

The Lawful Scope of Practice of Medical Assistants — 2012 Update

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[Editor's note: The following is a substantially updated and expanded version of an article originally published in March 1996 and previously updated in the March 2003 issue of AMT Events.]

The AMT office frequently receives inquiries from Registered Medical Assistants about the lawful extent of their clinical practice scope. Typical of such inquiries are the following:

- The state nurses' association says that medical assistants aren't allowed to give injections. Is this correct?
- Is a medical assistant permitted to start an IV?
- Am I allowed to perform "scratch tests" for allergies?
- Can medical assistants do pulmonary function testing?
- What types of laboratory testing are medical assistants qualified to perform?

For better or worse, there is no universal answer to these questions. There is no uniform, national definition of a medical assistant's scope of practice. These types of inquiries usually must be answered by reference to the particular laws and customs of the state in which the medical assistant works. With respect to diagnostic lab testing, in addition to any applicable state laws, an MA's qualifications to perform a particular test depends on whether he or she meets the applicable criteria for testing personnel under the CLIA regulations.

In a vast majority of states, medical assistants may perform basic clinical procedures under the direct supervision of a licensed medical practitioner (e.g., physician, osteopath, podiatrist, and in some cases physician assistants or nurse practitioners). However, the legal framework governing the delegation of clinical tasks to unlicensed assistive personnel varies greatly from state to state. While most states still don't have laws or regulations specifically addressing the practice of medical assisting, the number of states with such laws has continued to grow in recent years. Many states that do not address medical assisting by name nevertheless have statutes or rules acknowledging a licensed practitioner's authority to delegate clinical tasks to an unlicensed assistant, as long as certain conditions are met.

State laws affecting the scope of medical assisting practice generally fall into one of three categories:

1. Laws that expressly recognize the practice of medical assisting and list some of the specific clinical functions that properly qualified medical assistants may perform;
2. Provisions in state practice acts that preserve the right of licensed practitioners to delegate basic clinical tasks to unlicensed assistants or exempt such assistants' performance of delegated tasks from legal definitions of unauthorized practice; or
3. Laws governing licensed practitioners of the healing arts that are totally silent as regards the delega-

tion of clinical tasks to unlicensed personnel.

Recent Laws Expressly Recognizing Medical Assisting

When we last published a survey of state laws in 2003, there were just seven states (Arizona, California, Florida, Maryland, New Jersey, South Dakota, and Washington) that had statutes or regulations directly addressing the practice of medical assisting. Since then, four more states have passed laws recognizing a clinical practice scope for medical assistants: Arkansas, Montana, Georgia and Nevada. In addition, earlier this year the State of Washington enacted comprehensive medical assisting legislation that will replace that State's previous, unwieldy scheme for regulating "health care assistants." A brief survey of MA-specific laws follows, starting with the most recent developments.

Washington — On March 29, 2012, Governor Christine Gregoire signed into law Senate Bill 6237, described as an Act creating a career pathway for medical assistants. The new law replaces the prior scheme of registering seven different categories of health care assistants (HCAs) with a new system for certification or registration of four separate levels of medical assistants. The new categories are: (1) medical assistant-certified; (2) medical assistant-phlebotomist; (3) medical assistant-hemodialysis technician; and (4) medical assistant-registered. The Washington Department of Health will administer the program for certifying or registering medical assistants in appropriate categories. Individuals currently registered with the Department as HCAs will be grandfathered into a corresponding category of MA, and the HCA registrations will be discontinued.

To qualify as a **medical assistant-certified**, an individual must complete a medical assisting training program approved by the Health Department, pass a certification exam approved by the Department, and meet any additional requirements imposed by regulations to be developed by the Department. The scope of practice of the medical assistant-certified may encompass a broad range of clinical procedures, including capillary blood withdrawal, venipuncture, intradermal, subcutaneous and intramuscular injections, EKGs, respiratory testing, lab tests classified as "waived" under CLIA, and administering medication only by unit or single dosage, or by a dosage calculated and verified by a health care practitioner. A medical assistant-certified may also administer intravenous injections for diagnostic or therapeutic agents, if he or she meets minimum standards to be established by rule.

A licensed practitioner must certify to the Department the scope of clinical procedures that an individual medical assistant-certified is competent to perform, which may be less inclusive, but not more inclusive, than the list

of procedures set forth in the law. The certification is portable from one employer to another.

The **medical assistant-registered** category is for assistive personnel who do not meet all the qualification requirements for the certified category but whose current employer attests the individual is competent to perform basic clinical procedures. The scope of practice for medical assistant-registered is more limited than for medical assistant-certified. It cannot include, for example, venipunctures, capillary blood draws, or injections other than vaccines. An individual's scope of practice is further limited by the endorsement received from his or her current employer. Unlike with the medical assistant-certified, the employer endorsement for a medical assistant-registered is not portable and must be renewed by each new employer.

While the new statute is an improvement over the prior system of registering HCAs, the unfortunate use of the terms "certified" and "registered" to distinguish more highly-trained MAs from those with lesser education and skills is bound to create confusion. It should be emphasized that the legislative distinction between "medical assistant-certified" and "medical assistant-registered" has nothing to do with private, voluntary credentials (e.g., whether someone is credentialed as a Certified Medical Assistant by the AAMA or as a Registered Medical Assistant by AMT). But the public is bound to be misled by the statutory titles, and it is extremely important for RMAs in



Washington State to educate employers that, regardless of the title of your credential, you are indeed "certified," and not just "registered." Indeed, most RMAs who have completed a medical assistant education program at an accredited institution should qualify as medical assistant-certified. Those who have previously been registered with the State as a Category C, D, E, or F health care assistant will be grandfathered as medical assistant-certified.

The **medical assistant-phlebotomist** is essentially a phlebotomy technician, who may perform capillary, venous, or arterial invasive procedures for blood withdrawal when delegated and supervised by a licensed health care practitioner. The qualifications for this category will be determined by rulemaking. Individuals holding AMT's Registered Phlebotomy Technician (RPT) credential should qualify, and those currently registered as a Category A or B health care assistant will be grandfathered as MA-phlebotomists. (This article will not discuss the medical assistant-hemodialysis technician category, as it is not part of traditional medical assisting practice and we believe relatively few RMAs will be affected by it.)

The Washington statute includes a broad definition of licensed "health care practitioner" that can delegate tasks

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to medical assistants. Such practitioners can include physicians, doctors of osteopathy, and (to the extent acting within the scope of their respective licensure) podiatrists, registered nurses, or advanced registered nurse practitioners, naturopaths, physician assistants, osteopathic physician assistants, and optometrists.

Georgia — In 2009 the Georgia legislature added a new section to that state's Medical Practice Act for the express purpose of clarifying the role of medical assistants. The new provision makes clear that MAs may perform "medical tasks, including subcutaneous and intramuscular injections; obtaining vital signs; administering nebulizer treatments; or other tasks approved by the board pursuant to rule, if under the supervision by a physician in his or her office." The law also clarifies that "supervision" does not necessarily require on-site supervision at all times. It also provides that MAs may perform medical tasks ordered by a physician assistant or advanced practice registered nurse with authority to delegate such tasks.¹

The new law authorized the Georgia Composite Medical Board to approve by rule other clinical tasks a medical assistant may perform in addition to those quoted above. To date, the Board has not adopted a regulation expanding the scope of functions MAs may perform. However, the Georgia Medical Practice Act still contains a general provision preserving a physician's right "to delegate to a qualified person any acts, duties, or functions which are otherwise permitted by law or established by custom."²

Arkansas — For many years, a cloud existed over the right of physicians to delegate clinical tasks to medical assistants in Arkansas. The state nurses' association periodically claimed that that administering injections fell within the scope of nursing practice, and that unlicensed assistants were therefore prohibited from giving them. The absence of a state law addressing a physician's right to delegate left the State Medical Board with little guidance to go on, leading to frequent disputes.

All of that changed in 2009 when the Arkansas General Assembly enacted an amendment to the Arkansas Medical Practices Act, creating a statutory basis for physician delegation to medical assistants. The amendment directs the Arkansas State Medical Board to adopt rules that "establish standards to be met and procedures to be followed by a physician with respect to the physician's delegation of the performance of medical practices to a qualified and properly trained employee who is not licensed or otherwise specifically authorized by the Arkansas Code to perform the practice."³ The amendment goes on to set forth a number of parameters the Board is required to follow in adopting regulations with

respect to supervision of the unlicensed employee, limits on the types of drugs that can be administered by the assistant, prohibiting delegation of anesthesia administration, and so forth.

The Arkansas State Medical Board responded by adopting Regulation 31 in February 2010. Titled the "Physician Delegation Regulation," Regulation 31 defines "Medical Assistant" as "an employee of a Physician who has been delegated medical practices or tasks, and who has not been licensed by or specifically authorized to perform the practice or task pursuant to other provisions of Arkansas law." Rather than set forth a defined scope of practice for medical assistants, Regulation 31 established mandatory guidelines for physicians to follow in delegating tasks while leaving the physician with substantial discretion to determine what procedures may be delegated to a particular assistant. Among the guidelines that must be observed are:

- The delegating physician remains responsible for the acts of the employee;
- The employee must not be represented to the public as a licensed practitioner;
- The task to be delegated is within the physician's authority to perform;
- The assistant to whom the task is delegated is qualified and properly trained to perform the task;
- The medical assistant cannot re-delegate a task to another unlicensed person, nor can the delegating physician transfer responsibility for supervising the assistant except to another physician who is qualified and has knowingly accepted that responsibility;
- With respect delegating the administration of drugs:
 - (a) The physician may delegate only the administration of drugs that do not require substantial, specialized judgment and skill based on knowledge and application of the principles of biological, physical and social sciences;
 - (b) Administration of drugs by delegation must occur within the physical boundaries of the delegating physician's offices;
 - (c) The physician must evaluate the acuity of the patient, as well as the competency of the person to whom administration of the medication is being delegated.

This is just a partial listing of the more important provisions of the regulation. Arkansas medical assistants and their employers can review the entire text of Regulation 31 and § 17-95-208 of the Medical Practices Act on the State Medical Board's website.⁴

Nevada — In recent years, the ability of Nevada medical assistants to administer injections had been questioned, and even temporarily suspended by the Nevada State Board of Medical Examiners. Controversy had arisen over the widespread use of medical assistants in that

state to administer Botox and other cosmetic “fillers,” often in “spa” settings without adequate supervision by a licensed physician. On September 30, 2009, the Nevada Board issued a policy statement declaring that medical assistants may *not* administer *any* prescription drugs, by injection or otherwise. Six days later, in the face of intense political pressure, the Board issued a statement rescinding the September 30 notice, restoring medical assistants’ ability to administer medications under certain parameters, and announcing that the Board would undertake a rulemaking to address the use of medical assistants by physicians and physician assistants.

After several abortive attempts by the Board to promulgate medical assisting regulations, the Nevada Legislature took matters into its own hands and passed Senate Bill 294 on the final day of the 2011 session. The bill confirms the authority of medical assistants to possess and administer “dangerous drugs” (i.e., any medication requiring a prescription, other than controlled substances) “at the direction of the prescribing physician and under the supervision of a physician or physician assistant.”⁵ SB 294 authorized the Board of Medical Examiners and the State Board of Osteopathic Medicine to develop regulations further addressing the delegation of administration of dangerous drugs to MAs (as of this writing, neither board had initiated such rulemaking proceedings). The bill also creates a statutory definition of “Medical assistant”: an unlicensed person who performs clinical tasks under the supervision of a physician, an osteopathic physician, or a physician assistant; and does not include a person who performs only administrative, clerical, executive or other nonclinical tasks.⁶

Montana — Prior to 2003, a lack of statutory guidance had muddied the waters in Montana with regard to the functions a physician could delegate to unlicensed assistants. That year the State Legislature enacted an amendment to the Medical Practice Act directing the Board of Medical Examiners to adopt guidelines for “the performance of administrative and clinical tasks by a medical assistant that are allowed to be delegated by a physician or podiatrist, including the administration of medications.”⁷

The Montana Board adopted a final rule in March 2006 establishing delegation guidelines as directed by the legislature.⁸ The rule contains both general standards for delegation or routine tasks, and specific requirements and limitations with respect to delegation of invasive procedures, drug administration, and allergy testing. As a general matter:

The supervising physician or podiatrist is responsible for determining the competency of a medical assistant to perform the administrative and clinical tasks assigned to the medical assistant. . . . A physician (or podiatrist) may only assign tasks that the physician (or podiatrist) is qualified to perform and tasks that the physician (or podia-

trist) has not been legally restricted from performing. Any tasks performed by the medical assistant will be held to the same standard that is applied to the supervising physician or podiatrist.

The Montana rule provides that supervision of tasks assigned to medical assistant must be “active and continuous,” but does not require the actual presence of the delegating practitioner, except that the supervising physician or podiatrist must be “onsite” - i.e., “in the facility and quickly available to the person being supervised” - when a MA: (a) performs invasive procedures; (b) administers medicine; or (c) performs allergy testing. In addition, a delegating practitioner must exercise “direct” supervision - defined as being within audible and visible reach of the person being supervised (and not merely “onsite”) - when the MA is performing conscious sedation monitoring or administering fluids or medications through an IV.

The Montana regulation prohibits MAs from providing care to an inpatient in an acute care hospital, or administering blood products by IV. The MA is also barred from delegating to another unlicensed person any task assigned to the MA by a licensed practitioner.

Review of “Older” Medical Assisting Practice Laws

Among the first states to enact laws officially recognizing a scope of practice for medical assistants were **South Dakota** and **Florida**. Both states’ statutes provide a fairly extensive, non-exclusive list of administrative and clinical duties a MA may perform under supervision of a licensed physician. Among others, the clinical tasks mentioned in both states’ laws include performing aseptic procedures; venipunctures and nonintravenous injections; collecting routine laboratory specimens; performing basic laboratory procedures; and administering medications as directed by a physician. The Florida law also lists dialysis procedures, including home dialysis.

The South Dakota statute requires individuals to register with the State Board of Medical and Osteopathic Examiners before practicing as a medical assistant. A modest initial registration fee of \$10.00 is assessed, and the registration may be renewed biannually for a fee of \$5.00. Qualifications for registration include graduation from an accredited school or a school which meets standards similar to an accredited school, and compliance with such qualifications as may be established by the Board of Medical and Osteopathic Examiners and the Board of Nursing.

A Joint Board committee of the South Dakota medical and nursing boards has issued a series of determinations further defining the medical assistant’s scope of practice. Among other clarifications, the committee ruled that MAs may perform skin testing by intradermal or scratch techniques; may perform EKG’s and glucose testing; may

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administer medications from either a single or multi-dose vial as long as the supervising physician assures appropriate training and competence, and assumes ultimate responsibility for administration of such drugs. MAs may not administer medications which require calculation of a dose; may not inject insulin; and may not perform arterial withdrawal of blood.⁹

The Florida law does not require medical assistants to register with the state nor does it prescribe minimum qualifications, but it expressly recognizes that MAs may be certified as a Registered Medical Assistant by AMT or as a Certified Medical Assistant by the American Association of Medical Assistants (AAMA).¹⁰

In **New Jersey**, pursuant to regulations of the State Board of Medical Examiners, a “certified medical assistant” may administer subcutaneous and intramuscular injections under the supervision of a physician. The physician must be on premises and within reasonable proximity to the treatment room at all times that a medical assistant is administering injections. The assistant may not inject certain substances, including any substance related to allergenic testing or treatment, local anesthetics, controlled substances, experimental drugs, or any antineoplastic chemotherapeutic agent other than corticosteroids.

To qualify as a “certified medical assistant” in New Jersey, an individual must be a graduate of a post-secondary medical assisting program accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP), the Accrediting Bureau of Health Education Schools (ABHES), or other accrediting organization approved by the U.S. Department of Education. Medical assistants also must be currently certified by either AMT, the AAMA, the National Center for Competency Testing (NCCT), or other certifying body recognized by the State Board of Medical Examiners.¹¹

In **Arizona**, there are separate laws and regulations governing medical assisting in each of four different fields of medicine: allopathic, osteopathic, homeopathic, and naturopathic. Homeopathic and naturopathic medical assistants must have specialized training in those disciplines and must be either registered or certified by the respective State Boards of Medical Examiners for those disciplines.

Medical assistants working for allopathic (traditional physicians) and osteopathic practitioners in Arizona need not be registered or certified by the applicable Board, but must possess certain qualifications. Under regulations of both the Arizona Medical Board¹² and the Board of Osteopathic Examiners,¹³ medical assistants must meet one of the following requirements: (1) complete an edu-

cation program accredited by ABHES, CAAHEP, or another accrediting agency recognized by the U.S. Department of Education; (2) complete an Armed Forces medical services training program; or (3) hold RMA(AMT) or CMA(AAMA) certification.

Medical assistants may, under the direct supervision of a physician, osteopath, or physician assistant, perform the medical procedures listed in the 2003 revision of CAAHEP’s *Standards and Guidelines for an Accredited Educational Program for the Medical Assistant*, Section (III)(C)(3)(a) through (III)(C)(3)(c).” Besides the tasks listed in the CAAHEP Standards, medical assistants in Arizona may perform the following additional procedures under direct supervision: whirlpool treatments, diathermy treatments, electric galvanation stimulation treatments, ultrasound therapy, massage therapy, traction treatments, transcutaneous nerve stimulation unit treatments, and small volume nebulizer treatments.

In **California**, the legislature recognizes a core scope of practice for medical assistants,¹⁴ and the Medical Board has prescribed minimal training requirements for such basic procedures as intramuscular, subcutaneous, or intradermal injections; skin tests; or venipuncture for withdrawing blood. The basic required training includes 10 clock-hours of training in each of administering injections and phlebotomy, as well as successful performance of at least 10 each of intramuscular, subcutaneous and intradermal injections; 10 venipunctures; and 10 skin punctures (finger-sticks).

In addition to these core functions, a medical assistant in California may perform “additional supportive services,” provided that the MA has received supplemental training which the employer determines is sufficient for the particular task to be delegated. These additional supportive services may include, among others: administration of medication other than by injection, EKGs, EEGs, plethysmography tests (other than full-body), removal of sutures and staples, applying and removing dressings and bandages, orthopedic appliances, etc., performing ear lavage, collecting and preserving specimens for testing, performing simple laboratory and screening tests, and cutting patients’ nails. The supplemental training may be administered in an accredited vocational school or by a medical assistant who is certified by an approved certification organization, including AMT.¹⁵

In **Maryland**, the state Board of Physicians (formerly the Board of Physician Quality Assurance) administers regulations providing for a broad scope of functions that physicians may delegate to medical assistants under various levels of supervision.¹⁶ The Maryland rules do not establish particular education, training or certification requirements for MAs, leaving it up to the supervising physician to insure that their assistants are properly qual-

ified to perform whatever clinical tasks are delegated. The regulations do, however, contain fairly comprehensive lists of functions that may be delegated under various levels of supervision.

Compared with other states, the Maryland board permits doctors to assign relatively sophisticated clinical tasks to MAs with “on-site” supervision (meaning the physician is “present at the site and able to be immediately available in person during the performance of a delegated act”). Those tasks include, in addition to standard non-intravenous injections, administering small doses of local anesthetics, establishing peripheral intravenous lines, and injecting fluorescein-like dyes for retinal angiography. With “direct” supervision (i.e., the physician is in the immediate presence of the MA and the patient), a medical assistant may also inject IV drugs or contrast materials. These are in addition to a host of more routine, non-invasive tasks that may be delegated without direct or even on-site supervision.

State Laws Permitting General Delegation of Clinical Functions

While the foregoing states have laws or regulations expressly recognizing a role for medical assistants, a greater number of states have statutes that more generally allow physicians (and in many cases, other licensed practitioners) to delegate clinical tasks to unlicensed personnel.

Some states’ laws explicitly authorize delegation to assistive personnel under specified conditions. These include: Alaska, Illinois, Massachusetts, Maine, Michigan, Ohio, Pennsylvania, South Carolina, Texas, and Virginia.

Other states effectively allow such delegation by exempting from licensing requirements and unauthorized practice prohibitions the performance of routine clinical duties by unlicensed personnel under the supervision of a licensed practitioner. States with such exemptions include: Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, and Wisconsin. It should be emphasized that simply because a state is not listed above does not necessarily mean it has no statute or rule allowing physician delegation. There may be others; these are simply the ones that have come to our attention over the years while representing the interests of RMAs.

Ohio has one of the most comprehensive regulations governing the delegation of medical tasks. The State Medical Board rule, which apply to physicians, osteopaths and podiatrists, includes the following stipulations:¹⁷

Prior to a physician’s delegation of the performance of a medical task, that physician shall determine each of the following:

- (1) That the task is within that physician’s authority;

- (2) That the task is indicated for the patient;
- (3) The appropriate level of supervision;
- (4) That no law prohibits the delegation;
- (5) That the person to whom the task will be delegated is competent to perform that task; and,
- (6) That the task itself is one that should be appropriately delegated when considering the following factors:
 - (a) That the task can be performed without requiring the exercise of judgment based on medical knowledge;
 - (b) That results of the task are reasonably predictable;
 - (c) That the task can safely be performed according to exact, unchanging directions;
 - (d) That the task can be performed without a need for complex observations or critical decisions;
 - (e) That the task can be performed without repeated medical assessments; and,
 - (f) That the task, if performed improperly, would not present life threatening consequences or the danger of immediate and serious harm to the patient.

The Ohio rule further requires that a physician shall provide onsite supervision when delegating the administration of drugs, with limited exceptions, e.g., the administration of a topical drug such as medicated shampoo. The conditions under which the Ohio rule allows delegation are typical of those adopted in other states, although somewhat more detailed than most. Other states with relatively comprehensive delegation laws include **Illinois**,¹⁸ **Pennsylvania**,¹⁹ **Michigan**²⁰ and **Texas**.²¹

Typical of jurisdictions that allow delegation through various forms of statutory exemptions is **Indiana**, whose Medical Practice Act includes the following exclusion:²²

This article, as it relates to the unlawful or unauthorized practice of medicine or osteopathic medicine, does not apply to any of the following:

* * * *

- (20) An employee of a physician or group of physicians who performs an act, a duty, or a function that is customarily within the specific area of practice of the employing physician or group of physicians, if the act, duty, or function is performed under the direction and supervision of the employing physician or a physician of the employing group within whose area of practice the act, duty, or function falls. An employee may not make a diagnosis or prescribe a treatment and must report the results of an examination of a patient conducted by the employee to the employing physician or the physician of the employing group under whose supervision the employee is working. An employee may not administer medication without the specific order of

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the employing physician or a physician of the employing group. * * * *

Utah presents a particularly interesting example of a state that authorizes delegation through exemptions. Utah specifically exempts a “medical assistant” from licensure under three separate practice acts: the Medical Practice Act, the Osteopathic Medical Practice Act, and the Physician Assistant Act. The two medical practice laws provide licensing exemptions for “a medical assistant while working under the direct and immediate supervision of a licensed [or osteopathic] physician and surgeon, to the extent the medical assistant is engaged in tasks appropriately delegated by the supervisor in accordance with the standards and ethics of the practice of medicine.”²³ The Utah Physician Assistant Act similarly exempts from licensing any medical assistant who is working under the direct supervision of a physician; does not diagnose, advise, independently treat, or prescribe medication to or on behalf of any person; and for whom the supervising physician accepts responsibility.²⁴ Each act defines “medical assistant” as “an unlicensed individual working under the direct and immediate supervision of a licensed [or osteopathic] physician and surgeon, and engaged in specific tasks assigned by the licensed [or osteopathic] physician and surgeon in accordance with the standards and ethics of the profession.”²⁵

It should be noted that in some states, the legal provision allowing a physician to assign tasks to an unlicensed assistant does not appear in the medical practice act, but in the practice act of another licensed profession such as physician assistant or nursing. For example, the only pertinent statutory reference we can find in **Oregon** is in the Physician Assistant Act, which exempts from licensing “an employee of a person licensed to practice medicine . . . , or of a medical clinic or hospital . . . , unless the employee is practicing as a physician assistant in which case the individual shall be licensed”²⁶ Similarly, the **Louisiana** Physician Assistant Act provides that: “Nothing herein shall prohibit or limit the authority of physicians to employ auxiliary personnel not recognized under this Part.”²⁷ The **Alabama** nursing practice law includes an exemption for “persons, including nursing aides, orderlies and attendants, carrying out duties necessary for the support of nursing services”²⁸

Delegation under Nursing Practice Laws

Although the traditional role of a medical assistant is as an auxiliary to a licensed physician who supervises and remains professionally and legally responsible for the actions of the MA, in many jurisdictions MAs may also accept delegated tasks from a registered nurse or nurse

practitioner. Delegation of clinical duties in those cases is controlled by state nursing practice laws - and the legal relationship is between MA and nurse, not MA and physician. A number of state nursing boards have developed policies on nurses’ delegation of duties to unlicensed assistive personnel, and in January 2012 the American Nurses Association issued draft Principles for Delegation by Registered Nurses to Unlicensed Assistive Personnel. The delegation of nursing functions to MAs is beyond the scope of this article; however, a couple of state regulatory scenarios deserve mention here.

Alaska’s regulatory scheme is noteworthy because it not only preserves the physician’s right to utilize unlicensed assistants,²⁹ but also includes provisions in the Nursing Board rules authorizing the delegation of nursing duties to appropriately trained unlicensed personnel. In addition to providing for delegation of routine and specialized nursing duties under specified conditions, the nursing rules permit an advanced nurse practitioner to delegate administration of injectable medication to a certified medical assistant.³⁰ The term “certified medical assistant” is defined as “a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section.” (All of AMT’s certification programs, including the RMA, are accredited by NCCA.) Besides holding an accepted national certification, a medical assistant to whom the administration of an injectable medication may be delegated must successfully complete a training course in administration of medication approved by the nursing board.

The status of MAs in **North Dakota** is particularly unusual, inasmuch as it appears to be the only state where delegation of injections is within the exclusive purview of the nursing profession. For many years physicians in that state were assumed to have authority to delegate injections to MAs, but they were effectively deprived of that authority in 2004 by an Attorney General’s interpretation of the state’s medical practice act. Shortly thereafter, largely at the urging of the medical assisting community, the North Dakota Board of Nursing agreed to amend its existing rules regarding the delegation of medication administration to “medication assistants.” The rules were supplemented to create a new category known as “Medication Assistant III,” the qualifications for which include individuals (1) with two years of nursing education, or (2) who have completed a board-approved medical assistant education program and hold the RMA(AMT) or CMA(AAMA) certification. In addition to a number of routine medication routes, a Medication Assistant III may administer drugs via intramuscular, subcutaneous and intradermal injections, as well as gastronomy and jejunostomy. A complete list of authorized and prohibited med-

ication routes is available on the North Dakota legislature's website.³¹

In 2007, **New Hampshire** nearly became the first state to enact licensure for medical assistants. By the time AMT became aware of the legislation, the licensure bill already had passed the state Senate and was scheduled to be reported by a committee of the New Hampshire House of Representatives within a few days. After reviewing the legislation, AMT determined it should oppose the bill because it would have given the state Board of Nursing total control of the licensing program, including virtually unlimited authority to define the scope of practice, educational prerequisites, and examination requirements for licensed medical assistants. (The AAMA supported the bill, largely because of the recent successful collaboration between medical assistants and the North Dakota nursing board discussed above.) After AMT registered its opposition with each member of the House committee, that body decided not to pass the bill onto the House floor for a vote, and the bill therefore died. Despite the bill's failure, the New Hampshire nursing board has continued to work with the medical assisting community to develop protocols for delegation of clinical duties. The board recently issued a document entitled, *Toolkit: Licensed Nurses, Medical Assistants and Delegation: Safe and Effective Teamwork*, which is accessible on the board's website.³²

States Without Laws Addressing Delegation to Unlicensed Assistants

While the above survey does not purport to identify each and every state that may have a law addressing physician delegation to unlicensed personnel, the inevitable fact is that a handful of states have no law or regulation either directly or implicitly authorizing such delegation. In most of those cases, it can nevertheless be assumed that common law customs support the physician's right to assign tasks to a medical assistant, provided that: (1) the MA is qualified by education and/or training to perform the delegated tasks; (2) the delegated functions fall within the scope of practice of the licensed practitioner who assigns the tasks; (3) the tasks will be performed under the licensee's supervision; and (4) the performance of the task by an unlicensed individual is not expressly prohibited by law. **Missouri** is a good example of a state whose laws appear to be silent on delegation,³³ but where large numbers of RMAs have enjoyed a comprehensive scope of practice for many years.

Unfortunately, there are several jurisdictions in which this common law presumption is not observed and physicians are denied the right to delegate injections and other clinical functions to MAs. **New York** is a prime example. Medical assistants have long struggled to have a scope of practice recognized in the Empire State that matches their

training and skills. In April 2010, the Executive Secretary to the New York State Board for Medicine issued an official Practice Alert and Guidelines reaffirming the board's longstanding position on the limited scope of functions that can be delegated to MAs. Although MAs in New York may take vital signs and obtain laboratory specimens, including venipunctures, the board emphasized that they may not perform any of the following:

- triage,
- administering medications through any route,
- administering contrast dyes or injections of any kind,
- placing or removing sutures,
- taking x-rays or independently positioning patients for x-rays,
- applying casts,
- first assisting in surgical procedures.

In response to a specific inquiry by AMT Board of Directors member Janet Sesser, RMA, on behalf of a New York RMA last October, the medical board's executive secretary further stated that pulmonary function testing and allergy "scratch" testing are outside the lawful scope of a medical assistant's practice in New York.

Connecticut is another state in which physicians' ability to delegate clinical functions to MAs has been limited considerably. As in New York, a cloud has long existed over Connecticut MAs' practice scope, and in 2011 the Connecticut Department of Public Health issued an interpretive memorandum that noted, among other things:

Section 20-9 of the General Statutes of Connecticut dictate to whom a licensed physician may delegate aspects of care. Medical assistants are not identified in that listing of providers. * * * * Examples of specifically prohibited activities are radiography and medication administration by any route (including oxygen, immunizations, and tuberculin testing). * * * *

Nebraska is an additional jurisdiction where the ability of medical assistants to administer medication, including by injection, has been called into question. Last year, the Director of Public Health in Nebraska's Department of Health and Human Services engaged in correspondence with the program director of an accredited medical assisting education program in that state. The DHHS Director noted that state law prohibits a licensed healthcare provider from allowing an unlicensed individual to perform activities that require a state credential. She took issue with the school administrator's claim that a MA can administer any type of medication, including intravenous chemotherapy and IV moderate sedation. The Director suggested that the provision of medication can only be delegated by a Registered Nurse to a registered Medication Aide under Nebraska's Medication Aide Act. She went on to suggest

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that MAs, under direction of a licensed practitioner, may perform only “auxiliary” tasks such as “measuring vital signs, drawing blood, and assisting individuals with activities of daily living.”

However, subsequent correspondence from the legal counsel for the Nebraska Medical Association emphasized that the Director’s response was focused primarily on the inability of MAs to administer intravenous medications, which he noted is “a far different issue than whether medical assistants can give injections in a physician’s office.” The attorney went on to note that, “The NMA is unaware of any physician who has had difficulties with the DHHS concerning use of medical assistants.”

During the H1N1 influenza outbreak in 2009, the **District of Columbia** Department of Health issued a memorandum listing various professions and occupations that are and are not legally authorized to administer vaccines in that jurisdiction. Medical assistant was listed as *not* being authorized, with the comment: “Medical assistants are not licensed in the District and no authority exists for them to give immunizations.” As of this writing, the memo was still posted on the Department’s website.³⁴ The author is unaware, however, of any chronic issues with recognition of MAs’ practice scope in D.C. It is possible that the memorandum was intended to address the administration of vaccines in health-fair or portable clinic settings where a physician is not readily available to supervise those giving the flu shots.

Clinical Laboratory Testing

Many doctors’ offices perform laboratory testing on-site. The question often arises as to what types of lab testing a medical assistant is qualified to perform.

The AMT Board of Directors has adopted an official policy that Registered Medical Assistants are qualified, on the basis of their entry-level education and training, to perform only laboratory procedures classified as “waived” under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Waived tests are those which the U.S. Department of Health and Human Services (HHS) has determined are relatively simple to administer, require minimal scientific and technical knowledge to perform, and pose little risk of harm to the patient if performed incorrectly.³⁵

This does not necessarily mean, however, that RMAs can never become qualified to perform more complex lab tests. With the requisite additional training and experience, medical assistants may acquire the knowledge and skills needed to perform tests classified as “moderately complex” under CLIA. (Most lab tests performed in physicians’ offices are either waived or moderately complex.) An individual may conduct moderately complex test pro-

Table 1

STATE LAWS AND/OR REGULATIONS EXPRESSLY RECOGNIZING MEDICAL ASSISTING PRACTICE	
Arizona	Ariz.Rev. Stat. § 32-1456 (statute); Az. Admin. Code §§ R4-16-401, R4-16-402 (Medical board rule); Az. Admin. Code §§ R4-22-110, R4-22-111 (Osteopathic medical board rule)
Arkansas	Ark.Code Ann. § 17-95-208 (statute); Regulation 31 (State Medical Board rule)
California	Cal. Bus. & Prof. Code §§ 2069-2071 (statute); 16 C.C.R. §§ 1666-1666.4 (rule)
Florida	Fla. Stat. § 458.3485
Georgia	Ga. Code Ann. § 43-34-44; see also § 43-34-23(f) (preserves physician’s right to delegate tasks to UAPs)
New Jersey	N.J. Admin. Code § 13:35-6.4
Maryland	Code of Md. Regs. §§ 10.32.12.01–10.31.12.05
Montana	Mont. Code Ann. § 37-3-104 (statute); A.R.M. § 24.156.640 (rule)
Nevada	Nev. Rev. Stat. § 454.213(22)
North Dakota*	N.D. Admin. Code Ch. 54-07-05 (Nursing board rule)
South Dakota	S.D. Codified Laws §§ 36-9B-1–36-9B-9 (statute); see also: http://doh.sd.gov/boards/Nursing/medasst.aspx (MA practice scope determinations by Joint Board Committee of state medical & nursing boards)
Washington	SB 6237, enrolled as Chapter 153, Laws of 2012 (to be codified as a new chapter in Title 18, R.C.W.)

* North Dakota treats medical assistants as “Medication Assistant IIs” under Nursing Board rules.

STATE LAWS AND/OR REGULATIONS GENERALLY ALLOWING PHYSICIAN DELGATION TO UNLICENSED ASSISTIVE PERSONNEL (UAPs)	
Alaska	12 Alaska Admin. Code § 40.480(b)
Illinois	225 Ill. Comp. Stat. § 60/54.2 (statute); 68 Ill. Admin. Code § 1285.335(f) (rule).
Massachusetts	243 C.M.R. § 2.07
Maine	32 Me. Rev. Stat. Ann. § 3270-A
Michigan	Mich. Comp. Laws § 333.16215
Ohio	Ohio Admin. Code § 4731-23-02
Pennsylvania	63 Pa. Cons. Stat. § 422.17 (statute); 49 Pa. Code § 18.402 (rule).
South Carolina	S.C. Code Ann. § 40-47-30
Texas	Tex. Occ. Code § 157.001 (General Authority of Physician to Delegate); § 157.002 (Delegation of Admin. of Dangerous Drugs)
Virginia	Va. Code Ann. § 54.1-2901

STATE LAWS AND/OR REGULATIONS EXEMPTING UAPs’ PERFORMANCE OF DELEGATED TASKS FROM LICENSURE REQUIREMENTS OR UNAUTHORIZED PRACTICE PROHIBITIONS	
Colorado	Colo. Rev. Stat. § 12-36-106
Hawaii	Haw. Rev. Stat. § 453-5.3
Idaho	Idaho Code § 54-1804
Indiana	Ind. Code § 25-22.5-1-2(a)
Kansas	Kan. Stat. Ann. § 65-2872
Louisiana	La. Rev. Stat. § 37:1360.38
New Mexico	N.M. Stat. Ann. § 61-6-17
North Carolina	N.C. Gen. Stat. § 90-18(c)(13)
Oklahoma	59 Okla. Stat. § 492
Oregon	Or. Rev. Stat. § 677.505
Rhode Island	R.I. Gen. Laws § 5-54-3(5)
Tennessee	Tenn. Code Ann. § 63-19-110(b)
Utah	Ut. Code §§ 58-67-305(6); 58-68-305(6); 58-70a-305(2)
Wisconsin	Wis. Stat. § 448.03(2)

cedures if he or she has the following training and skills, in addition to a high school education:

- (A) The skills required for proper specimen collection, including patient preparation, if applicable, labeling, handling, preservation or fixation, processing or preparation, transportation and storage of specimens;
- (B) The skills required for implementing all standard laboratory procedures;

(C) The skills required for performing each test method and for proper instrument use;

(D) The skills required for performing preventive maintenance, trouble-shooting and calibration procedures related to each test performed;

(E) A working knowledge of reagent stability and storage;

(F) The skills required to implement the quality control policies and procedures of the laboratory;

(G) An awareness of the factors that influence test results; and

(H) The skills required to assess and verify the validity of patient test results through the evaluation of quality control sample values prior to reporting patient test results.³⁶

In states that license clinical laboratory personnel, a state license may also be required to perform tests other than those classified as waived under CLIA.³⁷

AMT administers a certification program known as the Certified Medical Laboratory Assistant (CMLA), which recently replaced the COLT (Certified Office Laboratory Technician) certification program. As with the COLT credential, with appropriate additional training RMAs can utilize the CMLA as a career-path enhancement tool to help demonstrate they have acquired the necessary knowledge and training to perform moderately complex tests as well as pre- and post-analytical tasks in the laboratory.

Conclusion

The formal recognition of a practice scope that does justice to the training and skills of appropriately credentialed medical assistants continues to expand nationally, as more and more states have enacted laws and regulations allowing licensed medical practitioners to delegate injections and other clinical duties to MAs. Although there are common threads to most of the laws authorizing such delegation, there are many nuances from state to state - e.g., some states expressly permit MAs to perform allergy scratch tests, while others explicitly prohibit them, even when other injections are allowed. Registered Medical Assistants should familiarize themselves with the rules in their respective states so they can help educate their employers to utilize their medical assisting skills to the fullest extent of the law, without over-stepping it. ■

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References

1. Ga. Code Ann. § 43-34-44.
2. Ga. Code Ann. § 43-34-23(f).
3. Ark. Code Ann. § 17-95-208.
4. <http://www.armedicalboard.org/Professionals/pdf/mpa.pdf> (accessed June 18, 2012).
5. Nev. Rev. Stat. § 454.213(22). The authorization also applies to MAs working under direction of osteopathic practitioners.
6. Nev. Rev. Stat. §§ 630.0129; 633.075.
7. Mont. Code Ann. § 37-3-104.
8. A.R.M. § 24.156.640, accessible through the Montana Secretary of State's website: <http://www.mtrules.org/gateway/ruleno.asp?RN=24.156.640> (accessed June 18, 2012).
9. The South Dakota medical assisting statute (S.D. Codified Laws §§ 36-9B-1-36-9B-9) and the Joint Board committee's scope-of-practice determinations can both be viewed on the Nursing Board's website: <http://doh.sd.gov/boards/Nursing/medasst.aspx> (accessed June 18, 2012).
10. Fla. Stat. § 458.3485.
11. N.J. Admin. Code § 13:35-6.4.
12. Az. Admin. Code §§ R4-16-401, R4-16-402.
13. Az. Admin. Code §§ R4-22-110, R4-22-111.
14. Cal. Bus. & Prof. Code §§ 2069-2071.
15. 16 C.C.R. §§ 1666-1666.4.
16. Code of Md. Regs. §§ 10.32.12.01-10.31.12.05.
17. Ohio Admin. Code § 4731-23-02.
18. 225 Ill. Comp. Stat. § 60/54.2 (statute); 68 Ill. Admin. Code § 1285.335(f) (regulation).
19. 63 Pa. Cons. Stat. § 422.17 (statute); 49 Pa. Code § 18.402 (Medical board rule).
20. Mich. Comp. Laws § 333.16215.
21. Tex. Occ. Code §§ 157.001 (General Authority of Physician to Delegate); 157.002 (Delegation of Administration of Dangerous Drugs).
22. Ind. Code § 25-22.5-1-2(a).
23. Utah Code §§ 58-67-305(6) (Medical Practice Act); 58-68-305(6) (Osteopathic Medical Practice Act).
24. Utah Code § 58-70a-305(2) (Physician Assistant Act).
25. Utah Code §§ 58-67-102(9) (Medical Practice Act); 58-68-102(9) (Osteopathic Medical Practice Act).
26. Or. Rev. Stat. § 677.505.
27. La. Rev. Stat. § 37:1360.38.B
28. Ala. Code § 34-21-6.
29. 12 Alaska Admin. Code § 40.480(b).
30. 12 Alaska Admin. Code § 44.966.
31. N.D. Admin. Code Ch. 54-07-05, <http://www.legis.nd.gov/information/acldata/pdf/54-07-05.pdf> (accessed June 18, 2012).
32. <http://www.nh.gov/nursing/documents/ma-toolkit.pdf> (accessed June 18, 2012).
33. The only Missouri law we can find that remotely addresses the performance of medical tasks by unlicensed personnel is that state's Physician Assistant Practice Act, which contains a vague - and, in this author's opinion, confusing - exemption from licensing, as follows: "Nothing in sections 334.735 to 334.749 [the sections requiring licensure of physician assistants] shall be construed as prohibiting any individual whether licensed pursuant to sections 334.735 to 334.749 or not from providing the services of physician assistant."
34. http://dchealth.dc.gov/doh/lib/doh/h1n1/who_can_administer_vaccines_in_dc.pdf (accessed June 18, 2012).
35. A current list of tests classified as waived under CLIA can be viewed on the website HHS's Center for Medicare and Medicaid Services: <http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf> (accessed June 18, 2012).
36. 42 C.F.R. § 493.1423 (2011).
37. The following states currently require some form of licensing or mandatory certification of clinical laboratory testing personnel: California, Florida, Georgia, Hawaii, Nevada, Louisiana, New York, North Dakota, Montana, Rhode Island, Tennessee, and West Virginia. Some, but not all of these states' licensing laws exempt personnel employed in physician office labs.