

Procedures: Daily Logs

Date Written: 08/07

Date Revised: 08/09

Sumlar Therapy Services, Inc.

Purpose

The Daily Log (DL) has many functions: patient billing, therapist time sheet, therapist mileage reimbursement. It serves as a **permanent record** that may be viewed by any of our payor sources should questions arise.

Due

- ✓ **At the end of every day, Monday through Friday.**
- ✓ **Noted as late if not in the office at 8:00AM the next business day.**
- ✓ Even if you worked zero hours, you will need to submit a DL prior to 8:00 next business day so the Office Administrator will not consider your DL late.
- ✓ If you work on a weekend, fill out a DL dated appropriately and fax or turn it in by Monday at 8:00AM.
- ✓ If you do not correctly document your working time on the DL, you will miss the opportunity to be reimbursed for your time.
- ✓ Lateness may cause the employee's payroll to be delayed or deferred to the following pay period.

Use

Write clearly. The DL must be legible after faxing—use a black pen. Make sure your copies of the DL are clean, dark copies. Don't scribble. You may use white-out.

1. Print your **name, day of the week, and date** at the top
2. **TIME: HOURS:** Note the time, divided into hours, in the first column on the left. Begins at 7 a.m. and runs through 5 p.m. Four blank sections follow. You may fill in the blank sections or you may mark through the number provided and write in the correct hour. For instance, if you started working prior to 7 a.m., you can cross through the 7 and write a 6, changing each subsequent number. Or you can add the time in at the bottom of the sheet in the blank row. If you are working after 5, but didn't work during the 3, 4, or 5 o'clock hours, then cross through any of those hour indicators and put the correct hour in. If you work more hours in one day than the DL will accommodate, use a 2nd DL and write page 1 of 2 on the 1st DL and page 2 of 2 on the 2nd.
3. **TIME: MINUTES:** every row is a 15 minute unit. Never divide a unit. Record your time based on what you were doing for the greater part of the 15 minute unit (more than 7.5 minutes).
4. **Document complete:** Documentation complete? This box is for your use, to help assure you that you have completed every note required for the day. It is not a required tracking system, but can be very helpful to keep up with multiple notes and evaluations.
5. **Description (optional):** this column is for your use. You do not have to write anything in this column. You may choose to write out a name if you are concerned your initial code is not clear or if the initial code has not been assigned yet. If you are seeing two or three students, use this area to start

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writing all the initial codes, preceding the group code. You may wish to record what town or school you were at. If you take a break, you can note where you were in this column (i.e., “getting gas”)

6. **Initial Code:** This column is specifically for the 6-digit initial codes that identify each patient. These codes are found on the e-Referrals and the compiled list. Once an initial code is assigned it is never changed. Do not ever make up an initial code. Do not assume that the initial code always fits a pattern, because it does not. Use of an incorrect initial code will result in incorrect billing or loss of billing. If you find you have used an incorrect code, it is your responsibility to immediately notify the OA.
7. **Therapy Code:** Refer to the list of Therapy Codes on the right hand side of the page. You will see 13 one letter codes with their descriptions. Only one code can be used in each box. You do not have to have a code written in every box. The last code used will be assumed to be the same code for descending boxes until it is “changed” with the addition of a new code. These Therapy Codes, when entered into the database in conjunction with a therapist’s code, translate into CPT codes appropriate for the discipline of PT, OT, or ST.
8. **Odometer start _____:** Record your beginning mileage on the line at the top of the column. When you arrive at your destination, record your ending mileage. This should be recorded in the same row as when the travel time is actually ending, so the mileage will be billed to the correct payor source.
9. **Miles:** This column is to record the actual number of miles that should be billed to a payor source and should be on the same line as, or referencing, an initial code and payor source. You will get this figure by subtracting your ending destination mileage from your odometer start, which will be the last mileage recorded on a previous line in the Odometer Start column. The mileage billed to a payor source cannot exceed the maximum distance from the clinic to the service location. (Mileage can be split between patients/payor sources to ensure the maximum is not exceeded. It is the therapist’s responsibility to know the approximate mileage from the clinic to the service location.) Total this column at the end of the day. Do not bill any mileage to a payor source if you are “taking a detour” for personal reason, such as to pick up your lunch at a restaurant. Always use “whole” miles, never tenths.
10. **Payor source:** Refer to the column on the right side of the page. There are three main payor sources: clinic, school, EI. “Other” is reserved for use only under specific circumstances, and then only with prior approval.
11. **Check One:** You may only check one of the three boxes in this column, either Travel, Direct, or Indirect, but you must check one for every unit that you are working. If you are on a break (getting lunch or gas, personal errands, or otherwise engaged and not performing work for Sumlar Therapy) then do not check any of the three boxes and draw a line or blot out the three boxes. When you total up each column at the end of the day, you should have a check mark in every box from the time you started your day, until you finished your day, with the exception of those boxes that you have blotted out. This creates a very visual, easy way to account for each of your units and therefore your time.

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- 12. Travel:** check this box when you are relocating from one service area to another. When the travel box is checked, an initial code, mileage, and payor source should be noted. There would never be a therapy code associated with travel, unless when you arrived your patient was absent and listed A or N.
- 13. Direct:** check this box when you are providing direct therapy or consultation. When you check this box you are indicating that the therapy you are providing is related directly to a particular child, and should be counted towards their clinic therapy time, IEP time, or IFSP time. That is why C, the consultation code, is a direct code. In general, the direct time is therapy that can be billed using one of several CPT codes designated for therapy. While consultation time cannot be billed to an insurance company, it is one of our primary functions as school and early intervention therapy providers, and does count towards IEP and IFSP time, and will be recorded as such on the bill to the school and EI programs. *
- 14. Indirect:** check this box when you are performing job functions (dictation, documenting, researching, waiting) or recording information (patient is absent, deferred therapy, cancelled) and you are not directly treating a patient.**

* **Direct codes** may be used as follows:

- C = Consultation
- E = Evaluation (must be used sparingly in the clinic due to reimbursement issues)
- J = Group of 2 (one therapist, 2 patients)
- K = Group of 3 (one therapist, 3 patients)
- L = Group of 4 (one therapist, 4 patients)
- R = NM Re-Ed (Neuromuscular Re-Education, for use as a second unit code for PT's when performing aquatic therapy. Not for Speech or OT use.)
- T = Treatment
- W = Aquatic (for use for PT's only, for the 1st unit of aquatic therapy, to be paired with R)

****Indirect Codes** may be used as follows:

- M = Miscellaneous
- A = Absent (for use in schools)
- N = No Show (for use in clinic and EI; indicates that no attempt was made by the parent to cancel or communicate with the therapist regarding rescheduling)
- X = Cancelled (for use in clinic and EI; indicates the parent communicated in advance that they would not be present for a scheduled appointment)
- D = Deferred (for use in the schools and EI; may be used when the therapist, teacher, or parent defers therapy for a child who is present but

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unable to participate in therapy; may be due to illness, refusal, prior commitments such as a test or school party)

For Time Sheet (box at bottom right corner of DL): Enter time in and out, gathering the information from the rows on the left-hand side of the DL. Total hours worked and multiply by four (4) to find the number of total units for the day.

Notes (upper right-hand corner): Use this section to record any cancellations, no-shows, deferments, etc. that you did not record previously during a time slot. Also make notes about anything unusual, such as travel time without mileage (i.e., “rode with Susie today”) or unusual amounts of Miscellaneous time (i.e., “preparing documentation for school”).

Check and Recheck:

- Check your total mileage. Subtract your beginning mileage from your ending mileage. Compare the total to the total you get when you add up all your individual stops for the day. If your two totals don't match, find your error.
- Compare your total units for the day (found in For Time Sheet) to the total of the three columns to the left: Travel, Direct, and Indirect. If your two totals do not match, find your error.
- Check all initial codes to make sure they are legible and correct.
- Ensure that you have a therapy code properly entered or understood for each patient.
- Ensure you have entered the correct payor source for your patients.
- Don't forget to record all your cancellations for the day in the *Notes* section at the upper right.