Medical Assisting Scope of Practice

Federal and State Updates

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1. "*Credentialing* is the umbrella term that includes the concepts of accreditation, licensure, registration, and professional certification."

2. "*Licensure* is the ***mandatory*** process by which a *governmental agency* grants time-limited permission to an individual to engage in a given occupation after verifying that he/she has met predetermined and standardized criteria, and offers title protection for those who meet the criteria." The holder of a license is called a *licensee*.

3. "Professional *certification* is the ***voluntary*** process by which a *non-governmental entity* grants a time-limited recognition and use of a credential to an individual after verifying that he or she has met predetermined and standardized criteria…The holder of a professional certification is called a *certificant*."

4. If a credential is *mandatory* by law, it is a *license*—regardless of the name or initialism of the credential. If a credential is *voluntary*, and not legally mandated, it is a *certification*—regardless of the name or initialism of the credential. (Some licensure laws require a licensee to obtain and maintain a national certification as a condition of licensure.)

5. For example, the RMA(AMT) and the CMA (AAMA) *are both certifications*. The RMA(AMT) is not a "higher" credential because it has the word "registered" in its title. Only individuals who hold a current CMA (AAMA) are permitted to use the initialism "CMA (AAMA)" or "CMA." Individuals not holding a current CMA (AAMA) are also forbidden from using the phrase "Certified Medical Assistant."

6. "Regulation of professions rests primarily with *the states*, not with the federal government. This time-honored legal principle is rooted in the 'police power' reserved to the states by the Tenth Amendment of the United States Constitution. The police power consists of the authority of each state to safeguard the health, safety, and welfare of its residents by legislation, executive branch regulations, and the enforcement of these provisions."

7. There are exceptions to this legal principle, however. For example, the Centers for Medicare & Medicaid Services (CMS) rule for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that required/requires a certain percentage of medication, laboratory, and diagnostic imaging orders to be entered by either *licensed health care professionals* or "*credentialed medical assistants*" for meeting the meaningful use requirements of the Incentive Programs is an instance of *federal* credentialing requirements. (The Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] initiated the phasing out of the *Medicare* EHR Incentive Program. However, the *Medicaid* EHR Incentive Program and its meaningful use requirements remain in effect until at least December 31, 2021, barring any congressional action.)

8. *Definitions*—A *statute* is legislation that has been enacted into law by a legislative body. A *regulation/rule* is a "statement of general applicability" issued by an executive branch entity that has been given the authority by statute to do so. A regulation must not contradict or go beyond the language of the

enabling statute. If a regulation exceeds statutory parameters, the regulation is null and void. "Regulation" and "rule" are synonymous terms.

9. There are two types of licensure: (a) licensure in order to perform *all tasks* of the licensed profession and (b) licensure in order to perform *some, but not all, tasks* of the profession. The former may be referred to as *full licensure*, and the latter may be referred to as *limited licensure*.

10. An example of a state that has established *full licensure* for medical assistants is *South Dakota*. South Dakota law provides for joint regulation of medical assisting by its Board of Medical and Osteopathic Examiners and its Board of Nursing. The SD *statute* reads, in part, as follows: "No person may practice as a medical assistant unless that person is registered with the Board of Medical and Osteopathic Examiners pursuant to this chapter… An applicant for registration shall provide proof of graduation from a medical assistant program approved by the boards." The *rule* reads, in part, as follows: "[The applicant must submit] [p]roof of having passed a national certifying exam approved by the boards."

11. An example of a state that has established *limited licensure* for medical assistants is *New Jersey*. In order to be delegated by a physician certain types of intramuscular, intradermal, and subcutaneous *injections*, a medical assistant must: (a) have graduated from a postsecondary medical assisting education program and (b) maintain current certification from a recognized certifying body approved by the New Jersey State Board of Medical Examiners.

12. Why don't medical assistants pursue licensure?

State legislatures do not enact licensing legislation to upgrade, standardize, increase the prestige of, or increase the earnings of a profession. State legislatures pass licensing legislation if there is *objective evidence* that the lack of licensure is causing significant, tangible *harm to consumers* of the professionals' services. Because medical assistants work under direct/onsite provider supervision, it is difficult to adduce sufficient evidence that the health, safety, and welfare of patients are being jeopardized by the lack of licensing for medical assistants.

13. To prevent unnecessary licensure and regulation of professions and occupations, many states have enacted *sunrise statutes*. Sunrise laws require a profession seeking state regulation to prove the necessity of the regulation at the beginning point of a legislative effort, and that is the reason for the use of the word "sunrise." "Sunrise is a process under which an occupation or profession wishing to receive … licensure must propose the components of the legislation, along with the cost and benefit estimates of the proposed regulation. The profession must then convince the legislators that *consumers will be unduly harmed if the proposed legislation is not adopted*…The key element in the sunrise review is the adherence to the philosophy that credentialing should be enacted only when it is in the public's best interest. Furthermore, the level of regulation should be no more restrictive than necessary to protect the public."

14. There are also *sunset statutes*. "Sunset is the automatic termination of regulatory boards and agencies unless legislative action is taken to reinstate them … [Sunset] refers to the process by which a periodic review of specified regulatory agencies is made to determine whether there continues to be a need for the regulation or regulatory body and, if so, whether the agency is fulfilling its statutory responsibilities in an effective and efficient manner. …[Sunset] has resulted in several changes, including combining boards that deal with similar professions into one board, thereby improving the manner in which regulatory activities are conducted."

15. As was the case in the late 1970s and early 1980s, an anti-licensure, anti-professional-regulation mindset has become prominent on the federal and state levels of government. Note the following from the White House report, July 2015, *Occupational Licensing: A Framework for Policymakers*:

1. Carry out comprehensive cost-benefit assessments of licensing laws through both sunrise and regular sunset reviews, incorporating criteria like:

- The presence of legitimate public health and safety concerns or substantial fiduciary responsibilities;
- Whether existing legal remedies, consumer rating and reputational mechanisms, and less-burdensome regulatory approaches are adequate to protect consumers;
- Whether the proposed licensing requirements are actually well-tailored to ensure quality and protect consumers;
- The effect that the license would have on practitioner supply;
- The effect that the license would have on the price of goods and services; and
- Administrative costs of enforcing the license. (page 42)

16. *Definition*—Medical assistants are allied health professionals who work under *provider* supervision in *outpatient settings* and are delegated clinical and administrative tasks.

17. In the above definition, a *provider* usually means a physician (i.e., an MD or DO), nurse practitioner, or physician assistant. Some medical assistants, however, work under other licensed health care providers, such as podiatrists (DPMs) or dentists (DDSs or DMDs).

18. The degree of autonomy under which nurse practitioners (NPs) practice varies from state to state. Under some state laws, NPs practice with total autonomy (i.e., without a collaboration agreement with a physician). In such cases, the tasks that NPs are permitted to delegate to unlicensed health professionals (such as medical assistants) are determined by the state nurse practice act and the regulations/rules, policies, and decisions of the state board of nursing.

19. In states with laws that grant less autonomy to nurse practitioners, NPs work under some degree of physician oversight. (In states that have total autonomy for nurse practitioners, NPs may choose to work under some degree of physician supervision, even though they are permitted to practice with total autonomy.) In these situations, the scope of practice for medical assistants working under NP supervision may be determined by both the medical practice act (and its regulations) and the advanced practice registered nurse (APRN) practice act (and its regulations).

20. Under the laws of all states, physician assistants (PAs) work under physician authority and oversight. However, in some states the degree of oversight/supervision that must be exercised by an MD/DO over a PA is very general. The tasks that PAs are permitted to delegate to unlicensed professionals such as medical assistants are determined by the statutes and regulations/rules that govern PAs.

21. The laws of most states permit physicians to assign to other licensed health professionals (e.g., NPs, PAs, RNs) the responsibility of supervising medical assistants when the medical assistants are performing tasks delegated to them by the overseeing/delegating physician.

22. The degree of supervision that providers must exercise over medical assistants varies from state to state, and from delegated task to delegated task. The names given to these degrees of supervision also vary from state to state: (a) "*Over-the-shoulder/personal supervision*" may be defined as the delegating provider being in the same room as the medical assistant when the medical assistant is performing a delegated task. The provider must be able to see and hear the medical assistant as the task is being performed; (b) "*Direct/onsite supervision*" may be defined as the delegating provider being on the premises/in the office suite and immediately available when the medical assistant is performing a delegated task. The degree of immediate availability is based on the nature of the task and other facts and

circumstances; (c) "*General supervision*" may be defined as the delegating provider not being on the premises, but available within a reasonable time by electronic means.

23. Medical assisting scope of practice is determined primarily by laws governing what providers are permitted to delegate to unlicensed professionals such as medical assistants working under their authority and supervision. The laws of most states do not refer to "medical assistants" by name.

The fact that the outpatient setting may be located on the premises of an inpatient setting (such as a hospital or a correctional institution), or that the official employer of the medical assistant may be a corporation or an institution, does not impact the provider's right to delegate, and therefore the medical assistant's scope of practice.

24. *The Standards for Ambulatory Care* and *Comprehensive Accreditation Manual for Hospitals* of The Joint Commission **do not impact medical assisting scope of practice**.

25. Medical assistants do not work clinically as medical assistants *per se* in inpatient settings. Medical assistants must meet the state educational and testing requirements to become *certified nursing assistants (CNAs)* or *medication aides* [states have different titles for this category of health professionals] if they want to work as CNAs or medication aides (or in similar, primarily clinical, positions) in inpatient settings.

26. General legal principles—

- It is not permissible for medical assistants to be delegated and to perform any tasks that constitute the practice of medicine, or require the knowledge and/or skill of a physician or another provider;
- It is not permissible for medical assistants to perform tasks that are restricted in state law to other health professionals;
- It is not permissible for medical assistants to perform tasks that *require the exercise of independent clinical judgment, and/or the making of clinical assessments, evaluations, or interpretations*;
- Medical assistants must not be delegated (and must not perform) any tasks for which they are not sufficiently knowledgeable and competent;
- If a medical assistant performs a task in a negligent manner, *both* the delegating provider *and* the medical assistant may be held liable civilly for *negligence*;
- If a medical assistant performs a task not permitted by state law, *both* the delegating provider *and* the medical assistant may be subject to *legal sanctions*;
- ***It is incumbent on employers to verify the credentials of their medical assistants—both at the time of hiring and on an ongoing basis***.

27. Under the laws of most states, providers are permitted to delegate to knowledgeable and competent unlicensed professionals such as medical assistants working under their direct/onsite supervision in outpatient settings the administration of medication and other substances orally, and by subcutaneous, intradermal, and intramuscular injection—including vaccinations/immunizations. It is my legal opinion that, if there is a likelihood of significant harm to a patient if a medication or other substance is selected/prepared improperly, the delegating provider *must verify the identity and the dosage* of the medication or substance before it is administered by the medical assistant.

28. If there is ambiguity under state law about the delegability to medical assistants of certain tasks, it may be advisable to ask (or request one or more delegating physicians to ask) the state board of medical examiners whether physicians are permitted to delegate a certain task to unlicensed professionals working

under their direct/onsite supervision in outpatient settings. **It is very important that "medical assistant" not be mentioned when requesting an opinion from a state board of medical examiners. If the question contains the two words "medical assistant," the staff member of the board of medical examiners will immediately respond by indicating that the board has no jurisdiction over medical assistants, and you will not receive an answer to your scope of practice question.**

29. (This leads to a general question of relevance: What state agency/department has jurisdiction over medical assistants? In some states, the answer to this question is apparent from state statutes. In most states, it is not apparent. My standard response for states in the latter category is that there is no state agency that has *direct jurisdiction* over medical assistants. However, the board of medical examiners has *indirect jurisdiction* over medical assistants because it has direct jurisdiction over physicians, who are the primary delegators to medical assistants.)

30. Depending on the response from the state board of medical examiners, it may be prudent to ask the *malpractice insurance carrier* for the practice/clinic/health system whether it would cover any negligence by a medical assistant in performing the task. The insurance carrier should be asked to put its opinion in writing.

31. To formulate a legal opinion on whether a particular task is delegable to medical assistants when state law does not address the legality or when state law is ambiguous, and when the state board of medical examiners is unwilling to offer its interpretation of state law, I often begin my analysis by evaluating whether the task is *usually and customarily* delegated to medical assistants in the state, and in other states. I also determine whether the task is contained in the "Core Curriculum" of the current CAAHEP *Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting*. [The Core Curriculum of the CAAHEP *Standards* takes into account the results of the most recent occupational analysis of the medical assisting profession.]

32. An employer is permitted to establish a delegation policy *stricter than* what state law allows. It is important to distinguish between what state and federal law require, and what *employer policy* requires.

33. Under the laws of some states, providers are permitted to delegate to medical assistants certain intravenous (IV) tasks such as initiating IVs, performing IV infusion, and (in very few states) performing IV injections. In some of these states, medical assistants must meet educational and credentialing requirements in order to be delegated certain IV tasks.

34. Under the laws of some states, providers are permitted to delegate to medical assistants limited-scope radiography. In some of these states, medical assistants must complete a limited-scope radiography course and/or pass a limited-scope radiography examination to be delegated limited-scope radiography.

35. Medical assistants are most often classified as "unlicensed assistive personnel" (UAP) under state nursing laws. This is not usually the case in state medical practice acts and the regulations/rules of the boards of medical examiners.

36. I am not aware of any state law that requires medical assistants to obtain a phlebotomy credential in order to be delegated venipuncture/phlebotomy by a provider in an outpatient setting. In some states, however, phlebotomists *who do not work under direct/onsite provider supervision* must obtain the state-mandated phlebotomy certification.

37. Medical assistants must not refer to themselves as "office nurses" or "doctors' nurses." This is a violation of the nurse practice act and/or the regulations/rules and policies of the state board of nursing.

38. I define *triage* as a communication process with a patient (or patient representative) during which a health care professional is required to exercise independent clinical judgment and/or to make clinical assessments or evaluations. Based on the third bullet of 26 (above), it is my legal opinion that *it is not permissible* for medical assistants to be delegated triage (as I define the term). I define *non-triage communication* as a process during which a non-provider health care professional follows provider-approved protocols or decision trees in verbatim receiving and verbatim conveying of information. In non-triage communication, the health professional does *not* exercise independent clinical judgment. It is my legal opinion that *it is permissible* for knowledgeable and competent unlicensed professionals such as medical assistants to be delegated non-triage communication.

39. It is my legal opinion that it is permissible for providers to delegate to knowledgeable and competent unlicensed professionals such as medical assistants working under their authority and direction in outpatient settings the providing of *patient education* as long as (a) the content of such education has been approved by the delegating provider and (b) the medical assistant is not permitted to exercise independent clinical judgment or to make clinical assessments or evaluations during the education process.

40. It is my legal opinion that medical assistants are permitted to receive and execute *verbal orders* from an overseeing/delegating provider as long as the following conditions are met:

(1) The verbal order is understood by the medical assistant;
(2) The task to be performed is within the medical assisting scope of practice 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.

It is my legal opinion that medical assistants are permitted to receive and execute *standing orders* from an overseeing/delegating provider as long as the following conditions are met:

(1) The standing order is understood by the medical assistant;
(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.

41. The Chronic Care Management (***CCM***) and Transitional Care Management (***TCM***) programs were created to provide reimbursement for services for Medicare recipients who have health needs not included within standard Medicare coverage. Medicare recipients who have "multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, [that] place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline" are eligible for CCM services. Medicare recipients who are being discharged from an inpatient setting and are returning home or to an assisted living (or similar) facility are eligible for TCM services.

The Current Procedural Terminology (CPT) definition of a "*clinical staff*" member is "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." An appropriately educated and

credentialed medical assistant working under provider supervision and authority meets the CPT definition of "*clinical staff*" for two reasons:

(1) The laws of all states permit physicians and non-physician practitioners (NPPs) to delegate to competent and safe medical assistants some tasks that must be performed under *direct/onsite* provider supervision, and some tasks that may be performed under *general* provider supervision.
(2) Medical assistants do not individually report professional services because their services may only be billed *incident to* the services of a provider.

To summarize, appropriately educated and credentialed medical assistants fall within the CPT definition of "clinical staff." Such medical assistants also are "auxiliary personnel" according to chapter 15, section 60.1, "Incident to Physician's Professional Services," of the *Medicare Benefit Policy Manual*. Therefore, it is legally permissible for appropriately educated and credentialed medical assistants to be delegated by a provider (i.e., a physician or a non-physician practitioner) some Chronic Care Management (CCM) and Transitional Care Management (TCM) tasks that are delegable to knowledgeable and competent unlicensed professionals such as medical assistants under state law, and some of the tasks are billable *incident to* the provider's services under CPT Code 99490 (CCM) or CPT codes 99495 and 99496 (TCM).

If you have any questions or would like the documentation for the material references above, contact Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.