DIETITIANS IN PRIVATE PRACTICE · 2026

The Time-Back Sheet

Where the hours in a private practice actually go — and the fixes that give them back.

1. Where your hours actually go

TIME SINK	WHAT IT REALLY COSTS	THE FIX
Notes written after hours	The stack you sign on Sunday night — and unsigned notes on claims that already paid.	Close each note before the next session. A 10-minute buffer beats an end-of-day pile.
Benefits calls you repeat	20–40 minutes on hold per new patient, sometimes twice.	One scripted call, reference number saved in the chart. **See §2.**
Claims batched monthly	Slow cash flow, and some plans give you only 90 days to file.	Submit every Friday. A month of sessions is how a backlog starts.
Bad intake data	Denials you only discover weeks later, after the patient is gone.	Collect the five fields in **§3** before the first visit.
Cash vs. insurance, case by case	The same decision re-made at every visit.	Decide once, before visit one, and write it down.

2. The one-call benefits check

1. Are `97802` and `97803` covered on this plan?
2. Which diagnoses does the plan require?
3. Preventive or medical benefit? Preventive is often $0 to the patient; medical usually hits the deductible.
4. How many visits or units per year?
5. Is telehealth covered — to the patient's home (POS 10)?
6. Referral or prior authorization required?
7. Rep's name and call reference number — **into the chart.**

3. The 5 intake fields behind most denials

- [ ] Photo of the insurance card — **front and back**
- [ ] Member ID exactly as printed, prefix included
- [ ] Subscriber name and DOB when the patient isn't the policyholder
- [ ] Patient DOB checked against the card
- [ ] Cash or insurance — decided and written before visit one

Typos in these fields don't fail at intake. They fail weeks later, as a denial you have to rework.

4. Medicare MNT at a glance

RULE	WHAT IT MEANS FOR YOUR SCHEDULE
Who qualifies: diabetes, chronic kidney disease, or a kidney transplant in the last 36 months	Everyone else is commercial, cash, or not covered by Medicare MNT.
Referral: required from the treating physician	No referral on file, no billable visit. Get it before you book.
Hours: **3** in the first calendar year, **2** each year after — no carryover	Map the hours across the year **before** the first visit, not after they run out.
Patient pays: $0 — the Part B deductible doesn't apply	Easy yes for the patient; don't collect a copay you'll have to refund.
More hours: new physician order for a change in condition or treatment	Billed as `G0270` (individual) or `G0271` (group).

5. The weekly rhythm

- [ ] **Monday** — run the benefits check for every new patient booked this week.
- [ ] **Every day** — no note leaves the office unsigned.
- [ ] **Friday** — submit every claim from the week, then read the ERAs: each denial gets a decision the same day.
- [ ] **Always** — many solo RDs cap at 5–6 sessions a day. Past that, notes slip and errors climb.

Sources: Medicare.gov, Medical Nutrition Therapy services; CMS National Coverage Determination 180.1 (Medical Nutrition Therapy). Commercial coverage for 97802/97803, preventive vs. medical processing and telehealth rules vary by plan — verify each patient's benefits. Billing guidance, not legal advice.