PRACTICE TIPS: Implementing Ordering Privileges for the RDN

APPENDIX

The Practice Tips and the accompanying Appendix provide the background on the CMS Final Rule effective July 11, 2014, that allowed hospitals the option of granting order writing privileges to qualified dietitians or clinically qualified nutrition professionals if consistent with state law. It is important for registered dietitian nutritionists (RDNs) to understand the origin of order writing privileges to speak authoritatively with hospital leaders, physicians, and interprofessional team members to advocate for gaining, maintaining, and expanding privileges over time. The Practice Tips and the Appendix provide a guide for those new to RDN order writing privileges or when new opportunities arise. In the Final Rule, review pages 27117-27119 and 27145-27147 for the rationale and cost benefit of allowing RDN ordering privileges; and that lead to the use of the terms "qualified dietitian and qualified nutrition professional" that now appear in the CMS State Operations Manuals for Hospitals (Appendix A) and Critical Access Hospitals (Appendix W). The link to the Final Rule is in Section A and the link to the State Operations Manuals is in Section B.

PREP Work

Information needed to plan and dialogue effectively with hospital medical staff and decision makers

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Section A – Information on the 2014 Final Rule

Step 1. Review **May 12, 2014, Federal Register Final Rule effective July 11, 2014 Regulatory Reforms Impacting Hospital Conditions of Participation (CoPs)**

Agency: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), which sets standards for any hospital accepting Medicare Reimbursement. (pages 27105-27157; search by "dietitian").

Learn more: https://www.govinfo.gov/content/pkg/FR-2014-05-12/pdf/2014-10687.pdf

Step 2. Identify the purpose of the Final Rule (Rule) (pg. 27106)

1. Understand the Rule's sections and pertinent statements.

a) Understanding the Rule statements will assist you with your outline and discussion presentation to the hospital medical staff and administration when seeking to obtain privileges.
b) Hospitals that choose to grant specific order writing privileges to the Registered Dietitian Nutritionist (RDN) may achieve a higher quality of care for their patients by allowing the RDN to fully and efficiently function as an important member of the hospital patient care team in the role for which the RDN is trained.
c) The final Rule states that CMS believes hospitals would realize significant cost savings in many of the areas affected by nutritional care. Read all sections in the Rule, including section §482.28 Food and Dietetic Services.

2. Assess what led CMS to issue the Rule revising the Hospital CoP. Review highlights of the President's Executive Order 13563: ''Improving Regulations and Regulatory Review''.

   In the Executive Order, the President (Obama):

   a) Recognized the importance of a streamlined, effective, and efficient regulatory framework designed to promote economic growth, innovation, job-creation, and competitiveness.
   b) Directed each executive agency to establish a plan for ongoing retrospective review of existing significant regulations.
   c) Requested agencies to identify rules that can be eliminated as obsolete, unnecessary, burdensome, or counterproductive or that can be modified to be more effective, efficient, flexible, and streamlined.

Step 3: Recognize the Rule's Major Provisions (Changes to CoP regulations effective 04-14-15)

1. Hospital registered dietitian privileges: Registered dietitians and other clinically qualified nutrition professionals are being permitted to be privileged to order patient diets under the hospital CoPs.
2. Hospital medical staff: A hospital's medical staff must be composed of doctors of medicine or osteopathy but it may also include, in accordance with state laws (including applicable scope of practice laws, and hospital laws and regulations), other categories of physicians and non-physician practitioners the governing board determines are eligible for appointment.
3. Practitioners permitted to order hospital outpatient services: The Outpatient Services CoP was revised to allow additional practitioners who are not appointed to the hospital's medical staff to order hospital outpatient services for their patients when authorized by the medical staff if permitted to do so under state law.
4. Hospital diet terminology: Terminology related to ''diets'' and ''therapeutic diets'' in the CoPs was revised and now appears along with the Interpretative Guidelines for Surveyors in the CMS State Operations Manual (SOM), Appendix A Hospital as of 04-01-15 (Hospital CoP §482.28(b)(1) and (2)).

Step 4: Know how "medical staff", "qualified dietitian" and "non-physician practitioners" are defined in the Rule. (Rule, page 27115; Hospital CoP §482.12(c)). Refer to this regulation and §482.22(a) in the updated SOM for the Interpretative Guidelines for Surveyors.

1. The intent of the Rule spells out greater flexibility for hospitals and medical staff to enlist the services of non-physician practitioners to carry out the patient care duties for which they are

trained and licensed. This will allow non-physician practitioners to meet the needs of their patients most efficiently and effectively.

2. The Rule clarifies that a hospital's medical staff may include other categories of non-physician practitioners the governing board determines are eligible for appointment, in accordance with state law, and including applicable scope of practice and laws and regulations.
3. The Rule includes language allowing for other types of non-physician practitioners such as *Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), Registered Dietitians (RDs), and Doctors of Pharmacy (PharmDs)* to be included on the medical staff because these practitioners, while not physicians, nevertheless add significant value as members of medical staff and in improving the quality of medical care provided to patients in the hospital. (Rule, page 27114; §482.12(a)(1)).
4. The hospital regulatory language was revised to now state that the ''medical staff must be composed of doctors of medicine or osteopathy,'' and that in accordance with state law, including scope of practice laws, the medical staff ''may also include other categories of physicians and non-physician practitioners who are determined to be eligible for appointment by the governing body.'' (Rule, page 27115)

   In states where state law or regulations limits appointments to certain categories of practitioners, privileges may still be granted without appointment to the medical staff **"as long as such privileges are recommended by the medical staff, approved by the governing body, and in accordance with State law."** The hospital and its medical staff is best qualified and best situated to "exercise oversight, such as credentialing and competency review, of those practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff" (Rule, page 27115).

   - **Non-physician Practitioners**: specifically include Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), Registered Dietitians (RDs), and Doctors of Pharmacy (PharmDs) (Rule, page 27114; Hospital CoP §482.22(a), page 147).
   - **Qualified Dietitian**: the term Registered Dietitian, "RD" is used to describe all qualified dietitians and any other clinically qualified nutrition professionals as long as each qualified dietitian or clinically qualified nutrition professional meets the requirements of their respective state laws, regulations, or other appropriate professional standards (Rule, page 27117; Hospital CoP §482.28(b)(2), page 291)

Step 5: Be familiar with the Rule's Costs and Benefits. (Rule, pages 27108, 27117, 27142-27147) (cost data at time rule was written)

1. "The Rule will create savings and reduce burden in many areas. Several of the changes create measurable monetary savings for providers and suppliers, while others create savings of time and administrative burden."
2. "Without the proposed regulatory changes allowing hospitals to grant appropriate ordering privileges to RDs, hospitals would not be able to effectively realize improved patient outcomes and overall cost savings that would be possible with such changes." (Rule, page 27117).

Rule Citation's include Reference 7 (Rule, page 27147). Barker LA, Bout BS, Crowe TC. Hospital malnutrition: Prevalence, identification and impact on patients and the healthcare system. *Int J Environ Res Public Health*. 2011;8(2):514-527. Other References are cited in the Rule that support RDN order writing privileges. (Rule, pages 27145-27146).

Step 6: Identify other sections in the Rule with potential implications for RDN privileging.

1. Parameters for laboratory test ordering (Rule, page 27119)
   a) The regulatory language does not require or specifically include privileges for ordering lab or other diagnostic services (e.g., indirect calorimetry measurements by RDN/qualified dietitian or qualified nutrition professional); they are instead an option left to the hospitals and their medical staffs to determine in consideration of relevant state law as well as any other requirements (e.g., state licensure) and/or incentives that CMS or other insurers might have.
   b) The RDN(s) requesting ordering privileges for specific scope of care (e.g., oncology, nutrition support, nephrology, pediatrics) that may include lab orders for nutrition assessment, and monitoring outcomes of nutrition intervention and nutrition modalities should assess hospital policies for Medicare payment requirements as well as Electronic Health Record incentives.
2. Revised hospital outpatient services CoPs (Rule, page 27120)
   a) CMS does not want to "limit the ability of practitioners, who are appropriately licensed, acting within their scope of practice, and authorized under hospital policies, to refer patients for outpatient services. CMS distinguishes these outpatient referral cases from cases where a practitioner provides care in the hospital, either to inpatients or outpatients, and must have medical staff privileges to do so."
   b) CMS believes it would be appropriate to revise § 482.54(c), the CoP governing outpatient services, which is silent on the issue of who may order such services, in order to explicitly address this issue.

      CMS revised the requirements to mean that orders for outpatient services may be made by any practitioner who is:
      - Responsible for the care of the patient;
      - Licensed in the state where they provide care to the patient;
      - Acting within their scope of practice under state law; and
      - Authorized in accordance with policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services.

   c) The need for RDN ordering privileges would extend to any of the hospital's ambulatory/outpatient clinics, satellite clinics, or dialysis center surveyed under the CMS Hospital CoP, if the RDN and physicians request ordering privileges for the RDN in these settings.
   d) Medicare, Medicaid, and private payer billing and reimbursement policies must be investigated to assure compliance and ethical billing practices. A physician's order may be necessary for the service to be billed to Medicare, Medicaid or third-party payers.
   e) Refer to the SOM CoP for Hospitals (Appendix A), standard §482.54 (c) for full description and Interpretative Guidelines for Surveyors: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.
3. Rural Health Clinics (Rule, pg 27135)
   a) Telehealth services in Rural Health Clinics (RHCs) (Rule, page 27135) Note: Review the following resources that addresses telehealth services–
      - MLN Fact Sheet: Telehealth Services, April 2024-- https://www.cms.gov/files/document/mln901705-telehealth-services.pdf
      - CDR Telehealth resources in the Case Studies and Practice Tips – www.cdrnet.org/tips
   b) CMS did not propose any policy changes for Rural Health Clinics (RHCs).

c) In the Rule, CMS stated that "RHCs that are located in rural Health Professional Shortage Areas (HPSAs), or in counties outside of Metropolitan Statistical Areas (MSA), are authorized by law to be telehealth originating sites (the location of an eligible Medicare beneficiary at the time the service is furnished via a telecommunications system)."

- CMS also stated that "the statute authorizes physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals to be distant site providers (practitioners furnishing covered telehealth services), and that the statute does not include RHCs as distant site providers."

- CMS noted that "RHC practitioners may be eligible to furnish and bill for telehealth distant site services when they are not working as an RHC practitioner at the RHC, but they cannot furnish and bill for telehealth services while working as an RHC practitioner because RHCs are not authorized distant site providers."

- CMS indicates that "these practitioners cannot bill Medicare Part B while they are working for a Medicare RHC since Medicare is paying the RHC through the Medicare RHC cost report an all-inclusive rate per visit that includes all direct and indirect costs, such as the practitioner's services, space to provide those services, support staff services, related supplies, records costs, and other services. To allow separate Medicare Part B physician fee schedule payments to a practitioner while that practitioner is working for the RHC would result in duplicate Medicare payment for the telehealth service, once through the Medicare RHC cost report and again through the Medicare Part B physician fee schedule payment. This would also apply to FQHCs."

d) "Federally Qualified Health Centers (FQHCs) are also statutorily authorized to be telehealth originating site providers and are also not included in the statutorily authorized list of distant site providers of telehealth."

4. Long term care settings and other healthcare facilities (Rule, Pages 27118-27119)

a) The Rule affects changes to the hospital setting and its regulations which were noted in the revised hospital CoPs. As for Long Term Care and other healthcare facilities, CMS stated that "To apply the hospital Rule to long term care and other healthcare settings is outside the scope of this Rule. However, [CMS] will keep the suggestion to extend the proposed revisions to the requirements for other providers and suppliers in consideration if CMS pursues future rulemaking in these areas."

b) See Final Rule and CoPs for Long Term Care Facilities (Appendix PP) – Access the Practice Tips-Reform Requirements for RDNs + NDTRs in Long Term Care Facilities (www.cdrnet.org/tips)

5. Critical Access Hospitals (see SOM, Appendix W) - Current revision 200, 02-21-2020; revisions since 2015 did not affect changes made by the Rule outlined in the information below.

a) CMS updated the interpretive guidelines for Critical Access Hospitals (CAHs) requirements that appear in Appendix W of the State Operations Manual (SOM) with Rev 138, Issued 04-07-15.

b) Revisions to §485.635(a)(3)(vii) reflect the changes made to the hospital regulations (Appendix A) §482.28(b) and §482.28(c) Food and Dietetic Services. §485.635(a)(3)(vii) that includes "All inpatients' diets, including therapeutic diets, must be provided in accordance with orders from a practitioner responsible for the care of the patient" followed by

information allowing privileging of "qualified dietitians or qualified nutrition professionals as practitioners with diet-ordering privileges" when permitted under state law.

c) Per CMS communication, the regulations under Nursing Facility §483.35(e) (which are part of the SNF regulatory requirements – Refer to SOM Appendix PP) requires that a therapeutic diet be prescribed by the attending physician. Because §483.35(e) is not one of the cross-referenced regulatory requirements for CAHs providing swing-bed services, CMS does not require that a therapeutic diet for a swing bed patient in a CAH be ordered by an MD or DO, and it could in fact be ordered by a qualified practitioner or a qualified dietitian.

Section B - Regulation changes to the CMS Conditions of Participation (CoP) for Hospitals and Critical Access Hospitals

Link to CoP Appendix; click on applicable letter:
https://www.cms.gov/files/document/som107appendicestoc.pdf

1. Review the CMS State Operations Manual (SOM), Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 122, 09-26-14 and 137, 04-01-15.

   Note: CMS periodically revises the SOM CoP (section/wording updates in red type); the updates since 2015 have not changed the revisions made with the Rule for both Hospitals (Rev. 220, 04-19-24) and Critical Access Hospitals (Rev. 200, 02-21-20) described below:

   a) The SOM Manual revision of 09-26-14 incorporated the changes to §482.12 (a)(1), §482.22(a) related to privileging, privileging process, and medical staff accountability for non-physician practitioners granted privileges.

      Transmittal R122 9/26/14 -- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R122SOMA.pdf

   b) The SOM Manual revision of 04-01-15 incorporated the revisions to §482.28(b) and §482.28(b)(2) Food and Dietetic Services and §482.54(c) Orders for Outpatient Services and provides the Interpretative Guidelines for Surveyors.

      Transmittal R137 4/1/15 -- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R137SOMA.pdf

   The Transmittals describe the changes made to the regulations back in 2014-15.

Per the Final Rule, see chart below for changes to Food and Dietetic Services, CoP §482.28(b)(1) and §482.28(b)(2) revisions.

Regulation effective July 11, 2014; Updated Interpretative Guidelines as of 04-01-15 (no changes in subsequent regulation updates)
Food and Dietetic Services §482.28(b)(1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. Interpretative Guidelines §482.28(b)(1) - (see SOM for full wording) • Patients . . .must have their nutritional needs met in a manner that is consistent with recognized dietary practice. • . . .includes all inpatients . . .patients in outpatient status, including the provision of observation services, who stay is sufficiently long that they must be fed. • Identifies DRIs as example of determining the way nutritional needs are met.

• Patients must be assessed for their risk of nutritional deficiencies or need for therapeutic diets and/or other nutritional supplementation. • Provides examples of patient who may have specialized dietary needs and may require a more detailed nutrition assessment.
§482.28(b)(2) All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals. Interpretive Guidelines §482.28(b)(2) - (see SOM for full wording) • Responsibility of hospital to ensure that individuals are qualified under State law before granting them privileges to order diets. • If chooses to not grant ordering privileges to dietitians, the patient's diet must be prescribed by a practitioner responsible for the patient's care. A dietitian may assess patient's nutritional needs and provide recommendations or consultations.

2. For Critical Access Hospitals, **review Appendix W, Survey Protocol, Regulations, and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing Beds in CAHs, Rev. 138, 04-01-15** (no change as of latest revision 200, 02 21 20)**.**
    a) Revision 138, 04-07-15 incorporates revisions based on the CMS Rule of July 11, 2014, into §485.635(a)(3) including the wording for RDN privileging to write orders. Information was edited to follow Appendix A wording in the 02-21-20 update.
    b) Revisions were also made to §485.635(c)(1)(iii) which address requirement for food and other services to meet inpatient's nutritional needs if services are not provided directly by the CAH.

3. **When needed, see CMS State Operations Manuals (SOM) for the various practice areas:**
    In the Appendix, use the Guidance Link to open each Medicare State Operations Manual Appendix for the specific practice setting (A-Hospital; W-Critical Access Hospital; H-End-Stage Renal Disease Facilities; PP-Long Term Care, etc.):
    https://www.cms.gov/files/document/som107appendicestoc.pdf --- Click on the corresponding letter in the SOM "Appendix Letter" column to see any available file in PDF.
    • Search by regulation number or key words such as "dietitian" (may need to use "dietician"), food and nutrition, or privileging.

4. **Monitor the CMS State Operations Manuals** for any updates to regulations and/or to the Interpretive Guidelines for Surveyors (check for wording in red type in a new revision).

Section C – Other useful information relative to privileging

1. **Review the CDR Definition of Terms** (www.cdrnet.org/definitions)
    a) The definitions are available for reference as the Final Rule does not define all relevant terms applicable to the practice of a Registered Dietitian Nutritionist (RDN).
    b) The following terms should be reviewed (Definition of Terms List):
        • Credentialing (Organizational Setting)
        • Credentialing (Professional)
        • Clinical Privileges
        • Competence

- Competency(ies)
- Therapeutic Diet

2. **Develop list of potential privileges for RDNs**: In developing the list of potential order writing privileges desired by the RDN staff for presentation to the medical staff, start with the following list of examples. The wording may need to be modified for your facility, be consistent with wording in the Nutrition Care Manual or facility diet manual, or other criteria. Consider if a specialist certification is necessary to manage certain order writing such as the Certified Specialist in Pediatrics (CSP), or Renal Nutrition (CSR) or Oncology (CSO); the Certified Nutrition Support Clinician (CNSC); or the Certified Diabetes Care Education Specialist (CDCES). This may necessitate two or more lists of types of order writing privileges.

    - initiating or modifying diet orders
    - initiating or modifying diet texture
    - initiating or changing a calorie level
    - initiating or changing enteral nutrition (i.e., product, volume or rate, supplemental water)
    - initiating or changing parenteral nutrition
    - inserting and monitoring nasogastric or nasoenteric feeding tubes
    - initiating physician-driven protocols and order sets
    - initiating therapeutic diets, i.e., sodium, fluid, potassium, gluten free, etc.
    - initiating or changing oral nutrition supplements
    - initiating or changing medical foods, e.g., formulas for inborn errors
    - initiating or changing dietary supplements
    - initiating or changing vitamins, minerals
    - initiating nutrition-related medications, medication management, medication adjustment
    - initiating laboratory tests - nutrition-related or other
    - conducting indirect calorimetry measurements
    - conducting bedside swallow screenings
    - conducting bedside swallow screenings with referral to the speech pathologist, when applicable
    - conducting nutrition education
    - conducting nutrition counseling
    - initiating referral to outpatient services
    - initiating referral to other practitioners

3. Review the references in the 2024 Scope and Standards for the RDN and any applicable focus area standards for websites/articles that would support RDN privileging or specific privileges.