What tasks are delegable to—and performable by—medical assistants?

Part II

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The following is adapted from the handout for my presentation of the same title for the 2020 American Academy of Ambulatory Care Nursing Annual (Virtual) Conference.

Part I discussed four legal axioms and their applications in determining tasks delegable to—and performable by—medical assistants. It also debunked three pervasive myths about medical assistants' scope of practice and proffered diagnostic questions for ascertaining the legality of a specific task. This article will address state laws about medical assistants (1) performing injections and venipuncture, (2) executing verbal and standing orders from licensed providers, and (3) entering orders under the Medicaid Promoting Interoperability Program (formerly the Medicaid Electronic Health Record [EHR] Incentive Program) and its meaningful use provisions for electronic order entry.

Injections delegated by physicians

Under the laws of all states except New York and Connecticut, physicians are permitted to delegate to knowledgeable and competent unlicensed allied health professionals such as medical assistants working under their authority and supervision the administration of intramuscular, intradermal, and subcutaneous injections—including vaccinations and immunizations. Medical assistants must meet certain requirements to administer physician-delegated injections according to the laws of South Dakota, Washington, North Dakota, Nebraska, Massachusetts, New Jersey, Arizona, and California.

My legal opinion is that—based on common law principles—if there is a likelihood of significant harm to a patient if a medication or other substance is selected or prepared improperly, the delegating physician must verify the identity and dosage of the injectable substance before the medical assistant administers it. Verification of all injections' identity and dosage before administration by medical assistants is required by the laws of some states. Depending on the specific state law, this verification of dosage and identity may be done by a licensed provider other than a physician or by a licensed health care professional, such as a registered nurse.

Injections delegated by nurse practitioners or physician assistants

In some states, the laws governing the delegation to medical assistants of injection administration vary depending on whether the delegating provider is a physician, nurse practitioner, or physician assistant. To complicate the legal analysis, the laws of some states permit a licensed provider to supervise a medical assistant who is performing injections delegated by a licensed provider of a different category. For example, in some states, a nurse practitioner is not permitted to delegate to medical assistants injection administration. However, in some of these states, a nurse practitioner may be allowed to supervise a medical assistant who is administering an injection delegated to the medical assistant by a physician.

Venipuncture

As is the case with injections, venipuncture may be delegated to medical assistants under state law, and some states have requirements that medical assistants must meet to be delegated this task. For example, California law has different requirements for medical assistants performing phlebotomy under licensed provider authority in outpatient settings and for medical assistants working as phlebotomists in clinical laboratories without physician, nurse practitioner, or physician assistant supervision.

IV tasks

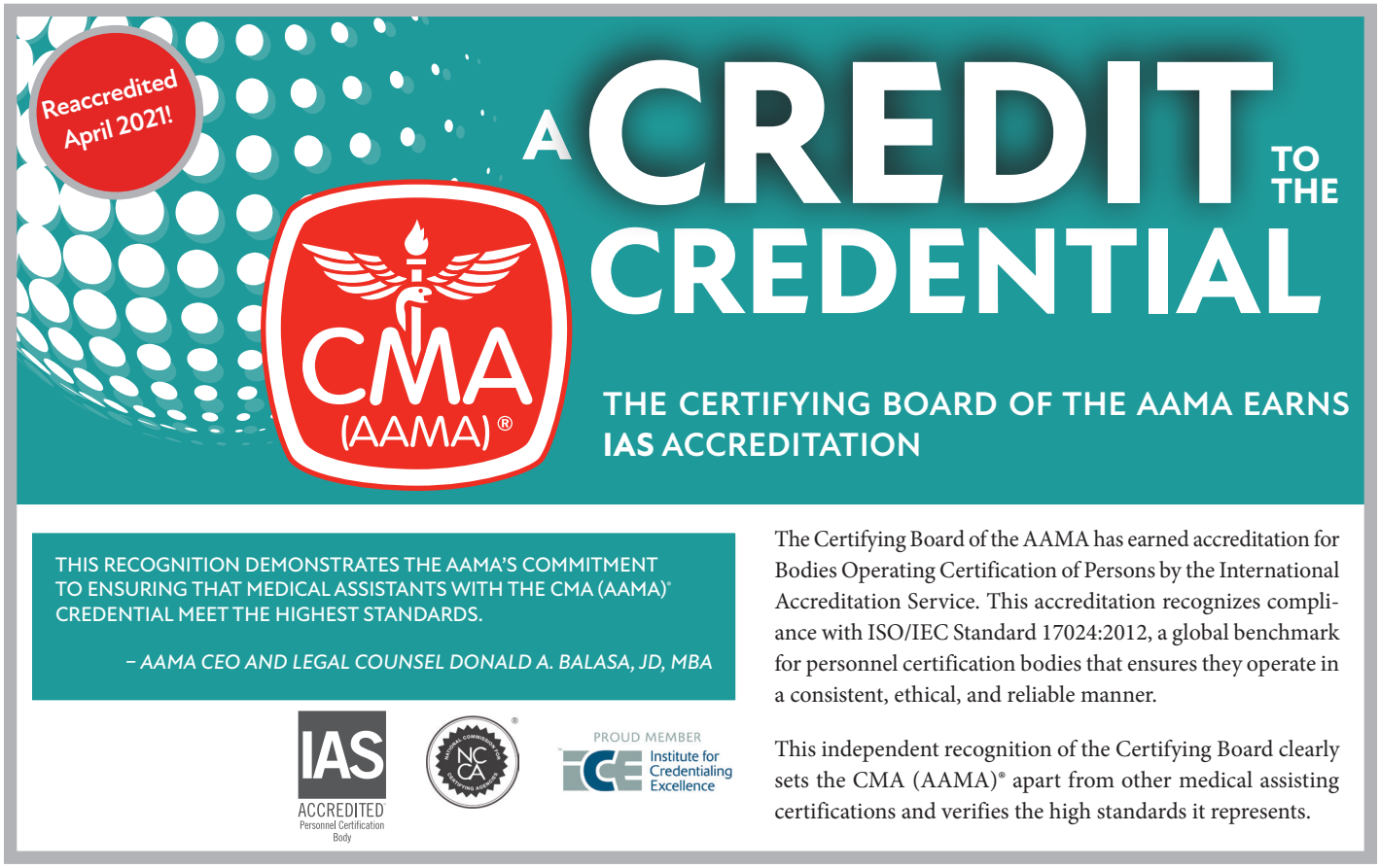
According to the laws of some states, licensed providers are neither specifically authorized nor forbidden from delegating to unlicensed allied health professionals such as medical assistants the performing of intravenous (IV) tasks. Some states' laws permit providers to delegate to medical assistants certain IV tasks such as initiating IVs, performing IV infusion, and (in Washington and Maryland) performing IV injections. For example, Florida law permits physicians to delegate to knowledgeable and competent medical assistants the performing of IV infusion under the physician's direct or on-site supervision. In some of these states, medical assistants must meet education and credentialing requirements to be delegated certain IV tasks.

Employer policy and state law

Employers of and delegators to medical assistants must abide by state law regarding the legally allowable scope of practice for medical assistants. An employer, however, is permitted to establish a delegation policy for medical assistants *stricter than* what state law allows. In other words, an employer may choose to not allow medical assistants to perform certain duties that are within the medical assistant's legal scope of practice. Not allowing competent medical assistants to work to the top of their education and credentialing under the law may not seem to make economic sense for the employer. However, such policy is legally permissible and does not violate any state or federal laws (e.g., anti-discrimination laws).

Verbal orders

My legal opinion is that—unless state laws



indicate otherwise—medical assistants are permitted to receive and execute verbal orders from an overseeing or delegating provider if the following conditions are met:

1. The medical assistant understands the verbal order.
2. The task to be performed is within the medical assisting scope of performable tasks under the laws of the state, and the delegating physician (or another provider) is exercising the degree of supervision required under state law for the delegated task.
3. The medical assistant is knowledgeable and competent in the delegated task.
4. Executing the order does not require the exercise of independent clinical judgment or the making of clinical assessments, evaluations, or interpretations.

Standing orders

My legal opinion is that medical assistants are permitted to receive and execute standing orders from an overseeing or delegating provider if the following conditions are met:

1. The medical assistant understands the standing order.
2. The standing order is for a task that is delegable to medical assistants under the laws of the state, and the delegating provider is exercising the degree of supervision required by the laws of the state.
3. The standing order is either patient-specific or applicable to all patients without exception.
4. The standing order does not require the medical assistant to exercise independent clinical judgment or make clinical assessments, evaluations, or interpretations.

Medicaid Promoting Interoperability order entry requirements

Despite the phasing out of the Medicare EHR Incentive Program by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), this Centers for Medicare & Medicaid Services (CMS) rule remains in effect: only licensed health care professionals or credentialed medical assistants are permitted to enter medication, laboratory, and diagnostic imaging orders into the computerized provider order entry (CPOE) system for meaningful use calculation purposes under the Medicaid Promoting Interoperability Program (formerly the Medicaid EHR Incentive Program).[1]

Consequently, CMAs (AAMA)® must keep their credential current to remain within the CMS definition of *credentialed medical assistants*. Similarly, medical assistants must have a current Assessment-Based Recognition in Order Entry (ABR-OE) to be classified as credentialed medical assistants under the CMS rule. ✦

Questions about this adapted presentation may be directed to AAMA CEO and Legal Counsel Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org.

Reference

1. Centers for Medicare & Medicaid Services. *Medicaid Promoting Interoperability Program Eligible Professionals Objectives and Measures for 2020 and 2021: Objective 4 of 8.* Accessed December 14, 2020. https://www.cms.gov/files/document/medicaid-ep-2020-cpoe-objective-4.pdf