Pain Management Coding Alert

Reader Question: Interpreter Won't Always Mean More MDM Points

Question: We recently took on a new patient who is deaf. The patient came with a family member who interpreted. Can we record two data points for medical decision making (MDM) as we determine the evaluation and management (E/M) level based on the fact that we obtained information from both the patient and the family member?

Arkansas Subscriber

Answer: Determining the E/M level in this situation by assigning one point to the history a patient provided and a second point for the history the interpreter communicated is potentially a risky move. The Centers for Medicare and Medicaid Services (CMS) guidelines state that "a decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented," so you will probably only be able to record one data point.

Translating implies that the interpreter is relaying the same information as the patient, not supplementing the information the patient gave and thereby substantially influencing the diagnosis and course of treatment the provider will choose.

Adding a point for the interpreter could also land you in hot water for two other reasons. First, it could create audit problems, as points alone are never a good way to substantiate an E/M level. Things like documenting that the symptoms are new or getting worse, urgent orders for tests or consultations, or factors influencing a substantial change in a care plan, are all far greater reasons for justifying a greater level of care than points assigned to MDM.

Second, the scenario also sets up a potential compliance issue, as it implies that you are charging more for your services based on a patient's disability. This would be in violation of most states' antidiscrimination laws, which may require your provider to supply an interpreter at no cost to the patient. So, to avoid any appearance of impropriety, you would probably be better off only documenting the patient's history unless the interpreter has clearly and substantially added to it.