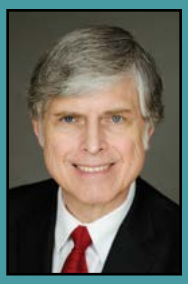
Protecting Medical Assistants' Right to Practice

A Retrospective: Part I



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The American Association of Medical Assistants® (AAMA) mission statement includes providing medical assistant professionals with scope-of-practice protection. The following article recounts highlights of the AAMA's successes in protecting their right to practice on the state level.

Connecticut

The struggle for medical assistants to secure the right to administer injections under Connecticut law is a long—and at times frustrating—saga. At least since the early 1990s, the Connecticut Department of Public Health had taken the position that unlicensed personnel such as medical assistants may not perform medication administration by any means, including by injection.

The Connecticut Society of Medical Assistants (CSMA) and the AAMA worked together to draft legislative language, submit testimony and comments, and engage with communities of interest to permit licensed independent providers to delegate the administration of vaccines to appropriately educated and currently credentialed medical assistants working under provider supervision in outpatient settings.

Finally, through my work on behalf of the AAMA and the dedication of my CSMA colleagues, legislation was passed and went into effect October 1, 2022:

> Sec. 47. (NEW) (*Effective October 1, 2022*) (a) For purposes of this section, "clinical medical assistant" means a person who (1) (A) is certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing or the American Medical Technologists, and (B) has graduated from a postsecondary medical assisting program … that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.
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> (b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370 of the general statutes, a physician assistant licensed pursuant to chapter 370 of the general statutes or an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines. Nothing in this section shall be construed to permit an employer of a physician, a physician assistant or an advanced practice registered nurse to require the physician, physician assistant or advanced practice registered nurse to oversee a clinical medical assistant in the administration of a vaccine without the consent of the physician, physician assistant or advanced practice registered nurse.[1]

Delaware

In Delaware, from 2020 through 2022, an increasing number of advanced practice registered nurses (APRNs)—including nurse practitioners—wanted to delegate to medical assistants the administration of injections. This trend may have been related to the COVID-19 pandemic and the need to meet expanded patient desire for access to care. Unfortunately, the state's nurse practice act lacked clarity in this regard. Accordingly, I wrote the following to the Delaware Board of Nursing in June 2022:

> It is the position of the AAMA that medical assistants who have completed a medical assistant training program that includes medication administration theory and technique, and who have a current national medical assistant certification such as the CMA (AAMA) that tests knowledge needed to safely administer medication, should be permitted to administer medication under the authority of advanced practice registered nurses (APRNs)—including nurse practitioners—and other licensed independent practitioners such as physicians.

The Delaware Board of Nursing subsequently added the following to its regulations:

> 8.7.15.1 APRNs are authorized to assign and supervise medication administration to a medical assistant if the medical assistant has successfully completed a medical assistant training program and possesses current national medical assistant certification.

A Note from the Author

Part II of this article, to be released in a future issue of *Medical Assisting Today*, will profile the AAMA's work in ensuring that credentialed medical assistants were allowed to enter orders into the computerized provider order entry system for meaningful use calculation purposes under the Medicare and Medicaid Electronic Health Record Incentive Programs.

> If a practice is solely operated by APRNs, the APRN must be present in the building when the medical assistant is administering medications and assumes liability for the actions of the medical assistant.
>
> 8.7.15.2 When a physician delegates to a medical assistant, and an organizational policy exists to allow the APRN to assign and supervise the medical assistant, the physician retains responsibility and accountability for the actions of the medical assistant and will be notified of unsafe or improper practices.[2]

Maryland

Similar to Delaware, in 2020 the authority of APRNs to delegate to medical assistants the administration of injections was not clearly established in Maryland law. I worked closely with the Maryland Society of Medical Assistants, the Nurse Practitioner Association of Maryland, and the Maryland Board of Nursing in drafting legislation to remedy this lack of clarity in Maryland law. All bodies representing organized nursing, as well as the Maryland Board of Physicians, supported the bill. It was subsequently enacted, and regulations were then promulgated by the Maryland Board of Nursing that eliminated any uncertainty about APRNs' authority to delegate to medical assistants the administration of injections.

Montana

In 2021, a misinterpretation of Montana medical assisting law was gaining credence within segments of the medical community. Some physicians were interpreting the law to mean that they were permitted to delegate to medical assistants the administration of injections but not the administration of immunizations.

I wrote and disseminated an opinion explaining that the Montana law permitted the administering of immunizations by medical assistants under a physician's *general* supervision, whereas other injections (and the intravenous administration of blood products and medication) could only be performed by medical assistants under the physician's *onsite* supervision. My opinion helped dispel this confusion.

Nevada

Nevada medical assistants were confronted with a grave crisis in 2009. An international medical graduate working as a medical assistant in a medical spa was indicted on nine felony counts for the unlawful practice of medicine for administering cosmetic injections. The Nevada Board of Medical Examiners (BOME) issued the following statement on September 30, 2009:

> **Medical Assistants and Administration of Prescription Drugs**
>
> Recent events have resulted in questions regarding what medical assistants (MAs) may or may not do related to the administration of prescription drugs. The short and correct answer is that MAs may ***NOT*** administer any prescription drugs. This document is intended: (1) to explain the law at issue; and (2) to explain the practical application of this law.
>
> …
>
> **Practical Application of the Laws**
>
> The Board [of Medical Examiners] is aware that most physicians and physician assistants in Nevada were allowing their MAs to administer prescription drugs. Our intent is to make clear that such practices must cease immediately. The practical application of the Nevada law includes the following points:
>
> - MAs may not administer any prescription drugs. MAs may not give injections. MAs may not administer an inhaled drug. MAs may not apply any prescription cream, ointment, or salve. MAs may not apply prescription ophthalmic or otic drops. MAs may not insert prescription suppositories. MAs may not start IVs (because doing so usually involves the use of saline or another product that is a prescription drug.) MAs may not apply or provide prescription drugs to the body of a patient by any other means.[3]

I assisted the Nevada Society of Medical Assistants with the drafting of legislation and regulations of the Nevada BOME. As part of this work, I attended in-person and virtual meetings and hearings of Nevada legislative committees and the BOME.

On October 6, 2009, the president of the Nevada BOME rescinded the September 30 order. Legislation and regulations that protect medical assistants' right to practice were adopted in Nevada and are still in effect.

North Dakota

For many years prior to 2004, North Dakota medical assistants had been permitted to administer intramuscular, intradermal, and subcutaneous injections under the authority and direct supervision of physicians. That changed on March 8, 2004, when the North Dakota attorney general issued an opinion stating that medical assistants would no longer be allowed to administer injections.

I attended a hearing in Jamestown, North Dakota, and worked with the North Dakota Society of Medical Assistants and the North Dakota Board of Nursing to regain medical assistants' right to be delegated injections. This effort was successful.

Nebraska

The fall 2018 *Nebraska Nursing News*, an official publication of the Nebraska Board of Nursing, contained inaccurate statements about the scope of practice of unlicensed personnel such as medical assistants. I responded to these inaccuracies by letter. The following are excerpts from my letter:

> You make the following statement in the [second] section of the first column of page 14:
>
> > Medical Assistants support the practice of licensed health care professionals. They may appropriately perform administrative duties like scheduling and computer entry—or clinical support tasks like rooming patients and collecting data and information from the patient that nursing and medical providers require to inform their plan of care (Nebraska Board of Nursing, July 2018a).[4]
>
> It is my legal opinion that Nebraska law permits physicians to delegate to medical assistants the duties and tasks referenced in the above paragraph. However, it is important to note that the Nebraska Medical Practice Act and the regulations and opinions of the Nebraska Board of Medicine and Surgery do not limit the tasks delegable by physicians to knowledgeable and competent unlicensed professionals such as medical assistants (under the legally-required physician supervision) to "rooming patients and collecting data and information."
>
> The following statements are made in the third column of page 14:

> Verbal orders are prescriptions from APRNs and medical providers responsible for the care of a particular patient with licensure authority to prescribe medications, diagnostic tests and therapeutic interventions. Medical Assistants, like other unlicensed persons, may not accept verbal orders from a licensed prescriber (Nebraska Board of Nursing, 2018b). They may, however, accept and complete a task for which they are otherwise qualified and may lawfully perform in response to a written order from a provider, e.g., phlebotomy to obtain a laboratory specimen.[4]

> The Nebraska Board of Nursing has the authority to forbid all nurses from issuing verbal orders to unlicensed allied health professionals such as medical assistants. However, the Nebraska Board of Nursing does not have the authority to forbid other licensed prescribers (such as physicians) from issuing appropriate verbal orders to knowledgeable and competent medical assistants.

To help eliminate such ambiguities about medical assisting scope of practice, I worked with the Nebraska Society of Medical Assistants and the Nebraska Medical Association in formulating an amendment to the Medical Practice Act. The amendment was enacted into law in 2020.

South Carolina

After medical assisting legislation was enacted in 2022, uncertainty quickly arose over the meaning of some of its provisions. I received the following question and responded as follows:

> [Question]
>
> I have been a Certified Medical Assistant (AAMA)® … since 1993. There were no accredited programs in my area back then, but I did take a review course that … enabled me to pass the [CMA (AAMA) Certification Exam]. With the [new 2022 legislation], my employer is stating that I have to complete a postsecondary medical assistant program to fulfill the state requirements. … I don't see anything in the new law about those who are certified having to go back and complete a postsecondary medical assisting program. I would appreciate it if you could please clarify this for me.
>
> [My response]
>
> Thank you for your question. Note the following from the new South Carolina law:
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> …
>
> B. CMAs include medical assistants who are currently employed in that capacity as of the effective date of this act who do not have the certification required by this Section but who achieve such certification no later than two years after the effective date of this act.
>
> My legal opinion is that … because you have a current CMA (AAMA), you meet the requirements of this section. It is also my opinion that the new law does not require you to go back to school to complete a medical assisting education program.[5]

This ambiguity and lack of clarity in the 2022 South Carolina law was eliminated by legislation enacted in 2024 through my work on behalf of the AAMA alongside the efforts of the South Carolina Society of Medical Assistants.

Tennessee

In 2021 the Tennessee attorney general issued an opinion that medical assistants working in ambulatory hospital outpatient clinics had to be addressed in statute differently from medical assistants working in other ambulatory care settings. I worked with the leaders of the Tennessee Society of Medical Assistants in offering comments on proposed legislation to protect medical assistants' right to practice. The final bill signed into law reads as follows:

> (1) "Certified medical assistant" means personnel with training to function in an assistive role to a licensed physician or nurse in the provision of patient care activities in a facility used as an ambulatory outpatient hospital clinic as delegated by the physician or nurse …
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> (c) A hospital licensed under this title may employ certified medical assistants to administer approved medications to its patients in a facility used as an ambulatory clinic or hospital outpatient department as set forth in this section.
>
> (d) When carrying out responsibilities under this section, a certified medical assistant shall wear a name tag visible to others that displays the designation "certified medical assistant".
>
> (f) To be eligible to register as a certified medical assistant, an applicant must:
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> (1) Be at least eighteen (18) years of age;
>
> (2) Have completed the twelfth grade or its equivalent, or have successfully passed the test for and received a general equivalency diploma; and
>
> (3) Be certified by the:
>
> (A) American Medical Technologists (AMT);
>
> (B) American Association of Medical Assistants (AAMA);
>
> (C) National Center for Competency Testing (NCCT);
>
> (D) National Healthcareer Association (NHA); or
>
> (E) National Association for Health Professionals (NAHP).[6]

Conclusion

In summary, the concerted work of the AAMA and its component state societies is essential to ensuring (and enhancing) medical assistants' right to practice their profession in the service of patients. In cases of confusion, crisis, or unclear state legislation concerning medical assisting scope of practice, the AAMA stands ready to marshal its estimable forces and help bring clarity to state laws, with patient access to safe and high-quality medical care at the forefront. ✦

Questions may be directed to CEO and Legal Counsel Donald A. Balasa, JD, MBA, at DBalasa@aama-ntl.org.

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