Interpreting Services for Patients

by Cindy Parman, CPC, CPC-H, RCC

PHOTOGRAPH/ISTOCKPHOTO

According to the American College of Physicians, approximately 51 percent of patients request an interpreter prior to their initial patient visit and 88 percent of healthcare providers frequently use an interpreter in their office or clinic.[1] Around 63 percent of hospitals treat patients with limited English proficiency on a daily basis.[2] Nearly 3,000 unexpected deaths, catastrophic injuries, and other sentinel events have been tied to communication breakdowns.[3] In addition, patients with limited English proficiency suffer a greater percentage of adverse events as a result of these communication challenges.[3]

So what do these statistics mean for *your* cancer program or practice? Title VI of the Civil Rights Act states that a healthcare provider must offer language assistance to limited English proficiency patients if the provider receives federal funds or operates from a hospital or clinic that receives federal funding. Federal funds include, but are not limited to, Medicare, Medicaid, TRICARE, or Federal Employees Health Benefits. Limited English proficiency patients are defined as individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand the English language. In addition, patients who are hearing impaired or have other obstacles to verbal communication may also require an interpreter or communication assistance.

According to new standards from The Joint Commission (TJC), all U.S. healthcare organizations must be able to talk with patients about their care in a language the patient can understand. In 2011 these standards will be implemented as part of a one-year pilot phase and call for healthcare entities to:

- Define and confirm staff interpreters' qualifications
- Document interpreters' proficiency and training
- Identify each patient's communication needs
- Keep a written policy on patients' rights.

TJC offers tips for ensuring compliance with these new standards:

- Implement a language plan that establishes access at every patient point of contact
- Implement ongoing training and education for interpreters
- Update existing protocols to incorporate the language standards.

Effective Communication Defined

A healthcare entity must make reasonable accommodation to ensure that a person with a disability can engage in effective communication regarding his or her care. Essentially, this requirement means that the limited English proficiency patient should enjoy the same level of effective communication as the patient who speaks or hears fluent English.

A New Jersey appeals court judge ruled that effective communication was essential during critical portions of the patient's treatment, such as informed consent, discussion of diagnosis and prognosis, and review of treatment options and significant procedures.[4] Remember that whether "effective communication" exists or not depends on the view of the patient, not the physician, facility, or cancer program.

For example, a patient goes to his doctor for a bi-weekly check-up, during which the nurse records his blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up. But upon experiencing symptoms of a mild stroke, the patient returns to his doctor for a thorough examination and battery of tests and requests that an interpreter be provided. The physician should arrange for the services of a qualified interpreter, as an interpreter is likely to be necessary for effective communication with the patient, given the length and complexity of the communication involved.

An interpreter may be required continually or periodically throughout the course of chemotherapy or radiation therapy, due to changes in drugs or drug regimens, updates to diagnosis or prognosis, and changes in treatment that will require further patient instruction.

The patient or patient's family is not required to formally request an interpreter or other effective means of communication. Instead, *the provider* is responsible for determining whether additional methods of communication are necessary to ensure that the patient is able to participate in medical decisions.

Consider the Options

State and federal law prohibit discrimination on the basis of disability and require healthcare providers to make reasonable accommodations to ensure effective communication with patients who have disabilities—at no additional cost to the family. These requirements apply equally to large

and small providers, and some of the options can be costly.

In addition to contracting with an onsite interpreter, a number of auxiliary aids are available for providers to use, including telephone interpreter services, closed-caption decoders, and video- or computer-based translation devices. In addition, many communities offer free translation or interpreter services through advocacy or other organizations to accommodate patients with LEP or medical disabilities.

It is generally impossible to rely on individuals known to the patient, such as a friend or relative, to act as interpreters. Friends or family members of the patient may not be qualified to serve as interpreters because their emotional or personal involvement with the patient may adversely affect their ability to communicate effectively, accurately, or impartially. In addition, the friend or family member may not correctly translate complex medical concepts, leaving the patient without a true understanding of the medical condition or treatment options.

It is also important to ensure the competency of interpreters or translational organizations, both with respect to language proficiency and medical terminology. Although some states have established standards, there is no commonly accepted national standard for interpreter competency.

Liability

An article in *AMA News*, posted online on January 5, 2009, discussed a lawsuit where a lupus patient was denied a sign language interpreter.[5] According to the patient, she repeatedly requested an interpreter, but the physician insisted on exchanging written notes with the patient and involved family members in discussions. The patient stated that she had no real understanding of her medical condition, treatment options, or prognosis and, significantly, "was deprived of an equal opportunity to fully participate in her medical care."[5]

Although the physician argued that as a solo practitioner he could not afford the cost of an interpreter (estimated at $150 to $200 per visit in 2008), the court found in favor of the patient and awarded a significant dollar amount for disability discrimination (both a violation of the Americans with Disabilities Act and a State anti-discrimination law) and punitive damages. This type of claim is typically not covered under traditional medical liability insurance, which means that any judgment would be paid exclusively by the physician.

Of note, the patient does not have to prove that anything went wrong with the care provided to bring a discrimination claim.

Coding

Although more than 2 million elderly people in the United States are limited English proficient, Medicare does not currently provide reimbursement for language assistance. There is a HCPCS Level II procedure code that was effective July 1, 2001, for use in certain Medicaid programs, but payment may be limited to assistance during psychiatric treatment or similar conditions:

- **T1013:** Sign language or oral interpretive services, per 15 minutes.

With respect to specific coverage guidelines, BlueCross BlueShield of Rhode Island (BCBSRI) states that assistive technology services (including a sign language or oral interpreter) are covered for a member age birth to three years as part of early intervention services performed by BCBSRI-credentialed staff.[6]

Last, when this service is covered, it may be necessary to add a modifier to this code, such as:

- **T1013-GT:** Telemedicine interpreter services, per 15 minutes.

Since this is a time-based service, only the actual interpretation time would be charged; any time spent waiting, driving, etc., would not be billed. At least eight minutes would need to be spent performing interpretation in order to charge for a unit of T1013.

One final note: Healthcare entities may also be entitled to tax credits for providing interpreter or translation services.

Additional Resources

- Standards Issued for Healthcare Interpreter Services. Available online at: *http://www.medpagetoday.com/tbprint.cfm?tbid=24954*.
- Language Line Services: *http://languageline.com/*.
- Paying for Language Services in Medicare: Preliminary Options and Recommendations. Available online at: *http://www.calendow.org/uploadedFiles/paying_for_language_services.pdf*.
- Interpreters Should Bill Insurers, not Physicians: Medicare's PPAC Recommends. Available online at: *http://findarticles.com/p/articles/mi_m0CYD/is_22_38/ai_110804657/*.
- Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care. Available online at: *http://www.jointcommission.org/Advancing_Effective_Communication/*.
- "What Did the Doctor Say?:" Improving Health Literacy to Protect Patient Safety. Available online at: *http://www.jointcommission.org/What_Did_the_Doctor_Say/*.

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc. in Powder Springs, Ga.

References

[1]American College of Physicians. Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians [A Position Paper]; 2007. Available online at: *http://www.acponline.org/advocacy/where_we_stand/policy/lep_paper.pdf*. Last accessed Mar. 31, 2011.

[2]Yonek J, Hedges Greising C. Overcoming the language barrier. HHN Magazine. Available online at: *www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006November/061114HHN_Online_Yonek&domain=HHNMAG*. Last accessed April 18, 2011.

[3]Arocha O, Moore DY. The New Joint Commission Standards for Patient-Centered Communication. [White Paper]. Language Line Services. Available online at: *http://www.languageline.com/page/jointcommission2011report/*. Last accessed Mar. 31, 2011.

[4]Borngesser v Jersey Shore Medical Center, 774A2d 615 (NJ Super AD 2001). Available online at: *http://signlanguageinterpreters.com/component/content/article/10*. Last accessed Mar. 31, 2011.

[5]Sorrel AL. Doctor liable for not providing sign language interpreter. Jan. 5, 2009. Available online at: *www.ama-assn.org/amednews/2009/01/05/prca0105.htm*. Last accessed Mar. 31, 2011.

[6]Blue Cross Blue Shield of Rhode Island. Medical Coverage Policies. Early Invention Services. Available online at: *https://www.bcbsri.com/BCBSRIWeb/plansandservices/services/medical_policies/EarlyInterventionServices.jsp*. Last accessed Mar. 31, 2011.