2021 Interpreting for follow-up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 07/31/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 07/31/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
Mailstop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083874324	11/04/21
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	009055

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

PAID
NOV 08 2021

OSN: MM0701110411-001486
BANK: 298
CHECK REF: 0083874324 DATE: 11/04/21 AMT: 90.00
INTERNAL BILL NO: 133225476 MSR: N1560935
CUST/EXTERNAL BILL NO: 1111350601
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-296
DOCUMENT NO: 2J2912103220003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 78124
SSN:
DOI: 04/26/17
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 20170501140944840742 23
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE FL XVI, INC.
ADDRESS: 7616 ROSECRANS AVENUE
PARAMOUNT, CA 90723

LOCATION CODE: R6INCTS

DATES OF SERVICE: 07/31/21-07/31/21
AUDIT DATE: 10/28/21

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
07/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 4480
										G1 5898
										G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
4480 RECOMMENDED ALLOWANCE HAS BEEN AUTHORIZED BY THE PAYOR
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083994102	06/09/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	008082

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

M

PAID
JUN 20 2022

OSN: MM0301060911-000187
BANK: 298
CHECK REF: 0083994102 DATE: 06/09/22 AMT: 90.00
INTERNAL BILL NO: 133225476 MSR: N0161877
CUST/EXTERNAL BILL NO: 2001412982
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-296
DOCUMENT NO: 11365499

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 78124
SSN:
DOI: 04/26/17
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 201705011409448407 4223
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE FL XVI, INC.
ADDRESS: 7616 ROSECRANS AVENUE
PARAMOUNT, CA 90723

LOCATION CODE: R6INCTS

DATES OF SERVICE: 07/31/21-07/31/21
AUDIT DATE: 06/08/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
07/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	90.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY. SIGN-UP TODAY TO

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC

B. CODE	CHECK NUMBER	CHECK DATE
199	03327681	06/09/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 001799

OSN: EE2801060903-002107

CLAIM #:
CONTRACT #: WP8-65B-290306-296

CONTROL #: 000002993 ID: C586B47
PROVIDER #: N3095671365268

PAYEE: JOYCE ALTMAN INTERPRETERS INC

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

PAID
JUN 20 2022

DATE OF INJURY: 04/26/17
EMPLOYEE:

EMPLOYER: ADP TOTALSOURCE FL XVI, INC.
DATES OF SERVICE 07/31/21-07/31/21
LOCATION CODE: R6INCTS

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
07/31/21	07/31/21	INDEPEND		180.00	180.00	

NOTE: IBR PROVIDER REFUND CB# CB22-0000618

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78124

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001351
Claim Number	
Assignment Date	07/08/2022
Claims Administrator	Liberty Mutual
Date(s) of service	09/25/2021 - 09/25/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	04/26/2017
Application Received	06/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/25/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/22/2022. Response received 06/28/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 09/25/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/25/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/25/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083918197	01/28/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	009938

OSN: MM0701012811-001699
BANK: 298
CHECK REF: 0083918197 DATE: 01/28/22 AMT: 90.00
INTERNAL BILL NO: 133968144 MSR: N1519833
CUST/EXTERNAL BILL NO: 1112113763
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-296
DOCUMENT NO: 2B0122210970003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

FEB 03 2022

PATIENT ACCT. #: 78124
SSN:
DOI: 04/26/17
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 201705011409448407 4223
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE FL XVI, INC.
ADDRESS: 7616 ROSECRANS AVENUE
PARAMOUNT, CA 90723

LOCATION CODE: R6INCTS

DATES OF SERVICE: 09/25/21-09/25/21
AUDIT DATE: 01/20/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
09/25/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 4480 G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
4480 RECOMMENDED ALLOWANCE HAS BEEN AUTHORIZED BY THE PAYOR
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

PROVIDER INQUIRIES. (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B CODE
298

CHECK REFERENCE	CHECK DATE
0084041070	08/31/22
CHECK AMOUNT	BLOCK NUMBER
*****$90 00	007075

RECEIVED
SEP 09 2022
BY:

M

OSN. MM0301083111-000136
BANK: 298
CHECK REF 0084041070 DATE 08/31/22 AMT 90 00
INTERNAL BILL NO 133968144 MSR N0070779
CUST/EXTERNAL BILL NO: 2001485571
BR PROVIDER #: 330956713-0003

CLAIM NO
CONTRACT NO WP8-65B-290306-296
DOCUMENT NO: 11121137630

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT # 78124
SSN
DOI: 04/26/17
PATIENT

PROVIDER JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #) 20170501140944840742 23
DIAG CODES T14.90

EMPLOYER ADP TOTALSOURCE FL XVI, INC.
ADDRESS: 7616 ROSECRANS AVENUE
PARAMOUNT, CA 90723

LOCATION CODE R6INCTS

DATES OF SERVICE. 09/25/21-09/25/21
AUDIT DATE 08/30/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
09/25/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90.00	90.00 G1	5898

TOTAL CHARGES.	180 00
TOTAL PREVIOUSLY PAID:	90.00
TOTAL CURRENT PAYABLE	90 00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0 00
TOTAL AMOUNT PAID	90.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732 TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB (ZC72)

Z849 GO PAPERLESS WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY SIGN-UP TODAY TO

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

BNA *002326*
916-564-1792
PO BOX 8016
WAUSAU, WI 54402

Helmsman
Management Services LLC

51-44/119
BANK OF AMERICA
HARTFORD, CT

*PAY*ONE*HUNDRED*EIGHTY*DOLLARS*NO*CENTS*

OFFICE NO.	B. CODE	PAYMENT IDENTIFICATION	CHECK NUMBER	CHECK DATE
608	199	CLAIM WC 608-C97685	03380123	08/30/22

PAY $ 180.00

VOID IF NOT PRESENTED WITHIN 90 DAYS OF DATE OF CHECK

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781

⑈03380123⑈ ⑆011900445⑆00000006758 7⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78574

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000051 July 1, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUL 0 5 2022

IBR Case Number	CB22-0000932
Claim Number	
Assignment Date	05/17/2022
Claims Administrator	Liberty Mutual
Date(s) of service	08/31/2021 - 08/31/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services
Date of Injury	03/19/2019
Application Received	04/22/2022

Dear Joyce Altman Interpreter, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 08/31/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/29/2022. Response received 05/11/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 08/31/2021 Interpreting for follow-up Acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect $90.00 reimbursement with the rationale: charges exceed maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/31/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 08/31/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
Mailstop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Liberty Mutual. INSURANCE

B. CODE
288

CHECK REFERENCE	CHECK DATE
0033124779	12/13/21
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	001159

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

PAID
DEC 20 2021

OSN: MM0701121302-001159
BANK: 288
CHECK REF: 0033124779 DATE: 12/13/21 AMT: 90.00
INTERNAL BILL NO: 133578853 MSR: N1558588
CUST/EXTERNAL BILL NO: 1111718099
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WA7-65D-292224-038
DOCUMENT NO: 2B3282102330003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

RECEIVED
DEC 17 2021
BY

PATIENT ACCT. #: 78574
SSN:
DOI: 03/19/19
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202008071112551200119l
DIAG CODES: T14.90

EMPLOYER: DIRECT AUCTION SERVICES LLC
ADDRESS: 11625 NINO WAY
MIRA LOMA, CA 91752

LOCATION CODE: DRLAD

DATES OF SERVICE: 08/31/21-08/31/21
AUDIT DATE: 12/06/21

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
08/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

MPA *000094*

LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742

Liberty Mutual. INSURANCE

CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0033370714
62-20/311
38621945

CHECK DATE
07/21/22

$ **********90.00

VOID IF NOT PRESENTED WITHIN 90 DAYS OF DATE OF CHECK

B.CODE	OFFICE NUMBER	PAYMENT IDENTIFICATION
288	570	CLAIM WC 648-C92701 HOD

PAY NINETY AND 00/100 DOLLARS**********

TO THE ORDER OF
JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

⑈0033370714⑈ ⑆031100209⑆ 38621945⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

BNA *002687*
818-240-1234
PO BOX 8016
WAUSAU, WI 54402

Liberty Mutual. INSURANCE

51-44/119
BANK OF AMERICA
HARTFORD, CT

*PAY*ONE*HUNDRED*EIGHTY*DOLLARS*NO*CENTS*

OFFICE NO.	B. CODE	PAYMENT IDENTIFICATION	CHECK NUMBER	CHECK DATE
648	189	CLAIM WC 648-C92701	05673148	07/20/22

PAY $ 180.00

VOID IF NOT PRESENTED WITHIN 90 DAYS OF DATE OF CHECK

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781

⑈05673148⑈ ⑆011900445⑆00000006758 5⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78805

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000058 September 14, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

SEP 19 2022

IBR Case Number	CB22-0001578
Claim Number	
Assignment Date	08/05/2022
Claims Administrator	Liberty Mutual
Date(s) of service	10/19/2021 - 10/19/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	07/08/2019
Application Received	07/08/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/19/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 07/20/2022. Response received 08/01/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 10/19/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/19/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/19/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Liberty Mutual. INSURANCE

B. CODE
288

CHECK REFERENCE	CHECK DATE
0033230995	03/21/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	001189

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

RECEIVED
MAR 25 2021
BY:

OSN: MM0701032102-001189
BANK: 288
CHECK REF: 0033230995 DATE: 03/21/22 AMT: 90.00
INTERNAL BILL NO: 134387905 MSR: N1558588
CUST/EXTERNAL BILL NO: 1112537581
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WC7-Z91-467550-019
DOCUMENT NO: 2H0602208320003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PAID
MAR 25 2022
BY:

PROVIDER: JOYCE ALTMAN INTEPRETERS INC

EMPLOYER: EASTERDAY HUNTER CORPORATION
ADDRESS: 19211 STUDEBAKER ROAD
CERRITOS, CA 90703

PATIENT ACCT. #: 78805
SSN:
DOI: 07/08/19
PATIENT:

AGENCY CLAIM #(BOARD COMM #): 202008082210151676043 4
DIAG CODES: T14.90

DATES OF SERVICE: 10/19/21-10/19/21
AUDIT DATE: 03/08/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
10/19/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

Liberty Mutual. INSURANCE

B CODE	CHECK REFERENCE	CHECK DATE
288	0033438053	09/21/22
	CHECK AMOUNT ****$90.00	BLOCK NUMBER 000115

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO:
LIBERTY MUTUAL INSURANCE
PO BOX 7203
LONDON, KY 40742

RECEIVED
SEP 29 2022
BY:

M

CLAIM NO.
CONTRACT NO: WC7-Z91-467550-019
DOCUMENT NO: 11125375810

OSN: MM0301092102-000115
BANK: 288
CHECK REF: 0033438053 DATE: 09/21/22 AMT: 90.00
INTERNAL BILL NO: 134387905 MSR: N0070779
CUST/EXTERNAL BILL NO: 2001504496
BR PROVIDER #: 330956713-0003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PROVIDER: JOYCE ALTMAN INTEPRETERS INC

EMPLOYER: EASTERDAY HUNTER CORPORATION
ADDRESS: 19211 STUDEBAKER ROAD
CERRITOS, CA 90703

PATIENT ACCT. #: 78805
SSN:
DOI. 07/08/19
PATIENT:

AGENCY CLAIM #(BOARD COMM #): 20200808221015167604 34
DIAG CODES: T14.90

DATES OF SERVICE: 10/19/21-10/19/21
AUDIT DATE: 09/20/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
10/19/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90 00 G1	5898

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	90.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY. SIGN-UP TODAY TO

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
503-239-5800

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	05765656	09/21/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 004323

CLAIM #:
CONTRACT #: WC7-Z91-467550-019

PAID
SEP 29 2022
BY

OSN: EE2701092105-000591
CONTROL #: 000002848 ID: C604B05
PROVIDER #: N3095671373804

PAYEE: JOYCE ALTMAN INTERPRETING

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

DATE OF INJURY: 07/08/19
EMPLOYEE:

EMPLOYER: EASTERDAY HUNTER CORPORATION
DATES OF SERVICE 10/19/21-10/19/21

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
10/19/21	10/19/21	INDEPEND		180.00	180 00	

NOTE: IBR PROVIDER REFUND SAI#11125375810 CASE:CB22-0001578

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0 00
TOTAL AMOUNT PAID:	180.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81137

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 14, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001858
Claim Number	
Assignment Date	08/31/2022
Claims Administrator	Liberty Mutual
Date(s) of service	05/26/2021 - 07/01/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 7
Date of Injury	02/26/2021
Application Received	08/05/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 7 submitted for dates of service 05/26/2021 – 07/01/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/15/2022. Claims Administrator indicated reimbursement was made on 08/30/2022. Copy of check and EOR were provided.
- Itemized invoice
    - 05/26/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 06/01/2021 Interpreting for initial acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/08/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/10/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/22/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 06/29/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 07/01/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 05/26/2021 – 07/01/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, and market rate examples; additional reimbursement is due.
Interpreter Services Overturned.
- Reimbursement received in the amount of $630.00, post IBR receipt. No additional reimbursement is due. $180.00 IBR application fee is the only amount due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 7
Date of Service: 05/26/2021 – 07/01/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
Mailstop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083962361	04/15/22
CHECK AMOUNT	BLOCK NUMBER
****$630.00	012361

PAID
APR 21 2022

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 0B0872200080003

OSN:
BANK: 298
CHECK REF: 0083962361 DATE: 04/15/22 AMT: 630.00
INTERNAL BILL NO: 134677422 MSR: N1501078
CUST/EXTERNAL BILL NO: 1112805484
BR PROVIDER #: 330956713-0003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

RECEIVED
APR 21 2022

PATIENT ACCT. #:
SSN:
DOI: 02/26/21
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

BY:.....

AGENCY CLAIM #(BOARD COMM #): 202106031147379534 6396
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC.
ADDRESS: 310 S MAPLE ST
SUITE F
CORONA, CA 92880
LOCATION CODE: 0H9NCTS

DATES OF SERVICE: 05/26/21-07/01/21
AUDIT DATE: 04/06/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
05/26/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
06/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
06/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
06/10/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
06/22/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
06/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601
07/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00 G1	5898
									G1	601

TOTAL CHARGES: 1260.00
TOTAL PREVIOUSLY PAID: 0.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

PROVIDER INQUIRIES· (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B CODE
298

CHECK REFERENCE	CHECK DATE
0084040785	08/30/22
CHECK AMOUNT	BLOCK NUMBER
****$630 00	013887

M

SEP 06 2022

PY:

CLAIM NO
CONTRACT NO WP8-65B-290306-290
DOCUMENT NO 20014781480

OSN: MM0801083011-005302
BANK: 298
CHECK REF 0084040785 DATE: 08/30/22 AMT· 630 00
INTERNAL BILL NO 134677422 MSR: N0170671
CUST/EXTERNAL BILL NO· 2001478148
BR PROVIDER # 330956713-0003

PAYEE JOYCE ALTMAN INTERPRETING
TAX ID 33-0956713
BILL PROV JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT # 81137
SSN
DOI 02/26/21
PATIENT

PAID
SEP 08 2022

PROVIDER JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #) 202106031147379534639 6
DIAG CODES· T14.90

EMPLOYER ADP TOTALSOURCE GROUP, INC
ADDRESS: 310 S MAPLE ST
SUITE F
CORONA, CA 92880
LOCATION CODE: 0H9NCTS

DATES OF SERVICE 05/26/21-07/01/21
AUDIT DATE: 08/29/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
05/26/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90 00	90.00 G1	5898
06/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180.00	N/A	90.00	90.00 G1	5898
06/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90 00	90 00 G1	5898
06/10/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180 00	180 00	N/A	90 00	90 00 G1	5898
06/22/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90 00	90 00 G1	5898
06/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90 00	90 00 G1	5898
07/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180.00	N/A	90.00	90 00 G1	5898

TOTAL CHARGES	1260.00
TOTAL PREVIOUSLY PAID:	630.00
TOTAL CURRENT PAYABLE	630.00
TOTAL WITHHOLDING - (FEDERAL AND STATE)	0 00
TOTAL AMOUNT PAID	630 00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC

B. CODE	CHECK NUMBER	CHECK DATE
199	03417098	10/25/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 003195

OSN: EE2801102503-004468

CLAIM #: WC 608-F23501
CONTRACT #: WP8-65B-290306-290

CONTROL #: 000001680 ID: C608B14
PROVIDER #: N3095671339600

PAYEE: JOYCE ALTMAN INTERPRETERS INC

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

DATE OF INJURY: 02/26/21
EMPLOYEE:

EMPLOYER: ADP TOTALSOURCE GROUP, INC.
DATES OF SERVICE 05/26/21-07/01/21
LOCATION CODE: 0H9NCTS

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
05/26/21	07/01/21	INDEPEND		180.00	180.00	

NOTE: IBR STICKER #: 11128054840 IBR CASE #:CB22-0001858

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

PAID
NOV 01 2022

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81305

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000035 December 01, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 5 2022

IBR Case Number	CB22-0002299
Claim Number	
Assignment Date	10/19/2022
Claims Administrator	Liberty Mutual
Date(s) of service	12/14/2021 - 12/14/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/18/2021
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/14/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/03/2022. Responses received 10/13/2022 and 10/18/2022. Claims Administrator indicated additional payment was due. Copy of EOR and check were provided.
- Itemized invoice
    - 12/14/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/14/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Service Overturned**
- Reimbursement received in the amount of $90.00, post IBR receipt. $180.00 IBR application fee is due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/14/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083982905	05/20/22
CHECK AMOUNT	BLOCK NUMBER
***$1980.00	019434

OSN:MM0701052012-000089

THIS CHECK REPRESENTS A COMBINATION OF BILLED SERVICES. PLEASE REFER TO EACH DETAILED ITEMIZATION FOR SPECIFIC INFORMATION TO SUPPORT THE PAYMENT.

PATIENT ACCT. #	DATES OF SERVICE	CUST/EXTERNAL BILL #	TOTAL BILL CHARGES	TOTAL PAID
83353	07/06/21-11/30/21	1113129705	2,700.00	1,350.00
82789	10/27/21-12/08/21	1113133278	1,080.00	540.00
81305	12/14/21-12/14/21	1113128950	180.00	90.00

RECEIVED
MAY 31 2022
BY:.....

PAID
JUN 01 2022
BY:.....

TOTAL BILLS COMBINED: 3

1,980.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B CODE
298

CHECK REFERENCE	CHECK DATE
0084067712	10/17/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	008527

M

OSN: MM0301101711-000220
BANK: 298
CHECK REF: 0084067712 DATE: 10/17/22 AMT: 90.00
INTERNAL BILL NO: 134964526 MSR: N0070779
CUST/EXTERNAL BILL NO: 2001522428
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-63B-510195-050
DOCUMENT NO: 11131289500

RECEIVED OCT 21 2022 BY:

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 81305
SSN:
DOI: 02/18/21
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

OCT 25 2022

AGENCY CLAIM #(BOARD COMM #): 202201141156274659528 3
DIAG CODES: T14.90

EMPLOYER: AMERIGAS PROPANE INC
ADDRESS: 460 N GULPH RD STE 100
KING OF PRUSSIA, PA 19406-2815

LOCATION CODE: W525402

DATES OF SERVICE: 12/14/21-12/14/21
AUDIT DATE: 10/14/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
12/14/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	90.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY. SIGN-UP TODAY TO

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC™

B. CODE	CHECK NUMBER	CHECK DATE
199	03462982	12/30/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 003203

OSN: EE2801123003-004177

CLAIM #:
CONTRACT #: WP8-63B-510195-050

CONTROL #: 000002371 ID: C608B14
PROVIDER #: N3095671370721

PAYEE: JOYCE ALTMAN INTERPRETERS

DATE OF INJURY: 02/18/21
EMPLOYEE:

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

EMPLOYER: AMERIGAS PROPANE INC
DATES OF SERVICE 12/14/21-12/14/21
LOCATION CODE: W525402

PROVIDER:

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
12/14/21	12/14/21	INDEPEND		180.00	180.00	

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

PAID
JAN 10 2023
BY.

BY.

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81375

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 19, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001919
Claim Number	
Assignment Date	09/02/2022
Claims Administrator	Liberty Mutual
Date(s) of service	06/15/2021 - 11/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 17
Date of Injury	09/11/2020
Application Received	08/12/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 17 submitted for dates of service 06/15/2021 – 11/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/17/2022. Responses received 09/06/2022 and 09/13/2022. Claims Administrator indicated that reimbursement was due. Copy of EOR with check information was provided.
- Itemized Invoices
    - 06/15/2021 Interpreting for Initial Exam $180.00 (Billed at a minimum of 2 hours)
    - 06/22/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 06/29/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 07/06/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 07/08/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 07/20/2021 Interpreting for PR2 Reeval $180.00 (Billed at a minimum of 2 hours)
    - 08/05/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/10/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/17/2022 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/24/2021 Interpreting for PR2 Reeval $180.00 (Billed at a minimum of 2 hours)
    - 08/31/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 09/14/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 09/21/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 09/28/2021 Interpreting for PR2 Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/09/2021 Interpreting for PR2 Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/17/2021 Interpreting for Initial acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 x 17 for each date of service 06/15/2021 – 11/17/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.

- Based on the documentation, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 17 Overturned.**
- Reimbursement received in the amount of $1,530.00, post IBR receipt. No additional reimbursement is due. $180.00 IBR application fee is the only amount due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 17.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 17
Date of Service: 06/15/2021 – 11/17/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 06/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/20/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/05/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/31/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/14/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/21/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/28/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083961627	04/14/22
CHECK AMOUNT	BLOCK NUMBER
***$1440.00	012637

RECEIVED
APR 18 2022
BY: .....

OSN: MM0701041411-004803
BANK: 298
CHECK REF: 0083961627 DATE: 04/14/22 AMT: 1,440.00
INTERNAL BILL NO: 134725051 MSR: N1558590
CUST/EXTERNAL BILL NO: 1112785984
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1I0842200100003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

DATES OF SERVICE: 06/15/21-11/09/21
AUDIT DATE: 04/12/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
06/15/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
06/22/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
06/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
07/06/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
07/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
07/20/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
08/05/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
08/10/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
08/17/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC

BLOCK NUMBER
012638

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

OSN: MM0701041411-004804
BANK: 298
CHECK REF: 0083961627 DATE: 04/14/22 AMT: 1,440.00
INTERNAL BILL NO: 134725051 MSR: N1558590
CUST/EXTERNAL BILL NO: 1112785984
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1I0842200100003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

DATES OF SERVICE: 06/15/21-11/09/21
AUDIT DATE: 04/12/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
										G1 601
08/24/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
08/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/07/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/14/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/21/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/28/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/09/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	2880.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	1440.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	1440.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY. SIGN-UP TODAY TO TAKE ADVANTAGE OF THE BENEFITS OF PAPERLESS BILLING AND PAYMENTS BY VISITING WWW.JOPARI.COM OR BY CALLING 1-800-630-3060. (Z849)

Z850 MEDICAL BILLS FOR THIS CLAIM SHOULD BE SUBMITTED TO THE 'SEND BILLS TO' ADDRESS REFERENCED IN THE UPPER LEFT CORNER OF THE EOP. (Z850)

5688 TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW FORM: HTTP://WWW.DIR.CA.GOV/DWC/DWCPROPREGS/IBR/FORMSBR_1.PDF AFTER AN EOR IS RECEIVED ON AN ORIGINAL BILL SUBMISSION, A HEALTH CARE PROVIDER, HEALTH CARE FACILITY, OR BILLING AGENT/ASSIGNEE (HEREIN REFERRED TO AS

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083973044	05/04/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	008567

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

OSN: MM0701050411-001336
BANK: 298
CHECK REF: 0083973044 DATE: 05/04/22 AMT: 90.00
INTERNAL BILL NO: 134805174 MSR: N1541715
CUST/EXTERNAL BILL NO: 1112966781
BR PROVIDER #: 330956713-0003

MAY 12 2022

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1H1042200020003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

MAY 09 2022

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

DATES OF SERVICE: 11/17/21-11/17/21
AUDIT DATE: 04/20/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
11/17/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

PROVIDER INQUIRIES (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B CODE
298

CHECK REFERENCE	CHECK DATE
0084044708	09/06/22
CHECK AMOUNT	BLOCK NUMBER
***$1440 00	014701

M

CLAIM NO.
CONTRACT NO WP8-65B-290306-290
DOCUMENT NO 20014836030

SEP 12 2022

OSN: MM0801090611-005188
BANK: 298
CHECK REF: 0084044708 DATE: 09/06/22 AMT: 1,440.00
INTERNAL BILL NO 134725051 MSR: N0170671
CUST/EXTERNAL BILL NO 2001483603
BR PROVIDER #: 330956713-0003

PAYEE JOYCE ALTMAN INTERPRETING
TAX ID. 33-0956713
BILL PROV JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PAID
SEP 12 2022

PROVIDER JOYCE ALTMAN INTERPRETERS INC

EMPLOYER ADP TOTALSOURCE GROUP, INC
ADDRESS 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

PATIENT ACCT. #:
SSN:
DOI 09/11/20
PATIENT

AGENCY CLAIM #(BOARD COMM #) 20210614120328744618 72
DIAG CODES. T14 90

DATES OF SERVICE: 06/15/21-11/09/21
AUDIT DATE: 09/02/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
06/15/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180.00	N/A	90 00	90 00 G1	5898
06/22/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180.00	N/A	90 00	90 00 G1	5898
06/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90 00	90 00 G1	5898
07/06/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90 00	90 00 G1	5898
07/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180 00	180.00	N/A	90.00	90.00 G1	5898
07/20/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180.00	N/A	90 00	90 00 G1	5898
08/05/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180 00	180 00	N/A	90 00	90 00 G1	5898
08/10/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180 00	180 00	N/A	90.00	90 00 G1	5898
08/17/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90.00	90.00 G1	5898
08/24/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90 00	90 00 G1	5898
08/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90.00	90 00 G1	5898
09/07/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180.00	N/A	90 00	90 00 G1	5898
09/14/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180.00	N/A	90.00	90.00 G1	5898
09/21/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180.00	N/A	90.00	90 00 G1	5898
09/28/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180 00	180 00	N/A	90.00	90 00 G1	5898
11/09/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180 00	180 00	N/A	90 00	90.00 G1	5898

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B CODE
298

CHECK REFERENCE	CHECK DATE
0084045600	09/08/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	007788

PAGE 1 OF 3

RECEIVED
SEP 13 2022
BY:

CLAIM NO.
CONTRACT NO WP8-65B-290306-290
DOCUMENT NO: 20014836030

OSN MM0301090811-000187
BANK 298
CHECK REF 0084045600 DATE: 09/08/22 AMT 90.00
INTERNAL BILL NO 134805174 MSR N0096661
CUST/EXTERNAL BILL NO 2001484963
BR PROVIDER # 330956713-0003

PAYEE. JOYCE ALTMAN INTERPRETING
TAX ID. 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

RECEIVED
SEP 12 2022
BY:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

EMPLOYER ADP TOTALSOURCE GROUP, INC
ADDRESS 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE 7ZFWNCT3

PATIENT ACCT. #:
SSN
DOI 09/11/20
PATIENT

AGENCY CLAIM #(BOARD COMM #) 20210614120328744618 72
DIAG CODES T14 90

DATES OF SERVICE: 11/17/21-11/17/21
AUDIT DATE 09/07/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
11/17/21	T1013		SIGN LANG/ORAL INTERPRETE	1 00	180.00	180 00	N/A	90 00	90 00 G1	5898

TOTAL CHARGES	180 00
TOTAL PREVIOUSLY PAID	90.00
TOTAL CURRENT PAYABLE	90 00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID	90 00

EXPLANATION CODE DESCRIPTIONS

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD (5898)

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY SIGN-UP TODAY TO

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC™

B. CODE	CHECK NUMBER	CHECK DATE
199	03422524	11/02/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 002095

OSN: EE2801110203-002652

CLAIM #:
CONTRACT #: WP8-65B-290306-290

CONTROL #: 000004112 ID: C608B14
PROVIDER #: N3095671382862

PAYEE: JOYCE ALTMAN INTERPRETERS INC

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

NOV 1 1 2022

PROVIDER:

DATE OF INJURY: 09/11/20
EMPLOYEE:

EMPLOYER: ADP TOTALSOURCE GROUP, INC
DATES OF SERVICE 06/15/21-11/17/21
LOCATION CODE: 7ZFWNCT3

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
06/15/21	11/17/21	INDEPEND		180.00	180.00	

NOTE: IBR PAYMENT STICKER #:11127859840 IBR CASE #:CB22-0001919

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81375

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000076 November 9, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 14 2022

IBR Case Number	CB22-0002098
Claim Number	
Assignment Date	09/30/2022
Claims Administrator	Liberty Mutual
Date(s) of service	11/22/2021 - 12/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	09/11/2020
Application Received	09/02/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 11/22/2021 – 12/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/14/2022. Responses received 09/26/2022 and 09/28/2022. Claims Administrator indicated payment was issued on 09/27/2022. EORs with check information was provided.
- Itemized invoices
    - 11/22/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/08/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/15/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/22/2021 – 12/15/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/22/2021 – 12/15/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- Reimbursement received in the amount of $270.00, received post IBR receipt. $180.00 IBR application fee is due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 11/22/2021 – 12/15/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083974506	05/06/22
CHECK AMOUNT ****$90.00	BLOCK NUMBER 012774

MAY 13 2022

OSN: MM0701050611-002110
BANK: 298
CHECK REF: 0083974506 DATE: 05/06/22 AMT: 90.00
INTERNAL BILL NO: 134948917 MSR: N1501088
CUST/EXTERNAL BILL NO: 1113046165
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1J1122200010003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

MAY 12 2022

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

DATES OF SERVICE: 11/22/21-11/22/21
AUDIT DATE: 05/05/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
11/22/21	T1013		SIGN LANG/ORAL INTERPRETE	2.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083978793	05/13/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	012589

OSN: MM0701051311-001921
BANK: 298
CHECK REF: 0083978793 DATE: 05/13/22 AMT: 90.00
INTERNAL BILL NO: 134890789 MSR: N1541715
CUST/EXTERNAL BILL NO: 1113058162
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 2H1152201410003

PAID
MAY 19 2022

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

MAY 19 2022

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

DATES OF SERVICE: 12/08/21-12/08/21
AUDIT DATE: 04/29/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
12/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083981435	05/18/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	008088

OSN: MM0701051811-001327
BANK: 298
CHECK REF: 0083981435 DATE: 05/18/22 AMT: 90.00
INTERNAL BILL NO: 134945021 MSR: N1524082
CUST/EXTERNAL BILL NO: 1113106068
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1I1182203060003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

RECEIVED
MAY 23 2022

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

PROVIDER: ANTONIETTA SCHULZ
JOYCE ALTMAN INTERPRETERS INC

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

PAID
MAY 24 2022

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

DATES OF SERVICE: 12/15/21-12/15/21
AUDIT DATE: 05/05/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
12/15/21	T1013		SIGN LANG/ORAL INTERPRETE	2.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0084056364	09/27/22
CHECK AMOUNT	BLOCK NUMBER
****$450.00	014224

OSN:MM0301092712-000419

M

THIS CHECK REPRESENTS A COMBINATION OF BILLED SERVICES. PLEASE REFER TO EACH DETAILED ITEMIZATION FOR SPECIFIC INFORMATION TO SUPPORT THE PAYMENT.

PATIENT ACCT. #	DATES OF SERVICE	CUST/EXTERNAL BILL #	TOTAL BILL CHARGES	TOTAL PAID
81375	11/22/21-11/22/21	2001504445	180.00	90.00
81375	11/24/21-11/24/21	2001504449	180.00	90.00
81375	11/29/21-11/29/21	2001504437	180.00	90.00
81375	12/08/21-12/08/21	2001504428	180.00	90.00
81375	12/15/21-12/15/21	2001504411	180.00	90.00

PAID
OCT 06 2022
BY: .....

TOTAL BILLS COMBINED: 5 450.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC

B. CODE	CHECK NUMBER	CHECK DATE
199	03438456	11/23/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 002000

OSN: EE2801112303-002619

CLAIM #:
CONTRACT #: WP8-65B-290306-290

CONTROL #: 000002698 ID: C608B14
PROVIDER #: N3095671395340

PAYEE: JOYCE ALTMAN INTERPRETERS

DATE OF INJURY: 09/11/20
EMPLOYEE:

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

EMPLOYER: ADP TOTALSOURCE GROUP, INC
DATES OF SERVICE 11/22/21-12/15/21
LOCATION CODE: 7ZFWNCT3

PROVIDER:

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
11/22/21	12/15/21	INDEPEND		180.00	180.00	

NOTE: IBR PV REFUND SAI 20015535600 IBR CASE #:CB22-0002098

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

PAID
NOV 2 9 2022

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81375

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000039 November 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 23 2022

IBR Case Number	CB22-0002171
Claim Number	
Assignment Date	10/06/2022
Claims Administrator	Liberty Mutual
Date(s) of service	11/29/2021 - 11/29/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	09/11/2020
Application Received	09/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/29/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/20/2022. Response received 09/28/2022. Claims Administrator indicated reimbursement was made on 09/27/2022. Copy of EOR and check information were provided.
- Itemized invoice
    - 11/29/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/29/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of $90.00, post IBR receipt. $180.00 IBR application fee is due.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/29/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083977889	05/12/22
CHECK AMOUNT	BLOCK NUMBER
*****$90.00	010639

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

PAID
MAY 18 2022

CLAIM NO.
CONTRACT NO: WP8-65B-290306-290
DOCUMENT NO: 1J1122200050003

OSN: MM0701051211-001702
BANK: 298
CHECK REF: 0083977889 DATE: 05/12/22 AMT: 90.00
INTERNAL BILL NO: 134882049 MSR: N1574495
CUST/EXTERNAL BILL NO: 1113046188
BR PROVIDER #: 330956713-0003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

RECEIVED
MAY 16 2022
BY:

PATIENT ACCT. #: 81375
SSN:
DOI: 09/11/20
PATIENT:

AGENCY CLAIM #(BOARD COMM #): 202106141203287446187 2
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC
ADDRESS: 9601 MASON AVE
CHATSWORTH, CA 91311

LOCATION CODE: 7ZFWNCT3

DATES OF SERVICE: 11/29/21-11/29/21
AUDIT DATE: 04/28/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
11/29/21	T1013		SIGN LANG/ORAL INTERPRETE	2.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	180.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	90.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	90.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)
601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742

Helmsman
Management Services LLC™

B. CODE
298

CHECK REFERENCE	CHECK DATE
0084056364	09/27/22
CHECK AMOUNT	BLOCK NUMBER
****$450.00	014224

OSN:MM0301092712-000419

M

THIS CHECK REPRESENTS A COMBINATION OF BILLED SERVICES. PLEASE REFER TO EACH DETAILED ITEMIZATION FOR SPECIFIC INFORMATION TO SUPPORT THE PAYMENT.

PATIENT ACCT. #	DATES OF SERVICE	CUST/EXTERNAL BILL #	TOTAL BILL CHARGES	TOTAL PAID
	11/22/21-11/22/21		180.00	90.00
	11/24/21-11/24/21		180.00	90.00
	11/29/21-11/29/21		180.00	90.00
	12/08/21-12/08/21		180.00	90.00
	12/15/21-12/15/21		180.00	90.00

PAID
OCT 06 2022
BY: .....

TOTAL BILLS COMBINED: 5 450.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC

B. CODE	CHECK NUMBER	CHECK DATE
199	03443143	12/02/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 002701

OSN: EE2801120203-003621

CLAIM #:
CONTRACT #: WP8-65B-290306-290

CONTROL #: 000004909 ID: CRWEA41
PROVIDER #: N3095671329784

PAYEE: JOYCE ALTMAN INTERPRETERS

DATE OF INJURY: 09/11/20
EMPLOYEE:

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

EMPLOYER: ADP TOTALSOURCE GROUP, INC
DATES OF SERVICE 11/29/21-11/29/21
LOCATION CODE: 7ZFWNCT3

PROVIDER:

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
11/29/21	11/29/21	INDEPEND		180.00	180.00	

NOTE: IBR PROVIDER REFUND SAI 11130461880 CASE #:CB22-0002171

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

PAID
DEC 08 2022

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82182

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000075 December 5, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 8 2022

IBR Case Number	CB22-0002308
Claim Number	
Assignment Date	10/21/2022
Claims Administrator	Liberty Mutual
Date(s) of service	08/31/2021 - 12/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 12
Date of Injury	12/01/2020
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 12 submitted for dates of service 08/31/2021 - 12/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/05/2022. Response received 10/13/2022. Claims Administrator indicated payment was made on 10/12/2022. Copy of EOR and check were provided.
- Itemized invoices
    - 08/31/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for initial acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 09/08/2021 Interpreting for initial physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/18/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/29/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/30/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/01/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 12/02/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/09/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/15/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 12/16/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/17/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,080.00 ($90.00 for each date of service 08/31/2021 – 12/17/2021). Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.

- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Services x 12 Overturned.**
- Reimbursement received in the amount of $540.00, post IBR receipt. $180.00 IBR application fee is due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 12.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 12
Date of Service: 08/31/2021 - 12/17/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/31/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/02/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612



B. CODE
288

CHECK REFERENCE	CHECK DATE
0033303229	05/20/22
CHECK AMOUNT	BLOCK NUMBER
***$1080.00	011927

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

RECEIVED
MAY 27 2022
BY:

OSN: MM0701052011-001261
BANK: 288
CHECK REF: 0033303229 DATE: 05/20/22 AMT: 1,080.00
INTERNAL BILL NO: 135001106 MSR: N1501078
CUST/EXTERNAL BILL NO: 1113133252
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: XWW (21) 58208407
DOCUMENT NO: 2L1222204550003

PAID
MAY 27 2022
BY:

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #:
SSN:
DOI: 12/01/20
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202106291733591919O977
DIAG CODES: T14.90

EMPLOYER: STANDRIDGE GRANITE CORPORATION
ADDRESS: 9437 SANTA FE SPRINGS RD
SANTA FE SPRINGS, CA 90670

DATES OF SERVICE: 08/31/21-12/17/21
AUDIT DATE: 05/11/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
08/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/07/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
09/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/18/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
12/02/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
12/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/30/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
12/09/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS



B. CODE
288

CHECK REFERENCE	CHECK DATE
0033461145	10/12/22
CHECK AMOUNT	BLOCK NUMBER
***$1080.00	013241

M

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO:
LIBERTY MUTUAL INSURANCE
PO BOX 7203
LONDON, KY 40742

OSN: MM0801101211-005812
BANK: 288
CHECK REF: 0033461145 DATE: 10/12/22 AMT: 1,080.00
INTERNAL BILL NO: 135001106 MSR: N0152400
CUST/EXTERNAL BILL NO: 2001521566
BR PROVIDER #: 330956713-0003

CLAIM NO.
CONTRACT NO: XWW (21) 58208407
DOCUMENT NO: 2L1222204550003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

OCT 19 2022

PATIENT ACCT. #: 82182
SSN:
DOI: 12/01/20
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202106291733591919O977
DIAG CODES: T14.90

EMPLOYER: STANDRIDGE GRANITE CORPORATION
ADDRESS: 9437 SANTA FE SPRINGS RD
SANTA FE SPRINGS, CA 90670

DATES OF SERVICE: 08/31/21-12/17/21
AUDIT DATE: 10/11/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
08/31/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
09/07/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
09/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/18/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/02/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/30/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/09/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/16/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/17/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/15/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898

TOTAL CHARGES:	2160.00
TOTAL PREVIOUSLY PAID:	1080.00
TOTAL CURRENT PAYABLE:	1080.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING. RETAIN STATEMENT FOR YOUR RECORDS

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
503-239-5800

Liberty Mutual. INSURANCE

B. CODE	CHECK NUMBER	CHECK DATE
189	05889583	12/14/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 003283

CLAIM #:
CONTRACT #: XWW (21) 58208407

OSN: EE2701121405-000500

CONTROL #: 000004672 ID: C604B05
PROVIDER #: N3095671388775

PAYEE: JOYCE ALTMAN INTERPRETING

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

PROVIDER:

PAID
DEC 21 2022

DATE OF INJURY: 12/01/20
EMPLOYEE:

EMPLOYER: STANDRIDGE GRANITE CORPORATION
DATES OF SERVICE 08/31/21-12/17/21

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
08/31/21	12/17/21	INDEPEND		180.00	180.00	

NOTE: IBR PROVIDER REFUND SAI#20015690230 IBR CASE CB22-0002308

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82789

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000060 December 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 5 2022

IBR Case Number	CB22-0002306
Claim Number	
Assignment Date	10/19/2022
Claims Administrator	Liberty Mutual
Date(s) of service	10/27/2021 - 12/08/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 6
Date of Injury	09/07/2021
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Liberty Mutual
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 6 submitted for dates of service 10/27/2021 – 12/08/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/03/2022. Response received 10/13/2022. Claims Administrator indicated payment was made on 10/12/2022. Copy of EOR and check were provided.
- Itemized invoices
    - 10/27/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 11/01/2021 Interpreting for initial chiro $180.00 (Billed at a minimum of 2 hours)
    - 11/03/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 11/15/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
    - 11/29/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 12/08/2021 Interpreting for follow up chiro $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $540.00 ($90.00 for each date of service 10/27/2021 – 12/08/2021). Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Services x 6 Overturned.**
- Reimbursement received in the amount of $540.00, post IBR receipt. $180.00 IBR application fee is due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 6.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 6
Date of Service: 10/27/2021 – 12/08/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Copy to:

Liberty Mutual
C/O CI Medical Bill Review
MailStop 2250; Attn: K. Foch
PO Box 8011
Wausau, WI 54401

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

Helmsman Management Services LLC

B. CODE
298

CHECK REFERENCE	CHECK DATE
0083982905	05/20/22
CHECK AMOUNT	BLOCK NUMBER
***$1980.00	019434

OSN:MM0701052012-000089

THIS CHECK REPRESENTS A COMBINATION OF BILLED SERVICES. PLEASE REFER TO EACH DETAILED ITEMIZATION FOR SPECIFIC INFORMATION TO SUPPORT THE PAYMENT.

PATIENT ACCT. #	DATES OF SERVICE	CUST/EXTERNAL BILL #	TOTAL BILL CHARGES	TOTAL PAID
83353	07/06/21-11/30/21	1113129705	2,700.00	1,350.00
82789	10/27/21-12/08/21	1113133278	1,080.00	540.00
81305	12/14/21-12/14/21	1113128950	180.00	90.00

RECEIVED
MAY 31 2022
BY: 82789

PAID
JUN 01 2022
BY:

TOTAL BILLS COMBINED: 3 1,980.00

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS
VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

LIBERTY MUTUAL - GAINESVILLE
P.O. BOX 7070
LONDON, KY 40742

Helmsman Management Services LLC

CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0083982905
62-20/311
38621953

B.CODE	OFFICE NUMBER	PAYMENT IDENTIFICATION
298	808	COMBINED PAYMENT

CHECK DATE 05/20/22

$ **********1,980.00

VOID IF NOT PRESENTED WITHIN 90 DAYS OF DATE OF CHECK

PAY ONE THOUSAND NINE HUNDRED EIGHTY AND 00/100 DOLLARS**********

TO THE ORDER OF
JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

⑈0083982905⑈ ⑆031100209⑆ 38621953⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
P.O. BOX 7070
LONDON, KY 40742

SEND ORIGINAL BILLS TO:
P.O. BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC

MAY 3 1 2022

BY: .....

BLOCK NUMBER
019438

OSN: MM0701052012-000093
BANK: 298
CHECK REF: 0083982905 DATE: 05/20/22 AMT: 540.00
INTERNAL BILL NO: 135000787 MSR: N1522844
CUST/EXTERNAL BILL NO: 1113133278
BR PROVIDER #: 330956713-0002

CLAIM NO.
CONTRACT NO: WP8-65B-290306-321
DOCUMENT NO: 2L1222204570002

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

PATIENT ACCT. #: 82789
SSN:
DOI: 09/07/21
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202110011206582137810 9
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC.
ADDRESS: 22541 ASPAN ST STE E
LAKE FOREST, CA 92630

LOCATION CODE: MPOWNCT3

DATES OF SERVICE: 10/27/21-12/08/21
AUDIT DATE: 05/11/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
10/27/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/03/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/15/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
11/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601
12/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	90.00	N/A	0.00	90.00	G1 5898 G1 601

TOTAL CHARGES:	1080.00
TOTAL PREVIOUSLY PAID:	0.00
TOTAL CURRENT PAYABLE:	540.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	540.00

EXPLANATION CODE DESCRIPTIONS:

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

5898 CONTESTED CHARGES MAY BE ADJUDICATED BEFORE THE WORKERS' COMPENSATION APPEALS BOARD. (5898)

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

ZC72 IN THE EVENT THIS PAYMENT NEEDS TO BE RETURNED TO THE PAYER, PLEASE RETURN THE CHECK TO PO BOX 734732, CHICAGO, IL 60673-4732. TO SUBMIT A DISPUTE OR APPEAL, PLEASE SEE THE ADDRESS IN THE UPPER LEFT HAND CORNER OF THIS EOB. (ZC72)

Z849 GO PAPERLESS. WE CAN ACCEPT ELECTRONIC BILL SUBMISSIONS AND ISSUE PAYMENTS ELECTRONICALLY. SIGN-UP TODAY TO TAKE ADVANTAGE OF THE BENEFITS OF PAPERLESS BILLING AND PAYMENTS BY VISITING WWW.JOPARI.COM OR BY CALLING 1-800-630-3060. (Z849)

Z850 MEDICAL BILLS FOR THIS CLAIM SHOULD BE SUBMITTED TO THE 'SEND BILLS TO' ADDRESS REFERENCED IN THE UPPER LEFT CORNER OF THE EOP. (Z850)

5688 TIME LIMITS TO DISPUTE PAYMENT AMOUNT REQUEST FOR SECOND REVIEW FORM: HTTP://WWW.DIR.CA.GOV/DWC/DWCPROPREGS/IBR/FORMSBR_1.PDF AFTER AN EOR IS RECEIVED ON AN ORIGINAL BILL SUBMISSION, A HEALTH CARE PROVIDER, HEALTH CARE FACILITY, OR BILLING AGENT/ASSIGNEE (HEREIN REFERRED TO AS 'PROVIDER') THAT DISPUTES THE AMOUNT PAID MAY SUBMIT AN APPEAL/RECONSIDERATION/REQUEST FOR SECOND REVIEW TO THE CLAIMS ADMINISTRATOR WITHIN 90 DAYS OF SERVICE OF THE EOR. THE REQUEST FOR SECOND REVIEW MUST CONFORM TO THE REQUIREMENTS OF THE DWC'S MEDICAL BILLING AND PAYMENT GUIDE, AND REGULATIONS AT TITLE 8, CA CODE OF

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742
SEND ORIGINAL BILLS TO:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7203
LONDON, KY 40742

Helmsman
Management Services LLC™

B CODE
298

CHECK REFERENCE	CHECK DATE
0084065614	10/12/22
CHECK AMOUNT	BLOCK NUMBER
****$540.00	013352

M

OCT 17 2022

CLAIM NO.
CONTRACT NO: WP8-65B-290306-321
DOCUMENT NO: 2L1222204570002

OSN: MM0801101211-005923
BANK: 298
CHECK REF: 0084065614 DATE: 10/12/22 AMT: 540.00
INTERNAL BILL NO: 135000787 MSR: N0152400
CUST/EXTERNAL BILL NO: 2001521559
BR PROVIDER #: 330956713-0003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

BY: .....

PATIENT ACCT. #: 82789
SSN:
DOI: 09/07/21
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 202110011206582137810 9
DIAG CODES: T14.90

EMPLOYER: ADP TOTALSOURCE GROUP, INC.
ADDRESS: 22541 ASPAN ST STE E
LAKE FOREST, CA 92630

LOCATION CODE: MPOWNCT3

DATES OF SERVICE: 10/27/21-12/08/21
AUDIT DATE: 10/11/22

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
10/27/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/01/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/03/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/15/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
11/29/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898
12/08/21	T1013		SIGN LANG/ORAL INTERPRETE	1.00	180.00	180.00	N/A	90.00	90.00 G1	5898

TOTAL CHARGES:	1080.00
TOTAL PREVIOUSLY PAID:	540.00
TOTAL CURRENT PAYABLE:	540.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	540.00

EXPLANATION CODE DESCRIPTIONS:
G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
916-564-1792

Helmsman
Management Services LLC™

B. CODE	CHECK NUMBER	CHECK DATE
199	03449878	12/12/22
	CHECK AMOUNT ****$180.00	BLOCK NUMBER 003226

OSN: EE2801121203-003822

CLAIM #:
CONTRACT #: WP8-65B-290306-321

CONTROL #: 000001016 ID: C608B14
PROVIDER #: N3095671369884

PAYEE: JOYCE ALTMAN INTERPRETERS

DATE OF INJURY: 09/07/21
EMPLOYEE:

TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

EMPLOYER: ADP TOTALSOURCE GROUP, INC.
DATES OF SERVICE 10/27/21-12/08/21
LOCATION CODE: MPOWNCT3

PROVIDER:

DATES OF SERVICE FROM	TO	SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
10/27/21	12/08/21	INDEPEND		180.00	180.00	

NOTE: IBR REFUND SAI 11131332780 CASE CB22-0002306

TOTAL CHARGES	180.00
TOTAL PAYABLE:	180.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	180.00

PAID
DEC 16 2022
BY: .....

CAREFULLY DETACH CHECK BEFORE DEPOSITING - RETAIN STATEMENT FOR YOUR RECORDS

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79170

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000039 December 2, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 5 2022

IBR Case Number	CB22-0002300
Claim Number	
Assignment Date	10/19/2022
Claims Administrator	NationWide
Date(s) of service	12/03/2021 - 12/03/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/31/2020
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: NationWide
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/03/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/03/2022. Response received 10/19/2022. Claims Administrator indicated payment was made on 10/04/2022. No EOR or check information were provided.
- Itemized invoice
    - 12/03/2021 Interpreting for P & S $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the OMFS allowance; charge has been adjusted to the schedule allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/03/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is due **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/03/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

NationWide
PO Box 182079
Columbus, OH 43218

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Nationwide®

RECEIVED
MAY 17 2022
BY: 79170

Nationwide Insurance
PO BOX 182166
COLUMBUS, OH 43218-2166
1-800-421-3535

RECEIVED
MAY 18 2022
BY:

Policy Holder: TADEMA CATTLE COMPANY
Policy Number: FPK WCN 3028551258
Contract Number:

Claim Key:
Check Number: 17955480
Check Issued: 05-13-2022 mdxservice

Below Check Covers Items Indicated

Company: NATIONWIDE AGRIBUSINESS INS NAIC

Payment of $90.00 for Workers Compensation is being paid under the Workers' Comp Medical Payments coverage.
Bill ID Number: 9574883581530000000O

Service/Wage Period Start: 12-03-2021 Service/Wage Period End: 12-03-2021
If you have questions about this check please contact Mitchell Service

Claimant Name:

13416000816017

Detach Stub Before Cashing And Keep For Your Record

G-2002-2D-0521-00

THIS IS WATERMARKED PAPER - HOLD TO LIGHT TO VERIFY WATERMARK

Nationwide Insurance
PO BOX 182166
COLUMBUS, OH 43218-2166
1-800-421-3535

Nationwide®

Check No: 17955480
Date: 05-13-2022
Void If Not Cashed Within 180 Days
Ref: 997073-GK
17955480

56-1544
441

PAY EXACTLY **NINETY AND 00/100 DOLLARS**

Pay To The Order Of JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

$*90.00*

JPMorgan Chase Bank, N.A.
Columbus, OH

Authorized Signature

⑈17955480⑈ ⑆044115443⑆ 97648523 5⑈

Nationwide®

Nationwide Insurance
PO BOX 182166
COLUMBUS, OH 43218-2166
1-800-421-3535

Policy Holder TADEMA CATTLE COMPANY
Policy Number
Contract Number

Claim Key 79170
Check Number 18490252
Check Issued 10-04-2022 terkea1

1461400456901 7

Below Check Covers Items Indicated

Company NATIONWIDE AGRIBUSINESS INS NAIC

Payment of $90 00 for Workers Compensation is being paid under the Workers' Comp Medical Payments coverage

Memo Claim 2nd payment of $90

Service/Wage Period Start 12-03-2021 Service/Wage Period End 12-03-2021
If you have questions about this check please contact Amelia TerKeurst 833-700-2461 x12063

Claimant Name

PAID
OCT 12 2022
BY

Detach Stub Before Cashing And Keep For Your Record

THIS IS WATERMARKED PAPER - HOLD TO LIGHT TO VERIFY WATERMARK

G 2002 2D 0521 00

Nationwide Insurance
PO BOX 182166
COLUMBUS, OH 43218-2166
1-800-421-3535

Nationwide®

Check No 18490252
Date 10-04-2022
Void if Not Cashed Within 180 Days
Ref 997073-GK
18490252

56-1544
441

PAY EXACTLY **NINETY AND 00/100 DOLLARS**

Pay To The Order Of JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

$*90 00*

JPMorgan Chase Bank, N A
Columbus OH

Authorized Signature

Security Features Included Details on back

⑈18490252⑈ ⑆044115443⑆ 97648523 5⑈

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81413

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000041 December 2, 2022

DEC 0 5 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002304
Claim Number	
Assignment Date	10/19/2022
Claims Administrator	Omaha National Underwriter
Date(s) of service	12/17/2021 - 12/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	12/28/2020
Application Received	09/20/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Omaha National Underwriter
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/03/2022. Response received not yet received.
- Itemized invoice
    - 12/17/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the OMFS allowance; charge was adjusted to the schedule allowance.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/17/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is due **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/17/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Omaha National Underwriter
PO Box 451139
Omaha, NE 68145

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Payee: JOYCE ALTMAN INTERPRETERS, INC.

Check Number: 114285
Check Date: 05/13/2022

WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty jail or prison, a fine, and loss of benefits.

ADVERTENCIA: Es necesario que usted le avise a su patrón o a su compañia de seguro todo dinero que usted ha ganado por trabajar, durante el tempo cubierto por éste cheque. Si usted no sigue estos reglamentos, Usted puede estar en violación de la ley el castigo podriá ser cárcel prisión, una multa, y pérdida de beneficios.

Review the enclosed supplemental document for payment detail.

PAID
MAY 18 2022
BY .....

MAY 17 2022
81413

Reorder from www.stockchecks.com #SCWLSTK9LNBY

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

114285

Omaha National Underwriters
PO Box 451139
Omaha, NE 68145

Bank of America, Illinois

Chicago, IL
2-3 / 710IL

DATE	05/13/2022
AMOUNT	$90.00

PAY TO THE ORDER OF: Ninety Dollars and 0/100 Cents

Joyce Altman Interpreters, Inc.
P.O. Box 4165
Tustin, CA, 92781

VOID IF NOT IMAGE FADES WITH HEAT

⑈114285⑈ ⑆071000039⑆ 8670215569⑈

Payee: JOYCE ALTMAN INTERPRETERS, INC.

Check Number: 143391
Check Date: 12/15/2022

1

WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty jail or prison, a fine, and loss of benefits.

ADVERTENCIA: Es necesario que usted le avise a su patrón o a su compañia de seguro todo dinero que usted ha ganado por trabajar, durante el tempo cubierto por éste cheque. Si usted no sigue estos reglamentos, Usted puede estar en violación de la ley el castigo podriá ser cárcel prisión, una multa, y pérdida de beneficios.

M

Claim Number: ON011083 Claimant: Ruiz, Raul

Payment Type	Start Date	End Date	Gross Amount	Net Amount	Reason
Translation	12/02/2022	12/02/2022	$180.00	$180.00	
Translation	12/17/2021	12/17/2021	$90.00	$90.00	

Reason Descriptions

Additional Reasons

Check Memo
81413

DEC 19 2022

PAID
DEC 21 2022

Reorder from www.stockchecks.com #SCWLSTK9LNBY

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

Omaha National Underwriters
PO Box 451139
Omaha, NE 68145

Bank of America, Illinois

Chicago, IL
2-3 / 710IL

143391

DATE	12/15/2022
AMOUNT	$270.00

PAY Two Hundred Seventy Dollars and 0/100 Cents

TO THE ORDER OF
Joyce Altman Interpreters, Inc.
PO Box 4165
Tustin, CA, 92781

RUB RED IMAGE FADES WITH HEAT

Security Features Included Details on back.

⑈143391⑈ ⑆071000039⑆ 8670215569⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80623

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000043 November 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 2 8 2022

IBR Case Number	CB22-0002188
Claim Number	
Assignment Date	10/07/2022
Claims Administrator	Pacific Comp Insurance
Date(s) of service	12/07/2021 - 12/09/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	03/02/2020
Application Received	09/12/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 12/07/2021 - 12/09/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/21/2022. Response received 10/11/2022. Claims Administrator upheld their determination.
- Itemized invoices
    - 12/07/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 12/09/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 12/07/2021 and 12/09/2021. Codes were assigned based on the available information as provider did not submit codes with the charges.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 12/07/2021 and 12/09/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 12/07/2021 – 12/09/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/07/2021** $90.00 (Market Rate for One Hour)* 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/09/2021** $90.00 (Market Rate for One Hour)* 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 255795292
DRAFT DATE 05/03/2022

PAYABLE THROUGH DRAFT Two Hundred Seventy & 00 / 100 DOLLARS

AMOUNT
**********$270.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William Bennett

⑈255795292⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022
BY:

PAID
JUL 07 2022
BY:

5/17/22 3:56 PM 3 0000023 20220615 SF5IR202 BW-ENV2 2 oz DOM SF5IR20000 158568 CN

Date of Service	POS	Rev.	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/3/21	99		00014	120	180.00	180.00	0.00	0.00	0.00	402, 224, A76, A90
			Billed units: 0.0000							
12/8/21	99		00014	120	180.00	180.00	0.00	0.00	0.00	402, 224, A76, A90
			Billed units: 0.0000							
			Totals:		360.00	360.00	0.00	0.00	0.00	

See NOTE-005

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889177	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	04/28/2022
		Bill Review #:	CPI-PCCA-35794	**Date of Injury:**	03/02/2020
		Jurisdiction:	CA	**Date Reviewed:**	04/30/2022
D.O.B:		**Adjuster:**	jquinn	**ProviderBill Date:**	04/20/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220429CPIPCIC72736	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	80623	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-006282-01-08302020			**PPO Subnet:**	
Employer:	Seafood House Inc				
Employer Address:	18329 S Pioneer Blvd Artesia CA 90701			**Bill Frequency Type:**	1
Diagnosis Codes:	T1490XA				

RECEIVED JUN 27 2022

PAID JUL 07 2022

BY: .....

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/7/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-004

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters, Inc P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889186	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-35859
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	jquinn
SSN:		**Network:**	
Bill Control #:	220220429CPIPCIC72570	**PPO/MPN ID:**	
		Patient Acct #:	80623
		Payment Method:	Check
Employer ID:	WA-006282-01-08302020		
Employer:	Seafood House Inc		
Employer Address:	18329 S Pioneer Blvd Artesia CA 90701		

Date Received:	04/28/2022
Date of Injury:	03/02/2020
Date Reviewed:	04/30/2022
ProviderBill Date:	04/21/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	01
Payment Status Desc:	Paid
PPO Subnet:	
Bill Frequency Type:	1

JUN 27 2022 JUL 07 2022

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/9/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-004

2-2

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889187	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-35860
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	kvaughn
SSN:		**Network:**	
Bill Control #:	220220429CPIPCIC72572	**PPO/MPN ID:**	
		Patient Acct #:	81631
		Payment Method:	
Employer ID:	WA-006282-01-08302020		
Employer:	TSAI Investment Group Inc		
Employer Address:	3521 Hamner Ave Norco CA 92860		

Date Received:	04/28/2022
Date of Injury:	01/02/2021
Date Reviewed:	05/02/2022
ProviderBill Date:	04/21/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	04
Payment Status Desc:	Denied
PPO Subnet:	
Bill Frequency Type:	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/14/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A76, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-004

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889188	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.	278011758
DRAFT DATE	12/09/2022

PAYABLE THROUGH DRAFT Eight Hundred Ten & 00 / 100 DOLLARS

AMOUNT
**********$810.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William Brimmer

⑈278011758⑈ ⑆044115126⑆ 0166950861 2⑈

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/7/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
				Totals:	180.00	0.00	0.00	90.00	90.00	

M

See NOTE-001

Statement Summary	Charged	Reductions	Net Payment Amount
	1,620.00	810.00	810.00

Are you struggling with receiving check payments in a timely manner? Interested in receiving payments and submitting ebills more expediently? These challenging times clearly demonstrate an immediate need for our industry to transition to electronic billing and payment methods. **Jopari Solutions is here to help!** If you would like to obtain information about enrolling in electronic billing, Virtual Card, or EFT payment receipt, please contact Jopari Solutions at 1-800-630-3060, via email at Support@Jopari.com, or visit: www.Jopari.com. Reduce your payment turnaround time - Enroll Today.

Comments:

NOTE-001 Unless otherwise noted, all reductions are in accordance with the medical or med-legal fee schedule as per the rules and regulations authorized by California Labor Code including but not limited to 4600.4, 4603.2, 4620 - 4628, 5307.1, or 8 CCR 9790 - 9794. TIME LIMITS TO DISPUTE PAYMENT AMOUNT Request for Second Review (SBR): After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee that disputes the amount paid may submit an appeal/reconsideration/Request for SBR to the claims administrator within 90 days of service of the explanation of review. The Request for SBR must conform to the requirements of the Division of Workers Compensation Medical Billing and Payment Guide, and regulations at CA Code of Regulations, Title 8 sections 9792.5.4 et seq. If the only dispute is the amount of payment and the health care provider, health care facility, or billing agent/assignee does not request a SBR within 90 days of the service of the explanation of review, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment. Request for Independent Bill Review (IBR): After a health care provider, health care facility, or billing agent/assignee submits a Request for SBR, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, for dates of service January 1, 2013 or after, a health care provider, health care facility, or billing agent/assignee that still disputes the amount paid may submit a request for IBR within 30 days of service of the EOR. The Request for IBR must conform to the requirements of CA Code of Regulations, Title 8 section 9792.5.4 et seq. If the health care provider, health care facility, or billing agent/assignee fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

Reason Code Cross Reference:

State	BR	CARC:RARCs
	@PRV	B13
G2	402	P12:N448
G4	B02	45
G1	B50	P12

Explanation of Codes:

Code	Description
G1	THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G2	THE OFFICIAL MEDICAL FEE SCHEDULE DOES NOT LIST THIS CODE. AN ALLOWANCE HAS BEEN MADE FOR A COMPARABLE SERVICE.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

Bill Review Reduction Codes:

BR	Description
@PRV	Prior Allowance
402	PLEASE NOTE THAT CODES WERE ASSIGNED BASED ON THE AVAILABLE INFORMATION AS THE PROVIDER DID NOT SUBMIT CODES WITH THE CHARGES.5307
B02	THIS AMOUNT HAS BEEN AGREED ON ACCORDING TO DIRECT NEGOTIATION BETWEEN THE PROVIDER AND THE ADJUSTER.
B50	ADDITIONAL PAYMENT RECOMMENDED ON APPEAL/RECONSIDERATION

VOID VOID VOID

CopperPoint Insurance Companies

3030 North 3rd Street
Phoenix Arizona 85012-3039

Check Code MED

Remittance Statement

Claim Number:	
Claimant:	
Date of Injury:	03/02/2020
Period Covered:	12/07/21 to 12/09/21
Benefit Type:	IBR CASE #CB22-0002188 FILE FEE

Check Date:	12/08/2022
Check Number:	350166136
Check Amount:	$180.00

PAID
DEC 13 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80623

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000074 December 8, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 12 2022

IBR Case Number	CB22-0002389
Claim Number	
Assignment Date	10/27/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	12/22/2021 - 12/22/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	03/02/2020
Application Received	09/23/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/22/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/11/2022. Response received 11/02/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 12/22/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Please note that codes were assigned based on the available information as the provider did not submit codes with the charges.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/22/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is due. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/22/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance Company
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

VOID VOID VOID

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions Fee Sched	Reductions PPO	Reductions Other	Paid	Explanation Codes
12/22/21	99		00014	1	180.00	90.00	0.00	0.00	90.00	402
			Billed units: 120.0000							
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6116114011	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/16/2022
		Bill Review #:	CPI-PCCA-45193	**Date of Injury:**	03/13/2021
		Jurisdiction:	CA	**Date Reviewed:**	05/17/2022
D.O.B:		**Adjuster:**	aramirez	**ProviderBill Date:**	05/05/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220516CPIPCIC73028	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81301	**Payment Status Code:**	04
		Payment Method:		**Payment Status Desc:**	Denied
Employer ID:	WA-004043-01-01012019			**PPO Subnet:**	
Employer:	Hart Food Products (A Corp)				
Employer Address:	14905 Paramount Blvd Paramount CA 90723			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions Fee Sched	Reductions PPO	Reductions Other	Paid	Explanation Codes
12/22/21	99		00014	1	180.00	90.00	0.00	90.00	0.00	402, A76
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6116114013	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc

DRAFT NO.	279191771
DRAFT DATE	12/21/2022

PAYABLE THROUGH DRAFT Ninety & 00 / 100 DOLLARS

AMOUNT
**********$90.00

VOID AFTER 215 DAYS

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

William A Grimaldi

⑈279191771⑈ ⑆044115126⑆ 0166950861 2⑈

M

RECEIVED
JAN 09 2023

RECEIVED
JAN 09 2023

12/9/22 3 20 PM 3 0005272 20221222 SL979102 BW-ENV1 1 oz DOM SL97910000 158566 CN

Electronic Payment Clearinghouse
CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

CopperPoint Insurance Companies

12/9/22 3 20 PM 3 0005272 20221222 SL979102 BW-ENV1 1 oz DOM SL97910000* 158568 CN

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

JAN 0 3 2023

Your name, Joyce Altman Interpreters Inc, and Tax ID have been verified by the IRS.

Tax ID: 330956713 *Payee ID:* abccPrd:37806 *EPC Draft #:* 279191771 *Payment Date:* 12/21/2022

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118940784	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/14/2022
		Bill Review #:	CPI-PCCA-156249	**Date of Injury:**	03/02/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/20/2022
D.O.B:		**Adjuster:**	jquinn	**ProviderBill Date:**	12/14/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221214CPIPCIC88814	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-98162	**Patient Acct #:**	80623	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-003655-02-09012019			**PPO Subnet:**	
Employer:	Seafood House Inc				
Employer Address:	18329 S Pioneer Blvd Artesia CA 90701			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/22/21	99		T1013	1	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

Statement Summary	Charged	Reductions	Net Payment Amount
	180.00	90.00	90.00

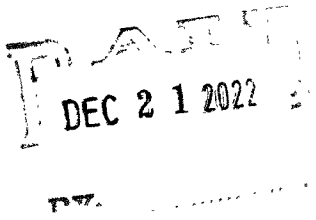
CopperPoint Insurance Companies

3030 North 3rd Street
Phoenix Arizona 85012-3039

Check Code MED

Remittance Statement

Claim Number:			
Claimant:		Check Date:	12/14/2022
Date of Injury:	06/19/2020	Check Number:	350167785
Period Covered:	12/22/21 to 12/22/21	Check Amount:	$180.00
Benefit Type:	IBR CASE #CB22-0002389 FILE FEE		



MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81292

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000053 December 14, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 19 2022

IBR Case Number	CB22-0002247
Claim Number	
Assignment Date	10/18/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	11/09/2021 - 11/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 3
Date of Injury	06/19/2020
Application Received	09/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 3 submitted for dates of service 11/09/2021 – 11/30/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/30/2022. Response received 10/24/2022. Claims Administrator upheld their determination.
- Itemized invoices
    - 11/09/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/12/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/30/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/09/2021 – 11/30/2021. Please note codes were assigned based on the available information as the provider did not submit codes with the charges.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/09/2021 – 11/30/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 11/09/2021 – 11/30/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance Company
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CHECK PAGE HAS A COLORED BACKGROUND ON WHITE PAPER

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 254023735
DRAFT DATE 04/14/2022

PAYABLE THROUGH DRAFT Two Hundred Seventy & 00 / 100 DOLLARS

AMOUNT
**********$270.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William Grimmick

⑈254023735⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022
BY:

PAID
JUL 07 2022
BY:

Claimant:

D.O.B:
SSN:
Bill Control #: 220220412CPIPCIC72369

Claim Number:
Bill Review #: CPI-PCCA-24483
Jurisdiction: CA
Adjuster: ims
Network:
PPO/MPN ID:
Patient Acct #: 81292
Payment Method: Check

Date Received: 04/12/2022
Date of Injury: 06/19/2020
Date Reviewed: 04/12/2022
ProviderBill Date: 03/29/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 01
Payment Status Desc: Paid
PPO Subnet:

Employer ID: WA-004939-02-08252020
Employer: Giant Inland EmpireRV Center Inc
Employer Address: 9150 Benson Ave Montclair CA 91763

RECEIVED JUN 27 2022

PAID JUL 07 2022

Bill Frequency Type: 1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
11/9/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115628471
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:

D.O.B:
SSN:
Bill Control #: 220220412CPIPCIC72367

Claim Number:
Bill Review #: CPI-PCCA-24488
Jurisdiction: CA
Adjuster: kgruner
Network:
PPO/MPN ID:
Patient Acct #: 80988
Payment Method:

Date Received: 04/12/2022
Date of Injury: 06/19/2019
Date Reviewed: 04/13/2022
ProviderBill Date: 03/31/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 04
Payment Status Desc: Denied
PPO Subnet:

Employer ID: WA-004939-02-08252020
Employer: Bar Bakers LLC
Employer Address: 10711 Bloomfield St Los Alamitos CA 90720

Bill Frequency Type: 1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
11/11/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115628473
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

CHECK PAGE HAS A COLORED BACKGROUND OR WHITE PAPER

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 254110693
DRAFT DATE 04/15/2022

PAYABLE THROUGH DRAFT Ninety & 00 / 100 DOLLARS

AMOUNT
**********$90.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William R Grimmick

⑈254110693⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022
BY: .....

PAID
JUL 07 2022
BY: .....

5/17/22 3:56 PM 3 0000016 20220615 SF5IR202 BW-ENV2 2 oz DOM SF5IR20000 158568 CN

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions Fee Sched	PPO	Other	Paid	Explanation Codes
11/17/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A90
			Billed units: 0.0000							
				Totals:	180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115649692
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:
D.O.B:
SSN:
Bill Control #: 220220414CPIPCIC71055
Employer ID: WA-004043-01-01012019
Employer: Giant Inland EmpireRV Center Inc
Employer Address: 9150 Benson Ave
Montclair CA 91763

Claim Number:
Bill Review #: CPI-PCCA-25798
Jurisdiction: CA
Adjuster: ims
Network:
PPO/MPN ID:
Patient Acct #: 81292
Payment Method: Check

Date Received: 04/13/2022
Date of Injury: 06/19/2020
Date Reviewed: 04/14/2022
ProviderBill Date: 04/05/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 01
Payment Status Desc: Paid
PPO Subnet:
Bill Frequency Type: 1

Diagnosis Codes: T1490XA

RECEIVED JUN 27 2022 BY:

FAXED JUL 07 2022

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions Fee Sched	PPO	Other	Paid	Explanation Codes
11/12/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
				Totals:	180.00	90.00	0.00	0.00	90.00	

See NOTE-001

1-16

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115649693
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:
D.O.B:
SSN:
Bill Control #: 220220414CPIPCIC71049
Employer ID: WA-004043-01-01012019
Employer: Manna Development Group LLC
Employer Address: 2211 Encinitas Blvd
Encinitas CA 92024

Claim Number:
Bill Review #: CPI-PCCA-25809
Jurisdiction: CA
Adjuster: jslagel
Network:
PPO/MPN ID:
Patient Acct #: 80732
Payment Method:

Date Received: 04/13/2022
Date of Injury: 11/22/2019
Date Reviewed: 04/14/2022
ProviderBill Date: 04/05/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 04
Payment Status Desc: Denied
PPO Subnet:
Bill Frequency Type: 1

Diagnosis Codes: T1490XA

CHECK FACE HAS A COLORED BACKGROUND ON WHITE PAPER

VOID VOID VOID

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/29/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A76, A81, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115833405
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:
D.O.B:
SSN:
Bill Control #: 220220423CPIPCIC72975
Employer ID: WA-001309-05-03012020
Employer: Giant Inland EmpireRV Center Inc
Employer Address: 9150 Benson Ave
Montclair CA 91763

Claim Number:
Bill Review #: CPI-PCCA-32408
Jurisdiction: CA
Adjuster: ims
Network:
PPO/MPN ID:
Patient Acct #: 81292
Payment Method: Check

Date Received: 04/23/2022
Date of Injury: 06/19/2020
Date Reviewed: 04/26/2022
ProviderBill Date: 04/15/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 01
Payment Status Desc: Paid
PPO Subnet:
Bill Frequency Type: 1

RECEIVED JUN 27 2022

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/30/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

1-2

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6115833408
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PAID JUL 07 2022

PROVIDER BILL DETAIL:

Claimant:
D.O.B:
SSN:
Bill Control #: 220220423CPIPCIC72981
Employer ID: WA-001309-05-03012020
Employer: Los Angeles Motor Cars Inc
Employer Address: 2025 S Figueroa St
Los Angeles CA 90007

Claim Number:
Bill Review #: CPI-PCCA-32418
Jurisdiction: CA
Adjuster: jahn
Network:
PPO/MPN ID:
Patient Acct #: 81027
Payment Method:

Date Received: 04/23/2022
Date of Injury: 12/31/2020
Date Reviewed: 04/29/2022
ProviderBill Date: 04/14/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 04
Payment Status Desc: Denied
PPO Subnet:
Bill Frequency Type: 1

Diagnosis Codes: T1490XA

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 279759472
DRAFT DATE 12/28/2022

PAYABLE THROUGH DRAFT One Thousand Two Hundred Sixty & 00 / 100 DOLLARS

AMOUNT
**********$1,260.00

VOID AFTER 215 DAYS

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

William A Rimpied

⑈279759472⑈ ⑆044115126⑆ 0166950866 12⑈

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6119025203	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/15/2022
		Bill Review #:	CPI-PCCA-156268	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/15/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	12/15/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220727CPIPCIC60350	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-85527	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

M

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/30/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6119025204	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

4-12

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/15/2022
		Bill Review #:	CPI-PCCA-156269	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/15/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	12/15/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220720CPIPCIC61951	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-81798	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

M

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/12/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

3-12

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6119025205	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/15/2022
		Bill Review #:	CPI-PCCA-156270	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/22/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	07/13/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221221CPIPCIC88802	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-81800	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/9/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6119025206	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/15/2022
		Bill Review #:	CPI-PCCA-156271	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/15/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	12/15/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220629CPIPCIC74444	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-70487	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/31/22	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

CopperPoint Insurance Companies
3030 North 3rd Street
Phoenix Arizona 85012-3039

Check Code MED

Remittance Statement

Claim Number:
Claimant:
Date of Injury: 06/19/2020
Period Covered: 11/09/21 to 11/09/21
Benefit Type: Independent Bill Review Fees CB22-0002247

Check Date: 12/21/2022
Check Number: 350169204
Check Amount: $180.00

PAID
DEC 30 2022
BY.

THE FACE OF THIS CHECK IS PRINTED BLUE • THE FORM CONTAINS A TRUE WATERMARK

CopperPoint Insurance Companies
3030 North 3rd Street
Phoenix Arizona 85012-3039

JPMorgan Chase Bank N.A.
Phoenix, AZ

350169204
12/21/2022

91-2 / 1221

VOID after six months

One hundred eighty and 00/100 Dollars

AMOUNT
$**180.00**

Pay To The Order Of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 927814165

Authorized Signature

⑈0350169204⑈ ⑆122100024⑆ 0307000⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81292

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000085 December 8, 2022

DEC 12 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002386
Claim Number	
Assignment Date	10/27/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	12/17/2021 - 01/11/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	06/19/2020
Application Received	09/23/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 12/17/2021 – 01/11/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/11/2022. Response received 11/01/2022. Claims Administrator upheld their determination.
- Itemized invoices
    - 12/17/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 01/07/2022 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 01/11/2022 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 12/17/2021, 01/07/2022 and 01/11/2022. Please note that codes were assigned based on the available information as the provider did not submit codes with the charges; workers compensation fee schedule adjustment.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 12/17/2021, 01/07/2022 and 01/11/2022 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is due. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 12/17/2021 – 01/11/2022
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/07/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/11/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance Company
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1513/441
Westerville OH 43081

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 256193390
DRAFT DATE 05/06/2022

PAYABLE THROUGH DRAFT Four Hundred Fifty & 00 / 100 DOLLARS

AMOUNT
**********$450.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William A Trimmer

⑈256193390⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022

PAID
JUL 07 2022

BY: .....

5/17/22 3:56 PM 3 0000001 20220615 SF5IR303 BW-ENV3 3 oz DOM SF5IR30000 158568 CN

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950347	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:	Felipe Dominguez Montoya 15529 S White Ave Compton CA 90221	**Claim Number:**	PC00088423	**Date Received:**	05/04/2022
		Bill Review #:	CPI-PCCA-38588	**Date of Injury:**	06/01/2021
		Jurisdiction:	CA	**Date Reviewed:**	05/05/2022
D.O.B:	05/30/1966	**Adjuster:**	vdesai	**ProviderBill Date:**	04/27/2022
SSN:	XXX-XX-8036	**Network:**		**Bill Type:**	PROF
Bill Control #:	220220504CPIPCIC72024	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	82608	**Payment Status Code:**	04
		Payment Method:		**Payment Status Desc:**	Denied
Employer ID:	WA-004043-01-01012019			**PPO Subnet:**	
Employer:	Hilty's Electric-California Inc				
Employer Address:	15 Peters Canyon Irvine CA 92606			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/14/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A81
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950398	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:	Estella Hernandez 2125 Saturn Ave Apt 1 Huntington Park CA 90255	**Claim Number:**	PC00088034	**Date Received:**	05/04/2022
		Bill Review #:	CPI-PCCA-38706	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	05/05/2022
D.O.B:	01/31/1964	**Adjuster:**	ims	**ProviderBill Date:**	04/26/2022
SSN:	XXX-XX-9109	**Network:**		**Bill Type:**	PROF
Bill Control #:	220220504CPIPCIC72120	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81392	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-004043-01-01012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

PAID
JUL 07 2022

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/17/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

3-3

VOID VOID VOID

Electronic Payment Clearinghouse
CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

RECEIVED
JUN 27 2022

BY: .....

CopperPoint Insurance Companies

5/17/22 3:56 PM 3 0000032 20220615 SF5IR202 BW-ENV2 2 oz DOM SF5IR20000* 158568 CN

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

PAID
JUN 30 2022

BY: .....

Your name, Joyce Altman Interpreters Inc, and Tax ID have been verified by the IRS.

Tax ID: *330956713* ***Payee ID:*** *abccPrd:37806* ***EPC Draft #:*** *259136293* ***Payment Date:*** *06/07/2022* *Page 1 of 12*

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6116378329	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/26/2022
		Bill Review #:	CPI-PCCA-51578	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	05/27/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	05/17/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220527CPIPCIC70527	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/7/22	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6116378333	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/26/2022
		Bill Review #:	CPI-PCCA-51694	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	06/01/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	05/18/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220527CPIPCIC70615	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/11/22	99		00014	1	180.00	90.00	0.00	0.00	90.00	790-4
			Billed units: 120.0000							
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:** **Billing Provider Address:**	Joyce Altman Interpreters Inc PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6116378335	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/26/2022
		Bill Review #:	CPI-PCCA-51732	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	06/06/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	05/18/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220527CPIPCIC71602	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81292	**Payment Status Code:**	04
		Payment Method:		**Payment Status Desc:**	Denied
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.	279383741
DRAFT DATE	12/22/2022

PAYABLE THROUGH DRAFT Two Hundred Seventy & 00 / 100 DOLLARS

AMOUNT
**********$270.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William A Trimmer

⑈279383741⑈ ⑆044115126⑆ 0166950861 2⑈

PAID
JAN 10 2023

BY. .....

12/9/22 3 20 PM 3 0004578 20221223 SL9MU102 BW-ENV1 1 oz DOM SL9MU10000 158568 CN

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500		
Check Number:	6118957667	**Billing Provider NPI:**	
Payor ID:		**Provider State License # :**	
Payee ID:	abccPrd:37806	**Rendering Provider:**	Joyce Altman Interpreters
		Rendering Provider NPI:	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/12/2022
		Bill Review #:	CPI-PCCA-155395	**Date of Injury:**	06/01/2021
D.O.B:		**Jurisdiction:**	CA	**Date Reviewed:**	12/21/2022
SSN:		**Adjuster:**	vdesai	**ProviderBill Date:**	12/02/2022
Bill Control #:	220221212CPIPCIC70259	**Network:**		**Bill Type:**	PROF
		PPO/MPN ID:		**Payment Type:**	MED
		Patient Acct #:	82608	**Payment Status Code:**	04
Employer ID:	WA-007085-00-08012020	**Payment Method:**		**Payment Status Desc:**	Denied
Employer:	Hilty's Electric-California Inc			**PPO Subnet:**	
Employer Address:	15 Peters Canyon Irvine CA 92606			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/21/22	99		T1013	120	180.00	90.00	0.00	90.00	0.00	402, A81
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-002

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500		
Check Number:	6118957713	**Billing Provider NPI:**	
Payor ID:		**Provider State License # :**	
Payee ID:	abccPrd:37806	**Rendering Provider:**	Joyce Altman Interpreters
		Rendering Provider NPI:	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/14/2022
		Bill Review #:	CPI-PCCA-156034	**Date of Injury:**	06/19/2020
D.O.B:		**Jurisdiction:**	CA	**Date Reviewed:**	12/15/2022
SSN:		**Adjuster:**	ims	**ProviderBill Date:**	12/14/2022
Bill Control #:	220221214CPIPCIC88811	**Network:**		**Bill Type:**	PROF
Original Bill Review #:	CPI-PCCA-102591	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81292	**Payment Status Code:**	01
Employer ID:	WA-000927-05-09012019	**Payment Method:**	Check	**Payment Status Desc:**	Paid
Employer:	Giant Inland EmpireRV Center Inc			**PPO Subnet:**	
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

JAN 0 6 2023

RV.

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/7/22	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-002

1-3

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118957750	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/14/2022
		Bill Review #:	CPI-PCCA-156245	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/15/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	05/18/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221214CPIPCIC8ee12	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-51694	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763		JAN 0 6 2023	**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/11/22	99		T1013	1	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-002

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118957751	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

2-3

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/14/2022
		Bill Review #:	CPI-PCCA-156246	**Date of Injury:**	06/19/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/20/2022
D.O.B:		**Adjuster:**	ims	**ProviderBill Date:**	04/26/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221214CPIPCIC88813	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-90596	**Patient Acct #:**	81292	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-000927-05-09012019			**PPO Subnet:**	
Employer:	Giant Inland EmpireRV Center Inc				
Employer Address:	9150 Benson Ave Montclair CA 91763			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/17/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-002

3-3

CopperPoint Insurance Companies

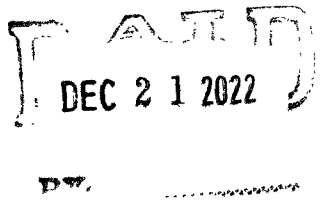
Check Code MED

3030 North 3rd Street
Phoenix Arizona 85012-3039

Remittance Statement

Claim Number:
Claimant:
Date of Injury: 06/19/2020
Period Covered: 12/17/21 to 01/11/22
Benefit Type: IBR CASE #CB22-0002386 FILE FEE

Check Date: 12/14/2022
Check Number: 350167784
Check Amount: $180.00



MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81653

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000080 November 30, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 9 2 2022

IBR Case Number	CB22-0002242
Claim Number	
Assignment Date	10/14/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	11/30/2021 - 12/09/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	06/08/2021
Application Received	09/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 11/30/2021 – 12/09/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/28/2022. Response received 10/19/2021. Claims Administrator provided copies of post IBR EORs reflecting an additional allowance for each service date 11/30/2021 -12/09/2021. No check information was provided.
- Itemized invoice
  - 11/30/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
  - 12/07/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
  - 12/09/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/30/2021 – 12/09/2021. Codes were assigned based on the available information as the provider did not submit codes with the charges.
- **CCR § 9795.3. Fees for Interpreter Services.**
  - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
    - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
    - A medical treatment appointment;
  - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
    2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/30/2021 – 12/09/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 11/30/2021 – 12/09/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance Company
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 255795292
DRAFT DATE 05/03/2022

PAYABLE THROUGH DRAFT Two Hundred Seventy & 00 / 100 DOLLARS

AMOUNT
**********$270.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William A Trimpol

⑈255795292⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022
BY: .....

PAID
JUL 07 2022
BY: .....

5/17/22 3:56 PM 3 0000023 20220615 SF5IR202 BW-ENV2 2 oz DOM SF5IR20000 158568 CN

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-35862
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	srosan
SSN:		**Network:**	
Bill Control #:	220220429CPIPCIC72573	**PPO/MPN ID:**	
		Patient Acct #:	81653
		Payment Method:	Check
Employer ID:	WA-006282-01-08302020		
Employer:	Shigeta America Inc		
Employer Address:	17840 S Western Ave Gardena CA 90248		

RECEIVED JUN 27 2022

PAID JUL 07 2022

Date Received:	04/28/2022		
Date of Injury:	06/08/2021		
Date Reviewed:	04/30/2022		
ProviderBill Date:	04/21/2022		
Bill Type:	PROF		
Payment Type:	MED		
Payment Status Code:	01		
Payment Status Desc:	Paid		
PPO Subnet:			
Bill Frequency Type:	1		

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
11/30/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-004

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889223	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-35930
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	kvaughn
SSN:		**Network:**	
Bill Control #:	220220430CPIPCIC72756	**PPO/MPN ID:**	
		Patient Acct #:	81631
		Payment Method:	
Employer ID:	WA-006282-01-08302020		
Employer:	TSAI Investment Group Inc		
Employer Address:	3521 Hamner Ave Norco CA 92860		

Date Received:	04/28/2022		
Date of Injury:	01/02/2021		
Date Reviewed:	05/02/2022		
ProviderBill Date:	04/21/2022		
Bill Type:	PROF		
Payment Type:	MED		
Payment Status Code:	04		
Payment Status Desc:	Denied		
PPO Subnet:			
Bill Frequency Type:	1		

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
12/14/21	99		00014	120	180.00	180.00	0.00	0.00	0.00	402, 224, A76, A90
			Billed units: 0.0000							
			Totals:		180.00	180.00	0.00	0.00	0.00	

See NOTE-006

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115889224	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

CHECK PAGE HAS A COLORED BACKGROUND ON WHITE PAPER

VOID VOID VOID

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950234	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/03/2022
		Bill Review #:	CPI-PCCA-37746	**Date of Injury:**	11/22/2019
		Jurisdiction:	CA	**Date Reviewed:**	05/05/2022
D.O.B:		**Adjuster:**	jslagel	**ProviderBill Date:**	04/22/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220504CPIPCIC70363	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	80732	**Payment Status Code:**	04
		Payment Method:		**Payment Status Desc:**	Denied
Employer ID:	WA-004043-01-01012019			**PPO Subnet:**	
Employer:	Manna Development Group LLC				
Employer Address:	2211 Encinitas Blvd Encinitas CA 92024			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/7/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950235	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	05/03/2022
		Bill Review #:	CPI-PCCA-37747	**Date of Injury:**	06/08/2021
		Jurisdiction:	CA	**Date Reviewed:**	05/04/2022
D.O.B:		**Adjuster:**	srosan	**ProviderBill Date:**	04/22/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220504CPIPCIC70364	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	81653	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-004043-01-01012019			**PPO Subnet:**	
Employer:	Shigeta America Inc				
Employer Address:	17840 S Western Ave Gardena CA 90248			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

JUN 27 2022 JUL 07 2022 BY:

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/7/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

1-2 →

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-38715
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	jlopez
SSN:		**Network:**	
Bill Control #:	220220504CPIPCIC72119	**PPO/MPN ID:**	
		Patient Acct #:	79533
		Payment Method:	
Employer ID:	WA-004043-01-01012019		
Employer:	Spectrum BSA Inc		
Employer Address:	4431 Corporate Center Dr Los Alamitos CA 90720		

Date Received:	05/04/2022
Date of Injury:	08/01/2020
Date Reviewed:	05/05/2022
ProviderBill Date:	04/26/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	04
Payment Status Desc:	Denied
PPO Subnet:	
Bill Frequency Type:	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
12/17/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	402, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-001

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950404	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-38716
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	srosan
SSN:		**Network:**	
Bill Control #:	220220504CPIPCIC72118	**PPO/MPN ID:**	
		Patient Acct #:	81653
		Payment Method:	Check
Employer ID:	WA-004043-01-01012019		
Employer:	Shigeta America Inc		
Employer Address:	17840 S Western Ave Gardena CA 90248		

Date Received:	05/04/2022
Date of Injury:	06/08/2021
Date Reviewed:	05/05/2022
ProviderBill Date:	04/26/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	01
Payment Status Desc:	Paid
PPO Subnet:	
Bill Frequency Type:	1

RECEIVED JUN 27 2022

AJD JUL 07 2022

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
12/9/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	402
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

2-2

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters, Inc
		Billing Provider Address:	P.O. Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115950405	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	DC 33095671300	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc

DRAFT NO. 277904757
DRAFT DATE 12/08/2022

PAYABLE THROUGH DRAFT Seven Hundred Twenty & 00 / 100 DOLLARS

AMOUNT
**********$720.00

VOID AFTER 215 DAYS

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

William A Brimmer

⑈277904757⑈ ⑆044115126⑆ 0166950861 2⑈

DEC 20 2022

Electronic Payment Clearinghouse
CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

CopperPoint Insurance Companies

12/9/22 12 28 PM 3 0000049 20221209 SL3YR203 BW-ENV2 2 oz DOM SL3YR20000* 158568 CN

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

DEC 2 0 2022

Your name, Joyce Altman Interpreters Inc, and Tax ID have been verified by the IRS.

Tax ID: 330956713 *Payee ID:* abccPrd:37806 *EPC Draft #:* 277904757 *Payment Date:* 12/08/2022 Page 1 of 11

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118771216	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/05/2022
		Bill Review #:	CPI-PCCA-151322	**Date of Injury:**	06/08/2021
		Jurisdiction:	CA	**Date Reviewed:**	12/07/2022
D.O.B:		**Adjuster:**	srosan	**ProviderBill Date:**	04/21/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221205CPIPCIC88805	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-92606	**Patient Acct #:**	81653	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-004691-02-07032020			**PPO Subnet:**	
Employer:	Shigeta America Inc				
Employer Address:	17840 S Western Ave Gardena CA 90248			**Bill Frequency Type:**	1

FAX DEC 2 0 2022 BY

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/30/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

FAX DEC 2 1 2022 BY

1-2

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118771217	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/06/2022
		Bill Review #:	CPI-PCCA-151323	**Date of Injury:**	06/08/2021
		Jurisdiction:	CA	**Date Reviewed:**	12/07/2022
D.O.B:		**Adjuster:**	srosan	**ProviderBill Date:**	04/22/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220813CPIPCIC63994	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-92605	**Patient Acct #:**	81653	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-004691-02-07032020			**PPO Subnet:**	
Employer:	Shigeta America Inc				
Employer Address:	17840 S Western Ave Gardena CA 90248			**Bill Frequency Type:**	1

Diagnosis Codes: T1490

DEC 2 0 2022

BY:

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/7/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-001

m

2-7

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118771330	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters Inc
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/05/2022
		Bill Review #:	CPI-PCCA-151836	**Date of Injury:**	02/26/2022
		Jurisdiction:	CA	**Date Reviewed:**	12/07/2022
D.O.B:		**Adjuster:**	jquinn	**ProviderBill Date:**	11/29/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221205CPIPCIC62004	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-107389	**Patient Acct #:**	84056	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-007526-00-09122021			**PPO Subnet:**	
Employer:	Mr D's Placentia Inc				
Employer Address:	919 Foothill Blvd La Verne CA 91750			**Bill Frequency Type:**	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
7/21/22	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B02, @PRV
8/8/22	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B02, @PRV
			Totals:		360.00	0.00	0.00	180.00	180.00	

See NOTE-001

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 272760569
DRAFT DATE 10/20/2022

PAYABLE THROUGH DRAFT Four Hundred Fifty & 00 / 100 DOLLARS

AMOUNT
**********$450.00

VOID AFTER 215 DAYS

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

⑈272760569⑈ ⑆044115126⑆ 0166950861 2⑈

10/21/22 9 10 AM 3 0000009 20221021 SJ7G5304 BW-ENV3 3 oz DOM SJ7G530000 158568 CN

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-126707
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	srosan
SSN:		**Network:**	
Bill Control #:	220221014CPIPCIC70643	**PPO/MPN ID:**	
Original Bill Review #:	CPI-PCCA-92607	**Patient Acct #:**	81653
		Payment Method:	Check
Employer ID:	WA-004691-02-07032020		
Employer:	Shigeta America Inc		
Employer Address:	17840 S Western Ave Gardena CA 90248		

Date Received:	10/12/2022
Date of Injury:	06/08/2021
Date Reviewed:	10/19/2022
ProviderBill Date:	08/03/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	01
Payment Status Desc:	Paid
PPO Subnet:	
Bill Frequency Type:	1

M

RECEIVED OCT 31 2022

Diagnosis Codes: T1490XA

BY:

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
12/9/21	99		00014	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
			Totals:		180.00	0.00	0.00	90.00	90.00	

See NOTE-002

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118141660	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

1-1

PAID NOV 02 2022

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**	
		Bill Review #:	CPI-PCCA-127264
		Jurisdiction:	CA
D.O.B:		**Adjuster:**	lwooden
SSN:		**Network:**	
Bill Control #:	220221015CPIPCIC71530	**PPO/MPN ID:**	
		Patient Acct #:	80586
		Payment Method:	
Employer ID:	WA-006974-00-05052020		
Employer:	EM Thomas Management Inc		
Employer Address:	177 Business Center Dr Corona CA 92880		

Date Received:	10/14/2022
Date of Injury:	06/04/2020
Date Reviewed:	10/20/2022
ProviderBill Date:	10/07/2022
Bill Type:	PROF
Payment Type:	MED
Payment Status Code:	04
Payment Status Desc:	Denied
PPO Subnet:	
Bill Frequency Type:	1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	PPO	Other	Paid	Explanation Codes
4/14/21	99		00014	120	180.00	180.00	0.00	0.00	0.00	402, 224
			Billed units: 0.0000							
			Totals:		180.00	180.00	0.00	0.00	0.00	

See NOTE-003

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6118141769	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

CopperPoint Insurance Companies

Check Code MED

3030 North 3rd Street
Phoenix Arizona 85012-3039

Remittance Statement

Claim Number:			
Claimant:		Check Date:	12/05/2022
Date of Injury.	06/08/2021	Check Number:	350165355
Period Covered:	11/30/21 to 12/09/21	Check Amount:	$180.00
Benefit Type:	CB22-0002242 FILE FEE		

RECD
DEC 13 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82412

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000066 December 14, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 19 2022

IBR Case Number	CB22-0002478
Claim Number	
Assignment Date	10/31/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	09/23/2021 - 12/01/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 6
Date of Injury	10/15/2020
Application Received	09/30/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $540.00 in additional reimbursement for a total of $720.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$720.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 6 submitted for dates of service 09/23/2021 – 12/01/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/13/2022. Response received 10/31/2022. Claims Administrator upheld their determination.
- Itemized invoices
    - 09/23/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 10/22/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/11/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/19/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/24/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/01/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $540.00 ($90.00 for each date of service 09/23/2021 – 12/01/2021). Workers compensation fee schedule adjustment.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, and market rate examples; additional reimbursement is indicated. **Interpreter Service x 6 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 6.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 6
Date of Service: 09/23/2021 – 12/01/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/23/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

VOID BY VOID

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 257475726
DRAFT DATE 05/19/2022

PAYABLE THROUGH DRAFT Five Hundred Forty & 00 / 100 DOLLARS

AMOUNT
**********$540.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William Grimsid

⑈257475726⑈ ⑆044115126⑆ 0166950861 2⑈

RECEIVED
JUN 27 2022
BY: .....

PAID
JUL 07 2022
BY: .....

5/17/22 3:56 PM 3 0000002 20220615 SFSIR404 BWLFMV4.4.nz DOM SFSIR40000 158568 CN

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
4/14/21	99		00014	120	180.00	90.00	0.00	90.00	0.00	790-4, A90
			Billed units: 0.0000							
			Totals:		180.00	90.00	0.00	90.00	0.00	

See NOTE-014

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6116132236
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:
D.O.B:
SSN:
Bill Control #: 220220518CPIPCIC71212

Claim Number:
Bill Review #: CPI-PCCA-46167
Jurisdiction: CA
Adjuster: nloban
Network:
PPO/MPN ID:
Patient Acct #: 82412
Payment Method: Check

Date Received: 05/18/2022
Date of Injury: 10/15/2020
Date Reviewed: 05/18/2022
ProviderBill Date: 05/09/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 01
Payment Status Desc: Paid
PPO Subnet:

Employer ID: WA-004331-01-04102019
Employer: Jam Benitez Restaurants Inc
Employer Address: 10246-A Indiana Ave
Riverside CA 92503

RECEIVED JUN 27 2022

PAID JUL 07 2022

Bill Frequency Type: 1

Diagnosis Codes: T1490

DX:

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
9/23/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
10/22/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
11/11/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
11/19/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
11/24/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
12/1/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-4
			Totals:		1,080.00	540.00	0.00	0.00	540.00	

See NOTE-014

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6116132238
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK
Westerville OH 43081

56-1512
441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 280068901
DRAFT DATE 12/30/2022

PAYABLE THROUGH DRAFT Two Thousand Five Hundred Forty & 00 / 100 DOLLARS

AMOUNT
**********$2,540.00

VOID AFTER 215 DAYS

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

William A Trimmer

⑈280068901⑈ ⑆044115126⑆ 0166950861 2⑈

PAID
JAN 11 2023

BY .....

Electronic Payment Clearinghouse
CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

JAN 1 1 2023
PV.

CopperPoint Insurance Companies

12/9/22 3:20 PM 3 0000050 20221231 SLC71208 BW-ENV2 2 oz DOM SLC7120000* 158568 CN

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Your name, Joyce Altman Interpreters Inc, and Tax ID have been verified by the IRS.

Tax ID: 330956713 *Payee ID:* abccPrd:37806 *EPC Draft #:* 280068901 *Payment Date:* 12/30/2022 Page 1 of 12

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6119056858	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	12/22/2022
		Bill Review #:	CPI-PCCA-159624	**Date of Injury:**	10/15/2020
		Jurisdiction:	CA	**Date Reviewed:**	12/22/2022
D.O.B:		**Adjuster:**	cdtorres	**ProviderBill Date:**	12/14/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220221221CPIPCIC88804	**PPO/MPN ID:**		**Payment Type:**	MED
Original Bill Review #:	CPI-PCCA-101126	**Patient Acct #:**	82412	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-006299-01-09012020			**PPO Subnet:**	
Employer:	Jam Benitez Restaurants Inc				
Employer Address:	10246-A Indiana Ave Riverside CA 92503			**Bill Frequency Type:**	1

PAID JAN 1 1 2023 PV.

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
12/1/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PRV
11/11/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PI
11/19/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PI
11/24/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PI
9/23/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
10/22/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, @PRV
				Totals:	1,080.00	0.00	0.00	540.00	540.00	

See NOTE-001

CopperPoint Insurance Companies
3030 North 3rd Street
Phoenix Arizona 85012-3039

Check Code MED

Remittance Statement

Claim Number:
Claimant:
Date of Injury: 10/15/2020
Period Covered: 09/23/21 to 12/01/21
Benefit Type: Independent Bill Review Fees CB22-002478

Check Date: 12/21/2022
Check Number: 350169142
Check Amount: $180.00

THE FACE OF THIS CHECK IS PRINTED BLUE • THE FORM CONTAINS A TRUE WATERMARK

CopperPoint Insurance Companies
3030 North 3rd Street
Phoenix Arizona 85012-3039

JPMorgan Chase Bank N.A.
Phoenix, AZ

350169142
12/21/2022

91-2 / 1221

One hundred eighty and 00/100 Dollars

VOID after six months

AMOUNT
$****180.00

Pay To The Order Of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 927814165

Authorized Signature

⑈0350169142⑈ ⑆122210000⑆

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82608

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000031 December 01, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 5 2022

IBR Case Number	CB22-0002248
Claim Number	
Assignment Date	10/18/2022
Claims Administrator	Pacific Comp Insurance Company
Date(s) of service	11/10/2021 - 11/10/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	06/01/2021
Application Received	09/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Pacific Comp Insurance Company
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/10/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/30/2022. Response received 10/24/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 11/10/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Workers compensation fee schedule adjustment.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/10/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/10/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Pacific Comp Insurance Company
PO Box 5042
Thousand Oaks, CA 91359

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

VOID BY VOID BY VOID BY

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO. 254241981
DRAFT DATE 04/18/2022

PAYABLE THROUGH DRAFT One Hundred Eighty & 00 / 100 DOLLARS

AMOUNT
**********$180.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William R Timmick

⑈254241981⑈ ⑆044115126⑆ 016695086121⑈

RECEIVED
JUN 27 2022

PAID
JUL 07 2022

BY. .....

Electronic Payment Clearinghouse
CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

RECEIVED
JUN 27 2022
BY:

CopperPoint Insurance Companies

5/17/22 3:56 PM 3 0000017 20220615 SF5IR202 BW-ENV2 2 oz DOM SF5IR20000* 158568 CN

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Your name, Joyce Altman Interpreters Inc, and Tax ID have been verified by the IRS.

Tax ID: 330956713 *Payee ID:* abccPrd:37806 *EPC Draft #:* 254241981 *Payment Date:* 04/18/2022 Page 1 of 12

Payor:	PacificComp Insurance Company 3011 Townsgate Road Suites 120 Westlake Village CA 91361	**Billing Provider:**	Joyce Altman Interpreters Inc
		Billing Provider Address:	PO Box 4165 Tustin CA 92781
Payor Contact #:	8663788500	**Billing Provider NPI:**	
Check Number:	6115666535	**Provider State License # :**	
Payor ID:		**Rendering Provider:**	Joyce Altman Interpreters
Payee ID:	abccPrd:37806	**Rendering Provider NPI:**	

PROVIDER BILL DETAIL:

Claimant:		**Claim Number:**		**Date Received:**	04/11/2022
		Bill Review #:	CPI-PCCA-24095	**Date of Injury:**	06/01/2021
		Jurisdiction:	CA	**Date Reviewed:**	04/12/2022
D.O.B:		**Adjuster:**	vdesai	**ProviderBill Date:**	03/30/2022
SSN:		**Network:**		**Bill Type:**	PROF
Bill Control #:	220220411CPIPCIC74758	**PPO/MPN ID:**		**Payment Type:**	MED
		Patient Acct #:	82608	**Payment Status Code:**	01
		Payment Method:	Check	**Payment Status Desc:**	Paid
Employer ID:	WA-007085-00-08012020			**PPO Subnet:**	
Employer:	Hilty's Electric-California Inc				
Employer Address:	15 Peters Canyon Irvine CA 92606			**Bill Frequency Type:**	1

RECEIVED JUL 07 2022 PAID

RECEIVED JUN 27 2022 BY:

Diagnosis Codes: T1490

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/10/21	99		00014	120	180.00	90.00	0.00	0.00	90.00	790-3
			Totals:		180.00	90.00	0.00	0.00	90.00	

See NOTE-001

L-1

CopperPoint Insurance Company
PacificComp Insurance Company
3030 N 3rd St
Phoenix AZ 85012

HUNTINGTON NATIONAL BANK 56-1512
Westerville OH 43081 441

Electronic Payment Clearinghouse
Echo Health, Inc

DRAFT NO.	278481725
DRAFT DATE	12/14/2022

PAYABLE THROUGH DRAFT Ninety & 00 / 100 DOLLARS

AMOUNT
**********$90.00

TO THE ORDER OF Joyce Altman Interpreters Inc
PO Box 4165

Tustin CA 92781

VOID AFTER 215 DAYS

William A Brimmick

⑈278481725⑈ ⑆044115126⑆ 0166950861 2⑈

DEC 2 3 2022

12/9/22 3 20 PM 3 0006951 20221215 SL6FD102 BW-ENV1 1 oz DOM SL6FD10000 158568 CN

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
1/21/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
1/23/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
1/24/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
1/9/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
1/13/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
1/15/20	99		T1013	120	180.00	90.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
3/23/20	99		T1013	120	150.00	60.00	0.00	90.00	0.00	790-4, A75, A76
			Billed units: 0.0000							
				Totals:	1,230.00	600.00	0.00	630.00	0.00	

See NOTE-001

Payor: PacificComp Insurance Company
3011 Townsgate Road
Suites 120
Westlake Village CA 91361
Payor Contact #: 8663788500
Check Number: 6118845838
Payor ID:
Payee ID: abccPrd:37806

Billing Provider: Joyce Altman Interpreters Inc
Billing Provider Address: PO Box 4165
Tustin CA 92781
Billing Provider NPI:
Provider State License # :
Rendering Provider: Joyce Altman Interpreters
Rendering Provider NPI:

PROVIDER BILL DETAIL:

Claimant:

D.O.B:
SSN:
Bill Control #: 220221209CPIPCIC88801
Original Bill Review #: CPI-PCCA-84973
Employer ID: WA-007085-00-08012020
Employer: Hilty's Electric-California Inc
Employer Address: 15 Peters Canyon
Irvine CA 92606

Claim Number:
Bill Review #: CPI-PCCA-153178
Jurisdiction: CA
Adjuster: vdesai
Network:
PPO/MPN ID:
Patient Acct #: 82608
Payment Method: Check

DEC 2 3 2022

Date Received: 12/09/2022
Date of Injury: 06/01/2021
Date Reviewed: 12/13/2022
ProviderBill Date: 03/30/2022
Bill Type: PROF
Payment Type: MED
Payment Status Code: 01
Payment Status Desc: Paid
PPO Subnet:

Bill Frequency Type: 1

Diagnosis Codes: T1490XA

Date of Service	POS	Rev	Procedure Modifiers	Qty	Charged	Reductions: Fee Sched	Reductions: PPO	Reductions: Other	Paid	Explanation Codes
11/10/21	99		T1013	120	180.00	0.00	0.00	90.00	90.00	402, B50, @PRV
				Totals:	180.00	0.00	0.00	90.00	90.00	

See NOTE-002

m

Statement Summary	Charged	Reductions	Net Payment Amount
	1,410.00	1,320.00	90.00

CopperPoint Insurance Companies

3030 North 3rd Street
Phoenix Arizona 85012-3039

Check Code MED

Remittance Statement

Claim Number:
Claimant:
Date of Injury: 06/01/2021
Period Covered: 11/10/21 to 11/10/21
Benefit Type: IBR FILE FEE; IBR CASE # CB22-0002248

Check Date: 12/09/2022
Check Number: 350166625
Check Amount: $180.00

PAID
DEC 19 2022

THE FACE OF THIS CHECK IS PRINTED BLUE • THE FORM CONTAINS A TRUE WATERMARK

CopperPoint Insurance Companies

3030 North 3rd Street
Phoenix Arizona 85012-3039

JPMorgan Chase Bank N.A.
Phoenix, AZ

350166625
12/09/2022

91-2 / 1221

VOID after six months

One hundred eighty and 00/100 Dollars

AMOUNT
$**180.00**

Pay To The Order Of
Joyce Altman Interpreters Inc
PO Box 4165
Tustin, CA 927814165

Authorized Signature

MF

⑈0350166625⑈ ⑆122100024⑆ 939206988⑈

77667

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 13 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000070 January 10, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0001833
Claim Number	
Assignment Date	11/22/2021
Claims Administrator	State Compensation Insurance Fund (SCIF)
Date(s) of service •	08/03/2020 - 09/18/2020
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	11/08/2018
Application Received	08/12/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: State Compensation Insurance Fund (SCIF)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 08/03/2020 – 09/18/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/17/2021. Response received 09/01/2021. Claims Administrator upheld their determination.
- Itemized invoices
    - 08/03/2020 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 09/18/2020 Interpreting for P&S $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 08/03/2020 and 09/18/2020 with the rationale: unless documentation has been provided for physician face-to-face time, reimbursement has been made for 2 hour minimum. Documented time in excess of 2 hours has been reimbursed at $11.25 for each additional 15 minutes.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 08/03/2020 and 09/18/2020 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 08/03/2020 – 09/18/2020
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/03/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/18/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

State Compensation Insurance Fund (SCIF)
C/O Todd Wright
2175 Shasta View Dr.
Redding, CA 96003

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338
http://www.statefundca.com/

Provider Number: XXXXX6713

Check #: **CU-495261**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 04/26/21
Doc #: 036310413

77667

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Charges	Amount Reduced	Reduction Codes	PPO Savings	Allowances
Patient Name:					**Claim #:**		**Date of Injury:**	11/08/18	
Employer name: RIVERA PAINTING PLUS					Employer ID: 0000009221176170				
MPN NAME: State Fund MPN					MPN ID: 3136				
ICD-10 Code:T14.90 INJURY, UNSPECIFIED									
1	SF1-SFCA-21496945	08/03/20	0999Q2	Interpreter Treatm	180.00	90.00	A01 G5 710	.00	90.00
-				Reviewed As Q00016					
				Sub-Totals:		180.00	90.00		90.00
				Adjustment:		-180.00	-180.00		.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
2	SF1-SFCA-21497015	09/18/20	0999Q2	Interpreter Treatm	180.00	90.00	A01 G5 710	.00	90.00
-				Reviewed As Q00016					
				Sub-Totals:		180.00	90.00		90.00
				Adjustment:		-180.00	-180.00		.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
				Total Allowances:					**$180.00**

APR 29 2021

APR 29 2021

BY: .....

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

0139692203631041300l 2

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338
http://www.statefundca.com/

Provider Number: XXXXX6713

Check #: **CU-517975**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 01/20/22
Doc #: 037027430

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Charges	Amount Reduced	Reduction Codes	PPO Savings	Allowances
	Patient Name:				**Claim #:**		**Date of Injury:**	11/08/18	
	Employer name: RIVERA PAINTING PLUS				Employer ID: 0000009221176170				
	MPN NAME: State Fund MPN				MPN ID: 3136				
	ICD-10 Code:T14.90	INJURY, UNSPECIFIED							
1	SF1-SFCA-22027583	08/03/20	0999Q2	Interpreter Treatm	180.00	.00	A01 G67 723	.00	180.00
-				Reviewed As Q00016					
2	SF1-SFCA-22027583	09/18/20	Q00016	Interpreter Treatm	180.00	180.00	710 788 A01 G5	.00	.00
				Sub-Totals:		360.00	180.00		180.00
				Adjustment:		-360.00	-270.00		-90.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
3	SF1-SFCA-22027600	09/18/20	0999Q2	Interpreter Treatm	180.00	.00	A01 G67 723	.00	180.00
-				Reviewed As Q00016					
				Sub-Totals:		180.00	.00		180.00
				Adjustment:		-180.00	-90.00		-90.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
							Total Allowances:		**$180.00**

Additional Amount Due Per Our Review: $90.00

PAID
JAN 25 2022
BY: .....

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

0130679103702743000 1 2

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338
http://www.statefundca.com/

Provider Number: XXXXX6713

Check #: **CU-518039**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 01/21/22
Doc #: 037030659

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Charges	Amount Reduced	Reduction Codes	PPO Savings	Allowances
	Patient Name:				**Claim #:**		**Date of Injury:**	11/08/18	
	Employer name: RIVERA PAINTING PLUS				Employer ID: 0000009221176170				
	MPN NAME: State Fund MPN				MPN ID: 3136				
1	SF1-SPCA-599005	08/03/20	999L1	General Loss Exp C	180.00	.00		.00	180.00
2	SF1-SPCA-599005	09/18/20	999L1	General Loss Exp C	.00	.00	G5 375	.00	.00
						Total Allowances:			**$180.00**

RECD
JAN 26 2022
BY: .....

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

0130684803703065900 1 2

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79149

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000088 June 9, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUN 13 2022

IBR Case Number	CB21-0003150
Claim Number	
Assignment Date	05/03/2022
Claims Administrator	State Compensation Insurance Fund (SCIF)
Date(s) of service	05/05/2021 - 05/05/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/31/2019
Application Received	12/23/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: State Compensation Insurance Fund (SCIF)
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/05/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/03/2022. Response received 01/18/2022. Claims Administrator upheld their determination.
- Itemized invoice
    - 05/05/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Unless documentation has been provided for physician face-to-face time, reimbursement has been made for 2 hour minimum; documented time in excess of 2 hours has been reimbursed at $11.25 for each additional 15 minutes.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/05/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/05/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

State Compensation Insurance Fund (SCIF)
C/O Todd Wright
2175 Shasta View Dr.
Redding, CA 96003

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338
http://www.statefundca.com/

Provider Number: XXXXX6713

Check #: **CP-098071**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 09/13/21
Doc #: 036683083

79149

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Charges	Amount Reduced	Reduction Codes	PPO Savings	Allowances
		Patient Name:			**Claim #:**		**Date of Injury:**	05/31/19	
	Employer name: D I G			Employer ID: 0000009055938180					
	MPN NAME: State Fund MPN			MPN ID: 3136					
	ICD-10 Code:T14.90 INJURY, UNSPECIFIED								
1	SF1-SFCA-21772838	05/05/21	0999Q2	Interpreter Treatm	180.00	90.00	G5 710	.00	90.00
	-			Reviewed As Q00016					
				Sub-Totals:		180.00	90.00		90.00
				Adjustment:		-180.00	-180.00		.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
							Total Allowances:		**$90.00**

FAXED
SEP 15 2021
BY: .....

RECEIVED
SEP 15 2021
BY: .....

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

Explanation of Review (EOR)

State Compensation Insurance Fund
PO BOX 65005
Fresno, CA 93650-5005
Questions & Appeals : (888)782-8338
http://www.statefundca.com/

Provider Number: XXXXX6713

Check #: **CP-116303**

JOYCE ALTMAN INTERPRETERS INC
Po Box 4165
Tustin CA 92781

Issue Date: 06/27/22
Doc #: 037434322

Medical

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Charges	Amount Reduced	Reduction Codes	PPO Savings	Allowances
	Patient Name:				**Claim #:**		**Date of Injury:**	05/31/19	
	Employer name: D I G			Employer ID: 0000009055938180					
	MPN NAME: State Fund MPN			MPN ID: 3136					
	ICD-10 Code:T14.90 INJURY, UNSPECIFIED								
1	SF1-SFCA-22313074	05/05/21	0999Q2	Interpreter Treatm	180.00	.00	A01	.00	180.00
-				Reviewed As Q00016					
				Sub-Totals:		180.00	.00		180.00
				Adjustment:		-180.00	-90.00		-90.00
				Adj-Totals:		.00	-90.00		90.00
								Subtotal:	**90.00**
	Patient Name: Gomez, Bertin				**Claim #:**	06560736	**Date of Injury:**	05/31/19	
SSN: XXX-XX-0006	Employer name: D I G			Employer ID: 0000009055938180					
	MPN NAME: State Fund MPN			MPN ID: 3136					
2	SF1-SPCA-626930	05/05/21	999L1	General Loss Exp C	180.00	.00	G5 375	.00	180.00
						Total Allowances:			**$270.00**

PAID
JUL 01 2022
BY: .....

Please refer to the last page(s) of EOR for an explanation of reduction codes and reviewer comments.

To ensure prompt payment of your bills, use the claim number shown above and the injured name on all future correspondence.
Please detach and retain the statement page(s) as your record of payment. THANK YOU.

"GO GREEN! Ebilling is an efficient way to submit bills that also expedites payment. Visit: www.statefundca.com/provider/ElectronicMedicalBilling.asp"

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77410

333

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000019 January 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 2 5 2022

IBR Case Number	CB21-0002143
Claim Number	
Assignment Date	12/01/2021
Claims Administrator	Sedgwick Claims
Date(s) of service	03/17/2021 – 03/17/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services
Date of Injury	09/12/2019
Application Received	09/10/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Sedgwick Claims
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 03/17/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/15/2021. Response not yet received.
- Itemized Invoice
    - 03/17/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 03/17/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 03/17/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Sedgwick Claims
PO Box 975
Sun Prairie, WI 53590

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Sedgwick Claims Management Services, Inc
P.O. Box 975
Sun Prairie, WI 53590-0975

DATE	CHECK AMOUNT	CHECK NUMBER
05/24/2021	90.00	113678543
PAYEE		TAX ID
JOYCE ALTMAN INTERPR		*****6713
SCMS UNIT		PAGE
281 Sedgwick Claims Management Services, Inc		01 of 01

0003431-0010429 0106 001 302798

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

77410

Claimant Name		Loss Date	Claim Number
		09/12/2019	
Amt Paid: 90.00	Description:	Interpreter	
Amt Billed: 180.00	Invoice:	5320210514029394	ICN:6224-1220620
Dates: 03/17/2021 - 03/17/2021	Comment:		

RECEIVED
MAY 28 2021
BY: .....

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

Sedgwick Claims Management Services, Inc
P.O. Box 975
Sun Prairie, WI 53590-0975

DATE	CHECK AMOUNT	CHECK NUMBER
03/02/2022	180.00	120354217
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
281 Sedgwick Claims Management Services, Inc		01 of 01

0002939-0011041 0106 001 393072

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

MAR 0 8 2022

Claimant Name		Loss Date		Claim Number
		09/12/2019		
Amt Paid:	180.00	Description:	Interpreter	
Amt Billed:	180.00	Invoice:	30193803767001	ICN:301938037670001
Dates:	03/17/2021 - 03/17/2021	Comment:	IBR reimb cb21-0002143	

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

77410

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000025 January 25, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 3 1 2022

IBR Case Number	CB21-0002688
Claim Number	
Assignment Date	12/02/2021
Claims Administrator	Sedgwick Claims
Date(s) of service	04/13/2021 - 04/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	09/12/2019
Application Received	10/29/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Sedgwick Claims
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 04/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/16/2021. Response not yet received.
- Itemized invoice
    - 04/13/2021 Interpreting for physio therapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 04/13/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 04/13/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Sedgwick Claims
PO Box 975
Sun Prairie, WI 53590

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Sedgwick Claims Management Services, Inc
P.O. Box 975
Sun Prairie, WI 53590-0975

0006702-0020979 0106 001 312519 SWK

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

DATE	CHECK AMOUNT	CHECK NUMBER
06/21/2021	270.00	113686421
PAYEE		TAX ID
JOYCE ALTMAN INTERPR		*****6713
SCMS UNIT		PAGE
281 Sedgwick Claims Management Services, Inc		01 of 01

PAID
JUN 28 2021

BY: .....

Claimant Name			Loss Date	Claim Number
			09/12/2019	
Amt Paid:	90.00	Description:	Interpreter	
Amt Billed:	180.00	Invoice:	5320210614026799	ICN:6224-1229832
Dates:	04/19/2021 - 04/19/2021	Comment:		
			09/12/2019	
Amt Paid:	90.00	Description:	Interpreter	
Amt Billed:	180.00	Invoice:	5320210614026965	ICN:6224-1229831
Dates:	04/22/2021 - 04/22/2021	Comment:		
			09/12/2019	
Amt Paid:	90.00	Description:	Interpreter	
Amt Billed:	180.00	Invoice:	5320210614026680	ICN:6224-1229837
Dates:	04/13/2021 - 04/13/2021	Comment:		

RECEIVED
JUN 2 5 2021

BY: .....

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

M

Sedgwick Claims Management Services, Inc
P.O. Box 975
Sun Prairie, WI 53590-0975

0004305-0016507 0106 001 385933 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
02/11/2022	270.00	120348137
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
281 Sedgwick Claims Management Services, Inc		01 of 01

PAID
FEB 16 2022
BY: .....

Claimant Name		Loss Date	Claim Number
		09/12/2019	
Amt Paid: 270.00	Description:	Interpreter	
Amt Billed: 270.00	Invoice:	1	ICN:301938037670001
Dates: 04/13/2021 - 04/13/2021	Comment:	IMR decision 1/25/2022	

SWK:RM:SDM:00:NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

77699

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000053 April 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

APR 2 5 2022

IBR Case Number	CB21-0002384
Claim Number	
Assignment Date	03/22/2022
Claims Administrator	Sedgwick Claims
Date(s) of service	09/18/2020 - 09/18/2020
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	06/14/2019
Application Received	10/01/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Sedgwick Claims
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for date of service 09/18/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/04/2022. Response not yet received.
- Itemized Invoices
    - 09/18/2020 Interpreting follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceeds the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/18/2020 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 09/18/2020
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Sedgwick Claims
PO Box 14447
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Sedgwick Claims Management Services, Inc
P O Box 14440
Lexington, KY 40512-4440

DATE	CHECK AMOUNT	CHECK NUMBER
05/03/2021	90.00	123211191
PAYEE		TAX ID
JOYCE ALTMAN INTERPR		*****6713
SCMS UNIT		PAGE
528 Sedgwick Claims Management Services, Inc		01 of 01

0000009-0000187 0716 001 990182

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

RECEIVED
MAY 06 2021
BY: .....

Claimant Name		Loss Date	Claim Number
		06/14/2019	
Amt Paid: 90.00	Description:	Interpreter	
Amt Billed: 180.00	Invoice:	5320201022027110	ICN:6361-18912
Dates: 09/18/2020 - 09/18/2020	Comment:		

RECEIVED
MAY 0[illegible] 2021
BY: .....

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

M

Sedgwick Claims Management Services, Inc
P O Box 14440
Lexington, KY 40512-4440

DATE	CHECK AMOUNT	CHECK NUMBER
05/16/2022	90.00	129391801

PAYEE	TAX ID
JOYCE ALTMAN INTERPR	*****6713

SCMS UNIT	PAGE
528 Sedgwick Claims Management Services, Inc	01 of 01

0000704-0001725 0106 001 415634

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781

Claimant Name	Loss Date	Claim Number
	06/14/2019	
Amt Paid: 90.00	Description: Interpreter	
Amt Billed: 0.00	Invoice:	ICN:6361-9910624
Dates: 09/18/2020 - 09/18/2020	Comment:	

PAID
MAY 18 2022
BY: .....

MAY 18 2022

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

Sedgwick Claims Management Services, Inc
P O Box 14440
Lexington, KY 40512-4440

0000510-0002005 0106 001 414294 SWK

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

DATE	CHECK AMOUNT	CHECK NUMBER
05/10/2022	180.00	127270594
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
528 Sedgwick Claims Management Services, Inc		01 of 01

Claimant Name		Loss Date	Claim Number
		06/14/2019	
Amt Paid:	180.00	Description: Application Fee	
Amt Billed:	180.00	Invoice: ICN 63619910624	ICN:301928541790001
Dates:	09/18/2020 - 09/18/2020	Comment: IBR Number: CB21-0002384	

PAID
MAY 16 2022
BY: .....

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

78167

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000052 February 11, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 14 2022

IBR Case Number	CB21-0002923
Claim Number	
Assignment Date	12/28/2021
Claims Administrator	Sedgwick Claims
Date(s) of service	05/13/2021 - 05/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	03/20/2020
Application Received	11/24/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: Sedgwick Claims
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/09/2021. Response not yet received.
- Itemized invoice
    - 05/13/2021 Interpreting for Shockwave Therapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/13/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/13/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 hours = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

Sedgwick Claims
PO Box 14421
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Sedgwick Claims Management Services, Inc
P O BOX 14421
Lexington, KY 40512-4421

0000306-0001287 0106 001 322989 SWK

JOYCE ALTMAN INTERPR
PO BOX 4165
TUSTIN CA 92781-4165

DATE	CHECK AMOUNT	CHECK NUMBER
07/23/2021	90.00	100069092
PAYEE		TAX ID
JOYCE ALTMAN INTERPR		*****6713
SCMS UNIT		PAGE
213 Sedgwick Claims Management Services Inc.		01 of 01

Claimant Name		Loss Date	Claim Number
		03/20/2020	
Amt Paid: 90.00	Description:	Interpreter	
Amt Billed: 180.00	Invoice:	5320210712031256	ICN:1639-707218
Dates: 05/13/2021 - 05/13/2021	Comment:		

JUL 28 2021

78167

RECEIVED

JUL 28

BY: .....

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

M

Sedgwick Claims Management Services, Inc
P O BOX 14421
Lexington, KY 40512-4421

0001433-0005181 0106 001 390967 SWK

DATE	CHECK AMOUNT	CHECK NUMBER
02/23/2022	90.00	111943434
PAYEE		TAX ID
JOYCE ALTMAN INTERPRETERS		*****6713
SCMS UNIT		PAGE
213 Sedgwick Claims Management Services Inc.		01 of 01

JOYCE ALTMAN INTERPRETERS
P.O. BOX 4165
TUSTIN CA 92781

Claimant Name		Loss Date	Claim Number
		03/20/2020	
Amt Paid: 90.00	Description:	Interpreter	
Amt Billed: 90.00	Invoice:	N/A	ICN:CA200838360001
Dates: 05/13/2021 - 05/13/2021	Comment:		

MAR 0 2 2022

SWK.RM.SDM.00.NP

For additional information about this payment or other bills, visit us at https://viaoneselfservice.sedgwickcms.net/User/Login

74055

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 24 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000051 January 19, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002632
Claim Number	
Assignment Date	11/29/2021
Claims Administrator	The Hartford
Date(s) of service	05/04/2021 - 05/04/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/22/2018
Application Received	10/22/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/04/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/09/2021. Response not yet received.
- Itemized invoice
    - 05/04/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/04/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/04/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

000189 1/4

MB 01 000189 66407 H 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

FEB 09 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133433311 4

Issue Date: 02/03/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133433311⑈ ⑆044115443⑆ 63255973⑧

RE-EVALUATION
Process Date: 02/02/2022
Re-Evaluation Control Number: 901663662
Original Control Number: 216825682
EOR Page 1 of 3
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 74055 Geo Zip: 91790
Provider License: 99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 02/02/2022
Packet Control Number: 8213061000474

000189 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/04/21	11	T1013		SIGN LANGUAGE/(	2.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY PAIN MANAGEMENT
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 74055 Geo Zip: 91790
Provider License: 99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 02/02/2022
Packet Control Number: 8213061000474

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

Employer Name: UNIVERSAL MOLDING EXTRUS, Employer ID: 20WN S38001, Employer Address: 9151 Imperial Hwy, Downey, CA 90242

Payer Name: Property and Casualty Insurance Company of Hartford, Payer Address: 501 Pennsylvania Parkway Ste. 400 Indianapolis, IN 46280, Payer ID Number: 061276326

Claimant Address: 5619 Quinn St Apt 1 Bell Gardens, CA 90201, Claimant D.O.B.: 11/09/1953

Payment Information: Payment Status Code: , Payment Date: 02/02/2022

TIME LIMITS TO DISPUTE PAYMENT AMOUNT
REQUEST FOR SECOND REVIEW
After an EOR is received on an original bill submission, a health care provider, health care facility, or billing agent/assignee (herein referred to as 'Provider') that disputes the amount paid may submit an appeal/reconsideration/Request for Second Review to the claims administrator within 90 days of service of the EOR. The Request for Second Review must conform to the requirements of the DWC's Medical Billing and Payment Guide, and regulations at Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the dispute is the amount of payment and the Provider does not request a second review within 90 days of the service of the EOR, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

REQUEST FOR INDEPENDENT BILL REVIEW
After the Provider submits a Request for Second Review, the claims administrator will review the bill and issue an EOR which is the final written determination by the claims administrator on the bill. After the EOR is received on the second bill review submission, the Provider that still disputes the amount paid may submit a request for independent bill review (IBR) within 30 days of service of the EOR. The Request for IBR must conform to the requirements of Title 8, CA Code of Regulations, section 9792.5.4 et seq. If the Provider fails to request an IBR within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for IBR, and the time limit for requesting IBR shall not begin to run until the resolution of that issue becomes final.

Unless otherwise stated, reimbursement is made according to the Official Medical Fee Schedule of the State of California, which prohibits billing of the patient for any balance in excess of the amount recommended. Any reduction is due to the billed charges exceeding the fee schedule allowance for the service provided and/or the application of the appropriate discounts based on the individual provider's agreement with the preferred provider organization.

Medical providers are encouraged to transmit bills electronically by having their bills sent to The Hartford's clearinghouse, P2P Link @ 866-450-3898, using the payer ID WCCA12101.

Submit reconsiderations for FL, NJ, CA & TX to:
The Hartford Medical Bill Processing Center
PO Box 14187
Lexington, KY 40512

Submit reconsiderations for all other states to:
The Hartford Medical Bill Processing Center
PO Box 14170
Lexington, KY 40512

For Reconsideration of this reimbursement determination, the following information must be submitted: Copy of this EOR, copy of the original bill and any supporting documentation to the address above. If you have any questions regarding this Explanation of Reimbursement (EOR) please call 800-662-5814 and reference the Control Number provided.

The Hartford is ready to support bills submitted with an ICD-10 diagnosis code for services rendered on or after 10/1/2015.



Bi l l Control No

THE HARTFORD MEDICAL BI LL PROCESSING CTR
P.O. BOX 14187
LEXINGTON, KY 40512

EXPLANATION OF REIMBURSEMENT

000189 4/4

CLAIM NC

INJURY DATE: 05/22/2018

PAYMENT INFORMATION

METHOD OF PAYMENT:	CHK
PAYMENT ID NUMBER:	1334333114
PAYMENT DATE:	02/03/2022
PAYMENT STATUS CODE:	1

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

000365 1/1

MB 01 000365 71801 H 2 C

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

PAID
FEB 15 2022
BY:

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901663662 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 05/04/2021 05/04/2021	$180.00

Claim Handler: ALICIA SMITH 8774699222 x2308456 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472	Additional Comments:

Issue Date	02/08/2022	Check Number	133445116 8	Total Check Amount	$180.00

Please keep the above information for your records.

12301375?

74055

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

FEB 18 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000112 February 23, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002995
Claim Number	
Assignment Date	01/06/2022
Claims Administrator	The Hartford
Date(s) of service	05/25/2021 - 05/26/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	05/22/2018
Application Received	12/02/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 05/25/2021 - 05/26/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/21/2021. Response not yet received.
- Itemized Invoices
    - 05/25/2021 Interpreting for PR2 / Re-Eval follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 05/26/2021 Interpreting for Initial Exam $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service. Charges exceed maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 05/25/2021 and 05/26/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 05/25/2021 – 05/26/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/25/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005146 76769 E 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
AUG 16 2021
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

AUG 13 2021
BY: .....

HAR-100-2

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

122255999

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 132917191 8

Issue Date: 08/06/2021

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

122255999

"132917191 8" :044115443: 632559738"

Process Date: 08/06/2021
Control Number: 216921874
EOR Page 1 of 3
Rev/Aud: PB/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 94806
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 07/27/2021
Packet Control Number: 30016202107273008109

005146 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 07

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/25/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR JOSE SERRANO
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

MB 01 000174 76769 B 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

74055

RECEIVED
AUG 13 2021
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

FAXED
AUG 16 2021
BY: .....

HAR-100-2

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

122251023

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 132917192 6

Issue Date: 08/06/2021

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

122251023

⑈132917192⑈ ⑆044115443⑆ 63255973⑈

The Hartford Medical Bill Processing Center 39

Process Date: 08/06/2021
Control Number: 216921875
EOR Page 1 of 3
Rev/Aud: RA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 74055 Geo Zip: 91723
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 07/21/2021
Packet Control Number: 30016202107212001510

000174 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/26/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: WILLIAM SIMPSON MD
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 002039 99916 G 12 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

002039 1/4

Attention: This remittance incorporates 0 claim payments

Special Handling 99

MAR 1 1 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

133127284

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133523707 0

Issue Date: 03/05/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133523707⑈ ⑆044115443⑆ 63255973⑧

133127284

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 03/04/2022
Re-Evaluation Control Number: 901675409
Original Control Number: 216921874
EOR Page 1 of 3
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 94806
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 03/04/2022
Packet Control Number: 8213001000457

002039 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 07

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/25/21	11	T1013		SIGN LANGUAGE/(	8.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR JOSE SERRANO
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

MB 01 000418 03303 H 3 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
MAR 14 2022
BY:

PAID
MAR 15 2022
BY:

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

123136441

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133529989 0

Issue Date: 03/08/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford
Authorized Signature

⑈133529989⑈ ⑆044115443⑆ 632559738⑈

123136441

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 03/08/2022
Re-Evaluation Control Number: 901675410
Original Control Number: 216921875
EOR Page 1 of 3
Rev/Aud: KD/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 74055 Geo Zip: 91723
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 03/04/2022
Packet Control Number: 8213001000437

000418 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
05/26/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: WILLIAM SIMPSON MD
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

JOYCE ALTMAN INTERPRETERS INC,
133542733 3

THE HARTFORD

Explanation Of Benefits

005750 2/2

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901675409 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 05/25/2021 05/25/2021	$180.00

Claim Handler: ALICIA SMITH 8774699222 x2308456 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472	Additional Comments:

Issue Date	03/11/2022	Check Number	133542733 3	Total Check Amount	$360.00

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

74055

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000047 May 17, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAY 2 0 2022

IBR Case Number	CB22-0000557
Claim Number	
Assignment Date	04/11/2022
Claims Administrator	The Hartford
Date(s) of service	08/19/2021 - 08/19/2021
Provider Name	Joyce Altman Interpreters, Inc
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/22/2018
Application Received	03/11/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 08/19/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/24/2022. Response not yet received.
- Itemized invoice
    - 08/19/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/19/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 08/19/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005445 84811 D 21 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
NOV 23 2021
BY: 74055

PAID
NOV 2[illegible] 2021
BY: .....

Please keep the above information for your records.

HAR-100-2

122700465

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133214795 0

Issue Date: 11/18/2021

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

122700465

⑈133214795⑈ ⑆044115443⑆ 632559738⑈

Process Date: 11/18/2021
Control Number: 217328383
EOR Page 1 of 3
Rev/Aud: PB/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 11/10/2021
Packet Control Number: 30016202111103001055

005445 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/19/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR MARINA RUSSMAN
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 006696 88721 G 27 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
JUN 01 2022
BY

Please keep the above information for your records.

1272742635

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133763946 0

Issue Date: 05/25/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133763946⑈ ⑆044115443⑆ 63255973⑈

1272742635

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 05/24/2022
Re-Evaluation Control Number: 901706626
Original Control Number: 217328383
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 05/24/2022
Packet Control Number: 4220459002567

006696 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/19/21	11	T1013		SIGN LANGUAGE/(	8.000	0.00	-90.00	0.00	0.00	90.00	G1,601, MNGR
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR MARINA RUSSMAN
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
MNGR -REIMBURSEMENT IS BASED UPON A PRE-DETERMINED AGREEMENT WITH INSURANCE CARRIER

Thank you, Provider Relations

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005044 93667 H 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
JUN 08 2022
BY:

005044 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901706626 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 08/19/2021 08/19/2021	$180.00

Claim Handler: ALICIA SMITH 8774699222 x2308456 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472	Additional Comments:

Issue Date	05/31/2022	Check Number	133780592 0	Total Check Amount	$180.00

Please keep the above information for your records.

127294959

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

74055

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000052 July 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUL 25 2022

IBR Case Number	CB22-0001090
Claim Number	
Assignment Date	06/09/2022
Claims Administrator	The Hartford
Date(s) of service	08/27/2021 - 08/27/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/22/2018
Application Received	05/12/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 08/27/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/24/2022. Response not yet received.
- Itemized invoice
    - 08/27/2019 Follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 08/27/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 08/27/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

JAN 12 2022

BY:

JAN 11 2022

BY: 74055

000237 1/2

MB 01 000237 33401 B 2 B

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Page 1 of 2

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
217380266 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$90.00
Nature of Benefits: Other Medical		Nature of Payment: Payment Reason - Other Medical	Service Dates 08/27/2021 08/27/2021	$90.00

Claim Handler: ALICIA SMITH 8774699222 x2308456 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472	Additional Comments: check payment for date of service 08/27/2021 - ref# 74055

Issue Date	01/04/2022	Check Number	133350426 8	Total Check Amount	$90.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

122871045

The Hartford Medical Bill Processing Center 39

Process Date: 12/02/2021
Control Number: 217380266
EOR Page 1 of 3
Rev/Aud: PB/SS

000237 2/2

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 74055 Geo Zip: 92801
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 11/22/2021
Packet Control Number: 30016202111222001022

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/27/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			180.00	90.00	0.00	0.00	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR. JAVAD NAJIB, D.C.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

MB 01 000214 93667 H 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUN 06 2022
BY: 74055

Please keep the above information for your records. 127290129

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133780763 0

Issue Date: 05/31/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

127290129

⑈133780763⑈ ⑆044115443⑆ 6325597 38⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 05/31/2022
Re-Evaluation Control Number: 901708819
Original Control Number: 217380266

Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 74055 Geo Zip: 92801
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 05/31/2022
Packet Control Number: 8221091000136

000214 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
08/27/21	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR. JAVAD NAJIB, D.C.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005334 63304 H 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

005334 1/1

PAID
AUG 11 2022
BY

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name	Amount Paid
901734628 05/22/2018	20WN S38001	UMC ACQUISITION CORP	$180.00

Nature of Benefits:	Nature of Payment:	Service Dates	Amount
Alternative Dispute Resolution	Payment Reason - Alt Dispute Resolution	08/27/2021 08/27/2021	$180.00

Claim Handler: ALICIA SMITH
8774699222 x2308456
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

Additional Comments:

Issue Date	08/04/2022	Check Number	133971791 3	Total Check Amount	$180.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124194212

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000028 June 24, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JUN 27 2022

IBR Case Number	CB22-0000896
Claim Number	
Assignment Date	05/10/2022
Claims Administrator	The Hartford
Date(s) of service	09/02/2021 - 09/02/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/22/2018
Application Received	04/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/02/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/22/2022. Response not yet received.
- Itemized invoice
    - 09/02/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/02/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/02/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005747 07962 E 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
DEC 20 2021
PV.

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
DEC 17 2021
PV. 74055

Please keep the above information for your records.

12277836O

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133279317 7

Issue Date: 12/10/2021

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133279317⑈ ⑆044115443⑆ 63255973⑧⑈

12277836O

Process Date: 12/09/2021
Control Number: 217425231
EOR Page 1 of 3
Rev/Aud: MS/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 91214
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 12/02/2021
Packet Control Number: 30016202112023003745

005747 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

IPN Claim: N Region: 18

OS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
9/02/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

endering Provider Name: ACU MI RAN PARK
endering Provider NPI:

WC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

ARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 003990 37595 H 15 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

JUL 18 2022

74055

AUG 06 2022

BY.

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133898786 0

Issue Date: 07/11/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133898786⑈ ⑆044115443⑆ 63255973⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date. 07/11/2022
Re-Evaluation Control Number: 901724771
Original Control Number: 217425231
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID 330956713 Vendor 0013541032-2
Provider Ref 74055 Geo Zip. 91214
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date. 07/06/2022
Packet Control Number: 4221269002422

003990 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1. T14.90 Injury unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/02/21	11	T1013		SIGN LANGUAGE/(	8.000	0.00	-90.00	0.00	0 00	90 00	G1,273,601, MNGR
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: ACU MI RAN PARK
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.
601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
MNGR -REIMBURSEMENT IS BASED UPON A PRE-DETERMINED AGREEMENT WITH INSURANCE CARRIER

Thank you, Provider Relations

Bi l l Control No

THE HARTFORD MEDICAL BI LL PROCESSING CTR
P.O. BOX 14187
LEXINGTON, KY 40512

003990 3/3

EXPLANATION OF REIMBURSEMENT

CLAIM NO:

INJURY DATE: 05/22/2018

PAYMENT INFORMATION

METHOD OF PAYMENT:	CHK
PAYMENT ID NUMBER:	1338987860
PAYMENT DATE:	07/11/2022
PAYMENT STATUS CODE:	1

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005383 39041 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

005383 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name	Amount Paid
901724771 05/22/2018	20WN S38001	UMC ACQUISITION CORP	$180.00

Nature of Benefits:	Nature of Payment:	Service Dates	Amount Paid
Alternative Dispute Resolution	Payment Reason - Alt Dispute Resolution	09/02/2021 09/02/2021	$180.00

Claim Handler: ALICIA SMITH
8774699222 x2308456
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

Additional Comments:

PAID
AUG 06 2022

Issue Date	07/12/2022	Check Number	133901888 8	Total Check Amount	$180.00

Please keep the above information for your records

124089179

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

74055

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 8, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001424
Claim Number	
Assignment Date	07/28/2022
Claims Administrator	The Hartford
Date(s) of service	10/11/2021 - 10/11/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/22/2018
Application Received	06/17/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/11/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 07/12/2022. Response not yet received.
- Itemized invoice
    - 10/11/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: charges exceed maximum allowance for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/11/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/11/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
P.O. Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

002793 1/4

SP 01 002793 86235 H 12 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
MAR 0 1 2022
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 0 2 2022
BY: .....

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

3230721790

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133484246 9

Issue Date: 02/21/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133484246⑈ ⑆044115443⑆ 63255973⑈

Process Date: 02/21/2022
Control Number: 217682875
EOR Page 1 of 3
Rev/Aud: MS/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 74055 Geo Zip: 92078
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 05/22/2018
Claims Received Date: 02/14/2022
Packet Control Number: 5220450000100

002793 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 72

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/11/21	11	T1013		SIGN LANGUAGE/	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR. JAVAD NAJIB, D.C.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

m



ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

005359 1/3

SP 01 005359 39041 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

PAID
AUG 06 2022
BY

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH



ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133900535 2

Issue Date: 07/12/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133900535 2⑈ ⑆044115443⑆ 6325597 38⑈

Bi l l Control No

THE HARTFORD MEDICAL Bi LL PROCESSING CTR
P.O. BOX 14187
LEXINGTON, KY 40512

005359 3/3

EXPLANATION OF REIMBURSEMENT

CLAIM NO:

INJURY DATE: 05/22/2018

PAYMENT INFORMATION

METHOD OF PAYMENT:	CHK
PAYMENT ID NUMBER:	1339005352
PAYMENT DATE:	07/12/2022
PAYMENT STATUS CODE:	1

THE HARTFORD
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005767 13058 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
SEP 2 9 2022

005767 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901725001 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$180 00
Nature of Benefits Alternative Dispute Resolution		Nature of Payment Payment Reason - Alt Dispute Resolution	Service Dates 10/11/2021 10/11/2021	$180 00

Claim Handler ALICIA SMITH
8774699222 x2308456
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

Additional Comments

Issue Date	09/21/2022	Check Number	134106428 0	Total Check Amount	$180 00

Please keep the above information for your records

126844500

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2308456

SP 01 005767 13058 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
SEP 29 2022

005767 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901725001 05/22/2018	20WN S38001	UMC ACQUISITION CORP		$180 00
Nature of Benefits Alternative Dispute Resolution		Nature of Payment Payment Reason - Alt Dispute Resolution	Service Dates 10/11/2021 10/11/2021	$180 00
Claim Handler ALICIA SMITH 8774699222 x2308456 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472		Additional Comments		

Issue Date	09/21/2022	Check Number	134106428 0	Total Check Amount	$180 00

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

126844500

HAR-100-2

77020

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000093 March 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

MAR 2 5 2022

IBR Case Number	CB21-0002476
Claim Number	
Assignment Date	02/15/2022
Claims Administrator	The Hartford
Date(s) of service	02/06/2020 - 02/11/2020
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	08/30/2019
Application Received	10/08/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 02/06/2020 - 02/11/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/28/2022. Response received 02/24/2022. Claims Administrator upheld their determination.
- Itemized Invoices
    - 02/06/2020 Interpreting FU acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 02/11/2020 Interpreting FU acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service. Charges exceeds the OMFS allowance
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 02/06/2020 and 02/11/2020 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 02/06/2020 – 02/11/2020
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/06/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 02/11/2020** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2305312

MB 01 000001 37155 A 1 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUL 06 2021
BY: .....

PAID
JUL 06 2021
BY: .....

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

122073473

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 132793249 0

Issue Date: 06/28/2021

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

122073473

⑈132793249⑈ ⑆044115443⑆ 632559738⑈

RE-EVALUATION
Process Date: 06/28/2021
Re-Evaluation Control Number: 901582383
Original Control Number: 214987553
EOR Page 1 of 3
Rev/Aud: CM/CM

Claim Number:	Y2EC16298	PPO/OSR ID:	ExternalReview QMED
Claimant:	De La Cruz Meza, Manuel	NPI Number:	1013210988
Provider Tax ID:	330956713 Vendor: 0013541032-1	Claimant SSN:	XXX-XX-9999
Provider Ref:	77020 Geo Zip: 95973	Date Of Injury:	08/30/2019
Provider License:	99999999	Claims Received Date:	06/25/2021
		Packet Control Number:	30016202003193004656

000001 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 55

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
02/06/20	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	1001,G1
		Original Charge/Allowance: $180.00/$0.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MARIA BARBOZA
Rendering Provider NPI: 1013210988

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

1001 -BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.

Thank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2305312

MB 01 000002 37155 B 1 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUL 06 2021
BY: .....

JUL 06 2021

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

122073475

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 132793250 4

Issue Date: 06/28/2021

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

122073475

⑈132793250⑈ ⑆044115443⑆ 632559738⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 06/28/2021
Re-Evaluation Control Number: 901582399
Original Control Number: 214987403
EOR Page 1 of 3
Rev/Aud: CM/CM*

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 77020 Geo Zip: 91789
Provider License: 99999

PPO/OSR ID: ExternalReview QMED
NPI Number:
Claimant SSN:
Date Of Injury: 08/30/2019
Claims Received Date: 06/25/2021
Packet Control Number: 30016202003253003302

000002 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
02/11/20	11	T1013		SIGN LANGUAGE/(	8.000	0.00	-90.00	0.00	0.00	90.00	1001,G1
		Original Charge/Allowance: $180.00/$0.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: KOSHY INTERPRISE INC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

1001 -BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.

Thank you, Provider Relations

m

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

MB 01 000173 33893 H 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates
0 claim payments

Special Handling 99

APR 1 1 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133615089 0

Issue Date: 04/05/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

⑈133615089⑈ ⑆044115443⑆ 63255973⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 04/05/2022
Re-Evaluation Control Number: 901687104
Original Control Number: 214987553

Rev/Aud: GP/GP

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 77020 Geo Zip: 95973
Provider License: 99999999

PPO/OSR ID: ExternalReview QMED
NPI Number: 1013210988
Claimant SSN:
Date Of Injury: 08/30/2019
Claims Received Date: 03/30/2022
Packet Control Number: 8213141001025

000173 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

APR 1 1 2022

MPN Claim: N Region: 55

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
02/06/20	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,1002
		Original Charge/Allowance: $180.00/$0.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MARIA BARBOZA
Rendering Provider NPI: 1013210988

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

1002 -DUE TO AN ERROR IN PROCESSING THE ORIGINAL BILL, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE.

Thank you, Provider Relations

m

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

MB 01 000172 33893 H 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

APR 1 1 2022

Attention: This remittance incorporates 0 claim payments

Special Handling 99

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133615088 2

Issue Date: 04/05/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford
Authorized Signature

⑈133615088 2⑈ ⑆044115443⑆ 63255973 8⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 04/05/2022
Re-Evaluation Control Number: 901687095
Original Control Number: 214987403

Rev/Aud: GP/GP

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 77020 Geo Zip: 91789
Provider License: 99999

PPO/OSR ID: ExternalReview QMED
NPI Number:
Claimant SSN:
Date Of Injury: 08/30/2019
Claims Received Date: 03/30/2022
Packet Control Number: 8213141001026

000172 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

APR 1 1 2022

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
02/11/20	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,1002
		Original Charge/Allowance: $180.00/$0.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: KOSHY INTERPRISE INC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

1002 -DUE TO AN ERROR IN PROCESSING THE ORIGINAL BILL, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE.

Thank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

000200 1/1

MB 01 000200 40717 H 1 C

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901687104 08/30/2019	72WEC AB0INX	KOSHU ENTERPRISES, INC.		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 02/06/2020 02/06/2020	$180.00

Claim Handler: ADRIENNE BOOKER 866/401-9222 Western Workers' Compensation Claim Center P.O. Box 14475 Lexington, KY 40512	Additional Comments:

Issue Date	04/11/2022	Check Number	133631515 6	Total Check Amount	$180.00

Please keep the above information for your records.

123267039

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

78936

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

JAN 10 2022

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000054 January 6, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB21-0002556
Claim Number	
Assignment Date	11/16/2021
Claims Administrator	The Hartford
Date(s) of service	04/14/2021 - 04/14/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/13/2019
Application Received	10/15/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 04/14/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/29/2021. Response not yet received.
- Itemized invoice
    - 04/14/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 04/14/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 04/14/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14472
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

005473 1/3

SP 01 005473 31992 E 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

JUN 2 9 2021

BY: .....

78936

JUN 2 8 2021

BY: .....

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

122054130

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 132778512 9

Issue Date: 06/22/2021

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

122054130

⑈132778512⑈ ⑆044115443⑆ 6325597 38⑈

Process Date: 06/22/2021
Control Number: 216738734
EOR Page 1 of 2
Rev/Aud: SM/MR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 78936 Geo Zip: 91790
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 06/03/2021
Packet Control Number: 30016202106032002356

005473 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/14/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	601,G1
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY
PAIN MANAGEMENT
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

m

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

SP 01 004818 52683 G 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

JAN 28 2022

RECEIVED
JAN 27 2022

BY: .....

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133397265 2

Issue Date: 01/21/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133397265 2⑈ ⑆044115443⑆ 632559738⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 01/20/2022
Re-Evaluation Control Number: 901658271
Original Control Number: 216738734

Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 78936 Geo Zip: 91790
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 01/13/2022
Packet Control Number: 4212511001202

004818 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/14/21	11	T1013		SIGN LANGUAGE/(	2.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY
PAIN MANAGEMENT
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

X



ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

004837 1/1

SP 01 004837 52683 H 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

JAN 28 2022

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901658271 11/13/2019	72WE OI4268	HORIZON PERSONNEL SERVICES, INC.		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 04/14/2021 04/14/2021	$180.00

Claim Handler: STACEY HUGHES 8774699222 x2303502 ClaimPlus Work Comp Claim Center PO Box 14472 Lexington, KY 40512-4472	Additional Comments:

Issue Date	01/21/2022	Check Number	133399041 3	Total Check Amount	$180.00

Please keep the above information for your records.

122946140

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

78936

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000060 April 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

APR 25 2022

IBR Case Number	CB22-0000332
Claim Number	
Assignment Date	03/17/2022
Claims Administrator	The Hartford
Date(s) of service	07/30/2021 - 07/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/13/2019
Application Received	02/18/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services submitted for dates of service 07/30/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/01//2022. Response received 03/11/2022. Claims Administrator indicated an additional $90.00 was recommended for payment. Check information was not provided.
- Itemized Invoices
    - 07/30/2021 Interpreting PR2 Re-Eval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceeds the OMFS allowance
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 07/30/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $180.00 ($90.00 per hour) as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services
Date of Service: 07/30/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14472
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

SP 01 005856 59976 E 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

78934

RECEIVED
NOV 01 2021
BY: .....

PAID
NOV 02 2021
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

122601185

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133149453 2

Issue Date: 10/26/2021

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

122601185

⑈133149453 2⑈ ⑆044115443⑆ 632559738⑈

Process Date: 10/26/2021
Control Number: 217240132
EOR Page 1 of 2
Rev/Aud: AA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 78936 Geo Zip: 92781
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 10/13/2021
Packet Control Number: 30016202110133000797

005856 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
07/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: fmr interventional queality pain management
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8665144833 x2304456

MB 01 000007 07796 H 1 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 17 2022

123158301

HAR-100-2

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

123158301

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133544473 4

Issue Date: 03/12/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123158301

⑈133544473⑈ ⑆044115443⑆ 63255973 8⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 03/11/2022
Re-Evaluation Control Number: 901677950
Original Control Number: 217240132
EOR Page 1 of 3
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 78936 Geo Zip: 92781
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 03/09/2022
Packet Control Number: 4220189005707

000007 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

Attn:

This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
07/30/21	11	T1013		SIGN LANGUAGE/(	1800.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: fmr interventional queality pain management
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

78936

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 9, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001226
Claim Number	
Assignment Date	06/27/2022
Claims Administrator	The Hartford
Date(s) of service	09/28/2021 - 09/28/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/13/2019
Application Received	05/26/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/28/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/09/2022. Response not yet received.
- Itemized invoice
    - 09/28/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/28/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/28/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14472
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

SP 01 005731 57975 G 24 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
FEB 03
BY:

Attention: This remittance incorporates 0 claim payments

Special Handling 99

FEB 03 2022
BY:

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133410911 7

Issue Date: 01/26/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133410911⑈ ⑆044115443⑆ 6325597388⑈

Process Date: 01/26/2022
Control Number: 217590583
EOR Page 1 of 2
Rev/Aud: MS/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 78936 Geo Zip: 91436
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 01/18/2022
Packet Control Number: 30016202201183000463

005731 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/28/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR. SIRLINA COOK, D.C.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

JOYCE ALTMAN INTERPRETERS INC.
134018924 0

THE HARTFORD

Explanation Of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
11/13/2019	72WE OI4268	HORIZON PERSONNEL SERVICES, INC.		$270 00
Nature of Benefits		Nature of Payment	Service Dates	
Doctor		Payment Reason - Doctor	09/28/2021 09/29/2021	$270 00

Claim Handler SHERI ANGELLO
8664019222 x2302102
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267

Additional Comments

PAID
SEP 0 h 2022

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
81419 03/01/2020	72WEC AC5H3W	OBAND INC AND OBAND MEDICAL G		$3 780 00
Nature of Benefits		Nature of Payment	Service Dates	
Miscellaneous Medical		Payment Reason - Misc Medical	06/21/2021 08/02/2022	$3,780 00

Claim Handler LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 11267
Lexington KY 40512-4267

Additional Comments

Issue Date	08/22/2022	Check Number	134018924 0	Total Check Amount	$4,300 00

M

THE HARTFORD

Claim Financial Integrity & Control Services
690 Asylum Avenue
Hartford CT 06115
8774699222 x2303695

MB 01 001543 81857 H 5 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 3 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
83932 07/17/2019	57WN OV5640	ENCLOS CORP		$250 00
Nature of Benefits Miscellaneous Medical		Nature of Payment Payment Reason - Misc Medical	Service Dates 06/22/2022 06/22/2022	$250 00

Claim Handler SHELLY SZYMANSKI
8774699222 x2303695
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

Additional Comments

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

1245553

THE HARTFORD

Claim Financial Integrity & Control Services
690 Asylum Avenue
Hartford, CT 06115

56-1544
441

Check Number 134018924 0

Issue Date 08/22/2022

$********4,300 00

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
FOUR THOUSAND THREE HUNDRED DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

⑈134018924⑈ ⑆044115443⑆ 637559738⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW # 78936

August 26, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001423
Claim Number	
Assignment Date	07/13/2022
Claims Administrator	The Hartford
Date(s) of service	10/12/2021 - 10/12/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	11/13/2019
Application Received	06/17/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/12/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/27/2022. Response not yet received.
- Itemized invoice
    - 10/12/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/12/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/12/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14472
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Process Date: 02/21/2022
Control Number: 217686057
EOR Page 1 of 2
Rev/Aud: AA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 78936 Geo Zip: 90746
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 02/11/2022
Packet Control Number: 30016202202113002846

002792 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/12/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY PAIN MANAGEMENT A
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES



ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2303502

MAR 0 2 2022

SP 01 002792 86235 G 12 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

78936

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

123072889



ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133484245 0

Issue Date: 02/21/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133484245⑈ ⑆044115443⑆ 63255973⑈

M

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2302102

SP 01 005357 39041 G 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
JUL 19 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124089153

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 133900533 6

Issue Date: 07/12/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133900533⑈ ⑆044115443⑆ 63255973⑈

E5168042T

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 07/11/2022
Re-Evaluation Control Number: 901725006
Original Control Number: 217686057
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 78936 Geo Zip: 90746
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 11/13/2019
Claims Received Date: 07/11/2022
Packet Control Number: 4221461001116

005357 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/12/21	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,273,601
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY PAIN MANAGEMENT A
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.
601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Thank you, Provider Relations

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2302102

002579 1/1

MB 01 002579 03219 H 8 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

SEP 2 2 2022

BY:

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
11/13/2019	72WE OI4268	HORIZON PERSONNEL SERVICES, INC		$180 00
Nature of Benefits		Nature of Payment	Service Dates	
Miscellaneous Expense		Payment Reason - Misc Expense - Non Legal	10/12/2021 10/13/2021	$180 00

Claim Handler SHERI ANGELLO 8664019222 x2302102 Centralized Workers Compensation Claim Center PO Box 14267 Lexington, KY 40512-4267	Additional Comments

Issue Date	09/12/2022	Check Number	134073841 4	Total Check Amount	$180 00

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

124620837

HAR 1_ _

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000056 September 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 0 3 2022

IBR Case Number	CB22-0001667
Claim Number	
Assignment Date	08/19/2022
Claims Administrator	The Hartford
Date(s) of service	10/12/2021 - 10/26/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 3
Date of Injury	06/27/2018
Application Received	07/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $270.00 in additional reimbursement for a total of $450.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$450.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 3 submitted for dates of service 10/12/2021 – 10/26/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/03/2022. Response not yet received.
- Itemized Invoices
    - 10/12/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 10/19/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 10/26/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 10/12/2021 – 10/26/2021. Charge exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 10/12/2021 – 10/26/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 3.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 3
Date of Service: 10/12/2021 – 10/26/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/12/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/26/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

MB 01 000271 11918 H 2 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

PAID
MAR 2 2 2022
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 2 1 2022
BY: 79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

123170850

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133553115 7

Issue Date: 03/16/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133553115⑈ ⑆044115443⑆ 63255973⑧

123170850

Process Date: 03/15/2022
Control Number: 217790358
EOR Page 1 of 2
Rev/Aud: DR/DR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 02/10/2022
Packet Control Number: 30016202202103005005

000271 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/12/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D.C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

MB 01 000543 13182 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 24 2022
BY: .....

RECEIVED
MAR 24 2022
BY: 79586

HAR-100-2

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

123177128

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133558615 6

Issue Date: 03/17/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133558615⑈ ⑆044115443⑆ 63255973⑧⑈

123177128

Process Date: 03/17/2022
Control Number: 217797995
EOR Page 1 of 2
Rev/Aud: SS/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 79598 Geo Zip: 92781
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 03/14/2022
Packet Control Number: 30016202203013001467

000543 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/19/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D.C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

MB 01 000437 56125 H 3 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

AUG 0 5 2022

BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

124158301

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 133950421 9

Issue Date: 07/28/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford

Authorized Signature

124158301

⑈133950421⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 07/28/2022
Re-Evaluation Control Number: 901732241
Original Control Number 217790358
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number
Claimant:
Provider Tax ID. 330956713 Vendor: 0002061871-3
Provider Ref 79598 Geo Zip: 91403
Provider License 99999999

PPO/OSR ID.
NPI Number:
Claimant SSN:
Date Of Injury 06/27/2018
Claims Received Date: 07/27/2022
Packet Control Number: 4221729003988

000437 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury unspecified

MPN Claim: N Region: 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/12/21	11	T1013		SIGN LANGUAGE/(	8.000	0 00	-90.00	0.00	0.00	90 00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

MB 01 000438 56125 H 3 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

RECEIVED
AUG 0 5 2022
BY:.....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

124158302

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 133950422 7

Issue Date: 07/28/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

124158302

⑈133950422⑈ ⑆044115443⑆ 632559738⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 07/28/2022
Re-Evaluation Control Number: 901732263
Original Control Number 217797995
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number.
Claimant:
Provider Tax ID. 330956713
Provider Ref: 79598
Provider License 99999999

Vendor: 0002061871-3
Geo Zip: 91431

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury 06/27/2018
Claims Received Date: 07/27/2022
Packet Control Number: 4221681001127

000438 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14 90 Injury unspecified

MPN Claim. N Region: 09

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/19/21	11	T1013		SIGN LANGUAGE/(	8 000	0.00	-90 00	0.00	0 00	90 00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

005426 1/3

SP 01 005426 11918 G 21 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
MAR 22 2022
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

MAR 21 2022
BY: 79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

123176005

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133553808 9

Issue Date: 03/16/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123176005

⑈133553808⑈ ⑆044115443⑆ 63255973⑧⑈

Process Date: 03/15/2022
Control Number: 217790295
EOR Page 1 of 2
Rev/Aud: PB/UA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 03/09/2022
Packet Control Number: 30016202203093007258

005426 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/26/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D.C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

MB 01 000539 99825 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

PAID
DEC 16 2022
BY

Attention: This remittance incorporates 2 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/27/2018	46WEC AB0TUS	ZAVALA ZAPATOS MANUFACTURE, INC.		$382.20
Nature of Benefits: Other Medical		Nature of Payment: Payment Reason - Other Medical	Service Dates 10/12/2021 10/26/2021	$382.20

Claim Handler: LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
IBR FEES AND UNPAID ONLY

Please keep the above information for your records.

124329471

HAR-100.2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 134336515 5

Issue Date: 12/09/2022

$************875.35**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
EIGHT HUNDRED SEVENTY-FIVE DOLLARS AND 35/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈134336515⑈ ⑆044115443⑆ 632559738⑈

JOYCE ALTMAN INTERPRETERS INC,
134336515 5

THE HARTFORD

Explanation Of Benefits

000539 2/2

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/27/2018	46WEC AB0TUS	ZAVALA ZAPATOS MANUFACTURE, INC.		$493.15
Nature of Benefits: Miscellaneous Medical		Nature of Payment: Payment Reason - Misc Medical	Service Dates 11/04/2021 11/16/2021	$493.15

Claim Handler: LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
IBR FEES AND UNPAID ITEMS ONLY

Issue Date	12/09/2022	Check Number	134336515 5	Total Check Amount	$875.35

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000083 September 30, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 0 3 2022

IBR Case Number	CB22-0001723
Claim Number	
Assignment Date	08/22/2022
Claims Administrator	The Hartford
Date(s) of service	10/06/2021 - 10/06/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	06/27/2018
Application Received	07/22/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/06/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/04/2022. Response not yet received.
- Itemized Invoice
    - 10/06/2021 Interpreting for follow-up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 with the rationale: charges exceed maximum allowable for interpreter services
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/06/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/06/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

000544 1/3

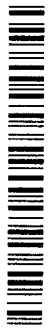
MB 01 000544 13182 H 4 A

JOYCE ALTMAN
INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 24 2022
BY:



HAR-100-2

Please keep the above information for your records.
FOLD AT DOTTED LINE AND DETACH

123177129

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133559115 0

Issue Date: 03/17/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN
INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

The Hartford
Authorized Signature

123177129

⑈133559115⑈ ⑆044115443⑆ 63255973⑧⑈

Process Date: 03/17/2022
Control Number: 217791671
EOR Page 1 of 2
Rev/Aud: BS/BS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013623940-1
Provider Ref: Geo Zip: 92781
Provider License: 99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 03/14/2022
Packet Control Number: 30016202201313000539

000544 2/3

JOYCE ALTMAN
INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/06/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: JOYCE ALTMAN
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

12449863O

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number 133995642 0

Issue Date 08/12/2022

$**********90.00

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN
INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

12449863O

⑈133995642O⑈ ⑆044115443⑆ 63255973B⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 08/12/2022
Re-Evaluation Control Number 901738810
Original Control Number 217791671
EOR Page 1 of 2
Rev/Aud KD/KD

Claim Number			PPO/OSR ID		
Claimant			NPI Number		
Provider Tax ID	330956713	Vendor 0013623940-1	Claimant SSN		
Provider Ref		Geo Zip 92781	Date Of Injury	06/27/2018	
Provider License	99999		Claims Received Date	08/11/2022	
			Packet Control Number	4221689001049	

002047 2/3

JOYCE ALTMAN
INTERPRETERS
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1 T14 90 Injury unspecified

MPN Claim N Region 26

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/06/21	11	T1013		SIGN LANGUAGE/	120 000	0 00	-90 00	0 00	0 00	90 00	G1 273
		Original Charge/Allowance $180 00/$90 00									
		TOTALS				0 00	-90 00	0 00	0 00	90 00	
		TOTAL RECOMMENDED ALLOWANCE								90 00	

Rendering Provider Name JOYCE ALTMAN
Rendering Provider NPI

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

MB 01 000539 99825 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

PAID
DEC 16 2022
BY

Attention: This remittance incorporates 2 claim payments

Special Handling 99

Explanation of Benefits

Page 1 of 3

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/27/2018		ZAVALA ZAPATOS MANUFACTURE, INC.		$382.20
Nature of Benefits: Other Medical		Nature of Payment: Payment Reason - Other Medical	Service Dates 10/12/2021 10/26/2021	$382.20

Claim Handler: LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
IBR FEES AND UNPAID ONLY

Please keep the above information for your records.

124329471

HAR-100.2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 134336515 5

Issue Date: 12/09/2022

$**********875.35

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
EIGHT HUNDRED SEVENTY-FIVE DOLLARS AND 35/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈134336515⑈ ⑆044115443⑆ 632559738⑈

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000041 October 20, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 24 2022

IBR Case Number	CB22-0001923
Claim Number	
Assignment Date	09/07/2022
Claims Administrator	The Hartford
Date(s) of service	11/04/2021 - 11/16/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 5
Date of Injury	06/27/2018
Application Received	08/12/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $450.00 in additional reimbursement for a total of $630.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$630.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 5 submitted for dates of service 11/04/2021 – 11/16/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/22/2022. Response not yet received.
- Itemized Invoices
    - 11/04/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/08/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/09/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/15/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/16/2021 Interpreting for follow up physiotherapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect $90.00 x 5 for each date of service 11/04/2021 – 11/16/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/04/2021 – 11/16/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 5 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 5.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 5
Date of Service: 11/04/2021 – 11/16/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/04/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/15/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304199

SP 01 003619 48724 G 15 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
APR 25 2022
BY: .....
RECEIVED
APR 25 2022
BY: 79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133653207 6

Issue Date: 04/18/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133653207⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

Process Date: 04/18/2022
Control Number: 217913451
EOR Page 1 of 2
Rev/Aud: RA/KK

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 04/06/2022
Packet Control Number: 30016202204063005813

003619 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/09/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR AZIMZADEH
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304199

SP 01 004480 56237 H 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

PAID
MAY 0 2022
BY:

RECEIVED
79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133673795 6

Issue Date: 04/25/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133673795⑈ ⑆044115443⑆ 63255973⑈

Process Date: 04/25/2022
Control Number: 217947596
EOR Page 1 of 2
Rev/Aud: MS/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 04/12/2022
Packet Control Number: 30016202204123005363

004480 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR. MAHNAZ AZIMZADEH
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304199

SP 01 006296 57643 G 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

79598

PAID
MAY 04 2022

Please keep the above information for your records.

HAR-10012

123339830

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133678607 8

Issue Date: 04/26/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133678607⑈ ⑆044115443⑆ 6325597 38⑈

Process Date: 04/26/2022
Control Number: 217957867
EOR Page 1 of 2
Rev/Aud: PB/UA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 04/11/2022
Packet Control Number: 30016202204113000817

006296 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/16/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D.C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304199

006016 1/3

SP 01 006016 42434 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

PAID

RECEIVED
APR 18 2022
BY: 79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133636860 8

Issue Date: 04/12/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133636860⑈ ⑆044115443⑆ 63255973⑈

Process Date: 04/12/2022
Control Number: 217894431
EOR Page 1 of 2
Rev/Aud: PB/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79598 Geo Zip: 91403
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 03/29/2022
Packet Control Number: 30016202203293000159

006016 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/04/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: MAHNAZ AZIMZADEH, D.C
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304199

MB 01 000736 51688 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

000736 1/3

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
APR 29 2022

79598

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133658303 7

Issue Date: 04/20/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133658303 7⑈ ⑆044115443⑆ 63255973 8⑈

Process Date: 04/19/2022
Control Number: 217924550
EOR Page 1 of 2
Rev/Aud: SM/AS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 79598 Geo Zip: 91790
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/27/2018
Claims Received Date: 04/06/2022
Packet Control Number: 30016202204063000805

000736 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/08/21	11	T1013		SIGN LANGUAGE/(	15.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY PAIN MANAGEMENT
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

SP 01 004876 87117 H 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
SEP 0 2 2022
BY: 79598

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
SEP 07 2022
BY:

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

124562018

Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number. 134034268 5

Issue Date 08/26/2022

$**********90.00

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

124562018

⑈134034268⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 08/25/2022
Re-Evaluation Control Number 901744296
Original Control Number 217894431

Rev/Aud KD/KD

Claim Number
Claimant
Provider Tax ID 330956713 Vendor 0013541032-2
Provider Ref 79598 Geo Zip 91403
Provider License 99999999

PPO/OSR ID
NPI Number
Claimant SSN
Date Of Injury 06/27/2018
Claims Received Date 08/25/2022
Packet Control Number 4221991001244

u0487o 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury unspecified

MPN Claim N Region 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
1/04/21	11	T1013		SIGN LANGUAGE/	8 000	0 00	-90 00	0 00	0 00	90 00	G1 273
		Original Charge/Allowance $180 00/$90 00									
		TOTALS				**0 00**	**-90 00**	**0 00**	**0 00**	**90 00**	
		TOTAL RECOMMENDED ALLOWANCE								**90 00**	

Rendering Provider Name MAHNAZ AZIMZADEH D C
Rendering Provider NPI

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

M

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

002010 1/3

MB 01 002010 87117 H 8 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

Please keep the above information for your records

124559152

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number 134033875 0

Issue Date: 08/26/2022

$**********90.00

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford

Authorized Signature

124559152

⑈134033875⑈ ⑆044116543⑆ 63255973⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 08/25/2022
Re-Evaluation Control Number 901744299
Original Control Number 217924550

Rev/Aud KD/KD

Claim Number			PPO/OSR ID		
Claimant			NPI Number		
Provider Tax ID	330956713	Vendor 0002061871-3	Claimant SSN		
Provider Ref	79598	Geo Zip 91790	Date Of Injury	06/27/2018	
Provider License	99999999		Claims Received Date	08/25/2022	
			Packet Control Number	4222009001786	

002010 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury unspecified

MPN Claim N Region 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/08/21	11	T1013		SIGN LANGUAGE/	15 000	0 00	-90 00	0 00	0 00	90 00	G1,273
		Original Charge/Allowance $180 00/$90 00									
		TOTALS				0 00	-90 00	0 00	0 00	90 00	
		TOTAL RECOMMENDED ALLOWANCE								90 00	

Rendering Provider Name FMR INTERVENTIONAL QUALITY PAIN MANAGEMENT
Rendering Provider NPI

OWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
8664019222 x2303993

MB 01 000539 99825 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

PAID
DEC 16 2022
BY

Attention: This remittance incorporates 2 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/27/2018	46WEC AB0TUS	ZAVALA ZAPATOS MANUFACTURE, INC.		$382.20
Nature of Benefits: Other Medical		Nature of Payment: Payment Reason - Other Medical	Service Dates 10/12/2021 10/26/2021	$382.20

Claim Handler: LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
IBR FEES AND UNPAID ONLY

Please keep the above information for your records.

124329471

HAR-100.2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 134336515 5

Issue Date: 12/09/2022

$********875.35**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
EIGHT HUNDRED SEVENTY-FIVE DOLLARS AND 35/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈134336515⑈ ⑆044115443⑆ 632559738⑈

JOYCE ALTMAN INTERPRETERS INC,
134336515 5

THE HARTFORD

Explanation Of Benefits

000539 2/2

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/27/2018	46WEC ABOTUS	ZAVALA ZAPATOS MANUFACTURE, INC.		$493.15
Nature of Benefits: Miscellaneous Medical		Nature of Payment: Payment Reason - Misc Medical	Service Dates 11/04/2021 11/16/2021	$493.15

Claim Handler: LISA CUSIMANO
8664019222 x2303993
Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

Additional Comments:
IBR FEES AND UNPAID ITEMS ONLY

Issue Date	12/09/2022	Check Number	134336515 5	Total Check Amount	$875.35

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

D9767

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001666
Claim Number	
Assignment Date	08/19/2022
Claims Administrator	The Hartford
Date(s) of service	10/26/2021 - 10/26/2021
Provider Name	Joyce Altman Interpreters, Inc
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/20/2020
Application Received	07/15/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 10/26/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/03/2022. Response received 08/03/2022. Claims Administrator provided copies of IBR documents.
- Itemized Invoice
    - 10/26/2021 Interpreting for follow up chiropractor $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 10/26/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is due. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 10/26/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308189

SP 01 004648 14401 G 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 25 2022

PAID
MAR 25 2022
BY: 79767

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

123186352

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133562944 0

Issue Date: 03/18/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133562944⑈ ⑆044115443⑆ 63255973⑧⑈

Process Date: 03/18/2022
Control Number: 217789766
EOR Page 1 of 2
Rev/Aud: AA/MR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79767 Geo Zip: 90746
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/20/2020
Claims Received Date: 03/09/2022
Packet Control Number: 30016202203093007251

004648 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/26/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY PAIN
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308189

M

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

OCT 25 2022

Attention: This remittance incorporates 1 claim payments

Special Handling RM

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
CB22-00001666 10/20/2020	72WEC AC1X2R	FOOD CASTLE INC		$270.00
Nature of Benefits: Interpreter Fees at Hearing		Nature of Payment: Payment Reason - Interpreter Fees at Hrng	Service Dates 10/26/2021 10/26/2021	$270.00

Claim Handler: CAROL AZZARITO
8664019222 x2308189
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:

Issue Date	10/13/2022	Check Number	134173330 0	Total Check Amount	$270.00

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

12710614

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134173330 0

Issue Date: 10/13/2022

$********270.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
TWO HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

M

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308189

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Attention: This remittance incorporates 1 claim payments

Special Handling RM

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
CB22-00001666 10/20/2020	72WEC AC1X2R	FOOD CASTLE. INC.		$270.00
Nature of Benefits: Interpreter Fees at Hearing		Nature of Payment: Payment Reason - Interpreter Fees at Hrng	Service Dates 10/26/2021 10/26/2021	$270.00

Claim Handler: CAROL AZZARITO 8664019222 x2308189 Western Workers' Compensation Claim Center P.O. Box 14475 Lexington, KY 40512	Additional Comments:

Issue Date	10/13/2022	Check Number	134173330 0	Total Check Amount	$270.00

Please keep the above information for your records.

127108144

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79767

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000040 November 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 2 8 2022

IBR Case Number	CB22-0002172
Claim Number	
Assignment Date	10/06/2022
Claims Administrator	The Hartford
Date(s) of service	12/06/2021 - 12/06/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/20/2020
Application Received	09/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/06/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/20/2022. Response received 10/04/2022. Claims Administrator indicated an additional allowance was recommended. Copy of EOR dated 10/04/2022 was provided. No check information was found.
- Itemized invoice
    - 12/06/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/06/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/06/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308189

005073 1/3

SP 01 005073 75184 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
MAY 19 2022
BY: 79767

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAY 19 2022
BY: .....

Please keep the above information for your records.

127220738

HAR-1062

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133727790 8
Issue Date: 05/12/2022

$********90.00**
JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

127220738

⑈133727790⑈ ⑆044115443⑆ 6325597 38⑈

Process Date: 05/11/2022
Control Number: 218023174
EOR Page 1 of 2
Rev/Aud: AA/DR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79767 Geo Zip: 90242
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/20/2020
Claims Received Date: 05/09/2022
Packet Control Number: 30016202204273008083

005073 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/06/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: fmr interventional quality pain management apc downey
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES



Western Workers' Compensation Claim Center
P O Box 14475
Lexington KY 40512
8664019222 x2308189

005734 1/3

SP 01 005734 27512 G 21 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

OCT 1 1 2022 L
BY: 79767

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
OCT 1 2 2022
BY.

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

126899886



Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134144898 3

Issue Date. 10/04/2022

$**********90.00

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

126899886

⑈134144898⑈ ⑆044115443⑆ 632559738⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 10/04/2022
Re-Evaluation Control Number 901759178
Original Control Number 218023174
EOR Page 1 of 2
Rev/Aud KD/KD

Claim Number
Claimant
Provider Tax ID 330956713 Vendor 0013541032-2
Provider Ref 79767 Geo Zip 90242
Provider License 99999999

PPO/OSR ID
NPI Number
Claimant SSN
Date Of Injury 10/20/2020
Claims Received Date 10/04/2022
Packet Control Number 4222289001299

005734 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury, unspecified

MPN Claim N Region 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/06/21	11	T1013		SIGN LANGUAGE/(	8 000	0 00	-90 00	0 00	0 00	90 00	G1 273
		Original Charge/Allowance $180 00/$90 00									
		TOTALS				**0 00**	**-90 00**	**0 00**	**0 00**	**90 00**	
		TOTAL RECOMMENDED ALLOWANCE								**90 00**	

Rendering Provider Name fmr interventional quality pain management apc downey
Rendering Provider NPI

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308189

000561 1/1

MB 01 000561 90935 H 3 D

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

PAID
DEC 0 9 2022

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
10/20/2020	72WEC AC1X2R	FOOD CASTLE, INC.		$270.00
Nature of Benefits: Translation Services		Nature of Payment: Payment Reason - Translation Services	Service Dates 12/06/2021 12/06/2021	$270.00

Claim Handler: CAROL AZZARITO
8664019222 x2308189
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:
IBR CASE CB22-0002172PER MAXIMUS DETERMINATION 11/21/22, PAYING THE ADDITIONAL SUM OF $270.00.

Issue Date	12/01/2022	Check Number	134310817 9	Total Check Amount	$270.00

Please keep the above information for your records.

124290998

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79854

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001300
Claim Number	
Assignment Date	07/05/2022
Claims Administrator	The Hartford
Date(s) of service	09/30/2021 - 09/30/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/04/2020
Application Received	06/03/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/30/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/16/2022. Response not yet received.
- Itemized invoice
    - 09/30/2021 Interpreting for Shockwave therapy $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/30/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/30/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
P.O. Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308988

SP 01 005698 67642 G 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
FEB 2 0
BY: 79854

Attention: This remittance incorporates 0 claim payments

Special Handling 99

FEB 0 9 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

123007720

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133440639 1

Issue Date: 02/04/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133440639⑈ ⑆044115443⑆ 632559738⑈

02255320

Process Date: 02/04/2022
Control Number: 217628128
EOR Page 1 of 2
Rev/Aud: SM/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79854 Geo Zip: 91790
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/04/2020
Claims Received Date: 01/21/2022
Packet Control Number: 30016202201213012498

005698 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: FMR INTERVENTIONAL QUALITY
PAIN MANAGEMENT
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

79854

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000041 November 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 23 2022

IBR Case Number	CB22-0002173
Claim Number	
Assignment Date	10/06/2022
Claims Administrator	The Hartford
Date(s) of service	12/09/2021 - 12/09/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/04/2020
Application Received	09/09/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/09/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/20/2022. Response not yet received.
- Itemized invoice
    - 12/09/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/09/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/09/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2308988

005074 1/3

SP 01 005074 75184 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAY 19 2022
BY:

RECEIVED
MAY 19 2022
BY: 79859

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

12722073?

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133729667 8

Issue Date: 05/12/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

12722073?

⑈133729667⑈ ⑆044115443⑆ 63255973⑈

Process Date: 05/12/2022
Control Number: 218023205
EOR Page 1 of 2
Rev/Aud: MS/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79854 Geo Zip: 90211
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/04/2020
Claims Received Date: 04/26/2022
Packet Control Number: 30016202204263000489

005074 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/09/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: MARINA RUSSMAN MD
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 005373 38648 H 20 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

OCT 21 2022
BY: 79857

Attention: This remittance incorporates 0 claim payments

Special Handling 99

OCT 25 2022

Please keep the above information for your records

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

126947846

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134176288 2

Issue Date: 10/14/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

126947846

⑈134176288⑈ ⑆044115443⑆ 63755973⑈

RE-EVALUATION
Process Date 10/13/2022
Re-Evaluation Control Number: 901763323
Original Control Number: 218023205
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 79854 Geo Zip: 90211
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 08/04/2020
Claims Received Date: 10/12/2022
Packet Control Number: 4222289001297

005373 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/09/21	11	T1013		SIGN LANGUAGE/(	8.000	0 00	-90 00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MARINA RUSSMAN MD
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80242

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 4, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001795
Claim Number	
Assignment Date	08/23/2022
Claims Administrator	The Hartford
Date(s) of service	11/08/2021 - 11/10/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 2
Date of Injury	12/20/2019
Application Received	07/29/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 2 submitted for dates of service 11/08/2021 – 11/10/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/05/2022. Response received 08/15/2022. Claims Administrator upheld their determination.
- Itemized invoices
    - 11/08/2021 Interpreting for initial acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/10/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/08/2021 and 11/10/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/08/2021 and 11/10/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 2
Date of Service: 11/08/2021 – 11/10/2021
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/08/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

000572 1/3

MB 01 000572 30174 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
APR 07 2022

RECEIVED APR 07 2022

BY: .....

Please keep the above information for your records.

123244774

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133606695 4

Issue Date: 04/01/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford
Authorized Signature

123244774

⑈133606695⑈ ⑆044115443⑆ 63255938⑈

The Hartford Medical Bill Processing Center 39

Process Date: 04/01/2022
Control Number: 217854840
EOR Page 1 of 2
Rev/Aud: RA/BS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 03/22/2022
Packet Control Number: 30016202203222001800

000572 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DAVID FEDER
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

RECEIVED APR 07 2022

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

005650 1/3

SP 01 005650 38612 G 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED APR 14 2022

APR 14 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133629140 0

Issue Date: 04/08/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133629140⑈ ⑆044115443⑆ 53755973⑈

Process Date: 04/08/2022
Control Number: 217888696
EOR Page 1 of 2
Rev/Aud: AA/SS

RECEIVED APR 14 2022

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 04/01/2022
Packet Control Number: 30016202204012001806

005650 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/10/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: EDMOND D FEDER LA
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

M

MB 01 000420 36002 H 3 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

OCT 19 2022

OCT 18 2022

BY: .....

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134170101 8

Issue Date: 10/12/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

The Hartford

Authorized Signature

⑈134170101⑈ ⑆044115443⑆ 63755973⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 10/12/2022
Re-Evaluation Control Number: 901762611
Original Control Number 217854840
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-1
Provider Ref: 80242 Geo Zip: 90048
Provider License 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 10/12/2022
Packet Control Number: 4221869003384

000420 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim. N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/08/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	MNGR
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DAVID FEDER
Rendering Provider NPI:

CARRIER EXPLANATION REASON CODE

MNGR -REIMBURSEMENT IS BASED UPON A PRE-DETERMINED AGREEMENT WITH INSURANCE CARRIER

Thank you, Provider Relations

THE HARTFORD
Western Workers' Compensation Claim Center
P O Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 004874 87117 G 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
SEP 07 2022
BY

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

124562016

THE HARTFORD
Western Workers' Compensation Claim Center
P O Box 14475
Lexington, KY 40512

56-1544
441

Check Number 134034267 7

Issue Date 08/26/2022

$********90 00**

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

124562016

⑈134034267⑈ ⑆044115443⑆ 63255973 8⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 08/25/2022
Re-Evaluation Control Number 901744275
Original Control Number 217888696
EOR Page 1 of 2
Rev/Aud KD/KD

Claim Number			PPO/OSR ID		
Claimant			NPI Number		
Provider Tax ID	330956713	Vendor 0013541032-2	Claimant SSN		
Provider Ref	80242	Geo Zip 91607	Date Of Injury	12/20/2019	
Provider License	99999999		Claims Received Date	08/25/2022	
			Packet Control Number	4221929001005	

004874 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury unspecified

MPN Claim N Region 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/10/21	11	T1013		SIGN LANGUAGE/(	8 000	0 00	-90 00	0 00	0 00	90 00	G1 273
				Original Charge/Allowance $180 00/$90 00							
				TOTALS		**0 00**	**-90 00**	**0 00**	**0 00**	**90 00**	
				TOTAL RECOMMENDED ALLOWANCE						**90 00**	

Rendering Provider Name EDMOND D FEDER LA
Rendering Provider NPI

OWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

005396 1/1

SP 01 005396 38648 H 20 ASNGLP

OCT 24 2022

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901744275 12/20/2019	72WE AB6MHY	COMFY U S A APPAREL INC		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 11/10/2021 11/10/2021	$180.00

Claim Handler: MICHAEL FALLIS 8664019222 x2304198 Western Workers' Compensation Claim Center P.O. Box 14475 Lexington, KY 40512	Additional Comments:

Issue Date	10/14/2022	Check Number	134178298 0	Total Check Amount	$180.00

Please keep the above information for your records.

126949869

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000045 October 21, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

OCT 24 2022

IBR Case Number	CB22-0001924
Claim Number	
Assignment Date	09/07/2022
Claims Administrator	The Hartford
Date(s) of service	11/15/2021 - 11/15/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	12/20/2019
Application Received	08/12/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 11/15/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/22/2022. Responses received 09/07/2022 and 09/20/2022. Claims Administrator indicated payment was made on 08/22/2022. Copy of EOR with check information was provided.
- Itemized Invoice
    - 11/15/2021 Interpreting for follow up acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 11/15/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- Reimbursement in the amount of $90.00 received post IBR receipt. No additional reimbursement is due. $180.00 IBR application is the only amount due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 11/15/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 003621 48724 H 15 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

RECEIVED
APR 25 2022
PT. 80242

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133653208 4

Issue Date: 04/18/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133653208⑈ ⑆044115443⑆ 63255973⑧⑈

Process Date: 04/18/2022
Control Number: 217922531
EOR Page 1 of 2
Rev/Aud: RA/UA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 04/07/2022
Packet Control Number: 30016202204072002091

003621 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: EDMOND D FEDER
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD
Western Workers' Compensation Claim Center
P O Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 004875 87117 H 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention. This remittance incorporates 0 claim payments

Special Handling 99

PAID
SEP 07 2022
BY: .....

Please keep the above information for your records

124562017

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
Western Workers' Compensation Claim Center
P O Box 14475
Lexington, KY 40512

56-1544
441

Check Number 134034266 9

Issue Date 08/26/2022

$********90.00**

JPMorgan Chase Bank, N A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈134034266⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 08/25/2022
Re-Evaluation Control Number 901744270
Original Control Number 217922531
EOR Page 1 of 2
Rev/Aud KD/KD

Claim Number
Claimant
Provider Tax ID 330956713 Vendor 0013541032-2
Provider Ref 80242 Geo Zip 90048
Provider License 99999999

PPO/OSR ID
NPI Number
Claimant SSN
Date Of Injury 12/20/2019
Claims Received Date 08/25/2022
Packet Control Number 4222029001049

004875 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury unspecified

MPN Claim N Region 18

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/15/21	11	T1013		SIGN LANGUAGE/	1 000	0 00	-90 00	0 00	0 00	90 00	G1 273
				Original Charge/Allowance $180 00/$90 00							
				TOTALS		**0 00**	**-90 00**	**0 00**	**0 00**	**90 00**	
				TOTAL RECOMMENDED ALLOWANCE						**90 00**	

Rendering Provider Name EDMOND D FEDER
Rendering Provider NPI

DWC CODE DESCRIPTION

G1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 005318 53687 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
NOV 07 2022

005318 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901744270 12/20/2019	72WE AB6MHY	COMFY U S A APPAREL INC		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 11/15/2021 11/15/2021	$180.00

Claim Handler: MICHAEL FALLIS 8664019222 x2304198 Western Workers' Compensation Claim Center P.O. Box 14475 Lexington, KY 40512	Additional Comments:

Issue Date	10/28/2022	Check Number	134218464 5	Total Check Amount	$180.00

Please keep the above information for your records.

127012094

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

This page was intentionally left blank

NOT NEGOTIABLE

NOV 1 4 2022

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80242

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000057 November 7, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002092
Claim Number	
Assignment Date	09/29/2022
Claims Administrator	The Hartford
Date(s) of service	11/22/2021 - 12/13/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 5
Date of Injury	12/20/2019
Application Received	09/02/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $450.00 in additional reimbursement for a total of $630.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$630.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 5 submitted for dates of service 11/22/2021 – 12/13/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/13/2022. Response not yet received.
- Itemized Invoices
    - 11/22/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/24/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/30/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 12/01/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 12/13/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 11/22/2021 – 12/13/2021. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 11/22/2021 – 12/13/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 5 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 5.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 5
Date of Service: 11/22/2021 – 12/13/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00 Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/01/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/13/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

005361 1/3

SP 01 005361 67262 G 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

MAY 10 2022

123362567

Please keep the above information for your records.

HAR 100 2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133706306 1

Issue Date: 05/05/2022

$********270.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
TWO HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123362567

⑈133706306⑈ ⑆044115443⑆ 632559738⑈

Process Date: 05/04/2022
Control Number: 217981050
EOR Page 1 of 2
Rev/Aud: MS/RK

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 04/20/2022
Packet Control Number: 30016202204202000899

005361 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/24/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
12/01/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**540.00**	**270.00**	**0.00**	**0.00**	**270.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**270.00**	

Rendering Provider Name: DR. GOFNUNG
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 005521 66095 H 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

MAY 1 0 2022

80242

Attention: This remittance incorporates 0 claim payments

Special Handling 99

MAY 1 3 2022

Please keep the above information for your records.

123376686

HAR-1002

FOLD AT DOTTED LINE AND DETACH

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133702173 3

Issue Date: 05/04/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133702173⑈ ⑆044115443⑆ 632559738⑈

Process Date: 05/03/2022
Control Number: 217985973
EOR Page 1 of 2
Rev/Aud: RA/UA

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 04/22/2022
Packet Control Number: 30016202204223011543

005521 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR MAYYA KRAVCHENKO DC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

MB 01 000015 69320 H 1 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates
0 claim payments

Special Handling 99

MAY 13 2022

RECEIVED
MAY 13 2022
80242

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133713711 1

Issue Date: 05/07/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133713711⑈ ⑆044115443⑆ 632559738⑈

Process Date: 05/06/2022
Control Number: 218005657
EOR Page 1 of 2
Rev/Aud: RA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 04/27/2022
Packet Control Number: 30016202204273008082

000015 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/13/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DAVID FEDER LAC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80242

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000072 November 30, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 0 2 2022

IBR Case Number	CB22-0002277
Claim Number	
Assignment Date	10/14/2022
Claims Administrator	The Hartford
Date(s) of service	12/29/2021 - 12/29/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	12/20/2019
Application Received	09/16/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $0.00 in additional reimbursement for a total of $180.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$180.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/29/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/28/2022. Response received 10/26/2022. Claims Administrator indicated additional reimbursement was due. Copy of EOR with check information was provided.
- Itemized invoice
    - 12/29/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charge exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/29/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Service Overturned.**
- Reimbursement in the amount of $90.00 received post IBR receipt. $180 IBR application fee is due.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/29/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = $0.00 **$180.00 (IBR Application Fee) Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

005479 1/3

SP 01 005479 81133 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
MAY 23 2022
BY: 80242

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAY 25 2022

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133745996 8

Issue Date: 05/18/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133745996⑧⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

Process Date: 05/18/2022
Control Number: 218055032
EOR Page 1 of 2
Rev/Aud: PB/GR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 95816
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 05/10/2022
Packet Control Number: 30016202205103003713

005479 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 63

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/29/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR DAVID FEDER
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

Western Workers' Compensation Claim Center
P O Box 14475
Lexington KY 40512
8664019222 x2304198

005250 1/3

SP 01 005250 31490 H 20 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

OCT 1 4 2022

Attention. This remittance incorporates 0 claim payments

Special Handling 99

PAID
OCT 14 2022
BY:

126919497

Please keep the above information for your records

FOLD AT DOTTED LINE AND DETACH

126919497

Western Workers' Compensation Claim Center
P O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134156230 1

Issue Date: 10/07/2022

$**********90.00

JPMorgan Chase Bank, N.A
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

126919497

⑈134156230⑆ ⑆044115443⑆ 63255973⑧

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date 10/06/2022
Re-Evaluation Control Number 901760527
Original Control Number 218055032
EOR Page 1 of 2
Rev/Aud KD/KD

Claim Number
Claimant
Provider Tax ID 330956713 Vendor 0013541032-2
Provider Ref 80242 Geo Zip 95816
Provider License 99999999

PPO/OSR ID
NPI Number
Claimant SSN
Date Of Injury 12/20/2019
Claims Received Date 10/06/2022
Packet Control Number 4222349001018

005250 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1 T14 90 Injury, unspecified

MPN Claim N Region 63

Attn Medical Provider
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient Based on the receipt of clarifying and/or additional information we hereby recommend the following

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/29/21	11	T1013		SIGN LANGUAGE/(	8 000	0 00	-90 00	0 00	0 00	90 00	G1,273
		Original Charge/Allowance $180 00/$90 00									
		TOTALS				**0 00**	**-90 00**	**0 00**	**0 00**	**90 00**	
		TOTAL RECOMMENDED ALLOWANCE								90 00	

Rendering Provider Name DR DAVID FEDER
Rendering Provider NPI

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED

Thank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 004373 09037 H 16 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

004373 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901760527 12/20/2019	72WE ARSMUY	COMFY U S A APPAREL INC		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 12/29/2021 12/29/2021	$180.00

Claim Handler: MICHAEL FALLIS
8664019222 x2304198
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:

PAID
DEC 30 2022
BY: .....

Issue Date	12/19/2022	Check Number	134362193 3	Total Check Amount	$180.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124371854

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000098 December 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 2 7 2022

IBR Case Number	CB22-0002576
Claim Number	
Assignment Date	11/14/2022
Claims Administrator	The Hartford
Date(s) of service	01/10/2022 - 01/19/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Services x 4
Date of Injury	12/20/2019
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $360.00 in additional reimbursement for a total of $540.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$540.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Services x 4 submitted for dates of service 01/10/2022 – 01/19/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/26/2022. Response not yet received.
- Itemized invoices
    - 01/10/2022 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 01/11/2022 Interpreting for P&S $180.00 (Billed at a minimum of 2 hours)
    - 01/12/2022 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 01/19/2022 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 01/10/2022 - 01/19/2022. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 01/10/2022 – 01/19/2022 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Services x 4 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services x 4.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Services x 4
Date of Service: 01/10/2022 – 01/19/2022
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/10/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/11/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/12/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/19/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

RECEIVED
JUN 21 2022
BY: 80242

006057 1/3

SP 01 006057 09364 G 24 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

PAID
JUN 22 2022
BY. .....

123973569

Please keep the above information for your records.

123973569

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133820092 5

Issue Date: 06/14/2022

$********270.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
TWO HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123973569

⑈133820092⑈ ⑆044115443⑆ 63255973 8⑈

Process Date: 06/13/2022
Control Number: 218132105
EOR Page 1 of 2
Rev/Aud: RA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 05/27/2022
Packet Control Number: 30016202205273005425

006057 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/10/22	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
01/11/22	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
01/12/22	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			540.00	270.00	0.00	0.00	270.00	
			TOTAL RECOMMENDED ALLOWANCE:							270.00	

Rendering Provider Name: DAVID FEDER LAC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 006048 02898 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
JUN 14 2022
BY: .....

RECEIVED
JUN 13 2022
BY: 80242

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

123948101

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133804201 7

Issue Date: 06/08/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133804201⑈ ⑆044115443⑆ 632559738⑈

123948101

Process Date: 06/07/2022
Control Number: 218129394
EOR Page 1 of 2
Rev/Aud: MS/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 06/01/2022
Packet Control Number: 4221529002150

006048 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/19/22	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR DAVID FEDER LAC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

80242

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000106 December 29, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

JAN 0 3 2023

IBR Case Number	CB22-0001571
Claim Number	
Assignment Date	11/16/2022
Claims Administrator	The Hartford
Date(s) of service	04/29/2021 - 10/19/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 12
Date of Injury	12/20/2019
Application Received	07/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 12 submitted for dates of service 04/29/2021 – 10/19/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/31/2022. Response received 11/11/2022. Claims Administrator provided copies of EORs dated 11/11/2022 and 07/01/2022 reflecting additional allowances. Check information was provided on EOR dated 07/01/2022 for dates of service 04/29/2021 – 09/07/2021. No check information was found for date of service 10/19/2021.
- Itemized invoices
    - 04/29/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 04/30/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 05/06/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 05/07/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 07/27/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 08/03/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/10/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/17/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/24/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 08/31/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 09/07/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 10/19/2021 Interpreting for P and S $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,080.00. $90.00 for each date of service 04/29/2021 – 10/19/2021. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 04/29/2021 – 10/19/2021 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Service x 12 Overturned.**

- Reimbursement received in the amount of $1,080.00 for dates of service 04/29/2021 – 09/07/2021. $90.00 reimbursement received for date of service 10/19/2021. Additional reimbursement is due for date of service 10/19/2021.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 12.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 12
Date of Service: 04/29/2021 – 10/19/2021
Interpreter Service

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 04/30/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/06/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 05/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 07/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/17/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 08/31/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00 $90.00 (post IBR receipt)
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/07/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $180.00 (Plan Allowed) = **$0.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/19/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

004746 1/3

SP 01 004746 90083 G 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

MAR 0 8 2022

RECEIVED MAR 0 4 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133495075 0

Issue Date: 02/24/2022

$********990.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINE HUNDRED NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

The Hartford Medical Bill Processing Center 39

Process Date: 02/24/2022
Control Number: 217705411
EOR Page 1 of 2
Rev/Aud: MS/LS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 02/16/2022
Packet Control Number: 30016202202162002413

004746 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/02/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/08/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/15/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/16/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/23/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	180.00	0.00	0.00	0.00	G57,NABA
04/29/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
04/30/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
05/06/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
05/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
07/27/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/03/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/10/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/17/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/24/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
08/31/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
09/07/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**3,060.00**	**2,070.00**	**0.00**	**0.00**	**990.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**990.00**	

Rendering Provider Name: MAYYA KRAVCHENKO DC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1	-THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.
G57	-THIS SERVICE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED.

CARRIER EXPLANATION REASON CODE

601	-CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
NABA	-REIMBURSEMENT IS BEING WITHHELD AS THE TREATING DOCTOR AND/OR SERVICES RENDERED WERE NOT APPROVED BASED UPON HANDLER REVIEW. IF YOU REQUIRE ADDITIONAL INFORMATION REGARDING THIS BILL DECISION, CONTACT THE CLAIM HANDLER.

RECEIVED MAR 0 4 2022

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

MB 01 000537 07056 H 4 A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
MAR 17 2022
BY: .....

RECEIVED
MAR 16 2022
BY: .....

Please keep the above information for your records.

123152964

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133543003 2

Issue Date: 03/11/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123152964

⑈133543003 2⑈ ⑆044115443⑆ 63255973 8⑈

Process Date: 03/11/2022
Control Number: 217754711
EOR Page 1 of 2
Rev/Aud: RA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0002061871-3
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 02/28/2022
Packet Control Number: 30016202202282001887

000537 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
10/19/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR MAYYA KRAVCHENKO DC
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

SP 01 005374 28013 H 19 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
JUL 12 2022
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUL 07 2022
BY: .....

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124052624

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133877800 5

Issue Date: 07/01/2022

$******1,530.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
ONE THOUSAND FIVE HUNDRED THIRTY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133877800⑈ ⑆044115443⑆ 632559738⑈

124052624

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 07/01/2022
Re-Evaluation Control Number: 901721192
Original Control Number: 217705411
EOR Page 1 of 3
Rev/Aud: MS/RP

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 06/30/2022
Packet Control Number: 50016202206275364260

005374 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
04/02/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273 2nd BR
		Original Charge/Allowance: $180.00/$0.00									
04/08/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273 2nd BR
		Original Charge/Allowance: $180.00/$0.00									
04/15/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273 2nd BR
		Original Charge/Allowance: $180.00/$0.00									
04/16/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273 2nd BR
		Original Charge/Allowance: $180.00/$0.00									
04/23/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273 2nd BR
		Original Charge/Allowance: $180.00/$0.00									
04/29/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
04/30/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
05/06/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
05/07/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
07/27/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
08/03/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
08/10/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
08/17/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
08/24/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
08/31/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									
09/07/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,1001
		Original Charge/Allowance: $180.00/$90.00									

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

M

006265 1/3

SP 01 006265 66753 H 25 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

NOV 18 2022

Attention: This remittance incorporates 0 claim payments

Special Handling 99

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

127063218

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134253238 4

Issue Date: 11/09/2022

$********270.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
TWO HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

127063216

⑈134253238⑈ ⑆044115443⑆ 632559738⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 11/09/2022
Re-Evaluation Control Number: 901773722
Original Control Number: 218132105
EOR Page 1 of 2
Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80242 Geo Zip: 91607
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 12/20/2019
Claims Received Date: 11/09/2022
Packet Control Number: 30016202205273005425

006265 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim. N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
11/10/22	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
11/11/22	11	T1013		SIGN LANGUAGE/(	120 000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
11/12/22	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-270.00**	**0.00**	**0.00**	**270.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**270.00**	

Rendering Provider Name: DAVID FEDER LAC
Rendering Provider NPI:

OWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

M

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304198

000656 1/1

MB 01 000656 36176 H 3 D

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin CA 92781-4165

JAN 23 2023

BY:

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
		COMFY U S A APPAREL INC		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 10/19/2021 10/19/2021	$180.00

Claim Handler: MICHAEL FALLIS
8664019222 x2304198
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:

Issue Date	01/11/2023	Check Number	134424066 6	Total Check Amount	$180.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124462521

IBR - 01-10-22
12-16-25
80639

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000090 December 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 27 2022

IBR Case Number	CB22-0002580
Claim Number	
Assignment Date	11/14/2022
Claims Administrator	The Hartford
Date(s) of service	01/10/2022 - 01/10/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	01/06/2021
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 01/10/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/26/2022. Response received 11/09/2022. Claims Administrator indicated payment was issued. Copy of EOR was provided but no check information was found.
- Itemized invoice
    - 01/10/2022 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 01/10/2022 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 01/10/2022
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2309125

SP 01 006047 02898 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

006047 1/3

Attention: This remittance incorporates 0 claim payments

Special Handling 99

FAXED
JUN 13 2022
BY: 80639

FAXED
JUN 14 2022
BY: .....

Please keep the above information for your records.

123948100

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133804202 5

Issue Date: 06/08/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123948100

⑈133804202⑈ ⑆044115443⑆ 63255973⑧⑈

Process Date: 06/07/2022
Control Number: 218129393
EOR Page 1 of 2
Rev/Aud: MS/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 80639 Geo Zip: 92648
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 01/06/2021
Claims Received Date: 06/01/2022
Packet Control Number: 4221529002149

006047 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/10/22	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: DR MOHAMED HASSANIN
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

81101·
75836

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 17, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0001298
Claim Number	
Assignment Date	07/05/2022
Claims Administrator	The Hartford
Date(s) of service	09/28/2021 - 09/28/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	10/28/2016
Application Received	06/03/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 09/28/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/16/2022. Response not yet received.
- Itemized invoice
    - 09/28/2021 Interpreting for PR2/Re-eval $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 09/28/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 09/28/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
P.O. Box 14472
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
8774699222 x2307354

001487 1/4

SP 01 001487 68444 H 12 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
FEB 09 2022
BY: 75836 81109

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
FEB 09 2022
BY:

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

56-1544
441

Check Number: 133442078 5

Issue Date: 02/05/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133442078⑈ ⑆044115443⑆ 63255973⑈

Process Date: 02/04/2022
Control Number: 217627104
EOR Page 1 of 3
Rev/Aud: SS/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 81101 Geo Zip: 90048
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 10/28/2016
Claims Received Date: 01/21/2022
Packet Control Number: 30016202201212003054

001487 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/28/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: MARINA RUSSMAN MD
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

THE HARTFORD

ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington KY 40512-4472
877/469-9222

OCT 0 3 2022

BY:

OCT 0 3 2022

BY:

OCT 0 3 2022

SP 01 005818 15653 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
10/28/2016	45WN R21500	TRANSDIGM GROUP, INC		$270 00
Nature of Benefits Translation Services		Nature of Payment Payment Reason - Translation Services	Service Dates 09/28/2021 09/28/2021	$270 00

Claim Handler JAMES MARINO
877/469-9222
ClaimPlus Work Comp Claim Center
PO Box 14472
Lexington, KY 40512-4472

Additional Comments
For interpreter services for Jorge Escobar related to workers compensation claim Y2PC64570 for DOS 09/28/2021

Issue Date	09/23/2022	Check Number	134115042 9	Total Check Amount	$270 00

Please keep the above information for your records

[redacted]

126857601

HAR 100

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82312

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000050 November 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

NOV 30 2022

IBR Case Number	CB22-0002276
Claim Number	
Assignment Date	10/13/2022
Claims Administrator	The Hartford
Date(s) of service	12/09/2021 - 12/09/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	06/23/2021
Application Received	09/16/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 12/09/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/27/2022. Response not yet received.
- Itemized invoice
    - 12/09/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 12/09/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Service Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 12/09/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 004944 83754 G 22 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

MAY 27 2022
BY: 82312

PAID
MAY 27 2022
BY:

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133752315 1

Issue Date: 05/20/2022

$**********90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133752315⑈ ⑆044115443⑆ 6325597 38⑈

Process Date: 05/19/2022
Control Number: 218053846
EOR Page 1 of 2
Rev/Aud: PB/GR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82312 Geo Zip: 90007
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/23/2021
Claims Received Date: 05/05/2022
Packet Control Number: 30016202205053000191

004944 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
12/09/21	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
		TOTALS:				**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: DR HOJUNG LEE
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

MB 01 000785 98659 H 4 D

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

RECEIVED
DEC 14 2022
BY:

000785 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
06/23/2021	72WEC AK3UAZ	FARMERS MARKET NATURAL FOOD		$270.00
Nature of Benefits: Translation Services		Nature of Payment: Payment Reason - Translation Services	Service Dates 12/09/2021 12/09/2021	$270.00

Claim Handler: KYLE RODRIGUEZ
866/401-9222
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:
DOS 12/9/2021Claim y2ec68096

Issue Date	12/08/2022	Check Number	134330910 7	Total Check Amount	$270.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124322424

82312

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000089 December 22, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

DEC 2 7 2022

IBR Case Number	CB22-0002574
Claim Number	
Assignment Date	11/10/2022
Claims Administrator	The Hartford
Date(s) of service	01/11/2022 - 01/17/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 2
Date of Injury	06/23/2021
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $180.00 in additional reimbursement for a total of $360.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$360.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 2 submitted for date of service 01/11/2022 – 01/17/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/25/2022. Response received 11/09/2022. Claims Administrator indicated additional payment was issued. EORs were provided but no check information was found.
- Itemized invoices
    - 01/11/2022 Interpreting for shock wave therapy $180.00 (Billed at a minimum of 2 hours)
    - 01/17/2022 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00 for each date of service 01/11/2022 and 01/17/2022. Charges exceed the maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavits dated 01/11/2022 and 01/17/2022 were signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavits, and market rate examples; additional reimbursement is indicated. **Interpreter Service x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 2.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 2
Date of Service: 01/11/2022 – 01/17/2022
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/11/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/17/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 004052 05401 G 15 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUN 15 2022
BY: 82312

DATED
JUN 16 2022
BY: .....

Please keep the above information for your records.

123958925

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133812577 0

Issue Date: 06/10/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

123958925

⑈133812577⑈ ⑆044115443⑆ 632559738⑈

Process Date: 06/09/2022
Control Number: 218139984
EOR Page 1 of 2
Rev/Aud: AA/SS

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82312 Geo Zip: 92781
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/23/2021
Claims Received Date: 05/23/2022
Packet Control Number: 30016202205232001013

004052 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/11/22	11	T1013		SIGN LANGUAGE/(	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: pro ivy medical group pc
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 006259 66753 G 25 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates 0 claim payments

Special Handling 99

NOV 18 2022

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

127063212

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134253239 2

Issue Date: 11/09/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

127063212

⑈134253239 2⑈ ⑆044115443⑆ 6325597 38⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 11/09/2022
Re-Evaluation Control Number: 901773887
Original Control Number: 218139984

Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82312 Geo Zip: 92781
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/23/2021
Claims Received Date: 11/09/2022
Packet Control Number: 6222509001885

006259 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

IPN Claim: N Region: 26

ttn Medical Provider

his is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on ne receipt of clarifying and/or additional information we hereby recommend the following:

OS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
1/11/22	11	T1013		SIGN LANGUAGE/(	8.000	0 00	-90.00	0.00	0.00	90 00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

endering Provider Name: pro ivy medical group pc
endering Provider NPI:

WC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

ARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

hank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 005148 20141 H 18 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
JUL 05 2022
BY: 82312

Attention: This remittance incorporates 0 claim payments

Special Handling 99

PAID
JUL 08 2022
BY:

Please keep the above information for your records.

124019095

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133854505 1

Issue Date: 06/24/2022

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford

Authorized Signature

⑈133854505⑈ ⑆044115443⑆ 632559738⑈

124019095

Process Date: 06/24/2022
Control Number: 218181757
EOR Page 1 of 2
Rev/Aud: PB/DR

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82312 Geo Zip: 90638
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/23/2021
Claims Received Date: 06/01/2022
Packet Control Number: 30016202206013000464

005148 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/17/22	11	T1013		SIGN LANGUAGE/I	8.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**180.00**	**90.00**	**0.00**	**0.00**	**90.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**90.00**	

Rendering Provider Name: TED PRIEBE
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 001594 29742 G 12 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
JAN 18 2023
PY.

Attention: This remittance incorporates
0 claim payments

Special Handling 99

PAID
JAN 17 2023
82312

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH

124449755

HAR 100

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134414617 1

Issue Date: 01/07/2023

$********90.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

124449755

⑈134414617⑈ ⑆044115443⑆ 63255973⑧⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date: 01/06/2023
Re-Evaluation Control Number: 901796666
Original Control Number: 218181757
EOR Page 1 of 2
Rev/Aud: KD/KD

M

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82312 Geo Zip: 90638
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 06/23/2021
Claims Received Date: 01/03/2023
Packet Control Number: 4222699002263

001594 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 18

Attn Medical Provider:
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
01/17/22	11	T1013		SIGN LANGUAGE/(	120.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-90.00**	**0.00**	**0.00**	**90.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**90.00**	

Rendering Provider Name: TED PRIEBE
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

273 -ADDITIONAL ALLOWANCE RECOMMENDED.

Thank you, Provider Relations

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 007190 37927 H 27 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
JAN 2 2023
JAN 2 3 2023

007190 1/1

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
901796666 06/23/2021		FARMERS MARKET NATURAL FOOD		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 01/17/2022 01/17/2022	$180.00

Claim Handler: KYLE RODRIGUEZ
866/401-9222
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

Additional Comments:

Issue Date	01/12/2023	Check Number	134426831 5	Total Check Amount	$180.00

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

124474752

MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

82519

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 28, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

IBR Case Number	CB22-0002584
Claim Number	
Assignment Date	11/15/2022
Claims Administrator	The Hartford
Date(s) of service	09/27/2021 - 01/07/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service x 13
Date of Injury	04/21/2021
Application Received	10/07/2022

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $1,170.00 in additional reimbursement for a total of $1,350.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,350.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: The Hartford
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service x 13 submitted for dates of service 09/27/2021 - 01/07/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/27/2022. Responses received 11/09/2022 and 12/15/2022. Claims Administrator indicated additional payment was made. Copy of EOR dated 11/09/2022 was provided, no check information was found. Claims Administrator also provided copies of IBR documents.
- Itemized Invoices
    - 09/27/2021 Interpreting for initial exam $180.00 (Billed at a minimum of 2 hours)
    - 10/22/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/27/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 10/29/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/03/2021 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
    - 11/09/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/11/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/16/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/18/2021 Interpreting for physiotherapy $180.00 (Billed at a minimum of 2 hours)
    - 11/22/2021 Interpreting for PR2/Reeval $180.00 (Billed at a minimum of 2 hours)
    - 11/24/2021 Interpreting for chiro $180.00 (Billed at a minimum of 2 hours)
    - 12/10/2021 Interpreting for EMG testing $180.00 (Billed at a minimum of 2 hours)
    - 01/07/2022 Interpreting for acupuncture $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $1,170.00 ($90.00 for each date of service 09/27/2021 – 01/07/2022). Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments. **Interpreter Service x 13 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service x 13.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service x 13
Date of Service: 09/27/2021 - 01/07/2022
Interpreter

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 09/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/27/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 10/29/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/03/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/09/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/11/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/16/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/18/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/22/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 11/24/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 12/10/2021** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Service Code	Interpreter Services
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn DOS 01/07/2022** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

The Hartford
PO Box 14475
Lexington, KY 40512

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2303163

SP 01 006288 07998 G 24 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

PAID
JUN 20 2022
BY: .....

Attention: This remittance incorporates 0 claim payments

Special Handling 99

RECEIVED
JUN 20 2022
BY: 82519

Please keep the above information for your records.

123966025

HAR 1002

FOLD AT DOTTED LINE AND DETACH

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 133816670 0

Issue Date: 06/13/2022

$******1,170.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
ONE THOUSAND ONE HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

⑈133816670⑈ ⑆044115443⑆ 63255973⑈

123966025

Process Date: 06/10/2022
Control Number: 218141852
EOR Page 1 of 2
Rev/Aud: RA/RP

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82519 Geo Zip: 92801
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN: XXX-XX-7687
Date Of Injury: 04/21/2021
Claims Received Date: 05/24/2022
Packet Control Number: 30016202205243900179

006288 2/3

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
09/27/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/27/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
10/29/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/03/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/09/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/11/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/16/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/18/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/22/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
11/24/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
12/10/21	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
01/07/22	11	T1013		SIGN LANGUAGE/(	1.000	180.00	90.00	0.00	0.00	90.00	G1,601
			TOTALS:			**2,340.00**	**1,170.00**	**0.00**	**0.00**	**1,170.00**	
			TOTAL RECOMMENDED ALLOWANCE:							**1,170.00**	

Rendering Provider Name: DR. JAVAD NAJIB, D.C.
Rendering Provider NPI:

DWC CODE DESCRIPTION

G1 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

CARRIER EXPLANATION REASON CODE

601 -CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES

M

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304016

SP 01 006260 66753 H 25 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

006260 1/4

Attention: This remittance incorporates 0 claim payments

Special Handling 99

NOV 18 2022

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

1270 63213

THE HARTFORD
Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134253231 7

Issue Date: 11/09/2022

$******1,170.00**

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
ONE THOUSAND ONE HUNDRED SEVENTY DOLLARS AND 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

The Hartford
Authorized Signature

1270 63213

⑈134253231⑈ ⑆044115443⑆ 63255973 8⑈

The Hartford Medical Bill Processing Center 39

RE-EVALUATION
Process Date. 11/09/2022
Re-Evaluation Control Number: 901773772
Original Control Number: 218141852

Rev/Aud: KD/KD

Claim Number:
Claimant:
Provider Tax ID: 330956713 Vendor: 0013541032-2
Provider Ref: 82519 Geo Zip: 92801
Provider License: 99999999

PPO/OSR ID:
NPI Number:
Claimant SSN:
Date Of Injury: 04/21/2021
Claims Received Date: 11/09/2022
Packet Control Number: 4222589001502

006260 2/4

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin, CA 92781

ICD-DX1: T14.90 Injury, unspecified

MPN Claim: N Region: 26

Attn Medical Provider.
This is in response to your recent inquiry regarding the bill review analysis for services rendered to the above referenced patient. Based on the receipt of clarifying and/or additional information we hereby recommend the following:

DOS	POS	Code	Mod	Service Description	Units	Charge	BR/Red	PPO/Red	Other/Red	Allowance	Reasons
9/27/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
0/22/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
0/27/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
0/29/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/03/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/09/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/11/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/16/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0 00	0.00	90 00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/18/21	11	T1013		SIGN LANGUAGE/(	1 000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/22/21	11	T1013		SIGN LANGUAGE/(	1.000	0 00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/24/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
2/10/21	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
1/07/22	11	T1013		SIGN LANGUAGE/(	1.000	0.00	-90.00	0.00	0.00	90.00	G1,273
		Original Charge/Allowance: $180.00/$90.00									
		TOTALS:				**0.00**	**-1,170.00**	**0.00**	**0.00**	**1,170.00**	
		TOTAL RECOMMENDED ALLOWANCE:								**1,170.00**	

endering Provider Name: DR. JAVAD NAJIB, D.C.
endering Provider NPI:

WC CODE DESCRIPTION

31 -THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

THE HARTFORD

Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2300043

006575 1/1

SP 01 006575 42012 H 23 ASNGLP

JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED
JAN 24 2023
BY: .....

Attention: This remittance incorporates 1 claim payments

Special Handling 99

Explanation of Benefits

Invoice Number/ Date of Loss	Policy Number/ Claim Number	Insured Name/ Claimant Name		Amount Paid
		GRAMERCY BAKERY, LLC		$180.00
Nature of Benefits: Alternative Dispute Resolution		Nature of Payment: Payment Reason - Alt Dispute Resolution	Service Dates 09/27/2021 01/07/2022	$180.00

Claim Handler: MICHELLE TRADER 8664019222 x2300043 Western Workers' Compensation Claim Center P.O. Box 14475 Lexington, KY 40512	Additional Comments:

Issue Date	01/17/2023	Check Number	134439334 9	Total Check Amount	$180.00

Please keep the above information for your records.

124625753

HAR-100-2

FOLD AT DOTTED LINE AND DETACH

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

75998

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

000030 January 27, 2022

Joyce Altman Interpreters, Inc.
Attn: Joyce Altman
PO Box 4165
Tustin, CA 92781

FEB 0 3 2022

IBR Case Number	CB21-0002754
Claim Number	
Assignment Date	12/06/2021
Claims Administrator	York
Date(s) of service	05/07/2021 - 05/07/2021
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	02/25/2019
Application Received	11/05/2021

Dear Joyce Altman Interpreters, Inc.:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $180.00 for the review cost and $90.00 in additional reimbursement for a total of $270.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$270.00** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination.

Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS Federal Services

Cc: York
Division of Workers' Compensation (DWC) Medical Unit

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- CCR § 9795.3
- Market Rate Examples

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider is seeking remuneration for Interpreter Service submitted for date of service 05/07/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/18/2021. Response not yet received.
- Itemized invoice
    - 05/07/2021 Interpreting for follow up chiro treatment $180.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of $90.00. No payment information provided or EOR did not include any payment reduction rationale.
- **CCR § 9795.3. Fees for Interpreter Services.**
    - a) Fees for services performed by a certified or provisionally certified interpreter, upon request of an employee who does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:
        - An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;
        - A medical treatment appointment;
    - b) The following fees for Interpreter Services provided by a certified or provisionally certified interpreter shall be presumed to be reasonable:
        2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.
- Interpretation Confirmation Affidavit dated 05/07/2021 was signed by the patient, medical provider and interpreter certify the patient is not proficient in English and requested a certified interpreter.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of $90.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Based on the documentation, signed affidavit, and market rate examples; additional reimbursement is indicated. **Interpreter Services Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Services.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service
Date of Service: 05/07/2021
Interpreter

Service Code	Interpreter Service
Provider Billed	$180.00
Plan Allowed	$90.00
Dispute Amount	$90.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	$180.00
Notes	**Overturn** $90.00 (Market Rate for One Hour) * 2 (hours) = $180.00 - $90.00 (Plan Allowed) = **$90.00** **Due Provider** Refer to Analysis

Copy to:

York
PO Box 619079
Roseville, CA 95661

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

75998

york.

Explanation of Review

PO Box 14841
Lexington, KY 40512
800.932.5535
(f) 866.548.2637

AUG 3 0 2021

Client: STATE OF CA - IHSS

Patient:

Adjuster: Collado, Sylvia
707 3RD STREET
West Sacramento, CA 95605

Claim #:
DOI: 02/25/19
Account #: 75998
Coverage: Workers Compensation

Employer: State of CA - IHSS

Claim Juris / JCN: CA / 20190510173018175403
Carrier Received: 08/12/21
Date Received: 08/16/21
Date Printed: 08/17/21
Processor: GW
Review #: 21322928
Document Name: YORK11838963
Check Number: 69436826
Check Date: 8/22/21

Provider: JOYCE ALTMAN INTERPRETERS, INC
PO BOX 4165
Tustin, CA 92781

Dates of Service: 05/07/21 - 05/07/21

Diagnosis Code(s):
T1490XA Injury, unspecified, initial encounter

TIN: 330956713
Rendering Zip: 92781
Bill Type: Other
NPI:

Treating Provider: JOYCE ALTMAN INTERPRETERS INC

Line	DOS	Procedure /Modifier	Description	Units	Billed Charges	FS/UCR Reductions	Audit Reductions	Network Reductions	Allowance	Qualify Code
1	05/07/21	T1013	SIGN LANG/ORAL INTERPRETER	8	$180.00	$90.00	$0.00	$0.00	$90.00	
			Totals:	**8**	**$180.00**	**$90.00**	**$0.00**	**$0.00**	**$90.00**	

0000001230

Qualify Code Descriptions:

Notes: Checks are mailed separately from the EOR
NOW USE OUR SECURE PROVIDER SITE TO LOOK UP BILL PAYMENT STATUS:https://providergateway.sedgwick.com DID YOU KNOW YOU CAN

Amounts billed above this payment or the recommended allowances as shown are hereby objected to as being in excess of amounts authorized under Labor Code sections 4603.2, 4600.4, 4620 through 4646 and 5307.1 or Regulation sections 9790 through 9795. A Second Review of the submitted charges may be requested in the manner prescribed by the Administrative Director within 90 days of service of the Explanation of Review pursuant to Labor Code section 4603.2(e). Should you dispute the amounts paid following receipt of the final determination of Second Review, you may request an Independent Bill Review pursuant to Labor Code section 4603.6 in the manner prescribed by the Administrative Director within 30 day of service of the final determination of Second Review. A copy of the request with the documentation shall be served on the employer. The request form and proof of payment of the fee required by the subdivision shall be filed with the Administrative Director. Upon notice of assignment of the independent bill reviewer, the requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within 10 days. Pursuant to Labor Code section 3751(b), a provider of medical services is prohibited from collecting compensation from the injured employee.

For questions regarding this review, please contact York Risk Services at 800.932.5535 (f) 866.548.2637