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Utilizing Medical Assistants to the Top of Their Training

How Recent Law Changes Have Expanded Their Scope of Service

The following is a summary of a presentation I gave to the Medical Group Management Association (MGMA) Medical Practice Excellence: Leaders Conference on October 25, 2021.

The scope of practice and service of medical assistants has expanded dramatically during the last 18 months because of changes in federal and state law. The purpose of this presentation is to highlight some of the major changes in medical assistants' scope of practice and service so clinicians and managers will be able to utilize medical assistants to the top of their education or training and credentialing.

Telemedicine/Telehealth

My legal opinion is that, under the laws of all states, knowledgeable and competent medical assistants are permitted to (1) receive information by electronic means for licensed providers and (2) convey information by electronic means as authorized by overseeing/delegating providers. Providers should specify in writing what information may be received and transmitted by medical assistants. When receiving and conveying information, medical assistants must avoid making independent clinical judgments and assessments.

In its *Telehealth Implementation Playbook*,[1] the American Medical Association recognizes the roles that medical assistants are able to assume in telemedicine/telehealth. Note the following excerpt from this publication:

> **MEDICAL ASSISTANT …**
>
> - Be familiar with the conditions and situations that are appropriate for a telehealth visit
> - Educate patients on telehealth expectations
> - Support patient troubleshooting related to platform pre-visit and during visit
> - Let [the] doctor know when a patient has "checked in" for a telehealth appointment[1]

Because of favorable laws and growing recognition of their unique capabilities, medical assistants are being assigned roles as telemedicine communicators in clinics and medical practices.

Remote Physiologic Monitoring

In their publications and policies, both the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services have acknowledged the expanding role of medical assistants in remote physiologic monitoring (RPM). The following is from the Centers for Disease Control and Prevention website:

> In some cases, peripheral medical equipment (e.g., digital stethoscopes, otoscopes, ultrasounds) can be used by another [health care professional] (e.g., nurse, *medical assistant* [emphasis added]) physically with the patient, while the consulting medical provider conducts a remote evaluation.[2]

From the Centers for Medicare & Medicaid Services perspective, a new code descriptor (*Current Procedural Terminology* [*CPT*] code 99457) for Medicare Part B went into effect January 1, 2020. The code description is as follows:

> [RPM] treatment management services, *clinical staff*/physician/other qualified health care professional [emphasis added] time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes[3]

RPM services reported with *CPT* code 99457 may be furnished under general supervision—rather than direct supervision—and may be billed incident to the services of the licensed provider.

Because medical assistants may be classified as clinical staff under *CPT* definitions,

code 99457 has provided additional opportunities for providers to delegate RPM to medical assistants and receive incident-to reimbursement for their medical assistants' services.

Chronic Care Management and Transitional Care Management

The Chronic Care Management (CCM) and Transitional Care Management (TCM) programs were created to provide reimbursement for services for Medicare recipients who have health needs not included within standard Medicare coverage. As noted above, medical assistants fall within the *CPT* definition of clinical staff. Medical assistants also are auxiliary personnel according to chapter 15, section 60.1, "Incident to Physician's Professional Services," of the *Medicare Benefit Policy Manual*.[4] Medical assistants may be delegated tasks that are billable incident to the provider's services under *CPT* code 99490 (CCM) or *CPT* codes 99495 and 99496 (TCM).

The CCM and TCM programs have provided new opportunities for medical assistants to fill care coordinator roles in a variety of health care delivery settings. Care coordinators provide general coaching and guidance to the patient as authorized by care providers such as physicians, advanced practice registered nurses (APRNs), physician assistants, physical therapists, and occupational therapists. Coordinators also transmit information to care providers, such as patients' vital signs, adherence to treatment plans, and questions.

Post-Discharge Medication Reconciliation

Medical assistants are not mentioned specifically in the following quality measure of the National Committee for Quality Assurance (NCQA):

> **Quality ID #46 (NQF 0097): Medication Reconciliation Post-Discharge**
>
> …
>
> **2019 Collection Type:**
>
> …
>
> **NUMERATOR (SUBMISSION CRITERIA 1 & 2 & 3)**
>
> Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge[5]

Because of this lack of specific mention in the above measure, health systems were reluctant to delegate to medical assistants post-discharge medication reconciliation.

At the direction of the AAMA Board of Trustees, I contacted NCQA staff. I received the following response:

> NCQA recognizes the supervising physician as providing the service when they have signed off on the medical record/documentation. It is our understanding many licensed practical nurses (LPNs) and medical assistants work with physicians and registered nurses (RNs). With this in mind, medication reconciliation provided by the medical assistant and signed off by a physician, [nurse practitioner, physician assistant, or clinical pharmacist with prescribing privileges] or RN may be counted toward NCQA Medication Reconciliation indicators as the signature indicates additional clinical oversight for this work.

Nurse Practitioner Delegation under Maryland Law

Maryland nursing law was ambiguous about whether APRNs, especially nurse practitioners, were permitted to delegate to unlicensed allied health professionals such as medical assistants the administration of certain types of injections. The AAMA worked with nurse leaders in Maryland to draft a bill that would eliminate this ambiguity. The legislation was enacted into law and requires the Maryland Board of Nursing to promulgate regulations authorizing APRN delegation of injections to unlicensed assistants (such as medical assistants).

Revised Supervision Requirement under Washington Law

The COVID-19 pandemic has necessitated less stringent supervision requirements for knowledgeable and competent medical assistants. In April 2021, the Washington legislature codified into statute the following revised supervision requirement previously included in an executive order by Washington Governor Jay Inslee:

> (b) The health care practitioner does not need to be present during procedures to withdraw blood [by a medical assistant], but must be immediately available [by telephone].
>
> (c) During a telemedicine visit, supervision over a medical assistant assisting a health care practitioner with the telemedicine visit may be provided through interactive audio and video telemedicine technology.[6] ✦

References

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