December 2015

Thank you for your inquiry concerning what duties are delegable legally to medical assistants according to Iowa law.

Chapter 152, Section 152.1, 5, c of the Iowa statutes reads as follows:
5. The "practice of nursing" means the practice of a registered nurse or a licensed practical nurse. It does not mean any of the following:
……
c. The performance of services by unlicensed workers employed in offices, hospitals, or health care facilities, as defined in section 135C.1, under the supervision of a physician or a nurse licensed under this chapter…and when acting while within the scope of the employer's license.

It is my legal opinion that the above statutory languages authorizes physicians to delegate a reasonable scope of clinical procedures (including venipuncture and the administration of intramuscular, intradermal, and subcutaneous injections—including immunizations/vaccinations), as well as verbatim transmission of prescription orders as specifically authorized by the supervising physician, to competent and knowledgeable medical assistants working under their direct supervision in outpatient settings.

To my knowledge, there is nothing in Iowa law which forbids supervising physician(s) from delegating procedures to medical assistants through intermediary personnel, such as resident physicians, physician assistants, nurse practitioners, registered nurses, or other individuals capable of undertaking subdelegatory responsibility.

Although the nurse practice act and the attendant regulations of the board of nursing govern what nursing duties can be delegated by nurses to unlicensed personnel, the medical practice act and the attendant regulations of the board of medical examiners govern what procedures can be delegated by a licensed physician to unlicensed employees such as medical assistants, regardless of whether such delegation takes place in an ambulatory or in-patient setting.

Procedures which constitute the practice of medicine, or which state law **specifically and unambiguously** permits only certain other allied health care professionals to perform, however, may not be delegated to medical assistants.

I have enclosed *Occupational Analysis of the CMA (AAMA)*, the entry-level competencies taught in medical assisting programs accredited by CAAHEP, and the *Content Outline* of the CMA (AAMA) Certification Examination. Although these documents do not have the force of law, they should offer some guidance on scope of practice.

I hope this information is helpful. Please do not hesitate to contact me if you have further questions or need additional assistance.

Donald A. Balasa, JD, MBA
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Frequent questions about medical assistants' scope of practice

As the utilization of medical assistants—especially CMAs (AAMA)—within the American health care delivery system continues to increase and diversify, different types of questions regarding permissible scope of practice are being directed to the American Association of Medical Assistants. Here are examples of this "new wave" of scope of practice questions and the answers.

? Are medical assistants permitted to accept verbal orders from the delegating physician?

Medical assistants are permitted to receive and execute orders from the overseeing, delegating, or supervising physician(s) as long as such orders do not require the medical assistant to exercise independent professional judgment in the execution of the orders, or to make clinical assessments or evaluations.

? Are physicians allowed to delegate patient education to medical assistants?

Physicians are allowed to delegate patient education to competent and knowledgeable medical assistants as long as the content of such education has been approved by the delegating physician, and the patient education process does not require the medical assistant to make any interpretive judgments or answer any questions from the patient or patient representative that require a diagnosis, assessment, or evaluation. Medical assistants should not go beyond the patient education information that has been approved by the physician.

? Are medical assistants permitted to call in prescription refills or new prescriptions?

In most states medical assistants are permitted to transmit (by telephonic, electronic, or other means) verbatim the physician's orders for new prescriptions or refills. Such transmission must be verbatim, and must not require the medical assistant to make interpretive judgments about the prescription before transmission.

? Is it legal for medical assistants to sign prescriptions on behalf of the physician?

It is *not* legal for medical assistants to sign, authorize, or approve prescription orders on behalf of the physician. Medical assistants may draft scripts and forward them to the overseeing physician for the physician's review, approval, and signature. They must not transmit prescriptions until the physician has reviewed, approved, and executed the prescription order.

? Are medical assistants permitted to triage patients?

In order to answer this question correctly, it is essential that terms be precisely defined and thoroughly understood. In interacting with patients or their representatives—by telephone or in person—medical assistants are allowed to convey verbatim physician-approved information and directions without exercising independent professional judgment or making clinical assessments or evaluations. This communication process is frequently called *screening*. Communication that *does* require the health professional to exercise independent judgment or to make clinical assessments or evaluations is frequently called *triage*. The general legal principle is that physicians are allowed to delegate screening, but not triage, to competent and knowledgeable medical assistants working under their direct supervision in outpatient settings.

It is likely that medical assisting scope of practice questions will increase in complexity and urgency. Feel free to direct such questions to Executive Director Balasa at dbalasa@aama-ntl.org.

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel

Medical assistants

Scope of practice, education, and credentialing

(The following was adapted from a presentation given by AAMA Executive Director Balasa for the National Council of State Boards of Nursing.)

Who are medical assistants?

Medical assistants are allied health professionals who work primarily in outpatient/ambulatory health care delivery settings, most often under direct physician supervision, who are able to be delegated both back-office clinical duties as well as front-office administrative duties. Medical assistants are different from: (1) nursing assistants; and (2) medication aides/assistants.

Nursing assistants work primarily in inpatient settings, most often under registered nurse (RN) supervision, and are delegated mostly bedside, clinical duties. Medication aides/assistants also work primarily in inpatient settings, and are able to pass medications to patients, usually under RN supervision.

From what laws do medical assistants derive their right to practice?

Because most medical assistants are delegated duties by physicians, in the majority of American jurisdictions medical assistants derive their legal authority to practice from state medical practice acts and/or the regulations and policies of the state boards of medical examiners. In most states, medical assistants work under direct physician supervision. "Direct supervision" is usually defined as the delegating/supervising/overseeing physician(s) being on the premises and reasonably available (although not necessarily in the same room) when medical assistants are undertaking clinical duties other than the most basic tasks, such as taking vital signs and collecting certain specimens (e.g., urine and sputum).

Does this mean that physicians are permitted to delegate any duties to a medical assistant as long as they are done under direct physician supervision?

No. Medical assistants cannot be delegated any duties that: (1) constitute the practice of medicine or require the skill and knowledge of a licensed physician; (2) are restricted in state law to other health professionals; (3) require the medical assistant to exercise independent professional judgment or to make clinical assessments, evaluations, or interpretations.

Is it legal for physicians to assign to other health professionals supervisory responsibilities over medical assistants?

Yes. Under the laws of most states, physicians are permitted (explicitly or implicitly) to ask health professionals, such as advanced practice nurses (APNs)—most often nurse practitioners—physician assistants, and registered nurses to supervise medical assistants in the performance of duties delegated to the medical assistants by the physician. This type of supervision is sometimes referred to as "intermediary supervision."

Are the health professionals exercising intermediary supervision legally liable for negligence by the medical assistants?

The delegating physician is legally responsible for negligent acts by the medical assistant. Medical assistants are also legally responsible for their negligent acts. Health professionals exercising intermediary supervision are usually *not* responsible for the negligent acts of medical assistants *unless* the physician has asked the intermediary professional to monitor and evaluate the competence of the medical assistants.

Is it legal for a nurse to exercise such intermediary supervision assigned by a physician if the physician's delegation to medical assistants is not based on the state nurse practice act and the rules and policies of the state board of nursing?

Yes. Note the following from *Working with Others: A Position Paper*, a publication of the National Council of State Boards of Nursing[1]:

> *Accepting an assignment to supervise*—There are situations when a nurse may be assigned to supervise a staff member who has been delegated tasks by another licensed provider (e.g., in a physician's office). There are other situations where the authority to provide tasks or procedures … has been granted by a statute or rule/regulation separate from the Nurse Practice Act or rules/regulations.

If an APN is working independently, what duties can the APN delegate to medical assistants?

An increasing number of American jurisdictions are permitting advanced practice nurses—especially nurse practitioners—to practice independently and autonomously. In other words, these APNs are allowed in some states to work without a collaboration agreement with an overseeing physician. In such situations, the operative law for determining what APNs are permitted to delegate to unlicensed allied health professionals, such as medical assistants, is the state nurse practice act and the rules, policies, and opinions of the state board of nursing.

What formal education programs do medical assistants attend?

There are many varieties of "medical assisting" education programs throughout the United States. Some of these programs only teach the administrative aspects of medical assisting, and others only teach the clinical aspects. "Medical assisting" courses are taught at both the secondary and postsecondary levels. Medical assisting programs at the postsecondary level are taught in community colleges and vocational/technical schools. Such postsecondary academic programs are either: (1) one-year certificate or diploma programs; or (2) two-year associate degree programs.

However, there are only two accrediting bodies that are recognized by the United States Department of Education or the Council for Higher Education Accreditation as programmatic accreditors of postsecondary medical assisting programs: (1) the Commission on Accreditation of Allied Health Education Programs (CAAHEP); and (2) the Accrediting Bureau of Health Education Schools (ABHES). Medical assisting programs accredited by CAAHEP and ABHES require that both clinical and administrative aspects of medical assisting be taught. Only graduates of CAAHEP or ABHES accredited medical assisting programs are eligible to take the CMA (AAMA) Certification Examination given by the Certifying Board of the American Association of Medical Assistants (AAMA).

What medical assisting credentials can medical assistants receive?

As is the case with medical assisting education programs, there are many different "medical assisting" credentials in the United States. There are "medical assisting" tests and credentials that are exclusively administrative. There are "medical assisting" tests and credentials that are exclusively clinical. There are medical assisting tests and credentials that measure both administrative and clinical knowledge.

The CMA (AAMA) certification is the only medical assisting credentialing program that requires candidates to graduate from an accredited postsecondary medical assisting program. As stated above, only graduates of CAAHEP or ABHES accredited medical assisting programs are eligible to sit for the CMA (AAMA) Certification Examination.

In addition, the CMA (AAMA) is the only medical assisting credentialing program that utilizes the National Board of Medical Examiners (NBME) as test consultant. As a result, the reliability, validity, and security of the CMA (AAMA) Certification Examination are of the highest order.

Does the AAMA inform medical assistants that it is against the law for medical assistants to refer to themselves as "nurses"?

Yes. For more than 20 years, the AAMA has stressed—both in writing and in oral presentations—that medical assistants must *not*, in any circumstances, refer to themselves as nurses. Note the following excerpt from an article in *CMA Today*:

> It is unethical, illegal, and a disservice to the medical assisting profession for medical assistants to refer to themselves as "nurses," "office nurses," "doctors' nurses," or any other generic term or phrase that even remotely implies that medical assistants are nurses.[2]

Medical assistants have become an integral part of the health care delivery team. As employers and other health professionals strive to understand the distinctions regarding the education, credentialing, and scope-of-practice issues of medical assisting staff, the AAMA stands dedicated in providing relevant and reliable information on the profession. ◂

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Questions? Contact Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.

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Your office staff can get you sued

Protect your practice by employing CMAs (AAMA)

Increasing numbers of employers prefer to hire, or insist on hiring, CMAs (AAMA) or, more specifically, medical assistants who have attained and maintained certification by the Certifying Board of the American Association of Medical Assistants. This article presents some of the legal reasons why employing CMAs (AAMA) is advantageous for all employers.

1. The delegating physician, the practice as a whole, and the medical assistant can be subject to disciplinary actions by the state if a medical assistant is delegated the following responsibilities:

    a. Any procedures that constitute the practice of medicine, and require the skill and knowledge of a licensed physician

    b. Any procedures that can only be delegated by state law to certain health professionals other than medical assistants

    An example of the latter is physical therapy. Although some states—explicitly or implicitly—permit physicians to delegate very minor physical therapy modalities to competent and knowledgeable medical assistants working under the physician's direct supervision, no state allows a physician to delegate the full range of physical therapy to anyone other than a licensed physical therapist.

2. State disciplinary actions can result in fines and other criminal or quasi-criminal penalties for the delegating physician, the practice, and the medical assistant. Professional liability (malpractice) insurance policies do not provide coverage for violations of state laws. These policies only offer coverage in civil matters, such as malpractice and wrongful death suits.

3. A medical assistant should never be referred to as a "nurse," "office nurse," or "doctor's nurse." In every state this is a violation of the Nurse Practice Act, and can result in fines and penalties. All office personnel should avoid referring to medical assistants as "nurses." If a patient addresses a medical assistant as a nurse, the patient should be corrected politely and pleasantly.

4. The delegating physician, the practice, and the medical assistant can be sued for negligence if the medical assistant does not perform a duty up to the standard of care of a reasonably competent medical assistant. The physician is potentially liable under the legal doctrine of *respondeat*

superior, and can also be liable under the theory of *negligent delegation.*

5. The fact that the practice's medical assistants are current CMAs (AAMA) is powerful evidence in a malpractice action. Having a staff of current CMAs (AAMA) can lessen the likelihood that physicians will be held liable for negligent delegation.

6. The "standard of care of a reasonably competent medical assistant" is not necessarily the same in all parts of the United States. The standard may vary from state to state, or even from one region of a state to another. This is a compelling reason for employing CMAs (AAMA). The fact that the CMA (AAMA) credential is nationally accredited by the National Commission for Certifying Agencies (NCCA), and that the National Board of Medical Examiners (NBME) serves as test consultant for the CMA (AAMA) Certification Examination, can be used as evidence demonstrating that the CMA (AAMA) has met or exceeded the "reasonably competent medical assistant" standard. In addition, the CMA (AAMA) must maintain currency to use the credential.

7. A court may hold a CMA (AAMA) to a higher standard of care than a medical assistant who does not have the CMA (AAMA) credential. This is another reason why continuing professional education is so important for the CMA (AAMA) and why more employers are supporting the continuing education of their CMAs (AAMA).

8. A delegating physician, however, can also be liable for the negligence of a *licensed* professional, such as a registered nurse (RN) or a licensed practical/vocational nurse (LP/VN). Contrary to common belief, the physician is not sheltered from civil liability when delegating to a licensed professional. A health professional—licensed or unlicensed—can be held civilly liable for negligent acts. Likewise, a supervising and overseeing physician is responsible for the negligent acts of professionals to whom the physician delegates—whether such professionals are licensed or unlicensed.

9. An increasing number of malpractice insurance carriers are requiring medical assistants to have a professional credential, and some even insist that the credential be the CMA (AAMA).

10. The CMA (AAMA) is the only medical assisting credential that requires graduation from a postsecondary medical assisting academic program that is accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES). The CMA (AAMA) Exam is the only medical assisting credentialing exam that uses the NBME as test consultant.

11. There is an important difference between programmatic (specialized) accreditation and institutional accreditation. Programmatic accreditation of a medical assisting program provides a greater degree of scrutiny and accountability of the program than institutional accreditation of a school that has a medical assisting program. CAAHEP and ABHES are the only accreditors that provide medical assisting programmatic accreditation.

12. The CMA (AAMA) certification/recertification program is accredited by the NCCA, a national accreditor of certifying boards and programs. Accreditation is an attestation of the high standards of the CMA (AAMA) credential. The proven quality of the CMA (AAMA) can be beneficial in many legal contexts, including malpractice actions.

13. Since the CMA (AAMA) represents a medical assistant who has attained and maintained certification by the Certifying Board of the AAMA, the AAMA can enforce its intellectual property rights in federal and state courts. The Certifying Board of the AAMA receives complaints against medical assistants who are unlawfully using the CMA (AAMA) credential, and takes appropriate action.

14. Only those medical assistants who have earned the CMA (AAMA) may use the credential. Other medical assistants, such as Registered Medical Assistants (RMAs), National Certified Medical Assistants (NCMAs), California Certified Medical Assistants (CCMAs), National Registered Medical Assistants (NRMAs), and their employers can be in legal jeopardy if they use the "CMA (AAMA)" initialism.

During this era of increasing litigation, all health care professionals should make sure that they and those they supervise have the education (initial and continuing) and credentials necessary to prevail against any type of legal challenge. Physicians and other employers would be prudent to employ CMAs (AAMA), see to it that the "CMA (AAMA)" appears on name badges, and make sure CMAs (AAMA) are referred to as CMAs (AAMA).

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Questions may be directed to Executive Director Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org or 800/228-2262.

Donald A. Balasa, JD, MBA,
Executive Director, Legal Counsel

CMAs (AAMA): Linchpins of the Patient-Centered Medical Home

At its November 2008 planning session, the Board of Trustees of the American Association of Medical Assistants (AAMA) directed AAMA Executive Director and Legal Counsel Donald A. Balasa, JD, MBA, to represent the AAMA at the December 2008 Conference on Practice Improvement: Blueprint for the Medical Home, *sponsored by the American Academy of Family Physicians and the Society of Teachers of Family Medicine. The meeting focused on providing resources and sharing experiences about how primary care medical practices can incorporate elements of the Patient-Centered Medical Home (PCMH) model into the delivery of care. What follows is Executive Director Balasa's report.*

The Patient-Centered Medical Home

In 2007 the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA)—representing approximately 333,000 physicians—issued *Joint Principles of the Patient-Centered Medical Home (Joint Principles)*.[1] This document defined the Patient-Centered Medical Home (PCMH) as follows:

> The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The following are the seven principles agreed to by the AAFP, AAP, ACP, and AOA to describe the characteristics of the PCMH:

1. Personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Care is coordinated and/or integrated
5. Quality and safety
6. Enhanced access
7. Payment reform

Linchpins of the PCMH

During the *Conference on Practice Improvement* it became apparent that CMAs (AAMA) are vital and important allied health professionals that will be needed for the successful implementation of the PCMH approach to primary care. Indeed, the *2008 Core Curriculum for Medical Assistants,* published by the Medical Assisting Education Review Board (MAERB), offers elements ideally targeted to prepare medical assisting students for crucial roles in the PCMH. The *2008 Core Curriculum* is appended to the *2008 Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting,* published by Commission on Accreditation of Allied Health Education Programs (CAAHEP).[2]

Essential Joint Principles and educational elements

Five of the seven joint principles are particularly relevant to the role of the CMA (AAMA) and are supported by the *2008 Core Curriculum for Medical Assistants*:

1. ***Physician directed medical practice****—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.*

   As reflected in this principle, *all* members of the primary health care team—not just the physicians—are responsible for the care and well-being of all patients. The following element of the *2008 Core Curriculum* prepares a CMA (AAMA) for this important responsibility: *Apply critical thinking skills in performing patient assessment and care*. For a CMA (AAMA), care of patients is not just performing tasks assigned by the supervising or delegating physician. Rather, by necessity, patient-centered care requires the CMA (AAMA) to exercise critical thinking skills and refer appropriate information pertaining to issues worthy of special attention to the physician and other care team members.

2. ***Whole person orientation****—the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all states of life; acute care; chronic care; preventive services; and end-of-life care.*

   The PCMH philosophy does not end when the patient leaves the delivery setting. The primary care provider and the provider's "teammates" must be able to immediately and seamlessly arrange ancillary care with other professionals (e.g., social workers, counselors, and physical therapists). The role of the CMA (AAMA) is central for making this "whole person orientation" a reality. Note the following *Core Curriculum* element: *Develop and maintain a current list of community resources related to patients' health care needs.*

3. ***Care is coordinated and/or integrated*** *across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, and nursing homes) and the patient's community (e.g., family, and public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

   The health care system is indeed complex. Information technology is a useful means for assuring that patients "get the indicated care when and where they need and want it." However, "electronically-facilitated" information can lose most or all of its value if it is not communicated to the patient "in a culturally and linguistically appropriate manner." The following *Core Curriculum* elements demonstrate the expertise of CMAs (AAMA) for communicating in appropriate and understandable ways:

   - *Use language/verbal skills that enable patients' understanding.*
   - *Demonstrate respect for diversity in approaching patients and families.*
   - *Demonstrate empathy in communicating with patients, family, and staff.*
   - *Apply active listening skills.*
   - *Demonstrate respect for individual diversity, incorporating awareness of one's own biases in areas including gender, race, religion, age, and economic status.*

4. ***Quality and safety*** *are hallmarks of the medical home:*

   - *Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.*

   The *Core Curriculum* contains two related elements:

   1. *Recognize the role of patient advocacy in the practice of medical assisting.*
   2. *Advocate on behalf of patients.*

   Therefore, CMAs (AAMA) are educated not only to be "communication liaisons," but also to be "advocates" that speak on behalf of patients (with the authorization by the overseeing/delegating physician and other designated health professionals) to third-parties so that the best interests of patients are always in mind.

   - *Patients actively participate in decision making and feedback is sought to ensure patients' expectations are being met.*

   If patients are to "actively participate in decision making" in the Patient-Centered Medical Home, and provide feedback about whether their expectations are being met, at least one "point person" in the delivery setting must be available as the following:

   1. An effective and empathetic communicator *to* patients
   2. An effective and accurate communicator *from* patients to members of the health team.

The following elements of the *Core Curriculum* ensure that CMAs (AAMA) are educated in these skills and professional attributes:

- *Explain the rationale for performance of a procedure to the patient*
- *Show awareness of patients' concerns regarding their perceptions related to the procedure being performed*
- *Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.*

Within the "Medical Business Practices" of the *Core Curriculum* is the following element: *Execute data management using electronic health care records, such as the electronic medical record (EMR)*. Quite often, a CMA (AAMA) becomes the "expert" among all health team members on the electronic medical record (also known as the electronic health record, or by other similar designations).

5. ***Enhanced access*** *to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.*

CMAs (AAMA) have also become competent and adept schedulers in primary care settings—whether such settings incorporate few or many elements of the Patient-Centered Medical Home paradigm. The following *Core Curriculum* elements provide convincing evidence as to why CMAs (AAMA) are such skilled and knowledgeable schedulers:

- *Manage appointment schedule, using established priorities.*
- *Schedule patient admissions and/ or procedures.*

Revolutionized care

The Patient-Centered Medical Home will revolutionize the delivery of primary health care and will dramatically increase the welfare of all Americans. In addition, preliminary reports point to the fact that the PCMH philosophy will be reflected in the health care reform proposals of the Obama Administration.

The CMA (AAMA) will quickly become the linchpin of the Patient-Centered Medical Home model. What evidence supports this assertion? First, "The CMA (AAMA) is the only allied health professional who is required to complete an accredited postsecondary medical assisting program that provides specific training for work in medical offices, clinics, and other outpatient care centers."[3] But more specifically, as demonstrated above, the *2008 Core Curriculum for Medical Assistants* of the Medical Assisting Education Review Board ensures that CMAs (AAMA) are educated in the cognitive knowledge elements, psychomotor skills, and affective behavior and professional attributes that are key to the successful operation of a PCMH.

The indispensable role of the CMA (AAMA) in the Patient-Centered Medical Home revolution is another reason why medical assisting will continue to be one of the fastest-growing professions during the next ten years.

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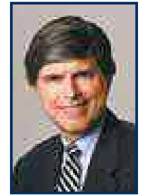

Donald A. Balasa, JD, MBA
Executive Director, Legal Counsel

Medical assistants must not refer to themselves as "nurses"

It is unethical, illegal, and a disservice to the medical assisting profession for medical assistants to refer to themselves as "nurses," "office nurses," "doctors' nurses," or any other generic term that even remotely implies that medical assistants are nurses.

The *Model Nurse Practice Act* published by the National Council of State Boards of Nursing (NCSBN) includes the following language:

> **Article VII. Title and Abbreviations**
> Section 1.
> a.
> …
> b. It shall be unlawful for any person to use the title "nurse," "registered nurse," "licensed practical/vocational nurse," "advanced practice registered nurse," their authorized abbreviations, or any other title that would lead a person to believe the individual is a licensed nurse unless permitted by this Act.

Note that this NCSBN document not only forbids the use of certain terms and abbreviations, but also prohibits "any other title that would lead a person to believe the individual is a licensed nurse." In other words, if a title or abbreviation or any other type of designation would cause a reasonable person to conclude that a certain health professional is a "nurse" of some sort, there could be a violation of the law.

The following excerpts from state Nurse Practice Acts provide examples of how states are addressing this issue:

> Texas—**Chapter 301, Section 301.251**
> …
> (d) Unless the person holds a license under this chapter, a person may not use, in connection with the person's name:
> (1) the title "nurse"; or
> (2) any other designation tending to imply that the person is licensed to provide nursing care.

> New York—**Article 138, Nursing, Section 6903**
>
> …No person shall use the title "nurse" or any other title or abbreviation that would represent to the public that the person is authorized to practice nursing unless the person is licensed or otherwise authorized under this article.

> Indiana—**Article 23, Nurses, Section 25-23-1-27, Violations; penalty**
> A person who:
> …
> (4) uses in connection with the person's name any designation tending to imply that the person is a registered nurse or a licensed practical nurse unless licensed to practice under this chapter…;
> …
> commits a Class B misdemeanor.

> Florida—**Chapter 464, Nursing, Part I, Nurse Practice Act, Section 464.016, Violations and penalties**
> …
> (2) Each of the following acts constitutes a misdemeanor of the first degree…
> (a) Using the name or title "Nurse,"…or any other name or title which implies that a person was licensed or certified as same, unless such person is duly licensed or certified.
> (b) Knowingly concealing information relating to violations of this part.

> Illinois—**225 ILCS 65, Nurse Practice Act, Article 50, General Provisions, Section 50-50, Prohibited acts**
>
> (a) No person shall:
> …(6) Use any words, abbreviations, figures, letters, title, sign, card, or device tending to imply that she or he is a registered professional nurse, including the titles or initials, "Nurse,"…or similar titles or initials with intention

of indicating practice without a valid license as a registered professional nurse;

…

(b) Any person, including a firm, association or corporation who violates any provision of this Section shall be guilty of a Class A misdemeanor.

As this author has frequently written and spoken about during the last 20 years, it is imperative that medical assistants scrupulously avoid conveying the message that they are nursing personnel, or members of any profession other than medical assisting. Recall the following admonition in "Your Office Staff Can Get You Sued":

> A medical assistant should never be referred to as a "nurse," "office nurse," or "doctor's nurse." In every state this is a violation of the Nurse Practice Act, and can result in fines and penalties. All office personnel should avoid referring to medical assistants as "nurses." If a patient addresses a medical assistant as a nurse, the patient should be corrected politely and pleasantly.[1]

As the medical assisting profession and, especially, the CMA (AAMA) become more prominent in the 21st century health workforce because of the Patient-Centered Medical Home movement, and in greater demand because of President Obama's Patient Protection and Affordable Care Act, it is more important than ever that medical assistants proudly and unambiguously identify themselves as members of one of the fastest growing and most important professions in the United States of America. ◂

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By Donald A. Balasa, JD, MBA
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Standards for Ambulatory Care and the CMA (AAMA) credential

TJC document reinforces the importance of certification and does not limit scope of practice

The American Association of Medical Assistants (AAMA) Executive Office has been receiving an increasing number of questions about the *Standards for Ambulatory Care (SAC)* of The Joint Commission (TJC) and their impact on the scope of practice of medical assistants. My legal opinion is that the current edition of the *SAC* does not supersede state and federal medical assisting laws, and thus does not reduce the scope of practice of medical assistants. Furthermore, several features of the CMA (AAMA) Certification Program are consistent with the *SAC*, and consequently reinforce and magnify the preeminence of the CMA (AAMA) credential.

(The following analysis is based on information in the 2014 edition of The Joint Commission Standards for Ambulatory Care.*)*

SAC and scope of practice

The *SAC* seeks to ensure that all health care professionals working in the outpatient setting are abiding by their legally defined scopes of practice. HR.01.02.07 is as follows: "The organization determines how staff function within the organization." Note the following Elements of Performance of this standard[1]:

1. All staff who provide patient care, treatment, or service possess a current license, certification, or registration, in accordance with law and regulation.

2. Staff who provide patient care, treatment, or services *practice within the scope of their license, certification, or registration and as required by law and regulation.* [Emphasis added.]

There is nothing in The Joint Commission *Standards for Ambulatory Care* that overrides or supersedes state or federal law governing the scope of practice of medical assistants.

TJC requires verification of staff qualifications

Standard HR.01.02.05 of the *SAC* is as follows: "The organization verifies staff qualifications." The Elements of Performance of HR.01.02.05 include the following[1]:

1. When law or regulation requires care providers to be *currently* licensed, certified, or registered to practice their professions, the organization both verifies these credentials with the primary source and documents this verification

when a provider is hired and when his or her credentials are renewed. [Emphasis added.]

Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

Note also the following point in HR.01.02.05[1]:

2. When the organization requires licensure, registration, or certification not required by law and regulation, the organization both verifies these credentials and documents this verification at time of hire and when credentials are renewed.

The above excerpt from HR.01.02.05 demonstrates the importance of CMAs (AAMA) keeping their credential current, especially in states that require medical assistants to have the CMA (AAMA) for certain purposes. The fact that employers and other parties can verify on the AAMA website whether a medical assistant holds a current CMA (AAMA) provides a great service for employers and prospective employers.

Distinguishing the CMA (AAMA) credential in education and experience

Note the following point in HR.01.02.05[1]:

3. The organization verifies and documents that the applicant has the *education* and experience required by the job responsibilities. [Emphasis added.]

The CMA (AAMA) is the only medical assisting certification that limits eligibility to candidates who have completed a postsecondary, *accredited* medical assisting academic program. Other medical assisting credentialing bodies permit an individual to take their tests without having any formal medical assisting education. Because hands-on, psychomotor competencies cannot be measured conclusively by a paper-and-pencil or computer-based test, the mandatory education requirement—which must include a practicum of 160 hours or more—distinguishes the CMA (AAMA) from all other medical assisting credentials, and provides employers, patients, malpractice insurance carriers, and third-party accrediting bodies such as The Joint Commission and the National Committee for Quality Assurance (NCQA) with tangible evidence that CMAs (AAMA) are not only knowledgeable about the multifaceted dimensions of the profession, but also competent in the clinical and administrative duties that are required in ambulatory care delivery settings.

The CMA (AAMA) advantage in continuing education

Standard HR.01.05.03 is as follows: "Staff participate in ongoing education and training." Note the following Elements of Performance[1]:

1. Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.

2. Staff participate in ongoing education and training whenever staff responsibilities change. Staff participation is documented.

The emphasis on documentation of staff "ongoing education and training" is apparent from these Elements of Performance. The fact that transcripts of AAMA Continuing Education Units (CEUs) are readily available is a decided advantage for CMAs (AAMA) and their supervisors and employers, and should facilitate compliance with The Joint Commission *Standards for Ambulatory Care.*

The rigor of the review of applications for CMA (AAMA) recertification by continuing education is another point of superiority of the CMA (AAMA) Certification Program. Unlike some other allied health credentialing programs, which only review a random sample of applications, all CMA (AAMA) recertification by continuing education applications are reviewed by staff. ✦

Definition of ambulatory care delivery settings

In its *Comprehensive Accreditation Manual for Ambulatory Care*, The Joint Commission includes the following delivery settings in its definition of ambulatory care[2]:

> Surgery centers, community health centers, group practices, imaging centers, sleep labs, rehabilitation centers, student health centers, urgent care clinics, and other ambulatory providers

The term "organization" in the *SAC* includes the above delivery settings.

References

1. The Joint Commission. *2014 Standards for Ambulatory Care.* Oakbrook Terrace, IL: Joint Commission Resources; 2014.
2. The Joint Commission. *Comprehensive Accreditation Manual for Ambulatory Care.* Oakbrook Terrace, IL: Joint Commission Resources; 2012.

General questions about The Joint Commission Standards for Ambulatory Care, or specific questions that arise about medical assisting scope of practice during an audit by TJC, should be directed to AAMA Chief Executive Officer and Legal Counsel Donald A. Balasa, JD, MBA, at dbalasa@aama-ntl.org, or 800/228-2262.

For further information, you may be interested in these documents:

- The CMA (AAMA) Credential: Rise Above the Crowd
- Medical Assisting Career
- Why More Employers are Hiring CMAs (AAMA)
- 2012-2013 Occupational Analysis of the CMA (AAMA)
- Standards and Guidelines for the Accreditation of Educational Programs in Medical Assisting
- CMA (AAMA) Certification/Recertification Examination Content Outline

Click on each of the above documents to access.