

Maximus IBR Determinations Market Rate Summary Graph 2024

No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
1	2043236	9/9/2022	2/23/2024	\$140.00	Follow up Physiotherapy (\$230)	\$140.00	100%	AIU Insurance / Constitution State Services
2	2043236	2/27/23- 3/11/23	5/8/2024	\$280.00	Follow up Physiotherapy; Follow up Physiotherapy (\$230 each)	\$280.00	100%	AIU Insurance / Constitution State Services
3	1962725	10/19/2022	2/26/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	AmeriTrust Group *
4	1962725	3/8/2023- 3/20/2023	5/10/2024	\$280.00	Acupuncture tx; Follow up Physiotherapy (\$230 each)	\$280.00	100%	AmeriTrust Group *
5	2015281	8/25/2022	1/2/2024	\$140.00	Follow up Physiotherapy (\$230)	\$140.00	100%	AmTrust North America
6	2031291	1/9/2023	4/1/2024	\$140.00	Follow up Chiro treatment (\$230)	\$140.00	100%	AmTrust North America
7	2189666	4/12/23- 4/14/23	11/26/2024	\$280.00	PR2/Re-eval; Follow up Chiro treatment (\$230 each)	\$280.00	100%	AmTrust North America
8	2096402	11/30/2022	3/8/2024	\$140.00	Follow up Acupuncture (\$230)	\$140.00	100%	Benchmark Administrators
9	2000169	9/23/2022	1/18/2024	\$140.00	Follow up Acupuncture (\$230)	\$140.00	100%	Cannon Cochran

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No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
10	2101535	4/11/2023	6/3/2024	\$140.00	Follow up Physiotherapy (\$230)	\$140.00	100%	Cannon Cochran
11	2331959	12/19/23- 1/16/24	12/13/2024	\$280.00	Follow up Chiro treatment; PR2/Re-eval (\$230 each)	\$280.00	100%	Cannon Cochran
12	2266330	5/15/2023- 6/26/2023	8/12/2024	\$370.00	Initial Exam; PR2/Re-eval (\$230 each)	\$370.00	100%	Church Mutual
13	2266330	10/18/2023	10/17/2024	\$185.00	Follow up Chiro treatment (\$230)	\$185.00	100%	Church Mutual
14	2266330	1/9/2024	12/16/2024	\$175.00	PR2/Re-eval Via Telemed (\$230)	\$175.00	100%	Church Mutual
15	2169051	3/7/23 3/8/23 3/15/23	4/16/2024	\$420.00	PR2/Re-eval; Follow up Physiotherapy; Follow up Physiotherapy (\$230 each)	\$420.00	100%	CNA-
16	2210376	4/12/23- 10/10/23	11/4/2024	\$280.00	Follow up Physical Tx & Acu; F/u Physical Tx & Acup Tx (\$230 each)	\$280.00	100%	Cottingham & Butler Claims
17	2424369	2/12/2024	1/30/2025	\$140.00	Follow up Physiotherapy (\$230)	\$140.00	100%	Cottingham & Butler Claims
18	2424369	3/22/2024	2/6/2025	\$140.00	EMG & NCV U/E (\$230)	\$140.00	100%	Cottingham & Butler Claims

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No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
19	2123746	5/24/2023	7/30/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Crum & Forster
20	2123746	8/29/23- 9/25/23	10/3/2024	\$280.00	Shockwave tx 1 R/Shldr; PR2/Re-eval (\$230 each)	\$280.00	100%	Crum & Forster
21	2238443	5/24/2023	7/22/2024	\$140.00	Acupuncture Tx & F/u Physical Tx (\$230)	\$140.00	100%	Crum & Forster
22	84034	9/16/2022	4/18/2024	\$50.00	PR2/Re-eval (\$230)	\$50.00	100%	Employers *
23	1965814	9/27/2022	2/14/2024	\$140.00	Follow up Acupuncture (\$230)	\$140.00	100%	Farmers Insurance *
24	1965814	10/10/2022	3/5/2024	\$140.00	Follow up Acupuncture (\$230)	\$140.00	100%	Farmers Insurance *
25	2281434	7/26/2023	8/21/2024	\$140.00	Follow up Physical Therapy (\$230)	\$140.00	100%	Gallagher Bassett *
26	2120926	5/10/2023	7/30/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Great American
27	1994700	7/25/2022- 7/27/2022	1/14/2024	\$325.00	Follow up Acupuncture; Follow up Physiotherapy (\$230 each)	\$325.00	100%	Guard Insurance Group

Maximus IBR Determinations Market Rate Summary Graph 2024

No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
28	1994700	9/19/2022	2/28/2024	\$140.00	Follow up Physiotherapy (\$230)	\$140.00	100%	Guard Insurance Group
29	2252092	1/15/2024	2/4/2025	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Guard Insurance Group
30	1966294	5/30/2023	7/22/2024	\$140.00	Acupuncture Tx (\$230)	\$140.00	100%	Helmsman Management
31	1966294	5/10/2023	12/2/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Helmsman Management
32	1952173	4/18/2023	6/14/2024	\$34.96	Acupuncture tx (\$230)	\$34.96	100%	ICW
33	1967592	8/24/2022- 8/25/2022	1/25/2024	\$100.00	Follow up Acupuncture; Follow up Physiotherapy (\$230 each)	\$100.00	100%	ICW
34	2212995	12/19/2023	12/5/2024	\$50.00	PR2/Re-eval (\$230)	\$50.00	100%	ICW
35	84264	9/22/2022	2/26/2024	\$140.00	P AND S (\$230)	\$140.00	100%	Liberty Mutual Insurance
36	84518	9/9/2022	5/16/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Liberty Mutual Insurance

Maximus IBR Determinations Market Rate Summary Graph 2024

No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
37	2086998	2/8/2023- 3/1/2023	4/4/2024	\$280.00	F/U Physical Tx & F/U Acu Tx; Acupuncture Tx & F/u Physical Tx (\$230 each)	\$280.00	100%	Liberty Mutual Insurance
38	2006221	9/8/2022	1/2/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	Republic Indemnity
39	2140640	5/2/2023	6/24/2024	\$140.00	Initial Exam (\$230)	\$140.00	100%	Republic Indemnity
40	2222628	8/29/2023- 9/28/2023	10/3/2024	\$280.00	Follow up Physiotherapy; PR2/Re-eval VIA TELEMED (\$230 each)	\$280.00	100%	Republic Indemnity
41	2246985	4/27/2023 5/8/2023 5/12/2023 5/24/2023 5/26/2023 5/31/2023 6/5/2023 6/8/2023 6/12/2023 7/7/2023 7/10/2023 7/20/2023 7/28/2023 7/31/2023 8/11/2023 8/30/2023 9/8/2023	12/9/2024	\$2,380.00	1-Initial Exam; 4-Acupuncture tx; 1-Initial Physiotherapy; 1-Follow up Chiro treatment; 6-Follow up Physiotherapy; 1- PR2/Re-eval; Follow up Physiotherapy; 1- EMG & NCV L/E; 1- PR2/Re-eval; 1-EMG & NCV UE + F/u Physion. (\$230 each)	\$2,380.00	100%	Sedgwick Claims

Maximus IBR Determinations Market Rate Summary Graph 2024

No	Invoice #/ Injured Worker ID#	Service Date(s)	Maximus Determination Date	Disputed Amt	Type of Svc(s)	Maximus Determined Addtl Reimb Amt to be Paid for DOS only	Market Rate % paid	Payment Authority
42	81799	12/9/2022	4/2/2024	\$140.00	Acupuncture Tx (\$230)	\$140.00	100%	The Hanover *
43	2013290	10/3/2022	1/30/2024	\$140.00	Follow up Acupuncture & F/u Phys Tx (\$230)	\$140.00	100%	The Hartford
44	2107341	11/15/2023	12/24/2024	\$140.00	PR2/Re-eval (\$230)	\$140.00	100%	The Hartford
45	2144220	5/18/24- 8/3/24	6/17/2024	\$100.00	Acupuncture tx; PR2/Re-eval (\$230 each)	\$100.00	100%	The Hartford
46	1962290	1/30/23- 2/8/23	4/8/2024	\$280.00	Follow up Physiotherapy; PR2/Re-eval. (\$230 each)	\$280.00	100%	Travelers
47	2093955	9/26/2022	2/22/2024	\$140.00	Initial Exam (\$230)	\$140.00	100%	Travelers
48	2305484	11/20/2023	11/25/2024	\$140.00	Acupuncture Tx (\$230)	\$140.00	100%	Travelers
49	73972	11/2/2018	2/15/2024	\$350.00	QME EVAL (\$575)	\$350.00	100%	UEF Uninsured Employers Trust Fund *
50	2415051	12/18/23- 1/15/24	12/31/2024	\$280.00	Initial Exam; Follow up Physiotherapy (\$230 each)	\$280.00	100%	Zurich

RECEIVED FEB 26 2024



MAXIMUS FEDERAL SERVICES, INC.

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

1) 2043236

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 23, 2024

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

IBR Case Number	CB23-0003408
Claim Number	FYV0832
Assignment Date	01/04/2024
Claims Administrator	AIU Insurance Company
Date(s) of service	09/09/2022 - 09/09/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	04/21/2022
Application Received	12/08/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: AIU 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 T1013 (Interpreter Service) submitted for date of service 09/09/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/19/2023. Response not yet received.
- CMS 1500, place of service 11
 - T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- 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 09/09/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 09/09/2022**Interpreter**

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

AIU Insurance Company
PO Box 650461
Dallas, TX 75265

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

CSS LLC - CSS WORKERS COMPENSATION
PO BOX 650461
DALLAS TX 75265-0461

903A 68288589

SD00506



Constitution
State
Services

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

DATE: 07/28/23
LOSS DATE: 04/21/22
FILE NUMBER: 730 CB FYV0832 N
REFERENCE #: 1034505802SW

ACCOUNT NAME:
NATIONAL FREIGHT INC

AIU INSURANCE COMPANY

EXPLANATION OF PAYMENT

THIS BILL HAS BEEN REPRICED. THE EXPLANATION FOR THE REPRICING
HAS BEEN SENT UNDER SEPARATE COVER.

RECEIVED AUG 02 2023

DATE OF SERVICE: 09/09/22

INVOICE # 3234DB10320180-1
TOTAL PAID: \$90.00

ENTERED AUG 02 2023

FOR ADDITIONAL INFORMATION, CONTACT: YOYO LEUNG AT (909)612-3761

209009311
DETACH CHECK

UNSUMM -111311
OVRPUNS2-121295
DETACH CHECK

CSS LLC - CSS WORKERS COMPENSATION
PO BOX 650461
DALLAS TX 75265-0461

SD00016

903A 68484772

**Constitution
State
Services**

DATE: 04/11/24
LOSS DATE: 04/21/22
FILE NUMBER: 730 CB FYV0832 N
REFERENCE #: 2002846119SW

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

ACCOUNT NAME:
NATIONAL FREIGHT INC

AIU INSURANCE COMPANY

EXPLANATION OF PAYMENT

DATE OF SERVICE: 09/09/22

TOTAL PAID: \$140.00
TAX INFO: 330956713 Y
PAY MISC: INVOICE # 3234DB10320180-1
PAYEE:
JOYCE ALTMAN INTERPRETERS INC

RECEIVED APR 22 2024

ENTERED APR 22 2024

FOR ADDITIONAL INFORMATION, CONTACT: CAROLINA CABRAL AT (909)612-3473

102007727
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

RECEIVED MAY 13 2024

2) 2043236

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



May 08, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000448
Claim Number	FYV0832
Assignment Date	03/26/2024
Claims Administrator	AIU Insurance Company
Date(s) of service	02/27/2023 - 03/11/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	04/21/2022
Application Received	03/01/2024

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: AIU 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 T1013 (Interpreter Service) x 2 submitted for dates of service 02/27/2023 – 03/11/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/08/2024. Response received 04/30/2024. Claims Administrator upheld their determination.
- CMS 1500, place of service 11
 - 02/27/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 03/11/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 02/27/2023 and 03/11/2023. 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 02/27/2023 and 03/11/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$180.00 for dates of service 02/27/2023 – 03/11/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 02/27/2023 – 03/11/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 02/27/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake 03/11/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

AIU Insurance Company
PO Box 650461
Dallas, TX 75265

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

CSS LLC - CSS WORKERS COMPENSATION
PO BOX 650461
DALLAS TX 75265-0461

SD00531

903A 68374872



JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

DATE: 11/17/23

TIN: 330956713

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

Our Customer Service Phone is (877)228-2758.
Please contact us if you have any questions.

AIU INSURANCE COMPANY

EXPLANATION OF PAYMENT

Name	File Number	Dates of Service	Amount	Reference	Remarks
	730 CB	03/11/23	\$ 90.00	1035468850SW	INVOICE # 3234DB11083001-1
	FYV0832N	02/27/23	\$ 90.00	1035388198SW	INVOICE # 3234DB11017168-1
	730 CB				
	FYV0832N				
RECEIVED NOV 27 2023				ENTERED NOV 27 2023	

Total Amount Paid

\$*****180.00

PAYMENT INQUIRIES? E-MAIL MBMPINQS@TRAVELERS.COM, FAX 888-558-8656, PH. 877-228-2758.

CSS LLC - CSS WORKERS COMPENSATION
PO BOX 650461
DALLAS TX 75265-0461

SD00025

903A 68516693



JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

DATE: 05/21/24
TIN: 330956713
PROVIDER: JOYCE ALTMAN INTERPRETERS INC

RECEIVED MAY 28 2024

Our Customer Service Phone is 1-877-331-0230.
Please contact us if you have any questions.

AIU INSURANCE COMPANY

EXPLANATION OF PAYMENT

Name	File Number	Dates of Service	Amount	Reference	Remarks
	730 CB FYV0832N	02/27/23	\$ 140.00	2002870399SW	INVOICE # 3234DB11017168-1
	730 CB FYV0832N	03/11/23	\$ 140.00	2002870403SW	INVOICE # 3234DB11083001-1
ENTERED MAY 28 2024					
Total Amount Paid			\$*****280.00		

RECEIVED FEB 29 2024

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

3) 1962725

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 26, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003409
Claim Number	WCDY22002002
Assignment Date	01/05/2024
Claims Administrator	AmeriTrust
Date(s) of service	10/19/2022 - 10/19/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	03/14/2022
Application Received	12/08/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: AmeriTrust

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 T1013 (Interpreter Service) submitted for date of service 10/19/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/20/2023. Response not yet received.
- CMS 1500, place of service 11
 - 10/19/2022 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$90.00. Charges exceed the OMFS allowance; charge 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 for date of service 10/19/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 10/19/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

AmeriTrust
PO Box 219559
Kansas City, MO 64121

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

PROCENTURY INSURANCE COMPANY
PO BOX 219559
KANSAS CITY, MO 64121
(800) 825-9489

RECEIVED AUG 14 2023

Date Issued
8/7/2023

Check No.
Bank of America.

35924
70-2328
719 IL

ENTERED AUG 15 2022

Payee: JOYCE ALTMAN INTERPRETERS INC

Insured Memo	Claimant Name Service Date(s)	Claim Number Loss Date	AMOUNT
SCOTT H ALLEN CADILLAC, INC 3234db10467375-1	10/19/2022-10/19/2022	WCDY22002002 3/14/2022	90.00

CHECK TOTAL: *****\$90.00



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED MAY 13 2024

4) 1962725

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



May 10, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000488
Claim Number	WCDY22002002
Assignment Date	04/01/2024
Claims Administrator	AmeriTrust Group Inc
Date(s) of service	03/08/2023 - 03/20/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	03/14/2022
Application Received	03/07/2024

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: AmeriTrust Group Inc
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 T1013 (Interpreter Service) x 2 submitted for dates of service 03/08/2023 – 03/20/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/14/2024. Response not yet received.
- CMS 1500, place of service 11
 - 03/08/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr. min)
 - 03/20/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr. min)
- EORs reflect reimbursement of \$90.00 for each date of service 03/08/2023 and 03/20/2023. Charges exceed OMFS allowance; charge 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 03/08/2023 and 03/20/2023, were signed by the patient, medical provider and interpreters 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$180.00 for dates of service 03/08/2023 – 03/20/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2

Date of Service: 03/08/2023 – 03/20/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 03/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 03/20/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

AmeriTrust Group Inc
PO Box 219559
Kansas City, MO 64121

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

PROCENTURY INSURANCE COMPANY
PO BOX 219559
KANSAS CITY, MO 64121
(800) 825-9489

RECEIVED DEC 01 2023

Date Issued
11/10/2023

Check No.
Bank of America.

36581
70-2328
719 IL

Payee: JOYCE ALTMAN INTERPRETERS INC

ENTERED DEC 04 2023

Insured Memo	Claimant Name Service Date(s)	Claim Number Loss Date	AMOUNT
SCOTT HALLEN CADILLAC, INC		WCDY22002002	
3234db11070751-1	3/8/2023-3/8/2023	3/14/2022	90.00

CHECK TOTAL:

*****\$90.00

PROCENTURY INSURANCE COMPANY
PO BOX 219559
KANSAS CITY, MO 64121
(800) 825-9489

Date Issued
11/21/2023

Check No.
Bank of America

36643
70-2328
719 IL

Payee: JOYCE ALTMAN INTERPRETERS INC

Insured Memo	Claimant Name Service Date(s)	Claim Number Loss Date	AMOUNT
SCOTT H ALLEN CADILLAC, INC 3234db11120672-1	3/20/2023-3/20/2023	WCDY22002002 3/14/2022	90.00

RECEIVED NOV 28 2023

ENTERED NOV 29 2023

CHECK TOTAL: *****\$90.00

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

MAXIMUS
Federal Services

RECEIVED JAN 05 2024

5) 2015281

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 02, 2024



000041

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0002967
Claim Number	3458896-1
Assignment Date	11/14/2023
Claims Administrator	AmTrust
Date(s) of service	08/25/2022 - 08/25/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	09/01/2021
Application Received	10/19/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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 T1013 (Interpreter Service) submitted for date of service 08/25/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/27/2023. Response not yet received.
- CMS 1500, place of service 11
 - T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- 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 08/25/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 08/25/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$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

TECHNOLOGY INSURANCE CO (Claims Funding)

PO Box 740042
Atlanta, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.

0006150906

3458896-1

TWC3966480

DATE

6/30/2023

AMOUNT

\$90.00

Ninety and 0/100's 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.

⑈0006150906⑈ ⑆021309379⑆

601877533⑈

Explanation Of Bill Review

Check Number:	0006150906	TECHNOLOGY INSURANCE CO (Claims Funding) on behalf of Technology Insurance Company, Inc.
Claim Number:	3458896-1	AmTrust North America
Regulatory ID:	50-937/213	PO Box 89404
Bill Number:	19110118	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-2400550	888.239.3909
Policy / Insured:	TWC3966480 / Joe s Italian Restaurant and Bar	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS, INC	
Loss Date:	9/1/2021	FP1-MJCA-2400550
Location:		
Examiner Code:	34147	
Network/PPO Network:		

RECEIVED JUL 07 2023

ENTERED JUL 07 2023

DATES of SERVICE	CPT Code	Description	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
8/25/2022	T1013	SIGN LANG/ORAL INTERPRET	120.00	230.00	140.00	0.00	90.00	G1, P12, 790
				230.00	140.00	0.00	90.00	

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.

P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

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. 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

NP 145364899

CHECK NO.

0006543344

3458896-1

TWC3966480

DATE

1/10/2024

AMOUNT

\$320.00

Three Hundred Twenty and 0/100's 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.

⑈0006543344⑈ ⑆021309379⑆

601877533⑈

Check Number: 0006543344
Claim Number: 3458896-1
Bill Number: 0
Invoice Number:
Policy / Insured: TWC3966480 / Joe's Italian Restaurant and Bar
Claimant Name:
Payee ID / Name: JOYCE ALTMAN INTERPRETERS
Loss Date: 9/1/2021
Location:
Examiner Code: 34147

ENTERED JAN 18 2024

Amount: \$320.00
Dates of Service: 8/25/2022 - 8/25/2022
Explanation: IBR Case #CB23-0002967 DOS 8/25/22
Category: M23 - Medical Interpreter
Placement: 2 - Medical
Transaction Type:

TECHNOLOGY INSURANCE CO (Claims Funding) on behalf of Technology Insurance Company, Inc.
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

RECEIVED JAN 18 2024





MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 04 2024

6) 2031291

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 01, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000111
Claim Number	3236689-1
Assignment Date	02/13/2024
Claims Administrator	AmTrust
Date(s) of service	01/09/2023 - 01/09/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	12/01/2019
Application Received	01/17/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 T1013 (Interpreter Service) submitted for date of service 01/09/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/26/2024. Response not yet received.
- CMS 1500, place of service 11
 - 01/09/2023 T1013 (interpreter services) x 2, \$230.00 (follow up chiro treatment 2hr min)
- EORs reflect reimbursement of \$90.00. Charges exceed the OMFS allowance; charge 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 01/09/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 01/09/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$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

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

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
0004779511
3236689-1
SWC1227655

DATE	AMOUNT
9/22/2023	\$90.00

Ninety and 0/100's 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.

⑈0004779511⑈ ⑆021309379⑆

790262463⑈

Explanation Of Bill Review

Check Number:	0004779511	ANA UBI Claims on behalf of Security National Insurance Company
Claim Number:	3236689-1	AmTrust North America
Regulatory ID:	50-937/213	PO Box 89404
Bill Number:	19458864	Cleveland, OH 44101
Invoice Number:	FP1-MJCA-2531077	888.239.3909
Policy / Insured:	SWC1227655 / JC Kitchens Inc. A Corp	
Claimant Name:	JOYCE ALTMAN INTERPRETERS, INC	
Payee ID / Name:	10753415	
Loss Date:	12/1/2019	FP1-MJCA-2531077
Location:		
Examiner Code:	37150	
Network/PPO Network:		

DATES of SERVICE	CPT Code	Description	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
1/9/2023	T1013	SIGN LANG/ORAL INTERPRET	120.00	230.00	140.00	0.00	90.00	G1, P12, 790
				230.00	140.00	0.00	90.00	

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.

P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

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. 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.

ENTERED SEP 27 2022

RECEIVED SEP 26 2023



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

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.

0005013595

3236689-1

SWC1227655

DATE

4/16/2024

AMOUNT

\$320.00

Three Hundred Twenty and 0/100's Dollars*****

JOYCE ALTMAN INTERPRETERS

PAY TO
THE
ORDER
OF

VOID AFTER 180 DAYS

Mail To

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



AmTrust Financial Services, Inc.

⑈0005013595⑈ ⑆021309379⑆

790262463⑈

Check Number: 0005013595
Claim Number: 3236689-1
Bill Number: 0
Invoice Number:
Policy / Insured: SWC1227655 / JC Kitchens, Inc. (A Corp)
Claimant Name:
Payee ID / Name: JOYCE ALTMAN INTERPRETERS
Loss Date: 12/1/2019
Location:
Examiner Code: 37150

Amount: \$320.00
Dates of Service: 1/9/2023 - 1/9/2023
Explanation: Medical interpreter
Category: M23 - Medical Interpreter
Placement: 2 - Medical
Transaction Type:

ANA UBI Claims on behalf of Security National Insurance Company
AmTrust North America
PO Box 89404
Cleveland, OH 44101
888.239.3909

ENTERED APR 24 2024

RECEIVED APR 22 2024



MAXIMUS FEDERAL SERVICES, INC.

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

RECEIVED DEC 02 2024

7) 2189666

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



November 26, 2024

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

IBR Case Number	CB24-0002408
Claim Number	3470939-1
Assignment Date	10/03/2024
Claims Administrator	AmTrust
Date(s) of service	04/12/2023 - 04/14/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	03/10/2022
Application Received	09/06/2024

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 T1013 (Interpreter Service) x 2 submitted for dates of service 04/12/2023 – 04/14/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/17/2024. Response not yet received.
- CMS 1500, place of service 11
 - 04/12/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
 - 04/14/2023 T1013 (interpreter services) x 2, \$230.00 (follow up chiro treatment 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 04/12/2023 and 04/14/2023. 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 04/12/2023 and 04/14/2023 were signed by the patient, the medical provider and the interpreters 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 04/12/2023 – 04/14/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 04/12/2023 – 04/14/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 04/12/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 04/14/2023 \$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

SEQUOIA INSURANCE COMPANY

P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase

Syracuse, NY

50-937/213

CHECK NO.

0000382878

3470939-1

QWC1161358

DATE

12/13/2023

AMOUNT

\$90.00

Ninety and 0/100's 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.

⑈0000382878⑈ ⑆021000021⑆ 226733883⑈

Explanation Of Bill Review

Check Number:	0000382878	SEQUOIA INSURANCE COMPANY on behalf of Sequoia Insurance Company
Claim Number:	3470939-1	AmTrust North America
Regulatory ID:	50-937/213	PO Box 89404
Bill Number:	19795585	Cleveland, OH 44101
Invoice Number:	FPI-MJCA-2664838	888.239.3909
Policy / Insured:	QWC1161358 / Gym Management Services Inc	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	3/10/2022	FPI-MJCA-2664838
Location:		
Examiner Code:	31356	
Network/PPO Network:		

11252494

DATES of SERVICE	CPT Code	Description	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/12/2023	T1013	SIGN LANG/ORAL INTERPRET	120.00	230.00	140.00	0.00	90.00	G1, P12, 790
				230.00	140.00	0.00	90.00	

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.

P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

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. 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.

RECEIVED DEC 20 2023

ENTERED DEC 21 2023



SEQUOIA INSURANCE COMPANY

P.O. BOX 740042

ATLANTA, GA 30374-0042

J.P. Morgan Chase

Syracuse, NY

50-937/213

CHECK NO.

0000382879

3470939-1

QWC1161358

DATE

12/13/2023

AMOUNT

\$90.00

Ninety and 0/100's 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.

⑈0000382879⑈ ⑆021000021⑆ 226733883⑈

Explanation Of Bill Review

Check Number:	0000382879	SEQUOIA INSURANCE COMPANY on behalf of Sequoia Insurance Company
Claim Number:	3470939-1	AmTrust North America
Regulatory ID:	50-937/213	PO Box 89404
Bill Number:	19795980	Cleveland, OH 44101
Invoice Number:	FPI-MJCA-2667327	888.239.3909
Policy / Insured:	QWC1161358 / Gym Management Services Inc	
Claimant Name:		
Payee ID / Name:	JOYCE ALTMAN INTERPRETERS INC	
Loss Date:	3/10/2022	FPI-MJCA-2667327
Location:		
Examiner Code:	31356	
Network/PPO Network:		

11269306

DATES of SERVICE	CPT Code	Description	Units	FEE CHARGED	REDUCT AMOUNT	PPO SAVINGS	FEE ALLOWED	REASON
4/14/2023	T1013	SIGN LANG/ORAL INTERPRET	120.00	230.00	140.00	0.00	90.00	G1, P12, 790
				230.00	140.00	0.00	90.00	

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.

P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

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. 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.

RECEIVED DEC 20 2023

ENTERED DEC 21 2023



SEQUOIA INSURANCE COMPANY

P.O. BOX 740042
ATLANTA, GA 30374-0042

JP Morgan Chase
Syracuse, NY
50-937/213

CHECK NO.
0000458966
3470939-1
QWC1161358
DATE
12/27/2024
AMOUNT
\$460.00

Four Hundred Sixty and 0/100's Dollars*****

PAY TO
THE
ORDER
OF

JOYCE ALTMAN INTEPRETERS INC

VOID AFTER 180 DAYS

Mail To

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



AmTrust Financial Services, Inc.

⑈0000458966⑈ ⑆021000021⑆ 226733883⑈

Check Number:	0000458966
Claim Number:	3470939-1
Bill Number:	0
Invoice Number:	
Policy / Insured:	QWC1161358 / Gym Management Services Inc
Claimant Name:	
Payee ID / Name:	JOYCE ALTMAN INTEPRETERS INC
Loss Date:	3/10/2022
Location:	
Examiner Code:	35624

Amount:	\$460.00	SEQUOIA INSURANCE COMPANY on behalf of Sequoia Insurance Company
Dates of Service:	4/12/2023 - 4/14/2023	AmTrust North America
Explanation:	inv case CB24-0002408	PO Box 89404
Category:	M23 - Medical Interpreter	Cleveland, OH 44101
Placement:	2 - Medical	
Transaction Type:		

RECEIVED JAN 08 2025

ENTERED JAN 09 2025





MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED MAR 11 2024

8) 2096402

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



March 08, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003493
Claim Number	20230002270
Assignment Date	01/23/2024
Claims Administrator	Benchmark Insurance Company
Date(s) of service	11/30/2022 - 11/30/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	07/21/2021
Application Received	12/19/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: Benchmark 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 T1013 (Interpreter Service) submitted for date of service 11/30/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/05/2024. Response not yet received.
- CMS 1500, place of service 11
 - 11/30/2022 T1013 (interpreter services) x 2, \$230.00 (follow up acupuncture 2hr min)
- 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 11/30/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)**

Date of Service: 11/30/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Benchmark Insurance Company
PO Box 46350
Las Vegas, NV 89114

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



Benchmark
ADMINISTRATORS

A TREAN COMPANY

Wells Fargo
P.O. Box 46350
Las Vegas, NV, 89114

17-1/910

CHECK DATE 9/5/2023 CHECK NO. 589491

301_000000173644

SERVICE DATES

11/30/2022 - 11/30/2022

FOR Miscellaneous Medical
Claim #: 20230002270 Invoice #: 3234db10611173-1

PAY EXACTLY Ninety Dollars and No Cents

CHECK AMOUNT

\$90.00

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX 4165
TUSTIN, CA 92781

Dean Clifton

AUTHORIZED SIGNATURE

SIGNATURE HAS A COLORED BACKGROUND • BORDER CONTAINS MICROPRESSING

⑈00589491⑈ ⑆091000019⑆

3987025529⑈

RECEIVED SEP 07 2023

ENTERED SEP 07 2022

Payee: Joyce Altman Interpreters, Inc

Check Number: 589491

Check Amount: 90.00

Date of Check: 9/5/2023

Check Memo:

Adjuster Name/Phone:

Claim Number	Claimant	Invoice Number / Bill Identifier	Loss Date	Service Dates	Payment Amount	Financial Category
20230002270		301000000173644	7/21/2021	11/30/2022 - 11/30/2022	90.00	Payment - Miscellaneous Medical

Benchmark Administrators a Trean Company
PO BOX 46350
Las Vegas, NV 89114



*****MIXED AADC 541
JOYCE ALTMAN INTERPRETERS, INC
PO BOX 4165
TUSTIN, CA 92781-4165

1452916911

RECEIVED MAR 25 2024

Insured Name: Pacific West Maintenance, Inc
Policy No: CST5020609
Check Amount: \$320.00
Check No: 9910041593
Invoice No:
Service Start Date: 11/30/2022

Payee Name:
Claim No: 20230002270
Check Date: 03/19/2024
Date of Loss: 07/21/2021
Coverage: Medical Payment - Settlement
Service End Date: 11/30/2022

Description:

Adjuster Name:

Adjuster Phone:

ENTERED MAR 26 2024

THE BACK OF THIS CHECK CONTAINS A SECURITY MARK - DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK



Service Start Date: 11/30/2022

Service End Date: 11/30/2022

The Bancorp Bank

Check No: 9910041593

Claim No: 20230002270

Date: 03/19/2024

Three Hundred Twenty Dollars

Amount

\$320.00

VOID AFTER 180 DAYS

Pay To The Order Of Joyce Altman Interpreters, Inc

Memo:

Invoice #:

9910041593 031101114 8351000059

**MAXIMUS FEDERAL SERVICES, INC.**

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

RECEIVED JAN 22 2024

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 18, 2024

9) 2000169



000053

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

IBR Case Number	CB23-0003096
Claim Number	21K37J884570
Assignment Date	11/29/2023
Claims Administrator	Cannon Cochran Mgmt Svcs
Date(s) of service	09/23/2022 - 09/23/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	03/31/2021
Application Received	11/03/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 T1013 (Interpreter Service) submitted for date of service 09/23/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/13/2023. Response not yet received.
- CMS 1500, place of service 11
 - T1013 (interpreter services) x 2, \$230.00 (follow up acupuncture 2hr min)
- 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 09/23/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 09/23/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Cannon Cochran Mgmt Svcs
PO Box 53550
Irvine, CA 92619

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

CCMSI OBO CLEAR SPRING PROPERTY & CASUALTY
COMPANY
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0166679056

Date: 07/20/2023

Batch#: 306855658

2-3/710 IL

Amount: ONE HUNDRED EIGHTY AND 00 / 100*****

Amount

\$****180.00

Void After 90 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Barney J. Golden

⑈0166679056⑈ ⑆071000039⑆ 8666622642⑈

Claim#	DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #	Comment	Adjuster/Office
21K371884570			230.00	140.00	90.00	3234db10366492-		WJONES
03/31/2021				STRATACARE		73912 DS 09/23/22		IRVINE
21K37K570634			230.00	140.00	90.00	3234db10363763-		WJONES
01/07/2021				STRATACARE		73913 DS 09/21/22		IRVINE

RECEIVED JUL 24 2023

ENTERED JUL 24 2023

Batch#: 306855658

Check# 166679056

Check Amount: \$****180.00

Loc: BARONHR WEST INC. DBA BARONHR

CCMSI OBO CLEAR SPRING PROPERTY & CASUALTY
COMPANY
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0166687465

Date: 02/09/2024

Batch#: 307533566

Amount

\$****740.00

Void After 90 Days

Amount: SEVEN HUNDRED FORTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Barney J. Golden

⑈0166687465⑈ ⑆071000039⑆ 8666622642⑈

Claim# \ DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. # \ Comment	Adjuster \ Office
21K37J884570		320.00	0.00	320.00		WJONES
03/31/2021						IRVINE
21K37J884570		420.00	0.00	420.00	CB24-0000058	WJONES
03/31/2021					CB24-0000058 DS 1.12.23/1.26.23	IRVINE

RECEIVED FEB 13 2024

ENTERED FEB 13 2024

Batch#: 307533566

Loc: BARONHR WEST INC. DBA BARONHR

Check# 166687465

Check Amount: \$****740.00



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JUN 07 2024

10) 2101535

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



June 03, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000677
Claim Number	22W57K562930
Assignment Date	04/18/2024
Claims Administrator	Cannon Cochran Management Service
Date(s) of service	04/11/2023 - 04/11/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	05/04/2022
Application Received	03/22/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 Service
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 T1013 (Interpreter Service) submitted for date of service 04/11/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/02/2024. Response not yet received.
- CMS 150, place of service 11
 - 04/11/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- 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 04/11/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 04/11/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Cannon Cochran Management Service
PO Box 53550
Irvine, CA 92619

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

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0185339529

Date: 12/13/2023

Batch#: 307339543

Amount

\$****180.00

Void After 90 Days

2-3/710 IL

Amount: ONE HUNDRED EIGHTY AND 00 / 100*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Bradley J. Golden

⑈0185339529⑈ ⑆071000039⑆ 8666622642⑈

Claim#DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #Comment	Adjuster\Office
22W57K562930		230.00	140.00	90.00	3234db11203508-	NIWALLACE
05/04/2022			STRATACARE	66402 DS 04/04/23		SCOTTSDALE
22W57K562930		230.00	140.00	90.00	3234db11239021-	NIWALLACE
05/04/2022			STRATACARE	66431 DS 04/11/23		SCOTTSDALE

RECEIVED DEC 18 2023

ENTERED DEC 20 2023

Batch#: 307339543

Check# 185339529

Check Amount: \$****180.00

Loc: ROYALTY EMPLOYMENT INC.

CCMSI OBO STATE NATIONAL INSURANCE
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0185351106

Date: 06/19/2024

2-3/710 IL

Batch#: 307969579

Amount: THREE HUNDRED TWENTY AND 00 / 100*****

Amount

\$****320.00

Void After 90 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS
PO BOX #4165
TUSTIN, CA 92781

Bradley J. Golden

⑈0185351106⑈ ⑆071000039⑆ 8888822642⑈

Claim#DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #Comment	Adjuster/Office
22W57K562930		320.00	0.00	320.00		NIWALLACE
05/04/2022					Additional payment for 4/11/2024 per Maximus	SCOTTSDALE

RECEIVED JUN 24 2024

ENTERED JUN 27 2024

Batch#: 307969579

Loc: ROYALTY EMPLOYMENT INC.

Check# 185351106

Check Amount: \$****320.00



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED DEC 20 2024

11) 2331959

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 13, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002677
Claim Number	23J34K672746
Assignment Date	10/22/2024
Claims Administrator	Cannon Cochran Management Services
Date(s) of service	12/19/2023 – 01/16/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	04/28/2023
Application Received	09/27/2024

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: 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 T1013 (Interpreter Service) x 2 submitted for dates of service 12/19/2023 – 01/16/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/04/2024. Response not yet received.
- CMS 1500, place of service 11
 - 12/19/2023 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Chiro treatment 2hr min)
 - 01/16/2024 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 12/19/2023 and 01/16/2024. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 12/19/2023 and 01/16/2024 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 12/19/2023 – 01/16/2024. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 12/19/2023 – 01/16/2024**Interpreter**

Service Code	T1013 (Interpreter Service)
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 12/19/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 01/16/2024 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Cannon Cochran Management Services
PO Box 53550
Irvine, CA 94520

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

CCMSI OBO STARSTONE NATIONAL WC LOSS FUND
ACCOUNT
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0186727634

Date: 06/10/2024

Batch#: 307937173

2-3/710 IL

Amount

Amount: NINETY AND 00 / 100*****

\$****90.00

Void After 90 Days

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Bradley J. Golden

⑈0186727634⑈ ⑆071000039⑆ 8666622642⑈

Claim#DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #Comment	Adjuster/Office
23J34K672746		230.00	140.00	90.00	3234db12383542-	MTACALO
04/28/2023			STRATACARE		106744 DS 12/19/23	IRVINE

ENTERED JUN 14 2024

RECEIVED JUN 13 2024

Batch#: 307937173

Loc: GARRETT J GENTRY GENERAL ENGINEERING
INCORPORATED

Check# 186727634

Check Amount: \$****90.00

CCMSI OBO STARSTONE NATIONAL WC LOSS FUND
ACCOUNT
2 EAST MAIN ST, SUITE 208
DANVILLE, IL 61832

BANK OF AMERICA
CHICAGO, IL 60603

Check No. 0186728033

Date: 06/19/2024

Batch#: 307969561

2-3/710 IL

Amount

\$****180.00

Amount: ONE HUNDRED EIGHTY AND 00 / 100*****

Void After 90 Days

PAY TO THE ORDER OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Bradley J. Golden

⑈0186728033⑈ ⑆071000039⑆ 8666622642⑈

Claim#DOL	Claimant	Inv. Amt	Disc. Amt	Net Paid	Inv. #Comment	Adjuster/Office
23J34K672746		230.00	140.00	90.00	3234db12451722-	MTACALO
04/28/2023			STRATACARE		107265 DS 01/16/24	IRVINE
23J34K673168		230.00	140.00	90.00	3234db12444381-	SROBERT
03/28/2023			STRATACARE		107266 DS 01/15/24	IRVINE

RECEIVED JUN 24 2024

ENTERED JUN 26 2024

Batch#: 307969561

Check# 186728033

Check Amount: \$****180.00

Loc: GARRETT J GENTRY GENERAL ENGINEERING
INCORPORATED

1867 CORE SPECIALTY
2 East Main Street Suite 208
Danville, IL 61832



023VPAY0DCHECK0004001-00065-01
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781



RECEIVED FEB 03 2025

ENTERED FEB 04 2025

The document you are holding is a payment for services provided. The attached check and Explanation of Payment(s) is sent to you by CCMSI on behalf of 1867 CORE SPECIALTY, who has partnered with VPay® to process their payments. If you have questions regarding your claim or pending payment status please contact the adjuster assigned to the claim. If you have a question regarding this transaction, please contact CCMSI at 1-844-750-0955 or email paymentstatus@ccmsi.com. You will need to provide the CCMSI Transaction ID number located on this page.

CCMSI Transaction ID: 548223749
VP Trans ID: 2776182176
CCM0001705
Date: 01/23/2025
Amount: \$460.00
Claimant Name: Ruben Escalante
Invoice Number: CB24-0002677 (-\$0.00)
Date of Service: 2/09/2023 to 12/09/2023 Comment: CB24-0002677 DS 12.9.
Check Number: 22080638
Claim Number: 23J34K672746

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.



CCMSI obo
1867 CORE SPECIALTY
2 East Main Street Suite 208
Danville, IL 61832

PATHWARD, N.A.
Sioux Falls, SD
78 7011/2739

22080638

01/23/2025

PAY TO THE
ORDER OF JOYCE ALTMAN INTERPRETERS INC

\$460.00

FOUR HUNDRED SIXTY DOLLARS AND 00/100

DOLLARS

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

VOID AFTER 180 DAYS

Gregory H. Smith

MEMO CB24-0002677 (-\$0.00)

⑈0022080638⑈ ⑆273970116⑆ 1700100408⑈



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED AUG 16 2024

12) 2266330

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



August 12, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001315
Claim Number	1487120
Assignment Date	06/28/2024
Claims Administrator	Church Mutual
Date(s) of service	05/15/2023 - 06/26/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	08/10/2022
Application Received	05/31/2024

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 \$370.00 in additional reimbursement for a total of \$550.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$550.00 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: Church 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 T1013 (Interpreter Service) x 2 submitted for dates of service 05/15/2023 – 06/26/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/12/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/15/2023 T1013 (interpreter services) x 2, \$230.00 (initial exam 2hr min)
 - 06/26/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$45.00 for each date of service 05/15/2023 and 06/26/2023. Charge was adjusted to comply with the rate and rules of the contract indicated; allowance 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 05/15/2023 and 06/26/2023 were signed by the patient, medical provider and interpreters 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Provider is asking for reimbursement at their market rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 06/28/2024, requesting a copy of the contract and any usual and customary guidelines, to support the reduction on the EORs. Response not yet received. Therefore, reimbursement will be based on 100% of the Provider's established market rate.
- Reimbursement received in the amount of \$90.00 for dates of service 05/15/2023 – 06/26/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2

Date of Service: 05/15/2023 – 06/26/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$45.00
Dispute Amount	\$185.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 05/15/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$45.00 (Plan Allowed) = \$185.00 + \$180.00 (IBR Application Fee) = \$365.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$45.00
Dispute Amount	\$185.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 06/26/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$45.00 (Plan Allowed) = \$185.00 Due Provider Refer to Analysis

Copy to:

Church Mutual
PO Box 342
Merrill, WI 54452

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

Claim Check No.

4547055

79-7142
2915

Associated Bank
www.associatedbank.com

Pay Exactly

Forty Five Dollars and 00/100 Cents

Pay to the Order of JOYCE ALTMAN INTERPRETERS INC

DATE	AMOUNT
02/15/24	\$*****45.00

VOID AFTER 180 DAYS

Alan Ogilvie
AUTHORIZED SIGNATURE

⑈4547055⑈ ⑆291571429⑆ 2173 325 412⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22
Insured:

Date of Check: 02/15/24
Check No.: 4547055

Claimant:
Description of Loss: Workers Compensation

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

The above check reflects payment for the following:

Payment: \$45.00

Patient No.: 3234DB114603501
Service Dates: 05/15/23 To 05/15/23

MEDICAL - TT OR TPD
Doctors - general practice

ENTERED APR 30 2024

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

Claim Check No.

4548872

79-7142
2915

Associated Bank
www.associatedbank.com

DATE	AMOUNT
02/23/24	\$*****45.00

VOID AFTER 180 DAYS

Pay Exactly

Forty Five Dollars and 00/100 Cents

Pay to the Order of JOYCE ALTMAN INTERPRETERS INC

Alan Ogilvie
AUTHORIZED SIGNATURE

⑈4548872⑈ ⑆291571429⑆ 2173 325 412⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22
Insured: TRIMICA LLC DBA VISTA ADHC
MAYWOOD, CA 90270-3118
Claimant: MANUEL ORTIZ
Description of Loss: Workers Compensation
Mail To: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

Date of Check: 02/23/24
Check No.: 4548872



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

The above check reflects payment for the following:

Payment: \$45.00

Patient No.: 3234DB116623691
Service Dates: 06/26/23 To 06/26/23

MEDICAL - TT OR TPD
Doctors - general practice

RECEIVED MAR 05 2024

ENTERED MAR 06 2024

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

Claim Check No.

4601732

79-7142
2915

Associated Bank
www.associatedbank.com

DATE	AMOUNT
08/22/24	\$*****550.00

VOID AFTER 180 DAYS

Pay Exactly

Five Hundred Fifty Dollars and 00/100 Cents

Pay to the Order of JOYCE ALTMAN INTERPRETERS INC

Alan Ogilvie
AUTHORIZED SIGNATURE

⑈4601732⑈ ⑆291571429⑆ 2173 325 412⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22

Date of Check: 08/22/24
Check No.: 4601732

Insured:

ENTERED AUG 28 2024

Claimant:
Description of Loss: Workers Compensation

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

The above check reflects payment for the following:

Payment: \$550.00

Service Dates: 05/15/23 To 06/26/23

MEDICAL - TT OR TPD
Lump Sum Settlement

RECEIVED AUG 28 2024

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.

Control No: 6425412



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED OCT 24 2024

13) 2266330

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



October 17, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002056
Claim Number	1487120-00002
Assignment Date	08/30/2024
Claims Administrator	Church Mutual
Date(s) of service	10/18/2023 - 10/18/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	08/10/2022
Application Received	08/09/2024

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 \$185.00 in additional reimbursement for a total of \$365.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$365.00** 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: Church 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 T1013 (Interpreter Service) submitted for date of service 10/18/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 08/14/2024. Response not yet received.
- CMS 1500, place of service 11
 - 10/18/2023 T1013 (interpreter services) x 2, \$230.00 (follow up chiro treatment 2hr min)
- EORs reflect reimbursement of \$45.00. Charge was adjusted to comply with the rate and rules of the contract indicated; allowance for procedure was made at the usual and customary amount for this geographic 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 Affidavit dated 10/18/2023 was signed by the patient, medical provider and interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Provider is asking for their market rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 08/30/2024, requesting a copy of the contract and any usual and customary guidelines, to support the reductions on the EORs. Response not yet received. Therefore, reimbursement will be based on 100% of the Provider's established market rate.
- Reimbursement received in the amount of \$45.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 10/18/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$45.00
Dispute Amount	\$185.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtun \$115.00 (Market Rate for One Hour) * 2 (hours) = \$220.00 - \$45.00 (Plan Allowed) = \$185.00 + \$180.00 (IBR Application Fee) = \$365.00 Due Provider Refer to Analysis

Copy to:

Church Mutual
PO Box 342
Merrill, WI 54452

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

Claim Check No. 4572083

79-7142
2915

Associated Bank
www.associatedbank.com

DATE	AMOUNT
04/29/24	\$*****45.00

VOID AFTER 180 DAYS

Pay Exactly

Forty Five Dollars and 00/100 Cents

Pay to the Order of JOYCE ALTMAN INTERPRETERS INC

Alan Ogilvie
AUTHORIZED SIGNATURE

⑈4572083⑈ ⑆291571429⑆ 2173 325 412⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22
Insured: TRIMICA LLC DBA VISTA ADHC

Date of Check: 04/29/24
Check No.: 4572083

Claimant:
Description of Loss: Workers Compensation

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

RECEIVED MAY 03 2024

The above check reflects payment for the following:

ENTERED MAY 08 2024

Payment: \$45.00

Patient No.: 3234DB121180911
Service Dates: 10/18/23 To 10/18/23

MEDICAL - TT OR TPD
Miscellaneous

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.



00549164 000084 001 001 000

Policy Number: 0415343-07-419814
Claim Number: 1487120
Date of Loss: 08/10/2022
Insured: TRIMICA LLC DBA VISTA ADHC

Date of Check: 10/23/2024
Check Number: 2081617
Page: 1 of 1

Claimant:
Patient Account No.: Not Available



P.O. Box 342
3000 Schuster Lane
Merrill, WI 54452-0342

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

Coverage:
370 Other Medical

This check reflects payment for the following:

Reference Number	From - Through Dates	Amount
Not Available	10/18/2023	365.00
Total:		365.00

RECEIVED OCT 29 2024

ENTERED OCT 29 2024

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 patrón o a su compañía de seguro todo dinero que usted ha ganado por trabajar, durante el tiempo cubierto por éste cheque, y antes de cambiar éste cheque. Si usted no sigue estos reglamentos, Usted puede estar en violación de la ley y el castigo podría ser cárcel o prisión, una multa, y pérdida de beneficios.

For questions concerning your claim, please contact your claim handler

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER



P.O. Box 342
3000 Schuster Lane
Merrill, WI 54452-0342

Claim Check No. 2081617
ASB-CC
Associated Bank

79-7142
2915

DATE	AMOUNT
10/23/2024	\$*****365.00

VOID AFTER 90 DAYS

Pay Exactly

Three hundred sixty five and 00/100 Dollars

Pay To The Order Of

JOYCE ALTMAN INTERPRETERS INC

Alan Ogilvie

AUTHORIZED SIGNATURE

0000 2081617 291571429 2914329087



MAXIMUS FEDERAL SERVICES, INC.

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

RECEIVED DEC 18 2024

14) 2266330

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 16, 2024

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

IBR Case Number	CB24-0002682
Claim Number	1487120-00002
Assignment Date	10/22/2024
Claims Administrator	Church Mutual
Date(s) of service	01/09/2024 – 01/09/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	08/10/2022
Application Received	09/27/2024

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 \$175.00 in additional reimbursement for a total of \$355.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$355.00** 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: Church 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 T1013 (Interpreter Service) submitted for date of service 01/09/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/04/2024. Response not yet received.
- CMS 1500, place of service 11
 - 01/09/2024 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval 2hr min Via Telemed)
- EORs reflect reimbursement of \$55.00. Allowance for this procedure was made at the usual and customary amount for this geographical area; charge was adjusted to comply with the rate and rules of the contract indicated.
- **CCR § 9795.3. Services 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 01/09/2024 was signed by the medical provider and the interpreter certifying the patient is not proficient in English and requested a certified interpreter for the Telemedicine appointment.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Provider is asking for their market rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 10/22/2024, requesting a copy of the contract and any usual and customary guidelines to support the reimbursement on the EORs. Response not yet received; therefore, reimbursement will be based on the Provider's established market rate.
- Reimbursement received in the amount of \$55.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 01/09/2024**Interpreter**

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$55.00
Dispute Amount	\$175.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$55.00 (Plan Allowed) = \$175.00 + \$180.00 (IBR Application Fee) = \$355.00 Due Provider Refer to Analysis

Copy to:

Church Mutual
PO Box 342
Merrill, WI 54452

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

Claim Check No.

4584929

79-7142
2915

Associated Bank
www.associatedbank.com

DATE	AMOUNT
06/14/24	\$*****55.00

VOID AFTER 180 DAYS

Pay Exactly

Fifty Five Dollars and 00/100 Cents

Pay to the Order of JOYCE ALTMAN INTERPRETERS INC

Alan Ogilvie
AUTHORIZED SIGNATURE

⑈4584929⑈ ⑆291571429⑆ 2173 325 412⑈

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22
Insured: TRIMICA LLC DBA VISTA ADHC

Date of Check: 06/14/24
Check No.: 4584929

Claimant:
Description of Loss: Workers Compensation

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

ENTERED JUN 28 2024

The above check reflects payment for the following:

Payment: \$55.00

Patient No.: 3234DB124264361
Service Dates: 01/09/24 To 01/09/24

MEDICAL - TT OR TPD
Doctors - general practice

RECEIVED JUN 26 2024

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.

Detach before depositing - Please cash within 30 days

Account/Policy No.: 0415343-07-419814
Claim No.: 1487120
Date of Loss: 08/10/22
Insured: TRIMICA LLC DBA VISTA ADHC

Date of Check: 09/25/24
Check No.: 4609964

Claimant:
Description of Loss: Workers Compensation

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



3000 Schuster Lane
P.O. Box 342
Merrill, Wisconsin
54452-0342

The above check reflects payment for the following:

Payment: \$175.00

Patient No.: 3234DB124264362
Service Dates: 01/09/24 To 01/09/24

MEDICAL - TT OR TPD
Doctors - general practice

RECEIVED OCT 01 2024

ENTERED OCT 01 2024

12426436

For questions concerning your claim, please call 1-800-554-2642. Select option 2 and enter my extension number; Melissa s. Henderson, Ext. 7111.



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 22 2024

15) 2169051

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 16, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000239
Claim Number	E2H08961
Assignment Date	02/28/2024
Claims Administrator	CNA
Date(s) of service	03/07/2023 – 03/15/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 3
Date of Injury	11/01/2022
Application Received	02/02/2024

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 \$420.00 in additional reimbursement for a total of \$600.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$600.00 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: CNA

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 T1013 (Interpreter Service) x 3 submitted for dates of service 03/07/2023 – 03/15/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 02/12/2024. Response not yet received.
- CMS 1500, place of service 11
 - 03/07/2023 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval 2hr min)
 - 03/08/2023 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
 - 03/15/2023 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 03/07/2023, 03/08/2023 and 03/15/2023. Workers' compensation jurisdictional fee schedule adjustment.
- **CCR § 9795.3. Services 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 03/07/2023, 03/08/2023 and 03/15/2023 were signed by the patient, the medical provider and the interpreters certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$270.00 for dates of service 03/07/2023 – 03/15/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 3 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 3.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 3**

Date of Service: 03/07/2023 – 03/15/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 03/07/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 03/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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	Overtake DOS 03/15/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

CNA
PO Box 8317
Chicago, IL 60680

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

CNA ATTN CLAIM
PO BOX 8317
CHICAGO IL 60680-8317



RECEIVED OCT 30 2023



*****AUTO**MIXED AADC 541

91594211



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

ENTERED OCT 31 2023

* To expedite handling of your claim, please include our claim number on all future correspondence to us			Claim Number *
Insured/Client VARIOUS	Claimant VARIOUS		
Date of Loss	From - Thru Dates		Amount
Reason:	BULK PMT--SEE ADVICE ATTACHED		\$1,170.00

To ensure timely delivery of your check, please verify that the address on this check is complete and correct. If not, please notify your claims representative with the correct information. Thank you.

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.

THE BACK OF THIS CHECK CONTAINS A SECURITY MARK - DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK



Continental Casualty Company
Chicago, IL 60604

UNDERWRITTEN BY:

Check No: 110166187 50-937
Date Issued: 20231019 213

Claim Number	Desk Code	InsuredClient	VARIOUS	Issuing Off. No.
Prefix & Contract No.		Claimant	VARIOUS	Date of Loss
From-thru (Dates)	In Payment of	BULK PMT--SEE ADVICE ATTACHED		

PAY One Thousand One Hundred Seventy Dollars

\$1,170.00

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

James A. Willbourne

Wells Fargo, N.A

VOID IF NOT CASHED IN SIX MONTHS FROM MONTH OF ISSUE

110166187

053101561

8018409956

CNA ATTN CLAIM
PO BOX 8317
CHICAGO IL 60680-8317



*****MIXED AADC 541

14272|63|1

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

RECEIVED MAY 20 2024

ENTERED MAY 25 2024

* To expedite handling of your claim, please include our claim number on all future correspondence to us		Claim Number *
Insured/Client VARIOUS	Claimant VARIOUS	
Date of Loss	From - Thru Dates	Amount
Reason:	BULK PMT--SEE ADVICE ATTACHED	\$2,380.00

To ensure timely delivery of your check, please verify that the address on this check is complete and correct. If not, please notify your claims representative with the correct information. Thank you.

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.

THE BACK OF THIS CHECK CONTAINS A SECURITY MARK - DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK

CNA Continental Casualty Company
Chicago, IL 60604

UNDERWRITTEN BY:

Check No: 110317680 50-937
Date Issued: 20240514 213

Claim Number	Desk Code	InsuredClient VARIOUS	Issuing Off. No.
Prefix & Contract No.		Claimant VARIOUS	Date of Loss
From-thru (Dates)	In Payment of	BULK PMT--SEE ADVICE ATTACHED	

PAY Two Thousand Three Hundred Eighty Dollars \$2,380.00

TO THE JOYCE ALTMAN INTERPRETERS INC
ORDER PO BOX 4165
OF TUSTIN, CA 92781

James A. Willbourne

Wells Fargo, N.A

VOID IF NOT CASHED IN SIX MONTHS FROM MONTH OF ISSUE

110317680

053101561

8018409956



MAXIMUS FEDERAL SERVICES, INC.

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

RECEIVED NOV 08 2024

16) 2210376

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



November 04, 2024

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

IBR Case Number	CB24-0002220
Claim Number	STI23161221
Assignment Date	09/19/2024
Claims Administrator	Cottingham and Butler Claims Services
Date(s) of service	04/12/2023 - 10/10/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	05/26/2022
Application Received	08/23/2024

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: Cottingham and Butler Claims 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 T1013 (Interpreter Service) x 2 submitted for dates of service 04/12/2023 – 10/10/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/03/2024. Response received 09/04/2024. Claims Administrator provided copies EORs and claim forms for the services in dispute. Claims Administrator also provided EORs, claim forms and medical records for various services and dates of service, that were not relevant to the services in dispute.
- CMS 1500, place of service 11
 - 04/12/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physical tx and acupuncture 2hr min)
 - 10/10/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physical and acupuncture tx 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 04/12/2023 and 10/10/2023. 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 04/12/2023 and 10/10/2023 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 04/12/2023 – 10/10/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 04/12/2023 – 10/10/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 04/12/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 10/10/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Cottingham and Butler Claims Services
PO Box 28
Dubuque, IA 52004

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

Arch Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 159359

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
04/17/2024
Void After 180 Days

AMOUNT
*****90.00

Pay Ninety Dollars And 00/100

TO THE
ORDER OF

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

⑈ 159359 ⑈ ⑆ 073901233⑆ 2036531⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Physician Services
Payment Status: Paid (1)
Check Number: 159359
Check Amount: 90.00
Check Date: 04/17/2024
From: 04/12/2023
Through: 04/12/2023
Payee TIN:
Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: STIARC
Payment For:

Claim Number: STI23161221
Claimant Name:
Injury Date: 05/26/2022
Jurisdiction: CA
Examiner: NBROWN
Insurer: Arch - STIL Captive
Employer Name: GT Expedited, Inc.
Document No: 00000036156834
Invoice No: 3234db11930666
Invoice Recvd: 03/25/2024

Date of Review: 04/09/2024
PPO Name:
Bill Type:
DRG Code:
ICD: Other general symptoms and signs
Bill Frequency:
Rx Number:
Provider ID: 1477186625
Payee License #:
Admission:
Discharge:
Physician Name: Altman, Joyce, Altman, Joyce
Physician NPI: 1477186625

Service Mod	Units	Service Description	Srv Date	Billed	BR Red	PPO Red	Other Red	Allowance	Reason Code
T1013	2	SIGN LANGUAGE/ORAL INTEPR SERV	04/12/2023	230.00	140.00	0.00	0.00	90.00	DG1 601
Totals:				230.00	140.00	0.00	0.00	90.00	

Reason Codes:

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
DG1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

ENTERED APR 25 2024

RECEIVED APR 23 2024

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.

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 "toll free". For reconsideration of denied or reduced payment, please respond either by email at reconappeals@optum.com or in writing to Optum, PO Box 240338, Montgomery, AL 36124-0338, Attn: Provider Services. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
05/02/2024
Void After 180 Days

AMOUNT
*****90.00

Pay Ninety Dollars And 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX #4165
TUSTIN, CA 92781

159568 073901233 20365311

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Physician Services
Payment Status: Paid (1)
Check Number: 159568
Check Amount: 90.00
Check Date: 05/02/2024
From: 10/10/2023
Through: 10/10/2023
Payee TIN:
Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: STIARC
Payment For:

Claim Number: STI23161221
Claimant Name:
Injury Date: 05/26/2022
Jurisdiction: CA
Examiner: NBROWN
Insurer: Arch - STIL Captive
Employer Name: GT Expedited, Inc.
Document No: 000000036169892
Invoice No: 3234db12076338
Invoice Recvd: 04/15/2024

Date of Review: 04/30/2024
PPO Name:
Bill Type:
DRG Code:
ICD: Other general symptoms and signs
Bill Frequency:
Rx Number:
Provider ID: 1477186625
Payee License #:
Admission:
Discharge:
Physician Name: Altman Joyce, Altman Joyce
Physician NPI: 1477186625

Service Mod	Units	Service Description	Srvc Date	Billed	BR Red	PPO Red	Other Red	Allowance	Reason Code
T1013	2	SIGN LANGUAGE/ORAL INTEPR SERV	10/10/2023	230.00	140.00	0.00	0.00	90.00	DG1 601
Totals:				230.00	140.00	0.00	0.00	90.00	

Reason Codes:

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
DG1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

RECEIVED MAY 06 2024

ENTERED MAY 08 2024

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.

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 *toll free*. For reconsideration of denied or reduced payment, please respond either by email at reconappeals@optum.com or in writing to Optum, PO Box 240338, Montgomery, AL 36124-0338, Attn: Provider Services. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

Arch Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 161991

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
11/15/2024
Void After 180 Days

AMOUNT
*****460.00

Pay Four Hundred Sixty Dollars And 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX #4165
TUSTIN, CA 92781



⑈ 161991 ⑈ ⑆ 073901233 ⑆ 2036531 ⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Physician Services
Payment Status: Paid (1)
Check Number: 161991
Check Amount: 460.00
Check Date: 11/15/2024
From: 04/12/2023
Through: 10/10/2023
Payee TIN:
Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: STIARC
Payment For: IBR determination

Claim Number: STI22016245
Claimant Name:
Injury Date: 05/26/2022
Jurisdiction:
Examiner: HSIEGENTHA
Insurer: Arch - STIL Captive
Employer Name: GT Expedited, Inc.
Document No:
Invoice No:
Invoice Recvd:

Date of Review:
PPO Name:
Bill Type:
DRG Code:
ICD:
Bill Frequency:
Rx Number:
Provider ID:
Payee License #:
Admission:
Discharge:
Physician Name:
Physician NPI:

Reason Codes:

RECEIVED NOV 20 2024

ENTERED NOV 25 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED FEB 03 2025

17) 2424369

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



January 30, 2025

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0003174
Claim Number	IWL24001558
Assignment Date	12/11/2024
Claims Administrator	Cottingham and Butler Claim Services
Date(s) of service	02/12/2024 - 02/12/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	12/01/2023
Application Received	11/08/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Cottingham and Butler Claim 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 T1013 (Interpreter Service) submitted for dates of service 02/12/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/25/2024. Response not yet received.
- CMS 1500, place of service 11
 - 02/12/2024 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- 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 02/12/2024 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 02/12/2024**Interpreter**

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Cottingham and Butler Claim Services
PO Box 28
Dubuque, IA 52004

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

IWLA Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 1039614

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
07/30/2024
Void After 180 Days

AMOUNT
*****90.00

Pay Ninety Dollars And 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX #4165
TUSTIN, CA 92781



⑈ 1039614 ⑈ ⑆073901233⑆ 4544808⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Physician Services
Payment Status: Paid (1)
Check Number: 1039614
Check Amount: 90.00
Check Date: 07/30/2024
From: 02/12/2024
Through: 02/12/2024
Payee TIN:

Claim Number: IWL24001558
Claimant Name:
Injury Date: 12/01/2023
Jurisdiction: CA
Examiner: OMEYER
Insurer: Zurich - IWLAIC
Employer Name: CG HoldCo, LLC
Document No: 000000036221907
Invoice No: 3234db12579782
Invoice Recvd: 07/10/2024

Date of Review: 07/26/2024
PPO Name:
Bill Type:
DRG Code:
ICD: Other general symptoms and signs
Bill Frequency:
Rx Number:
Provider ID:
Payee License #:
Admission:
Discharge:
Physician Name: Joyce Altman Interpreters, Inc, Joyce
Physician NPI: 1477186625

Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: IWLAIC
Payment For:

Service Mod	Units	Service Description	Srv Date	Billed	BR Red	PPO Red	Other Red	Allowance	Reason Code
T1013	2	SIGN LANGUAGE/ORAL INTEPR SERV	02/12/2024	230.00	140.00	0.00	0.00	90.00	DG1 601
Totals:				230.00	140.00	0.00	0.00	90.00	

Reason Codes:

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
DG1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

ENTERED AUG 07 2024

RECEIVED AUG 05 2024

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.

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 "toll free". For reconsideration of denied or reduced payment, please respond either by email at reconappeals@optum.com or in writing to Optum, PO Box 240338, Montgomery, AL 36124-0338, Attn: Provider Services. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

IWLA Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 1050477

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
02/14/2025
Void After 180 Days

AMOUNT
*****320.00

Pay Three Hundred Twenty Dollars And 00/100

TO THE
ORDER OF

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



⑈ 1050477 ⑈ ⑆073901233⑆ 4544808⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Interpreter
Payment Status: Paid (1)
Check Number: 1050477
Check Amount: 320.00
Check Date: 02/14/2025
From: 02/12/2024
Through: 02/12/2024
Payee TIN:
Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: IWLAIC
Payment For: IMR

Claim Number: IWL24001558
Claimant Name:
Injury Date: 12/01/2023
Jurisdiction:
Examiner: HSIEGENTHA
Insurer: Zurich - IWLAIC
Employer Name: CG HoldCo, LLC
Document No:
Invoice No:
Invoice Recvd:

Date of Review:
PPO Name:
Bill Type:
DRG Code:
ICD:
Bill Frequency:
Rx Number:
Provider ID:
Payee License #:
Admission:
Discharge:
Physician Name:
Physician NPI:

Reason Codes:

RECEIVED FEB 19 2025

ENTERED FEB 20 2025



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED FEB 10 2025

18) 2424369

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 06, 2025

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0003326
Claim Number	IWL24001558
Assignment Date	12/24/2024
Claims Administrator	Cottingham and Butler Claim Services
Date(s) of service	03/22/2024 - 03/22/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	12/01/2023
Application Received	11/22/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Cottingham and Butler Claim 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 T1013 (Interpreter Service) submitted for date of service 03/22/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/06/2024. Response not yet received.
- CMS 1500, place of service 11
 - 03/22/2024 T1013 (interpreter services) x 2, \$230.00 (EMG/NCV 2hr min)
- EORs reflect reimbursement of \$90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 Services 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 03/22/2024 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 03/22/2024

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Cottingham and Butler Claim Services
PO Box 28
Dubuque, IA 52004

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

IWLA Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 1040265

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
08/13/2024
Void After 180 Days

AMOUNT
*****90.00

Pay Ninety Dollars And 00/100

TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX #4165
TUSTIN, CA 92781

⑈ 1040265 ⑈ ⑆ 073901233 ⑆ 4544808 ⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Physician Services
Payment Status: Paid (1)
Check Number: 1040265
Check Amount: 90.00
Check Date: 08/13/2024
From: 03/22/2024
Through: 03/22/2024
Payee TIN:

Claim Number: IWL24001558
Claimant Name:
Injury Date: 12/01/2023
Jurisdiction: CA
Examiner: OMEYER
Insurer: Zurich - IWLAIC
Employer Name: CG HoldCo, LLC
Document No: 000000036231713
Invoice No: 3234db12800899-1
Invoice Recvd: 07/29/2024

Date of Review: 08/08/2024
PPO Name:
Bill Type:
DRG Code:
ICD: Other general symptoms and signs
Bill Frequency:
Rx Number:
Provider ID: 1477186625
Payee License #:
Admission:
Discharge:
Physician Name: Altman Joyce, Altman Joyce
Physician NPI: 1477186625

Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: IWLAIC
Payment For:

Service Mod	Units	Service Description	Srvc Date	Billed	BR Red	PPO Red	Other Red	Allowance	Reason Code
T1013	2	SIGN LANGUAGE/ORAL INTEPR SERV	03/22/2024	230.00	140.00	0.00	0.00	90.00	DG1 601
Totals:				230.00	140.00	0.00	0.00	90.00	

Reason Codes:

601 CHARGES EXCEED MAXIMUM ALLOWANCE FOR INTERPRETER SERVICES
DG1 THE CHARGE EXCEEDS THE OFFICIAL MEDICAL FEE SCHEDULE ALLOWANCE. THE CHARGE HAS BEEN ADJUSTED TO THE SCHEDULED ALLOWANCE.

RECEIVED AUG 19 2024
ENTERED AUG 22 2024

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.

If you have any questions regarding the contents of this review, please call Optum at 866-271-6317 "toll free". For reconsideration of denied or reduced payment, please respond either by email at reconappeals@optum.com or in writing to Optum, PO Box 240338, Montgomery, AL 36124-0338, Attn: Provider Services. Please include 1) A narrative explanation of why each item should be paid, 2) A copy of this Review Analysis, and 3) Supporting documentation.

IWLA Insurance Company Claim Account

MidWestOne Bank

CHECK NO. 1050921

c/o CBCS
PO Box 28
Dubuque, IA 520040028

DATE
02/21/2025
Void After 180 Days

AMOUNT
*****320.00

Pay Three Hundred Twenty Dollars And 00/100

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS, INC
P.O. BOX #4165
TUSTIN, CA 92781

⑈ 1050921 ⑈ ⑆073901233⑆ 4544808⑈

↑↑↑ PLEASE TEAR HERE ↑↑↑

Payer Name: CBCS WC
Payer Phone #: 877-241-6121
Payment Code: Interpreter
Payment Status: Paid (1)
Check Number: 1050921
Check Amount: 320.00
Check Date: 02/21/2025
From: 03/22/2024
Through: 03/22/2024
Payee TIN:
Payee Name: JOYCE ALTMAN INTERPRETERS, INC
Payee Address: P.O. BOX #4165, TUSTIN, CA 92781
Bank Code: IWLAIC
Payment For: IMR

Claim Number: IWL24001558
Claimant Name:
Injury Date: 12/01/2023
Jurisdiction:
Examiner: HSIEGENTHA
Insurer: Zurich - IWLAIC
Employer Name: CG HoldCo, LLC
Document No:
Invoice No:
Invoice Recvd:

Date of Review:
PPO Name:
Bill Type:
DRG Code:
ICD:
Bill Frequency:
Rx Number:
Provider ID:
Payee License #:
Admission:
Discharge:
Physician Name:
Physician NPI:

Reason Codes:

ENTERED FEB 26 2025

RECEIVED FEB 25 2025



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED AUG 05 2024

19) 2123746

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



July 30, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001200
Claim Number	PZC00265695
Assignment Date	06/18/2024
Claims Administrator	Crum and Forster
Date(s) of service	05/24/2023 - 05/24/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	06/10/2022
Application Received	05/17/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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 T1013 (Interpreter Service) submitted for date of service 05/24/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/31/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/24/2023 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 05/24/2023 was signed by the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 05/24/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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	Overtun \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Crum and Forster
305 Madison Ave
Morristown, NJ 07960

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



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240205B0A
J99D
8888 26688

J99D [1,561] 10 of 11



[CC]

Forwarding Service Requested

RECEIVED FEB 15 2024

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

ENTERED FL

Customer Service:	
Check #:	1314368258
Check Date:	02/05/24
Check Amount:	\$90.00
Payment ID:	449535471
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

This could have been an electronic deposit

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PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER

1314368258

36-1901/10

ISSUE DATE

Date 02/05/2024

AMOUNT

****\$90.00

Void if presented after 180 days.

Ninety Dollars and No Cents

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781

Authorized Signature

1314368258 101219017 5008023204



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240830B03
JFAE
8888 26688

JFAE [4,736] 3 of 4



[CC]

Forwarding Service Requested

RECEIVED SEP 09 2024

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

13

Customer Service:	
Check #:	1325290443
Check Date:	08/30/24
Check Amount:	\$140.00
Payment ID:	538475728
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

This could have been an electronic deposit

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**Help When
You Need It**

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Call us at 855.774.4395 to enroll with Zelis.

ENTERED SEP 09 2024



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER

1325290443
36-1901/10

ISSUE DATE

Date 08/30/2024

AMOUNT

****\$140.00

Void if presented after 180 days.

One Hundred Forty Dollars and No Cents

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

Authorized Signature

PAY
TO THE
ORDER
OF

1325290443 1012190170 5008023204



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED OCT 07 2024

20) 2123746

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



October 03, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001904
Claim Number	PZC00265695
Assignment Date	08/16/2024
Claims Administrator	Crum and Forster
Date(s) of service	08/29/2023 - 09/25/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	06/10/2022
Application Received	07/26/2024

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: 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 T1013 (Interpreter Service) x 2 submitted for dates of service 08/29/2023 – 09/25/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 07/31/2024. Response not yet received.
- CMS 1500, place of service 11
 - 08/29/2023 T1013 (interpreter services) x 2, \$230.00 (shockwave tx 2hr min)
 - 09/25/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 08/29/2023 and 09/25/2023. 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 08/29/2023 and 09/25/2023 were signed by the patient, medical providers and interpreters certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 08/29/2023 – 09/25/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 08/29/2023 – 09/25/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 08/29/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 09/25/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Crum and Forster
305 Madison Ave.
Morristown, NJ 07960

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



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240408B09
JEF7
8888 26688

JEF7 [3,806] 3 of 4



[CC]

Forwarding Service Requested

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

11

Customer Service:	
Check #:	1317332663
Check Date:	04/08/24
Check Amount:	\$90.00
Payment ID:	473927909
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

RECEIVED APR 15 2024

This could have been an electronic deposit

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ENTERED APR 17 2024



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PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER

1317332663
36-1901/10

ISSUE DATE

Date 04/08/2024

AMOUNT

****\$90.00

Void if presented after 180 days.

Ninety Dollars and No Cents

PAY
TO THE
ORDER
OF

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

Authorized Signature

1317332663 101219017 5008023204



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240930B0A
J095
8888 26688

J095 [11,720] 3 of 4



[-CC]

Forwarding Service Requested

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

3b

Customer Service:	
Check #:	1326937950
Check Date:	09/30/24
Check Amount:	\$140.00
Payment ID:	551727588
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

RECEIVED OCT 07 2024

ENTERED OCT 07 2024

This could have been an electronic deposit

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PO BOX 219717
KANSAS CITY MO 64121

20240418009
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JB9B [5,146] 12 of 13



[CC]

Forwarding Service Requested

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

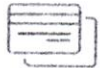
25

Customer Service:	
Check #:	1317948922
Check Date:	04/18/24
Check Amount:	\$90.00
Payment ID:	478418842
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

RECEIVED APR 26 2024

This could have been an electronic deposit

Take control of how and when you receive claim payments.



*Choose How You
Get Paid*

Choose payment and remittance options that match your workflow including ACH which puts funds into your account 12 days faster than checks.



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ENTERED APR 29 2024

zelis

PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER

1317948922

36-1901/10

ISSUE DATE

Date 04/18/2024

AMOUNT

****\$90.00

Void if presented after 180 days.

Ninety Dollars and No Cents

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781

Authorized Signature

1317948922 101219017 5008023204



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240930B0A
J095
8888 26688

J095 [11,720] 1 of 4



[-CC]

RECEIVED OCT 07 2024

Forwarding Service Requested



*****MIXED AADC 926

PB-CHI-6-ENV 11720

JOYCE ALTMAN INTERPRETERS, INC.

P.O. BOX # 4165

TUSTIN CA 92781-4165

36

ENTERED OCT 07 2024

Customer Service:	
Check #:	1326934672
Check Date:	09/30/24
Check Amount:	\$140.00
Payment ID:	551727587
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

This could have been an electronic deposit

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MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JUL 26 2024

21) 2238443

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



July 22, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001127
Claim Number	PZC00267262
Assignment Date	06/07/2024
Claims Administrator	Crum and Forster
Date(s) of service	05/24/2023 - 05/24/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	09/04/2022
Application Received	05/10/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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 T1013 (Interpreter Service) submitted for date of service 05/24/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/22/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/24/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx and follow up physical tx 2hr min)
- 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 05/24/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 05/24/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Crum and Forster
PO Box 14801
Lexington, KY 40512

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



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240131B0A
J4C4
8888 26688

J4C4 [2,160] 5 of 6



[-CC]

Forwarding Service Requested

RECEIVED FEB 07 2024

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

11

Customer Service:	
Check #:	1313902151
Check Date:	01/31/24
Check Amount:	\$90.00
Payment ID:	447569079
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

This could have been an electronic deposit

Take control of how and when you receive claim payments.



Choose How You
Get Paid

Choose payment and remittance options that match your workflow including ACH which puts funds into your account 12 days faster than checks.



Transparency
and Control

Experience the simplicity of one online portal to access payment and remittance data for 350+ insurers or receive data directly into your system.



Help When
You Need It

Spend less time on hold with one dedicated support team for payment or remittance issues with any insurer in the Zelis Payment Network.

Call us at 855.774.4395 to enroll with Zelis.

ENTERED FEB 08 2024



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY, MO 64121

UMB
3601 Mitchell Ave
St. Joseph, MO 64507

CHECK NUMBER

1313902151

36-1901/10

ISSUE DATE

Date 01/31/2024

AMOUNT

****\$90.00

Void if presented after 180 days.

Ninety Dollars and No Cents

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS, INC.
P.O. BOX # 4165
TUSTIN, CA 92781

Authorized Signature

1313902151 101219017 5008023204



PPS Elec Pmt Clearing House Trust
PO BOX 219717
KANSAS CITY MO 64121

20240809B0B
J7A2
8888 26688

J7A2 [244] 11 of 12



[-CC]

Forwarding Service Requested

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

2

RECEIVED AUG 19 2024

Customer Service:	
Check #:	1324145893
Check Date:	08/09/24
Check Amount:	\$140.00
Payment ID:	528690972
Provider Name:	JOYCE ALTMAN INTERPRETERS, INC.

This could have been an electronic deposit

Take control of how and when you receive claim payments.



Choose How You Get Paid

Choose payment and remittance options that match your workflow including ACH which puts funds into your account 12 days faster than checks.



Transparency and Control

Experience the simplicity of one online portal to access payment and remittance data for 350+ insurers or receive data directly into your system.



Help When You Need It

Spend less time on hold with one dedicated support team for payment or remittance issues with any insurer in the Zelis Payment Network.



Call us at 855.774.4395 to enroll with Zelis.

ENTERED AUG 19 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 22 2024

22) 84034

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 18, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003507
Claim Number	2022003903
Assignment Date	03/05/2024
Claims Administrator	Employers Insurance
Date(s) of service	09/16/2022 - 09/16/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	01/22/2022
Application Received	12/20/2023

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 \$50.00 in additional reimbursement for a total of \$230.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$230.00** 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: Employers 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 09/16/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 02/16/2024. Response not yet received.
- Itemized invoice
 - 09/16/2022 Interpreting for PR2/Reeval \$230.00 (Billed at a minimum of 2 hours)
- EORs reflect reimbursement of \$180.00. Charge exceeds the OMFS allowance; charge 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 09/16/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$180.00. Additional reimbursement is due up to the established market rate. **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:** 09/16/2022**Interpreter**

Service Code	Interpreter Service
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 + \$180.00 (IBR Application Fee) = \$230.00 Due Provider Refer to Analysis

Copy to:

Employers Insurance
PO Box 14792
Lexington, KY 40512

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

EMPLOYERS
PO BOX 14791
Lexington KY, 40512-4791

AUG 16 2023

EMPLOYERS®

America's small business insurance specialist®



BY: _____

216VPAY0DCHECK0004001-00509-01
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165



AUG 14 2023

841034

The attached check and Explanation of Payment(s) have been sent to you for benefits or services rendered on behalf of EMPLOYERS® who is working with VPay® to process its payments. **If you have general questions regarding the payment or cashing this check, please email VPay at support@vpayusa.com or call 1-855-523-9634.** Injured Employees: If you have questions regarding the payment amount or benefit calculation, please contact EMPLOYERS at 1-888-682-6671. Medical Providers: If you have questions regarding the payment amount, please contact CONDUENT at 1-888-853-4735, option 6. For all other payment inquiries, please contact EMPLOYERS at 1-888-682-6671.

Claim ID: 2022003903
Client Reference ID: 471462417
VP Trans ID: 1938801071
EIG0001001

Date: 08/04/2023
Amount: \$180.00
Check Number: 52896663

**Get Paid
Faster**



When you sign up for
VCard or ACH

Email
support@vpayusa.com
today to find out how.

Notice: This document, including any attachment(s) is confidential, proprietary and intended solely for the above-named individual(s). If you are the intended recipient, your use of any confidential, proprietary or personal information may be restricted by federal and state privacy or other laws. Any unauthorized use of this communication by others is strictly prohibited and may be unlawful. If you have received this document in error, please (1) notify VPay immediately at (877) 399-5917 and provide the VP Trans ID shown (2) destroy this communication and all attached information.

EMPLOYERS provides workers compensation insurance through Employers Preferred Insurance Company, Employers Assurance Company, Employers Compensation Insurance Company and Employers Insurance Company of Nevada. EIG Services, Inc. (in California, dba EIG Insurance Services) is an affiliated agency and adjuster.
Form #: CL_VEN_0033_US Rev. 3/2017

EMPLOYERS
PO BOX 14791
Lexington KY, 40512-4791

EMPLOYERS®

America's small business insurance specialist®

0000143-0000855 0106 001 648756 EIG



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
Tustin, CA 927814165
USA

RECEIVED MAY 16 2024

The attached check and Explanation of Payment(s) have been sent to you for benefits or services rendered on behalf of EMPLOYERS® who is working with VPay® to process its payments. **If you have general questions regarding the payment or cashing this check, please email VPay at support@vpayusa.com or call 1-855-523-9634.** Injured Employees: If you have questions regarding the payment amount or benefit calculation, please contact EMPLOYERS at 1-888-682-6671. Medical Providers: If you have questions regarding the payment amount, please contact CONDUENT at 1-888-853-4735, option 6. For all other payment inquiries, please contact EMPLOYERS at 1-888-682-6671.

Claim ID: 2022003903
Client Reference ID: 472000218
VP Trans ID: 2369398287
EIG0001001

Date: 05/10/2024
Amount: \$50.00
Check Number: 59180659

ENTERED MAY 18 2024

Notice: This document, including any attachment(s) is confidential, proprietary and intended solely for the above-named individual(s). If you are the intended recipient, your use of any confidential, proprietary or personal information may be restricted by federal and state privacy or other laws. Any unauthorized use of this communication by others is strictly prohibited and may be unlawful. If you have received this document in error, please (1) notify VPay immediately at (877) 399-5917 and provide the VP Trans ID shown (2) destroy this communication and all attached information.

EMPLOYERS provides workers compensation insurance through Employers Preferred Insurance Company, Employers Assurance Company, Employers Compensation Insurance Company and Employers Insurance Company of Nevada. EIG Services, Inc. (in California, dba EIG Insurance Services) is an affiliated agency and adjuster.
Form #: CL_VEN_0033_US Rev. 3/2017

EIG.RM.STD.OT



THE FACE OF THIS CHECK IS PRINTED BLUE - THE BACK CONTAINS A SIMULATED WATERMARK - SEE BACK FOR DETAILS

EMPLOYERS®
America's small business insurance specialist®

Employers Preferred Insurance Company
PO BOX 32036
Lakeland FL, 33802-2036

VPay
1-855-523-9634

PATHWARD, N.A.
Sioux Falls, SD
78-7011/2739

59180659

05/10/2024

PAY TO THE ORDER OF **JOYCE ALTMAN INTERPRETERS INC**

\$50.00

FIFTY DOLLARS AND 00/100

DOLLARS

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

VOID AFTER 180 DAYS

MEMO

Gregory Sigurdson

2369398287

59180659 273970116 1700012991



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED FEB 20 2024 23) 1965814

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 14, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003100
Claim Number	7004010675-1
Assignment Date	12/29/2023
Claims Administrator	Farmers Insurance
Date(s) of service	09/27/2022 – 09/27/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	12/19/2021
Application Received	11/03/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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 T1013 (Interpreter Service) submitted for date of service 09/27/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/13/2023. Response not yet received.
- CMS 1500, place of service 11
 - 09/27/2022 T1013 (Interpreter Service) x 2 \$230.00 (Follow up Acupuncture 2hr min)
- EORs reflect reimbursement of \$90.00 for date of service 09/27/2022. The charge exceeds the OMFS allowance.
- **CCR § 9795.3. Services 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 09/27/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00 for date of service 09/27/2022. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)**

Date of Service: 09/27/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 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:

1636747712

Date:

07/21/2023

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:

Date of Loss:

12/19/2021

Claim Number:

7004010675-1-1

Invoice Number:

FRM-FWCA-494152

Check Number:

1636747712

Payment Under Insured's:

Workers Compensation

Correspondence Reference:

YYZB8Z8MW

Print Date

07/21/2023 08:42 AM

Requested By

Kristin Lombardo

RECEIVED JUL 31 2023

ENTERED JUL 31 2023



62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
7004010675-1

Check No. 1636747712

Date: 07/21/2023

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

Citibank N.A. - One Penns Way - New Castle, DE 19720

Thomas S. Hoh

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

1636747712 0311002091

387243891

RECEIVED MAR 04 2024

Farmers Workers' Compensation Claims

Check Number:

1638561514

Date:

02/27/2024

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE
NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE

\$140.00*****

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:

Insured:

Date of Loss:

12/19/2021

Claim Number:

7004010675-1-1

Invoice Number:

FRM-FWCA-549803

Check Number:

1638561514

Payment Under Insured's:

Workers Compensation

Correspondence Reference:

81JRBZB0W

Print Date

02/27/2024 10:57 AM

Requested By

Kristin Lombardo

ENTERED MAR 04 2024



62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
7004010675-1

Check No. 1638561514

Date: 02/27/2024

PAY One Hundred Forty Dollars And No Cents

\$140.00*****

NOT GOOD AFTER SIX MONTHS

To the order of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Citibank N.A. - One Penns Way - New Castle, DE 19720

Thomas S. Hoh

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK.

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT.

1638561514 0311002091

38724389

01 01 000154 81JRBZB0W1 CE0228-1 03 1 000252



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED MAR 08 2024 **24) 1965814**

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



March 05, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003321
Claim Number	7004010675-1
Assignment Date	01/23/2024
Claims Administrator	Farmers Insurance
Date(s) of service	10/10/2022 - 10/10/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	12/19/2021
Application Received	11/30/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 T1013 (Interpreter Service) submitted for date of service 10/10/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/05/2024. Response received 01/22/2024. Claims Administrator upheld their determination.
- CMS 1500, place of service 11
 - 10/10/2022 T1013 (interpreter services) x 2, \$230.00 (follow up acupuncture 2hr min)
- 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 10/10/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)**

Date of Service: 10/10/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 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: 1636835526

Date: 08/01/2023

PAY NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE
NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE \$90.00*****

To Joyce Altman Interpreters
the PO Box 4165
order Tustin, CA, 92781-4165
of

Claimant/Patient:
Insured:
Date of Loss: 12/19/2021
Claim Number: 7004010675-1-1
Invoice Number: FRM-FWCA-496076
Check Number: 1636835526
Payment Under Insured's: Workers Compensation
Correspondence Reference: K5WB4K6ZW
Print Date: 08/01/2023 08:11 AM
Requested By: Kristin Lombardo

RECEIVED AUG 07 2023

ENTERED AUG 08 2023



62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
7004010675-1

Check No. 1636835526

Date: 08/01/2023

PAY Ninety Dollars And No Cents

\$90.00*****

NOT GOOD AFTER SIX MONTHS

To Joyce Altman Interpreters
the PO Box 4165
order Tustin, CA, 92781-4165
of

Citibank N.A. - One Penns Way - New Castle, DE 19720

Thomas S. Koh

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK

HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENT

1636835526 0311002091

387243891

RECEIVED MAR 28 2024

Farmers Workers' Compensation Claims

Check Number:

1638772283

Date:

03/21/2024

PAY

NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE
NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE NON-NEGOTIABLE

\$140.00*****

To
the
order
of

Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Claimant/Patient:

Insured:

Date of Loss:

12/19/2021

Claim Number:

7004010675-1-1

Invoice Number:

FRM-FWCA-556096

Check Number:

1638772283

Payment Under Insured's:

Workers Compensation

Correspondence Reference:

W2WM4DJPW

Print Date

03/21/2024 04:47 AM

Requested By

Kristin Lombardo

ENTERED MAR 28 2024



62-20/311

MID-CENTURY INSURANCE COMPANY
CLAIMS SERVICE CENTER
NATIONAL DOCUMENT CENTER PO BOX 268994
OKLAHOMA CITY OK 73126

Claim Number
7004010675-1

Check No. 1638772283

Date: 03/21/2024

PAY One Hundred Forty Dollars And No Cents

\$140.00*****

NOT GOOD AFTER SIX MONTHS

To
the
order
of
Joyce Altman Interpreters
PO Box 4165
Tustin, CA, 92781-4165

Thomas S. Koh

Citibank N.A. - One Penns Way - New Castle, DE 19720

THE ORIGINAL DOCUMENT HAS A HEAVY TINT WATERMARK AND IS NOT

REPRODUCED AND ANY OTHER USE IS A VIOLATION OF THE ENFORCEMENT

1638772283 031100209

38724389

01 01 000144 W2WM4DJPW1 CE0322P1 03 000247



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED AUG 28 2024

25) 2281434

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



August 21, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001438
Claim Number	030063-001120-WC-01
Assignment Date	07/11/2024
Claims Administrator	Gallagher Bassett
Date(s) of service	07/26/2023 - 07/26/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	03/17/2023
Application Received	06/12/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: Gallagher Bassett

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 T1013 (Interpreter Service) submitted for date of service 07/26/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 06/25/2024. Response not yet received.
- CMS 1500, place of service 11
 - 07/26/2023 T1013 (Interpreter Service) x 2, \$230.00 (Follow up physical therapy 2hr min)
- EORs reflect reimbursement of \$90.00. The charge exceeds the OMFS allowance; charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Services 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 07/26/2023 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 07/26/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Gallagher Bassett
PO Box 4210
Clinton, IA 52733

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

RECEIVED MAR 11 2024



0000058

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

ENTERED MAR 12 2024



GALLAGHER BASSETT EXPLANATION OF BENEFITS

FOR INQUIRES PLEASE CALL:

GALLAGHER BASSETT MANAGE CARE SERVICES AT 833-596-8350

OR SEND THE BILL AND THE ANALYSIS TO:

PO BOX 2831
CLINTON, IA 52733-2831

PAYER #: 00000

PAYER: AIU INSURANCE CO

EMPLOYER
ID/NAME: 030063 DECISIONHR, INC

CLAIM: 030063 001120 WC 01 (795201)

ADJUSTER: OVERTON

BRANCH: 000 BRANCH FAX #: 315-234-2605

DATE: 06Mar24

ICN #: ACCA125853

NETWORK:

MPN NAME:
MPN ID:
RENDERING PROVIDER NAME: JOYCE ALTMAN INTERPRETERS, IN
PROVIDER STATE: 999999999
LICENSE #:
RENDERING PROVIDER NPI: 1477186625
PAYMENT STATUS: 00001
CODE:
PAYMENT STATUS DESCRIPTION: Paid
BILL FREQUENCY: 00000
TYPE:
REVIEW DATE: 2024-03-05
INSURER ID: 135303710
JURISDICTION: CA
STATE:
DATE OF BIRTH:
EMPLOYER: 11101 ROOSEVELT BLVD N
ADDRESSES 1:
EMPLOYER ADDRESSES 2:
CASE: 00MC 0000 421678
FILE: 000000000000750
TAX ID#: 33-0956713
PROVIDER: JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781
BILL REVIEWER:
DIAGNOSIS CODE: R68.89
DIAGNOSIS DESC: OTHER GENERAL SYMPTOMS AND SIGNS
DATE OF SERVICE: 07-26-23 TO 07-26-23
DATE OF INJURY: 03-17-23
DATE BILL RECEIVED: 03-02-24
PATIENT ACCOUNT #: 3234DB11789223-1
SSN: 553-65-9458
PATIENT:

DCN #:

SEE REVERSE FOR PROCEDURE AND BILLING DETAILS
DETACH AND RETAIN THIS STUB FOR YOUR REFERENCE

P 0000058 001008 001 014

THE FACE OF THIS DOCUMENT HAS A BLUE BACKGROUND - THE BACK HAS AN ARTIFICIAL WATERMARK

NATIONAL UNION FIRE
INSURANCE CO. OF PITTSBURGH

CHECK NO. 0196237969 002425
VN. 0000460804
DATE: 06Mar24 62-20/311

CLAIM NO.: 030063 001120 WC 01 (795201)

BRANCH NO.: 269

PAY NINETY AND 00/100 DOLLARS

TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

NOT VALID AFTER 90 DAYS
PAY EXACTLY
\$ **90.00

Donna M. Korte

AUTHORIZED SIGNATURE

OR PAYABLE AT
CITIBANK, FSB CALIFORNIA

CITIBANK, N.A.
ONE PENN'S WAY
NEW CASTLE, DE 19720



0196237969 0311002091

40074901

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED AUG 05 2024

26) 2120926

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 30, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001201
Claim Number	A00479175
Assignment Date	06/18/2024
Claims Administrator	Great American Alliance Insurance Company
Date(s) of service	05/10/2023 - 05/10/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	10/07/2022
Application Received	05/17/2024

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: Great American Alliance 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 T1013 (Interpreter Service) submitted for date of service 05/10/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/31/2024. Response received 06/25/2024. Claims Administrator indicated additional payment was due. Check number and copy of the EOR was provided.
- CMS 1500, place of service 11
 - 05/10/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- 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 05/10/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$140.00, post IBR receipt, for a total of \$230.00. \$180.00 IBR application fee is due. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 05/10/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$90.00 \$140.00 (post IBR receipt)
Dispute Amount	\$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$230.00 (Plan Allowed) = \$0.00 \$180.00 (IBR Application Fee) Due Provider Refer to Analysis

Copy to:

Great American Alliance Insurance Company
PO Box 4081
Clinton, IA 52733

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

1032869660

AGENT:

BUILDERS & TRADESMEN'S INS
6610 SIERRA COLLEGE BOULEVARD
ROCKLIN, CA 95677-4306

RECEIVED FEB 02 2024

MAIL TO:

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

PAYEE:

CP JOYCE ALTMAN INTERPRETERS INC

ENTERED FEB 02 2024

CHECK # 3002521387 AMT \$90.00 ISSUED 1/26/24
FOR: INVOICE NUMBER 3234DB114485181, DATE(S) OF SERVICE 05/10/2023 - 05/10/2023

INSURED: LA PUENTE AUTO SPA INC

CLAIMANT:

POLICY # E893163 CLAIM # A00479175 DATE OF LOSS 10/7/22

IMPORTANT: WHEN CORRESPONDING WITH THE CLAIM OFFICE, PLEASE REFER TO YOUR CLAIM NUMBER
AND CONTACT THE ADJUSTER SHOWN BELOW:

JOY MAHMOOD
GREAT AMERICAN ALLIANCE INS. CO.
PO BOX 4081
CLINTON, IA 52733-4081

925-988-2272

3002521387

THE ENCLOSED INSTRUMENT WILL NOT BE PAID UNLESS IT BEARS THE ENDORSEMENTS OF ALL PARTIES NAMED AS PAYEES. ENDORSERS MUST SIGN EXACTLY AS THE NAME APPEARS ON THE FACE OF THE INSTRUMENT. IF THE ENDORSER IS A CORPORATION, SHOW THE FULL CORPORATE NAME WITH A SIGNATURE BY A DULY AUTHORIZED OFFICER AND TITLE. IF THE ENDORSER IS A PARTNERSHIP, ALL PARTIES MUST SIGN. IF AN ATTORNEY, EXECUTOR, ADMINISTRATOR, TRUSTEE OR GUARDIAN IS SIGNING A PAYEE'S NAME, SATISFACTORY EVIDENCE OF AUTHORITY MUST ACCOMPANY THE INSTRUMENT. IT IS RECOMMENDED THAT YOU DISCUSS THIS WITH YOUR CLAIMS REPRESENTATIVE BEFORE PRESENTING THE INSTRUMENT FOR PAYMENT AS ANY PAPERS SUBMITTED WITH THE CHECK WILL SLOW DOWN THE PROCESS. IF YOU HAVE ANY QUESTIONS CONCERNING THE PROPER ENDORSEMENT OF THE CHECK, PLEASE CONTACT YOUR CLAIMS REPRESENTATIVE. RHODE ISLAND ONLY: NOTICE: A RECIPIENT OF WEEKLY WORKERS' COMPENSATION BENEFITS HAS AN AFFIRMATIVE DUTY TO REPORT EARNINGS SO THAT COMPENSATION BENEFITS MAY BE PROPERLY COMPUTED. FAILURE TO REPORT EARNINGS MAY SUBJECT THE RECIPIENT TO CIVIL OR CRIMINAL LIABILITY.

**GREAT AMERICAN INSURANCE COMPANY, AS AGENT FOR:
GREAT AMERICAN ALLIANCE INS. CO.**

301 EAST FOURTH STREET, FLOOR 24
CINCINNATI, OH 45202

CLAIM NO.: A00479175
POLICY NO.: WC E893163
DATE/LOSS: 10/7/22
INSURED: LA PUENTE AUTO SPA INC
CLAIMANT: EDWIN OSORIO URIZAR
STMT. OF ACCT: INVOICE NUMBER 3234DB114485181, DATE(S) OF SERVICE 05/10/2023 - 05/10/2023

No. 3002521387
DATE 01/26/24
CHECK VOID AFTER 180 DAYS

90 DOLLARS AND 00 CENTS

\$90.00

PAY TO
THE
ORDER
OF

JOYCE ALTMAN INTERPRETERS INC

PRODUCER:

BUILDERS & TRADESMEN'S INS
6610 SIERRA COLLEGE BOULEVARD
ROCKLIN, CA 95677-4306

PNC Bank, N.A. 070
ASHLAND, OHIO

56-389/412

CP

PAYABLE IF DESIRED AT ANY BRANCH OF
WELLS FARGO
IN THE STATE OF CALIFORNIA

Great American Insurance Company

BY:

Annette D. Gardner

Annette D. Gardner, Senior Vice President & CFO

⑈ 300 252 1387 ⑈ ⑆ 04 1 203895⑆ 4239730564 ⑈

31400X13002521387256

F 11531H (9/14)

RECEIVED JUN 17 2024

AGENT:

BUILDERS & TRADESMEN'S INS
6610 SIERRA COLLEGE BOULEVARD
ROCKLIN, CA 95677-4306

1033036276

MAIL TO:

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

PAYEE:

CP

JOYCE ALTMAN INTERPRETERS INC

CHECK # 3002640823 AMT \$140.00 ISSUED 6/12/24
FOR: INVOICE NUMBER 3234DB114485182, DATE(S) OF SERVICE 05/10/2023 - 05/10/2023

INSURED: LA PUENTE AUTO SPA INC

CLAIMANT:

POLICY # E893163 CLAIM # A00479175 DATE OF LOSS 10/7/22

IMPORTANT: WHEN CORRESPONDING WITH THE CLAIM OFFICE, PLEASE REFER TO YOUR CLAIM NUMBER
AND CONTACT THE ADJUSTER SHOWN BELOW:

JOY MAHMOOD
GREAT AMERICAN ALLIANCE INS. CO.
PO BOX 4080
CLINTON, IA 52733-4080

925-988-2272

ENTERED JUN 18 2024 3002640823

THE ENCLOSED INSTRUMENT WILL NOT BE PAID UNLESS IT BEARS THE ENDORSEMENTS OF ALL PARTIES NAMED AS PAYEES. ENDORSERS MUST SIGN EXACTLY AS THE NAME APPEARS ON THE FACE OF THE INSTRUMENT. IF THE ENDORSER IS A CORPORATION, SHOW THE FULL CORPORATE NAME WITH A SIGNATURE BY A DULY AUTHORIZED OFFICER AND TITLE. IF THE ENDORSER IS A PARTNERSHIP, ALL PARTIES MUST SIGN. IF AN ATTORNEY, EXECUTOR, ADMINISTRATOR, TRUSTEE OR GUARDIAN IS SIGNING A PAYEE'S NAME, SATISFACTORY EVIDENCE OF AUTHORITY MUST ACCOMPANY THE INSTRUMENT. IT IS RECOMMENDED THAT YOU DISCUSS THIS WITH YOUR CLAIMS REPRESENTATIVE BEFORE PRESENTING THE INSTRUMENT FOR PAYMENT AS ANY PAPERS SUBMITTED WITH THE CHECK WILL SLOW DOWN THE PROCESS. IF YOU HAVE ANY QUESTIONS CONCERNING THE PROPER ENDORSEMENT OF THE CHECK, PLEASE CONTACT YOUR CLAIMS REPRESENTATIVE. RHODE ISLAND ONLY: NOTICE: A RECIPIENT OF WEEKLY WORKERS' COMPENSATION BENEFITS HAS AN AFFIRMATIVE DUTY TO REPORT EARNINGS SO THAT COMPENSATION BENEFITS MAY BE PROPERLY COMPUTED. FAILURE TO REPORT EARNINGS MAY SUBJECT THE RECIPIENT TO CIVIL OR CRIMINAL LIABILITY.

Security features included. Details on back.
GREAT AMERICAN INSURANCE COMPANY, AS AGENT FOR:
GREAT AMERICAN ALLIANCE INS. CO.

301 EAST FOURTH STREET, FLOOR 24
CINCINNATI, OH 45202

CLAIM NO.: A00479175
POLICY NO.: WC E893163
DATE/LOSS: 10/7/22
INSURED: LA PUENTE AUTO SPA INC
CLAIMANT: EDWIN OSORIO URIZAR
STMT. OF ACCT: INVOICE NUMBER 3234DB114485182, DATE(S) OF SERVICE 05/10/2023 - 05/10/2023

No. 3002640823
DATE 06/12/24
CHECK VOID AFTER 180 DAYS

140 DOLLARS AND 00 CENTS

\$140.00

PAY TO
THE
ORDER
OF

JOYCE ALTMAN INTERPRETERS INC

PRODUCER:

BUILDERS & TRADESMEN'S INS
6610 SIERRA COLLEGE BOULEVARD
ROCKLIN, CA 95677-4306

PNC Bank, N.A. 070
ASHLAND, OHIO

PAYABLE IF DESIRED AT ANY BRANCH OF
WELLS FARGO
IN THE STATE OF CALIFORNIA

Great American Insurance Company

BY:

Annette D. Gardner

Annette D. Gardner, Senior Vice President & CFO

56-389/412

CP

300 264 0823 04 1203895 4239730564

000048



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

27) 1994700

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 04, 2024



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

RECEIVED JAN 08 2024

IBR Case Number	CB23-0002523
Claim Number	PUWC252466-001
Assignment Date	11/17/2023
Claims Administrator	Guard Insurance Group
Date(s) of service	07/25/2022 – 07/27/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	01/27/2022
Application Received	08/31/2023

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 \$325.00 in additional reimbursement for a total of \$505.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$505.00** 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: Guard Insurance Group
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 T1013 (Interpreter Service) x 2 submitted for dates of service 07/25/2022 – 07/27/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/01/2023. Response not yet received.
- CMS 1500, place of service 11
 - 07/25/2022 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Acupuncture 2hr min)
 - 07/27/2022 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
- EORs reflect reimbursement of \$45.00 for date of service 07/25/2022 indicating this charge was adjusted to comply with the rate and rules of the contract. EORs reflect reimbursement of \$90.00 for date of service 07/27/2022 indicating the charge exceeds the OMFS allowance.
- **CCR § 9795.3. Services 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 07/25/2022 and 07/27/2022 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- The Provider is requesting reimbursement based on their Market Rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 11/17/2023 requesting a copy of the contract to support the reductions on the EORs for date of service 07/25/2022. Response not yet received; therefore, reimbursement will be based on CCR §9795.3.
- Total reimbursement received in the amount of \$135.00 for dates of service 07/25/2022 – 07/27/2022. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2**Date of Service:** 07/25/2022 – 07/27/2022**Interpreter**

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$45.00
Dispute Amount	\$185.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 07/25/2022 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$45.00 (Plan Allowed) = \$185.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 07/27/2022 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Guard Insurance Group
 PO Box 881716
 San Francisco, CA 94188

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

009880351

RECEIVED JUN 06 2023



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

ENTERED JUN 07 2023

CDN4669A05A0AAA.001181 01.02.000000

Please see attached documentation.

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

Wells Fargo Bank, N.A.

009880351

P.O. Box AII
Wilkes-Barre, PA 18703-0020

11-24
1210

⇒⇒⇒⇒⇒ PAY ONLY

\$45.00
DOLLAR FOUR FIVE PERIOD ZERO ZERO

DATE
06/01/2023

AMOUNT
*****\$45.00

NOT VALID AFTER 180 DAYS

■ FORTY-FIVE DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER \$45.00

009880351 121000248 2000519407927

009880859



RECEIVED JUN 07 2023

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

ENTERED JUN 07 2023

Please see attached documentation.

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

Wells Fargo Bank, N.A.

009880859

P.O. Box AH
Wilkes-Barre, PA 18703-0020

11-24
1210

⇒⇒⇒⇒⇒ PAY ONLY **\$90.00**
DOLLAR NINL ZERO PERIOD ZERO ZERO

DATE
06/02/2023

AMOUNT
*****\$90.00

NOT VALID AFTER 180 DAYS

■ NINETY DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER \$90.00

009880859 121000248 2000519407927

009960232

RECEIVED JAN 29 2024



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TRUSTIN CA 92781

CDN2949A05A0AAA.000598.01.01.000000

01/19/2024 330956713-0000 JOYCE ALTMAN INTERPRETERS INC

:11/17/2023

ENTERED JAN 29 2024

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

Wells Fargo Bank, N.A.

009960232

11-24
1210

P.O. Box AH
Wilkes-Barre, PA 18703-0020

DATE AMOUNT
01/19/2024 *****\$505.00

⇄⇄⇄⇄⇄ PAY ONLY **\$505.00**
DOLLAR FIVE ZERO TWO PERIOD ZERO ZERO

NOT VALID AFTER 180 DAYS

■ FIVE HUNDRED FIVE DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TRUSTIN CA 92781

VOID OVER \$505.00

0099602320 121000248 2000519407927



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED MAR 04 2024

28) 1994700

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 28, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003239
Claim Number	PUWC252466-001
Assignment Date	01/11/2024
Claims Administrator	Guard Insurance Group
Date(s) of service	09/19/2022 – 09/19/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	01/27/2022
Application Received	11/17/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: Guard Insurance Group
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 T1013 (Interpreter Service) submitted for date of service 09/19/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/26/2023. Response not yet received.
- CMS 1500, place of service 11
 - 09/19/2022 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
- EORs reflect reimbursement of \$90.00. The charge exceeds the OMFS allowance; the charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Services 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 09/19/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00 for date of service 09/19/2022. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 09/19/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Guard Insurance Group
PO Box 881716
San Francisco, CA 94188

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

009897956

RECEIVED JUL 31 2023



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

ENTERED AUG 01 2023

Please see attached documentation.

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

Wells Fargo Bank, N.A.

009897956

P.O. Box AH
Wilkes-Barre, PA 18703-0020

11-24
T2T0

⇒⇒⇒⇒⇒ PAY ONLY

\$90.00
DOLLAR NINE ZERO PERIOD ZERO ZERO

DATE
07/24/2023

AMOUNT
*****\$90.00

NOT VALID AFTER 180 DAYS

■ NINETY DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER \$90.00

⑈009897956⑈ ⑆121000248⑆ 2000519407927⑈

009981603

RECEIVED MAR 29 2024



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

CDN0377A05A0AAA.000767.01.01.000000

03/21/2024 330956713-0000 JOYCE ALTMAN INTERPRETERS INC

ENTERED MAR 29 2024

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

AmGUARD Insurance Company

Wells Fargo Bank, N.A.

009981603

11-24
1210

P.O. Box AH
Wilkes-Barre, PA 18703-0020

DATE	AMOUNT
03/21/2024	*****\$320.00

⇒⇒⇒⇒⇒PAY ONLY **\$320.00**
DOLLAR THREE TWO ZERO PERIOD ZERO ZERO

NOT VALID AFTER 180 DAYS

■ THREE HUNDRED TWENTY DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER \$320.00

009981603 121000248 2000519407927



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED FEB 10 2025

29) 2252092

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 04, 2025

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002707
Claim Number	KDWC358703-001
Assignment Date	12/20/2024
Claims Administrator	Guard Insurance Group
Date(s) of service	01/15/2024 - 01/15/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	11/12/2022
Application Received	09/30/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Guard Insurance Group
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 T1013 (Interpreter Service) submitted for date of service 01/15/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/04/2024. Response not yet received.
- CMS 1500, place of service 11
 - 01/15/2024 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- 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 01/15/2024 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 01/15/2024**Interpreter**

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$90.00
Dispute Amount	\$140.00
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Guard Insurance Group
PO Box 1368
Wilkes-Barre, PA 18703

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

010353747

RECEIVED JUN 20 2024



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TRUSTIN CA 92781

ENTERED JUN 21 2024

Please see attached documentation.

GDN1739A05A0AAA.001258.01.04.0000000

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

NorGUARD Insurance Company

Wells Fargo Bank, N.A.

010353747

P.O. Box AH
Wilkes-Barre, PA 18703-0020

11-24
1210

⇒⇒⇒⇒⇒ PAY ONLY **\$320.00**
DOLLAR THREE TWO ZERO PERIOD ZERO ZERO

DATE
06/13/2024

AMOUNT
*****\$320.00

NOT VALID AFTER 180 DAYS

■ THREE HUNDRED TWENTY DOLLARS AND 00 CENTS*****

PAY
TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TRUSTIN CA 92781

VOID OVER \$320.00

⑈010353747⑈ ⑆121000248⑆ 2000519409116⑈

010426295



JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

Please see attached documentation.

RECEIVED FEB 28 2025

ENTERED MAR 03 2025

CDN5792A05A0AAA.001339.01.03.000000

THIS CHECK CONTAINS MULTIPLE FRAUD DETERRENT SECURITY FEATURES

NorGUARD Insurance Company

Wells Fargo Bank, N.A.

010426295

P.O. Box AH
Wilkes-Barre, PA 18703-0020

11-24
1210

DATE AMOUNT
02/24/2025 *****\$320.00

⇒⇒⇒⇒⇒ PAY ONLY **\$320.00**

NOT VALID AFTER 180 DAYS

■ THREE HUNDRED TWENTY DOLLARS AND 00 CENTS*****

PAY TO THE ORDER OF
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

VOID OVER \$320.00

010426295 121000248 2000519409116



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JUL 26 2024

30) 1966294

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



July 22, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001123
Claim Number	WC 648-D15658
Assignment Date	06/07/2024
Claims Administrator	Helmsman
Date(s) of service	05/30/2023 - 05/30/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	07/15/2021
Application Received	05/10/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Helmsman
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 T1013 (Interpreter Service) submitted for date of service 05/30/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 05/22/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/30/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr min)
- 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 05/30/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 05/30/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtun \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Helmsman
PO Box 7070
London, KY 40742

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:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742



B. CODE
298

CHECK REFERENCE	CHECK DATE
0084366235	01/31/24
CHECK AMOUNT	BLOCK NUMBER
****\$180.00	011286

PAGE 1 OF 5
OSN:MM0701013111-004735

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
3234DB11551535-1	05/30/23-05/30/23	1119153012	230.00	90.00
3234DB11545651-1	05/30/23-05/30/23	1119140801	230.00	90.00

RECEIVED FEB 05 2024

ENTERED FEB 06 2024

TOTAL BILLS COMBINED: 2

180.00

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.

MPA *001484*

HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0084366235
62-20/311
38621953

B.CODE OFFICE NUMBER PAYMENT IDENTIFICATION
298 808 COMBINED PAYMENT

CHECK DATE
01/31/24

\$ *****180.00

PAY ONE HUNDRED EIGHTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

u-2 Per

0084366235 10311002091

38621953

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN SUBMITTING FOR VERIFICATION.

BRANCH OFFICE ADDRESS:
PO BOX 8016
WAUSAU, WI 54402
818-240-1234



B. CODE 199	CHECK NUMBER 03985604	CHECK DATE 09/24/24
	CHECK AMOUNT *****\$320.00	BLOCK NUMBER 002621

RECEIVED SEP 30 2024

PAGE 1 OF 1

CLAIM #: WC 648-D15658
CONTRACT #: WP8-69B-442257-291

OSN: EE3001092403-003483

CONTROL #: 000005600 ID: CRCEB96
PROVIDER #: N3095671354317

PAYEE: JOYCE ALTMAN INTERPRETING

DATE OF INJURY: 07/15/21
EMPLOYEE:

TAX ID:
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781

EMPLOYER: WESTFIELD, LLC
DATES OF SERVICE 05/30/23-05/30/23
LOCATION CODE:

PROVIDER:

DATES OF SERVICE		SERVICE DESCRIPTION	UNITS	CHARGE	PAYABLE	EXPL CODE
FROM	TO					
05/30/23	05/30/23	MISC		320.00	320.00	

NOTE: IBR CASE#CB24-0001123

TOTAL CHARGES	320.00
TOTAL PAYABLE:	320.00
TOTAL WITHHOLDING - (FEDERAL AND STATE):	0.00
TOTAL AMOUNT PAID:	320.00

ENTERED OCT 01 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED DEC 06 2024

31) 1966294

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 02, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002465
Claim Number	WC648D15658
Assignment Date	10/07/2024
Claims Administrator	Helmsman Management Services
Date(s) of service	05/10/2023 - 05/10/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	07/15/2021
Application Received	09/11/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: Helmsman 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 T1013 (Interpreter Service) submitted for date of service 05/10/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/19/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/10/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- 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 05/10/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 05/10/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Helmsman Management Services
PO Box 4555
Portland, OR 97208

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:
HELMSMAN MANAGEMENT SERVICES
PO BOX 7070
LONDON, KY 40742



B. CODE
298

CHECK REFERENCE	CHECK DATE
0084358041	01/17/24
CHECK AMOUNT	BLOCK NUMBER
****\$270.00	013344

PAGE 1 OF 7
OSN:MM0701011711-007195

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
3234DB11448539-1	05/10/23-05/10/23	1119001065	230.00	90.00
3234DB11154878-1	03/24/23-03/24/23	1119002219	230.00	90.00
3234DB11223481-1	04/07/23-04/07/23	1119002240	230.00	90.00

RECEIVED JAN 23 2024

ENTERED JAN 23 2024

TOTAL BILLS COMBINED: 3

270.00

Electronic Payment Clearinghouse

TRISTAR Risk Management
PO Box 2805
Clinton, IA 52733-2805

Wells Fargo Bank, N.A.

56-382
412

Electronic Payment Clearinghouse
Echo Health, Inc.

DRAFT NO.
DRAFT DATE

351857016
12/11/2024

PAYABLE THROUGH DRAFT
Three Hundred Twenty & 00 / 100 DOLLARS

TO THE ORDER OF
Joyce Altman Interpreters Inc
PO Box 4165
Tustin CA 92781

AMOUNT
*****\$320.00

VOID AFTER 180 DAYS

Kristopher T. Ken

DUPEPROOF ICON

MUST BE VISIBLE

⑈351857016⑈ ⑆041203824⑆ 9604000621⑈

RECEIVED DEC 23 2024

ENTERED DEC 23 2024





MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JUN 17 2024

32) 1952173

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



June 14, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000791
Claim Number	2022008641
Assignment Date	05/02/2024
Claims Administrator	Insurance Company of the West
Date(s) of service	04/18/2023 - 04/18/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	09/14/2021
Application Received	04/05/2024

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 \$34.96 in additional reimbursement for a total of \$214.96. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$214.96** 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 T1013 (Interpreter Service) submitted for date of service 04/18/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/16/2024. Response not yet received.
- CMS 1500, place of service 11
 - 04/18/2023 T1013 (interpreter services) x 2, \$230.00 (Acupuncture tx 2hr min)
- EORs reflect reimbursement of \$195.04. Charge was adjusted to comply with the rate and rules of the contract indicated.
- **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 04/18/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Provider is asking for their market rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 05/02/2024 requesting a copy of the contract and any usual and customary guidelines, to support the reductions on the EORs. Response not yet received. Therefore, reimbursement will be based on 100% of the provider's established market rate.
- Reimbursement received in the amount of \$195.04. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 04/18/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$195.04
Dispute Amount	\$34.96
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$195.04 (Plan Allowed) = \$34.96 + \$180.00 (IBR Application Fee) = \$214.96 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: 12/26/2023
Check Number: 5070488
Check Amount: \$195.04



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, 627241S

627241S

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED JAN 5 2024

ENTERED JAN 10 2024

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022008641		09/14/2021	\$230.00	\$34.96	\$195.04
Category	Stub Notes	Stub Amount			
180	The charges have been paid per ICW s usual and cus	\$0.00			

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 06/18/2024
Check Number: 5388807
Check Amount: \$34.96

FW891C

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, F7W891C

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED JUL 01 2024

ENTERED JUL 01 2024

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022008641		09/14/2021	\$230.00	\$195.04	\$34.96
Category	Stub Notes				Stub Amount
180	IBR OVERTURNED- ADDITIONAL ALLOWANCE\n\nAll sub				\$0.00

See attached page(s) for Explanations of Review

**MAXIMUS FEDERAL SERVICES, INC.**

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

33) 1967592

RECEIVED JAN 29 2024

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 25, 2024



000051

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

IBR Case Number	CB23-0002796
Claim Number	2022002487
Assignment Date	12/14/2023
Claims Administrator	ICW Group
Date(s) of service	08/24/2022 – 08/25/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	02/01/2022
Application Received	09/29/2023

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 \$100.00 in additional reimbursement for a total of \$280.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$280.00** 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: ICW Group
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 T1013 (Interpreter Service) x 2 submitted for dates of service 08/24/2022 – 08/25/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/28/2023. Response received on 12/21/2023. Claims Administrator provided copies of IBR documents.
- CMS 1500, place of service 11
 - 08/24/2022 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Acupuncture 2hr min)
 - 08/25/2022 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
- EORs reflect reimbursement of \$180.00 for each date of service 08/24/2022 and 08/25/2022 indicating the charge exceeds the OMFS allowance.
- **CCR § 9795.3. Services 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 08/24/2022 and 08/25/2022 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$360.00 for dates of service 08/24/2022 – 08/25/2022. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned x 2.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2

Date of Service: 08/24/2022 – 08/25/2022

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 08/24/2022 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 08/25/2022 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 Due Provider Refer to Analysis

Copy to:

ICW Group
 PO Box 2965
 Clinton, IA 52733

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: 02/12/2024
Check Number: 5151315
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, BJ1V41Y

BJ1V41Y

4/6/22 11:54 AM 3 0000316 20240213 VB5WI202 JOP-FEC 2 oz DOM VB5WI20000* 161281 CK



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



RECEIVED FFR 2 1 2024

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022002487		02/01/2022	\$180.00	\$0.00	\$180.00
Category	Stub Notes				Stub Amount
493	IBR OVERTURNED- REVIEW FEE FOR IWCA 5313572				\$0.00

ENTERED FEB 23 2024

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 02/12/2024
Check Number: 5151318
Check Amount: \$50.00



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, EJ1V417

EJ1V417

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022002487		02/01/2022	\$230.00	\$180.00	\$50.00
Category	Stub Notes	Stub Amount			
180	IBR OVERTURNED- ADDITIONAL ALLOWANCE\n\n\nAll sub	\$0.00			

RECEIVED FEB 21 2024

ENTERED FEB 23 2024

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 02/12/2024
Check Number: 5151320
Check Amount: \$50.00



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, FJ1V41A

FJ1V41A

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022002487		02/01/2022	\$230.00	\$180.00	\$50.00
Category	Stub Notes				Stub Amount
180	IBR OVERTURNED- ADDITIONAL ALLOWANCE\n\nAll sub				\$0.00

RECEIVED FEB 21 2024

ENTERED FEB 23 2024

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 06/29/2023
Check Number: 4768077
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, 68B3112

68B3112

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED JUL 14 2023

ENTERED JUL 14 2023

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2022002487		02/01/2022	\$230.00	\$50.00	\$180.00
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



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED DEC 09 2024

34) 2212995

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 05, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002517
Claim Number	2023004509
Assignment Date	10/11/2024
Claims Administrator	Insurance Company of the West
Date(s) of service	12/19/2023 - 12/19/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	01/01/2023
Application Received	09/13/2024

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 \$50.00 in additional reimbursement for a total of \$230.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$230.00** 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 T1013 (Interpreter Service) submitted for date of service 12/19/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/25/2024. Response not yet received.
- CMS 1500, place of service 11
 - 12/19/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$180.00. Allowance for this procedure was made at the usual and customary amount for this geographical area; charge was adjusted to comply with the rate and rules of the contract indicated.
- **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 12/19/2023 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Provider is asking for their market rate of \$115.00 per hour. Assignment letter was issued to the Claims Administrator on 10/11/2024, requesting a copy of the contract and any usual and customary guidelines, to support the reimbursement on the EORs. Response received 10/28/2024. Claims Administrator did not provide the requested documents. Therefore, reimbursement will be based on 100% of the Provider's established market rate.
- Reimbursement received in the amount of \$180.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 12/19/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overturn \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 + \$180.00 (IBR Application Fee) = \$230.00 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: 06/14/2024
Check Number: 5383508
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, VT5591U

VT5591U

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED JUN 24 2024

ENTERED JUN 26 2024

Payment Summary

Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2023004509		01/01/2023	\$230.00	\$50.00	\$180.00
Category	Stub Notes	Stub Amount			
180	The charges have been paid per ICW s usual and cus	\$0.00			

Insurance Company of the West
15025 Innovation Drive
San Diego, CA 92128

Check Date: 12/17/2024
Check Number: 5747696
Check Amount: \$50.00



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, 51HWF1D

51HWF1D

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

RECEIVED JAN 02 2025

Payment Summary

Payment Summary					
Claim #	Claimant	Date of Injury	Total Billed	Total Reduction	Total Payment
2023004509		01/01/2023	\$230.00	\$180.00	\$50.00
Category	Stub Notes				Stub Amount
180	IBR OVERTURNED- ADDITIONAL ALLOWANCE\n\nAll submit				\$0.00

ENTERED JAN 6 2025

See attached page(s) for Explanations of Review

RECEIVED FEB 29 2024

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

35) 84264

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 26, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003362
Claim Number	WC648C44586
Assignment Date	01/05/2024
Claims Administrator	Liberty Mutual
Date(s) of service	09/22/2022 - 09/22/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	12/31/2020
Application Received	12/05/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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 09/22/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/12/2023. Response received on 12/27/2023. Claims Administrator upheld their determination.
- Itemized Invoice
 - 09/22/2022 Interpreting for P and S \$230.00 (billed at a minimum of 2 hours)
- EORs reflect reimbursement of \$90.00. The charge exceeds the OMFS allowance.
- **CCR § 9795.3. Services 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 09/22/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00 for date of service 09/22/2022. Additional reimbursement is due up to the established market rate. **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:** 09/22/2022**Interpreter**

Service Code	Interpreter Service
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 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 95677

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:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742

B. CODE
288

CHECK REFERENCE	CHECK DATE
0033806333	08/07/23
CHECK AMOUNT	BLOCK NUMBER
***\$360.00	015803

PAGE 1 OF 9
OSN:MM0701080712-000265

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
3234DB10479395-1	10/21/22-10/21/22	1117469356	230.00	90.00
3234DB10479839-1	10/21/22-10/21/22	1117469032	230.00	90.00
84264	09/21/22-09/21/22	1117339631	230.00	90.00
84264	09/22/22-09/22/22	1117340041	230.00	90.00

RECEIVED AUG 15 2023

PAID
AUG 17 2023

BY

TOTAL BILLS COMBINED: 4

360.00

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 INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0033806333
62-20/311
38621945

B.CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 808 COMBINED PAYMENT

CHECK DATE
08/07/23

\$ *****360.00

VOID IF NOT PRESENTED WITHIN
90 DAYS OF DATE OF CHECK

PAY THREE HUNDRED SIXTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

de 2 per

0033806333 0311002091

38621945

THE ORIGINAL DOCUMENT HAS A REFLECTIVE UNDERLAY ON THE BACK WHEN HELD UP TO THE LIGHT



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:
NSUP LIBERTY MUTUAL INSURANCE
PO BOX 7203
LONDON, KY 40742

B. CODE
288

CHECK REFERENCE 0034044532	CHECK DATE 03/13/24
CHECK AMOUNT ***\$140.00	BLOCK NUMBER 001671

PAGE 1 OF 2

CLAIM NO. WC 648-C44586 HOD
CONTRACT NO: WC5-691-436651-020
DOCUMENT NO: 20019549720

RECEIVED MAR 18 2024

OSN: MM0801031302-001671
BANK: 288
CHECK REF: 0034044532 DATE: 03/13/24 AMT: 140.00
INTERNAL BILL NO: 139233567 MSR: N0170671
CUST/EXTERNAL BILL NO: 2001954972
BR PROVIDER #: 330956713-0003

PAYEE: JOYCE ALTMAN INTERPRETING
TAX ID: 33-0956713
BILL PROV: JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN, CA 92781-4165

ENTERED MAR 21 2024

PATIENT ACCT. #: 84264
SSN:
DOI:
PATIENT:

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 2022051111262530825557
DIAG CODES: T14.90

EMPLOYER: UNITY COURIER SERVICE
ADDRESS: 7555 N SAN FERNANDO RD
BURBANK, CA 91505

DATES OF SERVICE: 09/22/22-09/22/22
AUDIT DATE: 03/12/24

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
09/22/22	T1013		SIGN LANGUAGE/ORAL INTEPR	120.00	230.00	230.00	N/A	90.00	140.00	G1 5898
TOTAL CHARGES:							230.00			
TOTAL PREVIOUSLY PAID:							90.00			
TOTAL CURRENT PAYABLE:							140.00			
TOTAL WITHHOLDING - (FEDERAL AND STATE):							0.00			
TOTAL AMOUNT PAID:							140.00			

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 VISIT [HTTPS://RG.JOPARI.NET/](https://rg.jopari.net/) TO SIGN UP FOR EFT PAYMENTS & ELECTRONIC REMITTANCE - ITS FASTER & MORE SECURE



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED MAY 21 2024

36) 84518

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



May 16, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003340
Claim Number	WC608F73507
Assignment Date	04/08/2024
Claims Administrator	Liberty / Helmsman
Date(s) of service	09/09/2022 – 09/09/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	01/26/2022
Application Received	12/04/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 / Helmsman
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 09/09/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/11/2023. Response not yet received.
- Itemized Invoice
 - 09/09/2022 Interpreting for PR2 / Reeval \$230.00 (billed at a minimum of 2 hours)
- EORs reflect reimbursement of \$90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 09/09/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **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: 09/09/2022

Interpreter

Service Code	Interpreter Service
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Liberty / Helmsman
PO Box 7203
London, KY 40742

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:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



B. CODE
288

CHECK REFERENCE	CHECK DATE
0033801391	08/02/23
CHECK AMOUNT	BLOCK NUMBER
*****\$540.00	014574

PAGE 1 OF 13
OSN:MM0701080212-000857

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
3234DB10449738-1	10/14/22-10/14/22	1117423759	230.00	90.00
84518	09/09/22-09/09/22	1117287216	230.00	90.00
81399	09/07/22-09/07/22	1117290427	230.00	90.00
81822	09/08/22-09/08/22	1117290414	230.00	90.00
3234DB10448529-1	10/13/22-10/13/22	1117423713	230.00	90.00
84886	09/09/22-09/09/22	1117292610	230.00	90.00

RECEIVED AUG 09 2023

AUG 10 2023

RT.

TOTAL BILLS COMBINED: 6

540.00

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 INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0033801391
62-20/311
38621945

B. CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 808 COMBINED PAYMENT

CHECK DATE
08/02/23

\$ *****540.00

VOID IF NOT PRESENTED WITHIN
90 DAYS OF DATE OF CHECK

PAY FIVE HUNDRED FORTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

de 2 per

0033801391 0311002091

38621945

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD UP TO LIGHT TO VIEW WHEN NEAR THE LIGHT.



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 JUN 24 2024

PAGE 1 OF 2

CLAIM NO. WC 608-F73507 HOD
CONTRACT NO: WA5-65D-291862-011
DOCUMENT NO: 20020309760

OSN: MM0801061402-000909
BANK: 288
CHECK REF: 0034136772 DATE: 06/14/24 AMT: 140.00
INTERNAL BILL NO: 139209523 MSR: N0170671
CUST/EXTERNAL BILL NO: 2002030976
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. #: 84518
SSN:
DOI:
PATIENT:

ENTERED JUN 26 2024

PROVIDER: JOSSUE LUCAS
JOYCE ALTMAN INTERPRETERS INC

AGENCY CLAIM #(BOARD COMM #): 2022042911384661345992
DIAG CODES: T14.90

EMPLOYER: EATALY USA, LLC
ADDRESS: 10250 SANTA MONICA BLVD, STE 2
LOS ANGELES, CA 90067

LOCATION CODE: 40-200-1090

DATES OF SERVICE: 09/09/22-09/09/22
AUDIT DATE: 06/13/24

DATE OF SERVICE	PROCEDURE CODE	MOD CDE	SERVICE DESCRIPTION	UNITS	CHARGES	REVIEW ALLOW	PPO ALLOW	PREV PAID	CURR PAID	EXPL CODES
09/09/22	T1013		SIGN LANGUAGE/ORAL INTEPR	120.00	230.00	230.00	N/A	90.00	140.00	G1 5898
TOTAL CHARGES:							230.00			
TOTAL PREVIOUSLY PAID:							90.00			
TOTAL CURRENT PAYABLE:							140.00			
TOTAL WITHHOLDING - (FEDERAL AND STATE):							0.00			
TOTAL AMOUNT PAID:							140.00			

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 VISIT [HTTPS://RG.JOPARI.NET/](https://rg.jopari.net/) TO SIGN UP FOR EFT PAYMENTS & ELECTRONIC REMITTANCE - ITS FASTER & MORE SECURE



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 08 2024

37) 2086998

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 04, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000170
Claim Number	WC648C44369
Assignment Date	02/20/2024
Claims Administrator	Liberty Mutual
Date(s) of service	02/08/2023 – 03/01/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	06/23/2021
Application Received	01/25/2024

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 T1013 (Interpreter Service) x 2 submitted for dates of service 02/08/2023 – 03/01/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 02/01/2024. Responses received on 02/20/2024 and 02/26/2024. Claims Administrator indicated additional payment was due. Copies of EORs with check information were provided.
- CMS 1500, place of service 11
 - 02/08/2023 T1013 (Interpreter Service) x 2, \$230.00 (F/U Physical Tx & Acu Tx 2hr min)
 - 03/01/2023 T1013 (Interpreter Service) x 2, \$230.00 (Acupuncture Tx & F/U Physical Tx 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 02/08/2023 and 03/01/2023. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 02/08/2023 and 03/01/2023 were signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$280.00, post IBR receipt, for a total reimbursement of \$460.00 for dates of service 02/08/2023 – 03/01/2023. \$180.00 IBR application fee is due. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2**

Date of Service: 02/08/2023 – 03/01/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$90.00 \$140.00 (post IBR receipt)
Dispute Amount	\$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 02/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$230.00 (Plan Allowed) = \$0.00 \$180.00 (IBR Application Fee) Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$90.00 \$140.00 (post IBR receipt)
Dispute Amount	\$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 03/01/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$230.00 (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

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



B. CODE
288

CHECK REFERENCE 0033887181	CHECK DATE 10/16/23
CHECK AMOUNT ***\$900.00	BLOCK NUMBER 017113

PAGE 1 OF 21
OSN:MM0701101612-001448

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
3234DB10903331-1	02/06/23-02/06/23	1118139710	230.00	90.00
3234DB10908569-1	02/06/23-02/06/23	1118145116	230.00	90.00
3234DB10911554-1	02/07/23-02/07/23	1118147317	230.00	90.00
3234DB10921141-1	02/08/23-02/08/23	1118161231	230.00	90.00
3234DB10921591-1	02/09/23-02/09/23	1118161257	230.00	90.00
3234DB10921626-1	02/09/23-02/09/23	1118161226	230.00	90.00
3234DB10919485-1	02/08/23-02/08/23	1118159738	230.00	90.00
3234DB10919972-1	02/08/23-02/08/23	1118159667	230.00	90.00
3234DB10903013-1	02/06/23-02/06/23	1118139550	230.00	90.00
3234DB10903321-1	02/06/23-02/06/23	1118139549	230.00	90.00

RECEIVED OCT 24 2023

ENTERED OCT 25 2023

TOTAL BILLS COMBINED: 10

900.00

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.

017113

LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0033887181
62-20/311
38621945

CHECK DATE
10/16/23

B.CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 808 COMBINED PAYMENT

\$ *****900.00

PAY NINE HUNDRED AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

Handwritten signature

0033887181 0311002091

38621945

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



B. CODE
288

CHECK REFERENCE	CHECK DATE
0034023682	02/23/24
CHECK AMOUNT	BLOCK NUMBER
****\$280.00	014726

PAGE 1 OF 5
OSN:MM0301022311-006139

THIS CHECK REPRESENTS A COMBINATION OF BILLED SERVICES. PLEASE REFER TO
EACH DETAILED ITEMIZATION FOR SPECIFIC INFORMATION TO SUPPORT THE PAYMENT.

PATIENT ACCT #
3234DB10919485-1
3234DB11033092-1

DATES OF SERVICE
02/08/23-02/08/23
03/01/23-03/01/23

CUST/EXTERNAL BILL #
2001934110
2001934160

TOTAL BILL CHARGES
230.00
230.00

TOTAL PAID
140.00
140.00

RECEIVED FEB 28 2024

ENTERED FEB 29 2024

TOTAL BILLS COMBINED: 2

280.00

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.

MPA *001988*

LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0034023682
62-20/311
38621945

CHECK DATE
02/23/24

B.CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 570 COMBINED PAYMENT

\$ *****280.00

PAY TWO HUNDRED EIGHTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

u- 2 Per

0034023682 0311002091

38621945

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



B. CODE
288

CHECK REFERENCE	CHECK DATE
0033908946	11/03/23
CHECK AMOUNT	BLOCK NUMBER
***\$540.00	021864

PAGE 1 OF 13
OSN:MM0701110312-001135

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
3234DB11034421-1	03/02/23-03/02/23	1118338213	230.00	90.00
3234DB11027343-1	02/28/23-02/28/23	1118333508	230.00	90.00
3234DB11033092-1	03/01/23-03/01/23	1118337623	230.00	90.00
3234DB11006997-1	02/23/23-02/23/23	1118294563	230.00	90.00
3234DB11035678-1	03/03/23-03/03/23	1118338145	230.00	90.00
3234DB11017815-1	02/27/23-02/27/23	1118311543	230.00	90.00

RECEIVED NOV 14 2023

ENTERED NOV 15 2023

TOTAL BILLS COMBINED: 6

540.00

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.

021864

LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0033908946
62-20/311
38621945

B.CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 808 COMBINED PAYMENT

CHECK DATE
11/03/23

\$ *****540.00

PAY FIVE HUNDRED FORTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

de 2 per

0033908946 0311002091

38621945

PROVIDER INQUIRIES: (800) 500-7044
CUSTOMER SERVICE DEPARTMENT
FOR DISPUTES/APPEALS ONLY:
LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



B. CODE
288

CHECK REFERENCE	CHECK DATE
0034023682	02/23/24
CHECK AMOUNT	BLOCK NUMBER
*****\$280.00	014726

PAGE 1 OF 5
OSN:MM0301022311-006139

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
3234DB10919485-1	02/08/23-02/08/23	2001934110	230.00	140.00
3234DB11033092-1	03/01/23-03/01/23	2001934160	230.00	140.00

RECEIVED FEB 28 2024

ENTERED FEB 29 2024

TOTAL BILLS COMBINED: 2

280.00

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.

MPA *001988*

LIBERTY MUTUAL INSURANCE
PO BOX 7070
LONDON, KY 40742



CITIBANK NA, ONE PENNS WAY
NEW CASTLE, DE 19720

0034023682
62-20/311
38621945

B. CODE OFFICE NUMBER PAYMENT IDENTIFICATION
288 570 COMBINED PAYMENT

CHECK DATE
02/23/24

\$ *****280.00

PAY TWO HUNDRED EIGHTY AND 00/100 DOLLARS*****

TO THE
ORDER
OF

JOYCE ALTMAN INTERPRETING
PO BOX 4165
TUSTIN CA 92781-4165

Handwritten signature

0034023682 0311002091

38621945

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

38) 2006221**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 02, 2024



000043

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

RECEIVED JAN 05 2024

IBR Case Number	CB23-0002972
Claim Number	R00102610
Assignment Date	11/14/2023
Claims Administrator	Republic Indemnity
Date(s) of service	09/08/2022 - 09/08/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	08/18/2021
Application Received	10/19/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$320.00 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: Republic Indemnity
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 T1013 (Interpreter Service) submitted for date of service 09/08/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/27/2023. Response received 11/09/2023. Claims Administrator upheld their determination.
- CMS 1500, place of service 11
 - T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- 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 09/08/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)**Date of Service:** 09/08/2022**Interpreter**

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Republic Indemnity
PO Box 4275
Woodland Hills, CA 91365

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

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 07/13/2023
Check #: 1000601644
Payment Amount: 90.00



000100 R3N7TTA

Joyce Altman Interpreters, Inc.
PO BOX 4165
TUSTIN CA 92781



RECEIVED JUL 17 2023

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00102610		3234db103124	07/06/2023	09/08/22	09/08/22	230.00	90.00	A
		65-						
	122 Interpreter For Medical							
						Total	90.00	
A = Your bill(s) has been reduced based upon the recommendation of our review agency. If you have a question concerning the reduction please contact Stratacare at (949)743-1230.								
ENTERED JUL 18 2023								

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 01/16/2024
Check #: 1000627253
Payment Amount: 320.00



000746 R3N7T1A

Joyce Altman Interpreters Inc

PO BOX 4165

TUSTIN CA 92781-4165



RECEIVED JAN 19 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00102610		NA	01/16/2024	09/08/22	09/08/22	0.00	180.00	
	669 IBR Fee							
R00102610		NA	01/16/2024	09/08/22	09/08/22	140.00	140.00	
	122 Interpreter For Medical							
						Total	320.00	

ENTERED JAN 22 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JUN 28 2024

39) 2140640

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



June 24, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000915
Claim Number	R00106111
Assignment Date	05/13/2024
Claims Administrator	Republic Indemnity
Date(s) of service	05/02/2023 - 05/02/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	08/03/2022
Application Received	04/17/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Republic Indemnity
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 T1013 (Interpreter Service) submitted for date of service 05/02/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/25/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/02/2023 T1013 (interpreter services) x 2, \$230.00 (Initial exam 2hr min)
- 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 05/02/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)****Date of Service:** 05/02/2023**Interpreter .**

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

Republic Indemnity
PO Box 4275
Woodland Hills, CA 91365

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

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 01/05/2024
Check #: 1000625969
Payment Amount: 90.00



000119 R3N7TTA
Joyce Altman Interpreters, Inc.
PO BOX 4165
TUSTIN CA 92781



RECEIVED JAN 09 2024

ENTERED JAN 12 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00106111		3234db113625	12/22/2023	05/02/23	05/02/23	230.00	90.00	A
		36-						
		122 Interpreter For Medical						
						Total	90.00	
A = Your bill(s) has been reduced based upon the recommendation of our review agency. If you have a question concerning the reduction please contact Stratacare at (949)743-1230.								

PLEASE DETACH BEFORE DEPOSITING CHECK

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 07/03/2024
Check #: 1000651647
Payment Amount: 320.00



005166 R3N7T1A
Joyce Altman Interpreters Inc
PO BOX 4165
TUSTIN CA 92781-4165



RECEIVED JUL 18 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00106111		NA	06/24/2024	05/02/24	05/02/24	0.00	180.00	
	669 IBR Fee							
R00106111		NA	05/02/2024	05/02/24	05/02/24	140.00	140.00	
	122 Interpreter For Medical							
						Total	320.00	

ENTERED JUL 09 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED OCT 07 2024

40) 2222628

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



October 03, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001903
Claim Number	R00110375
Assignment Date	08/16/2024
Claims Administrator	Republic Indemnity
Date(s) of service	08/29/2023 – 09/28/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	02/03/2023
Application Received	07/26/2024

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: Republic Indemnity
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 T1013 (Interpreter Service) x 2 submitted for dates of service 08/29/2023 – 09/28/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 07/31/2024. Response not yet received.
- CMS 1500, place of service 11
 - 08/29/2023 T1013 (Interpreter Service) x 2, \$230.00 (Follow up Physiotherapy 2hr min)
 - 09/28/2023 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval Via Telemed 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 08/29/2023 and 09/28/2023. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 08/29/2023 was signed by the patient, the medical provider and the interpreter certifying the patient is not proficient in English and requested a certified interpreter.
- Interpretation Confirmation Affidavit dated 09/28/2023 was signed by the medical provider and the interpreter certifying the patient is not proficient in English and requested a certified interpreter for the Telemed appointment.
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 08/29/2023 – 09/28/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 08/29/2023 – 09/28/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 08/29/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 09/28/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Republic Indemnity
PO Box 4275
Woodland Hills, CA 91365

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

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 04/04/2024
Check #: 1000638649
Payment Amount: 90.00



000093 R3N7TTA

Joyce Altman Interpreters, Inc.
PO BOX 4165
TUSTIN CA 92781



RECEIVED APR 09 2024

ENTERED APR 10 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00110375		3234db119409	03/26/2024	08/29/23	08/29/23	230.00	90.00	A
		45-						
	122 Interpreter For Medical							
						Total	90.00	
A = Your bill(s) has been reduced based upon the recommendation of our review agency. If you have a question concerning the reduction please contact Stratacare at (949)743-1230.								

PLEASE DETACH BEFORE DEPOSITING CHECK

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 04/19/2024
Check #: 1000640907
Payment Amount: 90.00



000118 R3N7TTA

Joyce Altman Interpreters, Inc.
PO BOX 4165
TUSTIN CA 92781



RECEIVED APR 23 2024

ENTERED APR 24 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00110375		3234db120379	04/10/2024	09/28/23	09/28/23	230.00	90.00	A
		10-						
		102 Medical Payment Per OMFS						
						Total	90.00	
A = Your bill(s) has been reduced based upon the recommendation of our review agency. If you have a question concerning the reduction please contact Stratacare at (949)743-1230.								

PLEASE DETACH BEFORE DEPOSITING CHECK

REPUBLIC INDEMNITY COMPANY OF AMERICA
P.O. Box 4275
Woodland Hills, CA 91365
818-990-9860

Republic Indemnity

Page 1 of 1

Date: 10/15/2024
Check #: 1000666352
Payment Amount: 460.00



001356 R3N7T1A
Joyce Altman Interpreters Inc
PO BOX 4165
TUSTIN CA 92781-4165



RECEIVED OCT 18 2024

Invoice								
Claim Number	Claimant Name	Number	Date	From Date	To Date	Billed Amount or Rate	Paid Amount	Explanation Code
R00110375		NA	10/03/2024	08/29/23	09/28/23	0.00	180.00	
	669 IBR Fee							
R00110375		NA	10/03/2024	08/29/23	09/28/23	280.00	280.00	
	191 Additional Allowance							
						Total	460.00	

RECEIVED OCT 18 2024

ENTERED OCT 18 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED DEC 13 2024

41) 2246985

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 09, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0001972
Claim Number	23009306B
Assignment Date	10/16/2024
Claims Administrator	Sedgwick
Date(s) of service	04/27/2023 - 09/08/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 17
Date of Injury	04/14/2023
Application Received	08/02/2024

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 \$2,380.00 in additional reimbursement for a total of \$2,560.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$2,560.00** 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

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 T1013 (Interpreter Service) x 17 submitted for dates of service 04/27/2023 – 09/08/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/30/2024. Response not yet received.
- CMS 1500, place of service 11
 - 04/27/2023 T1013 (interpreter services) x 2, \$230.00 (initial exam 2hr min)
 - 05/08/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr min)
 - 05/12/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr min)
 - 05/24/2023 T1013 (interpreter services) x 2, \$230.00 (initial physiotherapy 2hr min)
 - 05/26/2023 T1013 (interpreter services) x 2, \$230.00 (follow up chiro treatment 2hr min)
 - 05/31/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 06/05/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 06/08/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
 - 06/12/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 07/07/2023 T1013 (interpreter services) x 2, \$230.00 (EMG/NCV 2hr min)
 - 07/10/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr min)
 - 07/20/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
 - 07/28/2023 T1013 (interpreter services) x 2, \$230.00 (EMG/NCV + F/u physio 2hr min)
 - 07/31/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 08/11/2023 T1013 (interpreter services) x 2, \$230.00 (acupuncture tx 2hr min)
 - 08/30/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 09/08/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 04/27/2023, 05/08/2023, 05/12/2023, 05/24/2023, 05/26/2023, 05/31/2023, 06/05/2023, 06/08/2023, 06/12/2023, 07/07/2023, 07/10/2023, 07/20/2023, 07/28/2023, 07/31/2023, 08/11/2023, 08/30/2023 and 09/08/2023. Recommended allowance is considered fair and reasonable.
- **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 04/27/2023, 05/08/2023, 05/12/2023, 05/24/2023, 05/26/2023, 05/31/2023, 06/05/2023, 06/08/2023, 06/12/2023, 07/07/2023, 07/10/2023, 07/20/2023, 07/28/2023, 07/31/2023, 08/11/2023, 08/30/2023 and 09/08/2023 were signed by the



patient, the medical providers and the interpreters certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$1,530.00 for dates of service 04/27/2023 – 09/08/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 17 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 17.**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 17

Date of Service: 04/27/2023 – 09/08/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 04/27/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 05/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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 05/12/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 05/24/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 05/26/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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 05/31/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 06/05/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 06/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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 06/12/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 07/07/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 07/10/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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 07/20/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 07/28/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 07/31/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



Service Code	T1013 (Interpreter Service)
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 08/11/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 08/30/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 09/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis



COUNTY OF LOS ANGELES

TS 0034078743

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, I
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078743 071923284 87659 15848

↑ DETACH HERE ↑

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↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211807

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078743

23009306B

04/14/2023 Invoice #

3234db11338183-1

THRU

04/27/2023

LO9 Interpreter Fees

90.00

90.00

19078413 *272221

*KSALDIVAR

*HR999

04/27/2023

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

RECEIVED APR 19 2024

ENTERED APR 19 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

TS 0034078744

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, I
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount

\$*****90.00

70-2328
0719

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078744 071923284 87659 15848

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↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211808

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078744

23009306B

04/14/2023 Invoice #

3234db11431350-1

THRU

05/08/2023

109 Interpreter Fees

90.00

90.00

19078414 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

05/08/2023

ENTERED APR 19 2024

RECEIVED APR 19 2024

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YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

TS 0034078745

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA,
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078745 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211809

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078745

23009306B

04/14/2023 Invoice #

3234db11456146-1

THRU

05/12/2023

109 Interpreter Fees

90.00

90.00

19078415 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

05/12/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

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YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

TS 0034078746

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount

\$*****90.00

70-2328
0719

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

⑈0034078746⑈ ⑈071923284⑈ 87659⑈ 15848⑈

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211810

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078746

23009306B

04/14/2023 Invoice #

3234db11527361-1

THRU

05/24/2023

109 Interpreter Fees

90.00

05/24/2023

90.00

19078416 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

RECEIVED APR 19 2024

ENTERED APR 22 2024

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COUNTY OF LOS ANGELES

TS 0034078747

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, N
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078747 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME	PAYEE NUMBER	HANDLING CODE
JOYCE ALTMAN INTERPRETERS	WC1423BV239	
PAYMENT REFERENCE NUMBER	DISB CAT	ISSUE DATE
SWR-EB-WCB00211811	416	04/17/2024
AMOUNT	WARRANT NUMBER	
\$90.00	0034078747	

23009306B

04/14/2023 Invoice #

3234db11535803-1

THRU

05/26/2023

Log Interpreter Fees

90.00

90.00

19078417 *272221

*KSALDIVAR

*HR999

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05/26/2023

RECEIVED APR 19 2024

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COUNTY OF LOS ANGELES

TS 0034078748

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND: LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA,
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount
\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078748 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME	PAYEE NUMBER	HANDLING CODE
JOYCE ALTMAN INTERPRETERS	WC1423BV239	
PAYMENT REFERENCE NUMBER	DISB CAT	ISSUE DATE
SWR-EB-WCB00211812	416	04/17/2024
AMOUNT	WARRANT NUMBER	
\$90.00	0034078748	

23009306B

04/14/2023 Invoice #

3234db11552432-1

THRU

05/31/2023

L09-Interpreter Fees

90.00

90.00

19078418 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

05/31/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

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YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

TS 0034078749

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, F
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078749 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211813

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078749

23009306B

04/14/2023 Invoice #

3234db11572322-1

THRU

06/05/2023

LO9 Interpreter Fees

90.00

90.00

19078419 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

06/05/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

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YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078750

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA,
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

70-2328
0719

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount
\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078750 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211814

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078750

23009306B

04/14/2023 Invoice #

3234db11587178-1

THRU

06/08/2023

L09 Interpreter Fees

90.00

06/08/2023

90.00

19078420 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

RECEIVED APR 19 2024

ENTERED APR 22 2024

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YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078751

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH BANK OF AMERICA,
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount
\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078751 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211815

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078751

23009306B

04/14/2023 Invoice #

3234db11598432-1

THRU

06/12/2023

LO9 Interpreter Fees

90.00

90.00

19078421 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

06/12/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078752

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, I
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount

\$*****90.00

70-2328
0719

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078752 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211816

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078752

23009306B

04/14/2023 Invoice #

3234db11711711-1

THRU

07/07/2023

109 Interpreter Fees

90.00

90.00

19078422 *272221

*KSALDIVAR

*HR999

07/07/2023

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078753

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, N
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount
\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

⑈0034078753⑈ ⑆071923284⑆ 87659⑈ 15848⑈

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211817

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078753

23009306B

04/14/2023 Invoice #

3234db11721612-1

THRU

07/10/2023

L09 Interpreter Fees

90.00

90.00

19078423 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

07/10/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078754

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, N.
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount
\$*****90.00

PAY: Ninety And 00/100 Dollars

[Signature]

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078754 071923284 87659 15848

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COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211818

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078754

23009306B

04/14/2023 Invoice #

3234db11766462-1

THRU

07/20/2023

L09 Interpreter Fees

90.00

90.00

19078424 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

07/20/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078755

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, N
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078755 071923284 87659 15848

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211819

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078755

23009306B

04/14/2023 Invoice #

3234db11804957-1

THRU

07/28/2023

L09 Interpreter Fees

90.00

90.00

19078425 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B

07/28/2023
877-324-0710

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

TS 0034078756

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH BANK OF AMERICA, N.A.
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078756 071923284 87659 15848

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211820

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078756

23009306B

04/14/2023 Invoice #

3234db11814235-1

THRU

07/31/2023

L09 Interpreter Fees

90.00

90.00

19078426 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

07/31/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR



COUNTY OF LOS ANGELES

TS 0034078757

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA,
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078757 071923284 87659 15848

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211821

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078757

23009306B

04/14/2023 Invoice #

3234db11876579-1

THRU

08/11/2023

L09 Interpreter Fees

90.00

90.00

19078427 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

08/11/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0034078758

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH BANK OF AMERICA, N
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

70-2328
0719

Amount

\$*****90.00

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078758 071923284 87659 15848

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211822

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078758

23009306B

04/14/2023 Invoice #

3234db11942030-1

THRU

08/30/2023

109 Interpreter Fees

90.00

90.00

19078428 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

08/30/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact

YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND. LOS ANGELES, CALIFORNIA

TS 0034078759

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

April 17, 2024

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH BANK OF AMERICA, N
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount

\$*****90.00

70-2328
0719

PAY: Ninety And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

0034078759 071923284 87659 15848

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00211823

DISB CAT

416

ISSUE DATE

04/17/2024

AMOUNT

\$90.00

WARRANT NUMBER

0034078759

23009306B

04/14/2023 Invoice #

3234db11979331-1

THRU

09/08/2023

Log Interpreter Fees

90.00

90.00

19078429 *272221

*KSALDIVAR

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B 877-324-0710

09/08/2023

RECEIVED APR 19 2024

ENTERED APR 22 2024

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR

NOT NEGOTIABLE

NOT NEGOTIABLE

NOT NEGOTIABLE



COUNTY OF LOS ANGELES

TS 0035017195

AUDITOR CONTROLLER'S SPECIAL WARRANT
WARRANT CLEARANCE FUND, LOS ANGELES, CALIFORNIA

THE TREASURER OF THE COUNTY OF LOS ANGELES
500 W. TEMPLE ST. ROOM 502, LOS ANGELES, CA 90012

January 13, 2025

NOT PAYABLE AFTER SIX
MONTHS FROM DATE ISSUED

CONTROLLED DISBURSEMENT
PAYABLE THROUGH: BANK OF AMERICA, N.A.
NORTH BROOK, ILLINOIS

PAY TO THE ORDER OF:

70-2328
0719

JOYCE ALTMAN INTERPRETERS
PO BOX 4165
TUSTIN CA 92781-4165

WC1423BV239
001
416

Amount
\$*****2,560.00

PAY: Two Thousand Five Hundred Sixty And 00/100 Dollars

OSCAR VALDEZ, AUDITOR-CONTROLLER

⑈0035017195⑈ ⑆071923284⑆ 87659⑈15848⑈

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

↑ DETACH HERE ↑

COUNTY OF LOS ANGELES REMITTANCE ADVICE

PAYEE NAME

JOYCE ALTMAN INTERPRETERS

PAYEE NUMBER

WC1423BV239

HANDLING CODE

PAYMENT REFERENCE NUMBER

SWR-EB-WCB00261338

DISB CAT

416

ISSUE DATE

01/13/2025

AMOUNT

\$2,560.00

WARRANT NUMBER

0035017195

23009306B

04/14/2023 Invoice

#

04/27/2023 THRU

09/08/2023

L09 Interpreter Fees

2560.00

2560.00

22279222 *272221

*LSIMONS

*HR999

For more information, please contact: Sedgwick Claims Mgmt-B

877-324-0710

RECEIVED JAN 15 2025

ENTERED JAN 21 2025

For more information about this payment, please contact
YOUR THIRD PARTY ADMINISTRATOR



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 05 2024

42) 81799

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 02, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000126
Claim Number	8300083734
Assignment Date	02/14/2024
Claims Administrator	The Hanover
Date(s) of service	12/09/2022 – 12/09/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	08/01/2020
Application Received	01/19/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 Hanover
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 12/09/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 01/29/2024. Response not yet received.
- Itemized Invoice
 - 12/09/2022 Interpreting for Acupuncture Tx, \$230.00 (billed at a minimum of 2 hours)
- EORs reflect reimbursement of \$90.00. The charge for the procedure exceeds the amount indicated in the fee schedule.
- **CCR § 9795.3. Services 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 12/09/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00 for date of service 12/09/2022. Additional reimbursement is due up to the established market rate. **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: 12/09/2022

Interpreter

Service Code	Interpreter Service
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

The Hanover
PO Box 15144
Worcester, MA 01615

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

43) 2013290

RECEIVED FEB 02 2024

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



January 30, 2024

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

IBR Case Number	CB23-0003180
Claim Number	Y2EC80512
Assignment Date	12/14/2023
Claims Administrator	The Hartford
Date(s) of service	10/03/2022 - 10/03/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	09/15/2021
Application Received	11/13/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 T1013 (Interpreter Service) submitted for date of service 10/03/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 11/28/2023. Response not yet received.
- CMS 1500, place of service 11
 - T1013 (interpreter services) x 2, \$230.00 (follow up acupuncture and physical therapy 2hr minimum)
- 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 10/03/2022 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 10/03/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 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



Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
8664019222 x2304010

SP 01 005601 54644 H 21 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED AUG 01 2023

ENTERED AUG 02 2023

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

126536319



Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington, KY 40512

56-1544
441

Check Number: 134970988 3

Issue Date: 07/25/2023

\$*****90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

Pay
NINETY DOLLARS AND 00/100

TO THE JOYCE ALTMAN INTERPRETERS INC
ORDER PO BOX SUITE 4165
OF Tustin, CA 92781

The Hartford
Authorized Signature

1349709883 0441154431

632559738

126536319



Western Workers' Compensation Claim Center
P.O. Box 14475
Lexington KY 40512
866/401-9222

SP 01 005123 72868 H 21 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

Attention: This remittance incorporates
0 claim payments

Special Handling 99

RECEIVED FEB 23 2024

ENTERED FEB 26 2024

Please keep the above information for your records.

126268192

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: 135514916 9

Issue Date: 02/13/2024

\$****140.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

ONE HUNDRED FORTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford
Authorized Signature

⑈ 1355149169⑈ ⑆044115443⑆

632559738⑈

005123.1/3

126268192



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED JAN 02 2025

44) 2107341

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 24, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002370
Claim Number	Y2EC80730
Assignment Date	11/04/2024
Claims Administrator	The Hartford
Date(s) of service	11/15/2023 - 11/15/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	11/03/2021
Application Received	09/04/2024

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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 T1013 (Interpreter Service) submitted for date of service 11/15/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/16/2024. Response received 09/25/2024. Claims Administrator upheld their determination.
- CMS 1500, place of service 11
 - 11/15/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- 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 11/15/2023 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 11/15/2023

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Copy to:

The Hartford
PO Box 14187
Lexington, KY 40512

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



Workers Compensation Field Claim Center
P.O. Box 14473
Lexington KY 40512-4473
877/673-9222

SP 01 007212 81705 H 26 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED MAY 29 2024

ENTERED MAY 30 2024

Attention: This remittance incorporates
0 claim payments

Special Handling 99

Please keep the above information for your records.

127347466

HAR-100-2

FOLD AT DOTTED LINE AND DETACH



Workers Compensation Field Claim Center
P.O. Box 14473
Lexington, KY 40512-4473

56-1544
441

Check Number: 135786425 6

Issue Date: 05/21/2024

\$****90.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

NINETY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford
Authorized Signature

⑈ 1357864256 ⑈ ⑈ 044115443⑈

632559738 ⑈

007212 1/3



127347466



Workers Compensation Field Claim Center
P.O. Box 14473
Lexington KY 40512-4473
877/673-9222

SP 01 006319 60482 H 27 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED JAN 16 2025

Attention: This remittance incorporates
0 claim payments

Special Handling 99

IBR

128185979

HAR-100-2

Please keep the above information for your records.

FOLD AT DOTTED LINE AND DETACH



Workers Compensation Field Claim Center
P.O. Box 14473
Lexington, KY 40512-4473

56-1544
441

Check Number: 136437812 4

Issue Date: 01/09/2025

\$****140.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

ONE HUNDRED FORTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford
Authorized Signature

1364378124 044115443

632559738

006319 1/3



128185979



MAXIMUS FEDERAL SERVICES, INC.

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

RECEIVED JUN 21 2024

45) 2144220

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



June 17, 2024

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

IBR Case Number	CB24-0000837
Claim Number	Y3WC39429
Assignment Date	05/06/2024
Claims Administrator	The Hartford
Date(s) of service	05/18/2023 – 08/03/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	09/09/2022
Application Received	04/10/2024

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 \$100.00 in additional reimbursement for a total of \$280.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$280.00** 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 T1013 (Interpreter Service) x 2 submitted for dates of service 05/18/2023 – 08/03/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/18/2024. Response not yet received.
- CMS 1500, place of service 11
 - 05/18/2023 T1013 (Interpreter Service) x 2, \$230.00 (Acupuncture tx 2hr min)
 - 08/03/2023 T1013 (Interpreter Service) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$180.00 for each date of service 05/18/2023 and 08/03/2023. The charge exceeds the OMFS allowance; charge has been adjusted to the scheduled allowance.
- **CCR § 9795.3. Services 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 05/18/2023 and 08/03/2023 were signed by the patient, the medical providers and the interpreters certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$360.00 for dates of service 05/18/2023 – 08/03/2023. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2

Date of Service: 05/18/2023 – 08/03/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 05/18/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 + \$180.00 (IBR Application Fee) = \$230.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$180.00
Dispute Amount	\$50.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtake DOS 08/03/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$180.00 (Plan Allowed) = \$50.00 Due Provider Refer to Analysis

Copy to:

The Hartford
PO Box 14187
Lexington, KY 40512

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



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
866/401-9222

SP 01 004888 23117 H 23 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED JAN 08 2024

ENTERED JAN 11 2024

Attention: This remittance incorporates
0 claim payments

Special Handling 99

Please keep the above information for your records.

125267302

HAR-100-2

FOLD AT DOTTED LINE AND DETACH



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 135389075 9

Issue Date: 12/29/2023

\$****180.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

ONE HUNDRED EIGHTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford

Authorized Signature

1353890759 044115443

632559738

004888 1/2



125267302



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
866/401-9222

SP 01 005938 29059 H 26 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED JUL 10 2024

Attention: This remittance incorporates
0 claim payments

Special Handling 99

ENTERED JUL 11 2024

127517315

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 135903362 9

Issue Date: 07/02/2024

\$****50.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

FIFTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford
Authorized Signature

1359033629 0441154431

632559738



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
866/401-9222

SP 01 004886 23117 G 23 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

ENTERED JAN 11 2024

RECEIVED JAN 08 2024

Attention: This remittance incorporates
0 claim payments

Special Handling 99

Please keep the above information for your records.

125267300

HAR-100-2

FOLD AT DOTTED LINE AND DETACH



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544

441

Check Number: 135389074 0

Issue Date: 12/29/2023

\$****180.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

ONE HUNDRED EIGHTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford

Authorized Signature

⑈ 1353890740 ⑈ ⑈ 044115443 ⑈

632559738 ⑈

125267300



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington KY 40512-4267
866/401-9222

SP 01 005939 29059 H 26 ASNGLP



JOYCE ALTMAN INTERPRETERS INC
PO BOX SUITE 4165
Tustin CA 92781

RECEIVED JUL 10 2024

Attention: This remittance incorporates
0 claim payments

Special Handling 99

ENTERED JUL 11 2024

127517316

Please keep the above information for your records.

HAR-100-2

FOLD AT DOTTED LINE AND DETACH



Centralized Workers Compensation Claim Center
PO Box 14267
Lexington, KY 40512-4267

56-1544
441

Check Number: 135903361 0

Issue Date: 07/02/2024

\$****50.00

JPMorgan Chase Bank, N.A.
Columbus, OH 43085

FIFTY DOLLARS AND 00/100

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX SUITE 4165
ORDER OF Tustin, CA 92781

The Hartford
Authorized Signature

⑈ 1359033610 ⑈ ⑈ 044115443⑈

632559738⑈

127517316



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

RECEIVED APR 11 2024

46) 1962290

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



April 08, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0000189
Claim Number	FQX4563
Assignment Date	02/21/2024
Claims Administrator	Travelers
Date(s) of service	01/30/2023 - 02/08/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	09/23/2020
Application Received	01/26/2024

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: Travelers

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 T1013 (Interpreter Service) x 2 submitted for dates of service 01/30/2023 – 02/08/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 02/05/2024. Response received 02/21/2024. Claims Administrator upheld their determination.
- CMS 1500, place of service 11
 - 01/30/2023 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
 - 02/08/2023 T1013 (interpreter services) x 2, \$230.00 (PR2/Re-eval 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 01/30/2023 and 02/08/2023. 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 for dates of service 01/30/2023 and 02/08/2023 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$180.00 for dates of service 01/30/2023 – 02/08/2023.
- **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 01/30/2023 – 02/08/2023**Interpreter**

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 01/30/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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	Overtake DOS 02/08/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Travelers
PO Box 660055
Dallas, TX 75266

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

THE TRAVELERS - TRAVELERS WORKERS C
TRAVELERS WORKERS COMP CLAIMS
PO BOX 660055
DALLAS TX 75266-0055

891A 93557737

0

TRAVELERS 

DATE: 10/13/23
LOSS DATE: 09/23/20
FILE NUMBER: 480 CB FQX4563 N
REFERENCE #: 1035200450SW
EMPLOYEE

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

RECEIVED OCT 19 2023

ENTERED OCT 20 2023

ACCOUNT NAME:
THERMAL EQUIPMENT CORP.

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: 01/30/23

INVOICE # 3234DB10871000-1

TOTAL PAID: \$90.00

FOR ADDITIONAL INFORMATION, CONTACT: PAUL B DAVIDSON AT (916)859-2651

286023761

DETACH CHECK

UNSUMM -111311
OVRPUNS2-121295

DETACH CHECK



THE TRAVELERS - TRAVELERS WORKERS C
TRAVELERS WORKERS COMP CLAIMS
PO BOX 660055
DALLAS TX 75266-0055

891A 93570303

RECEIVED OCT 31 2023

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

ENTERED NOV 01 2023

TRAVELERS 

DATE: 10/20/23
LOSS DATE: 09/23/20
FILE NUMBER: 480 CB FQX4563 N
REFERENCE #: 1035254876SW
EMPLOYEE

ACCOUNT NAME:
THERMAL EQUIPMENT CORP.

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: 02/08/23

INVOICE # 3234DB10920722-1
TOTAL PAID: \$90.00

FOR ADDITIONAL INFORMATION, CONTACT: PAUL B DAVIDSON AT (916)859-2651

293024349

DETACH CHECK

UNSUMM -111311
OVRPUNS2-121295

DETACH CHECK

THE TRAVELERS - TRAVELERS WORKERS C
TRAVELERS WORKERS COMP CLAIMS
PO BOX 660055
DALLAS TX 75266-0055

SA06452

891A 93893833

TRAVELERS 

DATE: 04/26/24
LOSS DATE: 09/23/20
FILE NUMBER: 480 CB FQX4563 N

EMPLOYEE

ACCOUNT NAME:

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

RECEIVED MAY 03 2024

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

Med Photocopy Exp (CA Only)

SERVICE DATE: 1/30/2023 TO: 2/8/2023

TOTAL PAID: \$460.00
TAX INFO: 330956713 Y C
PAY MISC: Per IBR CB24-0000189
PAYEE:
JOYCE ALTMAN INTERPRETERS INC

ENTERED MAY 06 2024

FOR ADDITIONAL INFORMATION, CONTACT: PAUL B DAVIDSON AT (916)859-2651

117006520

DETACH CHECK 

UNSUMM -111311
OVRPUNS2-121295
DETACH CHECK 

RECEIVED FEB 26 2024

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

47) 2093955

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 22, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003391
Claim Number	FWS7265
Assignment Date	01/03/2024
Claims Administrator	Travelers
Date(s) of service	09/26/2022 – 09/26/2022
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	06/06/2022
Application Received	12/07/2023

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 \$140.00 in additional reimbursement for a total of \$320.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$320.00** 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: Travelers

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 T1013 (Interpreter Service) submitted for date of service 09/26/2022.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/15/2023. Response not yet received.
- CMS 1500, place of service 11
 - 09/26/2022 T1013 (Interpreter Service) x 2, \$230.00 (Initial Exam 2hr min)
- EORs reflect reimbursement of \$90.00. The charge exceeds the OMFS allowance.
- **CCR § 9795.3. Services 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 09/26/2022 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$90.00 for date of service 09/26/2022. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 09/26/2022

Interpreter

Service Code	T1013 (Interpreter Service)
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 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Travelers
PO Box 660055
Dallas, TX 75266

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

THE TRAVELERS - WORKERS' COMPENSATION UNIT
P O BOX 660055
DALLAS TX 75266-0055
SJ00520

896D 97815777

RECEIVED AUG 17 2023

ENTERED AUG 17 2022

TRAVELERS

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781

DATE: 08/11/23

TIN: 330956713

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

Our Customer Service Phone is (877)228-2758.
Please contact us if you have any questions.

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

Name	File Number	Dates of Service	Amount	Reference	Remarks
	152 CB FNA7480P	07/31/23	\$ 9,500.00	1034729959SW	
	152 CB FVK7847T	10/31/22	\$ 90.00	1034746939SW	INVOICE # 3234DB10518894-1
	152 CB FWS7265J	09/26/22	\$ 90.00	1034734243SW	INVOICE # 3234DB10375688-1
Total Amount Paid			\$*****9680.00		

PAYMENT INQUIRIES? E-MAIL MBMPINQS@TRAVELERS.COM, FAX 888-558-8656, PH. 877-228-2758.

223024108

DETACH CHECK

SUMM -111311
OVRPSUM1-021509

DETACH CHECK

THIS DOCUMENT HAS A RED BACKGROUND - BORDER CONTAINS MICRO PRINTING AND AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

Citibank, N.A.
One Penns Way
New Castle DE 19720

TRAVELERS

P O BOX 660055
DALLAS TX 75266-0055

896D 97815777

62-20
311

DATE
08/11/23

ACCOUNT NUMBER
J99

TIN NUMBER
330956713

FILE NUMBER
SUMMARIZED

VOID IF NOT PRESENTED WITHIN
ONE YEAR AFTER DATE OF ISSUE

NINE THOUSAND SIX HUNDRED EIGHTY AND 00/100

PAY: \$*****9680.00

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX #4165
ORDER OF TUSTIN CA 92781
014862
SJ00520

Larry Mills
AUTHORIZED SIGNATURE

97815777 031100209

38622892

THE TRAVELERS - WORKERS' COMPENSATI
WORKERS' COMPENSATION UNIT
P O BOX 660055
DALLAS TX 75266-0055

SD00497

896D 98416840

RECEIVED MAR 13 2024

JOYCE ALTMAN INTERPRETERS INC
PO BOX #4165
TUSTIN CA 92781


TRAVELERS

DATE: 03/06/24

LOSS DATE: 06/06/22

FILE NUMBER: 152 CB FWS7265 J

REFERENCE #: 2002823177SW

EMPLOYEE

ACCOUNT NAME:

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

DATE OF SERVICE: 09/26/22

TOTAL PAID: \$140.00

TAX INFO: 330956713 Y

PAY MISC: INVOICE # 3234DB10375688-1

PAYEE:

JOYCE ALTMAN INTERPRETERS INC

ENTERED MAR 14 2024

FOR ADDITIONAL INFORMATION, CONTACT: MATTHEW S RENTERIA AT (909)569-0229

066008662

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

RECEIVED DEC 02 2024

48) 2305484

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



November 25, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002374
Claim Number	F0S5743
Assignment Date	10/02/2024
Claims Administrator	Travelers
Date(s) of service	11/20/2023 – 11/20/2023
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service)
Date of Injury	04/03/2022
Application Received	09/04/2024

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: Travelers

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 T1013 (Interpreter Service) submitted for date of service 11/20/2023.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 09/16/2024. Response received on 10/08/2024. Claims Administrator indicated additional payment was made and provided a copy of the EOR with check information.
- CMS 1500, place of service 11
 - 11/20/2023 T1013 (Interpreter Service) x 2, \$230.00 (Acupuncture tx 2hr min)
- EORs reflect reimbursement of \$90.00. Charges exceed maximum allowance for interpreter services.
- **CCR § 9795.3. Services 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 11/20/2023 was signed by the patient, the medical provider and the interpreter certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$140.00, post IBR receipt for a total reimbursement of \$230.00. \$180.00 IBR application fee is due. **T1013 (Interpreter Service) Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service).**

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



DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service)

Date of Service: 11/20/2023

Interpreter

Service Code	T1013 (Interpreter Service)
Provider Billed	\$230.00
Plan Allowed	\$90.00 \$140.00 (post IBR receipt)
Dispute Amount	\$140.00
Assist Surgeon	N/A
Units	2
Workers' Comp Allowed Amt.	\$230.00
Notes	Overtun \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$230.00 (Plan Allowed) = \$0.00 \$180.00 (IBR Application Fee) Due Provider Refer to Analysis

Copy to:

Travelers
PO Box 660055
Dallas, TX 75266

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

THE TRAVELERS - WORKERS' COMPENSATION
WORKERS' COMPENSATION UNIT
P O BOX 660055
DALLAS TX 75266-0055
SJ00460

891A 93941272

TRAVELERS

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

DATE: 05/24/24

TIN: 330956713

PROVIDER: JOYCE ALTMAN INTERPRETERS INC

ENTERED MAY 31 2024

Our Customer Service Phone is (877)228-2758.
Please contact us if you have any questions.

RECEIVED MAY 29 2024

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

Name	File Number	Dates of Service	Amount	Reference	Remarks
	152 CB	11/29/23	\$ 90.00	1036987350SW	INVOICE # 3234DB12302106-1
	FWH2630M				
	152 CB	11/28/23	\$ 90.00	1036987326SW	INVOICE # 3234DB12299642-1
	FWH2630M				
	152 CB	05/03/24	\$ 1,600.00	1036996697SW	
	FWH6464P				
	152 CB	11/28/23	\$ 90.00	1036986970SW	INVOICE # 3234DB12300409-1
	FYR2280R				
	152 CB	05/19/23	\$ 90.00	1036905059SW	INVOICE # 3234DB11508095-1
	FYR2292M				
	152 CB	11/21/23	\$ 90.00	1036963894SW	INVOICE # 3234DB12279033-1
	F0B0640K				
	152 CB	11/29/23	\$ 90.00	1036986797SW	INVOICE # 3234DB12303417-1
	F0B0640K				
	152 CB	11/29/23	\$ 90.00	1036986846SW	INVOICE # 3234DB12301383-1
	F0S5743T				
	152 CB	11/20/23	\$ 90.00	1036952237SW	INVOICE # 3234DB12264103-1
	F0S5743T				
Total Amount Paid			\$*****2320.00		

PAYMENT INQUIRIES? E-MAIL MBMPINQS@TRAVELERS.COM, FAX 888-558-8656, PH. 877-228-2758.

SUMM -111311
OVRPSUM1-021509

145023101

DETACH CHECK

DETACH CHECK

THIS DOCUMENT HAS A RED BACKGROUND - BORDER CONTAINS MICRO PRINTING AND AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

Citibank, N.A.
One Penns Way
New Castle DE 19720

TRAVELERS

891A 93941272

82-20
311

P O BOX 660055

DALLAS

TX 75266-0055

DATE
05/24/24

ACCOUNT NUMBER
J99

TIN NUMBER
330956713

FILE NUMBER
SUMMARIZED

TWO THOUSAND THREE HUNDRED TWENTY AND 00/100

PAY: \$*****2320.00

PAY JOYCE ALTMAN INTERPRETERS INC
TO THE PO BOX 4165
ORDER OF TUSTIN CA 92781

012566
SJ00460

Young
AUTHORIZED SIGNATURE

93941272

031100209

38621267

THE TRAVELERS - WORKERS' COMPENSATI
WORKERS' COMPENSATION UNIT
P O BOX 660055
DALLAS TX 75266-0055

SD00466

896D 98967831

TRAVELERS 

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

DATE: 09/24/24
LOSS DATE: 04/03/22
FILE NUMBER: 152 CB F0S5743 T
REFERENCE #: 2002955130SW
EMPLOYEE

ACCOUNT NAME:

RECEIVED SEP 30 2024

TRAVELERS PROP CAS CO OF AMERIC

EXPLANATION OF PAYMENT

DATE OF SERVICE: 11/20/23

TOTAL PAID: \$140.00

TAX INFO: 330956713 Y

PAY MISC: INVOICE # 3234DB12264103-1

PAYEE:

JOYCE ALTMAN INTERPRETERS INC

ENTERED OCT 01 2024

ENTERED OCT 01 2024

FOR ADDITIONAL INFORMATION, CONTACT: RANDY V OCEAN AT (909)612-3298

268008500

DETACH CHECK

UNSUMM -111311
OVRPUNS2-121295
DETACH CHECK

RECEIVED FEB 20 2024



MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

P.O. Box 138006

Sacramento, CA 95813-8006

(855) 865-8873 Fax: (916) 605-4280

49) 73972

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



February 15, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB23-0003023
Claim Number	UEF4477858
Assignment Date	12/28/2023
Claims Administrator	Uninsured Employers Benefits Trust Fund
Date(s) of service	11/02/2018 – 11/02/2018
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	Interpreter Service
Date of Injury	05/25/2006
Application Received	10/25/2023

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 \$350.00 in additional reimbursement for a total of \$530.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$530.00 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: Uninsured Employers Benefits Trust 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 submitted for date of service 11/02/2018.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 12/07/2023. Response received on 12/15/2023. Claims Administrator upheld their determination.
- Itemized Invoice submitted by the Provider
 - 11/02/2018 Interpreting for QME Eval 5 hours, \$575.00
- Itemized Invoice submitted by the Claims Administrator
 - 05/22/2018 Interpreting for Legal WCAB, \$156.50
 - 11/02/2018 Interpreting for QME Eval x 5 hrs (face-to-face 0.75), \$575.00
 - 03/31/2022 Interpreting for C&R Reading, \$250.00
- Submitted check copies reflect reimbursement of \$556.50. EORs reflect the following payment explanations: \$156.50 for half day rate for date of service 05/22/2018, \$175.00 for half day rate for date of service 03/31/2022 and \$225.00 for 5 hour rate for date of service 11/02/2018. Market rate sheet submitted does not meet the requirement per LC 9795.3.
- **CCR § 9795.3. Services 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 11/02/2018 was signed by the patient, the medical provider and the interpreter certifying the patient is not proficient in English and requested a certified interpreter for the appointment from 8:00am to 1:00pm. **Interpreter Service for 5 hours Overturned.**
- Market rate was established by submitted examples of recent similar services performed and the amounts paid for those services in the amount of \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Reimbursement received in the amount of \$225.00 for date of service 11/02/2018. Additional reimbursement is due up to the established market rate.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for Interpreter Service for 5 hours.**

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



DETERMINATION OF ISSUE IN DISPUTE: Interpreter Service

Date of Service: 11/02/2018

Interpreter

Service Code	Interpreter Service
Provider Billed	\$575.00
Plan Allowed	\$225.00
Dispute Amount	\$350.00
Assist Surgeon	N/A
Units	5
Workers' Comp Allowed Amt.	\$575.00
Notes	Overturn 5 hours \$115.00 (Market Rate for One Hour) * 5 (hours) = \$575.00 - \$225.00 (Plan Allowed) = \$350.00 Due Provider Refer to Analysis

Copy to:

Uninsured Employers Benefits Trust Fund
320 W Fourth St. Ste. 690
Los Angeles, CA 90013

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

RECEIVED JAN 06 2025

50) 2415051

INDEPENDENT BILLING REVIEW FINAL DETERMINATION



December 31, 2024

Joyce Altman Interpreters, Inc.

Attn: Joyce Altman

PO Box 4165

Tustin, CA 92781

IBR Case Number	CB24-0002826
Claim Number	2010440942
Assignment Date	11/07/2024
Claims Administrator	Zurich American Insurance Company
Date(s) of service	12/18/2023 - 01/15/2024
Provider Name	Joyce Altman Interpreters, Inc.
Employee Name	
Disputed Codes	T1013 (Interpreter Service) x 2
Date of Injury	11/16/2023
Application Received	10/11/2024

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: Zurich American 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 T1013 (Interpreter Service) x 2 submitted for dates of service 12/18/2023 – 01/15/2024.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/22/2024. Response not yet received.
- CMS 1500, place of service 11
 - 12/18/2023 T1013 (interpreter services) x 2, \$230.00 (initial exam 2hr min)
 - 01/15/2024 T1013 (interpreter services) x 2, \$230.00 (follow up physiotherapy 2hr min)
- EORs reflect reimbursement of \$90.00 for each date of service 12/18/2023 and 01/15/2024. 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 12/18/2023 and 01/15/2024 were signed by the patient, the medical providers and the interpreters certifying 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 \$115.00 per hour as reflected on invoices, copies of paid checks, and Explanation of Payments.
- Total reimbursement received in the amount of \$180.00 for dates of service 12/18/2023 – 01/15/2024. Additional reimbursement is due up to the established market rate. **T1013 (Interpreter Service) x 2 Overturned.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for T1013 (Interpreter Service) x 2.**

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

**DETERMINATION OF ISSUE IN DISPUTE: T1013 (Interpreter Service) x 2****Date of Service:** 12/18/2023 – 01/15/2024**Interpreter**

Service Code	T1013 (Interpreter Service)
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 12/18/2023 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 + \$180.00 (IBR Application Fee) = \$320.00 Due Provider Refer to Analysis

Service Code	T1013 (Interpreter Service)
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 01/15/2024 \$115.00 (Market Rate for One Hour) * 2 (hours) = \$230.00 - \$90.00 (Plan Allowed) = \$140.00 Due Provider Refer to Analysis

Copy to:

Zurich American Insurance Company
PO Box 968070
Schaumburg, IL 60196

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

ZURICH Zurich American Insurance Company
PO BOX 968070
SCHAUMBURG IL 60196-8070

Forwarding Service Requested



*****MIXED AADC 926
PB-STL_UNSORTED-MACH-ENV 2252
JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781-4165

RECEIVED JUL 10 2024

I understand that endorsement hereon or deposit to my accounts constitutes my affirmation that I am receiving these benefits under this State's Worker's Compensation Act; that circumstances affecting my entitlement have not changed, and I have made no false claims or statements or concealed any material fact, and that doing so could make me liable for civil and criminal penalties including jail.

ENTERED JUL 11 2024

Explanation of Review (EOR) Payment Information

Customer Service:	877-738-8070
Check Date:	07/03/2024
Check Amount:	\$90.00
Bill ID:	ZU1-ZNCA-10720095
Payee Name:	JOYCE ALTMAN INTERPRETERS INC
Claim #:	2010440942001
Date of Service:	12/18/2023
Payment Method:	Check
Payment ID:	8700189027
Payment Date:	7/3/2024

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your fingertips

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To update your payment preference:

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<https://www.zelis.com/provider-solutions/provider-enrollment>
for more information.



ZURICH

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, IL 60196-1056

JPMORGAN CHASE BANK, N.A.
New York, NY
70-2322/719

Ninety Dollars and No Cents

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

CHECK NUMBER

8700189027

ISSUE DATE

07/03/2024

CLAIM NUMBER

2010440942001

AMOUNT

\$90.00

VOID AFTER 180 DAYS

Let's Hi

Authorized Signature

11870018902711 10719232261

95178586911

ZURICH Zurich American Insurance Company
PO BOX 968070
SCHAUMBURG IL 60196-8070

Forwarding Service Requested

JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN CA 92781

RECEIVED JUL 10 2024

I understand that endorsement hereon or deposit to my accounts constitutes my affirmation that I am receiving these benefits under this State's Worker's Compensation Act; that circumstances affecting my entitlement have not changed, and I have made no false claims or statements or concealed any material fact, and that doing so could make me liable for civil and criminal penalties including jail.

Explanation of Review (EOR) Payment Information

Customer Service:	877-738-8070
Check Date:	07/03/2024
Check Amount:	\$90.00
Bill ID:	ZU1-ZNCA-10720096
Payee Name:	JOYCE ALTMAN INTERPRETERS INC
Claim #:	2010440942001
Date of Service:	01/15/2024
Payment Method:	Check
Payment ID:	8700189028
Payment Date:	7/3/2024

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ENTERED JUL 11 2024



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<https://www.zelis.com/provider-solutions/provider-enrollment>
for more information.



ZURICH

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, IL 60196-1056

JPMORGAN CHASE BANK, N.A.
New York, NY
70-2322/719

CHECK NUMBER

8700189028

ISSUE DATE

07/03/2024

CLAIM NUMBER

2010440942001

AMOUNT

\$90.00

Ninety Dollars and No Cents

PAY TO THE ORDER OF JOYCE ALTMAN INTERPRETERS INC
PO BOX 4165
TUSTIN, CA 92781

VOID AFTER 180 DAYS

Authorized Signature

Authorized Signature

⑈8700189028⑈ ⑆071923226⑆

951785869⑈

Zurich American Insurance Company
PO Box 968070
Schaumburg, IL 60196-8070



*****MIXED AADC 541
JOYCE ALTMAN INTERPRETERS, INC.
PO BOX 4165
TUSTIN, CA 92781-4165

18691|89|1

RECEIVED JAN 29 2025

ENTERED JAN 30 2025

Insured: THE NATIONAL ASSOCIATION FOR ...
Policy No: 0943211
Check Amount: \$460.00
Check No: 2500311106
Invoice Number:
Claim: Stephanie Salazar
Professional: +18182271323

Claimant Name:
Claim No: 2010440942
Check Date: 01/22/2025
Date of Loss: 11/16/2023
Start Date: 12/18/2023
End Date: 01/15/2024
Requested By:

Nature of Payment:
Independent Bill Review Determination 12/31/24; CB24-0002826

THE BACK OF THIS CHECK CONTAINS A SECURITY MARK - DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK



Zurich American Insurance Company
PO Box 968070
Schaumburg, IL 60196-8070

56-1544 / 441
Check No: 2500311106
Claim No: 2010440942
Date: 01/22/2025

Four hundred sixty and 00/100 Dollars

Amount
\$460.00

VOID AFTER 180 DAYS

Pay To The Order Of Joyce Altman Interpreters, Inc.

Authorized Signature

JPMorgan Chase Bank, N.A.
Columbus, OH

⑈ 2500311106 ⑈ ⑆044115443⑆ 956951575⑈