

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-11

Subject: Interpreter Services and Payment Responsibilities

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee G  
(Jane C.K. Fitch, MD, Chair)

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1 Policy D-215.991 calls for the American Medical Association (AMA) to study the feasibility of  
2 requiring hospitals to provide and pay for interpreter services for the follow-up care of patients that  
3 physicians are required to accept as a result of that patient's emergency room visit, and to evaluate  
4 the impact on a physician practice of any federal mandate that requires an interpreter be present for  
5 patients who cannot communicate proficiently in English, or are hearing impaired. The Board of  
6 Trustees assigned the requested study to the Council on Medical Service.

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8 This report provides background on federal policies related to language and hearing interpreter  
9 services, summarizes AMA policy and advocacy on interpreter guidance, discusses interim  
10 solutions to addressing care and recommends a comprehensive strategy to provide and pay for  
11 interpreter services.

## 12 BACKGROUND

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15 The immigrant population in the United States is growing, and for many immigrants, English is not  
16 a first language. According to the 2009 US Census Bureau's American Community Survey, 24.5  
17 million or 8.6 percent of the US population speaks English less than "very well." Many states  
18 report significantly higher percentages of people who are limited English proficient (LEP).  
19 Interpretation is the act of facilitating oral communication between individuals who do not speak  
20 the same language and may not share the same culture. Translation is changing written documents  
21 from one language into another. Providing interpretation and translation services to patients who  
22 are LEP has been shown to improve health care quality, the patient experience, adherence to  
23 recommended care, and ultimately health outcomes (Flores, Medical Care Research and Review,  
24 2005, Jacobs et al, The Milbank Quarterly, 2006, Karliner, Journal of General Internal Medicine,  
25 2004).

### 26 *Language Services*

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29 Title VI of the Civil Rights Act of 1964 is a federal law that protects persons from unlawful  
30 discrimination based on race, color, or national origin in programs and activities that receive  
31 federal financial assistance. These regulations recognize that an individual's primary language is  
32 often an essential national origin characteristic. Unlawful discrimination means that recipients of  
33 federal dollars may not utilize criteria or methods of administration that have the effect of delaying  
34 or denying services to persons on the basis of their race, color, or national origin.  
35 Physicians and providers who receive federal dollars, such as Medicaid or State Children's Health  
36 Insurance Program reimbursement, are required to comply with the guidance for all of their  
37 patients with LEP, including Medicare beneficiaries. HHS clarified that Medicare Part B payments

1 do not trigger language service obligations. Long-standing AMA policy recognizes the lack of  
2 funding for interpreter services for patients who are hearing impaired or do not speak English, as a  
3 financial and legal burden, opposes such requirement and urges reinterpretation of Title VI (e.g.,  
4 Policies D-160.992, H-385.928, D-385.978, H-160.924, D-345.997 and H-285.985). In particular,  
5 Policy H-160.924[4] advocates that when trained medical interpreters are needed, the costs of their  
6 services shall be paid directly to the interpreters by patients and/or third party payers and  
7 physicians shall not be required to participate in payment arrangements.  
8

9 In 2003, the Office of Civil Rights of the Department of Health and Human Services (HHS) issued  
10 guidance on Title VI called Culturally and Linguistically Appropriate Services (CLAS) in health  
11 care. Four factors were presented for providers to weigh in determining an appropriate response to  
12 LEP patients: the number of patients with language difficulties, the frequency of their visits, the  
13 importance of the service provided and the available resources. The CLAS guidance provided  
14 more flexibility for smaller office settings to use translated documents, community advocates,  
15 referrals to physicians with appropriate capabilities and use of family members (where the  
16 physician makes clear to the patient that another translator will be provided if they desire) as  
17 appropriate.  
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### 19 *Services for the Hearing Impaired*

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21 State and federal laws generally prohibit discrimination on the basis of disability and require  
22 physicians and other private, covered entities to provide reasonable public accommodations to  
23 ensure “effective communication” with patients who have disabilities such as blindness or hearing  
24 impairment and with their family members. The Americans with Disabilities Act (ADA) of 1990  
25 protects persons with disabilities with respect to employment and access to goods and services  
26 offered by private, state, and local government entities. AMA legal analysis of the ADA and  
27 hearing interpreter standards indicates that “reasonable accommodation” for the hearing impaired  
28 does not necessarily imply the use of an interpreter in all cases. Reasonable accommodations may  
29 include a range of auxiliary aids that doctors can use, including note-takers or video or computer-  
30 based transcription devices, which can be less expensive than an interpreter service. According to  
31 the law, health care professionals or facilities cannot impose a surcharge on an individual with a  
32 disability directly or indirectly to offset the cost of the hearing interpreter. However, unlike costs  
33 for interpretive services for patients with LEP, tax credits are available to meet ADA standards to  
34 provide qualified interpreters or other accessible tools for individuals with hearing impairments.  
35 For the most part, both CLAS and ADA standards have been treated as voluntary guidelines  
36 without the force of law. For additional information related to CLAS and ADA guidance, refer to  
37 the AMA Litigation Center online at <http://www.ama-assn.org/go/litigationcenter>.  
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### 39 *Federal Funding for Interpreter Services*

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41 In 2010, the Centers for Medicare and Medicaid Services (CMS) provided guidance to states  
42 regarding the implementation of the Children’s Health Insurance Program (CHIP) Reauthorization  
43 Act of 2009, which provides increased administrative funding for translation or interpretation  
44 services provided under CHIP and Medicaid for the enrollment, retention, and use of services by  
45 children whose families do not speak English. With increased funding, only 14 states pay for  
46 language services in their Medicaid and CHIP programs. The remainder of states opt out due to a  
47 lack of financial resources needed to take advantage of higher matches.  
48

49 Other sources of federal funding include the Office of Minority Health Bilingual/Bicultural Service  
50 Demonstration Grant program, the Health Resources Services Administration Bureau of Primary  
51 Care, and several state and city offices of minority health.

1 The AMA is committed to obtaining federal funding for medical interpretive services and to work  
2 with governmental officials and other organizations to make language interpretive services a  
3 covered benefit for all health plans inasmuch as health plans are in a superior position to pass on  
4 the cost of these federally mandated services as a business expense (Policies D-385.978 and  
5 D-345.997).

#### 6 7 HOSPITAL RESPONSIBILITY FOR INTERPRETER SERVICES

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9 Policy D-215.991[1] calls for the AMA to study the feasibility of requiring hospitals to provide and  
10 pay for interpreter services for the follow-up care of patients that physicians are required to accept  
11 as a result of the patient's emergency room visit. Hospital-based initiatives to improve  
12 communication with patients, coordinate care after discharge and improve the quality of care  
13 during the initial admission have been shown to help avert adverse events such as readmissions.  
14 Accordingly, the intent of Policy D-215.991[1] complements Policy H-215.982, which encourages  
15 hospitals that serve populations with a significant number of non-English speaking patients to  
16 provide trained translator services.

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18 In its report entitled, "Providing Language Services in Small Health Care Provider Settings:  
19 Examples from the Field," the Commonwealth Fund recognized the efforts of a small community  
20 hospital, in Northampton, MA, that provided on-site interpreter services 24 hours per day, seven  
21 days a week (Youdelman, Commonwealth Fund, 2005). As a condition of Massachusetts  
22 Department of Health approval for adding a new magnetic resonance imaging unit, the hospital  
23 provided any primary or specialty provider on medical staff with admitting privileges access to  
24 interpreter services, and providers did not pay for these services. Two local community-based  
25 organizations provided interpreters and the hospital paid the organization a monthly administrative  
26 fee and a per-appointment usage fee.

27  
28 To successfully provide interpreter services, hospitals may have to expand their business operations  
29 to promote appropriate use of services, develop payment mechanisms, ensure professional quality,  
30 and guarantee consistency of care. A December 2010 cross-sectional study of national hospitals  
31 found that many hospitals are not providing language services in a manner consistent with related  
32 CLAS standards (Diamond, et al, *Medical Care*, December 2010). Enforcement of hospital  
33 regulations to provide interpreters is inconsistent, and hospitals are not likely to be motivated to  
34 comply.

35  
36 In 2009, all California health plans were required to submit their proposals to provide services,  
37 materials, and information to plan members in a language that they speak and understand.  
38 California's Department of Managed Health Care worked with health plans, providers, interpreter  
39 agencies and trade organizations to coordinate the language needs of consumers and work within  
40 the constraints of health plan business operations. Some plans designed their language services to  
41 rely solely on bilingual staff and telephone interpreter services through designated phone lines;  
42 others designed a system that mixes phone lines, face-to-face interpreters, and community member  
43 telephone services to comply with the California law (Au et al., Mathematica Policy Research, Inc.,  
44 2009). Physicians must shoulder the responsibility to provide appropriate language assistance  
45 services as needed for uninsured patients.

#### 46 47 IMPACT ON PHYSICIAN PRACTICES

48  
49 Policy D-215.991[2] calls for evaluating the impact on a physician practice of requiring that an  
50 interpreter be present for patients who cannot communicate proficiently in English, or are hearing  
51 impaired. The Council notes that language services, such as translation and interpretation, can

1 facilitate communication between physicians and patients and thus improve health care quality, the  
2 patient experience, adherence to recommended care, and health outcomes.

3  
4 The AMA has previously conducted an informal state survey, which indicated that interpreter  
5 services consistently cost more than the total amount paid by Medicaid for the physician visit. The  
6 survey showed that the cost of hiring an interpreter can vary greatly between \$30 and \$400 which  
7 is significantly higher than payment for a Medicaid office visit, which in many states ranges  
8 between \$30 and \$50. As noted in the AMA's December 8, 2003, comment letter to Deena Jang  
9 at the Department of Health and Human Services, asking physicians to incur the financial burden  
10 of providing interpretation services for LEP patients in their practice, can impose severe economic  
11 losses that are difficult to sustain, especially when the cost of providing interpreter services far  
12 exceeds the payment for treating the LEP patient. Further, such a requirement may cause  
13 physicians to limit LEP patients, which could create an access problem particularly for poor and  
14 medically indigent patients.

#### 15 16 SHORT-TERM OPTIONS FOR PROVISION AND PAYMENT OF INTERPRETER SERVICES

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18 During its study of payment for interpreter services, the Council questioned whether a CPT Code  
19 could be developed. In 2000, the CPT Editorial Panel responded to a request of the House of  
20 Delegates to review the development of a CPT Code for use of medical interpreters. The Panel  
21 recommended that when the services of the interpreter took place during an Evaluation and  
22 Management visit that the appropriate level Evaluation and Management service code should be  
23 reported with the modifier '-32' appended. The Panel indicated that the modifier '-32' had been  
24 specifically revised to depict services related to governmental, legislative, or other regulatory  
25 requirements, such as the requirement for use of an interpreter when necessary.

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27 Alternatively, "HCPCS - Level II" is a standardized coding system that is used primarily to identify  
28 products, supplies, and services not included in the CPT codes, such as ambulance services and  
29 durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's  
30 office. HCPCS Code, T1013 described as "sign language or oral interpretive services, per 15  
31 minutes," could allow for physicians and other health providers to bill payers in 15 minute  
32 increments for these services.

33  
34 The Council also reviewed other cost-effective solutions to provide interpreter services that could,  
35 when possible, be accessed in advance of caring for LEP patients. Internet based resources include  
36 the federal government Web site (<http://www.lep.gov>) or the Industry Collaboration Effort toolkit  
37 ([http://www.iceforhealth.org/library/documents/ICE\\_C&L\\_Provider\\_Toolkit\\_7.10.pdf](http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Toolkit_7.10.pdf)). In  
38 addition, with the evolution of networking devices such as smart phones and computer tablets,  
39 there has been an increase in the number of internet-accessible translation products and  
40 applications. The Council recognizes the emerging availability of low-cost translation and  
41 transcription solutions (e.g., Google Translate, Dragon Naturally Speaking, and Instant Medical  
42 History), but notes that there may be drawbacks to the use of any technology as a substitute for  
43 human interpreters, such as an interruption of human contact and perhaps increased potential for  
44 errors in translation.

#### 45 46 DISCUSSION

47  
48 Patients with limited English proficiency are more likely than English-speaking patients to  
49 experience either preventable medical errors and/or adverse events. Federal law, the myriad state  
50 laws and uneven hospital efforts to provide services to LEP individuals have been mostly  
51 ineffective at addressing the financial and legal risks that physicians face in providing care to the

1 LEP population. Federal efforts to provide increased funding for translation service for Medicaid  
2 patients is only being used in 14 states. Existing coding methods are available, but their use is  
3 limited because payers expect physicians to absorb the cost of interpretation services as part of  
4 their business expenses. Policy D-215.991 highlights problems of the unfunded interpreter  
5 mandate. Accordingly, the Council recommends reaffirming Policy D-385.978, which states that  
6 our AMA will continue to work to obtain federal funding for medical interpretive services,  
7 redouble its efforts to remove the financial burden of medical interpretive services from physicians  
8 and urges reconsideration of the Title VI requirement for medical interpretive services without  
9 reimbursement.

10  
11 The underlying intent of Policy D-215.991[1] complements Policy H-215.982, which encourages  
12 hospitals that serve populations with a significant number of non-English speaking patients to  
13 provide trained translator services. Models exist of small health care providers working within  
14 their communities to improve the provision of health care services. For instance a Northampton,  
15 MA hospital provided language services to offices of physicians affiliated with the hospital. The  
16 Council supports incorporating the language in Policy D-215.991[1] into a new policy that  
17 encourages hospitals to provide and pay for interpreter services for the follow-up care of patients  
18 that physicians are required to accept as a result of that patient's emergency room visit.

19  
20 With respect to Policy D-215.991[2], the Council notes strong AMA policy and advocacy opposing  
21 a mandate that physicians provide interpreter services. Policy H-160.924[4] specifies that when  
22 trained medical interpreters are needed, the costs of their services shall be paid directly to the  
23 interpreters by patients and/or third party payers and physicians shall not be required to participate  
24 in payment arrangements. California state law is leading the nation in requiring that health plans  
25 provide interpreter services, and the Council supports such comprehensive payment models, with  
26 the understanding that such models do little to help with the uninsured. In view of that, the Council  
27 notes the increasing availability of low-cost interpretation and translation solutions, including print  
28 materials, digital and other electronic or telecommunication services. Despite the limitation of  
29 these tools, the Council believes that technologies are useful in engaging LEP patients in their care.  
30 The Council supports physicians' continued resourcefulness in their use of appropriate  
31 technologies to help facilitate communication, particularly to prepare for encounters with LEP  
32 patients and notes that Policy H-160.924[3] supports the use of such innovations. Accordingly, the  
33 Council recommends reaffirmation of Policy H-160.924.

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35 Finally, the Council believes this report accomplishes the study called for in Policy D-215.991 and  
36 accordingly, recommends that Policy D-215.991 be rescinded:

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38 **RECOMMENDATIONS**

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40 The Council of Medical Service recommends that the following be adopted and that the remainder  
41 of the report be filed.

- 42  
43 1. That our American Medical Association support efforts that encourage hospitals to provide  
44 and pay for interpreter services for the follow-up care of patients that physicians are  
45 required to accept as a result of that patient's emergency room visit and Emergency  
46 Medical Treatment and Active Labor Act (EMTALA)-related services. (New HOD  
47 Policy)  
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49 2. That our AMA reaffirm Policy D-385.978, which states that our AMA will: (1) continue to  
50 work to obtain federal funding for medical interpretive services; (2) redouble its efforts to  
51 remove the financial burden of medical interpretive services from physicians; (3) urge the

1 Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as  
2 requiring medical interpretive services without reimbursement; (4) consider the feasibility  
3 of a legal solution to the problem of funding medical interpretive services; and (5) work  
4 with governmental officials and other organizations to make language interpretive services  
5 a covered benefit for all health plans inasmuch as health plans are in a superior position to  
6 pass on the cost of these federally mandated services as a business expense. (Reaffirm  
7 HOD Policy)  
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- 9 3. That our AMA reaffirm Policy H-160.924, which states that AMA policy is that: (1)  
10 further research is necessary on how the use of interpreters--both those who are trained and  
11 those who are not--impacts patient care; (2) treating physicians shall respect and assist the  
12 patients' choices whether to involve capable family members or friends to provide  
13 language assistance that is culturally sensitive and competent, with or without an  
14 interpreter who is competent and culturally sensitive; (3) physicians continue to be  
15 resourceful in their use of other appropriate means that can help facilitate communication--  
16 including print materials, digital and other electronic or telecommunication services with  
17 the understanding, however, of these tools' limitations--to aid LEP patients' involvement  
18 in meaningful decisions about their care; and (4) physicians cannot be expected to provide  
19 and fund these translation services for their patients, as the Department of Health and  
20 Human Services' policy guidance currently requires; when trained medical interpreters are  
21 needed, the costs of their services shall be paid directly to the interpreters by patients  
22 and/or third party payers and physicians shall not be required to participate in payment  
23 arrangements. (Reaffirm HOD Policy)  
24

- 25 4. That our AMA Rescind Policy D-215.991. (Rescind HOD Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.