

PRACTICE TIPS: Hospital Regulation - Ordering Privileges for the RDN

This Practice Tips provides 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: Implementation Steps – Ordering Privileges for the RDN provides a step-by-step 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 State Operations Manuals for Hospitals (Appendix A) and Critical Access Hospitals (Appendix W). The link to the Final Rule is in Step 1 and the link to the State Operations Manuals is in Step 1 c).

STEPS to prepare a dialogue with your hospital medical staff and employer!

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- Step 1: Read the May 12, 2014 Federal Register Final Rule effective July 11, 2014 along with the updated Centers for Medicaid and Medicare Services (CMS) State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretative Conditions of Participation for Hospitals or Appendix W for Critical Access Hospitals containing the updated regulations and interpretative guidelines as of April 1, 2015 (no change in latest revision - Rev. 200, 02-21-20).
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Step 1: Read the May 12, 2014 Federal Register Final Rule effective July 11, 2014.

1. Learn more: <http://www.gpo.gov:80/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf>
 - a) **Final Rule Title:** “Rules and Regulations – Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II – Final Rule - Pages 27105-27157 (FR DOC # 2014-10687)”.
 - b) **Responsible Agency:** Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), which sets standards for any hospital accepting Medicare reimbursement.
 - c) **See CMS State Operations Manuals (SOM) for the various practice areas:**
 - Use the Guidance Link to open each Medicare State Operations Manual Appendix for the specific practice area (Hospital; Critical Access Hospital; End-Stage Renal Disease Facilities; Long Term Care, etc.): <https://www.cms.gov/files/document/appendices-table-content.pdf> --- Click on the corresponding letter in the “Appendix Letter” column to see any available file in PDF.

- SOM – Hospital: Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (CMS periodically revises the SOM Conditions of Participation [updates in red type]); the latest revision 200, 02-21-2020 reflects the revisions described below):
 - Revision 137, 04-01-15 incorporates 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.
 - Revision 122, 09-26-14 incorporates the revisions to §482.12(a)(1), §482.22(a) related to privileging, privileging process, and medical staff accountability for non-physician practitioners granted privileges.
- SOM Critical Access Hospital: Appendix W, Survey Protocol, Regulations and Interpretative Guidelines for Critical Access Hospitals (CAHs) and Swing Beds in CAHs (current revision 200, 02-21-2020; no change to wording below)
 - 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 has since been edited to follow Appendix A wording in the 02-21-20 update.
 - 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.

Step 2: Identify the purpose of the Final Rule (Rule).

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 Conditions of Participation (CoP). Review highlights of the President’s Executive Order 13563: “Improving Regulations and Regulatory Review”.

In the Executive Order, the President:

 - 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.

3. Know the purpose of the Rule (Rule pg 27106).
 - a) It responds directly to the President's Executive Order instructions by reducing outmoded or unnecessarily burdensome rules, thereby enabling healthcare entities to better allocate resources to providing high quality patient care.
 - b) Bottom line: The Rule reduces regulatory burden on providers and suppliers by modifying, removing, or streamlining current regulations that are excessively burdensome.

Step 3: Recognize the Rule's Major Provisions.

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 is being 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 is being updated 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 staffs 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 will be 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)).
- **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 his or her respective state laws, regulations, or other appropriate professional standards (Rule, page 27117; Hospital CoP §482.28(b)(2)).

Step 5: Be familiar with the Rule’s Costs and Benefits. (Rule, pages 27108, 27142-27147)

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, pages 27117)
3. Due to the regulatory change for Hospital Food and Dietetic Services to allow the qualified dietitian or other qualified nutrition professional to be granted ordering privileges, the economic impact estimate for hospitals is \$459 million reoccurring annually.
4. Estimates were based on:
 - a) 4,900 hospitals that are certified by Medicare and/or Medicaid; 3,675 or 75% used for estimates of cost savings.
 - b) Average hourly costs of \$57 for registered dietitians. (BLS Wage Data by Area and Occupation at <http://www.bls.gov/bls/blswage.htm>, adjusted upward by 5 percent to inflate—on a projected basis—to 2014 dollars and by a further 100 percent to include fringe benefits and overhead costs).
 - c) The difference between physician’s / APRN’s / PA’s and RD’s average hourly costs of \$69.00.
5. Calculations of the cost savings for hospitals were based on several conservative assumptions.
 - a) “On average, each non-complex dietary order, including ordering and monitoring laboratory tests, subsequent modifications to orders, and dietary orders for discharge / transfer / outpatient follow-up as needed, will take 8 minutes (0.13 hours) of a physician’s / APRN’s / PA’s / RD’s time per patient during an average 5-day stay;

- b) On average, MNT or more complex dietary orders (for example, parenteral nutrition [PN], tube feedings, patients with multiple comorbidities, transition of patient from parenteral to enteral feeding, etc.), including ordering and monitoring of laboratory tests, subsequent modifications to orders, and dietary plans and orders for discharge / transfer / outpatient follow-up as needed, will take 18 minutes (0.30 hours) of a physician's / APRN's / PA's / RD's time per patient during an average 5-day stay; and
- c) The average number of hospital inpatient stays where the patient is determined to be either "at risk for malnutrition" or "malnourished" and/or requires medical nutrition therapy (MNT) or a more complex dietary plan and orders for other clinical reasons is 1,400 (or 20 percent of inpatient hospital stays)⁷ per hospital per year, with a remaining average of 5,600 (or 80 percent) of hospital inpatient stays per hospital per year where the patient is determined to be "not at risk for malnutrition" and/or requires a less complex dietary plan and orders." (Rule, page 27147-27146)

In Rule Citation's:

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)

- 6. "The resulting savings estimate is \$291,104,100 ([3,675 hospitals × 5,600 inpatient hospital stays × 0.13 hours of a physician's/ APRN's/ PA's/ RD's time × \$69 per hourly cost difference] + [3,675 hospitals × 1,400 inpatient hospital stays × 0.30 hours of a physician's/ APRN's/ PA's/ RD's time × \$69 per hourly cost difference]) annually.
 - a) Hourly estimates are about 57 percent higher than in the proposed Rule, due to the improved estimate for fringe benefits and overhead costs, plus inflation update.
 - b) The estimate of hours saved was reduced to reflect the likelihood that physician supervision will remain substantial in some cases.
 - c) When combined with the savings estimate of \$167,730,675 from reduced inappropriate PN usage, this brings the **total savings estimate from the Hospital CoP changes to \$458,834,775 or approximately \$459 million annually.**"

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).
 - b) However, although such privileges for the RDN/qualified dietitian or qualified nutrition professional are not required or specifically allowed by this requirement, 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.
 - c) 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.
 - d) Revised hospital outpatient services CoPs (Rule, page 27120)

- i. 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.”
 - ii. “On February 17, 2012, CMS issued SC–12– 17 (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter12_17.pdf) which clarified that outpatient services may be ordered by any practitioner responsible for the care of the patient, who is licensed and acting within his or her scope of practice in the state where he or she provides care to the patient, and who has been authorized by the medical staff and approved by the governing body to order specific outpatient services.”
 - iii. CMS believes it would be appropriate to revise § 482.54, the CoP governing outpatient services, which is silent on the issue of who may order such services, in order to explicitly address this issue.
 - iv. CMS is revising the requirements to mean that orders for outpatient services may be made by any practitioner who is:
 - o Responsible for the care of the patient;
 - o Licensed in the state where he or she provides care to the patient;
 - o Acting within his or her scope of practice under state law; and
 - o Authorized in accordance with policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services.
 - v. 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.
 - vi. 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 in order for the service to be billed to Medicare, Medicaid or third party payers.¹
 - vii. 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. Telehealth services in Rural Health Clinics (RHCs) (Rule, page 27135) Note: Because of the COVID-19 pandemic, CMS may be allowing temporary changes – review resources on the Academy’s Telehealth page at <https://www.eatrightpro.org/career/career-resources/telehealth-quick-guide>.
- a) CMS is not proposing any policy changes for Rural Health Clinics (RHCs).
 - b) 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).”
 - c) 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.”
 - 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.”

- e) 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.”
 - f) 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.”
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 will be noted in upcoming revised hospital Conditions of Participation (CoPs). **As for Long Term Care and other healthcare facilities**, CMS states 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) For recent CMS UPDATE – see Final Rule and COPs for Long Term Care Facilities – Access the [Practice Tips-Reform Requirements for RDNs + NDTRs in Long Term Care Facilities](#)
5. Critical Access Hospitals (see SOM, Appendix W) - Current revision 200, 02-21-2020; revisions since 2015 did not affect changes outlined in the information below.
- a) CMS has updated the interpretive guidelines for the 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 §482.28(b) and §482.28(c) Food and Dietetic Services. §485.635(a)(3)(vii) 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.

In this Practice Tips, the CDR has chosen to use the term RDN to refer to both registered dietitians (RD) and registered dietitian nutritionists (RDN) and to use the term NDTR to refer to both dietetic technician, registered (DTR) and nutrition and dietetics technician, registered (NDTR).

References:

1. Payment Webpage. Academy of Nutrition and Dietetics. Accessed August 29, 2022.
<https://www.eatrightpro.org/payment>
2. State Licensure. Commission on Dietetic Registration. Accessed December 7, 2022.
<https://www.cdrnet.org/licensure>