



Dental Record Manager Plus (DRM Plus)

Administrator Manual

Version 6.6

July 2015



© 2015 Document Storage Systems, Inc. All rights reserved.

Document Storage Systems (DSS) is a privately held corporation and has been the premier provider of health information and document imaging distribution and storage systems to Veterans Affairs facilities for over seventeen years. DSS is located at 12575 US Highway One, Suite 200, Juno Beach, Florida 33408.

World Wide Web: www.dssinc.com

Dental Record Manager Plus is a trademark of Document Storage Systems, Inc. Outlook, Internet Explorer, and Windows are trademarks of Microsoft Corporation. VistA is a trademark of the Department of Veterans Affairs, Software Services, and Computerized Patient Record System.

No portion of this manual or software may be reproduced without the prior written consent of Document Storage Systems, Inc.

Table of Contents

- Introduction..... 8**
 - Document Storage Systems, Inc. 8
 - From the Department of Veterans Affairs 8
 - Introduction..... 8
 - Quality Improvement/Performance Measures and Benefits 9
 - Customer Support 9
- Dental Record Manager Plus User and Administrator Requirements..... 10**
 - DRM Plus User Requirements..... 10
 - Administrator Option 11
- Accessing DRM Plus 12**
 - Access 12
- Using the DRM Plus Drop-Down Menus..... 16**
 - File 16
 - Refresh Patient Chart* 16
 - File Administrative Time* 16
 - File Fee Basis* 17
 - Print* 18
 - Spell Check* 19
 - Save Unfiled Data*..... 20
 - Exit*..... 21
 - Edit..... 21
 - Copy*..... 21
 - Cut*..... 21
 - Paste* 22
 - Select All* 22
 - Dental Encounter Data..... 23
 - Create New PCE Visit*..... 23
 - View Scheduled Appointments and Historical Visits* 24
 - Treatment & Exam..... 27
 - Show Configuration*..... 28
 - Add/Edit Personal QuickList* 39
 - Add Medical Codes to ADA Table*..... 40
 - Edit Code Information in the ADA Table* 42
 - Edit Procedure Costs*..... 43
 - Filter View* 44
 - Clean Slate*..... 45
 - Undo Clean Slate*..... 50
 - All Planned Care to Clipboard*..... 51
 - Tools 52
 - Windows Calculator* 52
 - Windows Explorer*..... 52
 - Windows Notepad*..... 52
 - User Inquiry*..... 53
 - User Options*..... 55
 - Administrative Toolbox*..... 71
 - Panel Add/Edit*..... 84
 - Provider Add/Edit*..... 85
 - Ancillary Tool Functions – ADA Website*..... 88
 - Reports 89

<i>Reports</i>	89
<i>Service Reports</i>	111
<i>Data Warehouse Reports</i>	113
<i>Extract History File</i>	115
<i>New Extract History File</i>	117
Help.....	120
<i>Contents</i>	120
<i>Version Release Notes</i>	120
<i>Last Broker Call</i>	121
<i>VA Intranet Website</i>	122
<i>About</i>	122
DRM Plus Banner	123
Patient Information.....	123
Visit Information.....	124
Dental Provider Information.....	125
Vitals Lite.....	126
Dental Class Information.....	126
Clean Slate.....	126
Icons.....	127
<i>Coding Standards</i>	127
Patient Flags.....	127
<i>Clinical Reminders</i>	127
<i>Consult</i>	127
<i>Exam Quality Indicator</i>	128
<i>Fluoride Quality Indicator</i>	128
<i>Alerts</i>	129
Cover Page	131
Dental Eligibility.....	132
<i>Dental Class</i>	132
<i>Service Connected Teeth/Service Trauma</i>	132
<i>Adjunctive Medical Condition(s)</i>	133
<i>Eligibility Expiration Date</i>	134
<i>Anticipated Rehab Date</i>	134
Demographics.....	135
Case Management.....	135
<i>Status</i>	135
<i>Suggested Recare Date</i>	135
Recent Dental Activity.....	136
Fluoride Indicator Prescription Date.....	136
Dental Alerts.....	137
Notes.....	137
Filed Planned Care.....	138
Clinical Record	139
Problems.....	141
Consultations.....	141
Notes.....	142
<i>Adding a New TIU Progress Note</i>	143
<i>Adding a New TIU Progress Note Addendum</i>	145
Dental History	146
Viewing Dental Information By Tooth.....	147
Viewing Other Dental History Information.....	147

Viewing All Dental History Information	147
Viewing Dental History Information by Episode of Care	148
Episode in Date Range.....	148
Deleting an Encounter.....	148
Chart/Treatment – Treatment & Exam.....	150
Diagnostic Findings	152
<i>Editing Diagnostic Finding Descriptions</i>	153
<i>Deleting a Diagnostic Finding</i>	153
Treatment Plan.....	154
<i>Entering a Treatment Plan</i>	154
<i>Editing a Treatment Plan Description</i>	156
<i>Deleting a Treatment Plan</i>	157
<i>Completing a Treatment Plan</i>	157
Completed Care	158
<i>Entering Completed Care</i>	158
<i>Editing Completed Care Description</i>	159
<i>Deleting a Completed Care</i>	159
Include “Completed”/Include “Findings and Completed”/Include “Findings”	160
Perio Buttons Icon	161
Seq Plan/Sequencing Button.....	162
<i>Plan a Treatment Sequence</i>	163
<i>Complete a Planned Treatment in the Sequencing Screen</i>	163
<i>Deleting a Planned Treatment in the Sequencing Screen</i>	164
Chart Hx (History) Button	164
Summary Button.....	165
H&N Button.....	166
PSR Button	169
OHA (Oral Health Assessment) Button.....	170
TMJ Button.....	172
Occl (Occlusion) Button	173
Habits (Parafunctional) Button	175
Social Hx (Social History) Button	176
<i>Multiple Filings to Same Modal on Same Day</i>	177
Chart/Treatment – Periodontal Chart.....	179
History and Compare Buttons.....	180
Summary Button	181
H&N Button.....	181
PSR Button	181
Stats Button.....	182
OHA (Oral Health Assessment) Button.....	182
Notes Button	183
Entering Periodontal Information	184
Other Tools	185
Exam	186
Exam Elements	188
<i>Presentation/Chief Complaint Element</i>	188
<i>Vitals Elements</i>	189
<i>PMH (Past Medical History) and Medications Element</i>	190
<i>Social History Element</i>	191
<i>H&N (Head and Neck) Findings Element</i>	192
<i>Radiographic Findings Element</i>	193

<i>Diagnostic Findings Element</i>	194
<i>Periodontal Assessment Element</i>	195
<i>Parafunctional Habits Element</i>	198
<i>TMJ Findings Element</i>	199
<i>Occlusal Findings Element</i>	200
<i>Salivary Flow Element</i>	201
<i>Removable Prosthesis Element</i>	202
<i>Assessment/Plan Element</i>	203
<i>Patient Education Element</i>	204
<i>Disposition Element</i>	205
<i>Import Previously Filed Data Screen</i>	206
Completing the Encounter	208
Potential Duplicate Transactions Screen.....	212
File Data Option Screen.....	213
<i>File to PCE/DES with Code</i>	213
<i>File to DES-Only Data</i>	214
Filing Options Screen	214
<i>Filing Options</i>	214
<i>Visit Date/Time</i>	214
<i>Encounter Dental Class</i>	215
<i>Disposition</i>	215
<i>Suggested Recare Date</i>	215
<i>Primary PCE Diagnosis & Send Dx to CPRS Problem List</i>	216
<i>Service Connection</i>	216
<i>Additional Providers/Additional Signers</i>	217
<i>Station</i>	218
Progress Note Screen.....	218
<i>Viewing/Importing DRM Object/Progress Note</i>	219
<i>Viewing/Importing CPRS Templates</i>	219
<i>Importing VistA Medical Information</i>	219
<i>Other Options in the Import Menu</i>	220
<i>Accessing Dental CNTs</i>	220
<i>Electronic Signature</i>	220
<i>Progress Note Addendum</i>	221
CNT Navigator	222
<i>Navigating Within CNTs</i>	223
Consult Notes.....	225
Resident Filing as Cosigners or Distributed Providers	227
Appendix A – Glossary of VA Terms	229
Appendix B – Common Application Functions	233
Appendix C – Hints and Notes	235
Save Unfiled Data.....	235
Dental Class Displayed on Banner	235
Diagnostic Findings	235
Treatment Plan.....	235
Multi-Add Screen	236
Ranged Codes	236
Speed Codes.....	236
Tx Planning/Sequencing Screen	236
Completed Care	237
Periodontal Chart	237

Completing the Encounter	238
Reports – Non-Clinical Time by Provider	240
Code Boilerplates.....	240
Last Broker Call.....	240
Recent Dental Activity.....	240
Appendix D – Icon Definitions	241
Diagnostic Findings	241
Treatment Plan.....	244
Completed Care	246
Special Descriptions – Bridge Icon.....	248
Special Descriptions – Conn Bar Icon.....	249
Special Descriptions – Notes Icon	249
Appendix E – Create Reports in MS Excel and Access.....	250
Developing Excel Reports	250
Creating Custom Reports Using Excel	253
<i>Deleting Columns or Rows</i>	<i>253</i>
<i>Expanding Columns or Rows.....</i>	<i>254</i>
<i>Field Formatting Options</i>	<i>254</i>
<i>Creating a Header For a Report</i>	<i>257</i>
<i>Sorting Data.....</i>	<i>259</i>
<i>Subtotaling Data.....</i>	<i>260</i>
<i>Pull Down Options.....</i>	<i>261</i>
Importing the DRM Plus Extract Text File into an Access Report.....	262
Importing the DRM Plus Extract Excel File into Access Database.....	269
Appendix F – Transmission & Correction of Processed DES Data	274
HL7 Transaction Data from Dental will be Automatically Resent.....	276
Additional Reporting Data will be Sent to CDCO.....	276
Appendix G – Using the Keyboard to Enter Periodontal Data	277
Overview.....	277
<i>Navigating the Periodontal Screen.....</i>	<i>277</i>
<i>Arch Views.....</i>	<i>277</i>
<i>Cursor Movement</i>	<i>277</i>
<i>Entering Data</i>	<i>278</i>
<i>Special Buttons</i>	<i>278</i>
<i>Other Functions</i>	<i>278</i>
Appendix H – Ranged Codes.....	279
Appendix I – Active-Inactive Maintenance Control.....	281
Appendix J – Option to Set Dental Patients to Inactive Status.....	283
Appendix K – How to Map Dental CNTs.....	284
Appendix L – Recommendations for Coding of Prosthetic Appliance	286
Appendix M – Business Use of DRM Plus.....	288
Local Policy and Practice.....	288
National Policy and Practice Coding Standards	288
Appendix N – Data Security	289
Appendix O – madExcept Application.....	289
Periodontal Keyboard Shortcuts Tear-Out	289

Introduction

Document Storage Systems, Inc.

DSS, Inc. specializes in the computerization of patient medical charts. Our core specialty within the medical market is building Windows Graphical User Interface (GUI) applications; which insert, update and retrieve patient data held in a MUMPS (M) data repository, or SQL database system. DSS offers an array of GUI products, which allow for the electronic documentation of TIU progress notes and other significant parts of medical records, scanning and viewing of clinical and administrative documents and automated medical record coding through simple points and clicks.

From the Department of Veterans Affairs

Dental Record Manager Plus (DRM Plus) captures specific dentally-related information elements not readily available in CPRS. These elements include: oral cavity/tooth related diagnostic findings, dental-specific care plans and a superset of completed care information. DRM Plus aids the provider in the entry of dental diagnostic information, coding and crediting dental procedures, completing TIU progress notes, and planning and tracking dental patient care. DRM Plus is adjunctive to CPRS and is not designed to replace CPRS for dental users. While some information from CPRS is available, and can be accessed in DRM plus, providers should use all the available tools in the VistA suite of applications. These tools include: VistA Imaging, I-Med Consent, and any clinical system applications specific to the local sites. DRM Plus is a Dental Graphical User Interface front end for data input into the VistA Dental files, as well as the Patient Care Encounter (PCE), Text Integration Utility (TIU) and CPRS Problem List packages.

Introduction

The DRM Plus program is designed to provide dental health care facilities with an intuitive, user-friendly Windows interface for end-users to create encounter information, evaluate patient dental conditions, and develop and maintain the treatment plan. The DRM Plus program is an application that uses RPC Broker technology, which permits the facility users to store and retrieve clinical data within the VistA System.

DRM Plus supports the Veterans Health Administration, Office of Dentistry, continuous quality improvement initiatives by providing added value to the clinical and administrative management of the patient's electronic dental record. The enhanced methods of data capture included in this application continue to eliminate unnecessary paperwork and administrative functions through the automation of clinical dental data.

The use of DRM Plus results in more accurate insurance billing for dental visits, consults and procedures. This application supports the filing of Dental Encounter System (DES) within the guidelines established by the Veterans Health Administration, Office of Dentistry.

Some features of DRM Plus are summarized in the following:

- Entry of dental conditions, plans and completed procedures through the use of graphic icons with extensive use of color schemes.
- Upper/Lower/Full Views with full color coded graphics.
- Sequencing of Treatment Plan procedures
- Dental History with date-change capability
- Quadrant or Tooth summaries
- Head/Neck Findings availability
- Periodontal charting
- Full Mouth Plaque Index with definitions
- ADA/Local/Quick Codes
- Creation and maintenance of tooth-specific and general patient notes.

Quality Improvement/Performance Measures and Benefits

DRM Plus supports the VA Administration, Office of Dentistry's continuous quality improvement initiatives by providing added value to the clinical and administrative management of the patient's electronic dental record. The efficient data capture methods included in this product eliminates unnecessary paperwork and administrative functions. Additional quality improvement benefits and sample performance measures include:

- Performances Measures
- Reductions in operating cost and improved services through better integration of VHA resources and data.
- Supports high level job satisfaction by providing clinicians with feedback regarding quality of care and promotes a culture that places a high value on individual and collective accountability through reporting.
- Promotes a VHA culture of ongoing quality improvement that is predicated on providing excellent health care value.
- Accuracy and usefulness of data increases based on the reduction of data entry points and decreased potential for error.
- Enhanced capability to measure quality of care consistent with the VA Dentistry GPRA Performance Plan.

Customer Support

DRM Plus is supported in the same manner as any other nationally supported software product. Problems should be reported to the local site ADPAC and/or Help Desk, who in turn utilize the Remedy system to log and track problems. Help desk support is provided from 8:00 AM to 7:00PM Eastern Standard Time, Monday through Friday. Documenting problems provides a means to find and disseminate solutions to those involved in any area of DRM Plus or VistA.

Dental Record Manager Plus User and Administrator Requirements

DRM Plus User Requirements

1. DRM Plus users must have a valid **Person Class** in VistA file 200 (New Person File) to file data in DRM Plus.
 - a. ALL residents and fellows must have one of the following three person classes: **V030300**, **V115500**, or **V115600**, and this requires the resident to select a distributive provider (attending) as the primary provider when filing to DES and PCE.
 - b. DRM Plus users must have a **Person Class** (different than the three listed above) to file data in DRM Plus. DRM Plus users that do NOT have a Person Class will receive an “!”-screen (Informational) stating the user is required to have an active Person Class to file data in DRM Plus. Please contact IT support for assignment of Person Class.
 - c. DRM Plus users without a **Person Class** assigned may file an unsigned encounter for another provider or save unfiled data for another provider.
2. Dental Residents and Fellows using DRM Plus must have a valid **User Class** in VistA TIU if they require a cosigner. Please refer to the Authorization/Subscription Utility (ASU) User Manual to insure that Dental Residents are prompted for cosignature on all Progress Notes and Consults. This is typically done by a Clinical Coordinator, IT Staff, ADPAC or other manager using the Document Parameter Edit option on the TIU Parameters Menu on the IRM Maintenance Menu. The USERS REQUIRING COSIGNATURE field within the Document Parameter Edit option indicates which groups of users (i.e., User Classes) require cosignature for the type of document in question.
3. All DRM Plus users filing TIU progress notes must have an **electronic signature** in VistA file 200 (New Person File).
4. All DRM Plus users must have a **default division (station number)** in VistA file 200 (New Person File) for the station number to appear as the default (preselected) when filing an encounter.
5. All DRM Plus users must have the secondary menu option **DENTV DSS DRM GUI** assigned to access DRM Plus.
6. All DRM Plus users filing encounters should have their **initials defined** in the new person file (200) so that they will appear in the DRM Plus transaction tables.
7. All DRM Plus users (except Cover Page Only users) must have an active **8-Digit Dental Provider ID** in the VistA Dental Provider File (220.5) to open DRM Plus and file data. DRM Plus users that do NOT have an 8-Digit Dental Provider ID will receive a “Red X”-screen (Stop) stating that they are required to have an active Dental Provider ID and will be denied access to DRM Plus. Note to DRM Plus application administrators: Use the DRM Plus option Provider Add/Edit on the Tools menu to enter this information. Select the New button if the user name does NOT display in the list.
8. Dental Students should NOT be assigned a Person Class in VistA; they only need an **8-digit Provider ID** and require a **User Class** in VistA TIU (student). The User Class allows them to access CPRS. The dental student may file data for another provider.
9. DRM Plus users that have **Cover Page Only** access require the secondary menu option DENTV DSS DRM GUI assigned and no other requirements to access DRM Plus. Cover Page Only access must be granted by a DRM Plus application administrator.

Note: DRM Plus users must have permission to write and modify to-and-from the **DOCSTORE** folder.

Administrator Option

All DRM Plus application administrators must be DRM Plus users. Enter VistA in Programmer Mode by typing D ^XUP at the VistA prompt and get to "Select Option".

1. At Select Option Name, type: **DENTV XPAR EDIT PARAMS.**
2. At the Select PARAMETER DEFINITION NAME, type: **DENTV DRM ADMINISTRATOR.**
3. At the Select NEW PERSON NAME, type in the name of the person to be made a dental administrator.
4. Set the value to **YES.**

Accessing DRM Plus

Access

To access DRM Plus, first open CPRS and select the desired patient. Open the **Tools** menu in the CPRS tool bar, and select **DRM Plus** from the available submenus.

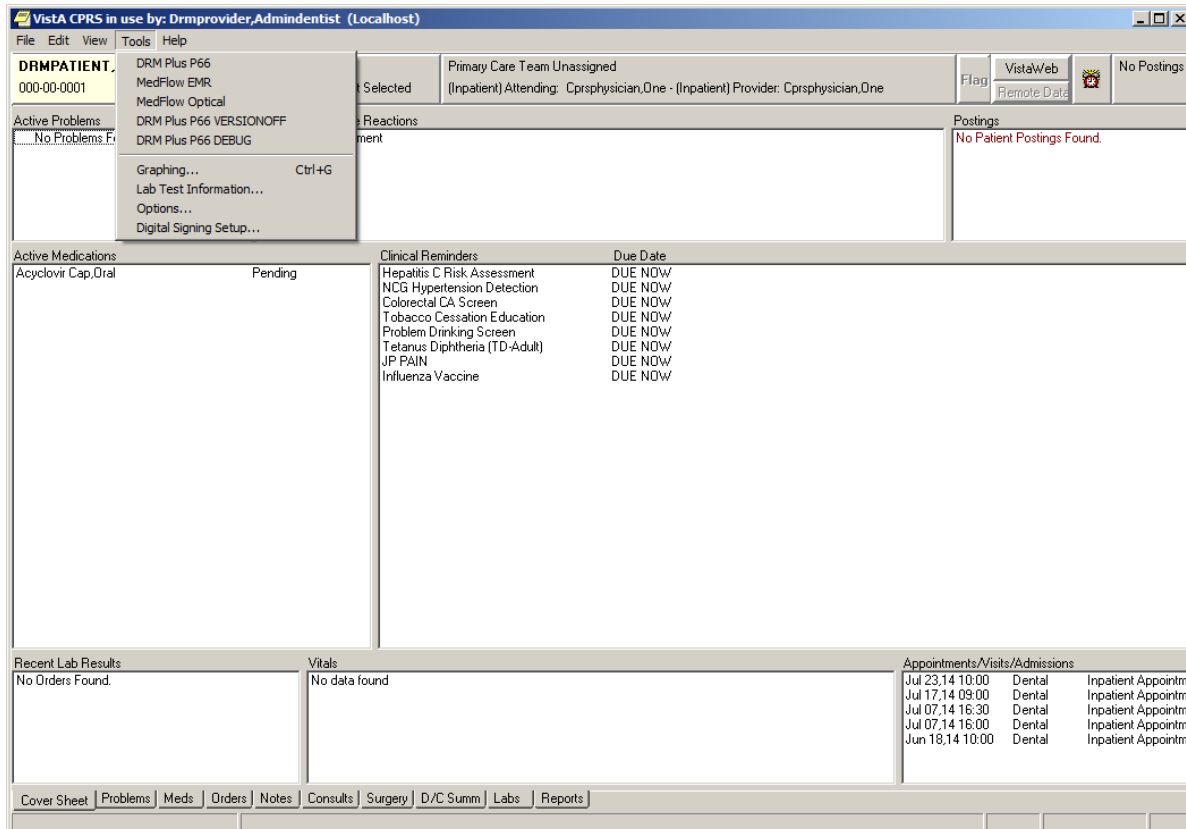


Figure 1: Access DRM Plus through CPRS

DRM Plus opens with the patient information loaded and, unless changed by the user, the **Chart/Treatment** tab as the default opening screen.

Note: Users may be required to re-enter Access/Verify codes when opening DRM Plus. The default opening settings of DRM Plus is the **Treatment Plan** screen on the **Chart/Treatment** tab, unless changed by the user.

Note: The proper ways to close DRM Plus are listed:

1. Selecting the **[X]** button in the upper right corner of the DRM Plus screen; or
2. Selecting **File** menu → **Exit** submenu; or
3. Selecting **Task Manager** → **Application** tab → highlight **Dental Record Manager Plus** task → **End Task** button.

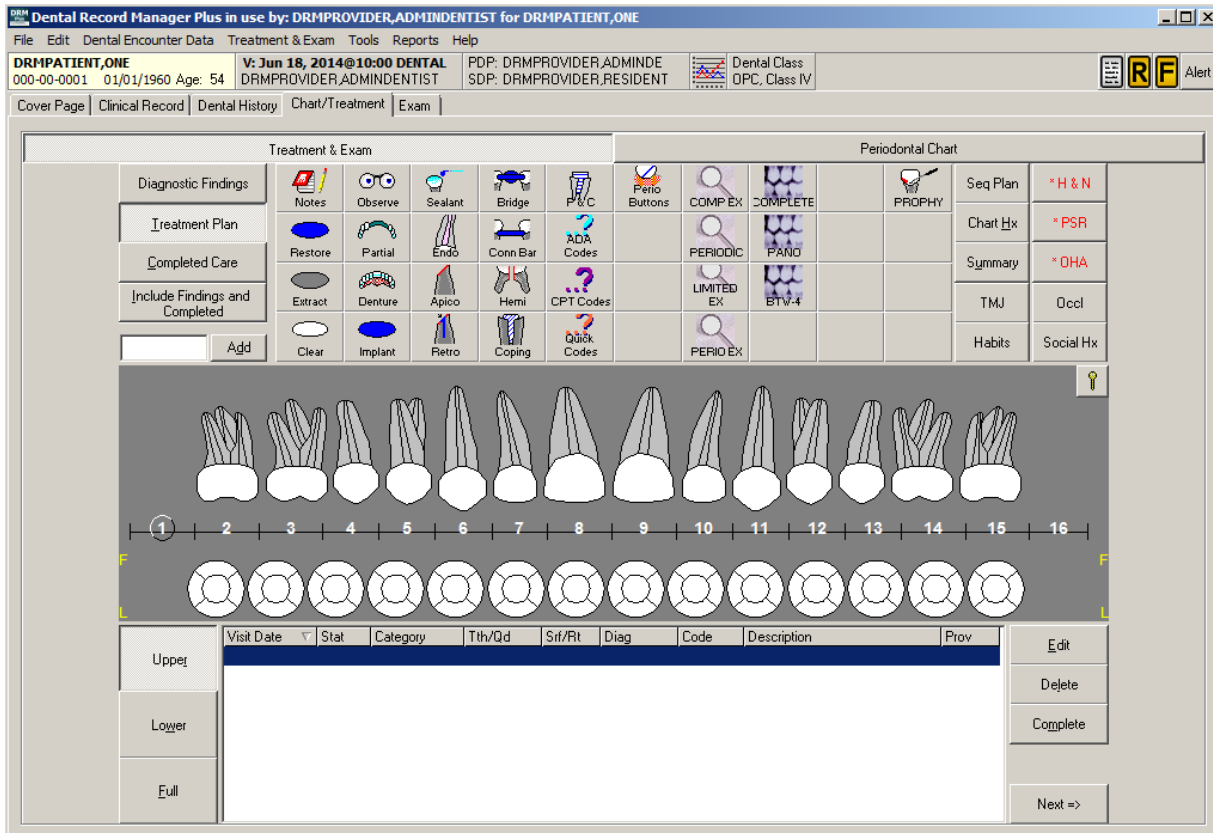


Figure 2: DRM Plus Chart/Treatment Tab

The “!”- screen (Informational) displays when a DRM Plus user does NOT have an active VistA **Person Class**. This user will need to contact the local Help Desk and request an active VistA **Person Class**. One of the requirements to file data in DRM Plus is to have an active VistA **Person Class**. However a DRM Plus user with NO VistA **Person Class** may file an unsigned encounter for another provider or save unfiled data for another provider.

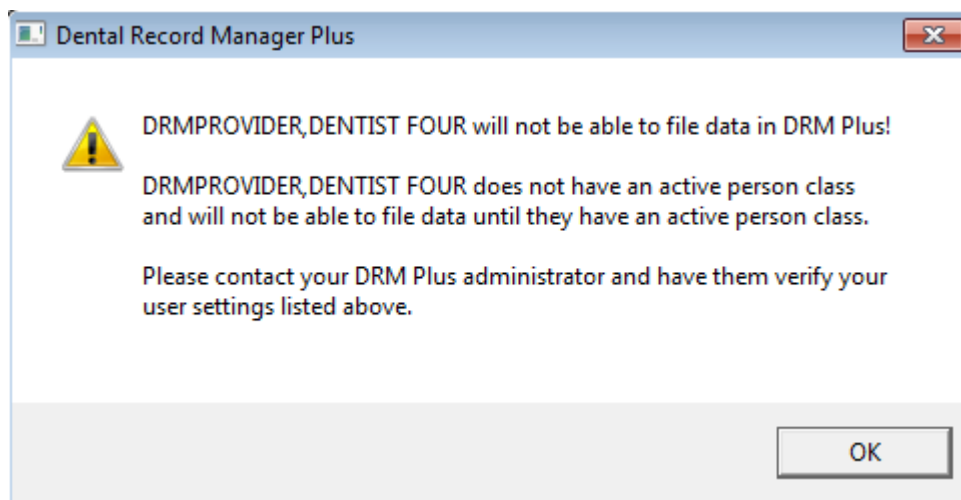


Figure 3: “!”-screen (Informational)

The “Red X”- screen (Stop) displays when a DRM Plus user does NOT have an active **8-Digit Dental Provider ID**. NO access will be allowed to open DRM Plus by the user. A DRM Plus Administrator may create an active **8-Digit Dental Provider ID** from the **Provider Add/Edit** submenu from the **Tools** menu in DRM Plus. One of the requirements to file data in DRM Plus is to have an active **8-Digit Dental Provider ID**.

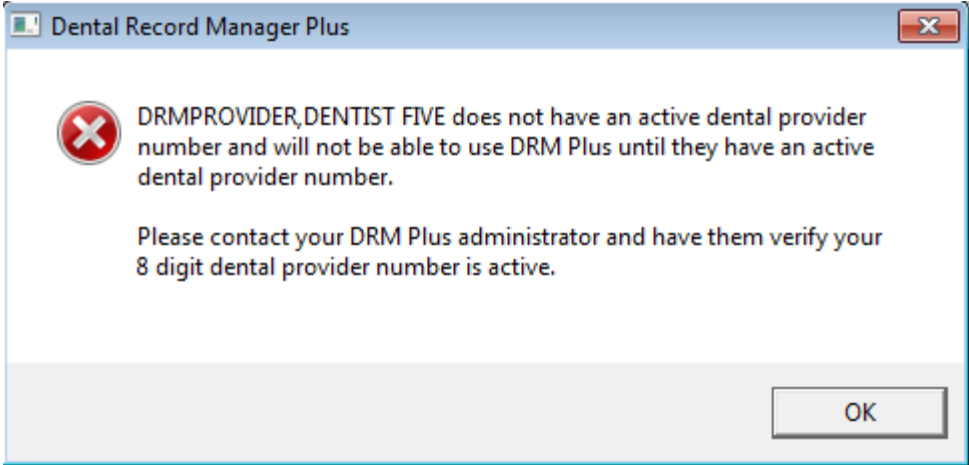


Figure 4: “Red X” –screen (Stop)

Note: No informational warning screen displays to a user with **Cover Page** tab access only.

Two informational screens will display simultaneously when someone opens a DRM Plus patient’s chart that someone else has open. The first informational screen displays the name of the user who first opened the patient’s chart. A second informational screen asks the user to only view the chart until the first user accessing the patient chart closes it, nothing should be entered, edited or deleted. The user receiving the warnings should refresh the patient’s chart or close and reopen DRM Plus after the other user has finished.

There can be issues in DRM Plus when filing entries such as unfiled data or patient’s TIU progress notes when more than one person is accessing the same patient chart.

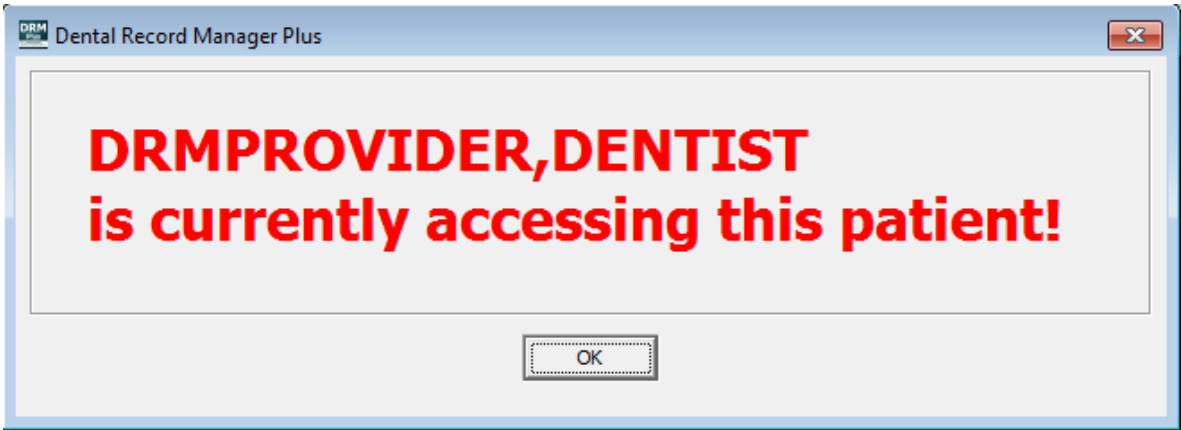


Figure 5: First Warning Informational Screen



Figure 6: Second Warning Informational Screen

In the following pages, the various parts of DRM Plus are highlighted and the functionality of the program is explored. The main screen is broken into three distinct parts. The drop-down menus allow the user to access various menus throughout the program, regardless of which tab is in use. Some drop-down menu functions are NOT available with every different tab. In this case, the menu function is disabled when the tab is open.

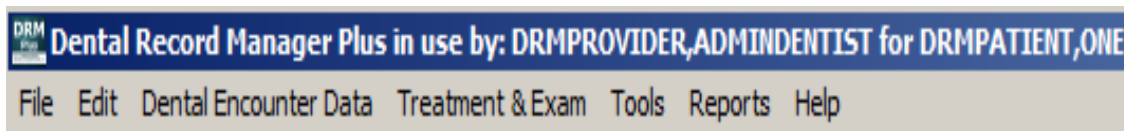


Figure 7: DRM Plus Drop-Down Menus

The banner contains patient, visit/location and provider/patient information. There are also coding standards and alerts icons on the banner.

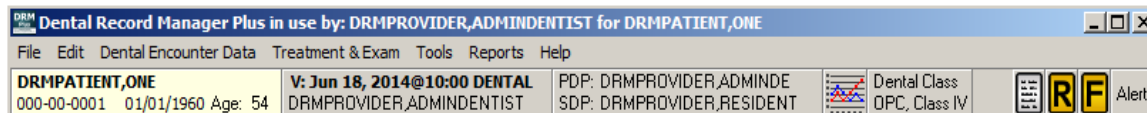


Figure 8: DRM Plus Banner

The tabs are the heart of DRM Plus. They allow the user to create a new exam template, new treatment plan, view the dental history of a patient, view clinical records, and create a text note or a text note addendum. All providers may perform myriad tasks by simply clicking through each of the tabs and adding the pertinent information that is allowed in the appropriate place.

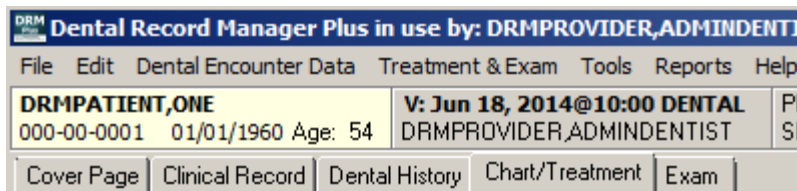


Figure 9: DRM Plus Tabs

The following chapters explore the functionality of each of the areas of the program in detail.

Using the DRM Plus Drop-Down Menus

The DRM Plus drop-down menus consist of seven menus: **File, Edit, Dental Encounter Data, Treatment & Exam, Tools, Reports and Help.**

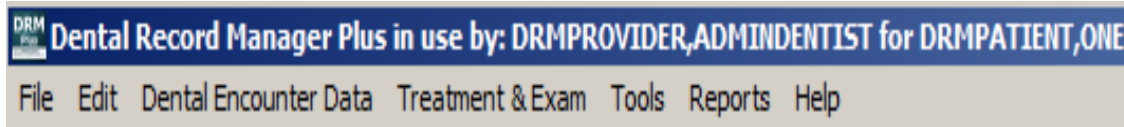


Figure 10: DRM Plus Drop-Down Menus

File

The **File** menu contains seven submenus: **Refresh Patient Chart, File Administrative Time, File Fee Basis, Print, Spell Check, Save Unfiled Data** and **Exit**. The **Spell Check** is only active in the note and note addendum screens.

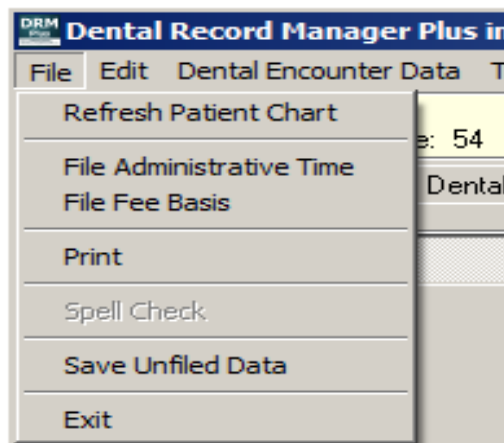


Figure 11: DRM Plus File Menu

Refresh Patient Chart

The **Refresh Patient Chart** submenu allows DRM Plus users to refresh the patient's chart while working in DRM Plus.

File Administrative Time

When the **File Administrative Time** submenu is selected from the **File** menu, the **File Administrative Time** screen displays.

Figure 12: File Administrative Time Screen

1. Use the drop-down menu near the top of the screen to select the desired **Station Number**.
2. Click the appropriate **radio button** to select the type of administrative time.
3. Use the **up and down arrows** next to the hours and minutes text boxes to adjust how much time is recorded. Note that the minutes can only be adjusted in 15 minute increments.
4. Click the **OK** button. The screen closes and files that administrative time for report usage.

Note: This filing of administrative time is for local use only and does NOT file to the VA-MCA Labor Mapping Access Database Program.

File Fee Basis

When the **File Fee Basis** submenu is selected, the **Dental Record Manager Fee Basis** screen displays.

Figure 13: Dental Record Manager Fee Basis Screen

1. Use the **Report Date** drop-down menu to select a date to edit/delete a previous fee basis entry.
2. Choose the station by clicking the appropriate **radio button**.
3. Click the **Dental Category** drop-down menu to choose a **Dental Class**.
4. Click the **Date Authorized for Payment** drop-down menu to display a calendar. The user may toggle through this calendar to choose the authorized date for payment.
5. Enter the **Total Cost** in the text box.
6. Click the **Finish** button.
7. A screen displays stating that a **Fee Basis** record has been added. Click the **OK** button.

End-user criteria required to allow entering fee basis data within DRM Plus includes:

- Does need to be in the **Dental Provider file** (8-digit provider ID).
- Does NOT need a **Person Class** in VistA.
- Does need access to **CPRS**.
- Does need access to DRM Plus (**DENTV DSS DRM GUI** secondary menu option).
- Does NOT need DRM Plus **administrative access**.

Note: DRM Plus Administrators can run all **Fee Basis** reports. Patient care provided by fee should be entered in DRM Plus as **Diagnostic Findings**.

Note: Fee basis data entered in DRM Plus is only available for local reports created in DRM Plus.

Print

Select the **Print** button to view the **Print** screen.

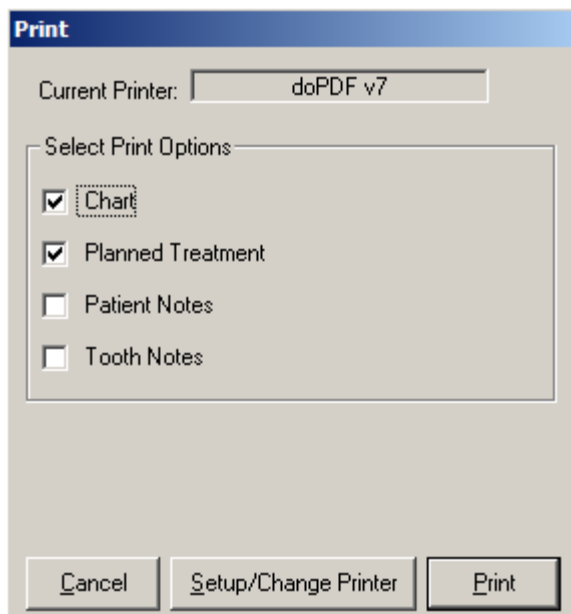


Figure 14: Print Screen

Select the check boxes that correspond to what is to be printed.

Spell Check

Select **Spell Check** to correct possible spelling errors. This feature is only active in note and note addendum screens.

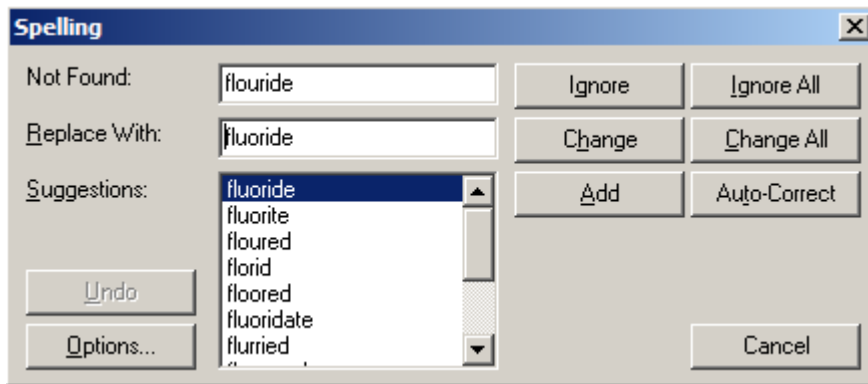


Figure 15: Spelling Screen

The program goes through the text and highlights words that may have been misspelled and suggests possible correct spellings. Use the buttons to **Ignore**, **Change** or **Add** words. Click the **Options** button to select various options, pick a dictionary or add a custom dictionary.

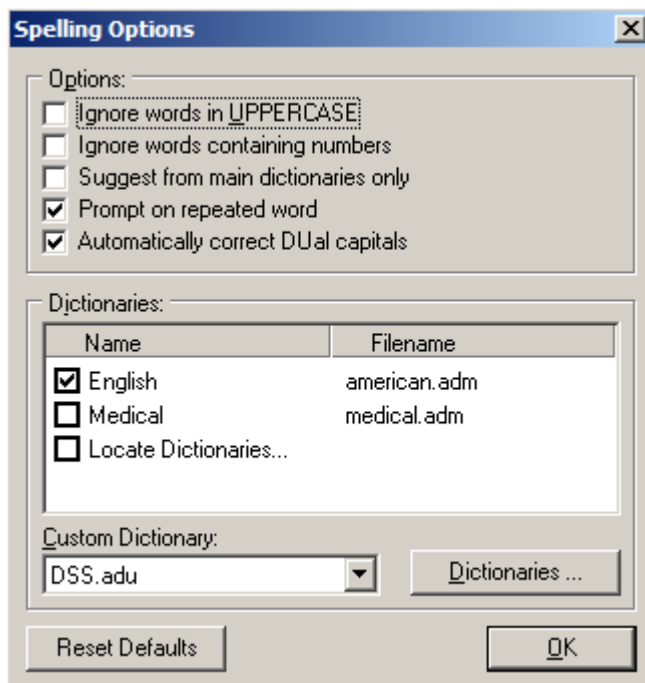


Figure 16: Spelling Options Screen

Click the check boxes beside the desired options and dictionaries and click the **OK** button. The **Spelling Options** screen closes.

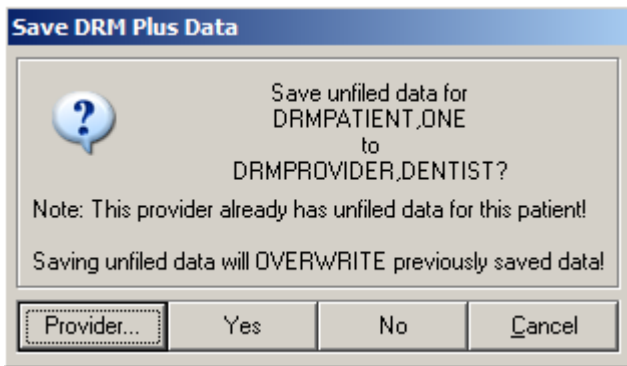


Figure 19: Provider Already Has Unfiled Data

If the user clicks the **Yes** button, previously saved unfiled data originally saved by another dental provider, or this provider, is overwritten. Only one unfiled data entry may be maintained by a single provider, per patient.

Exit

Exit the program by selecting the **Exit** submenu from the **File** menu. The CPRS main screen displays.

Edit

The **Edit** menu consists of four submenus: **Copy**, **Cut**, **Paste** and **Select All**.

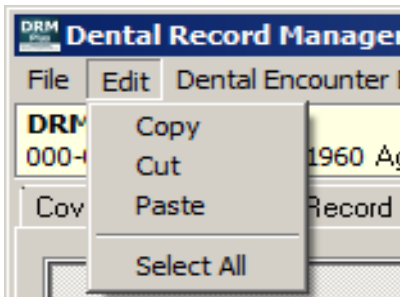


Figure 20: Edit Menu

Copy

To copy, highlight the desired text and choose **Copy**.

Cut

To cut, highlight the desired text and choose **Cut**. The selected text is removed.

Paste

To paste, move the cursor to the area where the copy or cut text is to be replaced. Select the **Paste** submenu to add the text to the chosen area.

Select All

Select All highlights all the text visible on the screen which can be copied and/or cut. Use the **Copy** or **Cut** submenus to complete the desired task.

Dental Encounter Data

The **Dental Encounter Data** menu has two submenus: **Create New PCE Visit** and **View Scheduled Appointments and Historical Visits**.

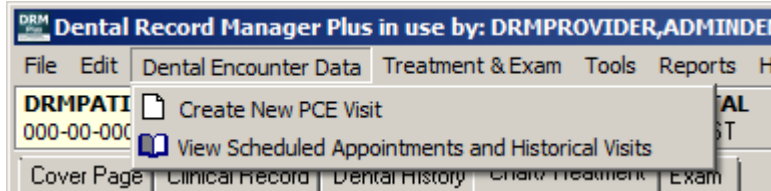


Figure 21: Dental Encounter Data Menu

Create New PCE Visit

Select the **Create New PCE Visit** submenu to display the **Provider and Location/Visit** screen.

Note: This submenu is only available if the DRM Plus Administrator allows new PCE visits to be created in the DRM Plus application. The opening default tab is the **New Visit** tab.

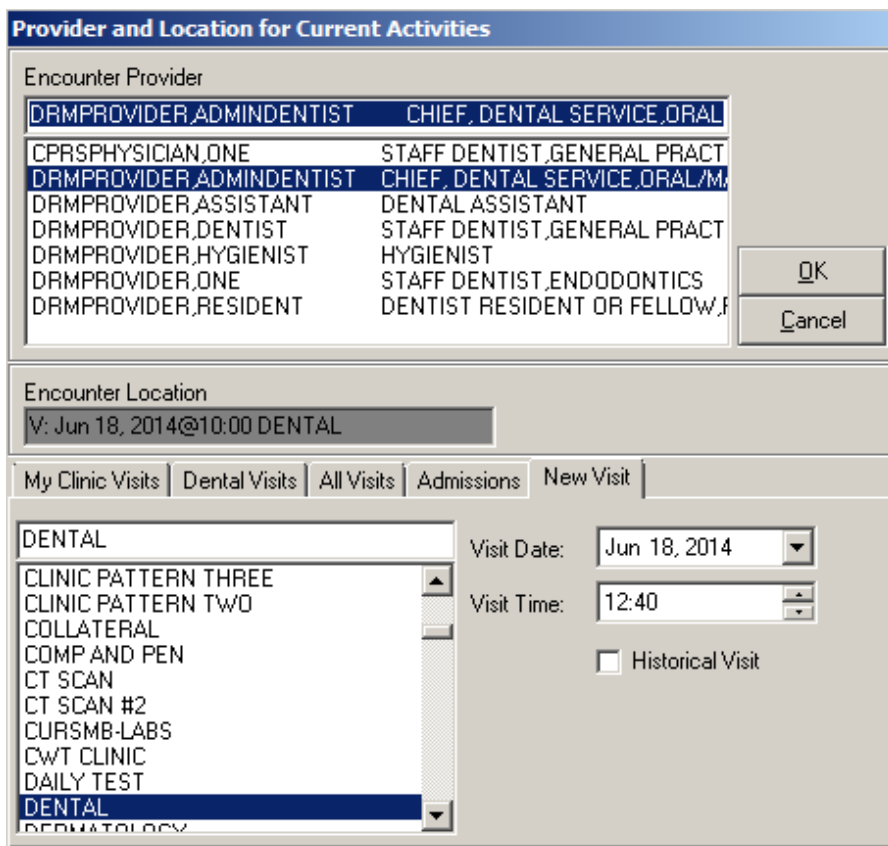


Figure 22: Provider and Location for Current Activities Screen

The **Encounter Provider** field should default to the correct end-user that is signed into Vista. Select the **Encounter Location** if the **Default Location** parameter is **NOT** set in advance. The **Default Location** parameter is explained in the Treatment System section in the Using the DRM Plus Drop-Down Menus chapter of this manual.

Visit Date/Time defaults to the present date/time for a new visit in the **New Visit** tab. The date and time may be changed if desired.

The screenshot shows a software window titled 'New Visit'. At the top, there is a text field for 'Encounter Location' containing 'V: Jun 18, 2014@10:00 DENTAL'. Below this are five tabs: 'My Clinic Visits', 'Dental Visits', 'All Visits', 'Admissions', and 'New Visit'. The 'New Visit' tab is active. On the left side, there is a scrollable list of clinic locations. The list includes: 'DENTAL', 'CLINIC PATTERN THREE', 'CLINIC PATTERN TWO', 'COLLATERAL', 'COMP AND PEN', 'CT SCAN', 'CT SCAN #2', 'CURSMB-LABS', 'CWT CLINIC', 'DAILY TEST', 'DENTAL', and 'DERMATOLOGY'. The 'DENTAL' entry is currently selected. To the right of the list, there are two input fields: 'Visit Date' set to 'Jun 18, 2014' and 'Visit Time' set to '12:40'. Below these fields is a checkbox labeled 'Historical Visit', which is currently unchecked.

Figure 23: New Visit Tab

To record a new visit other than the present date/time:

1. DRM Plus defaults to the present provider; however, a different provider may be selected using the **Encounter Provider** list.
2. Select the clinic location from the scroll menu if the **Default Location** is NOT set.
3. Use the drop-down arrow to toggle through the calendar screen and select a date.
4. Use the up and down arrows to adjust the **Visit Time**.
5. Check the **Historical Visit** check box, if applicable.
6. Click the **OK** button to create the new PCE visit.

Note: Future date appointments may NOT be created in DRM Plus.

Note: Creating a new PCE visit in DRM Plus does NOT update **Appointment Manager** in VistA.

View Scheduled Appointments and Historical Visits

The **My Clinic Visits** tab lists the patient visits for the selected clinic. This tab only displays if a default **Dental Location** parameter is selected. When no default **Dental Location** parameter is selected, the **Dental Visits** tab displays.

To record the scheduled appointment for the patient:

1. DRM Plus defaults to the present provider; however, another provider may be selected from the **Encounter Provider** list.
2. If there is only one scheduled visit, it is automatically defaulted.
3. Select the correct **scheduled visit** in the bottom window, if it is NOT defaulted.
4. Click the **OK** button and the provider/location is set for the scheduled visit.

Provider and Location for Current Activities

Encounter Provider

DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE, ORAL
CPRSPHYSICIAN,ONE	STAFF DENTIST,GENERAL PRACT
DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE, ORAL/M
DRMPROVIDER,ASSISTANT	DENTAL ASSISTANT
DRMPROVIDER,DENTIST	STAFF DENTIST,GENERAL PRACT
DRMPROVIDER,HYGIENIST	HYGIENIST
DRMPROVIDER,ONE	STAFF DENTIST,ENDODONTICS
DRMPROVIDER,RESIDENT	DENTIST RESIDENT OR FELLOW,F

OK
Cancel

Encounter Location

< Select a visit from the tabs below...>

My Clinic Visits | **Dental Visits** | All Visits | Admissions | New Visit

V	Jun 18, 2014@10:00	DENTAL
---	--------------------	--------

Figure 24: My Clinic Visits Tab

The **Dental Visits** tab lists all the dental clinic visits.

Encounter Location

< Select a visit from the tabs below...>

My Clinic Visits | **Dental Visits** | All Visits | Admissions | New Visit

V	Jun 18, 2014@10:00	DENTAL
---	--------------------	--------

Figure 25: Dental Visits Tab

The **All Visits** tab lists all dental visits and admission(s) if the selected patient is an inpatient.

Provider and Location for Current Activities

Encounter Provider

DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE,ORAL
CPRSPHYSICIAN,ONE	STAFF DENTIST,GENERAL PRACT
DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE,ORAL/M
DRMPROVIDER,ASSISTANT	DENTAL ASSISTANT
DRMPROVIDER,DENTIST	STAFF DENTIST,GENERAL PRACT
DRMPROVIDER,HYGIENIST	HYGIENIST
DRMPROVIDER,ONE	STAFF DENTIST,ENDODONTICS
DRMPROVIDER,RESIDENT	DENTIST RESIDENT OR FELLOW,F

Encounter Location
< Select a visit from the tabs below...>

My Clinic Visits | Dental Visits | **All Visits** | Admissions | New Visit

A	OCT 18,2005@13:46	7B
V	Jun 18, 2014@10:00	DENTAL

Figure 26: All Visits Tab

The **Admissions** tab lists the admissions for the selected patient.

Encounter Location
< Select a visit from the tabs below...>

My Clinic Visits | Dental Visits | All Visits | **Admissions** | New Visit

A	OCT 18,2005@13:46	7B
---	-------------------	----

Figure 27: Admissions Tab

Treatment & Exam

The **Treatment & Exam** menu has nine submenus: **Show Configuration**, **Add/Edit Personal QuickList**, **Add Medical Codes to ADA Table**, **Edit Code Information in ADA Table**, **Edit Procedure Costs**, **Filter View**, **Clean Slate**, **Undo Clean Slate** and **All Planned Care to Clipboard**.

Note: The **Add Medical Codes to ADA Table**, **Edit Code Information in ADA Table**, **Edit Procedure Costs**, **Clean Slate** and **Undo Clean Slate** are DRM Plus administrative submenus.

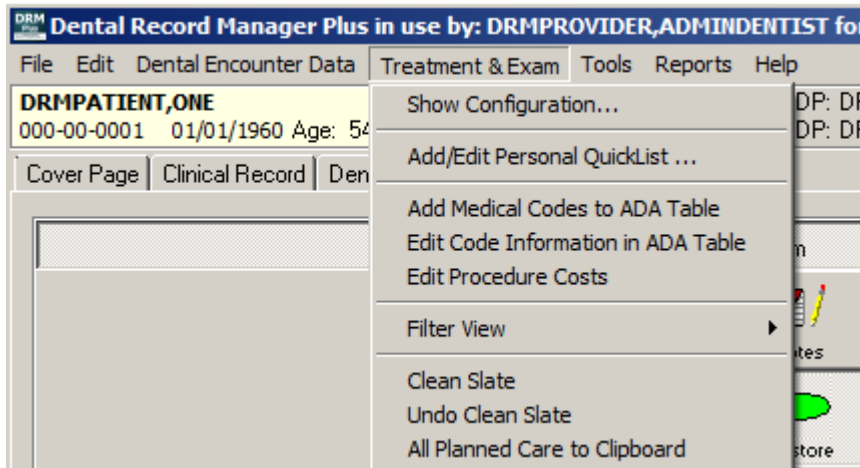


Figure 28: Treatment & Exam Menu

Show Configuration

Select the **Show Configuration** submenu to display the **Charting Configuration** screen.

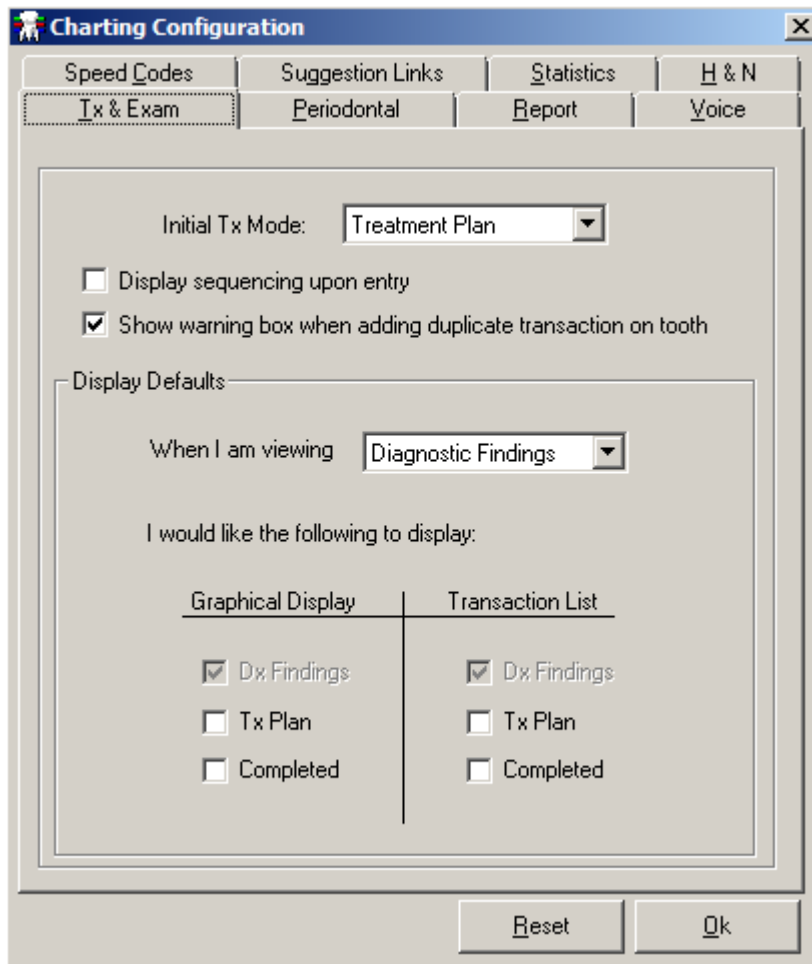


Figure 29: Charting Configuration Screen

Use the various tabs to configure the chart. The tabs are: **TX & Exam, Periodontal, Report, Voice, H&N, Statistics, Suggestion Links** and **Speed Codes**. These parameters on each tab are a user specific function; changing it does NOT impact other users. When finished, click the **OK** button.

Tx & Exam

Use the **Tx & Exam** tab to change the default view screen that displays when DRM Plus is first opened. The original default view screen is the **Treatment Plan** view.

The **Sequencing** screen displayed upon entry is NOT selected as a default parameter; however, showing a warning box when adding duplicate transactions on a tooth for each view chart is a default parameter. Use the check boxes to change these user specific parameter functions.

Use the functions on this tab to fine tune the **Display Defaults**; choose **Graphical Displays** or **Transaction Lists** to display check boxes based on the screen being viewed.

The screenshot shows the 'Tx & Exam' tab selected in a software interface. The tab is part of a larger window with other tabs like 'Speed Codes', 'Suggestion Links', 'Statistics', 'H & N', 'Periodontal', 'Report', and 'Voice'. The 'Tx & Exam' tab contains the following settings:

- Initial Tx Mode: Treatment Plan (dropdown menu)
- Display sequencing upon entry
- Show warning box when adding duplicate transaction on tooth
- Display Defaults section:
 - When I am viewing: Diagnostic Findings (dropdown menu)
 - I would like the following to display:

Graphical Display	Transaction List
<input checked="" type="checkbox"/> Dx Findings	<input checked="" type="checkbox"/> Dx Findings
<input type="checkbox"/> Tx Plan	<input type="checkbox"/> Tx Plan
<input type="checkbox"/> Completed	<input type="checkbox"/> Completed

At the bottom of the tab are 'Reset' and 'Ok' buttons.

Figure 30: Tx & Exam Tab

Periodontal

Choose the **Periodontal** tab to set pocket depth warning and choose the colors that display as pocket warnings and normal pockets on the **Periodontal Chart** screen. Other submenus on this tab include **Show MGJ Trace** and **Exam Sequence**.

The screenshot shows a software window titled "Periodontal" with several tabs: "Speed Codes", "Suggestion Links", "Statistics", "H & N", "Ix & Exam", "Periodontal" (selected), "Report", and "Voice". The main content area contains the following settings:

- Pocket Depth Warning:** A numeric input field containing the value "4".
- Normal Pocket Color:** A color selection box showing a black square.
- Warning Pocket Color:** A color selection box showing a red square.
- Enable ProbeOne:** An unchecked checkbox next to a dropdown menu currently set to "cboProbet".
- Show MGJ Trace:** A checked checkbox.
- Exam Sequence:** A text input field containing "F1, L16, F17, L32" and an "Edit" button to its right.

At the bottom of the window are "Reset" and "Ok" buttons.

Figure 31: Periodontal Tab

To change the exam sequence:

1. Click the **Edit** button.
2. The **Edit Perio Sequence** screen displays.

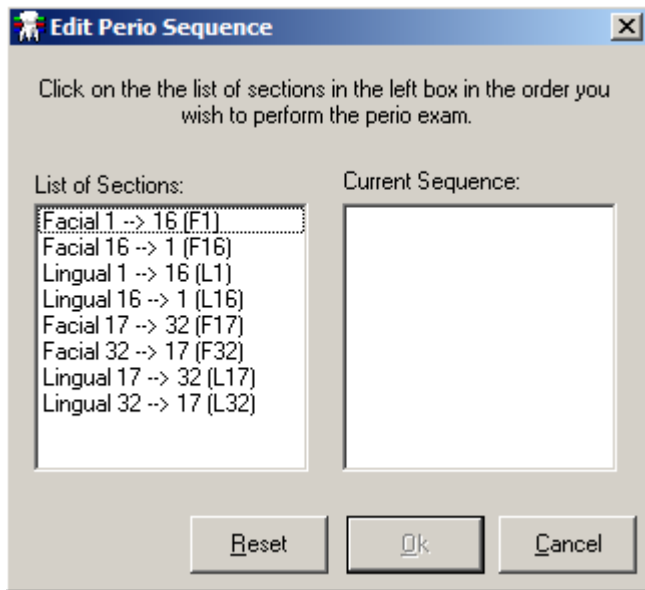


Figure 32: Edit Perio Sequence Screen

3. Click each **Section** in the order in which the perio exam sequence should be performed.
4. Click the **OK** button to save the new exam sequence.

To go back to the original settings, which appeared when this screen was first displayed, click the **Reset** button. Once the exam sequence has been changed and the user has clicked the **OK** button on the **Periodontal** tab, this becomes the permanent default exam sequence.

Report

Use the functions on the **Report** tab to select certain pieces of information, which appears on individual reports when using the **Print** option under the **File** menu. The **Chart** selection prints the graphic chart, displayed on the last view screen of the **Chart/Treatment** tab, prior to the chosen **Print** submenu. The **Transactions** selection prints the transaction table, displayed on the last view screen of the **Chart/Treatment** tab, prior to the chosen **Print** submenu. **Patient Notes** and **Tooth Notes** selections print the entries entered using the **Notes** icon.

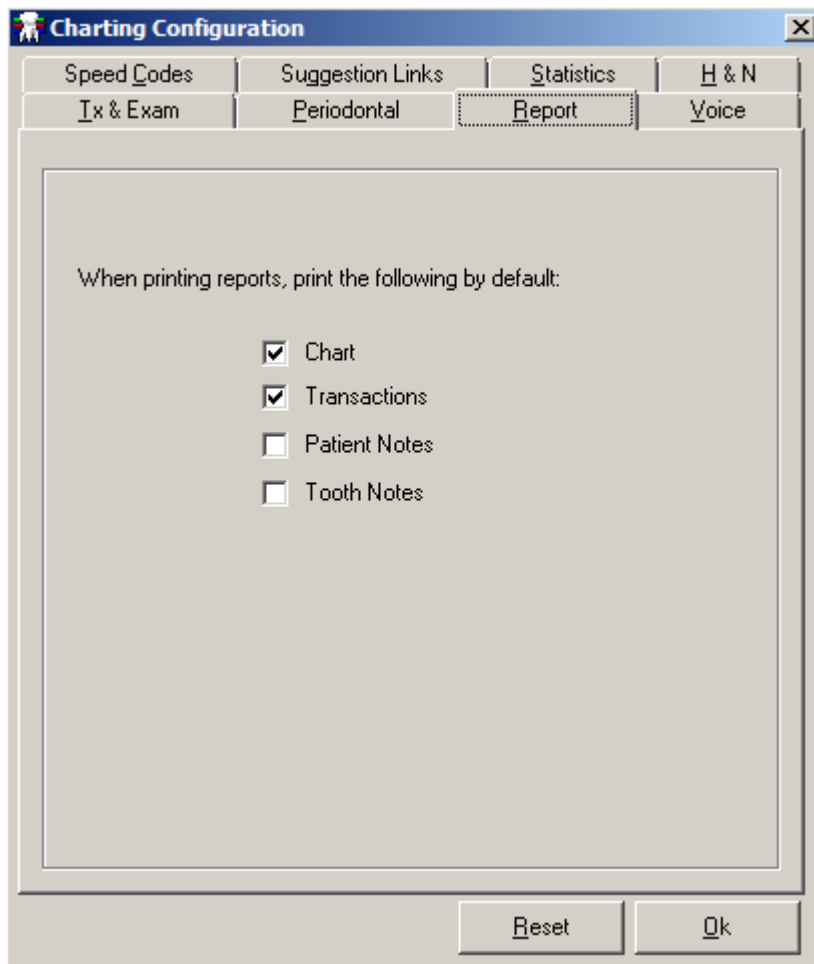


Figure 33: Report Tab

Voice

Voice is NOT enabled in DRM Plus.

Speed Codes

Use the **Speed Codes** tab to set/create individual icons in DRM Plus for frequently used procedure codes entered using the **Treatment Plan** or **Completed Care** viewing screens.

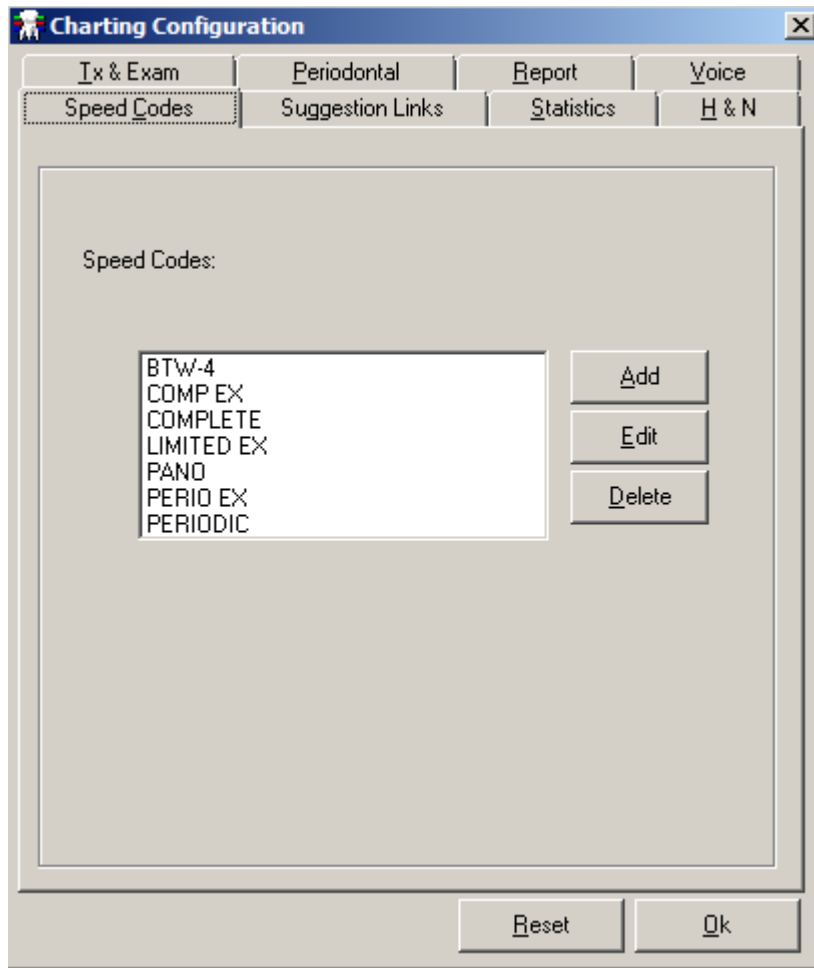


Figure 34: Speed Codes Tab

To add a Speed Code:

1. Click the **Add** button. The **Edit Speed Code** screen displays.
2. Add a new **Name**, which cannot exceed 10 characters. Entering a description is optional.
3. Use the search function, **ADA Codes**, to look up a procedure code(s) and add it to the new speed code.
4. Entering an icon is optional.
5. Click the **OK** button to begin finalization.

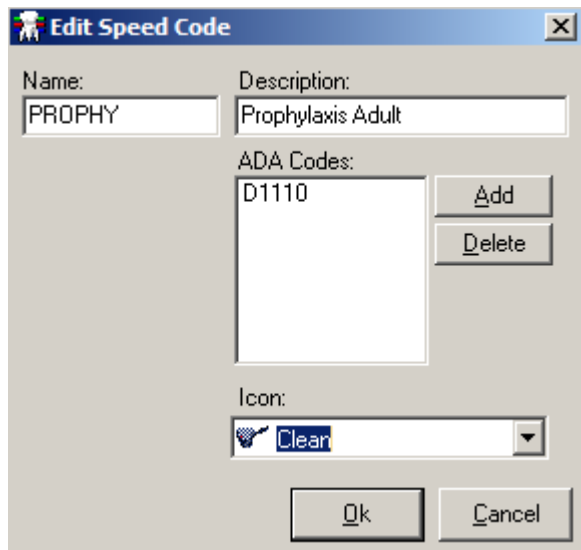


Figure 35: Edit Speed Code Screen

To edit or delete the speed code, highlight the **desired name** in the **Speed Codes** tab and click the **Edit** or **Delete** button. Provide appropriate entry in the subsequent screens; otherwise, click the **OK** button to complete this part of the process.

To complete the speed code process:

1. Move to the **Completed Care** or **Treatment Plan** view of the **Treatment & Exam** screen.
2. Click one of the undesignated icon squares. The **Configure Button** screen displays.

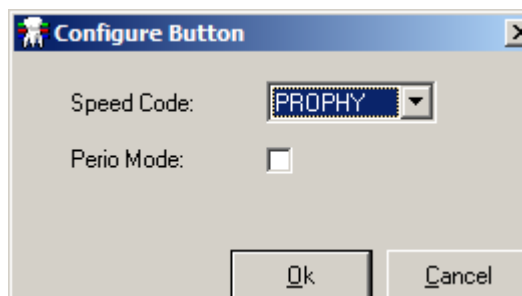


Figure 36: Configure Button Screen

3. Click the **drop-down arrow**, highlight and click the desired **Speed Code** name.
4. Click the **OK** button and the speed code is linked to that icon.

The **Perio Mode** check box on the **Configure Button** screen designates the viewing preference when the **Perio Buttons** icon is clicked. The **Perio Buttons** icon is used as a toggle for displaying another 19 available icon buttons. Clicking the **Perio Buttons** icon displays any 19 **Speed Code** icons that have been designated in the **Perio Mode** (check box clicked) while hiding any non-perio mode **Speed Code** icons from the display. Clicking the **Perio Buttons** icon again reverses the display. This option allows for a total of 38 **Speed Code** icons to be created. The 19 non-perio mode speed codes are the default **Speed Code** icons when DRM Plus is initially opened. Please see the Perio Buttons Icon section, in the Chart/Treatment – Treatment & Exam chapter of this manual, for more information.

Suggestion Links

Use this tab to enter code suggestions, when entering one procedure code which is linked to another procedure code(s), without having to use an icon to find the other code. A screen displays asking if other linked codes should be added providing an opportunity to decline the entry of suggested linked codes.

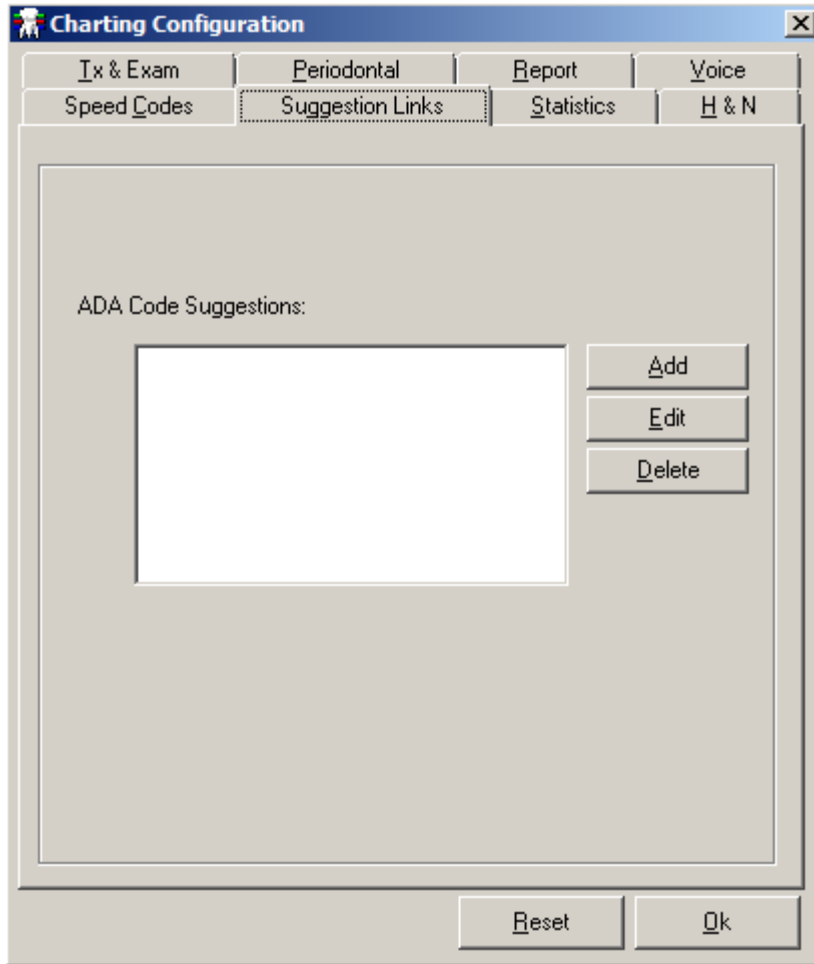


Figure 37: Suggestion Links Tab

To add a suggestion link:

1. Click the **Add** button.
2. A screen displays featuring a list of all DRM Plus procedure codes. Click the desired **primary procedure code** that other procedure codes are linked to, and then click the **OK** button.

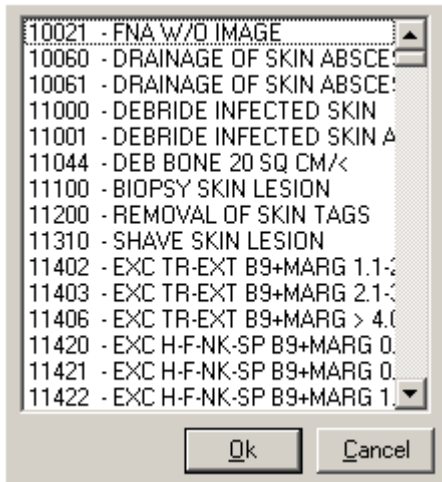


Figure 38: Suggestion Links Code List

3. A screen requesting the linked codes to the primary procedure code displays.

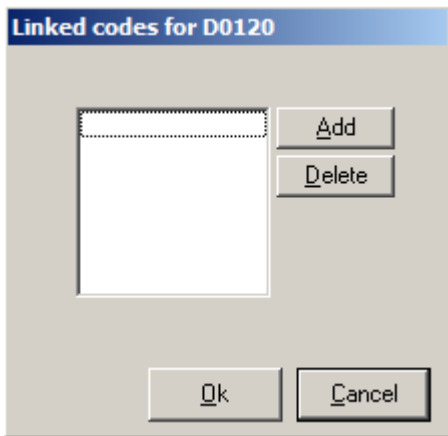


Figure 39: Linked Codes Screen

4. Click the **Add** button to add the first linked code. The list of all DRM Plus procedure codes displays again.
5. Choose the second code to be linked with the primary procedure code and click the **OK** button.
6. Add as many linked codes to the primary procedure code as desired. To finish and return to the tab, click the **OK** button.

Note: As many codes as necessary can be linked. Simply continue clicking the **Add** button on the **Linked codes** screen and choosing more codes from the list.

To edit the suggestion link:

1. Select a suggestion link to be edited and click the **Edit** button. The **Linked codes** screen displays.
2. Click the **Add** button for another procedure code, and the list of procedure codes displays. Click the **OK** button.
3. To remove a linked code entry, click the **Delete** button and then the **OK** button.

To delete the suggestion link, select the suggestion link and click the **Delete** button.

Statistics

Choose the **Statistics** tab to set the warning level for pocket depth, free gingival margin, mucogingival junction, furcation and mobility.

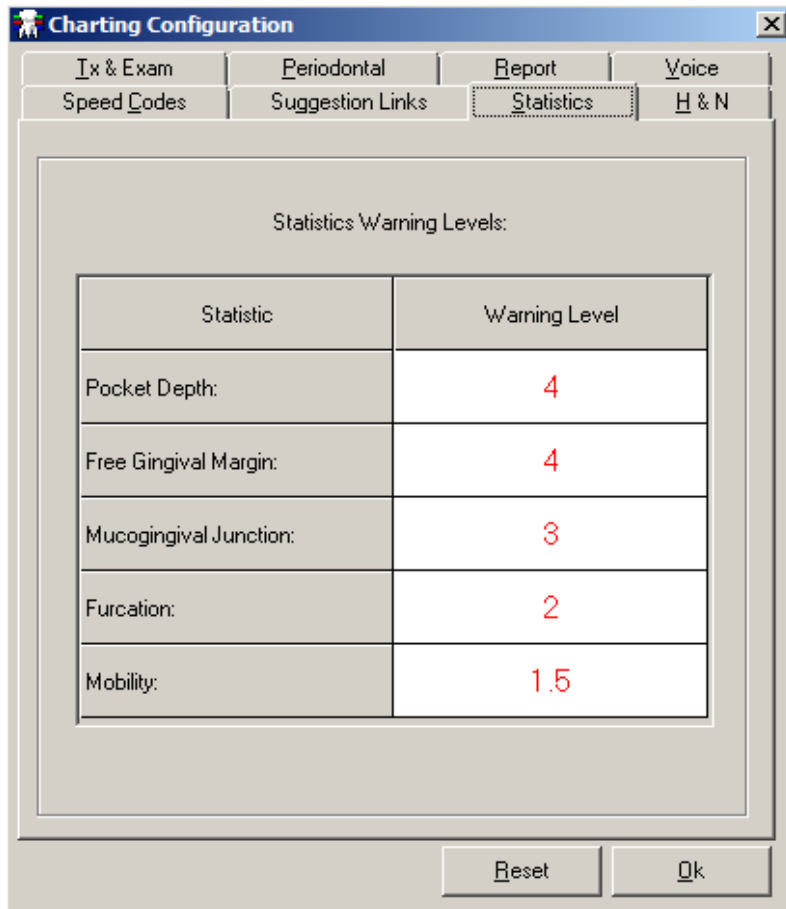


Figure 40: Statistics Tab

To change the warning level:

1. Double-click the box containing the **Warning Level** to be changed.
2. A screen displays. Enter the new warning level in the text box and click the **OK** button.

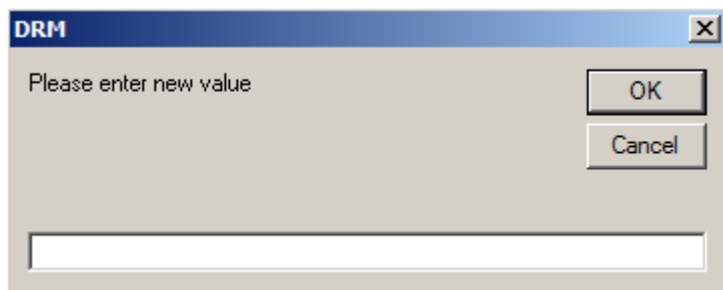


Figure 41: Adjust the Warning Level

3. The **Warning Level** is changed on the tab.

H&N

Use the **Add** and **Delete** buttons to add/delete the head and neck findings available on the **H&N** screen accessed from the **Treatment & Exam** and **Periodontal Chart** screens.

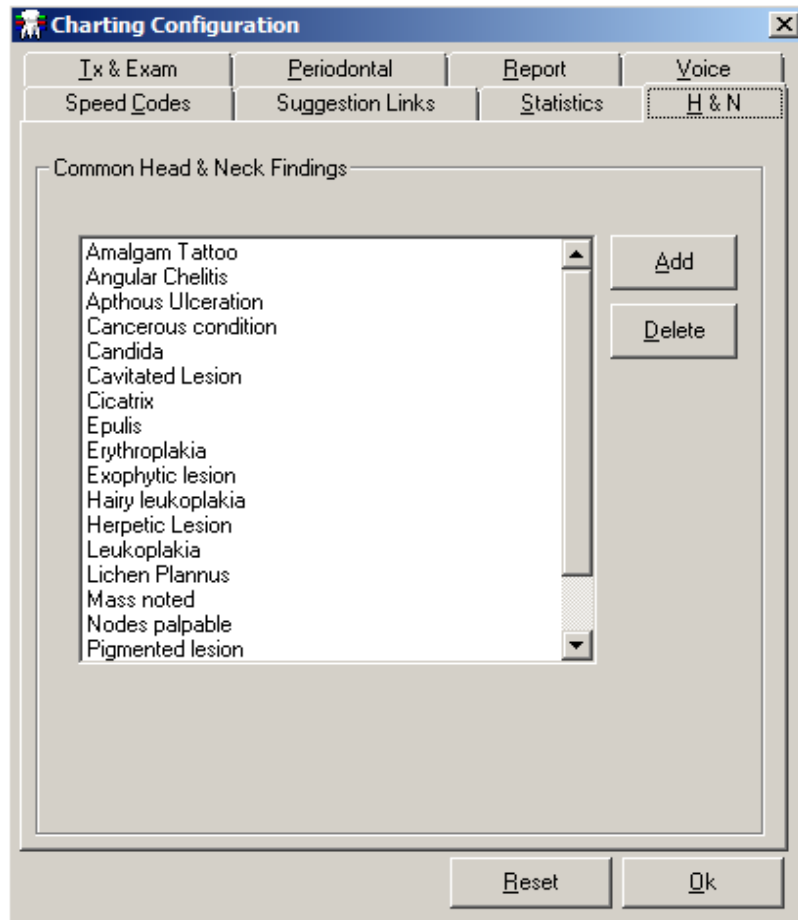


Figure 42: H&N Tab

To add an H&N finding:

1. Click the **Add** button.
2. A DRM screen displays. Enter the finding in the text box.

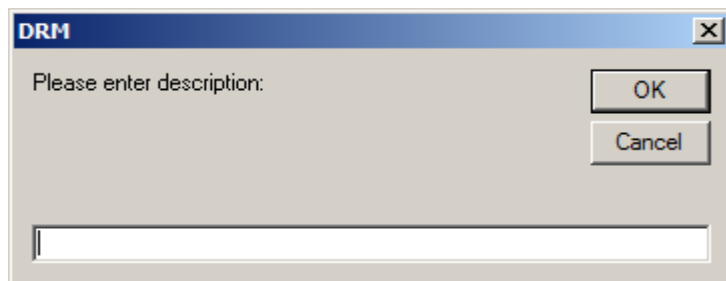


Figure 43: DRM Description Screen

3. Click the **OK** button. The finding is added.

To delete a finding, click the desired **H&N finding** in the list and then click the **Delete** button. The finding is removed from the list.

Note: All administrative descriptions added or deleted for head and neck findings are permanent for all users in the local DRM Plus server.

Add/Edit Personal QuickList

Select the **Add/Edit Personal QuickList** submenu to manage a **Quick List** of codes for personal use. For additional convenience, enter frequently used procedure codes that have multi-add functionality associated with the code, into the **Quick List**. The **Manage Personal QuickList** screen displays.

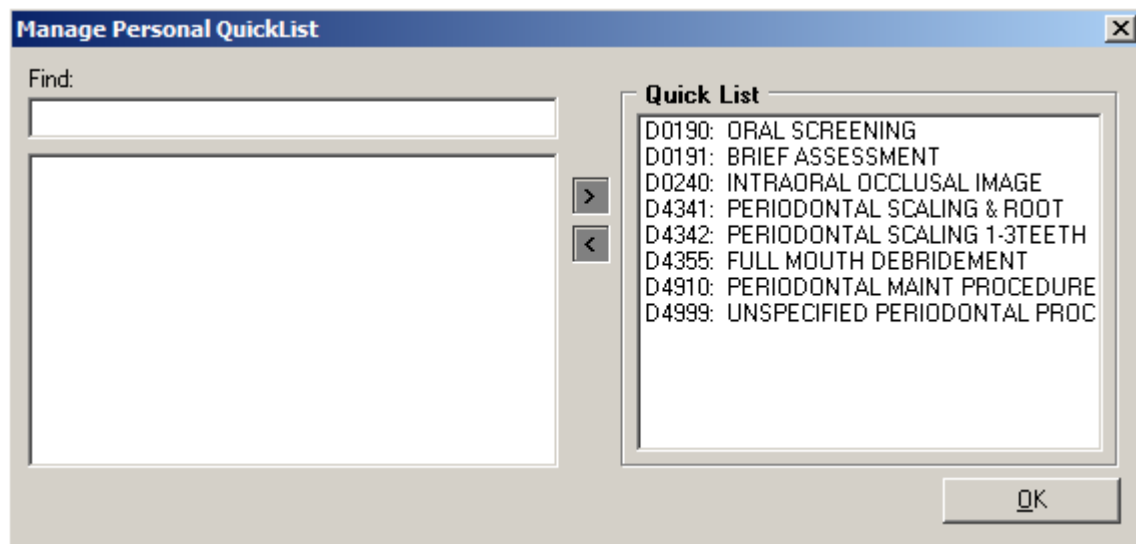


Figure 44: Manage Personal QuickList Screen

To add to the **Quick List**:

1. Type the search criteria into the **Find** text box. Search by words or numbers.
2. A matching list displays on the left side of the screen. Click one of them to select it.
3. Click the **right arrow** button to move the selected code to the **Quick List**.
4. Click the **OK** button to end and close the screen or repeat to add another code to the **Quick List**.

To remove from the **Quick List**:

1. Select an entry from the **Quick List** on the right side of the **Manage Personal QuickList** screen.
2. Click the **left arrow** button to remove it from the list. A screen displays confirming that the entry is to be deleted. Click the **Yes** button to continue.

Note: Codes entered into a **Quick List** are accessed through the **Quick Code** icon.

Add Medical Codes to ADA Table

A DRM Plus Administrator may select this submenu to add medical CPT procedure codes to the ADA mapping table. Each medical CPT procedure code must have at least one designated diagnosis code entered with it. Once a diagnosis code has been designated, it may be changed at any time. These changes apply only to the local VistA system for specific facilities.

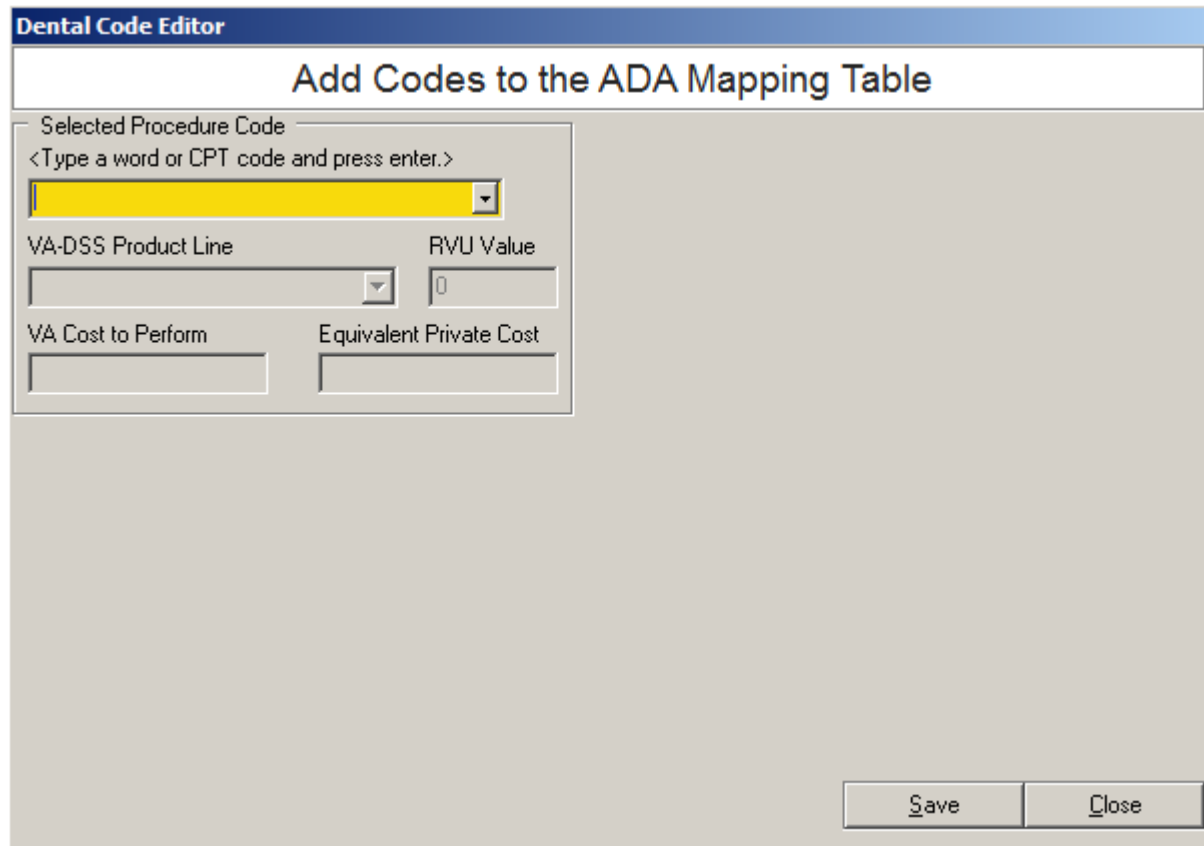


Figure 45: Dental Code Editor Screen

To add a medical procedure code to the ADA mapping table:

1. Type a word or medical CPT procedure code into the yellow **drop-down box**.
2. Press the **<Enter>** key.
3. Search results display in the drop-down menu. Select the correct result.
4. Once a new medical CPT procedure code is selected, several fields display on the **Dental Code Editor** screen.

Figure 44: Dental Code Editor Screen when Adding Procedure Code

5. Choose the VistA DES code from the **VA-DSS Product Line** drop-down menu. Enter the **VA Cost** to perform and the **Equivalent Private Cost** information in the respective text boxes. The **VA-DSS Product Line** field is required; the cost fields are optional.
6. The **RVU Value** in the text field is always zero for any local medical CPT procedure code added to the ADA mapping table.
7. Add the diagnosis code using the **Diagnosis Code Search**, by typing into the corresponding text box and pressing the **<Enter>** key.
8. Select the correct diagnosis code from the **Diagnosis Code Search** drop-down menu and click the **green icon [+]** button. The diagnosis code is added to the **Prioritized List of Diagnosis Codes**. Repeat this step until all necessary diagnosis codes are added.
9. To change the position of any diagnosis code on the list, first select the diagnosis code, and then use the **blue Up arrow** to move the diagnosis code up. Repeat until all diagnosis codes are in the correct order.
10. To remove a diagnosis code from the list, click the **red [X]** button.
11. Add an Administrative Note in the corresponding text box (optional).
12. When finished, click the **OK** button.

Note: Local DRM Plus Administrators can enter text freely in the **Administrative Note** text box to complement the local medical CPT procedure code. This field is NOT mandatory to save a local medical CPT procedure code.

Note: All locally-added medical CPT procedure codes are monitored nationally, and may be added in a future DRM Plus patch, with an appropriate RVU value set.

Edit Code Information in the ADA Table

Select this submenu to edit all CPT dental and medical procedure codes on the ADA mapping table from the local server. Diagnosis codes may be added onto the existing national list of diagnosis codes; however, the existing national list of diagnosis codes may NOT be edited.

The screenshot shows the 'Dental Code Editor' window. The main title is 'Edit Code Information in the ADA Master Database List'. The interface includes a search for a procedure code (D0120 - PERIODIC ORAL EVALUATION), fields for VA-DSS Product Line (DES001-Brief Exams) and RVU Value (30), and empty fields for VA Cost to Perform and Equivalent Private Cost. A search box for diagnosis codes is present. A list of diagnosis codes is displayed, including K02.52, K02.62, K02.53, K02.63, K02.7, K08.109, K05.00, K05.10, K05.20, K05.30, K05.32, K04.6, and K04.7. An Administrative Note field is empty, and Coding Standards are defined. Save and Close buttons are at the bottom right.

Figure 47: Dental Code Editor Screen when Editing Procedure Code

To edit a code in the **ADA Master Database List**:

1. Type in the search term in the yellow drop-down box. Only those codes which are in the ADA master database list display.
2. The **VA-DSS Product Line**, **RVU Value** and **Coding Standards** cannot be edited.
3. Type in the fields that are to be edited; the **VA Cost to Perform**, **Equivalent Private Cost**, **Prioritized List of Diagnosis Codes** and the **Administrative Note** fields can be edited.
4. To add a list of local diagnosis codes, see the previous Add Medical Codes to ADA Table section and follow steps (7-10).
5. When finished, click the **OK** button.

Note: When any diagnosis codes are added to a CPT procedure code, a line appears dividing the list into the preset national list of diagnostic codes above the line, and the added local diagnostic codes below the line.

Note: The **VA Cost to Perform**, **Equivalent Private Cost** and **Administrative Note** text boxes are optional.

Edit Procedure Costs

Select this optional submenu to add or edit procedure code costs.

ADA/CPT Code	RVU	VA Cost to Perform	Equiv. Private Cost
D0120 PERIODIC ORAL EVALUATION	30		
D0140 LIMIT ORAL EVAL PROBLM FOCUS	20		
D0145 ORAL EVALUATION CHILD <3 YRS	0		
D0150 COMPREHENSVE ORAL EVALUATION	45		
D0160 EXTENSV ORAL EVAL PROB FOCUS	45		
D0170 RE-EVAL,EST PT,PROBLEM FOCUS	20		
D0180 COMP PERIODONTAL EVALUATION	45		
D0190 ORAL SCREENING	10		
D0191 BRIEF ASSESSMENT	10		
D0210 INTRAORAL FULL IMAGE SERIES	18		
D0220 INTRAORAL PERIAPICAL FIRST	1		
D0230 INTRAORAL PERIAPICAL EA ADD	1		
D0240 INTRAORAL OCCLUSAL IMAGE	1		
D0250 EXTRAORAL FIRST IMAGE	5		
D0260 EXTRAORAL EA ADDL IMAGE	5		
D0270 DENTAL BITEWING SINGLE IMAGE	1		
D0272 DENTAL BITEWING TWO IMAGES	2		
D0273 DENTAL BITEWING THREE IMAGES	3		

Figure 48: Edit Procedure Costs Screen

To add/edit a procedure code cost:

1. Scroll through the list to find the desired ADA/CPT procedure code.
2. Select the cost to be added or edited. Both **VA Cost to Perform** and **Equivalent Private Cost** can be added or edited. RVU cannot be edited.
3. Type the cost value into the appropriate cell.
4. Press the **<Enter>** key or use the up/down arrow keys so that the new cost is saved. Left or right arrow keys do **NOT** save the cost value.
5. Click either **Save to XLS**, to view in Microsoft Excel, **Print** or **Close**.

Filter View

Use the **Filter View** submenu to choose which encounters display on the **Chart/Treatment** tab of DRM Plus.

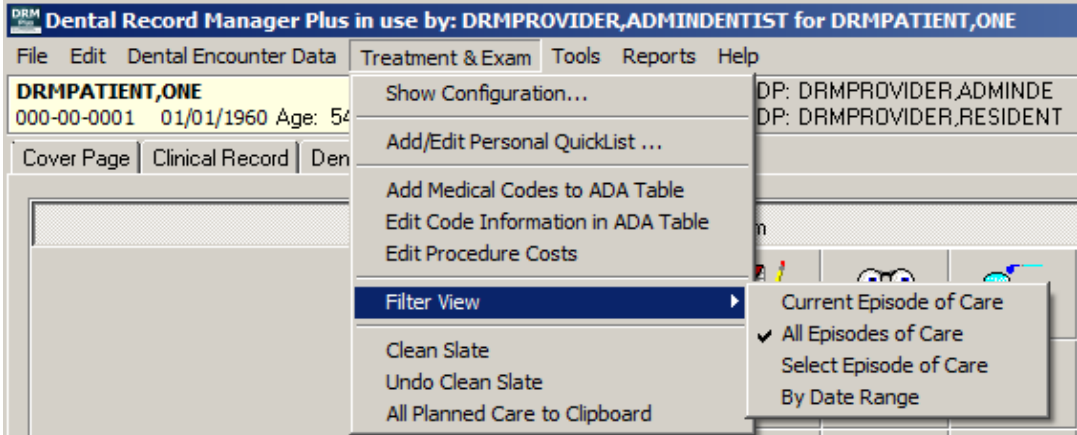


Figure 49: Filter View Submenus

Current Episode of Care

Select this filter to show only those treatments that have been completed for all visits during the current disposition or patient status.

All Episodes of Care

Select this filter to show all treatments completed for all visits. This is the default setting.

Select Episode of Care

Select this filter to see all the treatments completed for all visits during a previous specific disposition or patient status. When this submenu is selected, a screen listening all previous dispositions or patient statuses associated with a given patient displays.

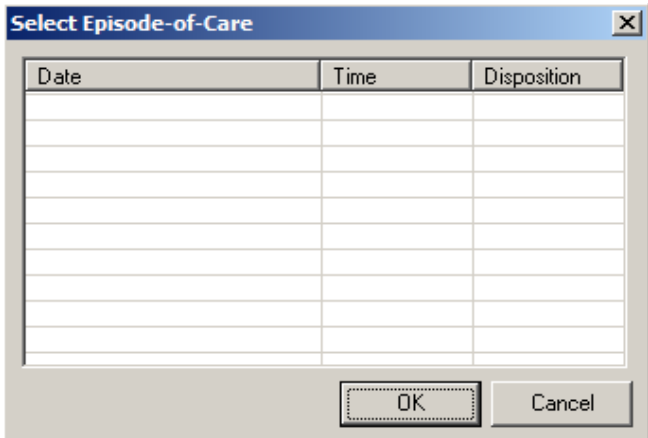


Figure 50: Select Episode of Care Screen

To select a previous disposition, click the desired one from the list and click the **OK** button.

Date Range

Select this filter to show treatments that have been completed within a specified date range. When this filter is selected, a screen displays. Use this screen to select a date range.

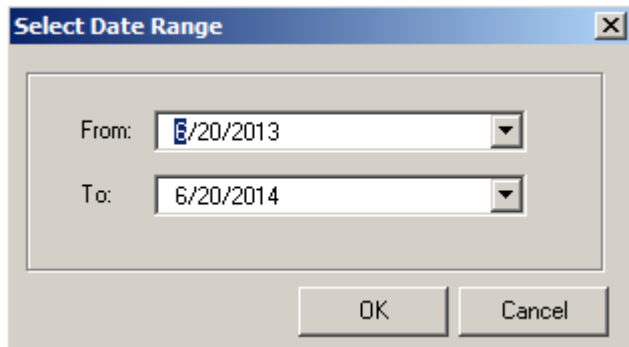


Figure 51: Select Date Range Screen

To filter by date range:

1. Use the drop-down menu to select the needed dates. Click the **OK** button.
2. The treatments completed in the entered date range display on the screen. If no entries were made during the selected date range, DRM Plus displays as a clean slate.

Clean Slate

The **Clean Slate** submenu functionality clears the graphical portion of the **Treatment & Exam** screen, and deletes all planned treatment for the selected patient. The new clean slate can be restored for this patient at any time until a new encounter has been filed on this patient's chart. The deleted planned treatment may never be recovered, only re-entered and filed on the patient's chart. Clean slate also inactivates all saved unfiled data entered during this session and all previous unfiled data saved by all providers for this patient. Clean slate removes all graphics on the three **Treatment & Exam** screens, but leaves the historical transactions in both tables of the findings and completed screens.

The submenus of **Clean Slate** and **Undo Clean Slate** are found under the **Treatment & Exam** menu. Only end-users who have the DRM Plus Administrative parameter option for clean slate are allowed to use this function.

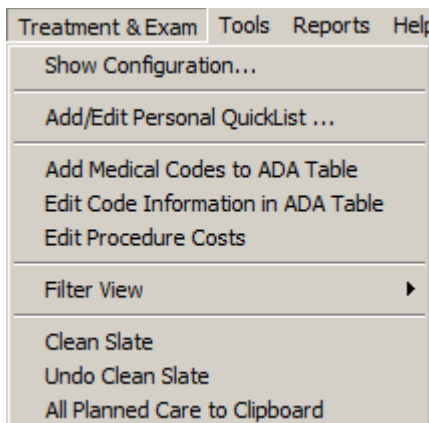


Figure 52: Clean Slate Submenu

The following dialog displays the planned treatment for the selected patient. This patient has extensive findings and completed treatment which have been filed previously on the DRM Plus patient chart.

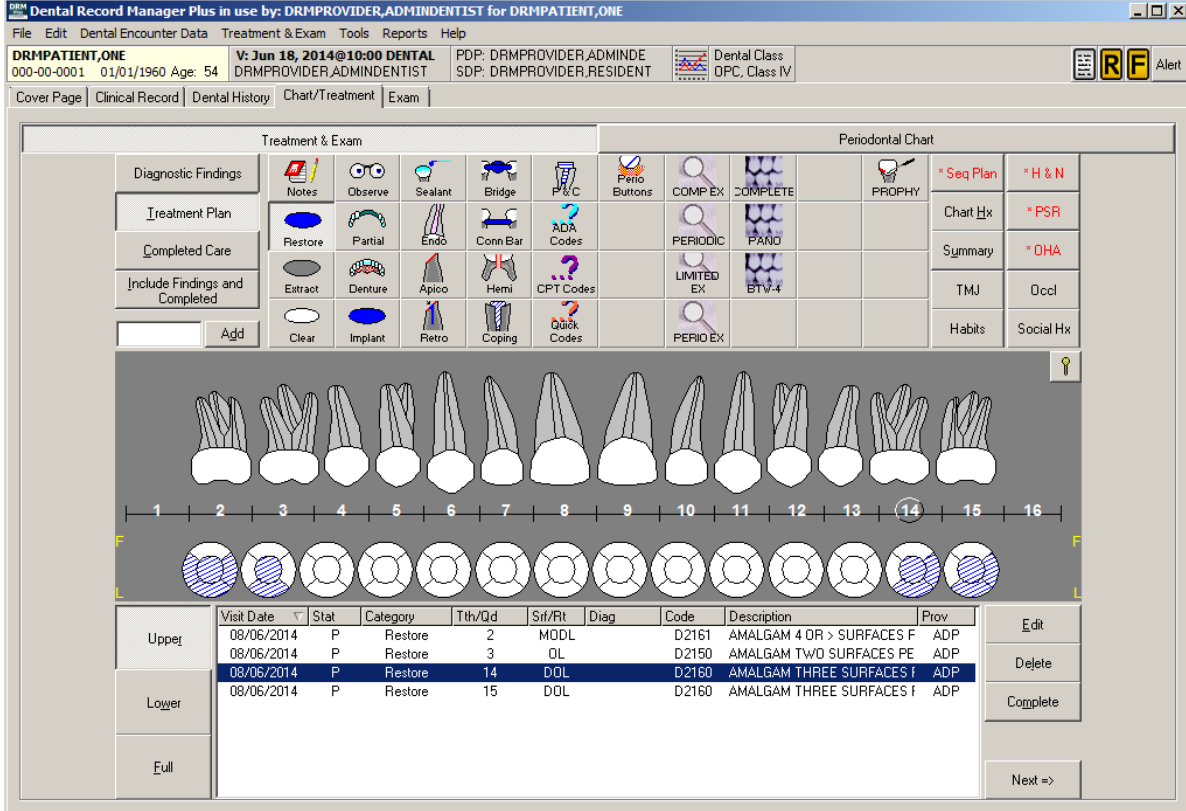


Figure 53: Patient Chart before Clean Slate

Selecting the **Clean Slate** submenu under the **Treatment & Exam** menu displays a screen informing the DRM Plus Administrator that planned treatment is deleted permanently. All current graphics are removed from the exam (findings) and completed treatment screens. All transactions entered during this session are saved as inactivated unfiled data. All unfiled transactions from all providers saved on this patient are inactivated.

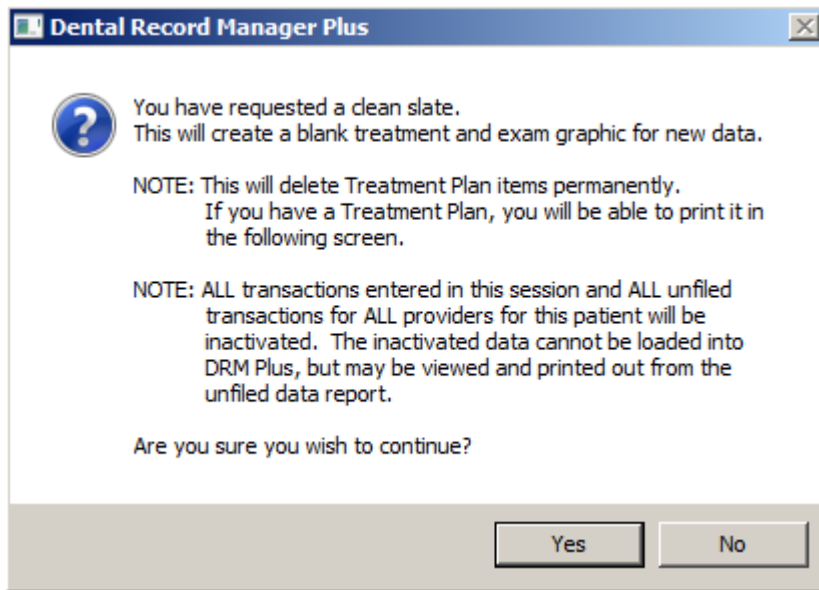


Figure 54: Clean Slate Information Screen

The next screens may or may NOT display to the DRM Plus Administrator. The first screen, **Dental Record Manager Plus**, only displays if there was any unfiled data that was saved for this patient by any provider in the past. This unfiled data is inactivated if a DRM Plus Administrator completes the clean slate.

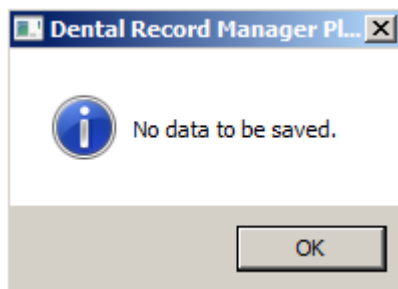


Figure 55: No Data Saved

Otherwise, the **Save DRM Plus Data** screen displays, which allows the DRM Plus Administrator to save new transactions as unfiled data. However, these transactions are inactivated when completing the clean slate. When the **No** button is selected on the **Save DRM Plus Data** screen, the user must again click the **No** button on the same screen after clean slate has recycled.

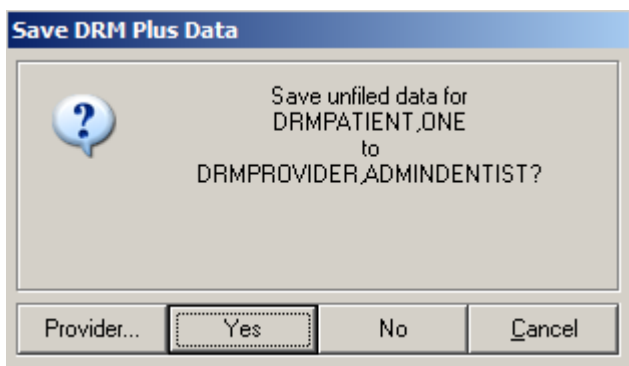


Figure 56: Save DRM Plus Data

The next screen, which always displays, has a message asking if the DRM Plus Administrator would like to print the planned treatment. Select the **Print** button if concerned about re-entering the planned treatment, because the planned treatment is deleted and cannot be recovered. When this is another provider's treatment plan, it should be printed and given to that provider to follow-up on the planned treatment for this patient. That provider must re-enter and file the planned treatment on this patient's chart.

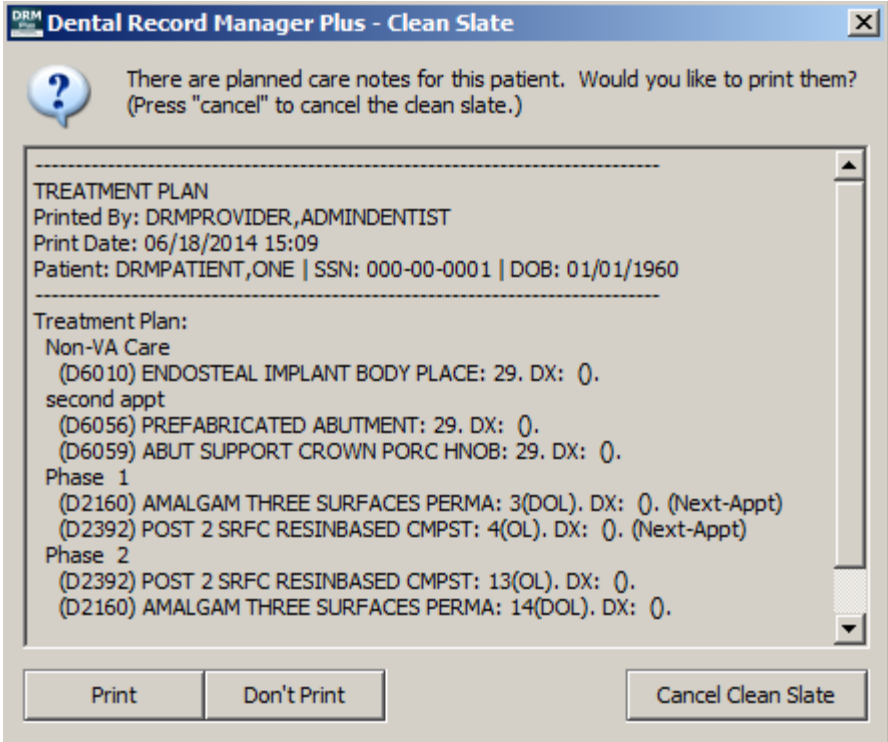


Figure 57: Print Planned Care Notes

The following screen displays to inform that **Clean Slate** was successful, click the **OK** button.

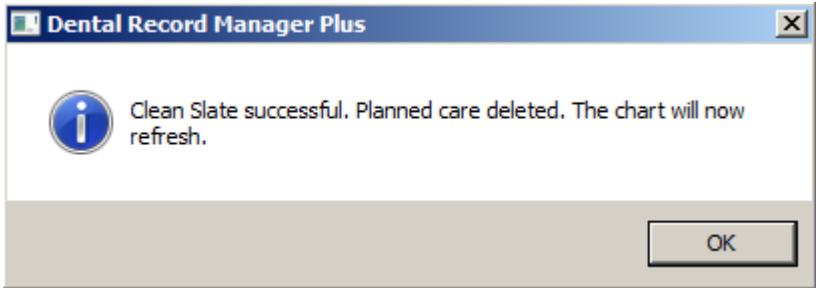


Figure 58: Clean Slate Successful

The chart displays no graphics for completed treatment and exam findings. All the historical transactions in the tables for both the completed treatment and exam findings are still present. The next dialog displayed shows that the **Seq Plan** button is no longer active, because all planned treatment has been deleted; both graphical and transactional.

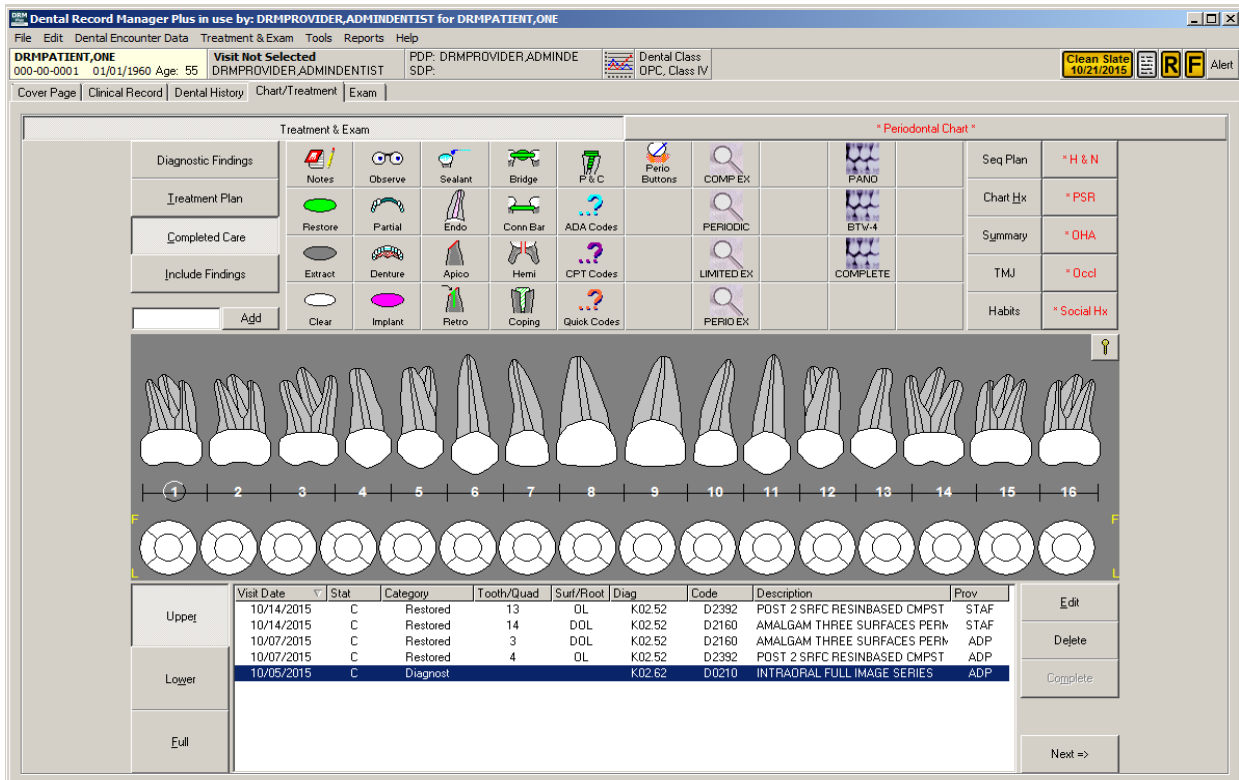


Figure 59: Patient Chart after Clean Slate

The following screen displays when a DRM Plus Administrator saved unfiled data during the clean slate process. It also displays for any provider opening this patient's chart after the clean slate has been completed, and there was previously saved unfiled data for this patient by that provider. It informs the provider that the patient now has inactive unfiled data. All end-users may delete the unfiled data using the screen by selecting the **Delete** button, or selecting the **View** button and then clicking either to **View** or **Delete** the inactive unfiled data from the Unfiled Data report.

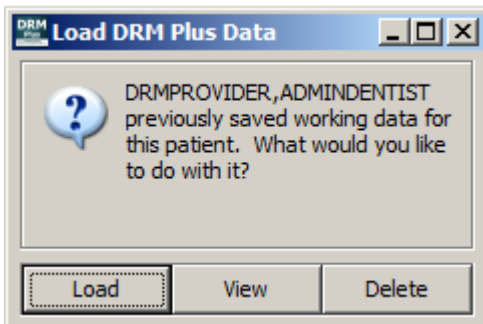


Figure 60: Load DRM Plus Data Screen

Clean slate displays an icon in the banner showing the last clean slate date performed on this patient's chart. This icon is permanently on this patient's chart; however, it could be updated when another clean slate is performed on this patient's chart.

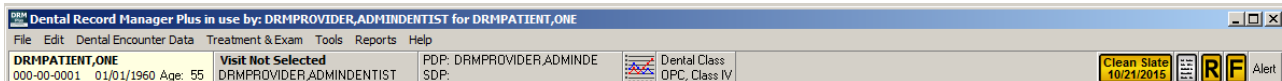


Figure 61: Clean Slate Banner Icon

Note: The **Clean Slate** submenu may NOT be used for any filed completed transaction corrections, or any encounters filed incorrectly on a dental patient. These still have to be deleted by the DRM Plus Administrator using the line item deletion function or the complete encounter deletion function.

Undo Clean Slate

The **Undo Clean Slate** submenu allows the DRM Plus Administrator to undo the last clean slate action taken on a given patient. All historical graphics of completed treatment and findings are returned to the chart, assuming only one clean slate has been performed. If it is the second time, it only returns the historical graphics created following the first clean slate.

To utilize the undo clean slate function:

1. Select the **Undo Clean Slate** submenu from the **Treatment & Exam** drop-down menu. The following screen displays.

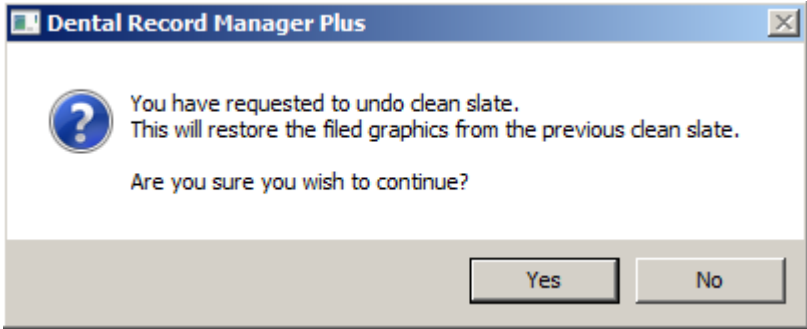


Figure 62: Undo Clean Slate Message Screen

2. Click the **Yes** button to reveal another screen, which confirms that **Clean Slate** is undone.

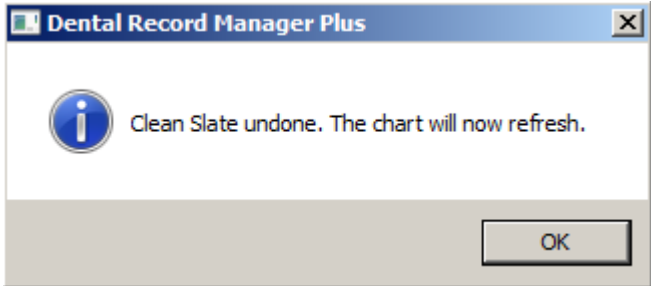


Figure 63: Clean Slate Undone

While the DRM Plus patient’s chart is refreshing, if inactive unfiled data exists, which had not been deleted, another screen displays. The options presented are the same that are provided when loading saved unfiled data into the patient’s chart.

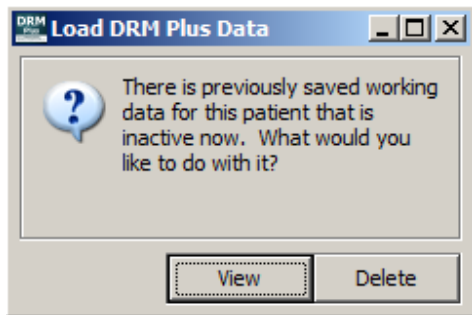


Figure 64: Previously Saved Inactive Data Message

The correct date range of completed treatment and findings graphics imports into the patient's chart, as shown below.

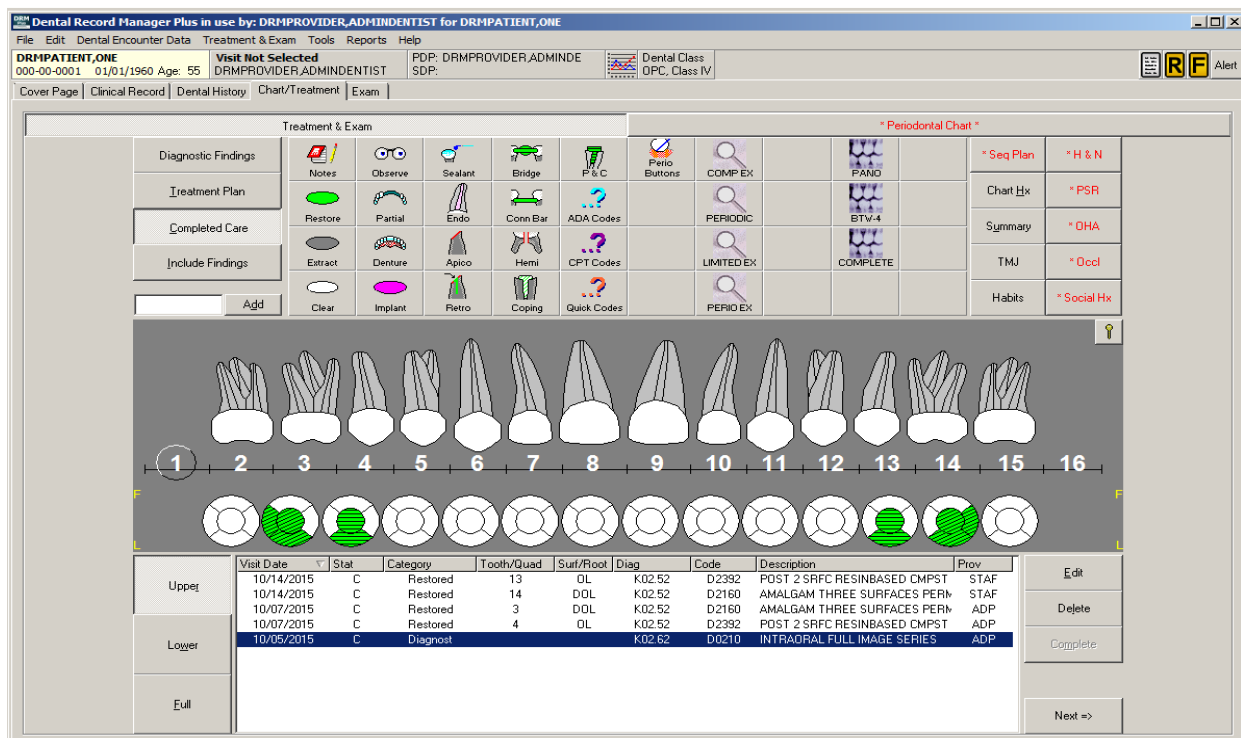


Figure 65: Completed Treatment Graphics Recovered

Note: Saved unfiled data for a patient may be recovered if the DRM Plus Administrator performs a **Clean Slate** for this patient and immediately uses the **Undo Clean Slate** submenu, before the inactive unfiled data is deleted.

All Planned Care to Clipboard

All Planned Care to Clipboard is a submenu located as the last header on the **Treatment & Exam** menu. This submenu when selected will allow the user to copy all planned data; filed and unfiled planned treatment from the **Seq Plan** screen with extra planned details that occur on the cover page. This copy may be pasted on any word document, text document or any application window if allowed.

Select the **All Planned Care to Clipboard** submenu and place your cursor in the word document, text document or any application window where you would like the planned data pasted.

Tools

The **Tools** menu has 9 submenus: **Windows Calculator**, **Windows Explorer**, **Windows Notepad**, **User Inquiry**, **User Options**, **Administrative Toolbox**, **Panel Add/Edit**, **Provider Add/Edit** and **Vitals**.

The **ADA Website** submenu is an ancillary application that the DRM Plus Administrator may customize for all users. The DRM Plus Administrator may customize up to 10 ancillary applications.

Note: Administrative Toolbox, Panel Add/Edit and Provider Add/Edit are DRM Plus administrative functions.

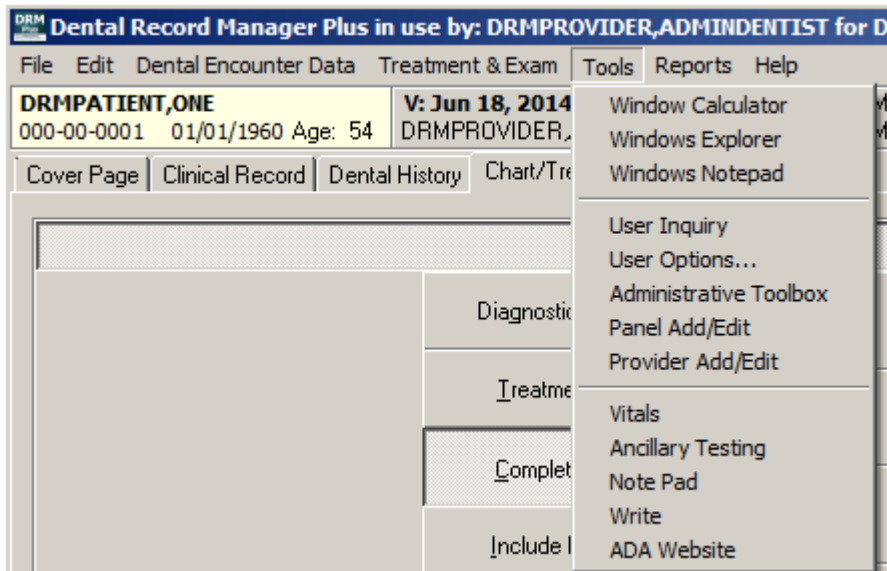


Figure 66: Tools Menu

Windows Calculator

Select this submenu to open **Windows Calculator**.

Windows Explorer

Select this submenu to open **Windows Explorer**.

Windows Notepad

Select this submenu to open **Windows Notepad**.

User Inquiry

Select this submenu to view and change the VistA fields or to view the VistA fields of other users. The **VistA User Inquiry** screen displays.

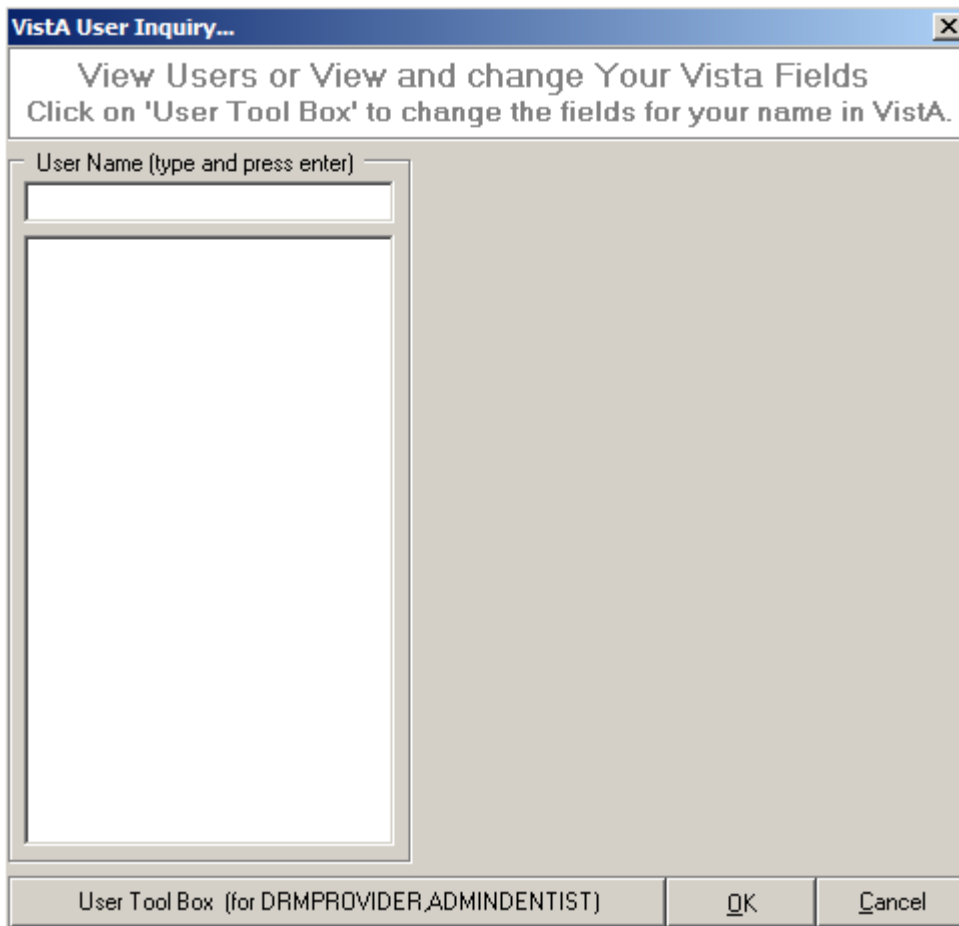


Figure 67: VistA User Inquiry Screen

1. Type the **User Name** into the input text box and press the <Enter> key.
2. The results display on the left side of the screen.
3. Select a **User Name** to view. The user's information displays on the right side of the screen as shown in the next figure.

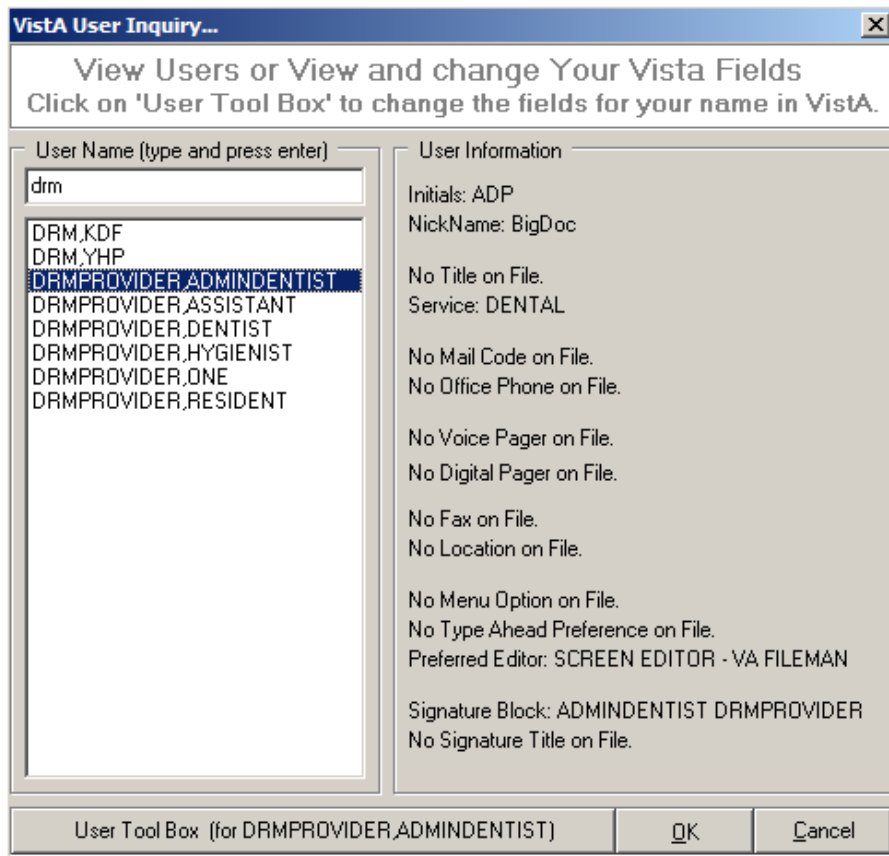


Figure 68: VistA User Inquiry Screen with User Information Displayed

Select the **User Tool Box** button to change the personal fields in VistA. Click the **User Tool Box** button at the bottom of the screen and the **User's TBox** screen displays.

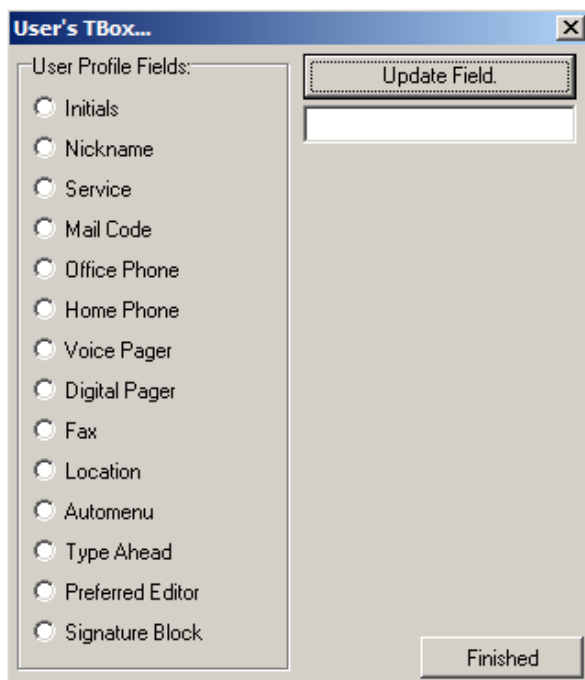


Figure 69: User's TBox Screen

4. Select the desired **User Profile Fields** by clicking the corresponding radio button.
5. Edit the new text in the text box.
6. Click the **Update Field** button.
7. Click the **Finished** button. The **Vista User Inquiry** screen displays again.

User Options

Adjust various user settings in this submenu. The screen contains five tabs: **General**, **Printing**, **Progress Note**, **Treatment System** and **Exam Settings**.

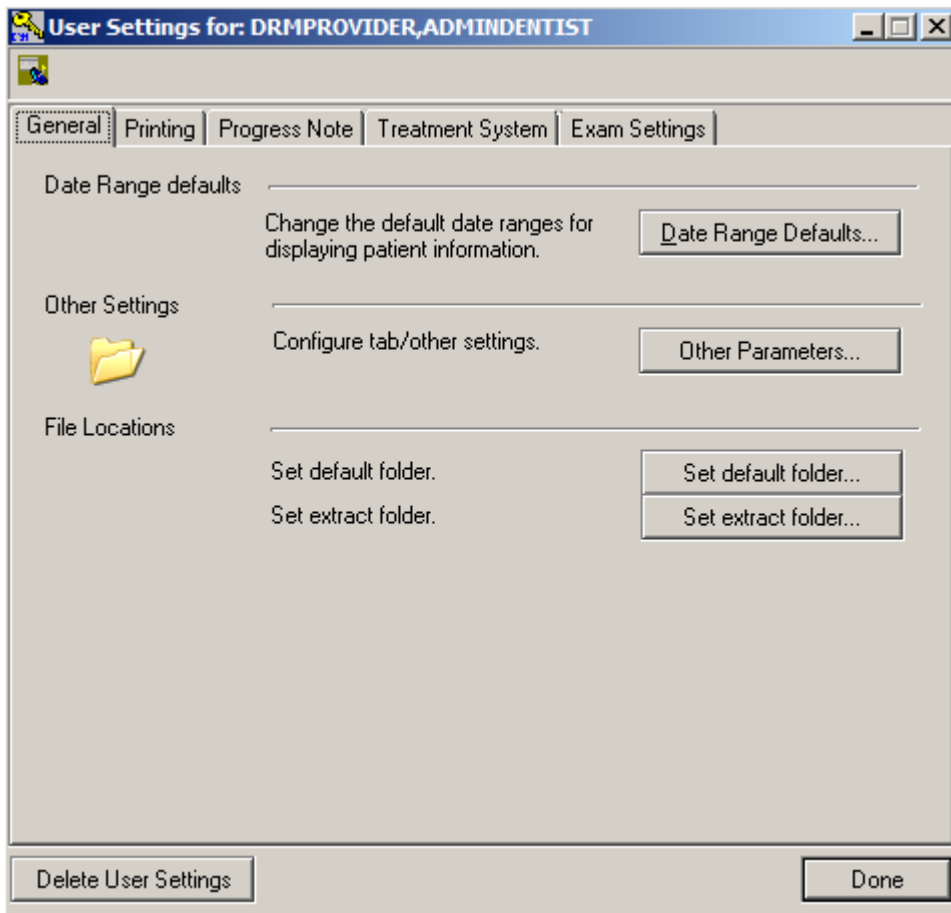



Figure 70: User Settings Screen

The **Broker Call History** icon  opens the broker calls screen. Please see the Last Broker Call section, in the Using the DRM Plus Drop-Down Menus chapter of this manual, for more information.

General

Select this tab to change **Date Range defaults**, **Other Settings** and **File Location** folders.

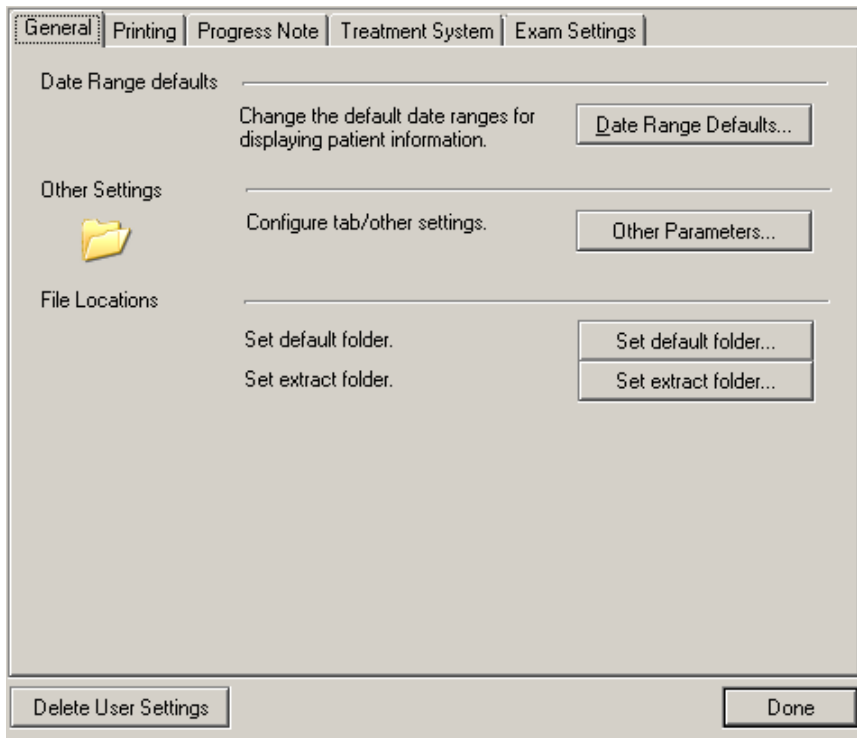


Figure 71: General Tab

To change the default date ranges:

1. Click the **Date Range Defaults** button.
2. The **Date Range** screen displays.

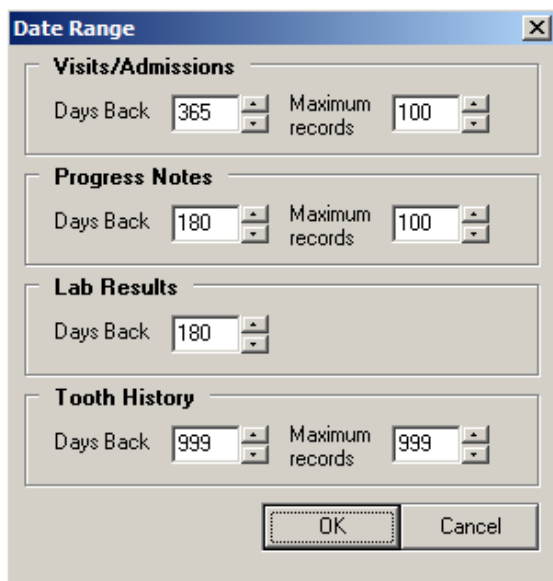


Figure 72: Date Range Screen

3. Use the **up and down arrows** to set the desired date range.
4. Click the **OK** button to return to the **User Setting** screen.

To change other parameter settings:

1. Click the **Other Parameters** button.
2. The **Other Parameters** screen displays.

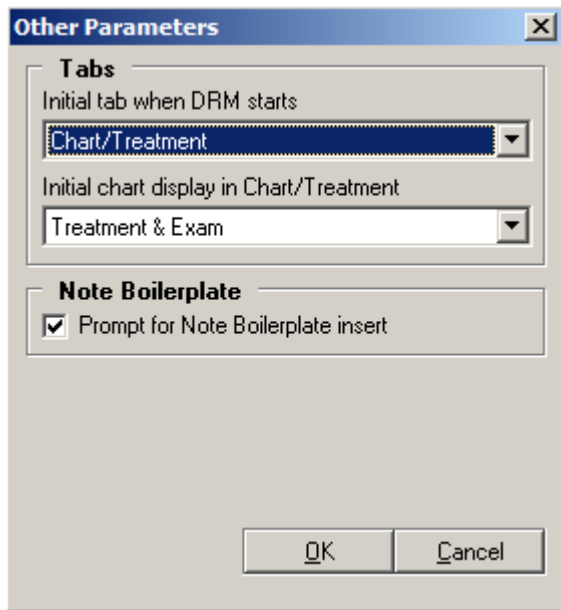


Figure 73: Other Parameters Screen

3. Use the **Tabs** drop-down menu to set the initial tab and chart display in DRM Plus.
4. Use the **Note Boilerplate** check box to indicate whether the program should prompt for the boilerplate insert associated with the VistA TIU progress note title selection.

To change the file folder location:

1. Click the **Set default folder** button.
2. The **Select Default Folder** screen displays.

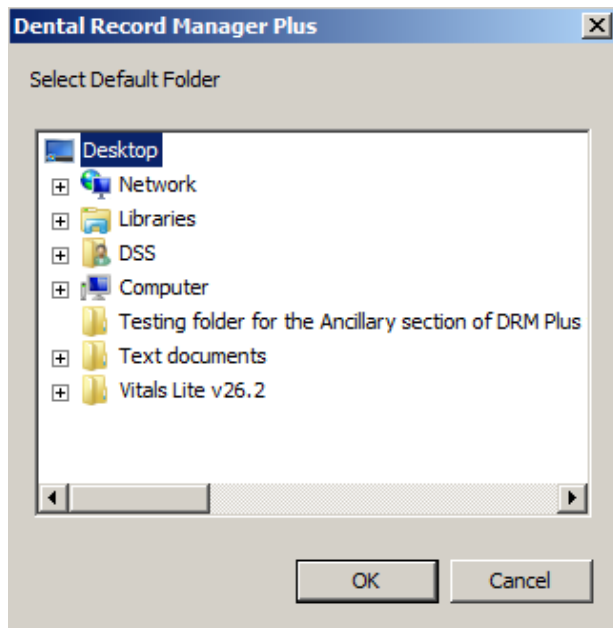


Figure 74: Select Default Folder Screen

3. Navigate to and click the **desired folder**.
4. Click the **OK** button to select it.

Note: This option allows the importing of information stored as a .txt file into the TIU progress note.

To set the extract folder location:

1. Click the **Set extract folder** button.
2. The **Select Extract Folder** screen displays.

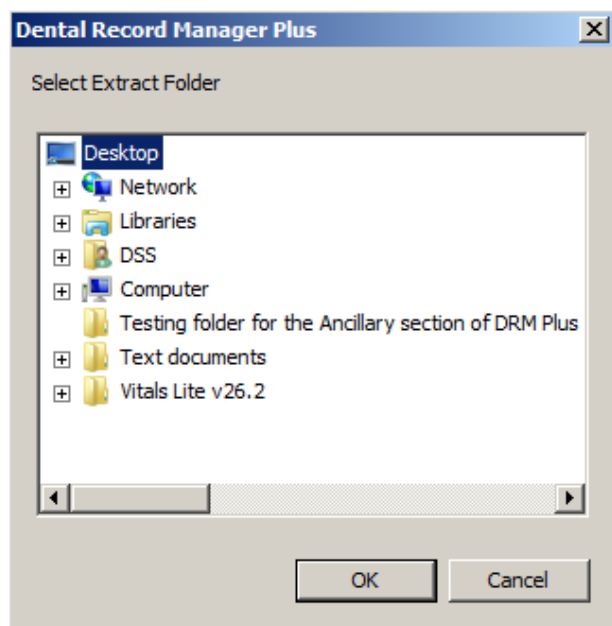


Figure 75: Select Extract Folder Screen

3. Navigate to the desired folder and click it.
4. Click the **OK** button to select the folder. A confirmation screen displays.
5. Click the **OK** button. **Extract History** reports are saved to this location.

Printing

Use the **Printing** tab to set print margins, orientations, etc.

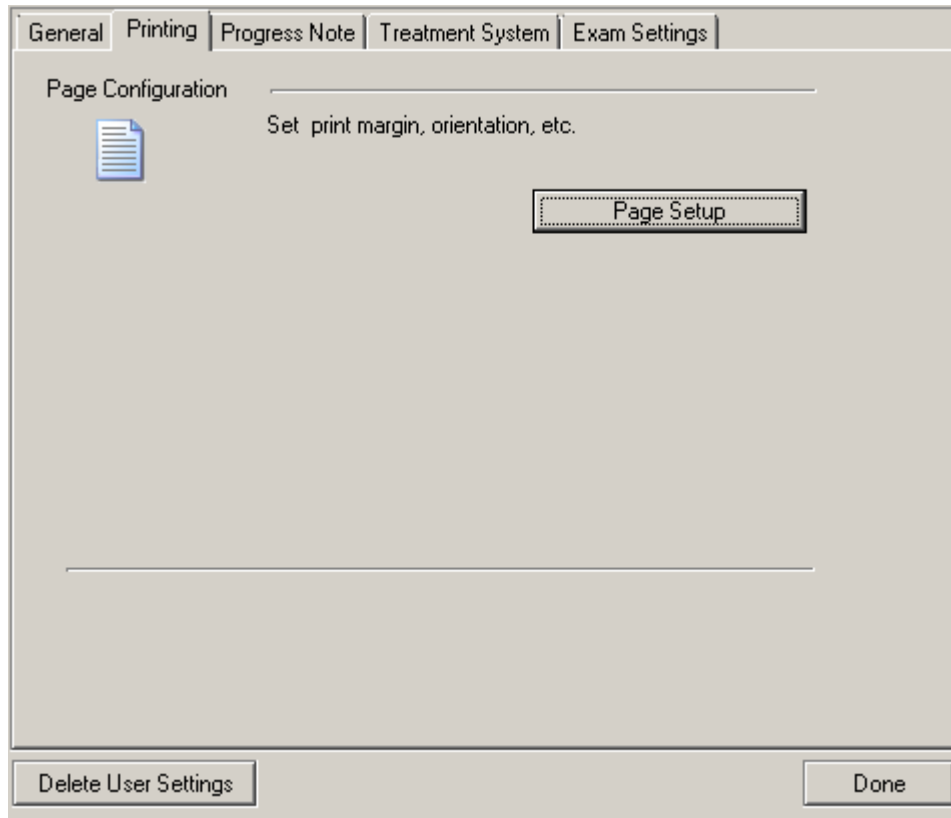


Figure 76: Printing Tab

To change the page configuration:

1. Click the **Page Setup** button.
2. The **Page Setup** screen displays.

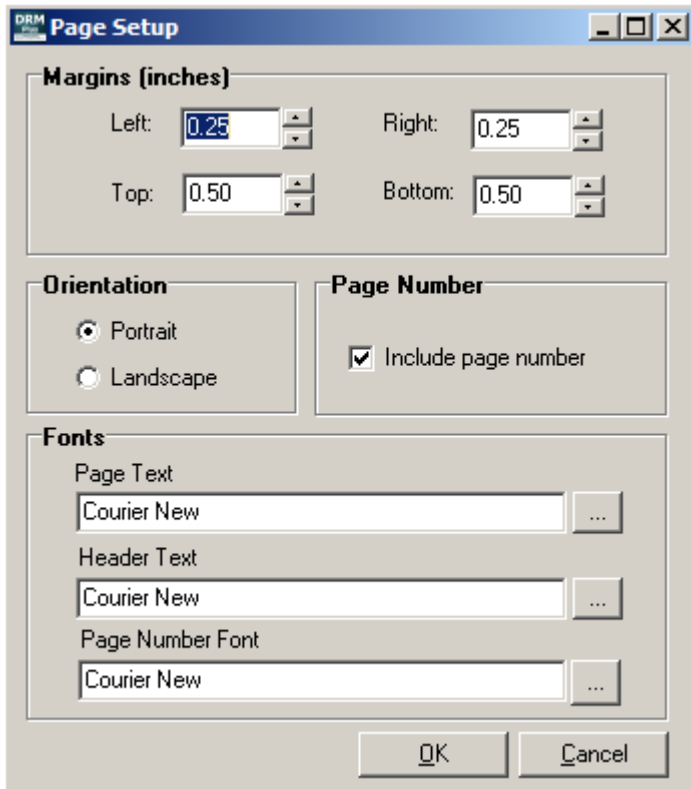


Figure 77: Page Setup Screen

3. Use the **up and down arrows** to adjust the margins.
4. Use the **Orientation** radio buttons to change the orientation of the printed document.
5. Use the **Page Number** check box to indicate whether page numbers are to be included.
6. Use the **Ellipsis** buttons to choose fonts for the **Page Text**, **Header Text** and **Page Number**.
7. Click the **OK** button to return to the **User Settings** screen.

Progress Note

Use the buttons in the **Progress Note** tab to configure progress note data objects, configure note data sequence and configure code boilerplates.

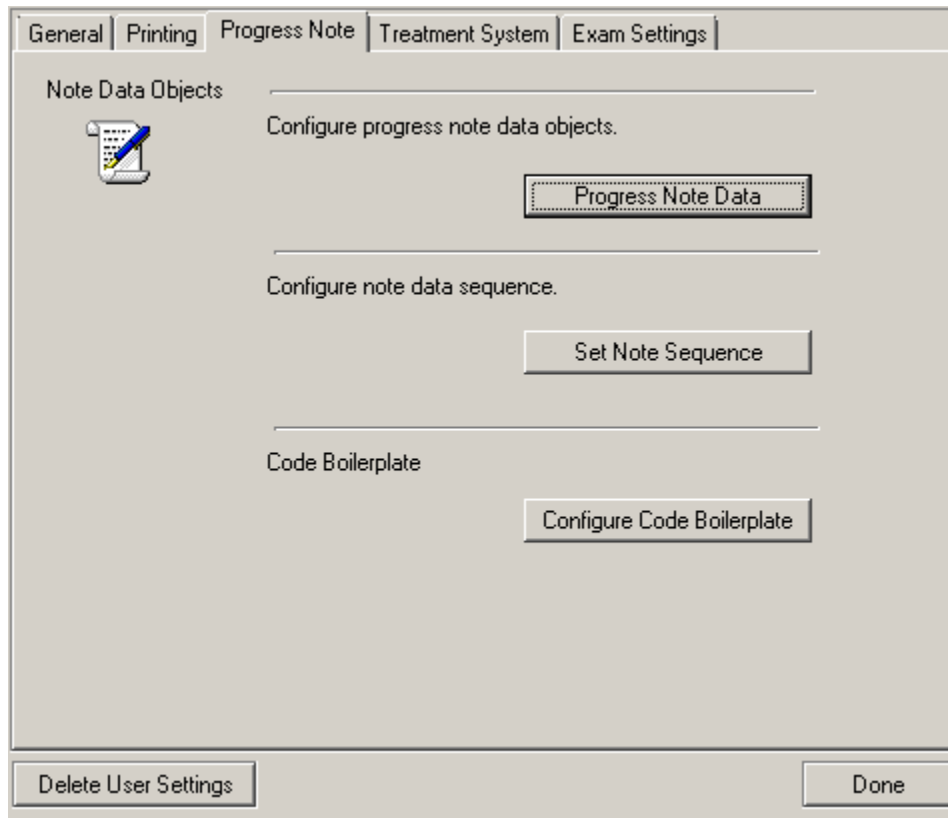


Figure 78: Progress Note Tab

To configure progress note data objects:

1. Click the **Progress Note Data** button.
2. The **Progress Note Data Objects** screen displays.

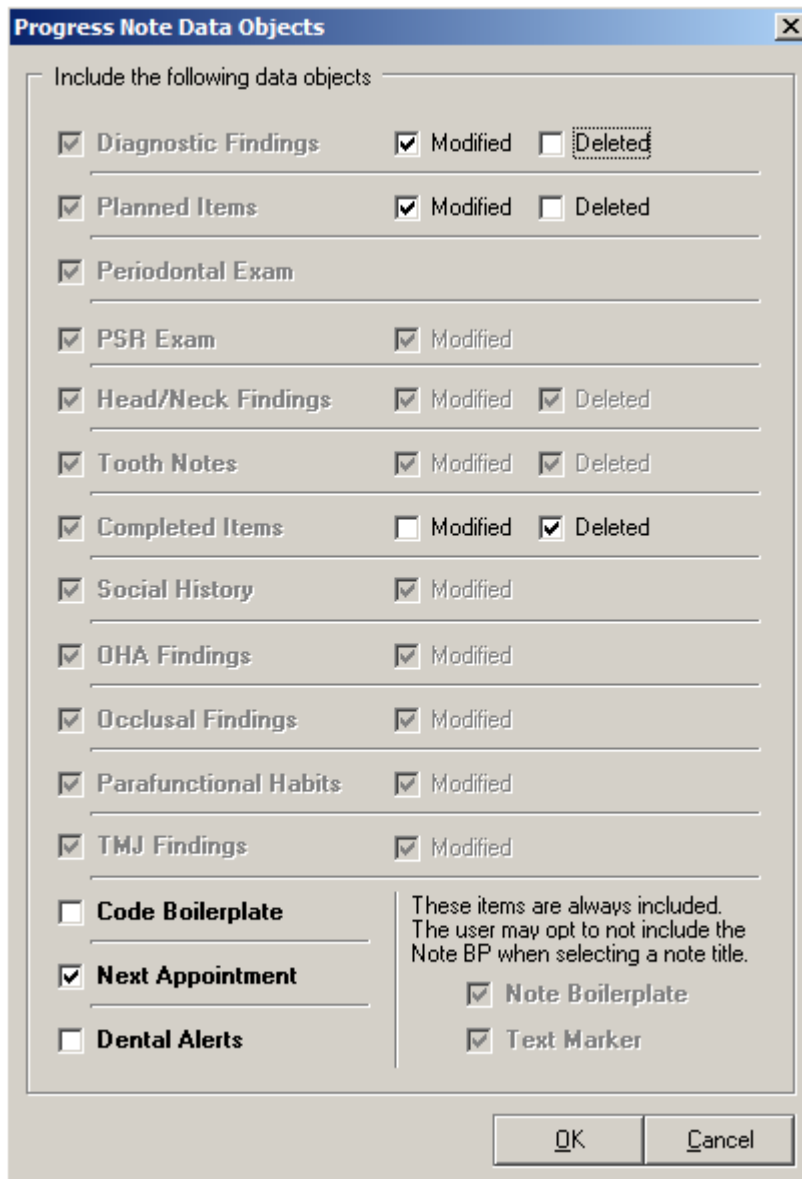


Figure 79: Progress Note Data Objects Screen

3. Use the various check boxes to include or exclude desired progress note data objects.
4. Click the **OK** button to return to the **User Settings** screen.

Note: The **Code Boilerplate** check box activates the automatic importing into the TIU progress note of any code boilerplate created in DRM Plus.

To configure the note data sequence:

1. Click the **Set Note Sequence** button.
2. The **Note Object Sequence** screen displays.

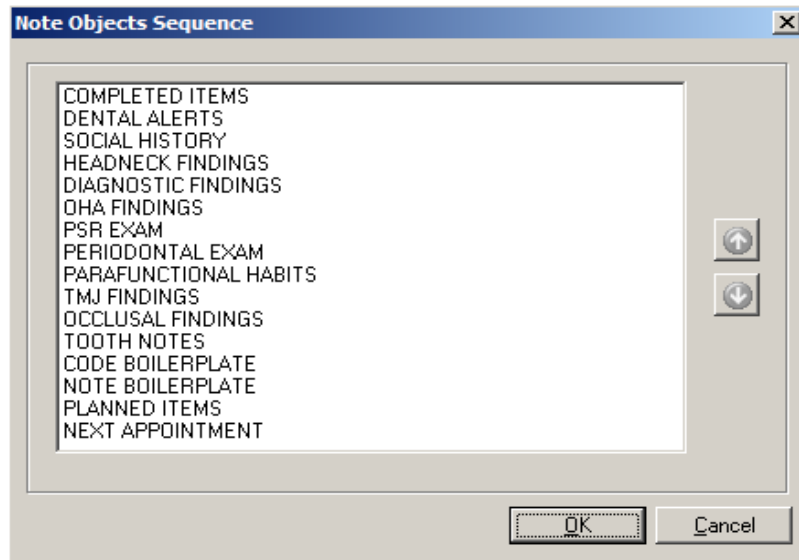


Figure 80: Note Object Sequence Screen

3. Select the note object to be moved in the list.
4. Use the **up and down arrows** on the right side of the screen to change the sequence of the note object on the list.
5. Click the **OK** button to return to the **User Settings/Progress Note** tab screen.

To configure the code boilerplate:

1. Click the **Configure Code Boilerplate** button.
2. The **Code Boilerplate** screen displays.

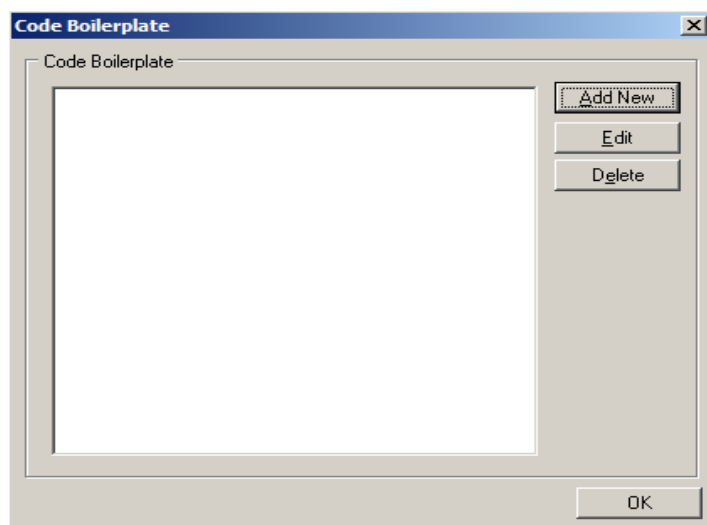


Figure 81: Code Boilerplate Screen

To add a new code boilerplate:

1. Click the **Add New** button.
2. The **New Boilerplate** screen displays.

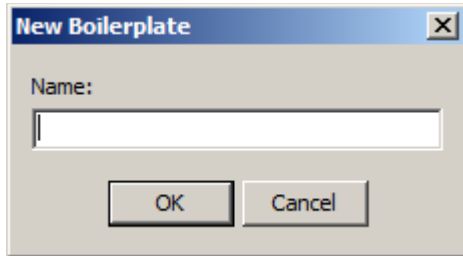


Figure 82: New Boilerplate Screen

3. Enter the name in the text box and click the **OK** button.
4. The **Code Boilerplate Text** screen displays.

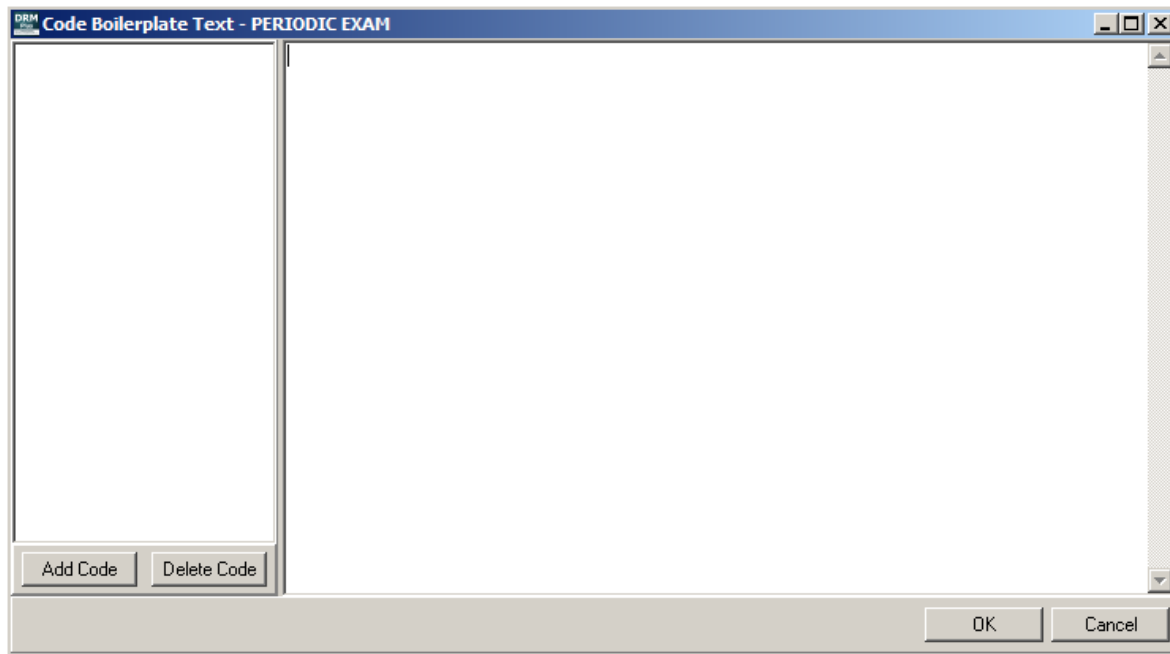


Figure 83: Code Boilerplate Text Screen

5. Click the **Add Code** button to add a code to the boilerplate.
6. The **Find CPT Code or CPT Description Text** screen displays.

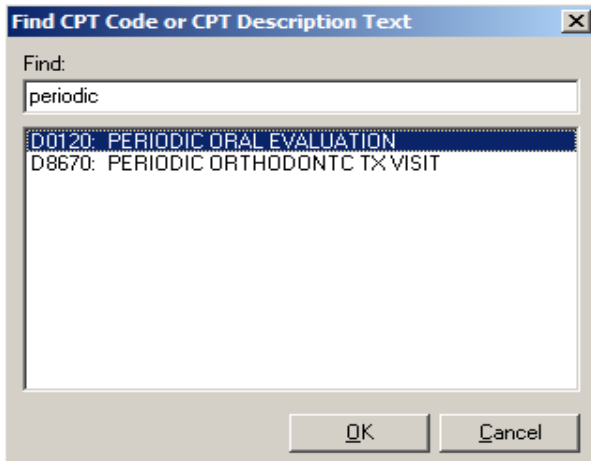


Figure 84: Find CPT Code Screen

7. Type in the CPT code. A partial number is acceptable. Press the <Enter> key.
8. The search results display in the screen. Select one and click the **OK** button.
9. The selected code displays on the **Code Boilerplate Text** screen. The provider may add more than one CPT code to this code boilerplate.
10. To delete that code, click the **Delete Code** button in the **Code Boilerplate Text** screen.
11. Type the desired associated text into the right side of the **Code Boilerplate Text** screen.
12. Click **OK**. A confirmation screen displays. Click **OK** to return to the **Code Boilerplate** screen.

To edit a code boilerplate:

1. Select the code boilerplate to be edited from the **Code Boilerplate** screen.
2. Click the **Edit** button.
3. The **Code Boilerplate Text** screen displays.

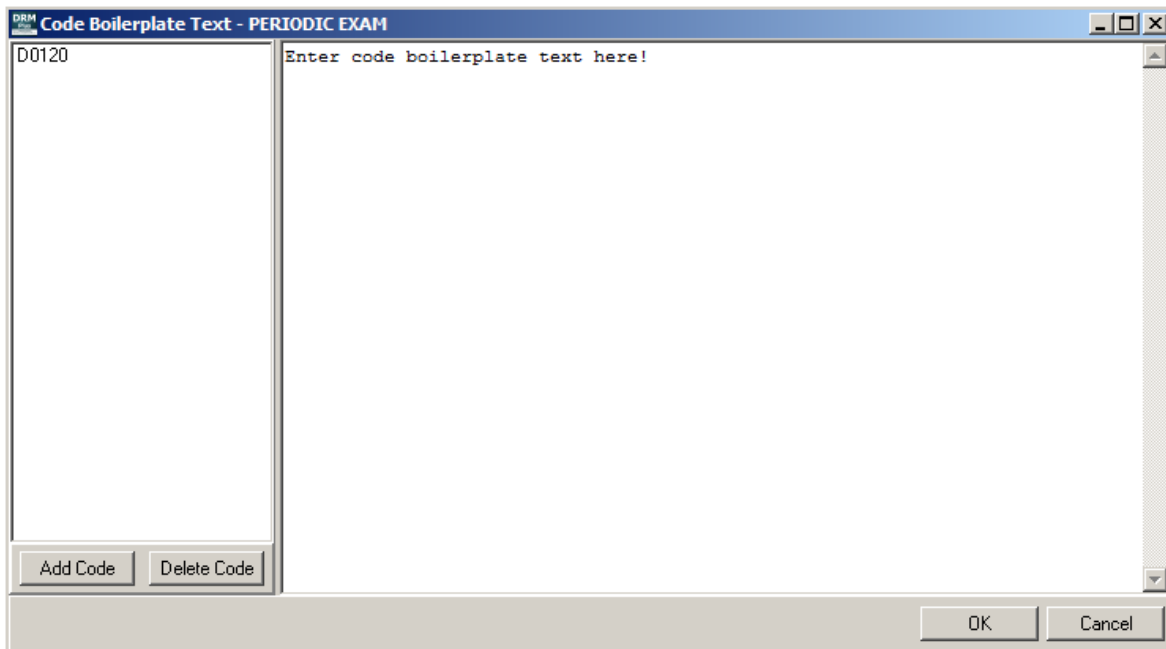


Figure 85: Code Boilerplate Text Screen

4. From here, type in the right side of the screen to add or delete text from the boilerplate. Use the **Add Code** and **Delete Code** buttons to add or delete codes form the boilerplate.
5. Click the **OK** button. An information screen displays. Click the **OK** button to return to the **Code Boilerplate** screen.

To delete a code boilerplate:

1. Select a code boilerplate from the list on the **Code Boilerplate** screen.
2. Click the **Delete** button.
3. A confirmation screen displays. Click the **Yes** button to delete the boilerplate.
4. An information screen displays. Click the **OK** button to return to the **Code Boilerplate** screen.

Treatment System

The **Treatment System** tab allows access to additional options.

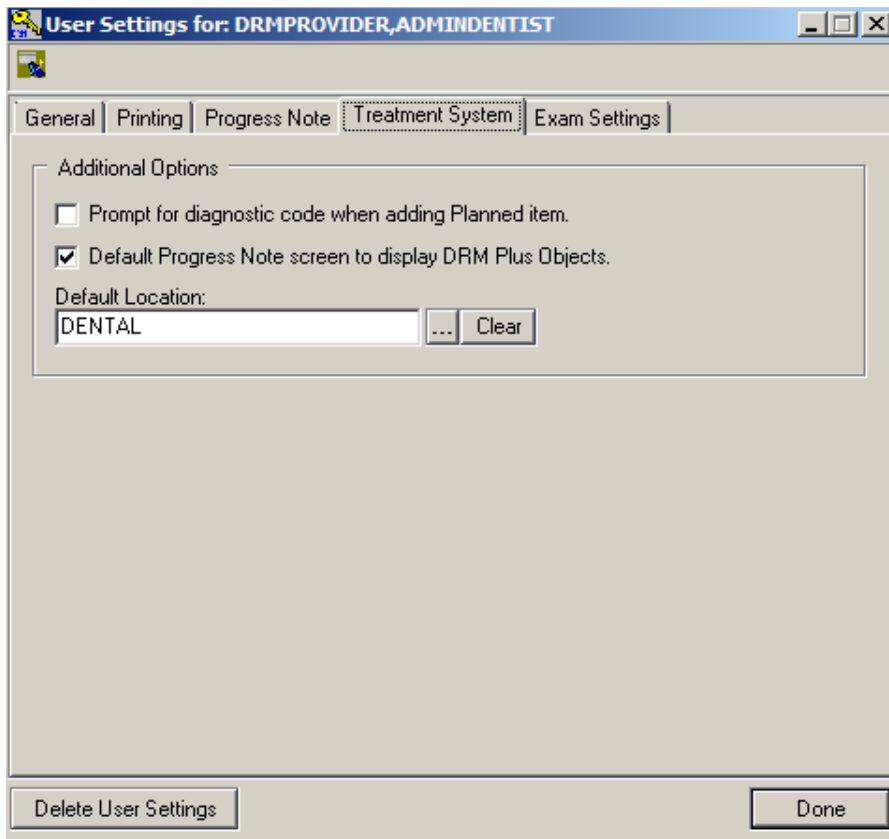


Figure 86: Treatment System Tab

Use the **check boxes** to choose whether to prompt for a diagnostic code when adding a planned item, or select the default tree view to display DRM Plus note objects.

To choose a default location:

1. Click the **Ellipsis (...)** button next to the **Default Location** text box.
2. The **Select Location** screen displays.

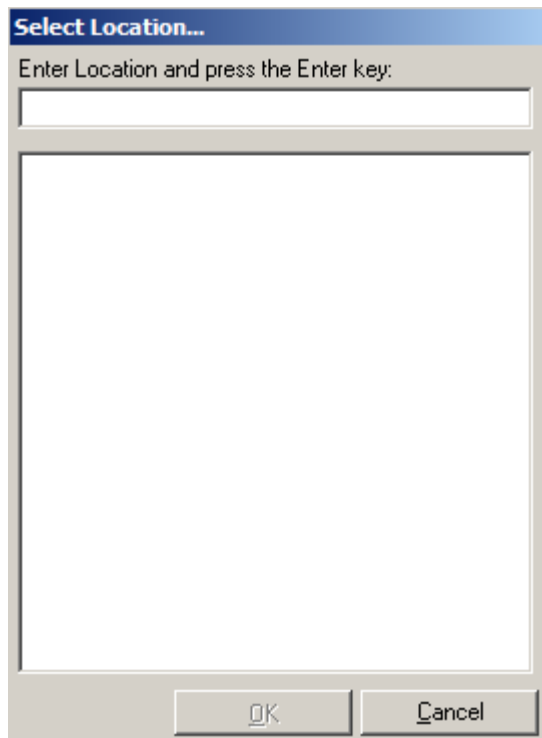


Figure 87: Select Location Screen

3. Type the location into the text box and press the <Enter> key.
4. Search results display on the **Select Location** screen.
5. Choose the desired location and click the **OK** button.
6. Select the **OK** button from the informational screen and the location is saved.
7. Use the **Clear** button if the location should be removed, then the **OK** button on the informational screen.
8. The user may also change the default location by using the **Select Location** screen.
9. Always select the **OK** button from the informational screen to save any changes.
10. Select the **Done** button at the bottom of the screen to close the **User Settings** screen.

The **Delete User Settings** button located on the lower left corner of the screen displays in all the tabs. This button allows the user to delete any new changes in this session before the parameter is saved.

Note: The **Delete User Settings** function only applies to the user that is currently logged in. Other users are NOT affected if one chooses to delete user settings.

Exam Settings

The **Exam Settings** tab provides the user with several options. These include: **Canned Statements**, **Next/Back Button** and **Requirements**.

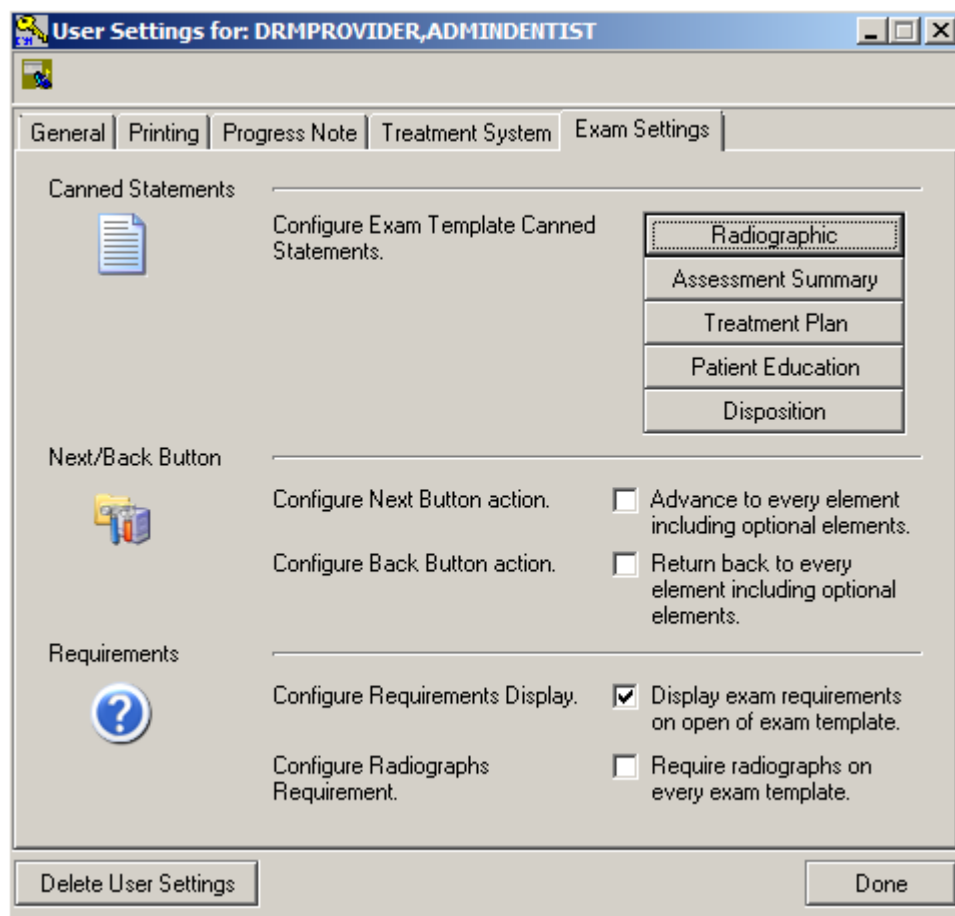


Figure 88: Exam Settings Tab

The **Canned Statements** parameter allows adding of additional pre-defined statements by the end-user to four elements. All local providers are end-users when utilizing this function from the **User Options** submenu, whether or not they are DRM Plus administrators. Any changes made from the **User Settings** screen affect only the individual end user.

Pre-defined statements are broken into five categories: **Radiographic**, **Assessment Summary** and **Treatment Plan** (located in the same element), **Patient Education** and **Disposition**. There is a maximum of twelve pre-defined statements allowed per category.

The local DRM Plus Administrator has priority when entering these statements system-wide, utilizing the administrator settings parameter (NOT displayed here).

When any of these element categories are maxed out with pre-defined statements, the DRM Plus Administrator may add another. This can be done by utilizing the administrator settings parameter. This hides the last pre-defined statement entered by any end-user, and only affects those end-users with twelve entered and displayed in the given category.

To add a pre-defined statement (admin or non-admin) from the **User Settings** screen:

1. Select one of the five pre-defined statement buttons, such as **Assessment Summary**.
2. Type or copy/paste a pre-defined statement in the lower text box.
3. Click the green **Add (+)** button.
4. Click the **OK** button to confirm the new pre-defined statement addition.

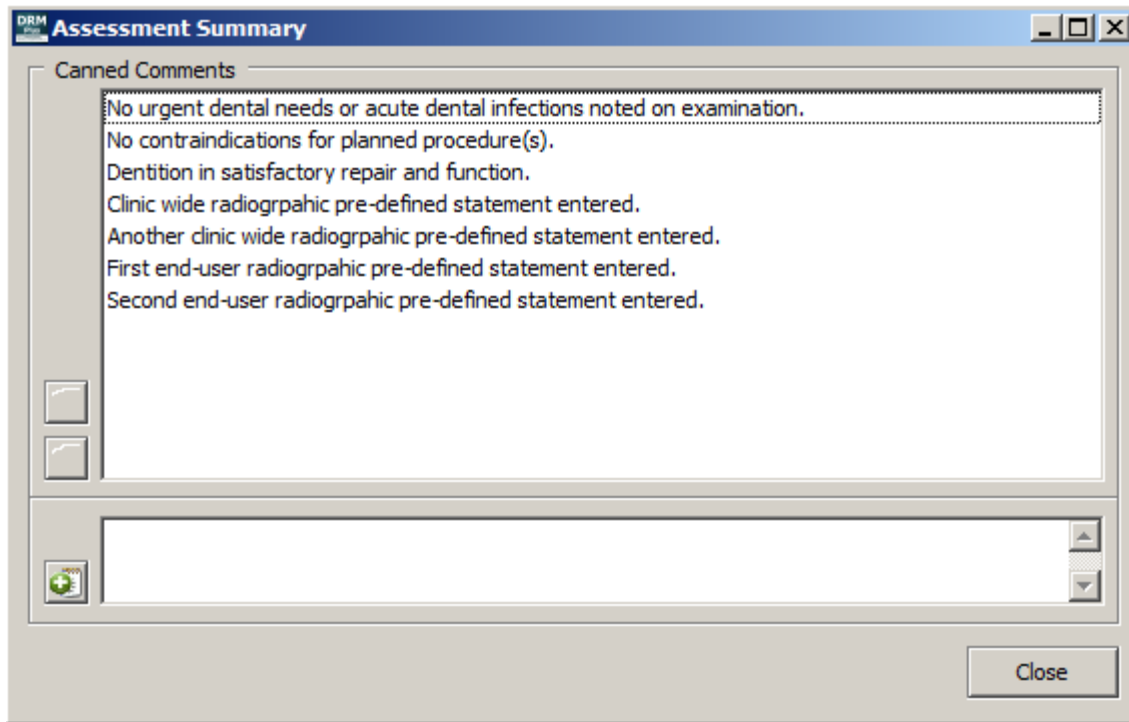


Figure 89: Assessment Summary Screen

The end-user may highlight any of the pre-defined statements that were entered from their **User Settings** screen and either delete that statement or move the statement's position in the list. This deletion or rearranging of the order only affects the end-user's list of pre-defined statements and not any entered by the DRM Plus Administrator or any national pre-defined comment that was kept by the DRM Plus Administrator; these are listed at the top.

The **Next/Back Button** parameter setting allows end-users, when selecting the **Next** or **Back** buttons located on any **Exam** tab element screen, to go directly to the next proceeding or previous required element screen for that exam code and skip all optional element screens.

Note: There is no **Back** button on the first **Presentation/Chief Complaint** element screen and there is no **Next** button on the last **Disposition** element screen.

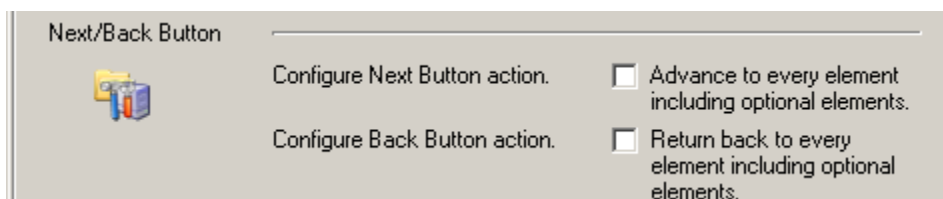


Figure 90: Next/Back Button Parameters

Both options are unchecked by default. When unchecked, the **Next** button skips any element that is optional or has been completed from new data entered during this session and opens the next required element. When checked, the **Next** button opens the very next element regardless of whether it is optional or completed during this session.

The **Back** button when unchecked skips any element that is optional but opens all previous required elements that are completed or NOT. When checked, the **Back** button opens the previous element regardless of whether it is optional or required.

The user is required to complete any optional or required element when selecting the **Next** button when trying to move forward. Selecting the **Back** button does NOT require the element to be completed to open a previous element.

Note: When this parameter has been formatted in the **User Settings** screen, these selections only affect the end-user's profile and follows that end-user to any computer when loading DRM Plus with their Vista access/verify codes.

The first requirements parameter, **Configure Requirements Display**, allows the end-user to keep the requirements display open when selecting any element from the **Exam** tab or the definitions from the **OHA** and **Occlusal** screens. The second requirements parameter, **Configure Radiographs Requirement**, allows the end-user to require a **Radiograph Finding** entry with any exam/consult code entered as completed care and requires data entered into the **Exam** tab.

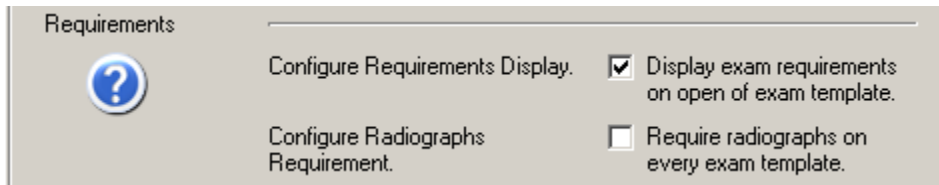



Figure 91: Requirements Parameters

The **Configure Requirements Display** parameter is checked by default and displays the element's requirements whenever an element screen is open. When unchecked, the end-user must select the **Done** button and then close/reopen DRM Plus to activate. This parameter change requires the end-user to open the **Element Requirements Panel** manually.

The **Requirements** icon  located in the upper right corner of the element screen when selected displays the **Element Requirements Panel**.

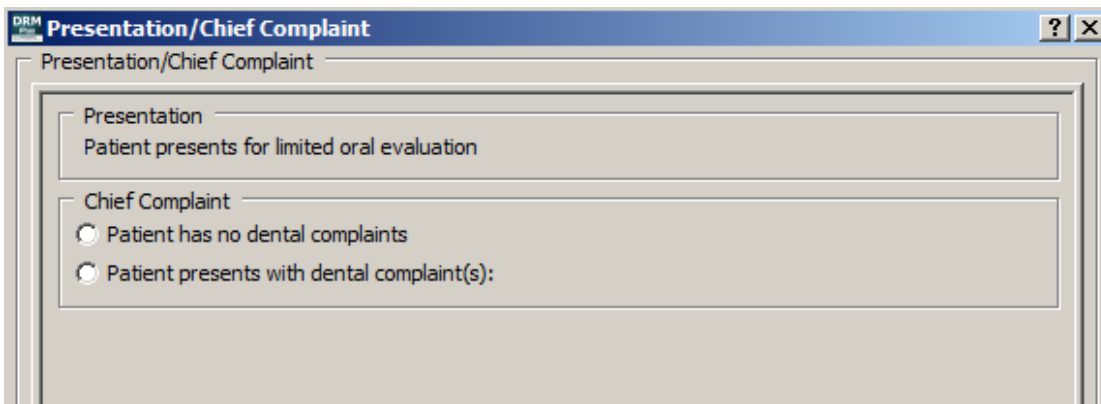


Figure 92: Presentation/Chief Complaint Element Screen

The **Configure Radiographs Requirement** is unchecked by default and only requires radiographs for the D0150 and D0180 exams. When checked, the end-user must select the **Done** button and then close/reopen DRM Plus to activate. This parameter change requires the end-user to enter data from the **Radiographic Findings** element with any exam/consult code entered as completed care and requires data entered into the **Exam** tab.

Note: The ADA exam codes D0145, D0171, D0190 and D0191 are NOT included with the DRM Plus **Exam** tab functionality when entered in DRM Plus by a provider.

Administrative Toolbox

The **Administrative Toolbox** submenu serves to change various administrative settings. It includes six tabs: **General, Printing, Progress Note, Ancillary, Alerts** and **Exam Settings**. The **Delete Admin Settings** button restores all default administrative settings present when DRM Plus was originally installed.

Changing the parameter settings for a non-DRM Plus Administrator in the clinic requires a DRM Plus Administrator to select the **Double Heads** icon on the **Administrative Settings** screen. The DRM Plus Administrator must enter and select the user's name which opens the **User Settings** screen for the selected user. A non-DRM Plus Administrator may overwrite any parameter change(s) entered by a DRM Plus Administrator when setting parameters through their **User Options** submenu.

Note: A non-DRM Plus Administrator may NOT overwrite canned statements used in the **Exam** tab elements entered by a DRM Plus Administrator.

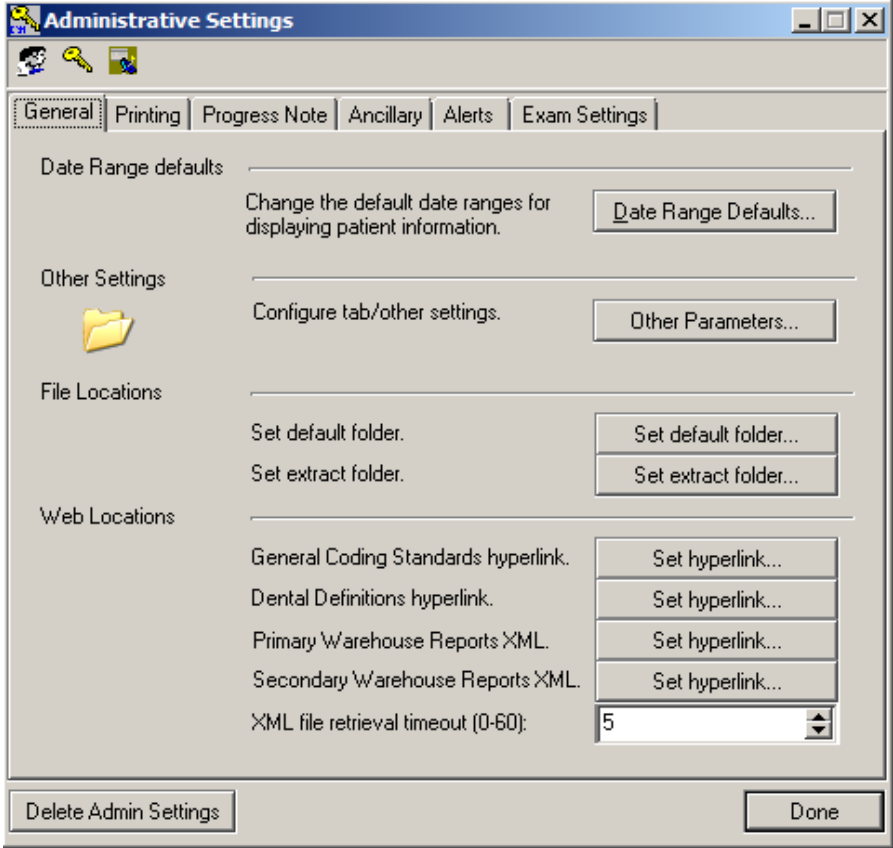



Figure 93: Administrative Settings Screen

The three icons found in the upper left corner allow access to other functions. Click the **Double Heads**  icon to select another end-user, allowing the DRM Plus Administrator to become that end-user. The admin end-user screen displays the five tabs normally found with the user settings of this provider and a sixth named **Security** tab.

The DRM Plus Administrator may also grant full or partial administrative privileges to the provider using the **Security** tab. The other five tabs allow the administrator to change parameters for the end-user, which supersedes current user options settings.

To change administrative privileges or parameters for another end-user:

1. Click the **Double Heads** icon. The **Select User** screen displays.



Figure 94: Select User Screen

2. Enter the search name for the provider in the text box.
3. Press the **<Enter>** key.
4. Select the desired user from the results.
5. Click the **OK** button.
6. The screen displayed then is the **User Settings for: Provider's Name** screen.
7. Select the **Security** tab, click the appropriate check boxes to grant this provider any administrative parameter(s) required.

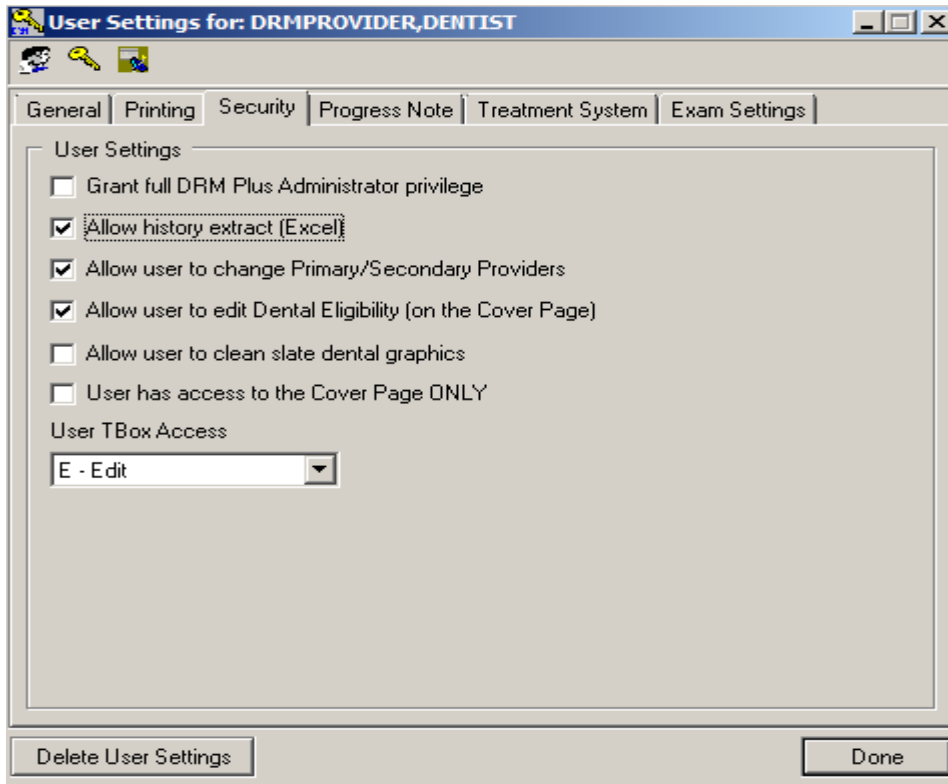




Figure 95: Security Tab With the Administrative Toolbox

8. Check the **Grant full Administrator privilege** check box to grant full administrative permission.
9. Check the **Allow history extract (Excel)** check box to allow the designated user to save **Extract History** reports to be used in Excel/Access.
10. Check the **Allow user to change Primary/Secondary Providers** check box to allow the user to change the patient's primary and secondary provider.
11. Check the **Allow user to edit Dental Eligibility (on the Cover Page)** check box to allow the designated user to edit the patient's dental eligibility information.
12. Check the **Allow user to clean slate dental graphics** check box to allow the designated user to clear all of the graphics in the three **Treatment & Exam** view screens.
13. Check the **User has access to the Cover Page ONLY** check box to allow the user to view/edit only the **Cover Page** tab of DRM Plus.
14. The **User TBox Access** drop-down menu is provided to allow users the option to customize their profiles.
 - a. The default for all users is **E – Edits** allowed, some VA facilities may prefer to deny this permission.
 - b. The **N – No Access Allowed** option allows no editing of the user's profile.
 - c. The **D– Display Only** setting allows the user to view their profile setting.
15. Check any other tab to change this provider's **User Settings** parameters.

Click the **Key**  icon to return back to the main **Administrative Settings** screen.

The **Broker Call History**  icon opens the broker calls screen. Please see the Last Broker Call section in this chapter, for more information.

General

General tab parameters set by a DRM Plus Administrator can only be set for one user at a time. If a DRM Plus Administrator is setting **General** tab parameter(s) for another DRM Plus user, then the DRM Plus Administrator must select the **Double Heads** icon on the **Administrative Settings** screen. The DRM Plus Administrator must enter, select the user's name which opens the **User Settings** screen for the selected user and enter the parameter setting(s) or change(s). This process needs to be repeated for each user requiring **General** tab parameter setting(s) or change(s).

The **General** tab parameter settings entered by a DRM Plus Administrator will be the default settings until that user resets or changes those parameter settings from their **User Options** submenu.

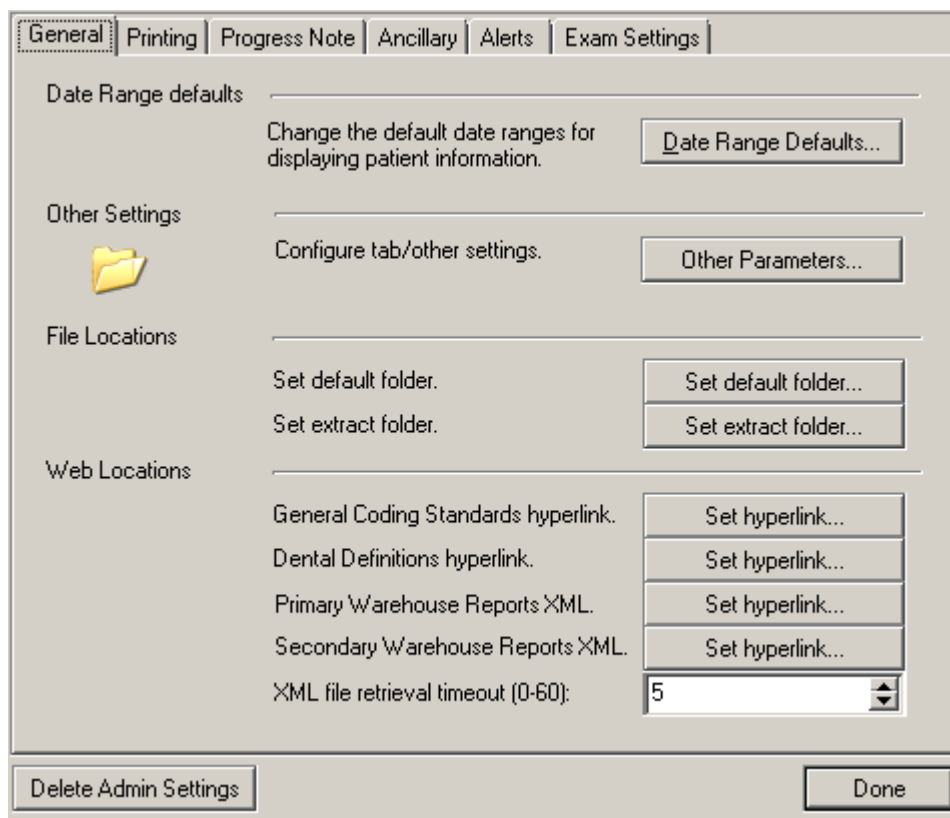


Figure 96: General Tab

To change the date range defaults, please see the **User Options** section of this chapter.

Note: Date range defaults should NOT be changed unless the DRM Plus Administrator first checks with local IT support. Increasing these values can degrade overall network/systems performance.

To change other parameter settings:

1. Click the **Other Parameters** button. The **Other Parameters** screen displays.

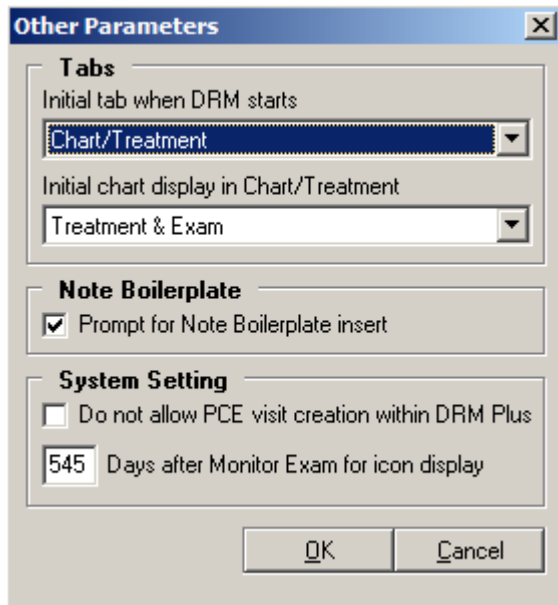


Figure 97: Other Parameters Screen

2. Use the first **Tabs** drop-down menu to change the tab that displays when the program first opens. Use the second drop-down menu to choose **Treatment & Exam** or **Periodontal Chart** for the default view of the **Chart/Treatment** tab.
3. Click the **Note Boilerplate** check box to choose whether to be prompted for a TIU boilerplate insert. The TIU boilerplates reside in VistA and are tied to a TIU progress note title. The parameter when selected displays a screen asking the user if they would like to import a note boilerplate after they select a specific TIU progress note title.
4. Click the **System Setting** check box to determine if PCE visit creation within DRM Plus is allowed in the local dental clinic. May set the number of days for the **Exam Quality Indicator** to display for the entire local dental clinic. This option is unavailable in the **User Options** settings.

To set the default file folder, please see the **User Options** section of this chapter for more information.

The **Set Extract Folder** allows the DRM Plus Administrator, or users with the administrative parameter option for **Extract History** reports, to set the directory/file location where the extraction of the dental history file is stored.

To set the extract folder location:

1. Click the **Set extract folder** button.
2. Use the **Select Extract Folder** screen to navigate to the desired folder.
3. Click the **OK** button.
4. A confirmation screen displays with the new file location. Click the **OK** button.

To set the hyperlinks:

The **General Coding Standards** hyperlink located on the banner and on the **Diagnosis Code** selection screen may be updated by a DRM Plus Administrator by changing the VA Office of Dentistry web address if needed. The same functionality has been established for the **Dental Definitions** hyperlink which is located in the **OHA** modal screen and the **Occlusion** modal screen. This hyperlink should be changed by the DRM Plus Administrator when instructed to do so by the VA Dental Informatics and Analytics Director.

The **Primary/Secondary Warehouse Reports XML** hyperlinks will connect to specific reports as maintained by the Office of Dentistry. These hyperlinks should be changed by the DRM Plus Administrator when instructed to do so by the VA Dental Informatics and Analytics Director.

The **XML file retrieval timeout (0-60)** option allows the retrieval timeout to be adjusted by the DRM Plus Administrator. A setting of 0 seconds does **NOT** mean there will **NOT** be a delay. Also a setting of 0 may **NOT** allow your site time enough to connect and get the submenu, so use with caution. A setting of 5 seconds is the default. This may need to be adjusted (lengthened or shortened) based on your sites internet/network connectivity.

1. Click the General Coding Standards **Set hyperlink** button.
2. Copy and paste the correct web address in the field.

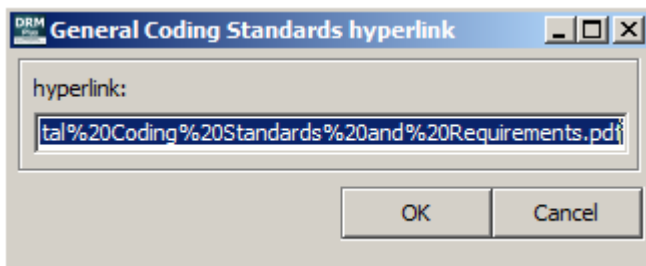


Figure 98: General Coding Standards Hyperlink Screen

3. Click the **OK** button to save the new hyperlink default sent by the VA Office of Dentistry.

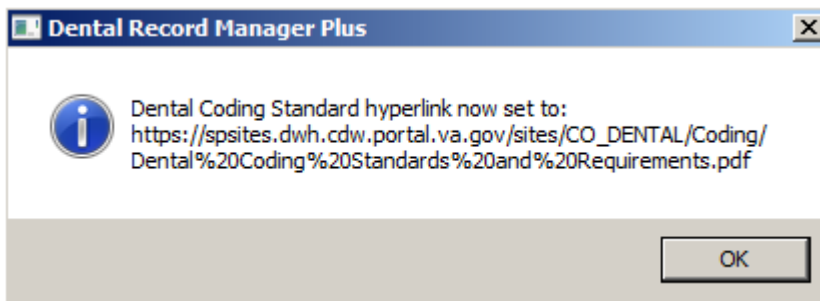


Figure 99: Confirmation Message

4. Click the **OK** button to close this informational screen.

The same process is used for the **Dental Definitions** hyperlink parameter.

1. Click the Dental Definitions **Set hyperlink** button.
2. Copy and paste the correct web address in the field.

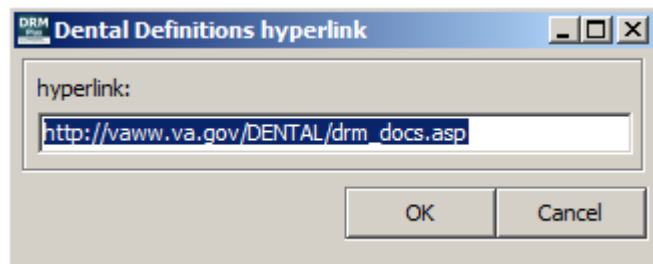


Figure 100: Dental Definitions Hyperlink Screen

3. Clicking the **OK** button saves the new hyperlink default sent by the VA Office of Dentistry.

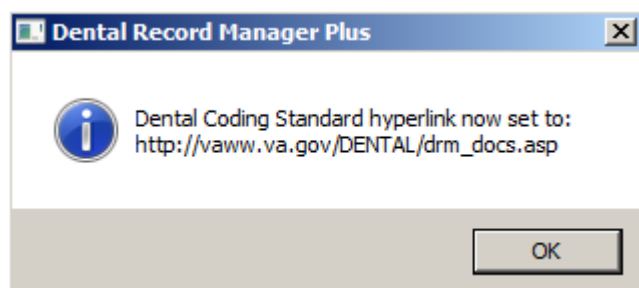


Figure 101: Confirmation Message

4. Click the **OK** button to close this informational screen.

The same process is used for the **Primary Warehouse Reports XML** and the **Secondary Warehouse Reports XML** hyperlink parameters.

1. Click the Primary Warehouse Reports XML **Set hyperlink** button.
2. Copy and paste the correct web address in the field.

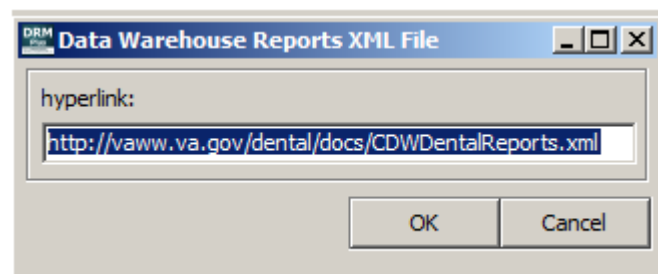


Figure 102: Data Warehouse Reports HML File Hyperlink

3. Clicking the **OK** button saves the new hyperlink default sent by the VA Office of Dentistry.

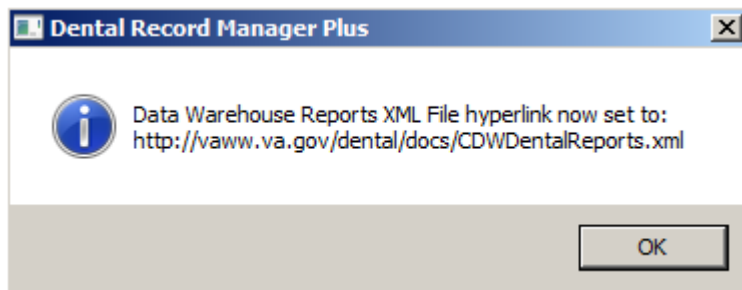


Figure 103: Confirmation Message

4. Click the **OK** button to close this informational screen.

Adjusting the **XML file retrieval timeout (0-60)** field allows the retrieval timeout to be adjusted by the DRM Plus Administrator. A setting of 0 seconds does NOT mean there will NOT be a delay. Also a setting of 0 may NOT allow your site time enough to connect and get the submenu, so use with caution. A setting of 5 seconds is the default. This may need to be adjusted (lengthened or shortened) based on your site's internet/network connectivity.

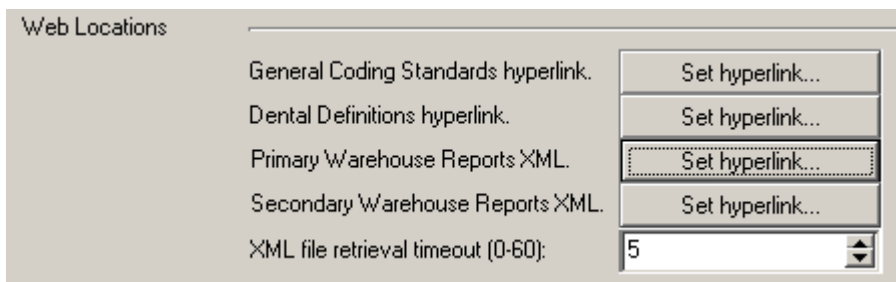


Figure 104: XML file retrieval timeout (0-60)

Printing

Printing tab parameters set by a DRM Plus Administrator can only be set for one user at a time. If a DRM Plus Administrator is setting **Printing** tab parameter(s) for another DRM Plus user, then the DRM Plus Administrator must select the **Double Heads** icon on the **Administrative Settings** screen. The DRM Plus Administrator must enter, select the user's name which results in the opening of the **User Settings** screen for the selected user and enter the parameter setting(s) or change(s). This process needs to be repeated for each user requiring **Printing** tab parameter setting(s) or change(s).

The **Printing** tab parameter settings entered by a DRM Plus Administrator is the default settings until that user resets or changes those parameter settings from their **User Options** submenu.

Progress Note

Setting the parameters in the **Progress Note** tab cannot be changed using the **Administrators Toolbox**.

The DRM Plus Administrator may configure code boilerplates from the **Progress Note** tab located on the **Administrative Settings** screen. Every end-user planning to access these code boilerplates must enter the exact name of the code boilerplate created by the DRM Plus Administrator. After entering the exact name of the code boilerplate in their **User Settings** screen and clicking the **OK** button, the administrative code boilerplate automatically imports.

Treatment System

Treatment System tab parameters set by a DRM Plus Administrator can only be set for one user at a time. If a DRM Plus Administrator is setting **Treatment System** tab parameter(s) for another DRM Plus user, then the DRM Plus Administrator must select the **Double Heads** icon on the **Administrative Settings** screen. The DRM Plus Administrator must enter, select the user's name which results in the opening of the **User Settings** screen for the selected user and enter the parameter setting(s) or change(s). This process will need to be repeated for each user requiring **Treatment System** tab parameter setting(s) or change(s).

The **Treatment System** tab parameter settings entered by a DRM Plus Administrator will be the default settings until that user resets or changes those parameter settings from their **User Options** submenu.

Ancillary

Use the functions in the **Ancillary** tab to add options to the tool menu. Use the check box to enable MiPACS. To add an application, type the name and website directly into the table, or use the browse function. The location for these application executables may require IT assistance.

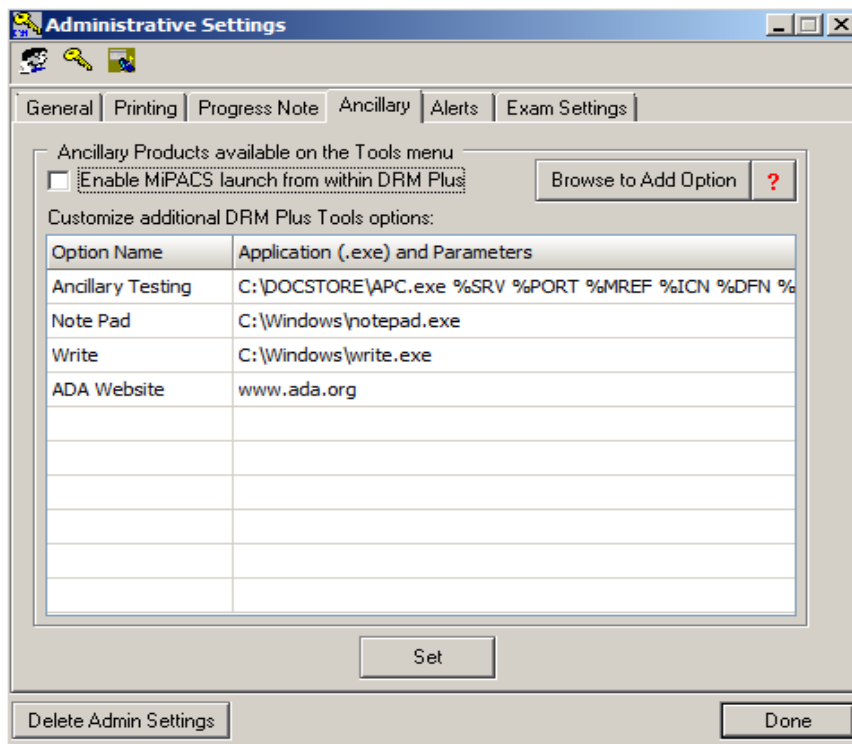


Figure 105: Ancillary Tab

The DRM Plus Administrator may customize up to 10 ancillary applications or websites to launch from the **Tools** menu.

To add an executable:

1. Click the **Browse to Add Option** button. The Microsoft **Open** browse screen displays.

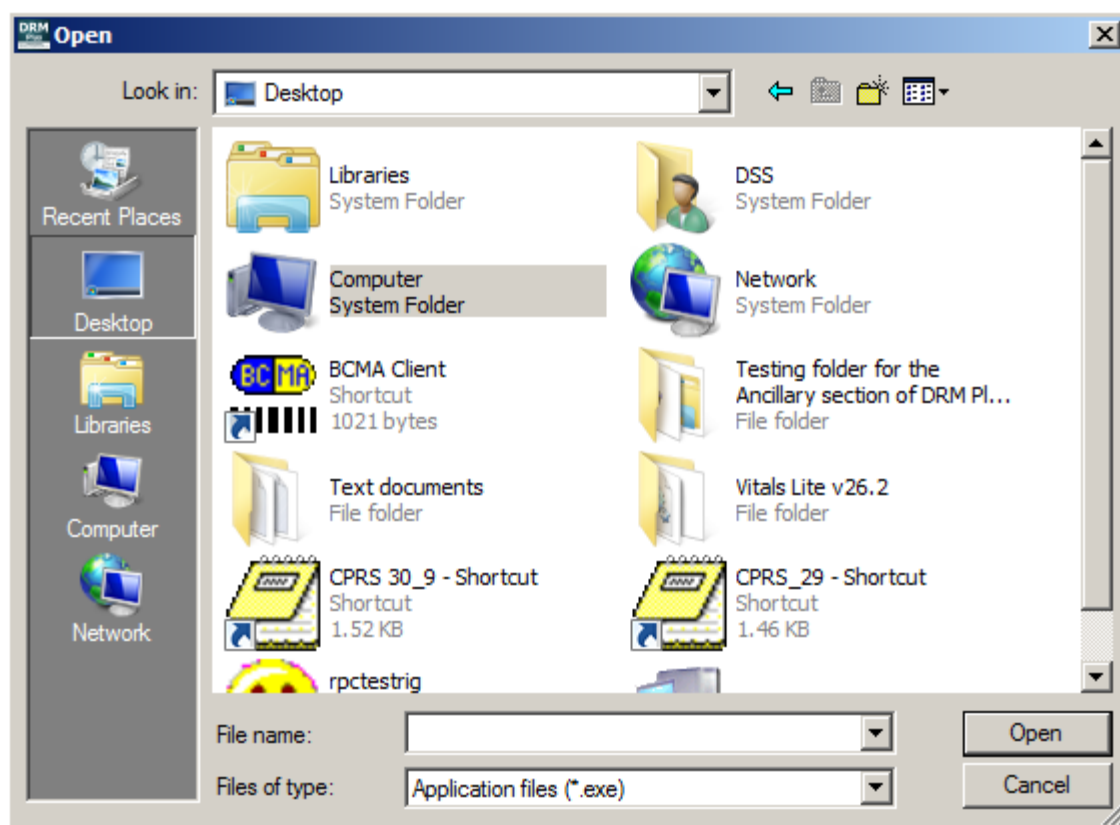


Figure 106: Microsoft Open Browse Screen

2. Navigate to the desired executable file and click the **Open** button.
3. The .exe file appears on the list.
4. Name the option by typing in the corresponding **Option Name** field.
5. Click the **Set** button to confirm the changes.
6. A confirmation screen displays. Click the **OK** button.
7. The option now appears in the **Tools** menu.

To delete an executable:

1. Highlight the desired executable in the table.
2. Press the <Delete> key.
3. Highlight the desired option name.
4. Press the <Delete> key.
5. The option is removed from the **Tools** menu.

Further guidance is available within the program. Click the **red question mark [?]** icon and the **Help for Customizing Tools Options** screen displays. IT can help with parameter passing, since this is similar to setting up CPRS **Tools** menu options.

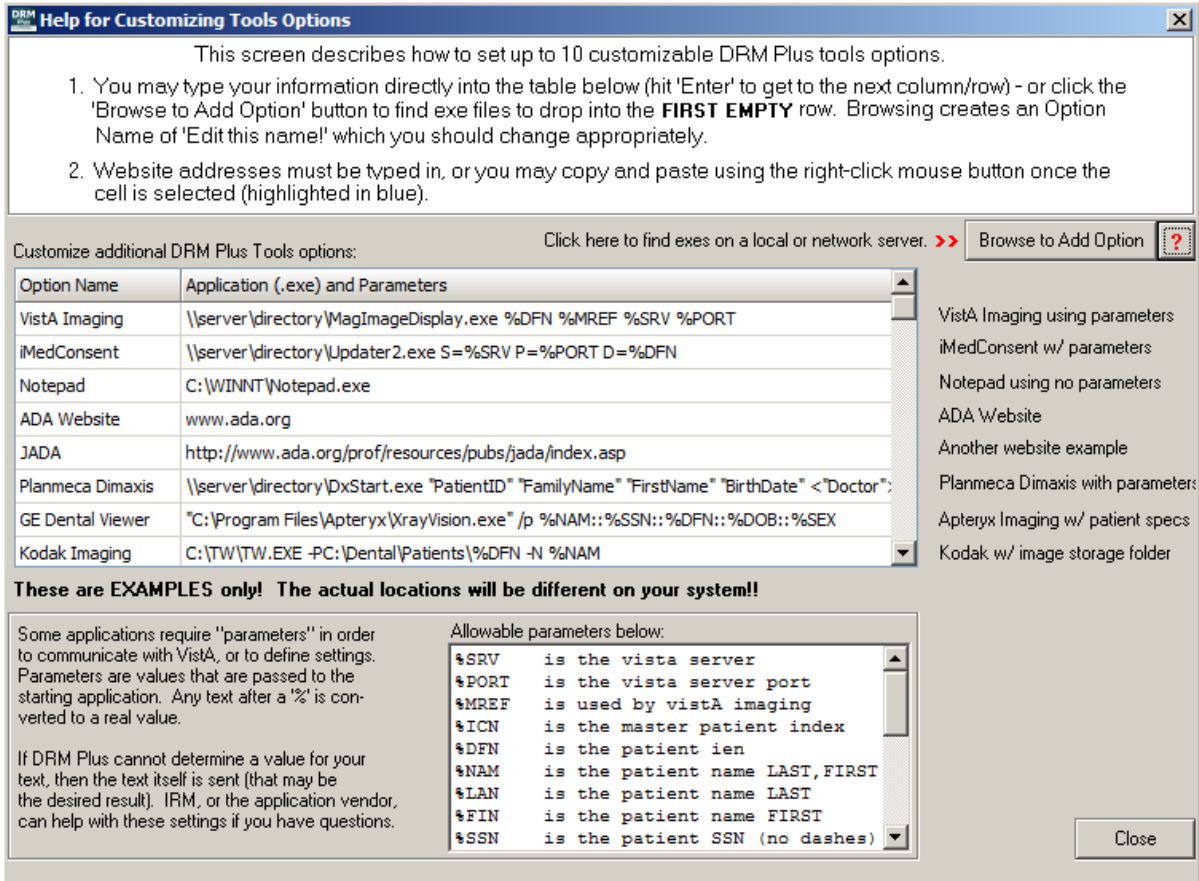


Figure 107: Help for Customizing Tools Options Screen

This page contains examples and definitions of allowable parameters that DRM Plus understands and can convert to real values.

Note: These are examples for illustration and some options might NOT be available at the user’s facility.

Alerts

Use the functions on this tab to add or delete DRM Plus alerts. These alerts permanently saved by the DRM Plus Administrator may be entered by any user with the **Alert** icon, located on the banner. When entered, the alerts display on the **Cover Page** tab.

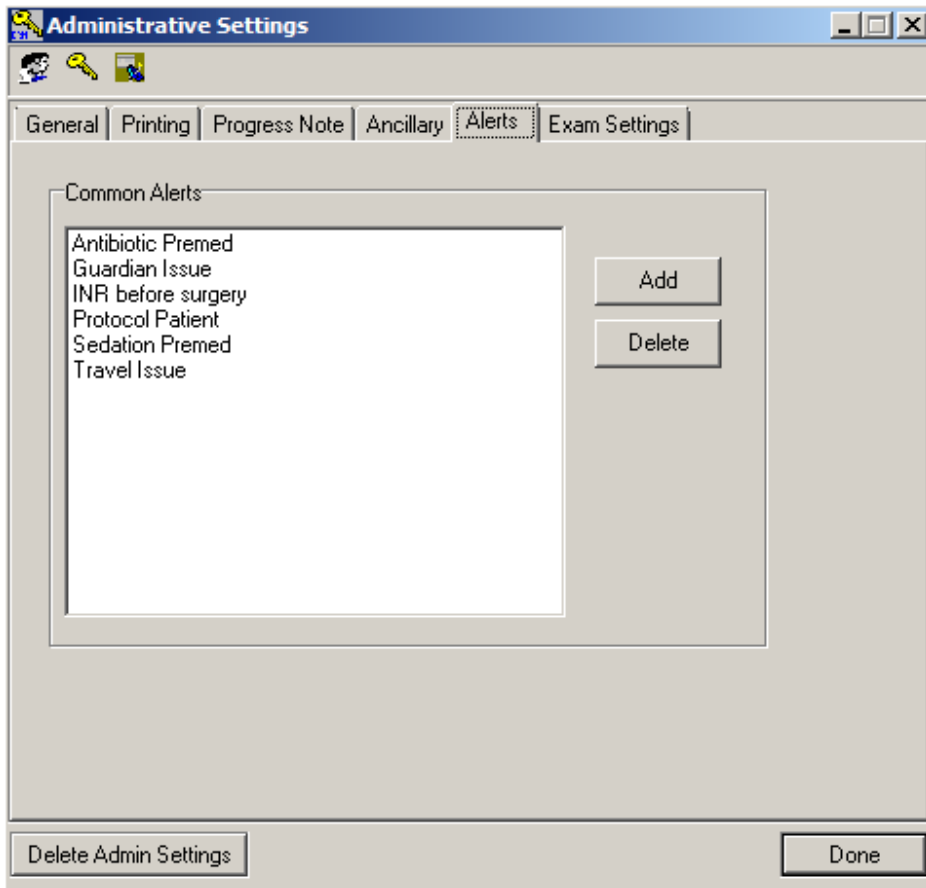


Figure 108: Alerts Tab

To add an alert:

1. Click the **Add** button. The **Add Dental Alert** screen displays.

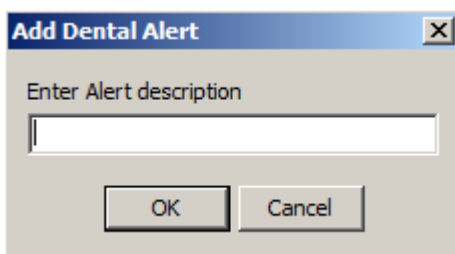


Figure 109: Add Dental Alert Screen

2. Type the alert name into the text box.
3. Click the **OK** button. The alert appears on the list.

To delete an alert:

1. Highlight the alert to be deleted.
2. Click the **Delete** button.
3. The alert is removed from the list.

Exam Settings

This **Administrative Settings** parameter allows the DRM Plus Administrator to add/delete, system wide, all the national and local administrative pre-defined statements. This parameter may be accessed from the **Tools** menu → **Administrative Toolbox** → **Exam Settings** tab, only by DRM Plus Administrators.

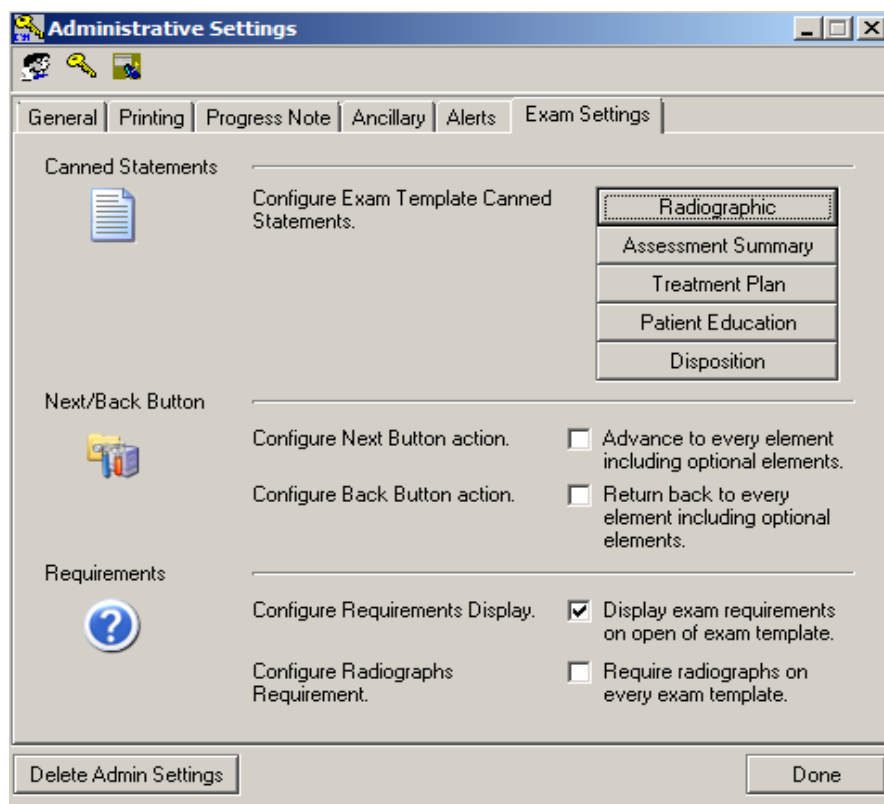


Figure 110: Exam Settings Tab

These parameters allow DRM Plus Administrators to create pre-defined statements that import to all end-user accounts using the local Vista system. The five pre-defined statement buttons are **Radiographic**, **Assessment Summary**, **Treatment Plan**, **Patient Education** and **Disposition**. There are two to four national pre-defined statements pre-developed for these five categories.

There is a maximum of twelve pre-defined statements allowed per comment field by any end-user. The DRM Plus Administrator has priority for entering pre-defined statements at any time and may add/delete a national or local admin pre-defined statement by following the same steps described when entering with the **User Settings**. The DRM Plus Administrator may only view the national pre-defined statements or those entered by the DRM Plus Administrator with this parameter. The pre-defined statements entered by any end-user's **User Settings** parameter are NOT viewable in this screen, which includes DRM Plus Administrator entries from their own **User Settings** parameter.

The DRM Plus Administrator may delete or rearrange the sequencing of any national or administrator pre-defined statements entered by this parameter. Highlight the pre-defined statement and use one of the two buttons on the left side of the screen to delete or rearrange the sequence of this pre-defined statement. The end-user may NOT delete or rearrange any of these admin pre-defined statements; they are always listed at the top in every user's list.

The **Next/Back Button** and the **Requirements** parameter from the **Administrative Settings** screen do NOT affect the entire local VistA system or any other end-user functionality, but only result in changing the admin end-user functionality. This action results in the same outcome when editing the **User Settings** screen.

Note: DRM Plus Administrators must use either **User Options** or the **Double Head** icon (selecting themselves) to enter end-user/personal pre-defined statements NOT intended for use by others in the clinic.

Panel Add/Edit

Use this submenu to change the primary/secondary physician's panel to a different provider. This administrative panel changes all patients associated with the original primary provider to any new primary provider for that block of patients. It works the same for any secondary providers completed together or separate.

Selecting the **Panel Add/Edit** submenu displays the following screen.

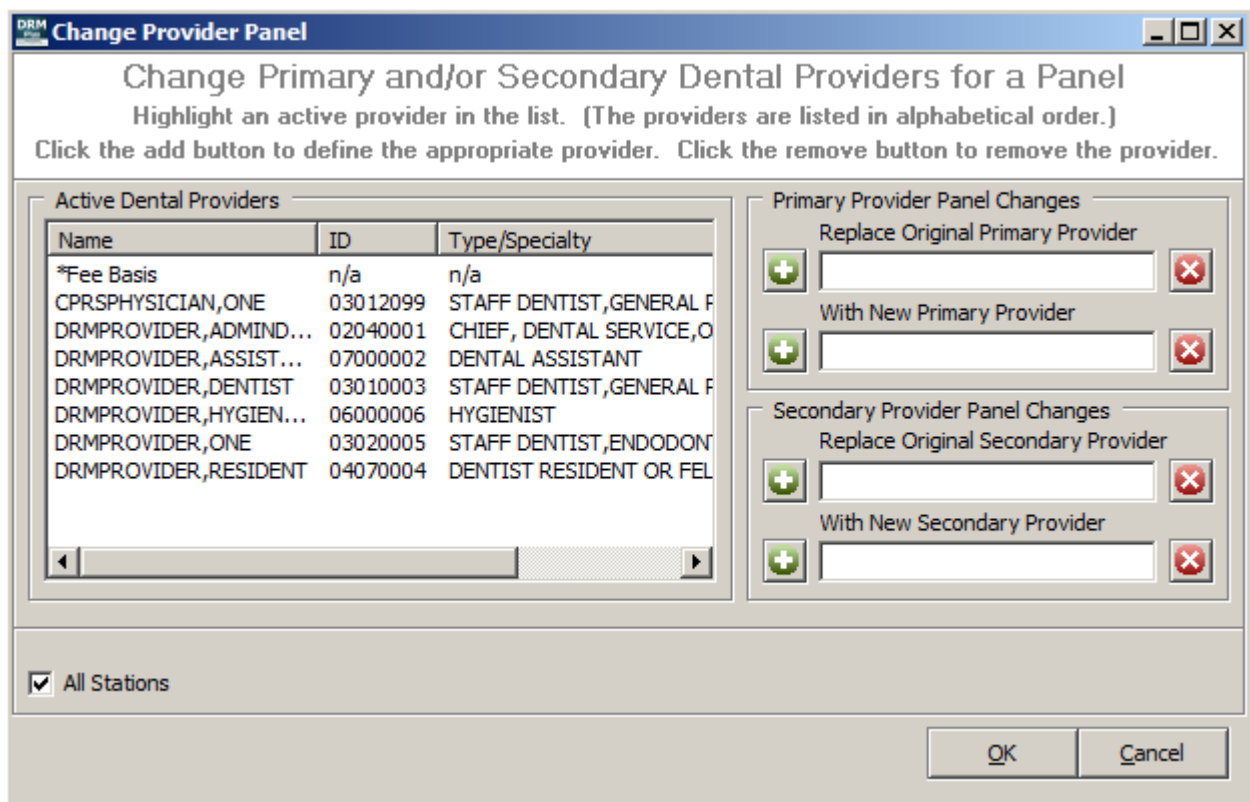


Figure 111: Change Provider Panel Screen

1. Highlight the original PDP from the **Active Dental Providers** list and select the **green [+]** icon.
2. Highlight the new PDP from the **Active Dental Providers** list and select the **green [+]** icon.
3. Select the **OK** button.

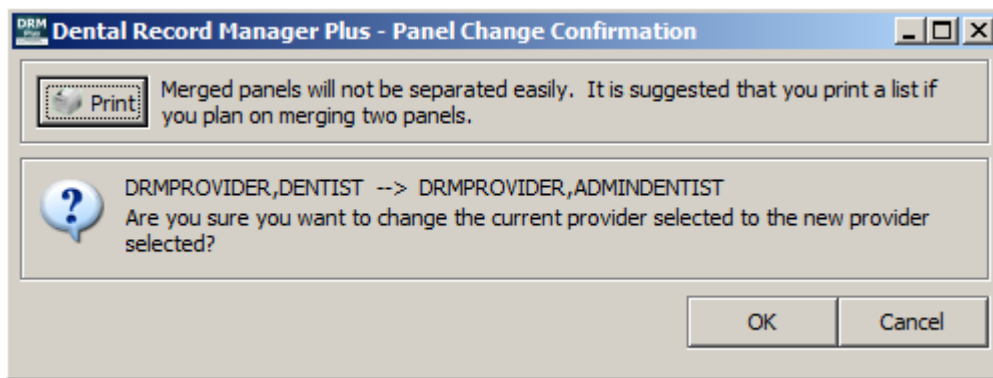


Figure 112: Panel Change Confirmation Message

4. It is highly recommended that a list of patients be printed if the user is planning on merging two panels.
5. Select the **OK** button if the panel of patients should be switched to a new provider.

Note: All patients listed on the print-out are changed to the new primary provider. If there are any patients listed on the print-out that should NOT be changed to the new primary provider, then the DRM Plus Administrator must make a decision to either change all patients listed to the new primary provider using this batch-change functionality and manually change the ‘exception’ patients one at a time back to the original provider after the batch change has been implemented, or change all patients listed on the print-out manually. Manually changing providers one patient at a time requires the change to be made from the **Designated Dental Providers** screen located in the DRM Plus banner in each patient’s chart.

Provider Add/Edit

Use this submenu to add a new provider, or to edit a provider’s 8-digit dental provider ID in DRM Plus. Dental providers may also be inactivated using this function. Inactivated providers cannot be selected for reports.

Figure 113: Dental Provider Edit Screen

Dental Provider Menu

This menu auto-fills with entries from the VistA dental provider file. Once a new provider is added to the dental provider file; they may NOT be deleted by the DRM Plus Administrator.

Checking the **Inactive** check box does NOT allow the provider to be selected for any reports.

Provider Type Menu

This menu displays a list of provider types and includes a two-digit code used to build the new eight digit dental provider ID.

Provider Specialty Menu

This menu displays a list of provider specialties and includes a two digit code used to build the new eight digit dental provider ID.

Provider Seq #

This is the next available four digit sequenced number that is computer generated to build the new eight digit dental provider ID. This number can be edited if desired; however, editing is not required.

Dental Provider Number

This displays the new 8-digit dental provider ID, which is a read only field. The first two digits are the two digit code from **Provider Type**. The next two digits are the two digit code from **Provider Specialty**. The last four digits are the **Provider Seq #** automatically generated or manually entered.

Old Provider ID

Old Provider IDs may be filed with old four digit IDs from previous provider numbers; however, this field is NOT required for new DRM Plus users.

Person Class

The VistA **Person Class** displaying at the bottom of the screen will be view only and flagged if there is some basic discrepancy between the 8-digit dental provider ID and the **Person Class**. The flag will be displayed in a red typed message as in the following dialog.

The screenshot shows a window titled "Dental Provider Edit". It contains several sections:

- Dental Provider:** A dropdown menu showing "DRMPROVIDER.DENTIST TWO" and a "New" button.
- Inactive:** A checkbox labeled "Inactive" which is unchecked.
- Provider Number:** A section containing:
 - Provider Type:** A dropdown menu showing "03-STAFF DENTIST".
 - Provider Specialty:** A dropdown menu showing "05-ORTHODONTICS".
 - Provider Seq#:** A text box containing "0010".
 - Old Provider ID:** An empty text box.
 - Dental Provider Number:** A yellow highlighted box displaying "03050010".
- Person Class:** A section with the text "Changes to Person Class must be performed in VistA." and "Inactive person class".

At the bottom of the dialog are "Save" and "Close" buttons. A red error message is displayed in the center: "Provider Number and Person Class do not appear to match!".

Figure 114: Provider Number/Person Class Flag

Note: All dental providers must have an **8-digit dental provider ID** to open and file data in DRM Plus.

To add a new provider:

1. Click the **New** button.
2. The **Search for Provider** screen displays.

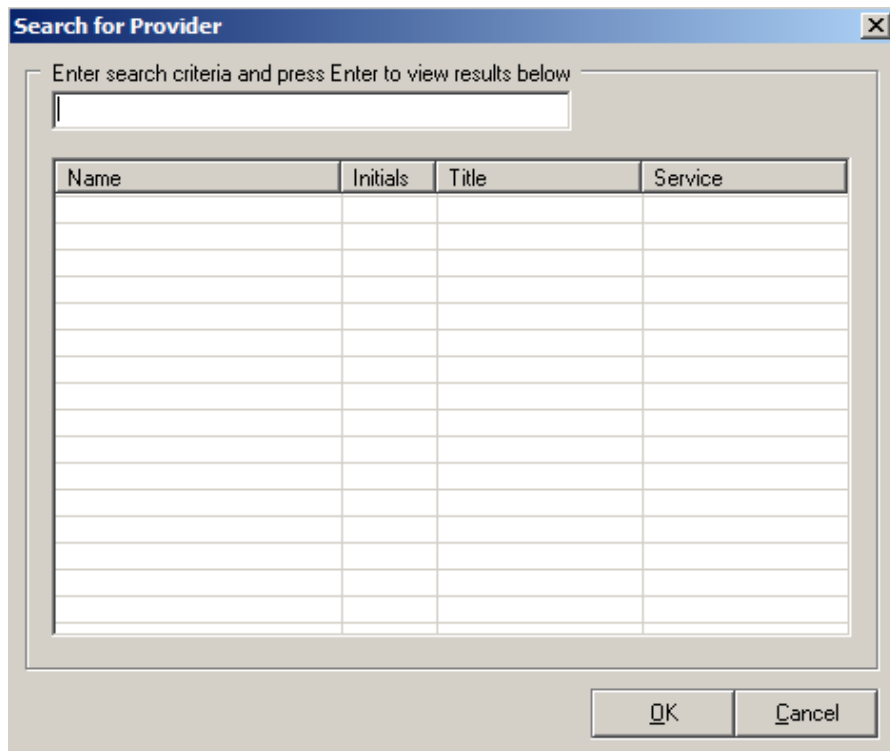


Figure 115: Search for Provider Screen

3. Enter the search terms in the text box and press the <Enter> key. The search results display.
4. Select the desired provider and click the **OK** button.
5. The provider is added, and their name displays on the **Dental Provider Edit** screen.

To edit either a new or existing provider's information:

1. Select the provider from the dental provider drop-down menu.
2. Select the **Provider Type** from the next drop-down menu.
3. Select the **Provider Specialty** from the next drop-down menu.
4. Enter the **Provider Sequence** number in the text box. (Populates automatically if new)
5. Select the **Inactive** check box, if appropriate.
6. The **Dental Provider Number** is listed.
7. Click the **OK** button.
8. A confirmation screen displays. Click the **OK** button.

Ancillary Tool Functions – ADA Website

This American Dental Association website is only available if the DRM Plus Administrator formats this in the administrator's **Ancillary** applications and parameters. Some users may NOT have permission to access the internet or have to enter/re-enter a user name/passcode.

Reports

The **Reports** menu has the five following submenus: **Reports** (DRM canned reports), **Service Reports** (old DAS reports), **Data Warehouse Reports**, **Extract History File** (for small date range extract reports), and **New Extract History File** (for large date range extract reports). All of these submenus (except **Data Warehouse Reports**) are the same as before except they are now located under the **Reports** menu instead of under the **Tools** menu.

Reports

When this submenu is selected, the **Report Selection** screen displays.

The screenshot shows the 'Report Selection' dialog box with the following details:

- General Tab:**
 - Report Types: Provider Summary, Clinic Summary, Visits by Provider, Visits by Clinic, Non Clinical Time by Provider, Fee Basis/Detailed Fee Basis, Encounter/Visits by Patient Type, Recare Report
 - Fiscal Year: n/a (dropdown)
 - Start Date: 6/24/2014 (dropdown)
 - End Date: 6/24/2014 (dropdown)
 - All Stations
 - All Providers? (with 'Select Provider(s)' text)
 - Use Provider Name on Reports
 - Include Distributed Provider Totals
 - Patient Status: Active, All Statuses, Inactive, Active/Maint, Maintenance
 - Transaction Status: Complete, Planned, Deleted
 - Report Category Type: 13 ADA Categories, 131 VA-DSS Prod, ADA/CPT Codes
 - Search for records using: Visit Date, Create Date
- Buttons:** OK, Cancel

Figure 116: Report Selection Screen

This screen has three tabs: **General**, **Patient** and **Planning**.

General Tab

The screenshot shows a 'Report Selection' dialog box with three tabs: 'General', 'Patient', and 'Planning'. The 'General' tab is active. It contains several sections of controls:

- Report Type Selection:** A group of radio buttons for selecting a report type. The selected option is 'Provider Summary'. Other options include 'Clinic Summary', 'Visits by Provider', 'Visits by Clinic', 'Non Clinical Time by Provider', 'Fee Basis/Detailed Fee Basis', 'Encounter/Visits by Patient Type', and 'Recare Report'.
- Date Selection:** Three dropdown menus for 'Fiscal Year' (set to 'n/a'), 'Start Date' (set to '6/24/2014'), and 'End Date' (set to '6/24/2014').
- Checkboxes:** A series of checkboxes for 'All Stations', 'All Providers?', 'Use Provider Name on Reports', and 'Include Distributed Provider Totals'. 'All Stations' and 'All Providers?' are checked.
- Patient Status:** A group of radio buttons for 'Patient Status'. The selected option is 'All Statuses'. Other options are 'Active', 'Inactive', and 'Maintenance'.
- Transaction Status:** A group of checkboxes for 'Transaction Status'. 'Complete' is checked, while 'Planned' and 'Deleted' are unchecked.
- Report Category Type:** A group of radio buttons for 'Report Category Type'. The selected option is 'ADA/CPT Codes'. Other options are '13 ADA Categories' and '131 VA-DSS Prod'.
- Search for records using:** A group of radio buttons for 'Search for records using'. The selected option is 'Visit Date'. The other option is 'Create Date'.

At the bottom of the dialog box are 'OK' and 'Cancel' buttons.

Figure 117: General Tab

To create a report:

1. Choose the desired report type.
2. Select the **Fiscal Year** or the **Start Date** and **End Date**.
3. Use the check box to indicate whether the provider name and the distributed provider totals should be included in the report.
4. Choose a **Patient Status**.
5. Indicate what the **Transaction Status** is.
6. Select the **Report Category Type**.
7. Choose the date type that is to be represented on the report.
8. Click the **OK** button to generate the report. The report screen displays.

DRM Report

Dental Service Treatment Report - Summary Report by Provider

From Jun 03, 2013 to Jun 24, 2014 Station: All Dental Provider: DRMPROVIDER,ADMINDENTIST

ADA/CPT Code	I	IIA	IIC	III	IV	V	VI	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION	1	1		2		1	1	6	180
D0140 LIMIT ORAL EVAL PROBLM FO	1	1				2		4	80
D0150 COMPREHENSVE ORAL EVALU.	1			1	1		1	4	180
D0210 INTRAORAL FULL IMAGE SERIE		1	1		1	1		4	72
D0274 DENTAL BITEWING FOUR IMA	2			1				3	12
D0330 DENTAL PANORAMIC IMAGE	2				2			4	40
D1110 DENTAL PROPHYLAXIS ADULT						1		1	45
D1208 TOPICAL FLUORIDE						1		1	15
D1320 TOBACCO COUNSELING						1		1	0
D1330 ORAL HYGIENE INSTRUCTION						1		1	0
D2150 AMALGAM TWO SURFACES PE		1		2	2			5	225
D2160 AMALGAM THREE SURFACES P	2	1		1	3			7	350
D2391 POST 1 SRFC RESINBASED CM	1			2	4			7	280
D2392 POST 2 SRFC RESINBASED CM		1		1	1			3	150
D2393 POST 3 SRFC RESINBASED CM				1				1	60
D2790 CROWN FULL CAST HIGH NOB				1				1	150
D6056 PREFABRICATED ABUTMENT				1				1	45
D7140 EXTRACTION ERUPTED TOOT	1	1		5	1	1	8	17	510
TOTAL	11	7	1	18	17	7	10	71	2394

Total Visits = 28
All data is complete Print Totals Only

Save All to XLS Save to XLS Print All Print Close

Figure 118: DRM Report Screen

This screen has options to save an Excel file (**Save to XLS** button) or close. Some of the options may NOT be available with every report type.

Eight report types are accessible through this tab:

- **Provider Summary:** Summary counts of procedures by Station/Provider and Dental Classification.
- **Clinic Summary:** Summary counts of procedures by Station and Dental Classification.
- **Visits by Provider:** Detailed listing of procedures by Station/Provider.
- **Visits by Clinic:** Detailed listing of procedures by Station.
- **Non-Clinical Time by Provider:** Total days by provider for time applied to Education, Administration, Research and Fees.
- **Fee Basis/Detailed Fee Basis:** Total amount authorized and number of cases by Dental Classification (for local dental use only).
- **Encounters/Visits by Pat Type:** Summary counts of encounters/visits by patient type.
- **Recare Report:** List of patients with recare dates.

Click the corresponding radio buttons to select the desired report types. Use the check boxes to customize these reports.

There are seven check box options:

- **All Stations:** This selection shows all stations of the parent facility.
- **All Providers?:** This selection shows the report for all providers using provider ID numbers.
- **Use Provider Name on Reports:** This selection shows the report using provider names.
- **Include Distributed Provider Totals:** This selection adds Distributed Provider workload totals to the two provider reports.
- **Completed:** This selection includes completed care in the report.
- **Planned:** This selection includes planned procedures in the report.
- **Deleted:** This selection includes deleted completed care procedures in the report.

Clinic Summary, Visits by Clinic and **Fee Basis** reports do NOT offer provider selection. **Provider Summary, Visits by Provider** and **Non Clinical Time by Provider** do allow provider selection. De-selecting the **All Providers?** check box displays a list of providers to choose from. One or more is selectable within the list for **Provider Summary** and **Visits by Provider** reports.

Start Date/End Date selections display a calendar on the drop-down. The dates default to the current date. Future dates are NOT allowed in these fields. The **Fiscal Year** allows selection to auto-select the date range for that fiscal year.

The station defaults to **All Stations**. This can be changed by selecting a single optioned station.

Patient Status allows the user to select either **Active, Inactive, Maintenance, Active/Maintenance** or **All Statuses**.

Distributed provider workload may be viewed on the **Provider Summary** or **Visits by Provider** report. When **All Providers?** is checked for these provider reports, and **Include Distributed Provider Totals** is checked, the distributed provider workload is included. The report may contain providers who are NOT in the dental provider file. This could occur because the distributed provider is auto-defined when the resident selects a cosigner for the note in DRM Plus. If the co-signer is NOT a dental provider, possibly from a wrong selection, the report contains the name of the distributed provider enclosed in parentheses, i.e., (DOCTOR, ATTENDING).

Note: The report names **Encounters by Provider** and **Encounters by Clinic** have been changed to replace the word **Encounters** with **Visits**. These reports (as well as the **Summary** reports) display the **Total Visits** at the bottom. The number of encounters in DRM Plus is not truly indicative of the times the provider has seen a patient.

Note: Selecting multiple reports from the **General** tab while the **Report Selection** screen is displayed always requires the selection of the report radio button first, followed by the selection of the **Fiscal Year**, even if the same fiscal year is desired for multiple reports.

Provider Summary

The **Provider Summary** report replaces the DENTREATPROV RPT in VistA. The optional third page prompted in VistA report displays as total values at the end of the columns. ADA/CPT Codes, listed under the date range, that are included in this report, come from the selection of either the **Visit Date** or the **Create Date** designated on the **General** tab.

ADA/CPT Code	I	IIA	IIC	III	IV	V	VI	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION	1	1		2		1	1	6	180
D0140 LIMIT ORAL EVAL PROBLM FOI	1	1			2			4	80
D0150 COMPREHENSVE ORAL EVALU.	1			1	1		1	4	180
D0210 INTRAORAL FULL IMAGE SERIE		1	1		1	1		4	72
D0274 DENTAL BITEWING FOUR IMAI	2			1				3	12
D0330 DENTAL PANORAMIC IMAGE	2				2			4	40
D1110 DENTAL PROPHYLAXIS ADULT						1		1	45
D1208 TOPICAL FLUORIDE						1		1	15
D1320 TOBACCO COUNSELING						1		1	0
D1330 ORAL HYGIENE INSTRUCTION						1		1	0
D2150 AMALGAM TWO SURFACES PE		1		2	2			5	225
D2160 AMALGAM THREE SURFACES P	2	1		1	3			7	350
D2391 POST 1 SRFC RESINBASED CM	1			2	4			7	280
D2392 POST 2 SRFC RESINBASED CM		1		1	1			3	150
D2393 POST 3 SRFC RESINBASED CM				1				1	60
D2790 CROWN FULL CAST HIGH NOB				1				1	150
D6056 PREFABRICATED ABUTMENT				1				1	45
D7140 EXTRACTION ERUPTED TOOT	1	1		5	1	1	8	17	510
TOTAL	11	7	1	18	17	7	10	71	2394

Total Visits = 28
All data is complete Print Totals Only

Save All to XLS Save to XLS Print All Print Close

Figure 119: Provider Summary

When creating a **Provider Summary** report, select one or more providers by pressing and holding the **<Shift>** and **<Ctrl>** keys, or select all providers by using the **All Providers?** check box. Use the same function to either show all rows/columns or to show just those rows/columns that contain data. The report information may be saved to an Excel spreadsheet by clicking the **Save All to XLS** or **Save to XLS** buttons. **Print** the selected information displayed for an individual provider, or select **Print All** to print for all providers.

Note: Checking the **Include Distributed Provider Totals** check box adds distributed provider workload totals, located at the bottom of each column in the two provider reports.

Clinic Summary

The **Clinic Summary** report replaces the DENTREATCLINIC RPT in VistA. This report is essentially the same as the **Provider Summary** report, except that the entire station is displayed (all providers).

ADA/CPT codes, listed under the date range, which are included in this report, come from the selection of either the **Visit Date** or the **Create Date** designated on the **General** tab.

ADA/CPT Code	I	IIA	IIC	III	IV	V	VI	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION	1	1		3	1	1	1	8	240
D0140 LIMIT ORAL EVAL PROBLM FC	1	1				2		4	80
D0150 COMPREHENSVE ORAL EVALL	2		1	1	2		1	7	315
D0210 INTRAORAL FULL IMAGE SERI		1	1		3	1		6	108
D0274 DENTAL BITEWING FOUR IMA	2			1				3	12
D0330 DENTAL PANORAMIC IMAGE	2			1	3			6	60
D1110 DENTAL PROPHYLAXIS ADUL				1	1	1		3	135
D1208 TOPICAL FLUORIDE				1	1	1		3	45
D1320 TOBACCO COUNSELING						1		1	0
D1330 ORAL HYGIENE INSTRUCTION						1		1	0
D2140 AMALGAM ONE SURFACE PER					1			1	35
D2150 AMALGAM TWO SURFACES PE		1		2	2	1	1	7	315
D2160 AMALGAM THREE SURFACES I	4	2		1	6	1	1	15	750
D2391 POST 1 SRFC RESINBASED CM	2	1		3	5	1	1	13	520
D2392 POST 2 SRFC RESINBASED CM		1		1	4		1	7	350
D2393 POST 3 SRFC RESINBASED CM				1				1	60
D2790 CROWN FULL CAST HIGH NOE		1		1				2	300
D6056 PREFABRICATED ABUTMENT				1				1	45
D6059 ABUT SUPPORT CROWN PORI				1				1	120
D7140 EXTRACTION ERUPTED TOOT	1	1	2	8	2	1	8	23	690
TOTAL	15	10	4	27	33	10	14	113	4180

Total Visits = 42
All data is complete Print Totals Only

Figure 120: Clinic Summary

Visits by Provider

The **Visits by Provider** report replaces the DENTTREATSITPROV RPT in VistA. Each transaction is displayed, making this a potentially enormous report. Treatment dates included in this report come from the selection of either the **Visit Date** or the **Create Date**, designated on the **General** tab. Data is displayed chronologically.

Treatment Date	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE	No.
Mar 20, 2014@12:00	IDOSEPATIENT,EIGHT 1919	15		D0150 COMPREHENSVE ORAL EVALUATION	1
Mar 20, 2014@12:00	IDOSEPATIENT,EIGHT 1919	15		D0210 INTRAORAL FULL IMAGE SERIES	1
Mar 20, 2014@12:00	IDOSEPATIENT,EIGHT 1919	15		D7140 EXTRACTION ERUPTED TOOTH/EXR	1
-----DATE SUBTOTAL 3					
Mar 27, 2014@15:00	IDOSEPATIENT,ELEVE 1946	14		D0150 COMPREHENSVE ORAL EVALUATION	1
Mar 27, 2014@15:00	IDOSEPATIENT,ELEVE 1946	14		D7140 EXTRACTION ERUPTED TOOTH/EXR	1
Mar 27, 2014@16:00	IDOSEPATIENT,ONE M 6001	9		D0274 DENTAL BITEWING FOUR IMAGES	1
Mar 27, 2014@17:00	IDOSEPATIENT,SEVEN 1945	9		D0274 DENTAL BITEWING FOUR IMAGES	1
-----DATE SUBTOTAL 4					
Mar 28, 2014@08:00	IDOSEPATIENT,TWELV 1951	14		D0274 DENTAL BITEWING FOUR IMAGES	1
Mar 28, 2014@09:00	IDOSEPATIENT,ONE M 6001	9		D0120 PERIODIC ORAL EVALUATION	1
Mar 28, 2014@09:00	IDOSEPATIENT,ONE M 6001	9		D0330 DENTAL PANORAMIC IMAGE	1
-----DATE SUBTOTAL 3					
Apr 01, 2014@14:00	IDOSEPATIENT,SEVEN 1945	9		D0150 COMPREHENSVE ORAL EVALUATION	1
Apr 01, 2014@14:00	IDOSEPATIENT,SEVEN 1945	9		D0330 DENTAL PANORAMIC IMAGE	1
Apr 01, 2014@15:00	IDOSEPATIENT,ONE M 6001	9		D0140 LIMIT ORAL EVAL PROBLM FOCUS	1
Apr 01, 2014@15:00	IDOSEPATIENT,ONE M 6001	9		D7140 EXTRACTION ERUPTED TOOTH/EXR	1
-----DATE SUBTOTAL 4					
Apr 04, 2014@10:00	IDOSEPATIENT,SEVEN 1945	9		D2160 AMALGAM THREE SURFACES PERMA	2
Apr 04, 2014@10:00	IDOSEPATIENT,SEVEN 1945	9		D2391 POST 1 SRFC RESINBASED CMPST	1
-----DATE SUBTOTAL 3					
Apr 18, 2014@08:00	IDOSEPATIENT,ELEVE 1946	14		D2150 AMALGAM TWO SURFACES PERMANE	1
Apr 18, 2014@08:00	IDOSEPATIENT,ELEVE 1946	14		D2391 POST 1 SRFC RESINBASED CMPST	1
Apr 18, 2014@08:00	IDOSEPATIENT,ELEVE 1946	14		D2393 POST 3 SRFC RESINBASED CMPST	1
Apr 18, 2014@09:00	IDOSEPATIENT,EIGHT 1919	15		D2150 AMALGAM TWO SURFACES PERMANE	1

Total Visits = 28
All data is complete

Hide Subtotals
[Click header columns to resort]

Save All to XLS Save to XLS Print All Print Close

Figure 121: Visits by Provider

To create a **Visits by Provider** report, select one or more providers by pressing the **<Shift>** and **<Ctrl>** keys, or select all providers by checking the **All Providers?** check box. Click the **Save All to XLS** or **Save to XLS** buttons to save the current data to an Excel spreadsheet. The print options are the same as those for the **Provider Summary** report.

On **Visits by Provider** reports, the items marked **Distributed** are those that were filed by a resident to this attending provider. The unmarked entries are the items filed by the attending provider.

Note: Total sittings are equal to the number of history file entries for the selected date range. If the report is large, and the number of rows displayed is greater than 65,000, the system does **NOT** allow a save to Excel. A message displays prompting the user to change the date range.

Visits by Clinic

The **Visits by Clinic** report replaces the DENTTREATSIT RPT in VistA. This report is essentially the same as the **Visits by Provider** report, except that the entire station is displayed (all providers). Treatment dates included in this report come from the selection of either the **Visit Date** or the **Create Date**, designated on the **General** tab.

Treatment Date	Prov No.	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE	No.
Mar 20, 2014@12:00	02040001	IDOSEPATIENT,EIGHT 1919	15		D0150 COMPREHENSVE ORAL EVALUA	1
Mar 20, 2014@12:00	02040001	IDOSEPATIENT,EIGHT 1919	15		D0210 INTRAORAL FULL IMAGE SERIE	1
Mar 20, 2014@12:00	02040001	IDOSEPATIENT,EIGHT 1919	15		D7140 EXTRACTION ERUPTED TOOTH	1
-----DATE SUBTOTAL 3						
Mar 27, 2014@15:00	02040001	IDOSEPATIENT,ELEVE 1946	14		D0150 COMPREHENSVE ORAL EVALUA	1
Mar 27, 2014@15:00	02040001	IDOSEPATIENT,ELEVE 1946	14		D7140 EXTRACTION ERUPTED TOOTH	1
Mar 27, 2014@16:00	02040001	IDOSEPATIENT,ONE M 6001	9		D0274 DENTAL BITEWING FOUR IMAG	1
Mar 27, 2014@17:00	02040001	IDOSEPATIENT,SEVEN 1945	9		D0274 DENTAL BITEWING FOUR IMAG	1
-----DATE SUBTOTAL 4						
Mar 28, 2014@08:00	02040001	IDOSEPATIENT,TWELV 1951	14		D0274 DENTAL BITEWING FOUR IMAG	1
Mar 28, 2014@09:00	02040001	IDOSEPATIENT,ONE M 6001	9		D0120 PERIODIC ORAL EVALUATION	1
Mar 28, 2014@09:00	02040001	IDOSEPATIENT,ONE M 6001	9		D0330 DENTAL PANORAMIC IMAGE	1
-----DATE SUBTOTAL 3						
Apr 01, 2014@14:00	02040001	IDOSEPATIENT,SEVEN 1945	9		D0150 COMPREHENSVE ORAL EVALUA	1
Apr 01, 2014@14:00	02040001	IDOSEPATIENT,SEVEN 1945	9		D0330 DENTAL PANORAMIC IMAGE	1
Apr 01, 2014@15:00	02040001	IDOSEPATIENT,ONE M 6001	9		D0140 LIMIT ORAL EVAL PROBLM FOC	1
Apr 01, 2014@15:00	02040001	IDOSEPATIENT,ONE M 6001	9		D7140 EXTRACTION ERUPTED TOOTH	1
-----DATE SUBTOTAL 4						
Apr 04, 2014@10:00	02040001	IDOSEPATIENT,SEVEN 1945	9		D2160 AMALGAM THREE SURFACES P	2
Apr 04, 2014@10:00	02040001	IDOSEPATIENT,SEVEN 1945	9		D2391 POST 1 SRFC RESINBASED CM	1
-----DATE SUBTOTAL 3						
Apr 16, 2014@16:23	03010003	IDOSEPATIENT,ONE M 6001	9		D0150 COMPREHENSVE ORAL EVALUA	1
Apr 16, 2014@16:23	03010003	IDOSEPATIENT,ONE M 6001	9		D2160 AMALGAM THREE SURFACES P	2
Apr 16, 2014@16:23	03010003	IDOSEPATIENT,ONE M 6001	9		D2391 POST 1 SRFC RESINBASED CM	1
-----DATE SUBTOTAL 4						

Total Visits = 42
All data is complete

Hide Subtotals
[Click header columns to resort]

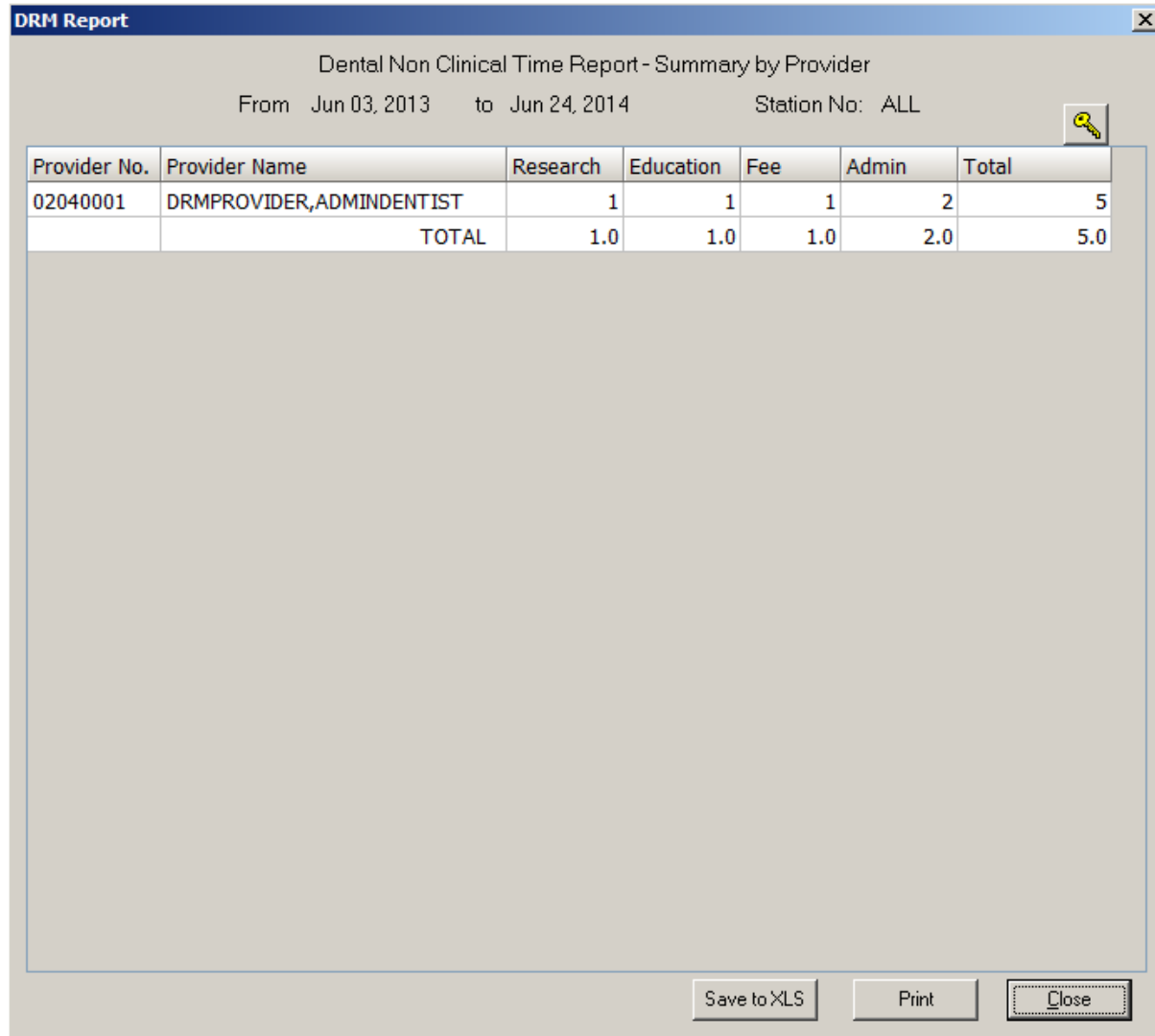
Save to XLS Print Close

Figure 122: Visits by Clinic

Note: This report may be very large and takes a considerable amount of time to process.

Non-Clinical Time by Provider Report

The **Non-Clinical Time by Provider** report replaces the DENTNCLINTIME PROV in VistA. The data on the **Non-Clinical Time by Provider** report only accounts for any non-clinical time entered in DRM Plus. This option is for local use only.



The screenshot shows a window titled "DRM Report" with a subtitle "Dental Non Clinical Time Report - Summary by Provider". It displays data for the period "From Jun 03, 2013 to Jun 24, 2014" and "Station No: ALL". A table with 7 columns (Provider No., Provider Name, Research, Education, Fee, Admin, Total) shows data for provider 02040001 (DRMPROVIDER,ADMINDENTIST) and a total row. The total row shows 1.0 days for Research, Education, and Fee, and 2.0 days for Admin, resulting in a total of 5.0 days. The window also includes buttons for "Save to XLS", "Print", and "Close".

Provider No.	Provider Name	Research	Education	Fee	Admin	Total
02040001	DRMPROVIDER,ADMINDENTIST	1	1	1	2	5
	TOTAL	1.0	1.0	1.0	2.0	5.0

Figure 123: Non-Clinical Time

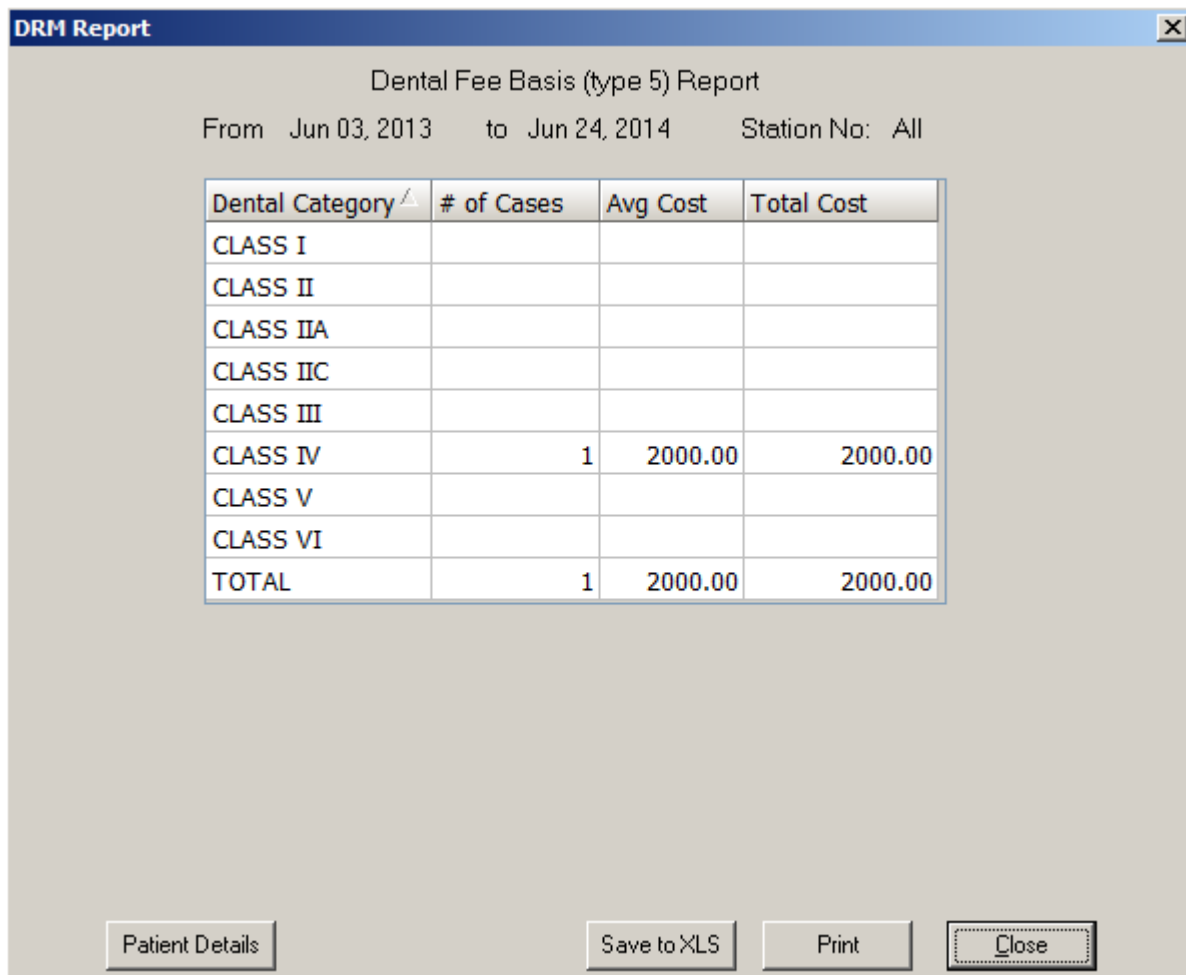
The entry option allows the user to record **Administrative, Fee Basis, Education and Training** and **Research** time in hours and minutes (15 minute increments) for local reporting only. The **Non-Clinical Time by Provider** report displays an approximate numerical unit of days (1 day = 8 hours). The accumulation of less than four hours results in rounding down to the nearest whole number day. The columns for **Research, Education, Fee** and **Admin** are summed independently in total days. The **Total** column includes the sum of all four categories combined together for its entry in total days.

Note: Filing non-clinical time in DRM Plus is for local DRM Plus reporting only. Workload credit for non-clinical time should be entered in **Labor Mapping**, which is accessed through the Macro Cost Accounting (VA-MCA) office. Contact the local VA-MCA office to obtain further information on Labor Mapping.

Fee Basis/Detailed Fee Basis Report

The **Dental Fee Basis (type 5)** report replaces the Applications and Dental Fee (type 5) report DENTFEE RPT in VistA. These two reports never have the same data, since they are from two different options (one in VistA, the other in DRM) and two separate VistA files.

The **Dental Fee Basis (type5)** report displays data from the **File Fee Basis** submenu available from the **File** drop-down menu.



Dental Category	# of Cases	Avg Cost	Total Cost
CLASS I			
CLASS II			
CLASS IIA			
CLASS IIC			
CLASS III			
CLASS IV	1	2000.00	2000.00
CLASS V			
CLASS VI			
TOTAL	1	2000.00	2000.00

Figure 124: Dental Fee Basis

Note: Fee basis data entered in DRM Plus is only available for local reports created in DRM Plus.

Encounters/Visits by Patient Type Report

The **Encounters/Visits by Patient Type** report has been created to display data from DRM Plus in an easily readable format of providers and patients by inpatient and outpatient categories.

Provider	Inpatient Visits	Inpatient Encounters	Outpatient Visits	Outpatient Encounters	Total DES Procedures
DRMPROVIDER,ADMINDENTIST			28	28	71
DRMPROVIDER,DENTIST			10	10	33
DRMPROVIDER,RESIDENT			2	2	5
DRMPROVIDER,HYGIENIST			2	2	4
TOTAL	0	0	42	42	113

Figure 125: Encounters/Visits by Patient Type

Recare Report

The **Recare** report is available to list patients with recare dates in the selected date range. Patient demographic and recent dental activity data are displayed on the report. **Maintenance** and **Active/Maintenance** were added as selectable statuses on various reports. **Maintenance** status is the default status on the **Recare** report.

Note: The **Recare** report is only accessible if the user is a DRM Plus Administrator. The DRM Plus Administrator is only allowed to run an **All Providers?** selection for this report.

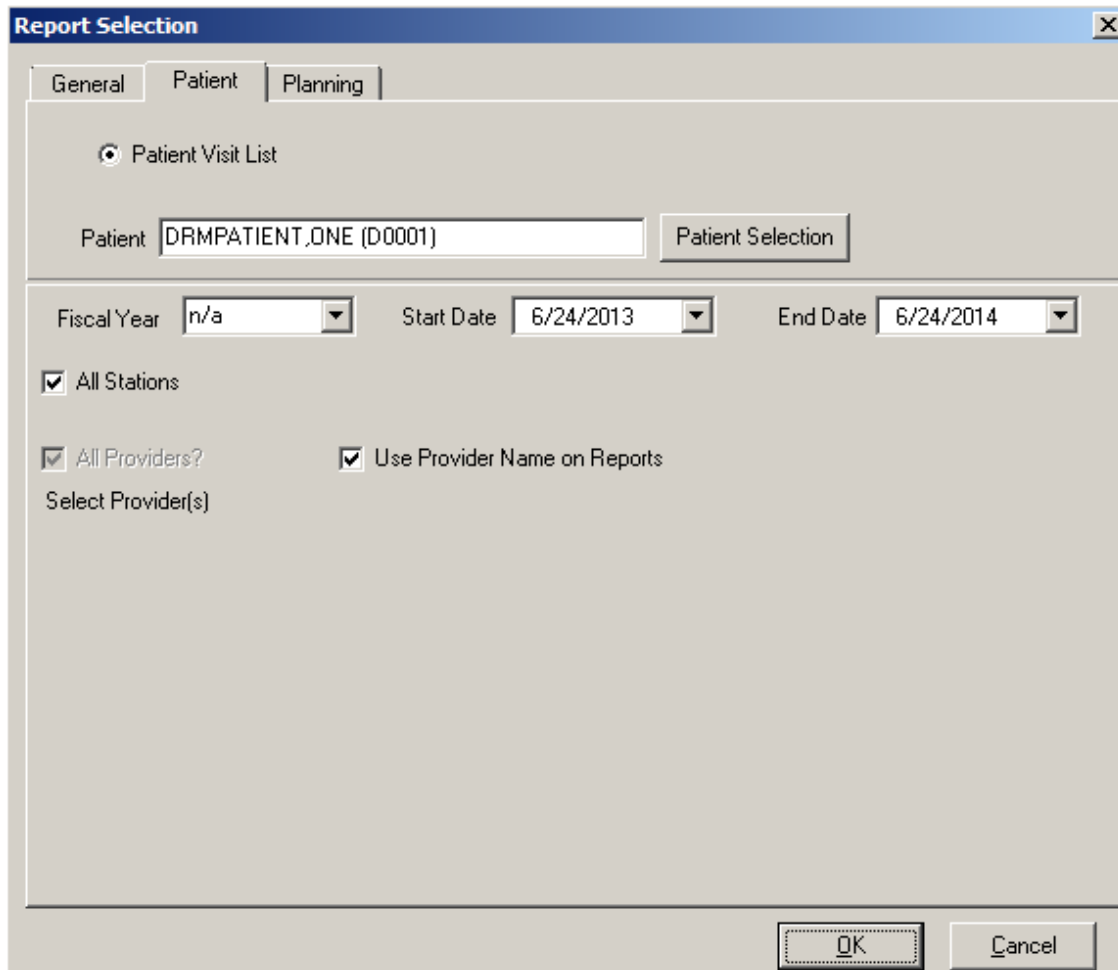
Recare Date	Class	Home Phone	Work Phone	SSN	Patient Name	Address 1	Address 2
Oct 05, 2014	IIA			XXX-XX-1930	Mr TWENTY C IDOSEPA1		
Oct 18, 2014	I			XXX-XX-6001	Mr ONE M IDOSEPATIEN	123 cummings street	
Apr 04, 2015	I			XXX-XX-1945	Mr SEVENTEEN R IDOSE		

Figure 126: Recare Report

A list of elements in **Recare** reports include: **Recare Date, Patient Class, Home Phone, Work Phone, SSN, Patient Name, Address 1, Address 2, City, State, Zip, Sex, Last Visit, Last Provider, Primary Provider, Secondary Provider, Dental Alerts, Next Appt, Next Appt Clinic, Last Comp Exam, Last Brief Exam, Last Perio Exam, Last Pano X-ray, Last Full Mouth X-ray, Last BW X-ray and Last Propy.**

Patient Tab

Use the **Patient** tab to run a report on any patient and view a list of visits. The patient is only used for report generation; changing patients in DRM Plus is NOT allowed.



The screenshot shows a dialog box titled "Report Selection" with three tabs: "General", "Patient", and "Planning". The "Patient" tab is selected. Inside the dialog, there is a radio button labeled "Patient Visit List" which is selected. Below this is a text field for "Patient" containing "DRMPATIENT.ONE (D0001)" and a "Patient Selection" button. Further down, there are three dropdown menus: "Fiscal Year" set to "n/a", "Start Date" set to "6/24/2013", and "End Date" set to "6/24/2014". Below these are three checked checkboxes: "All Stations", "All Providers?", and "Use Provider Name on Reports". At the bottom left, there is a label "Select Provider(s)". At the bottom right, there are "OK" and "Cancel" buttons.

Figure 127: Patient Tab

1. Click the **Patient Selection** button to select a patient. The program automatically defaults to the patient whose record is currently opened in DRM Plus.

2. The **Patient Selection** screen displays.

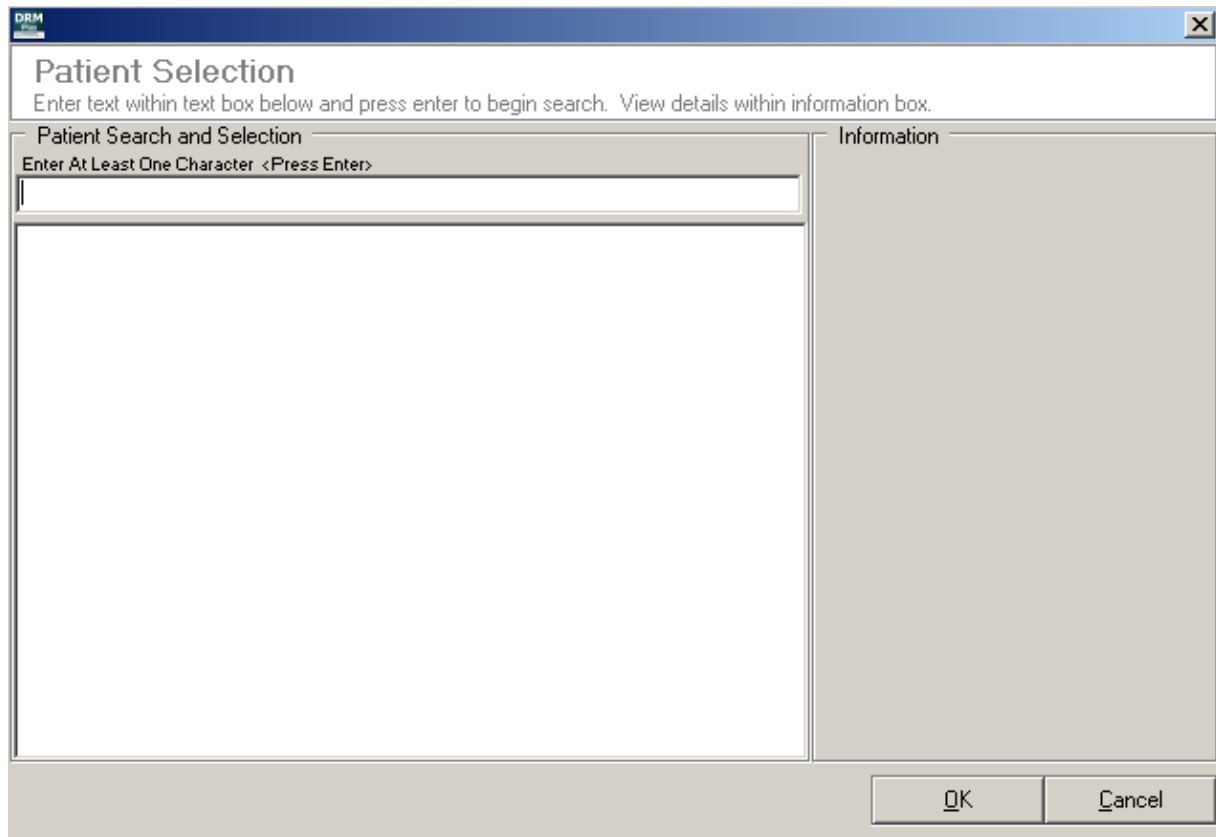


Figure 128: Patient Selection Screen

3. Type a patient name into the text box and press the **<Enter>** key. Partial names are acceptable.
4. Select the desired patient from the results box and click the **OK** button.
5. The selected patient's name now displays on the **Patient** tab.
6. Choose the date and select other information to be included or excluded using the check boxes on the **Patient** tab.
7. Click the **OK** button.
8. The **DRM Report** screen displays. Save to an Excel file, print or close.

Planning Tab

Use the options in this tab to run planning reports, active patients by provider or unfiled data by provider.

The screenshot shows a dialog box titled "Report Selection" with three tabs: "General", "Patient", and "Planning". The "Planning" tab is selected. It contains the following options:

- Four radio buttons for report types: "Provider Planning" (selected), "Planned Items List", "Active Patients by Provider", and "Unfiled Data by Provider".
- Three checkboxes for provider information: "Use Primary Provider" (checked), "Use Secondary Provider", and "Use Entered By Provider".
- Checkboxes for "All Stations" (checked) and "All Providers?" (checked).
- A "Select Provider(s)" text box.
- A "Use Provider Name on Reports" checkbox (checked).
- A "Patient Status" group box with three radio buttons: "Active" (selected), "All Statuses", and "Maintenance".

At the bottom right, there are "OK" and "Cancel" buttons.

Figure 129: Planning Tab

1. Select the type of report from the four radio buttons.
2. Use the check boxes to indicate provider information.
3. Choose a **Patient Status** except for the **Unfiled Data by Provider** report.
4. Click the **OK** button.
5. The **DRM Reports** screen displays. Print or save the results to Excel.

Note: The Primary/Secondary provider option is utilized for these reports: **Provider Planning**, **Planned Items List** and **Active Patients by Provider**.

The following reports are available from the **Planning** tab: **Provider Planning**, **Planned Items List**, **Active Patients by Provider** and **Unfiled Data by Provider**.

Provider Planning

The **Provider Planning** report contains the **Provider, Patient Name & Last 4 SSN, Patient Last Visit and Patient Category, Planned Procedures, Next Appointment/Location** and **Qty/RVU/Cost** columns.

Planning Report for Primary/Secondary Providers				
Primary Provider Planning Report				
Patient Type: Active			Station: All	
Provider	Patient Last Visit and Pat Cat	Next Appointment/Location		
Patient Name & Last 4 SSN	Planned Procedures		Qty	RVU
DRMPROVIDER,ADMINDENTIST				
IDOSPATIENT,THREE 1088	May 05, 2014@10:30 17			
	D2150 AMALGAM TWO SURFACES PERMANE		2	90
	D2160 AMALGAM THREE SURFACES PERMA		1	50
	D2391 POST 1 SRFC RESINBASED CMPST		2	80
	D3320 END THXPY BICUSPID TOOTH		1	120
IDOSPATIENT,FOUR G 2080	May 02, 2014@11:00 14			
	D2150 AMALGAM TWO SURFACES PERMANE		1	45
	D2160 AMALGAM THREE SURFACES PERMA		1	50
	D2391 POST 1 SRFC RESINBASED CMPST		1	40
	D2392 POST 2 SRFC RESINBASED CMPST		1	50
	D2790 CROWN FULL CAST HIGH NOBLE M		2	300
IDOSEPATIENT,TWENT 1930	May 05, 2014@12:30 11			
	D0330 DENTAL PANORAMIC IMAGE		1	10
	D2150 AMALGAM TWO SURFACES PERMANE		1	45
	D2160 AMALGAM THREE SURFACES PERMA		2	100
	D2391 POST 1 SRFC RESINBASED CMPST		2	80
	D2392 POST 2 SRFC RESINBASED CMPST		1	50
	D6010 ENDOSTEAL IMPLANT BODY PLACE		1	90

Figure 130: Primary Provider Planning

Note: The cost is included if it has previously been entered locally by a DRM Plus Administrator.

Planned Items List

The **Planned Items List** report contains most of the same information as the existing **Provider Planning** report, but in a sortable list format. Click the headings for **Provider**, **Patient Name & Last 4 SSN** or **Planned Procedures** to re-sort and subtotal by column.

Provider	Patient Name & Last 4 SSN	Planned Procedures	Qty	RVU
DRMPROVIDER,ADM	IDOSPATIENT,THREE 1088	D2150 AMALGAM TWO SURFACES PERM	2	90
DRMPROVIDER,ADM	IDOSPATIENT,THREE 1088	D2160 AMALGAM THREE SURFACES PER	1	50
DRMPROVIDER,ADM	IDOSPATIENT,THREE 1088	D2391 POST 1 SRFC RESINBASED CMPS	2	80
DRMPROVIDER,ADM	IDOSPATIENT,THREE 1088	D3320 END THXPY BICUSPID TOOTH	1	120
DRMPROVIDER,ADM	IDOSPATIENT,FOUR G 2080	D2150 AMALGAM TWO SURFACES PERM	1	45
DRMPROVIDER,ADM	IDOSPATIENT,FOUR G 2080	D2160 AMALGAM THREE SURFACES PER	1	50
DRMPROVIDER,ADM	IDOSPATIENT,FOUR G 2080	D2391 POST 1 SRFC RESINBASED CMPS	1	40
DRMPROVIDER,ADM	IDOSPATIENT,FOUR G 2080	D2392 POST 2 SRFC RESINBASED CMPS	1	50
DRMPROVIDER,ADM	IDOSPATIENT,FOUR G 2080	D2790 CROWN FULL CAST HIGH NOBLE I	2	300
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D0330 DENTAL PANORAMIC IMAGE	1	10
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D2150 AMALGAM TWO SURFACES PERM	1	45
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D2160 AMALGAM THREE SURFACES PER	2	100
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D2391 POST 1 SRFC RESINBASED CMPS	2	80
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D2392 POST 2 SRFC RESINBASED CMPS	1	50
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D6010 ENDOSTEAL IMPLANT BODY PLAC	1	90
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D6056 PREFABRICATED ABUTMENT	1	45
DRMPROVIDER,ADM	IDOSEPATIENT,TWENT 1930	D6059 ABUT SUPPORT CROWN PORC HM	1	120
DRMPROVIDER,ADM	IDOSEPATIENT,EIGHT 1919	D2150 AMALGAM TWO SURFACES PERM	1	45
DRMPROVIDER,ADM	IDOSEPATIENT,EIGHT 1919	D2160 AMALGAM THREE SURFACES PER	1	50
DRMPROVIDER,ADM	IDOSEPATIENT,EIGHT 1919	D2391 POST 1 SRFC RESINBASED CMPS	1	40

Hide Subtotals
 [Click header columns to resort]

Save to XLS Print Close

Figure 131: Planned Items List

Note: The cost is included if it has previously been entered locally by a DRM Plus Administrator.

Active Patients by Provider Report

The **Active Patients by Provider** report displays a list of patients with active dental encounters for providers. It displays by **Primary** and/or **Secondary** provider. The report also only lists the patient one time per provider.

This report may display many more patients than the provider truly has with an active status, due to the default filing flag in DRM Plus. The default is **Active**, and most users do not change this. There are two areas in DRM Plus to address this issue:

1. The most recent dental encounter may be updated by the user through the **Case Management Status** field on the **Cover Page**.
2. Users are prompted to change the status of the patient when completing the encounter when they click the **Finish** button. The provider is prompted because the patient no longer has any planned items.

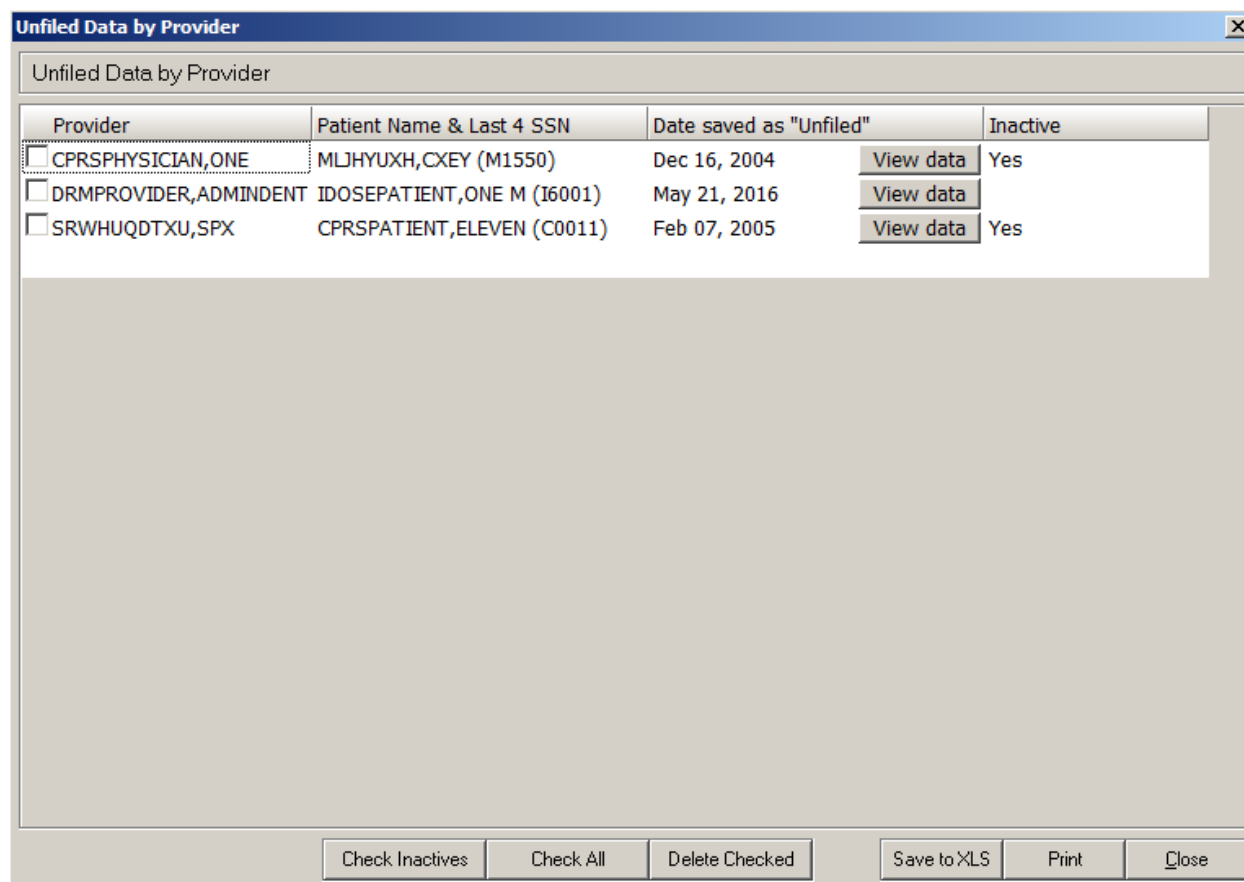
Active Patients by Provider				
Active Patients by Primary Provider		(from Jun 24, 2013 to Jun 24, 2014)		Station: All
Provider	Dental Class	Patient Name & Last 4 SSN	Last Visit Date	Status
DRMPROVIDER,ADMINDENTIS	OPC, Class I	IDOSEPATIENT,SEVENTEEN R (I194	Apr 04, 2014	Active
	OPC, Class IIA	IDOSEPATIENT,TWENTY C (I1930)	May 05, 2014	Active
	OPC, Class III	IDOSPATIENT,FOUR G (I2080)	May 02, 2014	Active
	OPC, Class IV	IDOSEPATIENT,EIGHTEEN O (I1919	May 06, 2014	Active
	OPC, Class VI	IDOSPATIENT,THREE (I1088)	May 05, 2014	Active
	OPC, Class VI	IDOSPATIENT,EIGHT N (I2891)	May 05, 2014	Active
----- Provider SUBTOTAL: 6				
DRMPROVIDER,DENTIST	OPC, Class I	IDOSEPATIENT,ONE M (I6001)	Apr 16, 2014	Active
	OPC, Class III	IDOSEPATIENT,ELEVEN (I1946)	May 05, 2014	Active
	OPC, Class III	IDOSEPATIENT,TWELVE G (I1951)	Jun 19, 2014	Active
	OPC, Class IV	IDOSPATIENT,FIVE M (I2489)	May 05, 2014	Active
	OPC, Class V	IDOSPATIENT,TWO J (I1185)	May 07, 2014	Active
----- Provider SUBTOTAL: 5				
Unassigned	OPC, Class IIC	RFBCS,PATIENT (R1210)	May 06, 2014	Active
	OPC, Class III	IDOSPATIENT,TEN A (I2179)	Jun 19, 2014	Active
	OPC, Class IV	IDOSPATIENT,SIX R (I1287)	Jun 19, 2014	Active
----- Provider SUBTOTAL: 3				
Total Patients: 14				
			Save to XLS	Print
			Close	

Figure 132: Active Patients by Provider

Unfiled Data by Provider Report

The **Unfiled Data by Provider** report displays a list of patients who have unfiled data for providers. Unfiled data is data that resides in a temporary scratch pad-type area, and is only visible by the provider the data is saved to.

This data is NOT part of the patient's chart record, and should be filed to completion in a timely manner. Unfiled data becomes inactive after eight calendar days; the saved data is viewable but no longer available to be filed.



Provider	Patient Name & Last 4 SSN	Date saved as "Unfiled"	Inactive
<input type="checkbox"/> CPRSPHYSICIAN,ONE	MLJHYUXH,CXEY (M1550)	Dec 16, 2004	Yes
<input type="checkbox"/> DRMPROVIDER,ADMINDENT	IDOSEPATIENT,ONE M (I6001)	May 21, 2016	
<input type="checkbox"/> SRWUQDTXU,SPX	CPRSPATIENT,ELEVEN (C0011)	Feb 07, 2005	Yes

Figure 133: Unfiled Data by Provider

After selecting an **Unfiled Data by Provider** report, the provider needs to select the **View data** button which allows the user to display the data that was saved as unfiled data on that patient.

The **TX Note Preview** screen opens and displays the save unfiled data. This displays the unfiled data saved by this provider or by some other provider who sent it to this provider on a specific patient.

The provider may print this unfiled data, especially if the data was made inactive either by the unfiled data now saved over the 8-day limit, or if a DRM Plus Administrator used the **Clean Slate** submenu option on this patient's chart. An example of inactive unfiled data would have a **Yes** listed in the **Inactive** column. Because DRM Plus is unable to reload this inactive data back into the patient's chart, the provider is required to re-enter the data manually with another encounter.

The provider may delete any unfiled data by selecting the check box under the **Provider** column and then selecting the **Delete Checked** button. The **Check Inactives/Uncheck Inactives** button allows the provider to select/unselect all the inactive unfiled data reports. The **Check All/Uncheck All** button allows the provider to select/unselect all the check boxes in the **Unfiled Data by Provider** report.

The following dialog is an example of unfiled data saved on a patient. The user may print the unfiled data by selecting the **Print** button or close the screen by clicking the **OK** button.

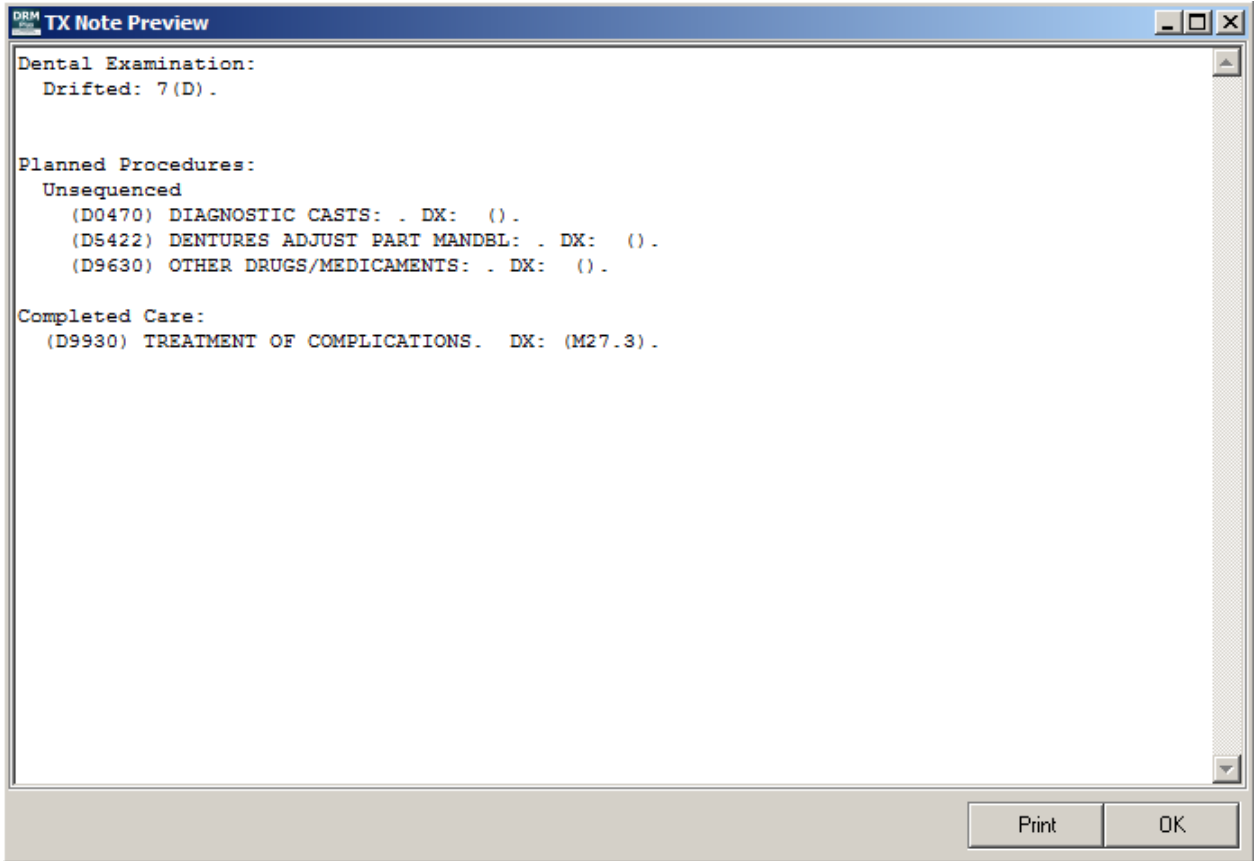


Figure 134: TX Note Preview

Non-administrative end-users are able to delete, view and print the active/inactive unfiled data for all their respective patients when accessing this report. The **Unfiled Data by Provider** report only allows a non-administrative provider to view their own saved unfiled data and NOT of other providers.

The following dialog is the screen that allows the provider to **Load, View** (non-load) or **Delete** any unfiled data when opening the DRM Plus chart for a patient. The **Delete** button allows the provider to delete unfiled data before it is loaded into this patient’s chart. The provider is NOT able to view the unfiled data when they select the **Delete** button from this screen.

The **Load DRM Plus Data** screen informs the provider the name of who saved the unfiled data to them. The name listed at the beginning of the statement on the screen is the person who saved the unfiled data to the user opening the patient’s chart.

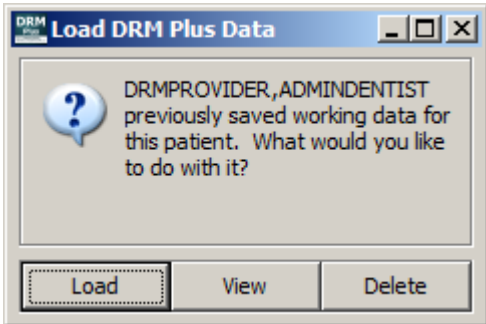


Figure 135: Load DRM Plus Data Screen

There are two ways to view the unfiled data before the provider deletes this data. The first is to select the **Load** option and go to the **Unfiled Data by Provider** report located on the **Reports** menu → **Reports** submenu → **Planning** tab → **Unfiled Data by Provider** report.

The second way to view unfiled data when the provider cannot remember exactly what was saved as unfiled data is to select the **View** button. This option directs the user to the **Unfiled Data by Provider** report, but it does NOT load the unfiled data. If the user wants the unfiled data loaded and filed, then they must close the report and select the **Refresh Patient Chart** option under the **File** menu.

Selecting the **View** button displays a screen giving instructions to the end-user on how to load the data into the patient’s chart. Selecting the **Load** button when the patient’s chart reopens after the refresh allows the user to file the encounter. The following informational screen displays the steps to **Load** the unfiled data.

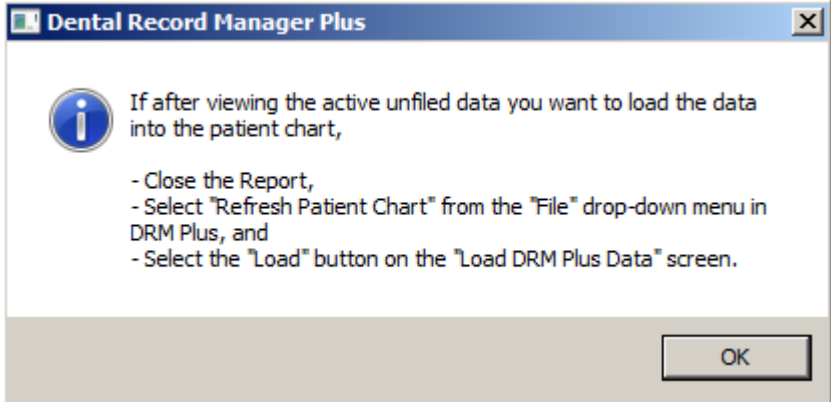


Figure 136: Instructional Steps to Load Unfiled Data

If **Load** or **View** were selected upon entry into the patient’s chart and the provider wants to delete the unfiled data after viewing it, use the **Delete Checked** button in the **Unfiled Data by Provider** report. If the **Load** button was selected, then the user also needs to select the **Refresh Patient Chart** submenu from the **File** menu.

Note: All data, including unfiled data saved or filed for ‘test’ patients configured with the first three digits of the SSN as zeros will NOT appear in any DRM Plus report.

Unfiled Data becomes inactive after eight calendar days. The end-user receives a screen message on the ninth day after saving data whenever they enter the patient's chart. This message provides two button options to either **View** or **Delete** the inactive unfiled data.

A screen displays when the patient's chart has inactive unfiled data present from the end-user who saved the unfiled data, or from another DRM user with access to the patient.

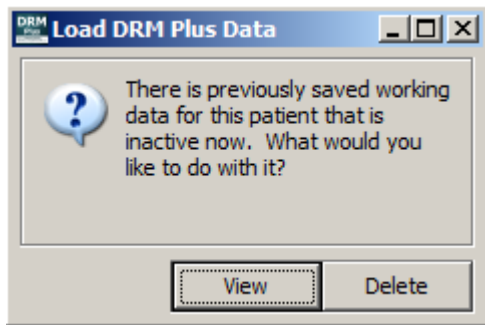


Figure 137: Previously Saved Inactive Data

The **View** button takes the user directly to the **Unfiled Data by Provider** report, where they can view, print or delete the inactive data. There is no way to load inactive unfiled data into the patient's chart except to re-enter all the data manually.

The **Delete** button deletes the patient's inactive unfiled data from the VistA scratch pad.

Service Reports

Use the **Service Reports** submenu from the **Reports** menu to select and create a service report.

The screenshot shows a dialog box titled "Service Report Selection" with a DRM logo in the top left corner. The dialog is divided into several sections. The main section, "Service Reports", contains 11 checkboxes arranged in two columns. The first checkbox, "All Reports", is checked. The second checkbox, "1: Observations per Month", is unchecked. The third checkbox, "2: Service Profile", is unchecked and has a dropdown menu next to it showing "ADA/CPT Codes". The fourth checkbox, "3: Service by Product Group", is unchecked. The fifth checkbox, "4: Provider Profile", is unchecked and has a checked checkbox next to it labeled "Use Provider Name". The sixth checkbox, "5: Patient Category Profile", is unchecked. The seventh checkbox, "6: Patients by Eligibility Setting", is unchecked. The eighth checkbox, "7: Patients by Eligibility Group", is unchecked. The ninth checkbox, "8: Patients by Dental Patient Category", is unchecked. The tenth checkbox, "9: Outpatient Service by Product Group", is unchecked. The eleventh checkbox, "10: Inpatient Service by Product Group", is unchecked. The twelfth checkbox, "11: Distribution of Dental Services", is unchecked. Below the "Service Reports" section are three dropdown menus: "Fiscal Year", "Start Date" (set to 6/24/2014), and "End Date" (set to 6/24/2014). Below these are two checkboxes: "All Stations" (checked) and "All Providers?" (checked). At the bottom right, there is a section titled "Search for records using" with two radio buttons: "Visit Date" (selected) and "Create Date". At the very bottom are two buttons: "OK" and "Cancel".

Figure 138: Service Report Selection Screen

1. Choose the desired type of service report.
2. Set the **Fiscal Year** or date range, if applicable.
3. Select the date type that is to be represented on the report.
4. Click the **OK** button.
5. The **Service Reports** screen displays with the results.

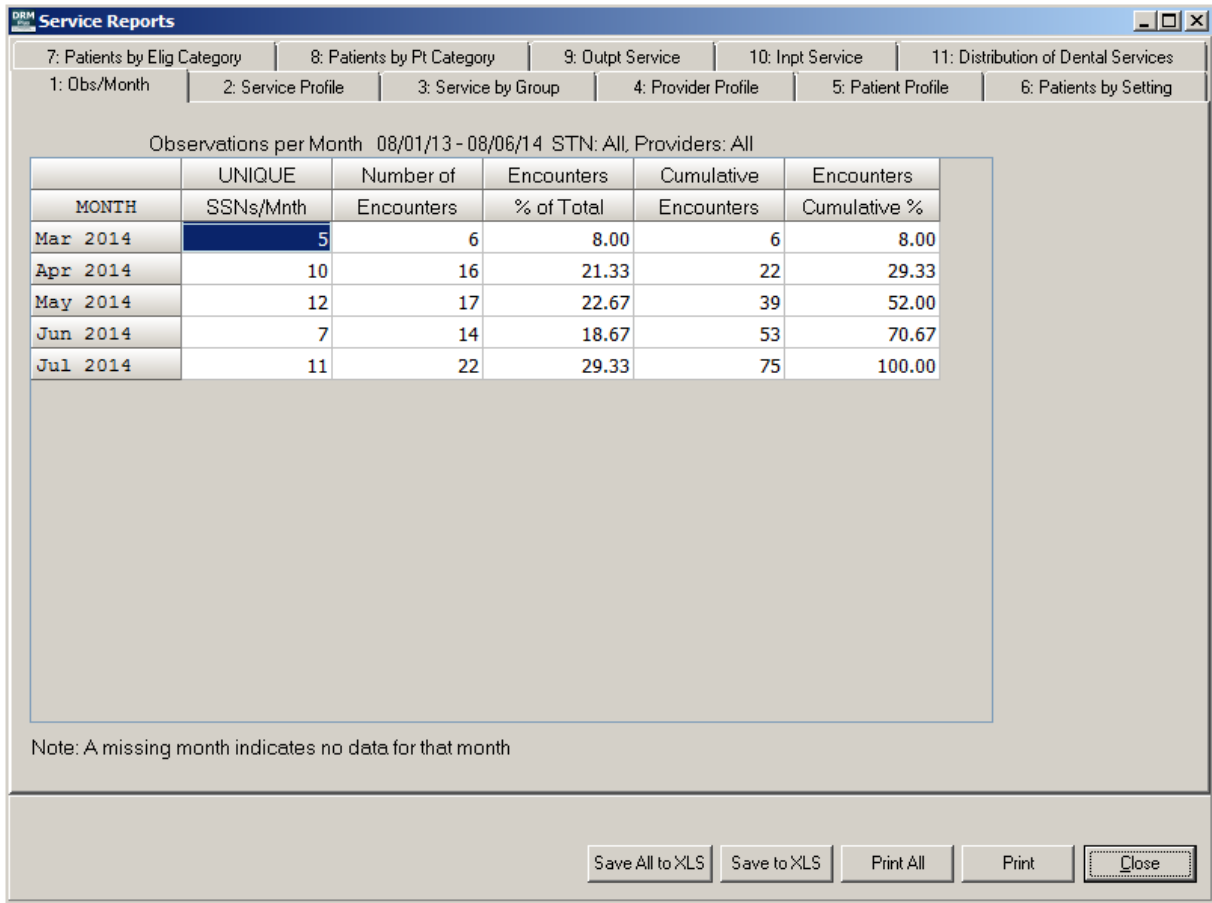


Figure 139: Service Reports

6. If more than one report, or all report options are checked on the **Service Reports Selection** screen, the reports appear in tabs on the **Service Reports** screen.
7. Save the report to Excel or print.

Data Warehouse Reports

The **Data Warehouse Reports** submenu will connect to specific reports as maintained by the Office of Dentistry. The Office of Dentistry may change this submenu at any time. The submenu is dynamically created based on settings of web addresses in the **Administrative Toolbox** settings in DRM Plus.

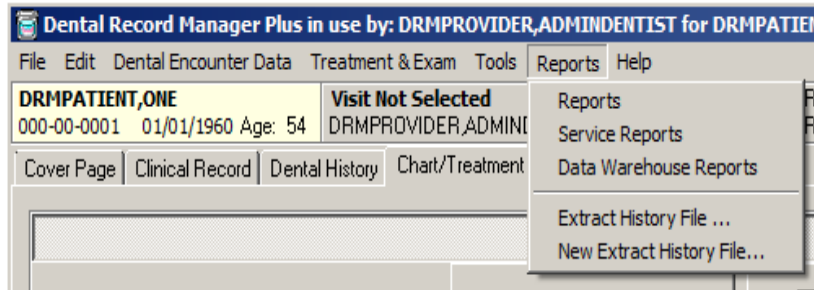


Figure 140: Reports Menu

The DRM Plus Administrator has the ability to maintain the web addresses for the **Data Warehouse Reports**. The website addresses should end in '.xml'. These XML addresses/files build the structure for the **Data Warehouse Reports** submenus.

When selecting the **Reports** menu there may be a few seconds delay. Once the submenu has been loaded, there should no longer be a delay. If there is a failure to load the submenus, the website is down or you have lost connection; the next time you try the **Reports** menu, it will try to load the submenus again.

This delay can be shortened by the retrieval timeout set by the DRM Plus Administrator (0-60 seconds). A setting of 0 seconds does NOT mean there will NOT be a delay. It may take DNS a few seconds to resolve the name of each website into an IP Address.

So in the case of a complete failure and a setting of 0 seconds on the timeout – you may still experience a delay of 20 seconds or so when clicking on that menu. The submenu would then display 'currently unavailable – try again later' as the submenu. It is suggested that you wait and try later in the day or even possible the next day. If the connection failure persists, please contact the local DRM Plus Administrator.

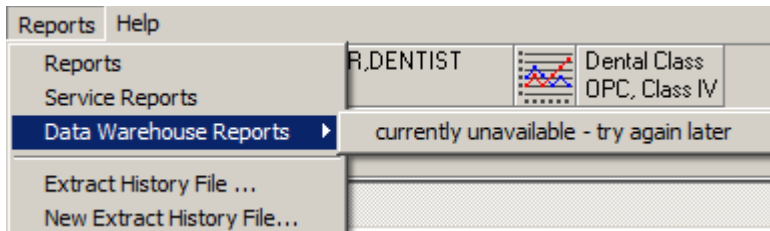


Figure 141: Data Warehouse Reports Submenu Options

Also a setting of 0 may NOT allow your site time enough to connect and get the submenu, so use with caution. A setting of 5 seconds is the default. This may need to be adjusted (lengthened or shortened) based on your sites Internet/network connectivity.

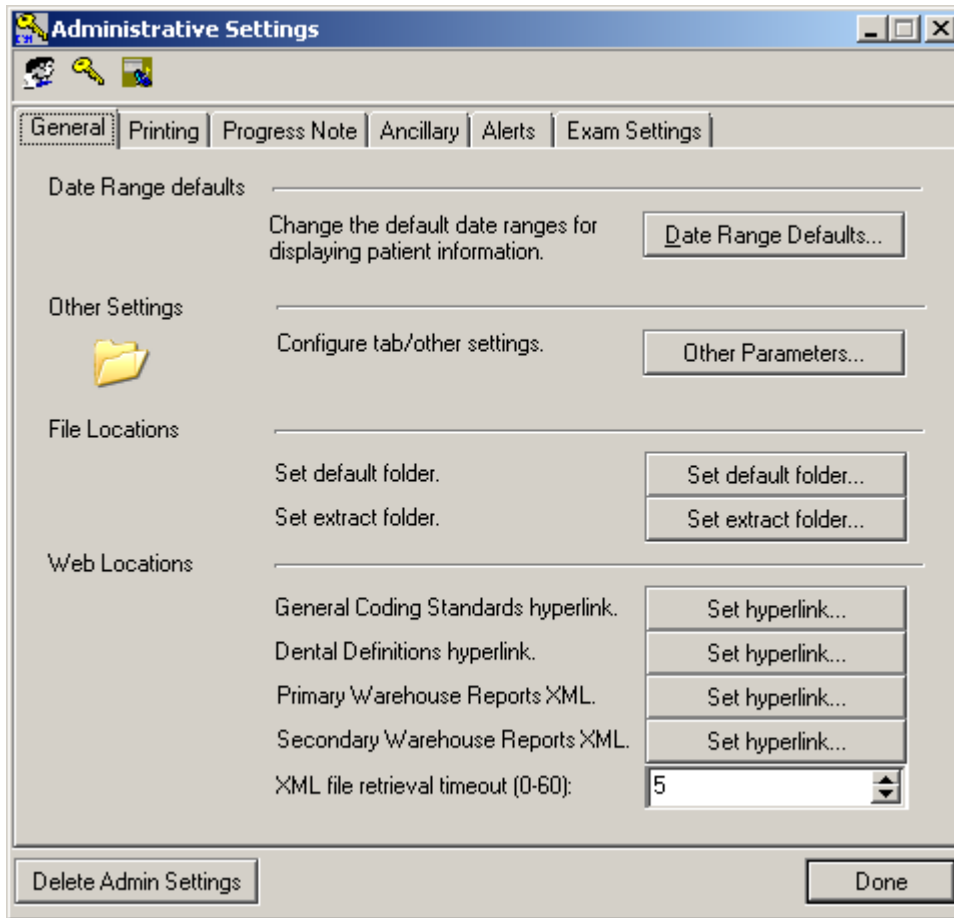


Figure 142: Administrative Toolbox Submenu - General Tab

Extract History File

The **Extract History File** submenu function is used to extract raw data and save it to a text (.txt) file, then convert to Microsoft Access or Excel. Prior to extracting data, the DRM Plus Administrator should create a folder on the hard drive or network. This folder can be designated in the **User Options** submenu, by clicking the **Set extract folder** button. Please see the **User Options** section in this chapter for additional information.

Extract History File Data

Select Extract Options

- Select start date: Click on down arrow next to start date box
- Select end date: Click on down arrow next to end date
- Select Output File Location, optional Station and/or Provider and Click OK

Start Date: Tuesday, June 24, 2014

End Date: Tuesday, June 24, 2014

Output file selection:

Look in: c:\

Select Directory:

- C:\
- TEMP

Select File to Replace:

- April 2014.txt
- April New Ex.TXT
- April-Oct-2013.TXT
- Janurary 2014.TXT
- October 12-13.txt

OR, Add new file to directory selected by adding \ filename.TXT

C:\TEMP

All Stations

Optional Select Provider

OK Cancel

Figure 143: Extract History File Data Screen

To extract data:

1. Use the drop-down menus to set the start and end dates.
2. The **Output file selection** requires the creation of a folder on the hard drive or network, as previously explained. The directory should default if the **Set extract folder** parameter is used.
3. **Select File to Replace** from the right window, or add a new file to the directory by typing it directly into the text box. Click in the text box, add a backslash <\>, then type the name of the file, and then type .txt.
4. The **All Stations** check box is checked by default. This can be changed by selecting a single optioned station.
5. Check the **Optional Select Provider** check box to retrieve information about a specific provider. The **Select Provider** screen displays.

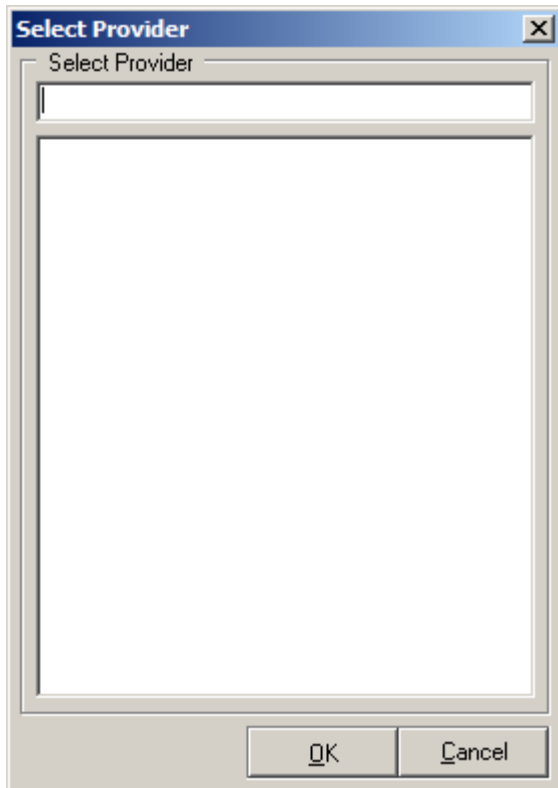


Figure 144: Select Provider Screen

6. Enter the search term, press the <Enter> key. Highlight the desired result and click the **OK** button. The provider name appears on the screen.
7. Click the **OK** button to complete the extract function and save the file to the designated folder.

Note: Do NOT use this extract function for long reports. The workstation screen displays an hourglass, and no other applications can be run until the extract report finishes. When planning to run a long report, use the **New Extract History File** function.

New Extract History File

The **New Extract History File** submenu allows larger sites to setup an extract to run in the background so that there is no effect on the functionality of the workstation. The **New Extract History File** submenu is available in the **Reports** menu, and runs via a TCP/IP server on the user's workstation, rather than through the VistA RPC Broker on a local PC.

This provides at least two major benefits: the workstation is NOT tied up while the extract is running, and the RPC Broker does NOT time out during long extracts.

Note: Obtain a valid **Port #** and **IPaddress** from the local IT department to use this function. The **Port #** should be 15,000 or greater.

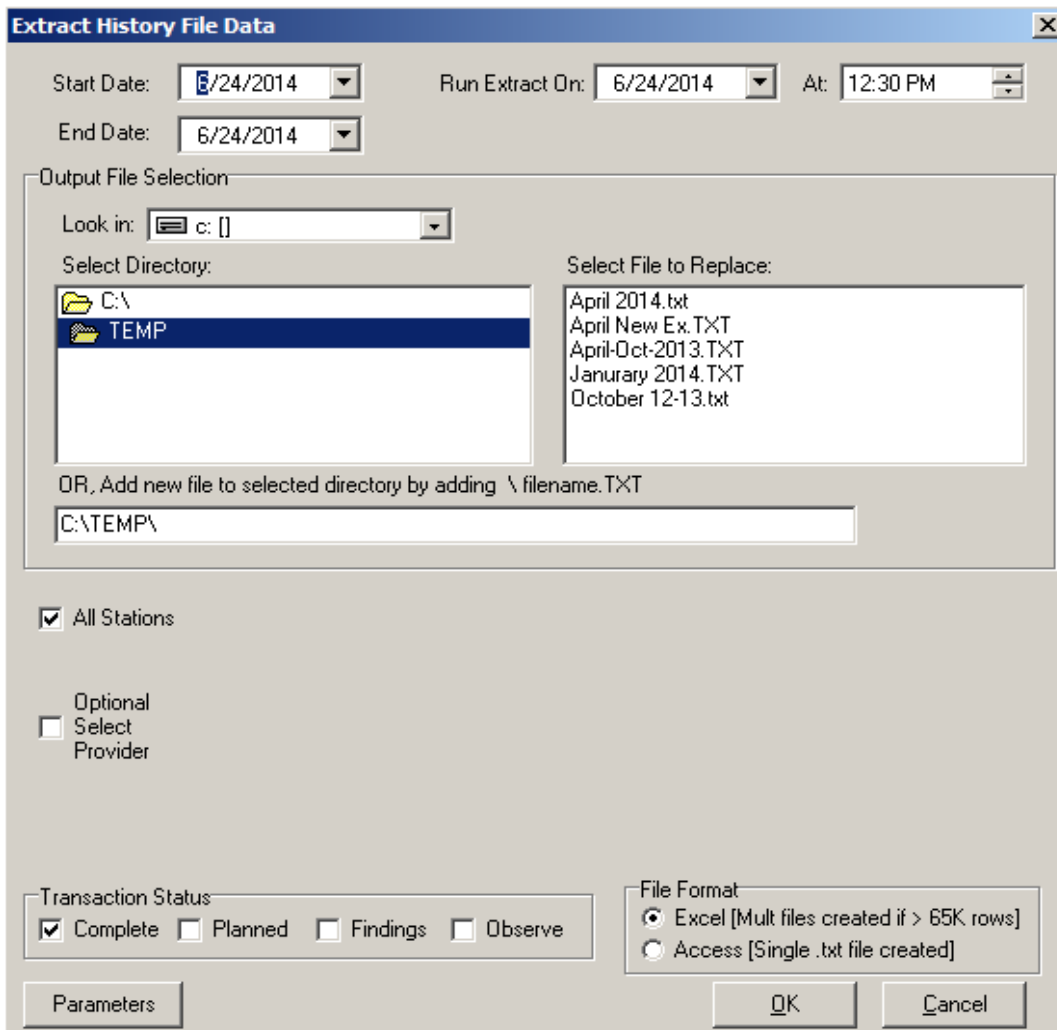


Figure 145: New Extract History File Data Screen

This screen is similar to the **Extract History File Data** screen, with several key differences:

1. Use the drop-down menus to choose the **Start Date** and **End Date** for the date range the extract is performed in. Use the **Run Extract On** drop-down menus to determine the date/time to perform the extract.

2. The **Output File Selection** and the **All Stations** functions are identical to those found on the **Extract History File Data** screen. See the previous section for further information.
3. Check the **Optional Select Provider** check box to gather information from a specific provider. The **Select Provider** screen does NOT display; instead, a scroll menu displays on screen. Select the provider by highlighting a specific name.
4. Check the desired **Transaction Status** check box.
5. Click the radio button corresponding to the desired **File Format**.
6. Click the **Parameters** button. The **Extract System Parameters** screen displays.

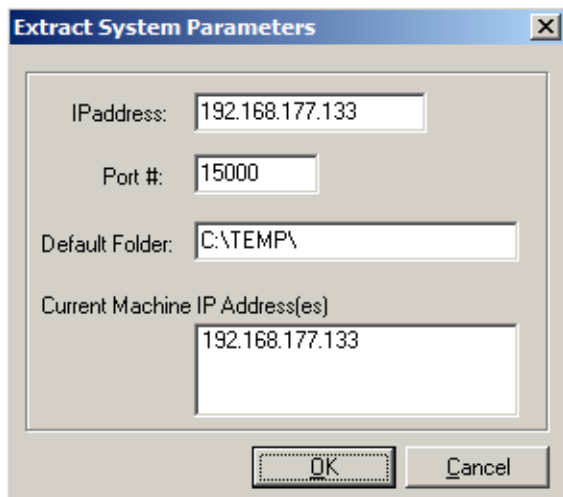


Figure 146: Extract System Parameters

7. Enter the **IPaddress** and **Port #** number. IT can provide this information.
8. Verify the **Current Machine IP Address(es)** is correct every time.
9. Once the parameter information is entered, click the **OK** button. This extracts the data to the chosen directory folder location.

Considerations and Additional Information

Output from the extract is sent to the file location specified on the **Extract History File Data** screen. No changes are made to the content, and no manipulations are part of the extract.

The extract application (DRMEXTSRV.exe) must reside in the same location as the DRM application (typically \DOCTSTORE). If upon clicking the **OK** button on the **Extract History File Data** screen, the user receives a message that reads “The specified file was not found,” this means the DRMEXTSRV.exe file was NOT found.

Clicking the **OK** button starts the DRMEXTSRV application listening on the **Port #** defined on the parameters screen. A **DRM Extract** icon appears in the system tray. It can be manually shut down by right-clicking the icon, and selecting **Shutdown** from the right-click menu. The DRMEXTSRV application can also be manually shut down by task manager from the **Processes** tab. If the **DRM Extract** process is actively “talking” to VistA, placing the cursor over the icon displays the message, “Receiving Data.” Extract successfully queued displays the following screen.

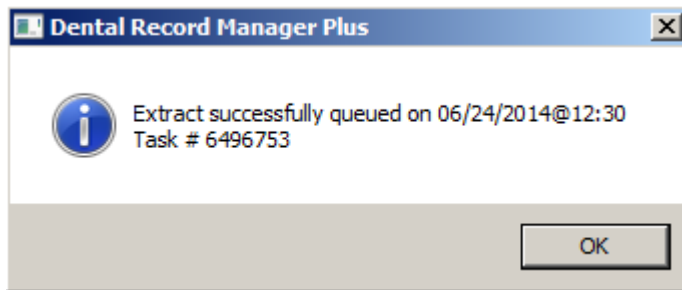


Figure 147: Extract Successfully Queued

The **Task #** refers to the Taskman job number, and can be used by the local IT department to check if the Taskman task is completed, or if an error has occurred. If an extract is queued on the VistA side, and DRMEXTSRV is NOT running, the tasked job quits without outputting the .txt file.

Note: Since the extract is queued, there is no notification to the user that the **IPaddress** or **Port #** might be wrong. It is critical that the **IPaddress** and **Port #** fields are confirmed correct.

Only one DRMEXTSRV application may run on a workstation at a time (specifically: only one may be performed after work hours on the same machine). Trying to queue another extract results in the following error message.

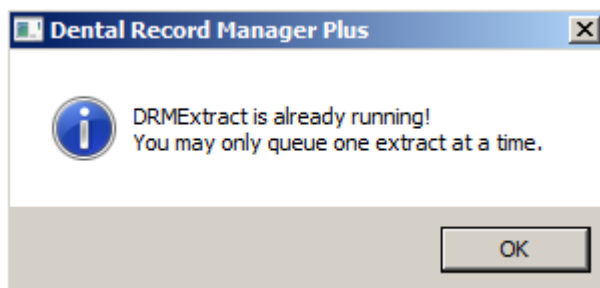


Figure 148: DRM Extract Already Running

When the extract is completed, the DRMEXTSRV application closes automatically, and another extract can be queued. If multiple files are generated for the extract, they are numbered sequentially, i.e., Extract.txt is the user selected name, followed by: Extract1.txt, Extract2.txt, etc. Since the extract is queued, and the user does NOT know if it ran to completion, the last row in the .txt file is "END OF FILE", denoting that all rows were sent to the workstation TCP/IP process. If there are multiple files, all files except the last contain the text END OF FILE (CONT...) to denote that additional extract data remains in other files.

Note: Multiple files are only output if the Excel format is selected from the extract screen, and there are greater than 65K rows of text.

Once the tasked job is completed, and the file is created, the process for retrieving and creating Excel worksheets is the same as discussed previously in the **Extract History File Data** section of this chapter.

Help

Use the **Help** menu to access more information on DRM Plus. There are five submenus: **Contents**, **Version Release Notes**, **Last Broker Call**, **VA Intranet Website** and **About**.

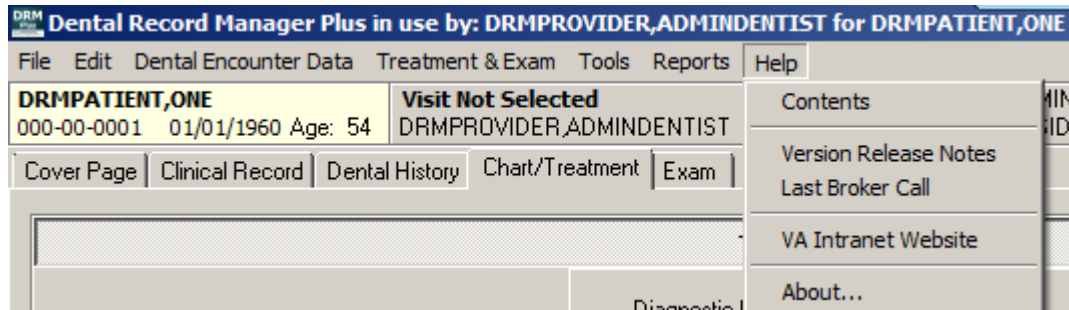


Figure 149: Help Menu

Contents

Use the **Contents** to find information on using DRM Plus.

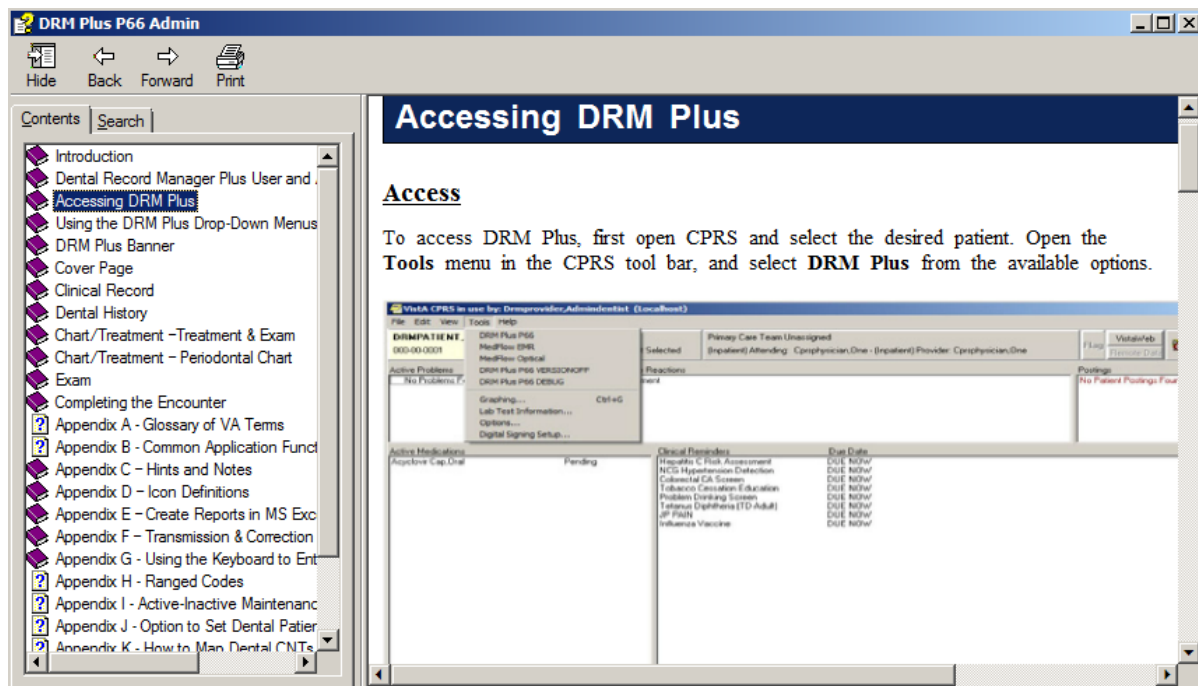


Figure 150: DRM Plus Contents Screen

Version Release Notes

Select this submenu to view what was introduced in the current version of DRM Plus.

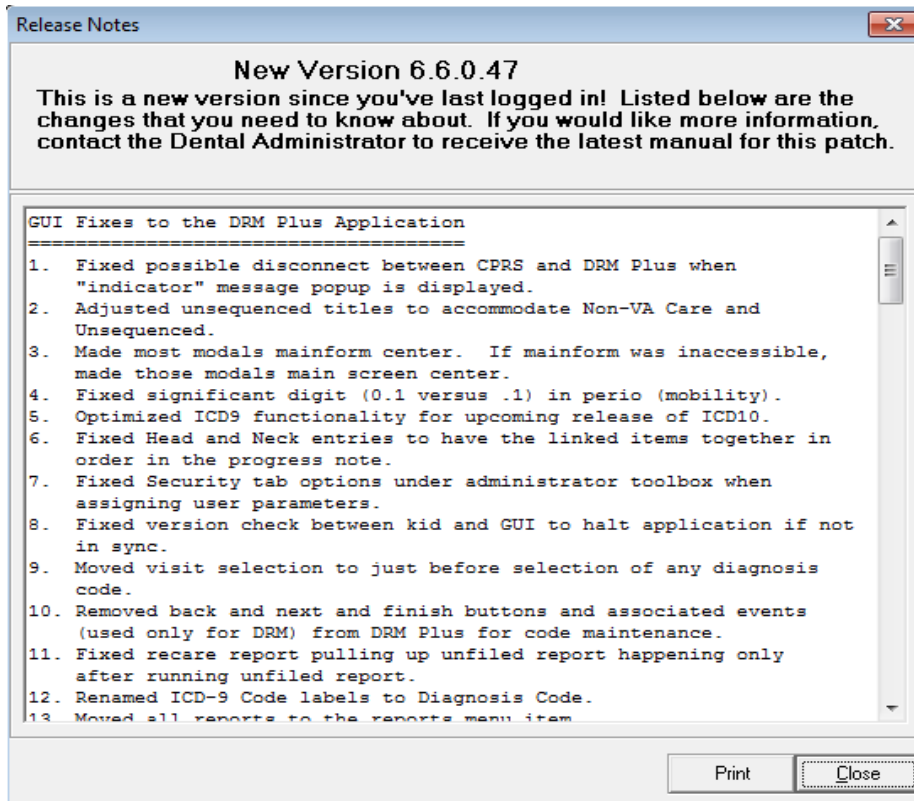


Figure 151: Release Notes Screen

Last Broker Call

Select this submenu to see the last broker call.

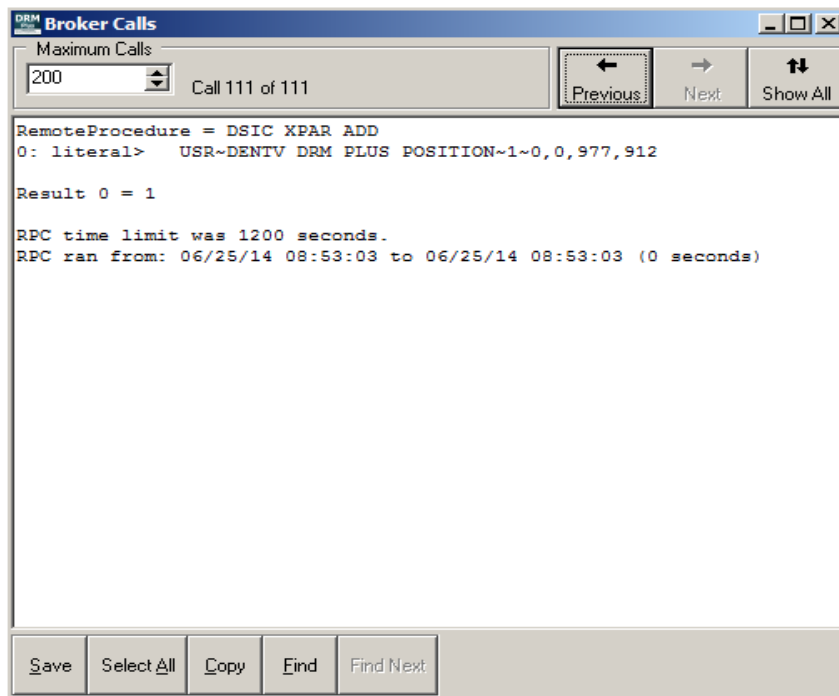


Figure 152: Broker Calls Screen

Use the **up and down arrows** next to the **Maximum Calls** text box to adjust how many broker calls are retrieved. Use the previous and next arrows to scroll through the broker calls. Use the **Show All** button to scroll through the list of broker calls.

VA Intranet Website

Select this submenu to access the VA Intranet website.

Note: Clicking this submenu connects the user to the VA Intranet website, where additional dental-related information can be obtained. This includes the latest DRM Plus manuals.

About

This screen contains information on the DRM Plus application currently in use at the facility, including the version number of the executable.



Figure 153: DRM Plus About Screen

DRM Plus Banner

The DRM Plus Banner contains vital information about the patient, providers, and also coding standards and alerts.

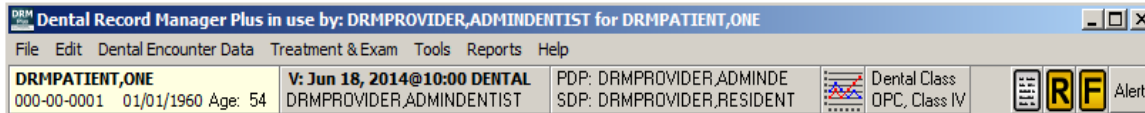


Figure 154: DRM Plus Banner

Patient Information

Patient information displays on the far left side of the DRM Plus banner.

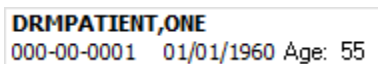


Figure 155: Patient Inquiry Button

The patient information area shows the patient's first and last name, social security number, date of birth and current age. Click the **Patient Inquiry** button of the banner to open the **Patient Inquiry** screen.

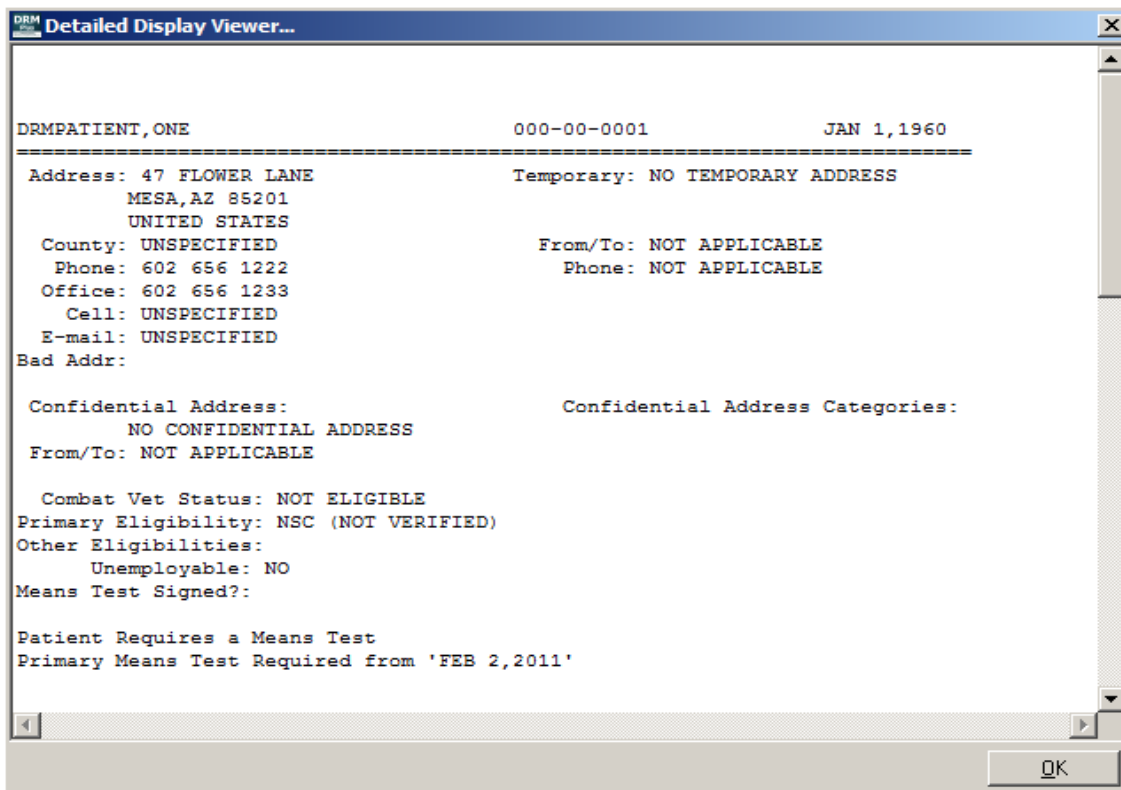


Figure 156: Patient Inquiry Screen

The **Patient Inquiry** screen contains more detailed information about the patient, including: address, phone number, means test information, status, and admissions information.

Visit Information

Visit information is displayed on the banner in the second box from the left. It contains information on the current encounter. A scheduled appointment automatically fills the field when the provider enters data into DRM Plus on the same day of the appointment.

When no scheduled appointment automatically imports into banner or if one is NOT manually selected from the banner after opening the dental chart then the following will result. After the first completed procedure code has been selected during the current session results in the launch of the **Provider and Location for Current Activities** screen. This will force the dental user to select a scheduled appointment before the first diagnosis code can be selected for the completed transaction.

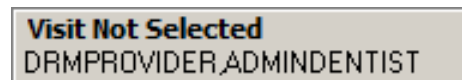
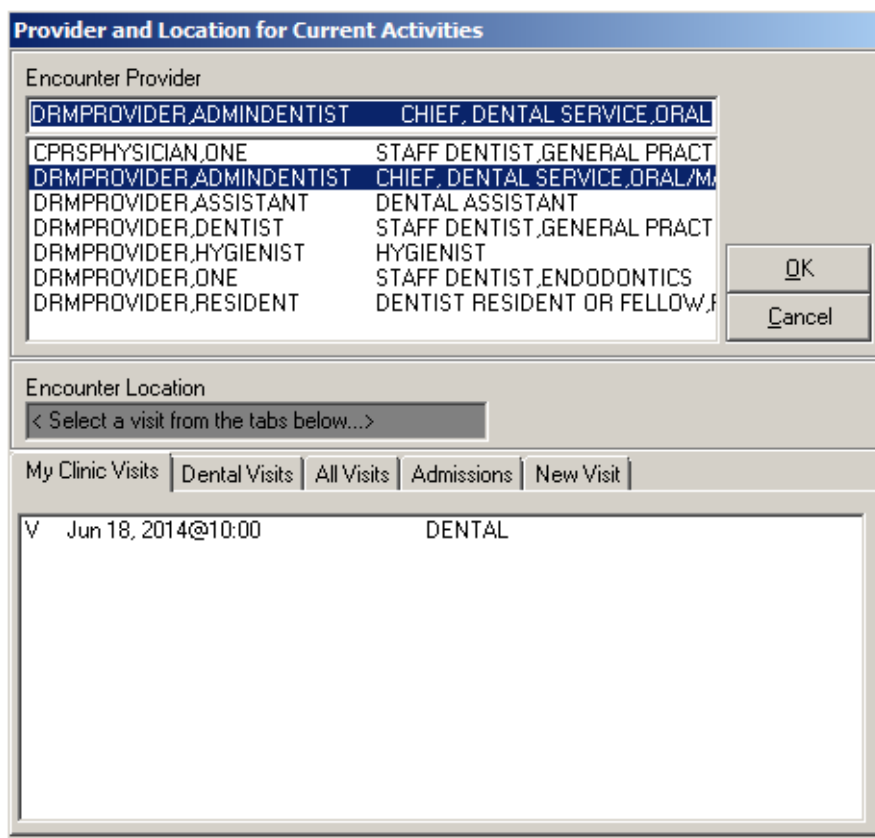


Figure 157: Provider/Visit Button

To change visit or provider information, click the **Provider/Visit** button of the banner. The **Provider and Location for Current Activities** screen displays.



Encounter Provider	
DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE, ORAL
CPRSPHYSICIAN, ONE	STAFF DENTIST, GENERAL PRACT
DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE, ORAL/M
DRMPROVIDER,ASSISTANT	DENTAL ASSISTANT
DRMPROVIDER,DENTIST	STAFF DENTIST, GENERAL PRACT
DRMPROVIDER,HYGIENIST	HYGIENIST
DRMPROVIDER, ONE	STAFF DENTIST, ENDODONTICS
DRMPROVIDER,RESIDENT	DENTIST RESIDENT OR FELLOW, F

Encounter Location
< Select a visit from the tabs below...>

My Clinic Visits | Dental Visits | All Visits | Admissions | New Visit

Visit ID	Date/Time	Location
V	Jun 18, 2014@10:00	DENTAL

Figure 158: Provider and Location for Current Activities Screen

Select the provider in the top part of the screen and the correct appointment information in the bottom part of the screen. The information in the banner changes to reflect the adjustments made on this screen. For more information on navigating this screen, please see the Dental Encounter Data section in the Using the DRM Plus Drop-Down Menus chapter of this manual.

Dental Provider Information

This section of the banner displays information on the primary and secondary dental providers. To assign a primary and/or secondary dental provider for a patient requires an administrative parameter option, given by the DRM Plus Administrator. Primary/Secondary providers are for planned care, and show who is responsible for a given patient, and what is upcoming for the patient, regardless of who entered the information.

PDP: DRMPROVIDER_ADMINDE
SDP: DRMPROVIDER_RESIDENT

Figure 159: Designate Dental Providers Button

To select a primary and/or secondary dental provider for a patient:

1. Click the **Designate Dental Providers** button of the banner.
2. The **Designated Dental Providers** screen displays.

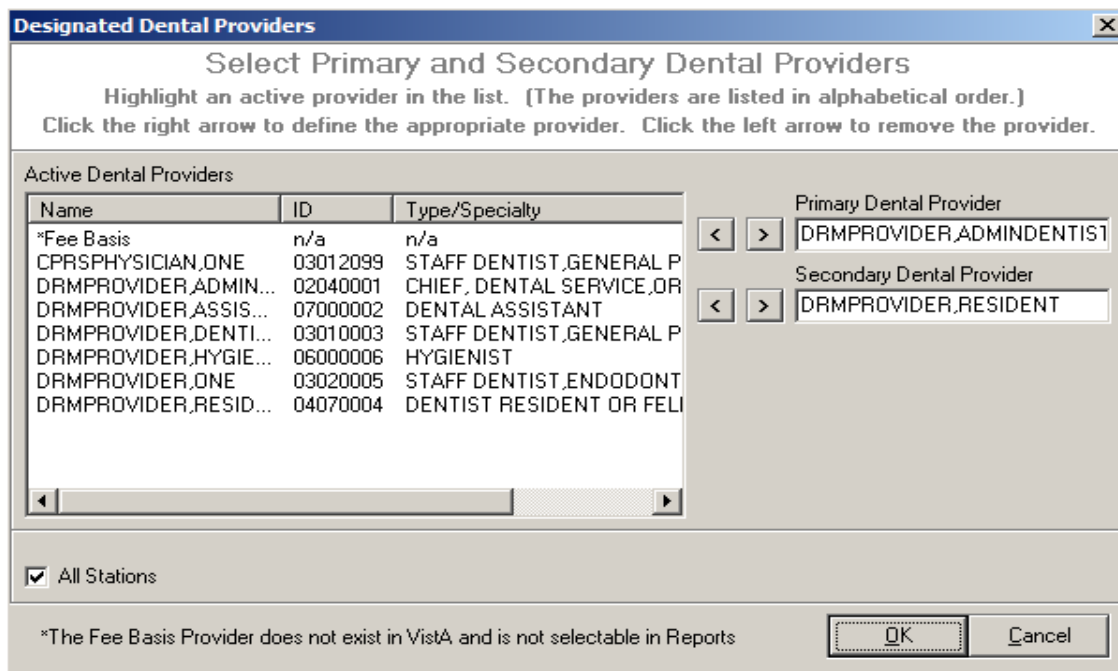


Figure 160: Designated Dental Providers Screen

3. Select the provider from the list of active dental providers.
4. Click the **right arrow** associated with the **Primary Dental Provider** and/or **Secondary Dental Provider** windows.
5. The provider's name displays in the designated provider area. To remove the provider, click the **left arrow**.
6. Click the **OK** button.
7. The provider information displays in the banner.

The primary dental provider or secondary dental provider can be set as **Fee Basis** in DRM Plus. The **Fee Basis** provider does NOT exist in VistA. This is a “free-text” entry and therefore, most reports in DRM Plus do NOT recognize the **Fee Basis** provider.

Designating primary and/or secondary provider(s) is optional. Since the field is located in the DRM Plus banner, it can be viewed from all DRM Plus screens.

Note: The **Panel Add/Edit** administrative option changes all patients assigned to the original primary provider to the selected new primary provider for the entire block of patients.

Note: This option is utilized for these DES reports: **Recare, Provider Planning, Planned Items List** and **Active Patients by Provider.**

Vitals Lite

This section of the banner contains a link to launch the **Vitals Lite** application and then entry of patient's vitals.



Figure 161: Vitals Lite Button

Dental Class Information

This section of the banner contains information on the patient's dental class.

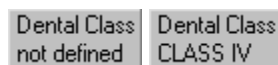


Figure 162: Dental Class Button

Click the **Dental Class** button of the banner to go to the DRM Plus **Cover Page** tab. However, only a DRM Plus Administrator or an end-user that has this administrative parameter option can change a patient's dental class. Please see the Cover Page chapter of this manual for more information.

Clean Slate

This section, when present, is located between the **Dental Class** button and the icons on the far right of the banner. **Clean Slate** is only a viewable window that displays the most recent date that a clean slate was performed on the patient's chart. Clean slate may only be performed by a DRM Plus Administrator, or an end-user who has received the administrative parameter option.

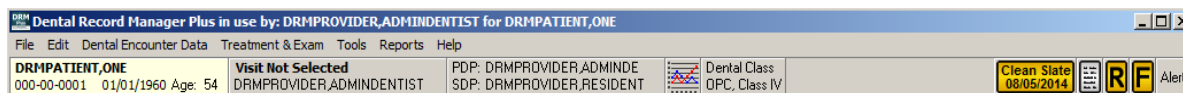


Figure 163: Clean Slate Notification

The clean slate functionality has been added to clear the graphical portion of the **Treatment & Exam** screens in DRM Plus, and delete all planned treatment for the selected patient. The recent clean slate can be restored for this patient at any time until a new encounter has been filed.


Icons

The icons located on the right side of the banner show patient flags, alerts and provide an easy way for the user to look up coding standards.



Figure 164: DRM Plus Banner Icons

Coding Standards


The first icon is the **Coding Standards**  icon. Clicking this icon takes the provider to the VA Office of Dentistry website where current **Coding Standards** may be viewed. This hyperlink should be changed by the DRM Plus Administrator if requested to do so by the VA Dental Informatics and Analytics Director.

Note: If NOT immediately directed to the website after clicking the icon please notify the Help Desk.

Patient Flags

There are four possible patient flags that can display in DRM Plus, including: **Clinical Reminders**, **Consult**, **Exam Quality Indicator** and **Fluoride Quality Indicator**.

Clinical Reminders

The **Reminders**  icon displays on the right side of the DRM Plus banner when there are clinical reminders due for the selected patient. Providers must still process clinical reminders using CPRS.

Clicking the **Reminders** icon displays an information screen, stating that the selected patient has clinical reminders due.

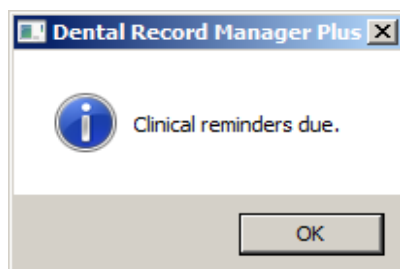




Figure 165: Clinical Reminders Due

The **Reminders** icon should only display if the current end-user is responsible for, and may resolve the clinical reminder(s) listed on the CPRS cover sheet. If clinical reminder(s) displaying in the list cannot be resolved by the end-user, contact local IT for assistance.

Consult

The **Consult**  icon displays when the patient has an incomplete consult in their chart. Click the icon. The **Clinical Record** tab displays with consultations selected. For more information, see the Clinical Record chapter of this manual.

Exam Quality Indicator

The **Exam Quality Indicator**  icon displays when the patient is due for a follow-up exam. The icon only displays if the patient meets certain class restrictions. Clicking this icon produces a screen, which reveals when the patient last received a qualifying exam.

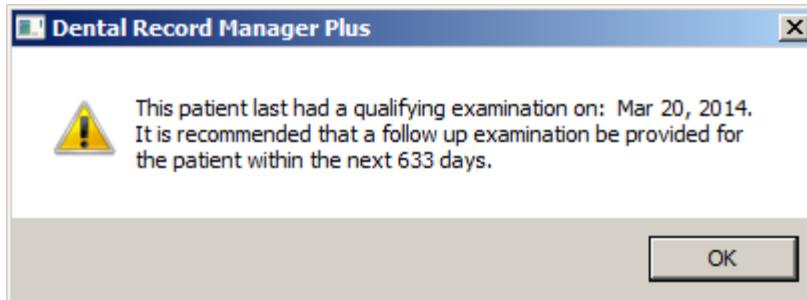



Figure 166: Exam Quality Indicator Screen

Click the **OK** button. The DRM Plus **Cover Page** tab displays. For more information, see the Cover Page chapter of this manual.

Note: The **Exam Quality Indicator** and **Fluoride Quality Indicator** only are active for VA dental care under **Class I, IIA, IIC** or **IV** classification. These dental classes are eligible for any necessary dental care to maintain or restore oral health and masticatory function, including repeat care.

Fluoride Quality Indicator

The **Fluoride Quality Indicator**  icon displays when the patient is due for a fluoride intervention. Clicking this icon displays an explanation of why the patient is at risk and needs intervention.

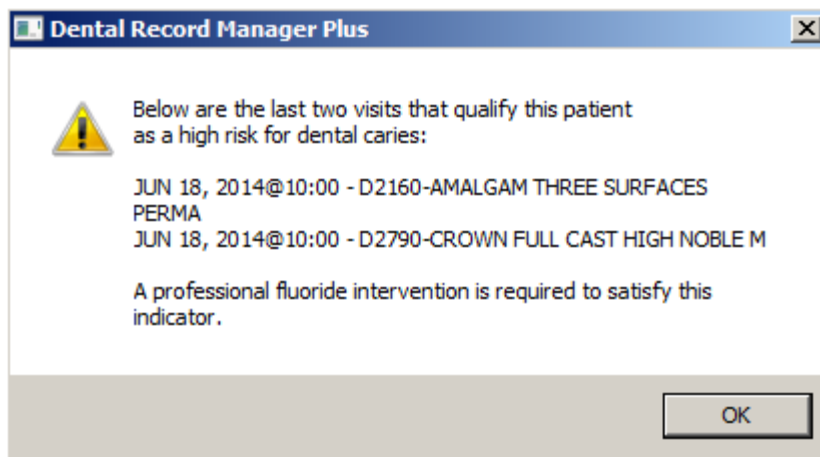


Figure 167: Fluoride Quality Indicator Screen

Click the **OK** button. The **Cover Page** tab displays. For more information, see the Cover Page chapter of this manual.

Note: The **Exam Quality Indicator** and **Fluoride Quality Indicator** only are active for VA dental care under **Class I, IIA, IIC** or **IV** classification. These dental classes are eligible for any necessary dental care to maintain or restore oral health and masticatory function, including repeat care.

Alerts



The DRM Plus **Alert** icon shows if the patient has any associated alerts. It can also be used to add alerts to the patient's chart in DRM Plus.

To add an alert:

1. Click the **Alert** icon.
2. The **Dental Alert** screen displays.

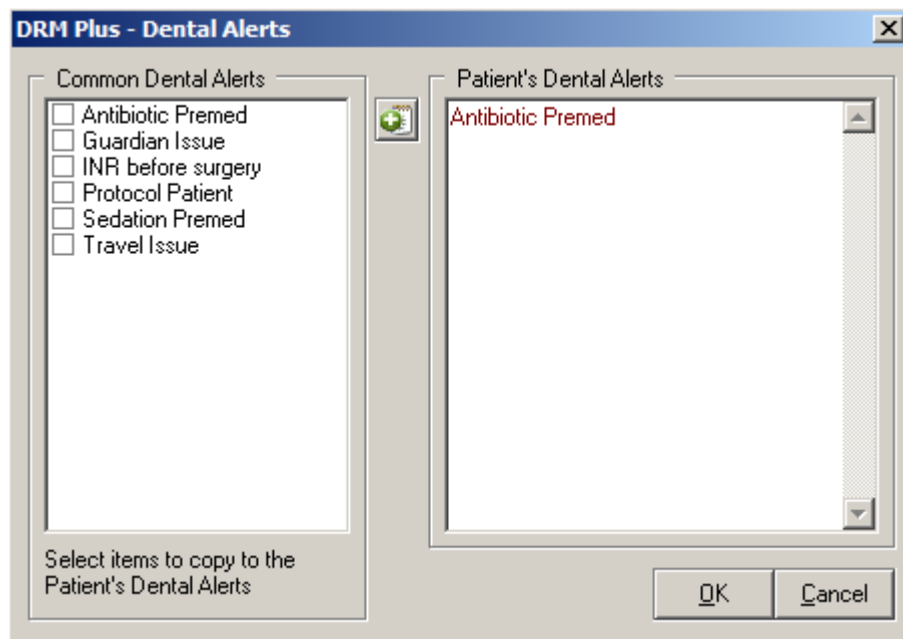


Figure 168: Dental Alerts Screen

3. Click the desired **Common Dental Alerts** check box on the left side of the screen.
4. Click the **right arrow** button.
5. The selected alert(s) display on the right side of the screen.
6. Alternatively, type the alert directly into the **Patient's Dental Alerts** screen window.
7. Click the **OK** button.



The **Alert** icon changes when patient alerts are present and displays as a **stop sign**.

To view the alerts:

1. Click the **Alert** icon displaying a stop sign.
2. The **Patient's Dental Alerts** screen displays.

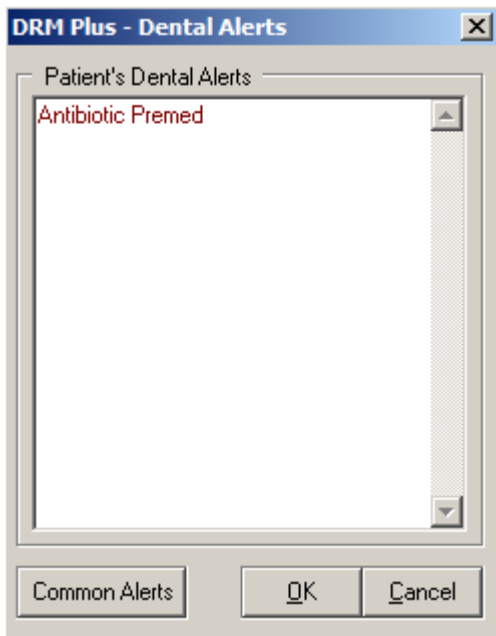


Figure 169: Patient's Dental Alerts Screen

3. Click the **Common Alerts** button to expand the **Common Dental Alerts** window.
4. The full **Dental Alerts** screen displays. From here, more dental alerts can be added, or the alert can be removed by placing the cursor into the **Patient's Dental Alerts** window and deleting the text.
5. Click the **OK** button to finish.

Cover Page

The DRM Plus **Cover Page** tab displays important patient information. The tab has 8 major sections: **Dental Eligibility, Demographics, Case Management, Recent Dental Activity, Fluoride Indicator Prescription Date, Dental Alerts, Notes** and **Filed Planned Care**.

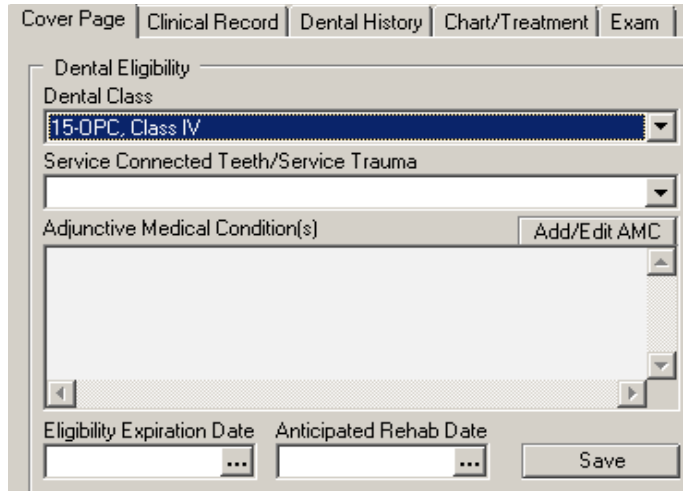
The screenshot displays the DRM Plus software interface for the 'Cover Page' tab. The window title is 'Dental Record Manager Plus in use by: DRMPROVIDER,ADMIDENTIST for DRMPATIENT,ONE'. The menu bar includes File, Edit, Dental Encounter Data, Treatment & Exam, Tools, Reports, and Help. The patient information bar shows: DRMPATIENT,ONE (000-00-0001, 01/01/1960, Age: 54), Visit Not Selected, DRMPROVIDER,ADMIDENTIST, PDP: DRMPROVIDER,ADMIND, SDP: DRMPROVIDER,RESIDENT, Dental Class: OPC, Class IV, and an Alert icon. The main content area is divided into several sections:

- Dental Eligibility:** Includes a dropdown for Dental Class (15-OPC, Class IV), Service Connected Teeth/Service Trauma, and a list of Adjunctive Medical Condition(s) (521.04 - ARRESTED DENTAL CARIES). It also has fields for Eligibility Expiration Date and Anticipated Rehab Date.
- Demographics:** A table showing Primary Eligibility (NSC) and Service Separation Date (JAN 1, 1980 (MARINE CORPS)).
- Case Management:** Features radio buttons for Status (Active, Inactive, Maintenance), a Suggested Recare Date field, and a Save button.
- Recent Dental Activity:** Lists various exam and image dates: Last Qualifying Exam, Last Comprehensive Exam, Last Brief Exam, Last Periodontal Exam, Last Panorex Image, Last Full Mouth Image (Jul 07, 2014), Last Bitewing Image, Last Prophylaxis (Jul 07, 2014), Last Visit (Jul 23, 2014), and Last Provider (DRMPROVIDER,DENTIS).
- Fluoride Indicator Prescription Date:** Includes a date field and a Save button.
- Dental Alerts:** A list area for alerts.
- Notes:** A large text area for notes with a Save button.
- Filed Planned Care:** A large text area for planned care with a Save button.

Figure 170: DRM Plus Cover Page Tab

Dental Eligibility

The patient's dental class, service connected teeth/service trauma, adjunctive medical conditions, eligibility expiration date, and anticipated rehab date are displayed in this area. **Dental Eligibility** can only be changed by a DRM Plus Administrator, or an end-user who has received this administrative parameter option.



The screenshot shows a software window titled "Dental Eligibility" with a tabbed interface. The tabs are "Cover Page", "Clinical Record", "Dental History", "Chart/Treatment", and "Exam". The "Dental Eligibility" tab is active. It contains a "Dental Class" dropdown menu with "15-OPC, Class IV" selected. Below it is a "Service Connected Teeth/Service Trauma" dropdown menu. Underneath is a text area for "Adjunctive Medical Condition(s)" with an "Add/Edit AMC" button. At the bottom, there are two date pickers for "Eligibility Expiration Date" and "Anticipated Rehab Date", and a "Save" button.

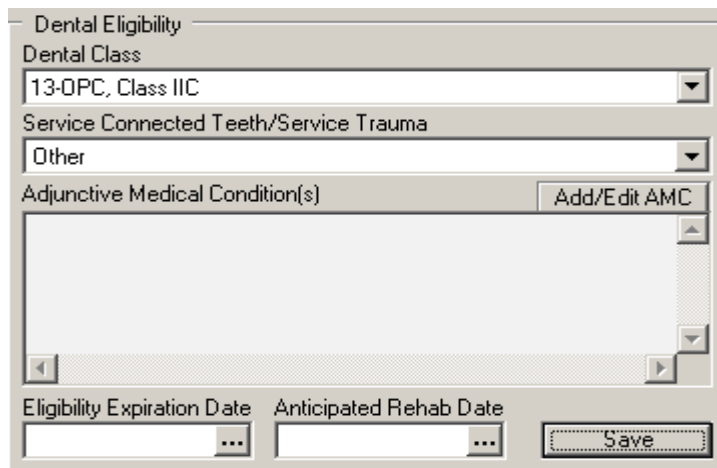
Figure 171: Dental Eligibility

Dental Class

Use the drop-down menu to change the patient's **Dental Class**. Selecting the top, empty field on this menu allows the administrator to remove any dental classification.

Service Connected Teeth/Service Trauma

The **Service Connected Teeth/Service Trauma** will be optional for any or all dental classes however a **Service Connected Teeth/Service Trauma** will still be required for all **Class IIA** patients. The **Class IIA** no longer requires trauma to a particular tooth, just some documentation of trauma to the oral cavity so the **Other** check box has been added.



The screenshot shows the same "Dental Eligibility" window. The "Dental Class" dropdown now shows "13-OPC, Class IIC". The "Service Connected Teeth/Service Trauma" dropdown now shows "Other". The "Adjunctive Medical Condition(s)" text area is empty. The "Eligibility Expiration Date" and "Anticipated Rehab Date" pickers are still present, along with the "Save" button.

Figure 172: Service Connected Teeth/Service Trauma

Adjunctive Medical Condition(s)

The **Adjunctive Medical Condition(s)** field is still required for all **Class III** & **Class VI** patients but maybe optional for all other dental classes if desired by the provider. Deletion of the **Adjunctive Medical Conditions** will **NOT** be required when changing a patient's dental class from **Class III** or **Class VI** to any other dental class.

1. Click the **Add/Edit AMC** button.
2. The **Add/Edit Adjunctive Medical Conditions** screen displays.

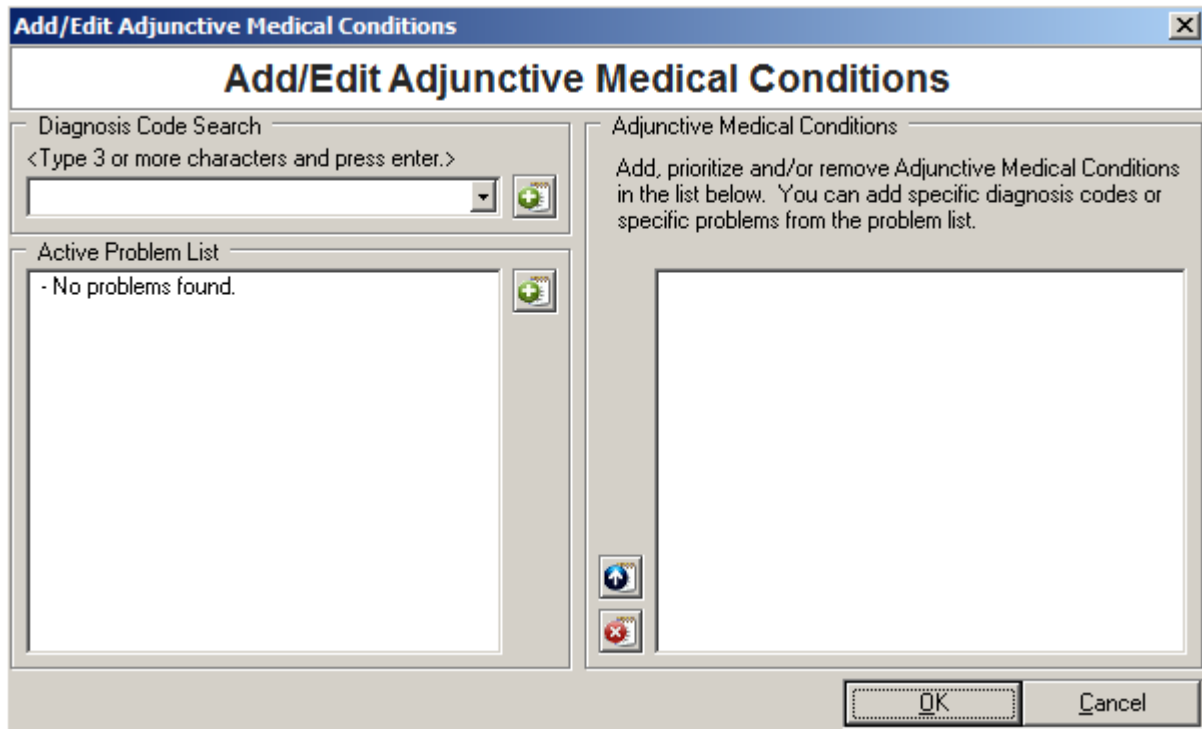


Figure 173: Add/Edit Adjunctive Medical Conditions Screen

3. Add the diagnosis code. Type in the word or diagnosis code and press the **<Enter>** key.
4. Choose the desired result from the drop-down menu.
5. Click the **green add** button to add the diagnosis code to the adjunctive medical conditions list.
6. **Active Problems**, if present, can also be added to the adjunctive medical conditions list.
7. Use the **blue up arrow** button to move conditions within the list.
8. Use the **red X** button to delete items from the list.
9. Click the **OK** button. The condition displays on the **Cover Page** tab.

Eligibility Expiration Date

The **Eligibility Expiration Date** field will be optional for all dental classes. A bubble pop-up informs the provider if they really want to include an eligibility expiration date for any **Class I**, **Class IIA**, **Class IIC** and **Class IV** since they rarely expire.

To change the eligibility expiration date:

1. Click the **Eligibility Expiration Date Ellipsis (...)** button.
2. The **Select Date/Time** screen displays.

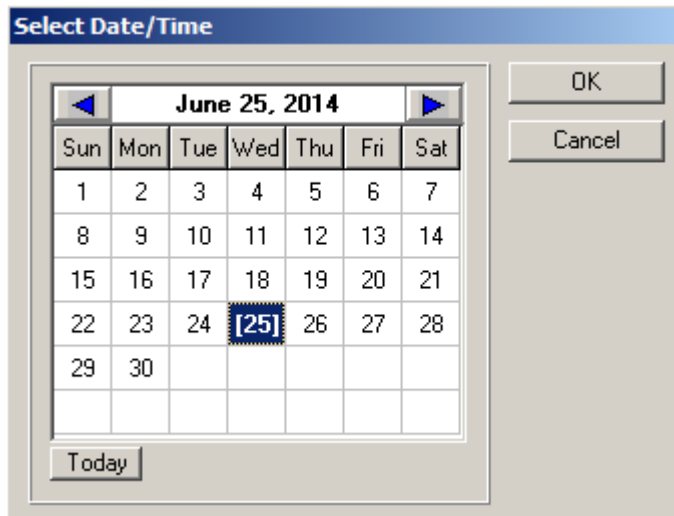


Figure 174: Select Date/Time Screen

3. Select the desired date from the screen.
4. Click the **OK** button. The date is updated.

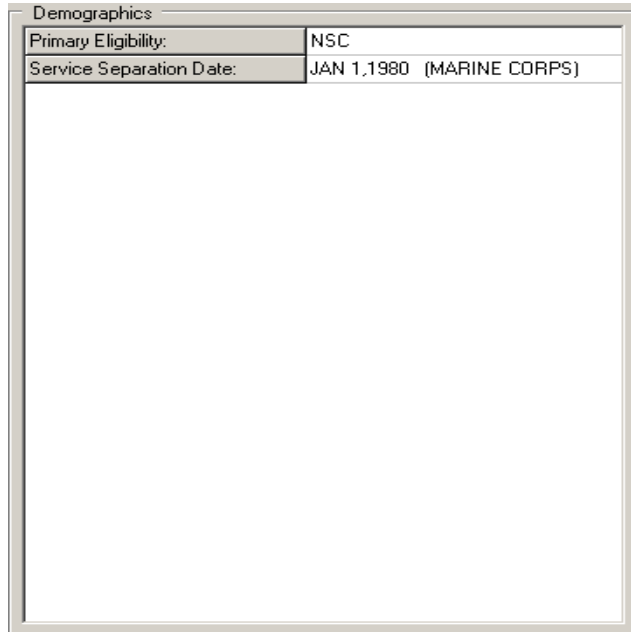
Anticipated Rehab Date

The **Anticipated Rehab Date** field had no updates to the **Anticipated Rehab Date** functionality. The **Anticipated Rehab Date** is required for all **Class V** patients and will NOT be allowed for any other dental classification.

Note: After entering any new dental eligibility, always click the **Save** button to update.

Demographics

Patient demographic information is located here and is imported from VistA. The fields cannot be updated or changed in DRM Plus.



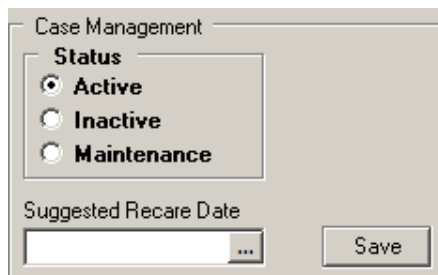
The screenshot shows a window titled "Demographics" with a table containing the following information:

Primary Eligibility:	NSC
Service Separation Date:	JAN 1, 1980 (MARINE CORPS)

Figure 175: Demographics

Case Management

Use the **Case Management** (Disposition) section to adjust the patient's status and file suggested recare dates. Click the **Save** button to update any new changes.



The screenshot shows a window titled "Case Management" with the following elements:

- Status** section with three radio buttons:
 - Active**
 - Inactive**
 - Maintenance**
- Suggested Recare Date** section with a text input field and an ellipsis (...) button.
- A **Save** button.

Figure 176: Case Management

Status

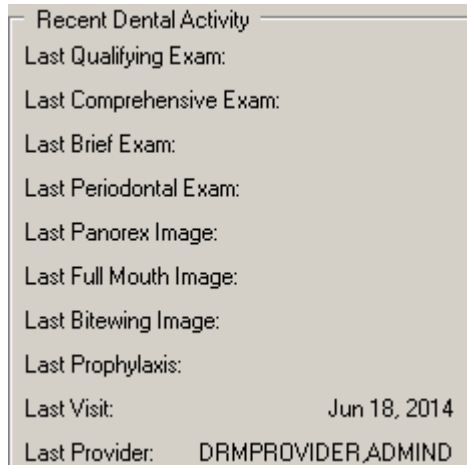
Change the **Status** of the patient by clicking the appropriate radio button.

Suggested Recare Date

1. Click the **Ellipsis (...)** button to display a calendar screen.
2. Select the desired date from the menu and click the **OK** button.
3. Click the **Save** button to file the data.

Recent Dental Activity

This section displays dates, if applicable, of when specific completed procedures were last performed on the patient. Procedure codes that activate the date in this section may be viewed by hovering the mouse cursor over the recent dental activity description.



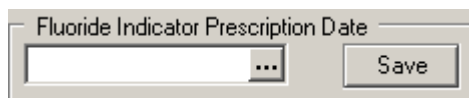
Recent Dental Activity

Last Qualifying Exam:	
Last Comprehensive Exam:	
Last Brief Exam:	
Last Periodontal Exam:	
Last Panorex Image:	
Last Full Mouth Image:	
Last Bitewing Image:	
Last Prophylaxis:	
Last Visit:	Jun 18, 2014
Last Provider:	DRMPROVIDER_ADMIND

Figure 177: Recent Dental Activity

Fluoride Indicator Prescription Date

Add a fluoride indicator prescription date here.



Fluoride Indicator Prescription Date

...

Figure 178: Fluoride Indicator Prescription Date

1. Click the **Ellipsis (...)** button.
2. Select a date from the calendar screen and click the **OK** button.
3. Click the **Save** button to file the date.

To delete the prescription date:

1. Click the **date** to place the cursor in the field.
2. Delete the date.
3. Click the **Save** button to file.

The field is active regardless of whether or NOT the patient has a fluoride quality indicator.

Note: No future dates are allowed for the fluoride indicator prescription date.

Dental Alerts

The patient's **Dental Alerts**, if any, are listed here.

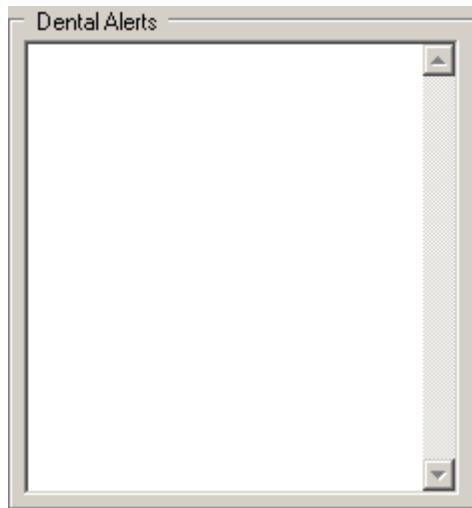


Figure 179: Dental Alerts

Please see the Alerts section in the DRM Plus Banner chapter of this manual for more information.

Notes

Add general notes in this text box. These notes are NOT imported into the TIU progress note.

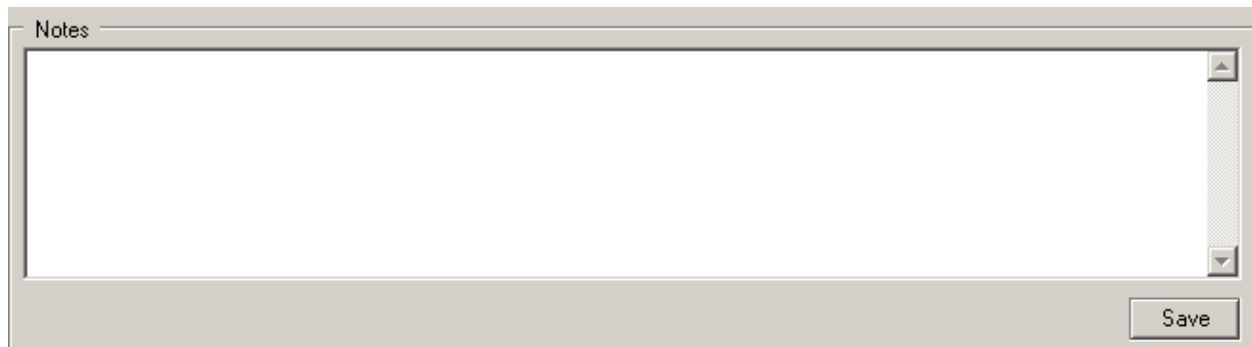


Figure 180: Notes

1. Place the cursor in the text box and begin typing.
2. Click the **Save** button to file the notes.
3. A screen displays showing that the information is saved. Click the **OK** button.

Filed Planned Care

The filed planned treatment for the patient, if applicable, is displayed here. It cannot be edited on this page.

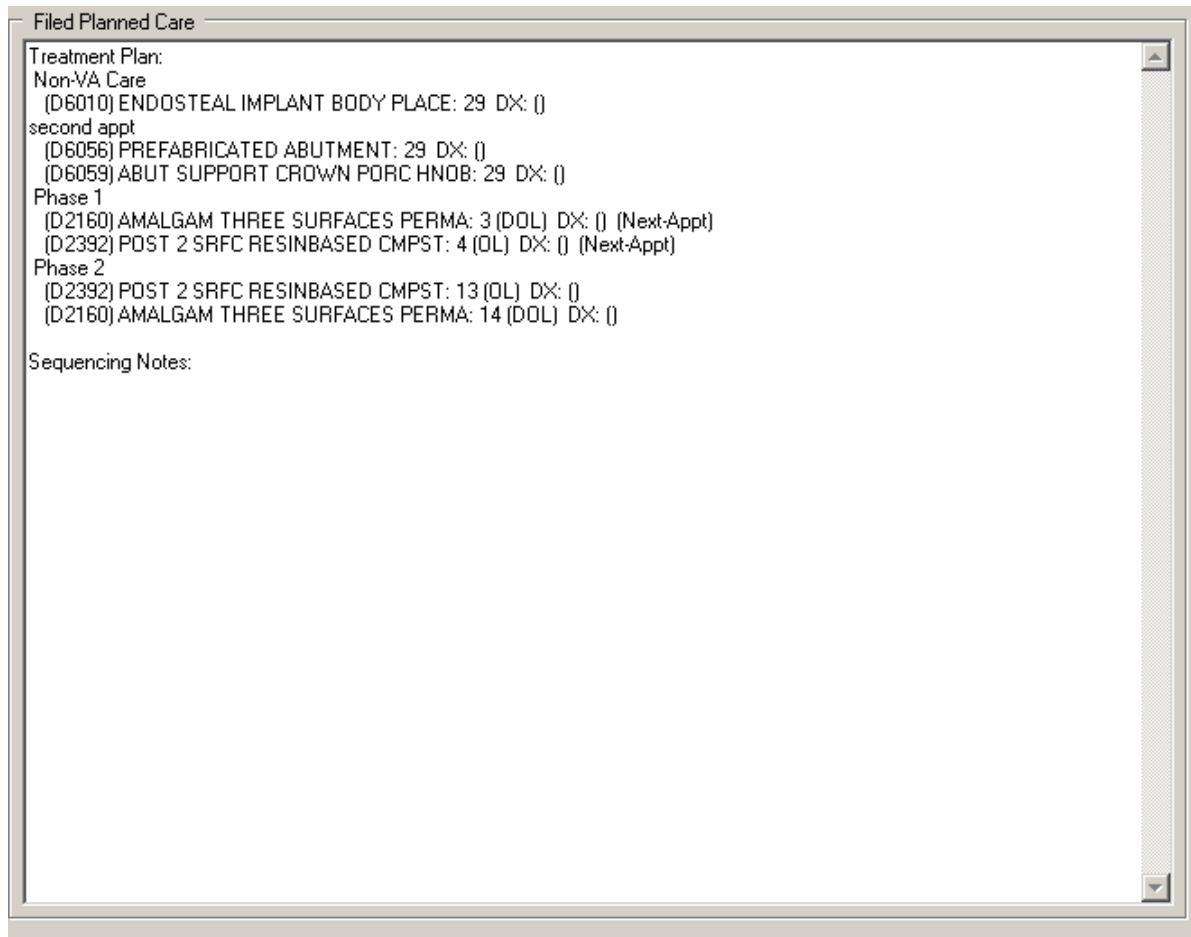


Figure 181: Filed Planned Care

Please see the Treatment Plan section in the Chart/Treatment -Treatment & Exam chapter of this manual for more information.

Clinical Record

The **Clinical Record** tab allows access to various areas of the patient's record. From here, view **Problems, Medications, Vital Signs, Radiology, Allergies, Lab Results, Postings, Immunizations, D/C Summaries, Consultations, Health Summary** and **Notes**.

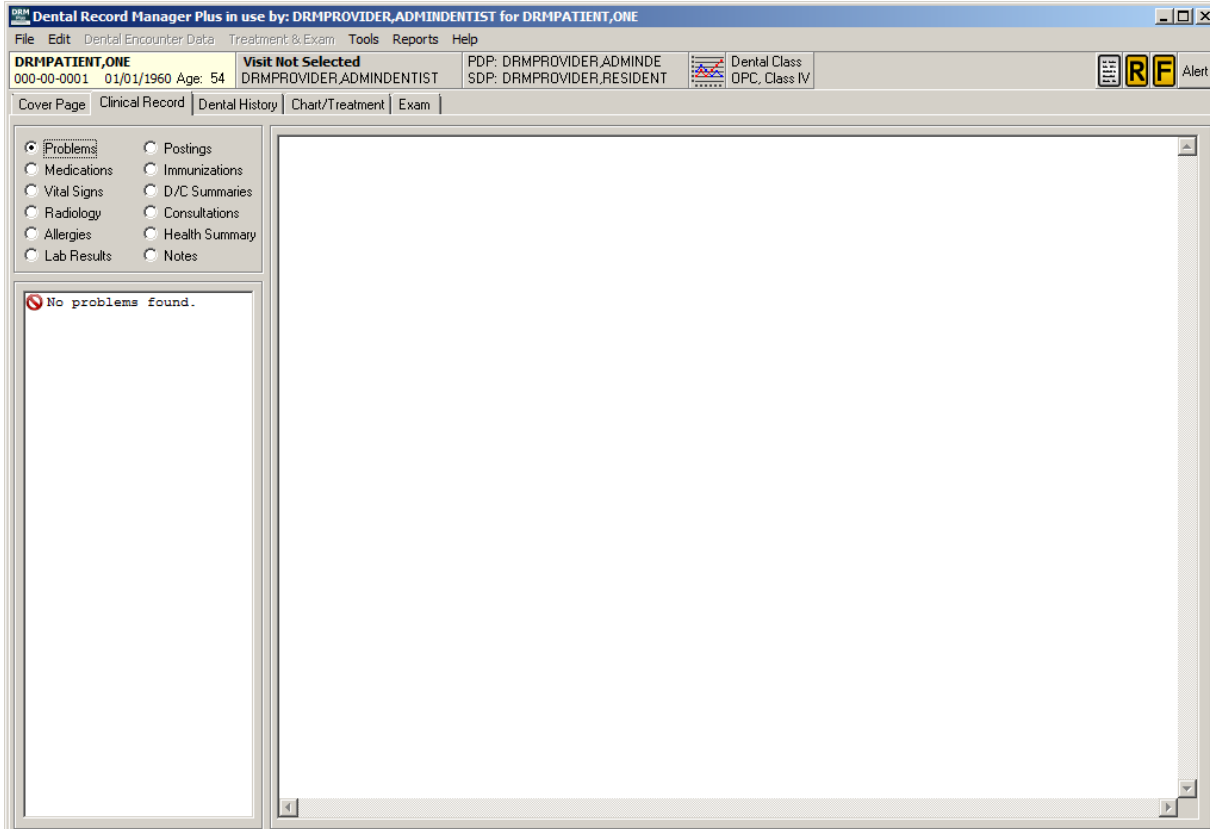


Figure 182: Clinical Record Tab

1. Click the **radio button** that corresponds to the type of clinical record to be viewed.

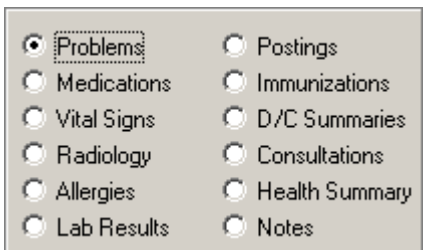


Figure 183: Clinical Record Radio Buttons

2. A list of note entries, corresponding to the selected clinical record types, displays in the area below the list of clinical record types.



Figure 184: Clinical Record Entries Window

3. Select a **note entry**. Details for the entry display on the right side of the screen.

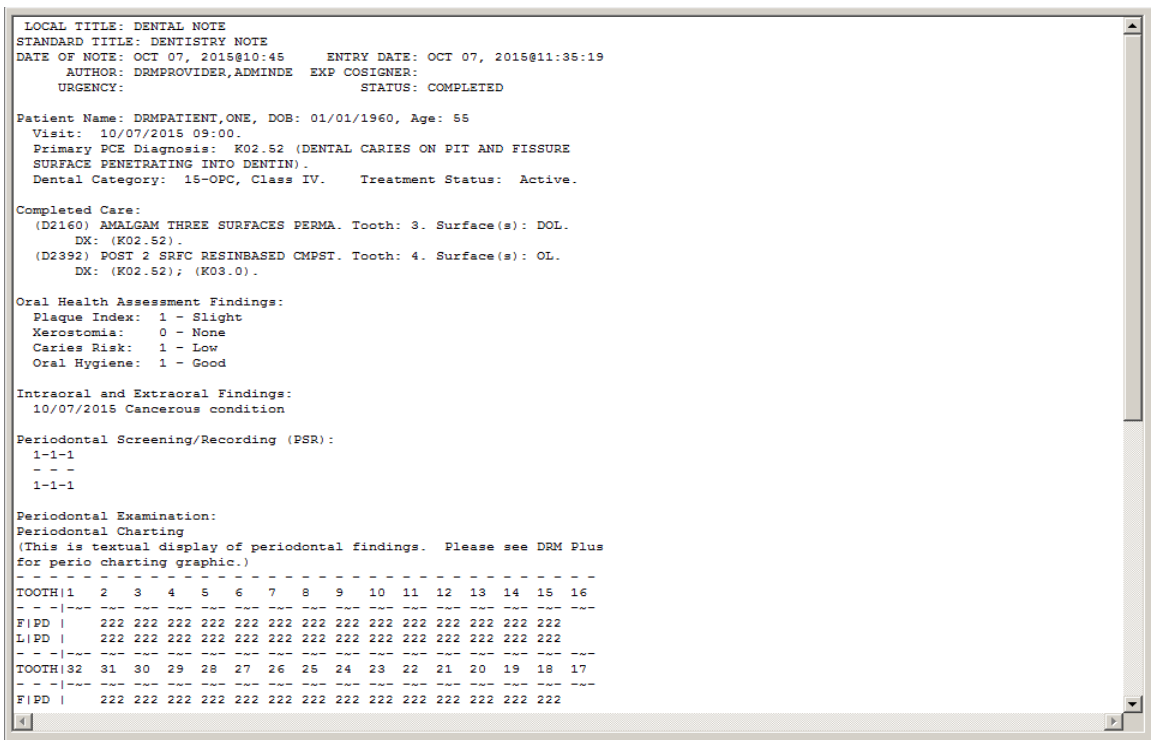


Figure 185: Clinical Record Entry Information Window

Problems

Click the **Problems** radio button to view a list of active problems previously entered.

To inactivate a problem:

1. Select the **problem** from the list that should be inactivated.
2. Right-click on the problem selected.
3. The **Inactive Highlighted Problem List Entry** button displays.

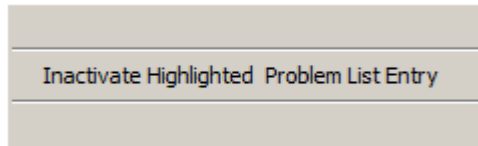


Figure 186: Inactivate Highlighted Problem List Entry Button

4. Select the **Inactive Highlighted Problem List Entry** button to inactivate the problem.
5. Select **Yes** and a screen displays, confirming the inactivation. The problem is removed from the list in DRM Plus and in CPRS the problem is listed as inactive.

Note: Use CPRS to reactivate the problem. Please see the File Data Option Screen section in the Completing the Encounter chapter of this manual for more information to add a new problem.

Consultations

Selecting the **Consultations** radio button displays a complete list of consults. They appear with the abbreviated notation of the consult status included in the listing. Consults can be filtered by status, service or date range.

To filter consultations by status, service or date range:

1. Click the **Consultations** radio button. Consultations, if present, display in the entries area.
2. Right-click in the entries area. The filter menu displays.



Figure 187: Consultations Filter Menu

3. Select the desired filter from the menu.
4. Consults filtered by status, service or date range have a drop-down menu to filter the consults into smaller sub-views.
5. The consultation sub-view list displays results in this consult on the right side of the **Clinical Record** tab screen.

Notes

Selecting the **Notes** radio button reveals a listing of all completed notes (the default listing). Right-clicking the note window, where all notes are listed, brings up an option box.

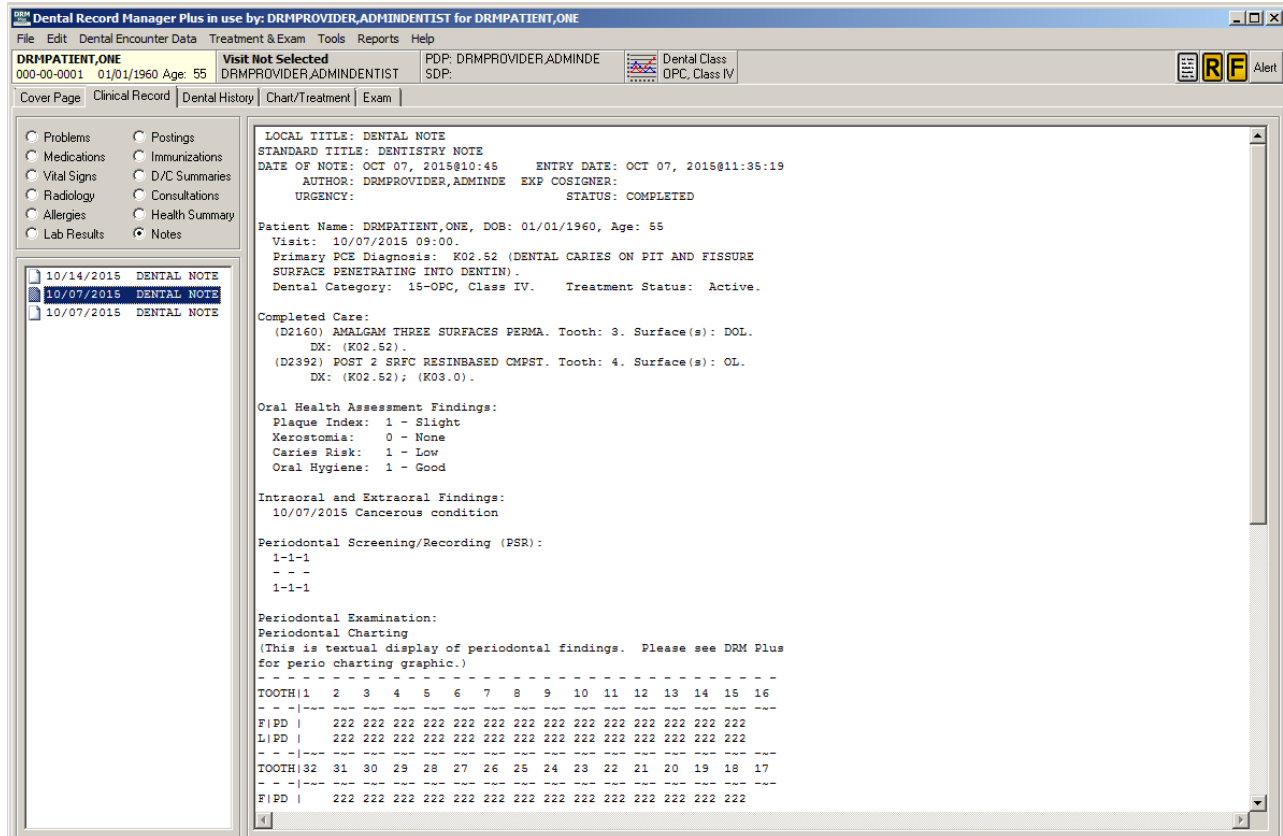


Figure 188: All TIU Completed Notes List

Select the **TIU Filters** menu to filter the list of TIU progress notes by the listed criteria.

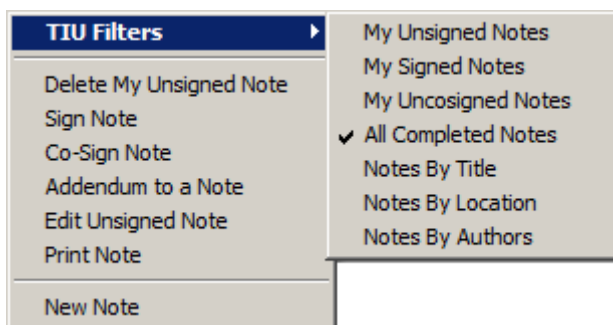


Figure 189: TIU Filters Submenus

Open the desired note. Right-click the list of notes again to view the functions available for the selected note.

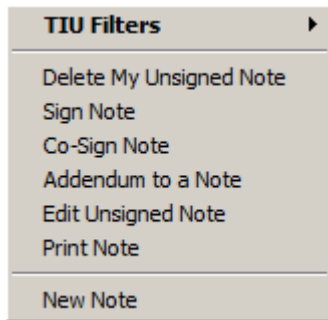


Figure 190: Note Functions Menu

The functions available coincide with the **Action** menu options, as seen on the **Notes** tab in CPRS, and works similarly. The note functions can be selected with a left-click.

Adding a New TIU Progress Note

To add a new TIU progress note for informational purposes only, without an ADA procedure code:

1. Select the **New Note** option from the **Note Functions** menu.
2. The **Set Progress Note Title** screen displays.

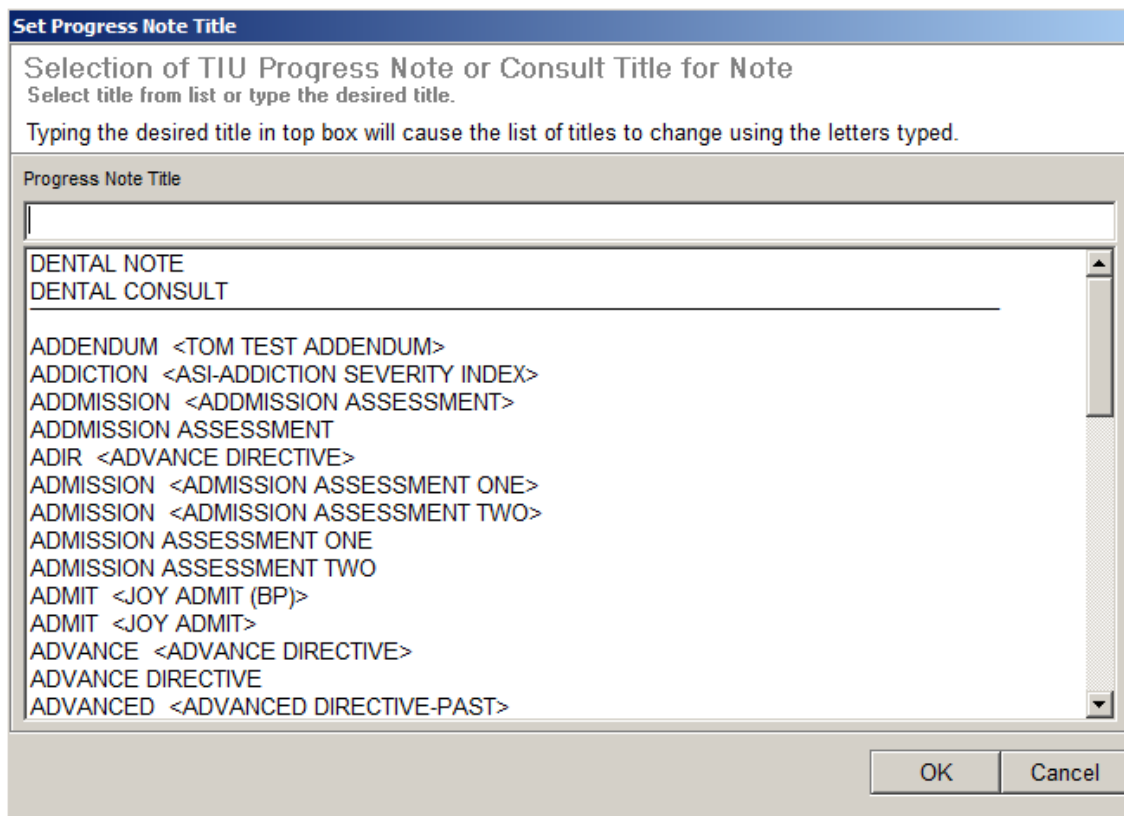


Figure 191: Set Progress Note Title Screen

3. Select the TIU progress note title from the list on the **Set Progress Note Title** screen. Note information displays on the screen.

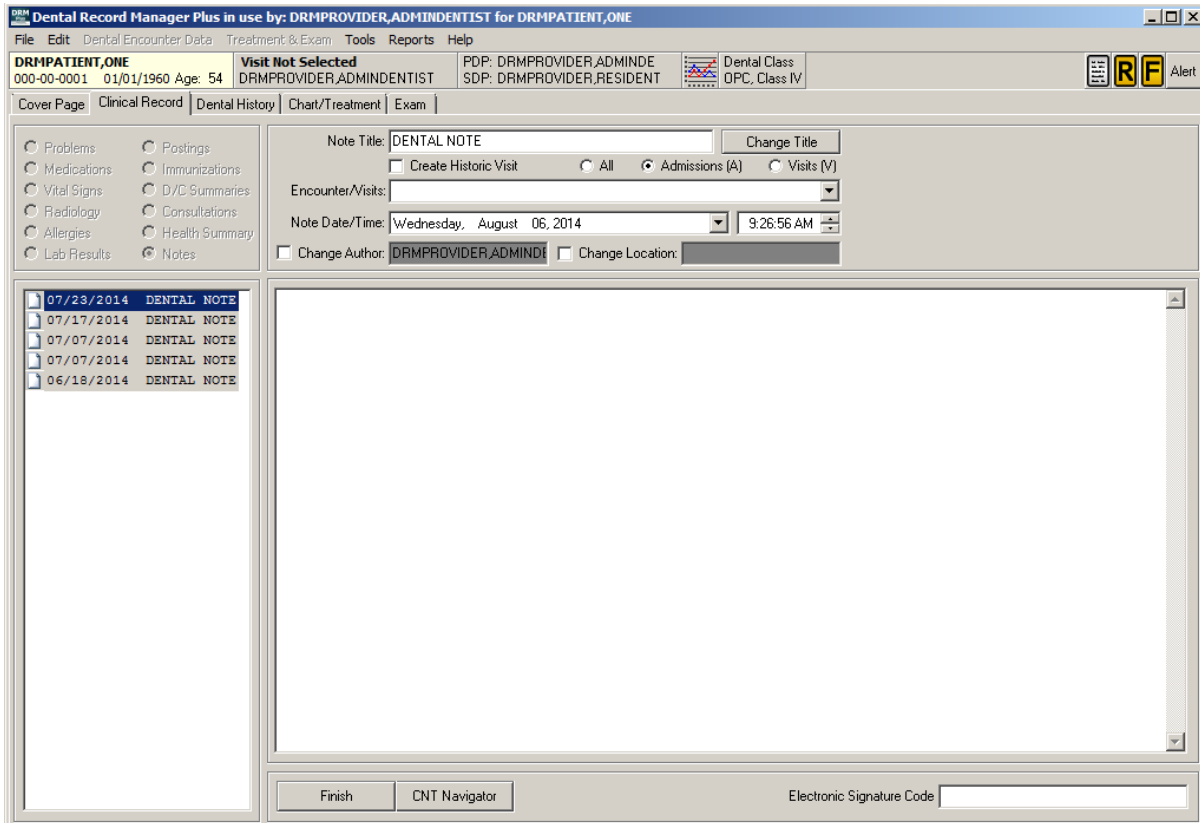


Figure 192: New TIU Progress Note without Any Procedures

4. Use the tools to create a historic visit or select a scheduled visit by using the drop-down menu.
5. Enter notation directly into the note.
6. Enter the Provider's electronic signature and click the **Finish** button to complete the note.

Note: Historical notes may be entered using this option.

Adding a New TIU Progress Note Addendum

Creating an addendum to a previously completed TIU progress note to provide additional information, or to clarify any issues, does **NOT** require entering an ADA/CPT procedure code. This type of addendum can be done from DRM Plus in the **Clinical Record** tab or in the CPRS GUI. An addendum that adds an ADA/CPT procedure to a signed note requires passing information to VistA PCE/DES and requires entering an ADA/CPT code through the **Completed Care** screen entry process.

To record a note addendum without an ADA/CPT procedure code:

1. Select the **note to be appended** from the list of notes.
2. The note displays in the viewer.
3. Right-click the area where the notes are listed to view the **Note Functions** menu.
4. Select **Addendum to a Note** from the menu. Only signed notes can have an addendum.
5. Type the note directly into the note viewer. Right-click on the note viewer to import menu information or cancel the note.

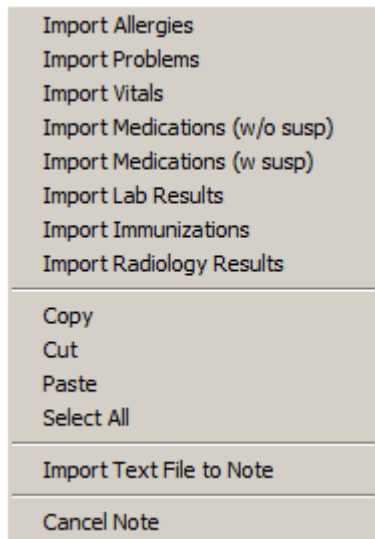


Figure 193: Import Menu Information Screen

6. Enter the provider's **Electronic Signature** and click the **Finish** button to add the addendum.
7. A confirmation screen displays. Click the **OK** button.

Note: If **Addendum to a Note** is selected in error, right-click the appended note and select the **Cancel Note** submenu.

Dental History

The **Dental History** tab displays all dental completed care information for each tooth and non-tooth entry filed in DRM Plus.

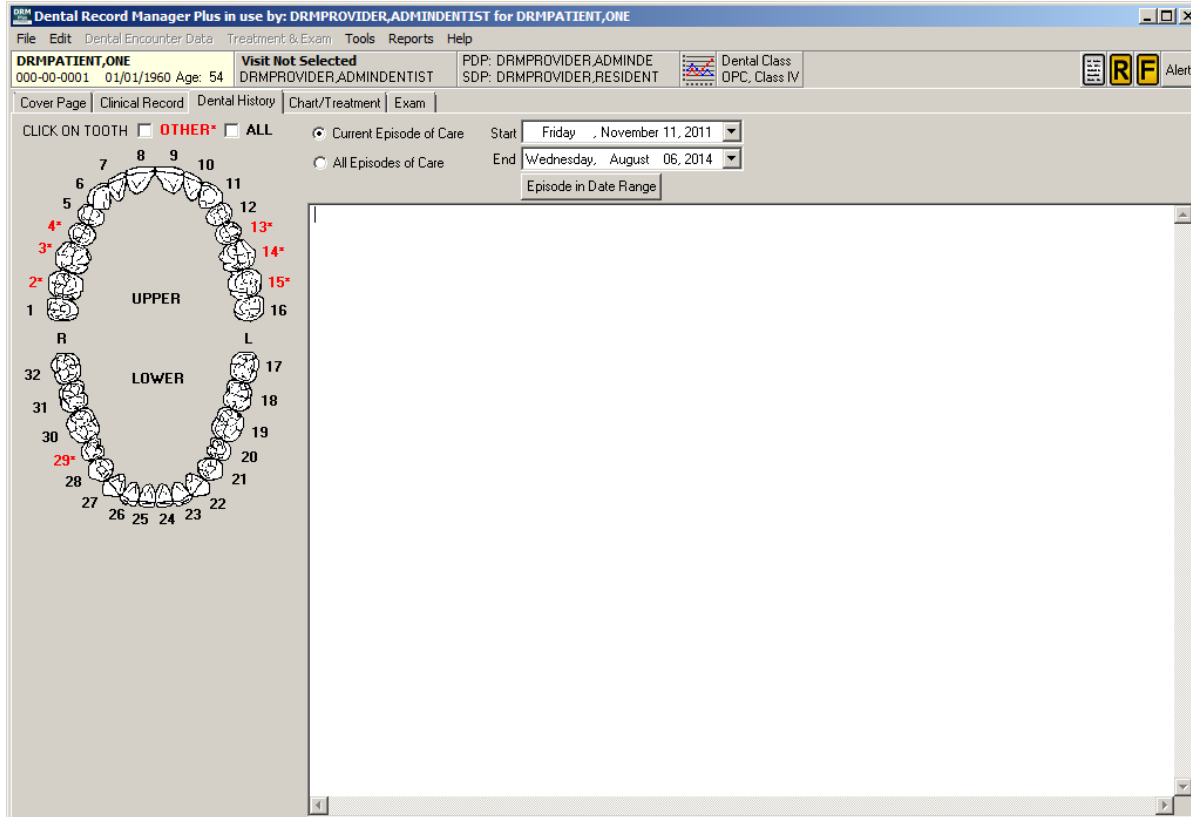


Figure 194: Dental History Tab

Viewing Dental Information By Tooth

To view dental information by tooth:

1. Click a **tooth** in the tab diagram. Teeth numbered in red with an asterisk have information associated with them. When a tooth is selected, the tooth graphic is colored red in the diagram.

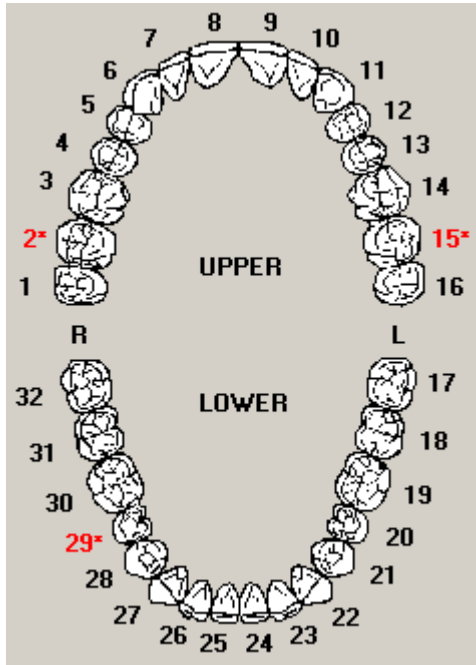


Figure 195: Dental History Teeth Diagram

2. Information about the selected tooth displays on the right side of the screen.
3. To de-select a tooth, click it again. The tooth graphic turns white and the information about the tooth is removed from the right side of the screen.

Viewing Other Dental History Information

To see dental history that is NOT listed by tooth, select the **Other** check box. The information displays on the right side of the screen.

Viewing All Dental History Information

To see all dental history associated with this patient, select the **All** check box. The information displays on the right side of the screen.

Viewing Dental History Information by Episode of Care

To view a patient's dental history by episode of care:

1. Choose whether to view the **Current Episode of Care** or **All Episodes of Care** by selecting the appropriate radio button.



Figure 196: Episode of Care Radio Buttons

2. Select the **tooth** or **teeth** to be viewed, or click the **Other** or **All** check boxes.
3. The information displays on the right side of the screen.

Episode in Date Range

To view a patient's dental history information by date:

1. Click the **Start** and **End** drop-down arrows.



Figure 197: Episode in Date Range

2. Use the calendar screen to choose the desired start and end dates.
3. Click the **Episode in Date Range** button. The results display on the right side of the screen.
4. Select the **tooth** or **teeth**, or the **Other** or **All** check boxes to view the desired information.

Deleting an Encounter

An erroneous dental history encounter may be deleted directly from DRM Plus. Only DRM Plus Administrators can delete filed dental history encounter data.

To delete an encounter:

1. Right-click in the large **window** on the tab. A pop-up button displays.

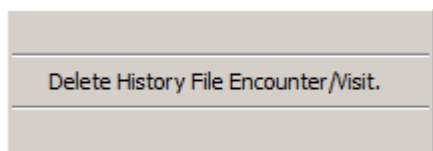


Figure 198: Delete History File Encounter/Visit Button

2. Select **Delete History File Encounter/Visit** button from the pop-up.
3. The **Delete Encounter/Visit Dental History** screen displays.

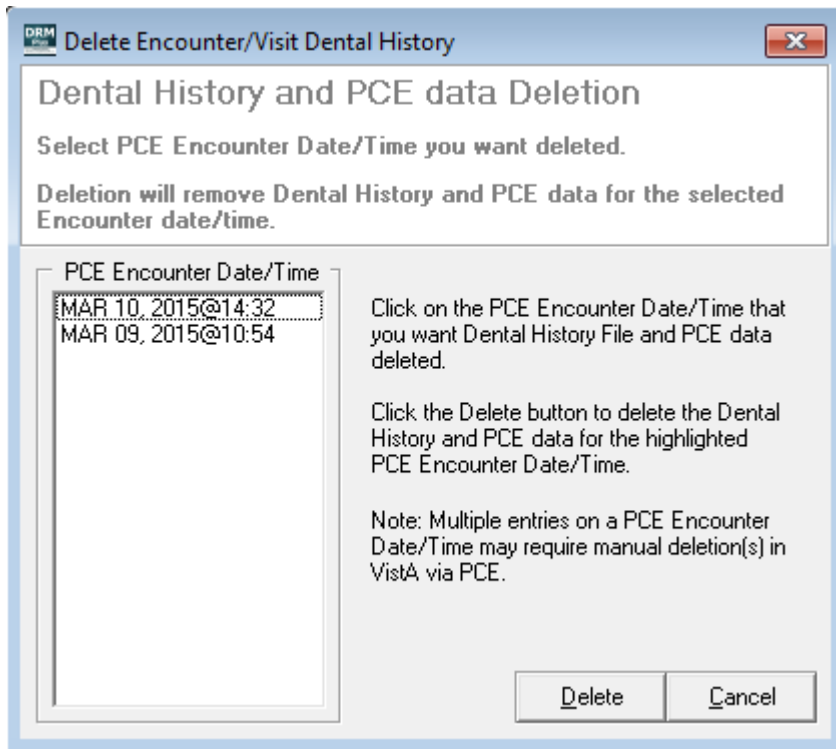


Figure 199: Delete Encounter/Visit History Screen

4. Select the **PCE Encounter Date/Time** from the list.
5. Click the **Delete** button. A confirmation screen displays.
6. Click the **OK** button. The PCE encounter dental data is deleted if there are no multiple entries.

Completed care transactions can also be deleted via the **Chart/Treatment – Treatment & Exam** screen. Please see the **Deleting Completed Care Line Item(s)** section, in the **Chart/Treatment – Treatment & Exam** chapter of this manual, for more information.

Note: Deleting information from the **Dental History** tab removes the entire encounter from the chart. Once an encounter is deleted, it cannot be recovered. DRM Plus automatically updates PCE encounter entries and deletes data from the VistA **PCE Encounter List**. Multiple entries on a **PCE Encounter List** may require manual deletion(s) in VistA via PCE.

Note: Local IT support follows local guidelines as to whether to append or hide the associated TIU (CPRS) Note.

Chart/Treatment – Treatment & Exam

There are two main sections to the **Chart/Treatment** tab: **Treatment & Exam** and **Periodontal Chart**.

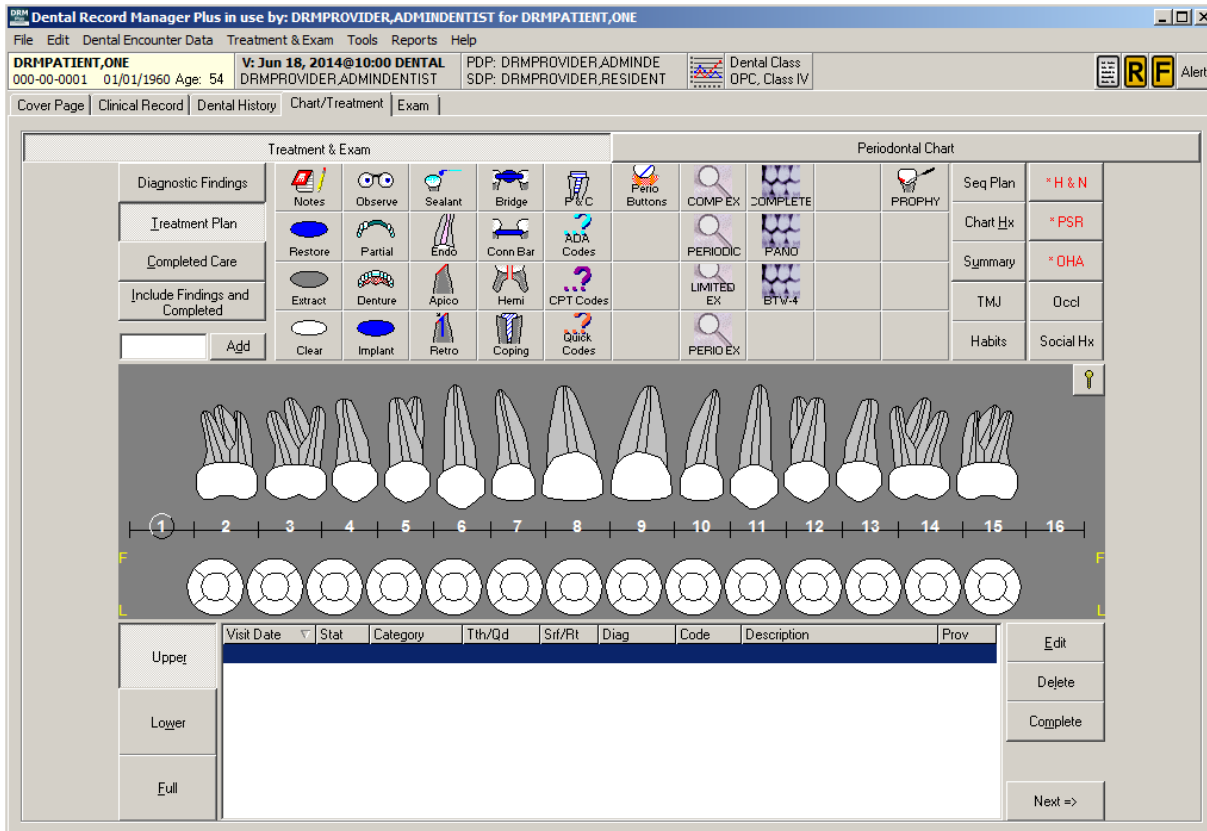


Figure 200: Chart/Treatment Tab Displaying Treatment & Exam Screen

The **Treatment & Exam** screen has several important component views. On the upper left side of the screen are the following functions: the **Diagnostic Findings**, **Treatment Plan** and **Completed Care** views, with their corresponding buttons. These tools are used to enter information on diagnostic findings, create treatment plans, view previously completed care, or enter dental procedures/diagnoses on today’s encounter. The **Include “...”** button allows the user to view information from a combination of the aforementioned views on one screen.



Figure 201: Diagnostic Findings, Treatment Plan, Completed Care and Include Buttons

The **Seq Plan** (Sequencing), **Chart Hx** (History), **Summary**, **TMJ**, **Habits** (Parafunctional), **H&N**, **PSR**, **OHA** (Oral Health Assessment), **Occl** (Occlusion), and **Social Hx** (History) buttons are on the upper right side of the screen.

* Seq Plan	* H & N
Chart Hx	PSR
Summary	* OHA
TMJ	Occl
Habits	Social Hx

Figure 202: Treatment & Exam Specialty Buttons

The center of the screen has a graphic display of all the teeth. Use the visual representation in combination with the **Diagnostic Findings**, **Treatment Plan** and **Completed Care** buttons and icons to enter information about the patient. There is also a **Key** button on the right side of the display that shows which conditions the various colors, patterns and symbols represent.

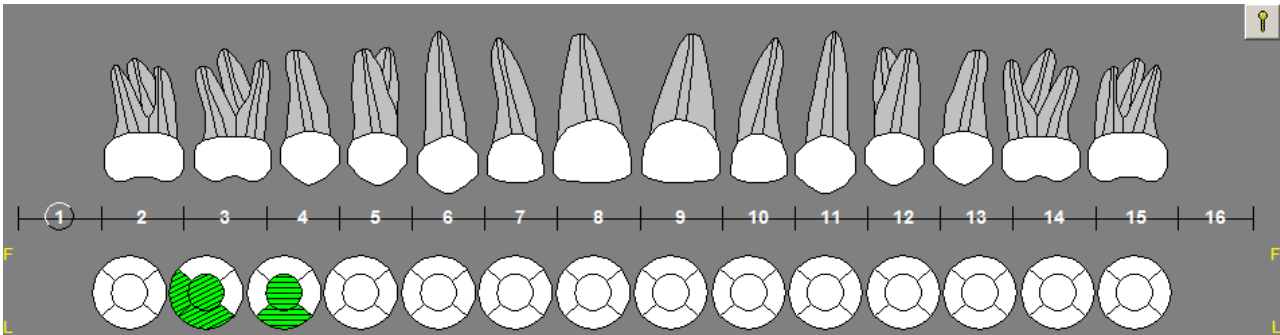


Figure 203: Completed Care Graphic Display

The lower portion of the screen has buttons to change the view in the graphic display. Additionally, the transaction table, which shows detailed information entered in the **Diagnostic Findings**, **Treatment Plan** and the **Completed Care** view screens. There are tool buttons to the right of the transaction table, which allow the user to **Edit**, **Delete** or **Complete** the planned treatment; the **Next** button moves on to updating the encounter. Toggle between the teeth of the upper and lower arch by clicking the **Upper** and **Lower** buttons to the left of the transaction table on the bottom section of the screen. The **Full** button allows the user to view both arches.

	Visit Date	Stat	Category	Tooth/Quad	Surf/Root	Diag	Code	Description	Prov	
Upper	10/07/2015	C	Restored	3	DOL	K02.52	D2160	AMALGAM THREE SURFACES PERI	ADP	Edit Delete Complete Next =>
	10/07/2015	C	Restored	4	DL	K02.52	D2392	POST 2 SRFC RESINBASED CMPST	ADP	
	10/05/2015	C	Diagnost			K02.62	D0210	INTRAOURAL FULL IMAGE SERIES	ADP	
Lower										
Full										

Figure 204: Completed Care Transaction Table

Diagnostic Findings

1. Click the **Diagnostic Findings** button on the left side of the screen.
2. Select the desired finding from the icons to the right of the **Diagnostic Findings** button.



Figure 205: Diagnostic Findings Button Active with Icons

3. Click the **tooth/area of the tooth** in the graphic display. Use the **Upper** and **Lower** buttons on the left side of the text display to view the arch and the previous diagnostic findings on the upper and lower arches.

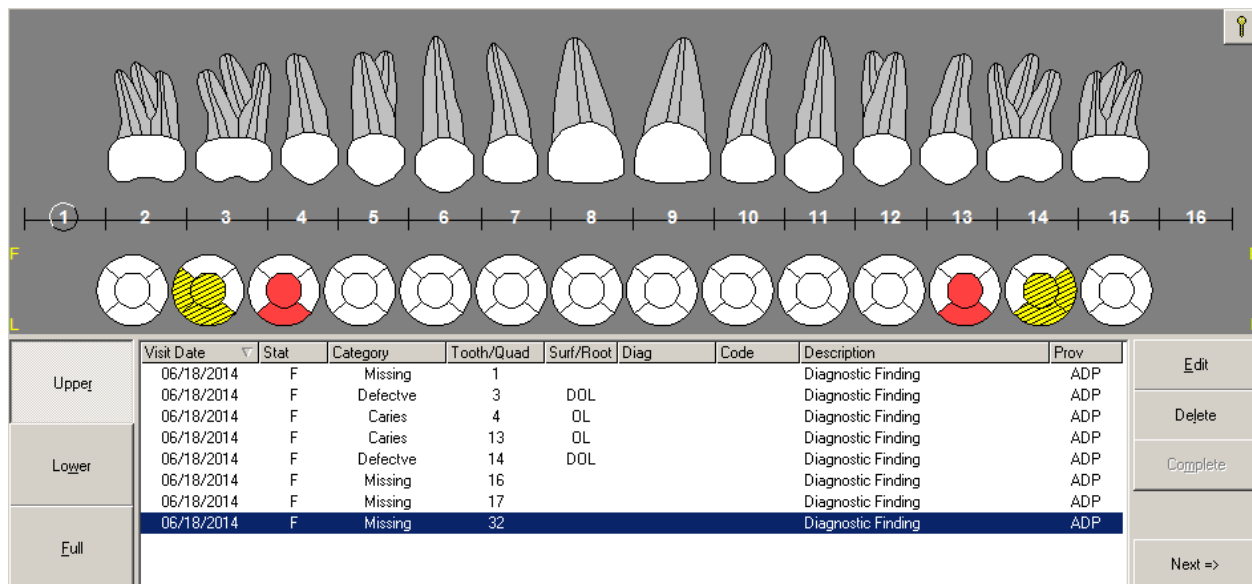


Figure 206: Diagnostic Findings Graphic Chart and Transaction Table

4. The finding appear in both the text and graphic display. Click the **Key** button in the upper right corner of the graphic display to see how various findings are shown in the graphic.
5. Use the **Clear** icon to remove any finding entered during today's encounter only. Click the **Clear** icon and then click the desired finding on the graphic to remove the finding from both the graphic and the transaction table.

Note: The **Stats** column in the transaction table displays an 'F' when the transaction is a finding.

Editing Diagnostic Finding Descriptions

Diagnostic Findings descriptions that have been entered, but for which no TIU progress note has yet been filed, can be edited.

To edit a diagnostic finding description:

1. Select the **finding** by highlighting it in the transaction table.
2. Click the **Edit** button to the right of the transaction table.
3. The **Edit Transaction** screen displays.

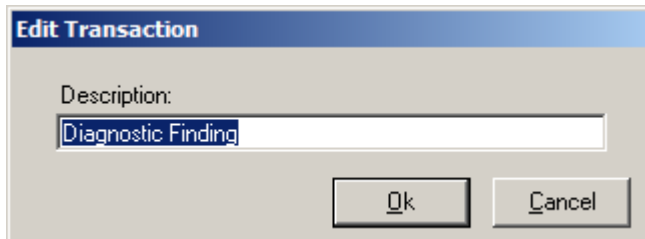


Figure 207: Edit Transaction Screen

4. Enter the new description in the text box. Note that only the description can be edited. The other information, such as **Visit Date, Tooth/Quad** or **Category** cannot be edited with this button.
5. Click the **OK** button. The edited information displays in the transaction table.

Deleting a Diagnostic Finding

Diagnostic Findings that have been entered, but for which no TIU progress note has yet been filed, can be deleted.

To delete a diagnostic finding:

1. Select the **finding** by highlighting it in the transaction table.
2. Click the **Delete** button on the right side of the transaction table.
3. The finding is deleted.

Note: If the user attempts to delete a finding that has already been filed with an old encounter, the item is removed from the graphic display, but remains in the transaction table with a line through it. The DRM Plus Administrator may delete the finding from the graphic and the transaction table, unless the transaction has previously been deleted by a DRM Plus non-Administrator.

Note: Clicking a transaction table **column heading** sorts the table. Generally in ascending order depending on the current view. Clicking the **column heading** a second time returns the table to the original descending view. This functionality works the same for all three **Treatment & Exam** transaction table views.

Treatment Plan

Entering a Treatment Plan

There are multiple ways to enter a planned procedure code for a patient: by adding the code directly utilizing the **Add** button with text box, or by selecting the icon that corresponds to the planned treatment and choosing the tooth from the graphic display. Use the **ADA Codes** icon, **CPT Codes** icon, **Quick Codes** icon or **Personal Speed Code** icon as additional ways to enter planned treatment for the patient.

Rules for entering a procedure code for a planned item in the **Treatment Plan** view include:

1. Always use a **standard** icon, first four columns and P&C, if one is available first.
2. When **NO** standard icon is available, use the **ADA Codes**, **CPT Codes**, **Quick Codes** or a **Speed Code** icon.
3. The **Add** button with text box may be used interchangeably with rule 2.
4. Always enter transactions in the same order that they are performed on the patient.



Figure 208: Treatment Plan Button Active with Icons

To enter a planned treatment using the **Add** button and text box:

1. Click the **Treatment Plan** button. Notice that the **Add** button and text box are active.
2. Type a word or procedure code into the **Add** text box and click the **Add** button.
3. The **Code Details** screen displays if the procedure code is tooth or quadrant related.

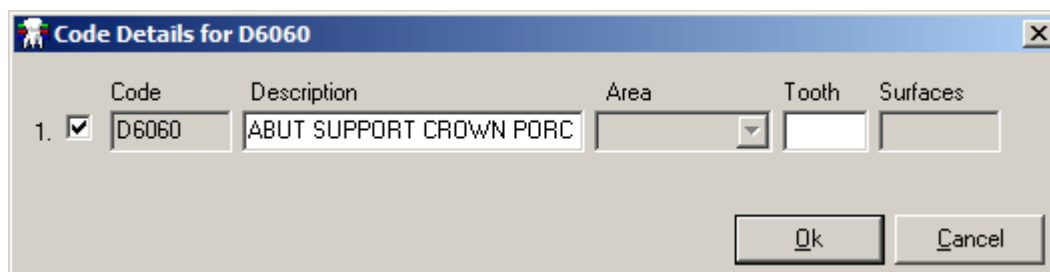


Figure 209: Code Details Screen

Enter the **Tooth** number and, if applicable, the **Area** or **Surfaces** modifiers and click the **OK** button. The graphic and the displays adjusts to reflect the addition.

Note: When surface modifiers are required for a procedure code, they must be entered using uppercase letters (**M, O, D, F, B, L, and I**). When root modifiers are required for a procedure code, they must be entered using lowercase letters (**r, b, l, d, and m**).

To enter a planned treatment using the standard **Treatment Plan** icons:

1. Click the **Treatment Plan** button.
2. Click the icon to the right that corresponds to the desired planned treatment.
3. Click the appropriate **tooth, area** and/or **surface**.
4. As in diagnostic findings, toggle between the upper and lower arch by clicking the **Upper** or **Lower** button on the left side of the display.
5. The graphic display and the transaction table display the new addition.

To enter a planned treatment using the **ADA Codes** icon or the **CPT Codes** icon:

1. Click the **ADA Codes** icon.



Figure 210: ADA, CPT and Quick Codes Icons

2. The **Procedure Code** selection screen displays for the selection.

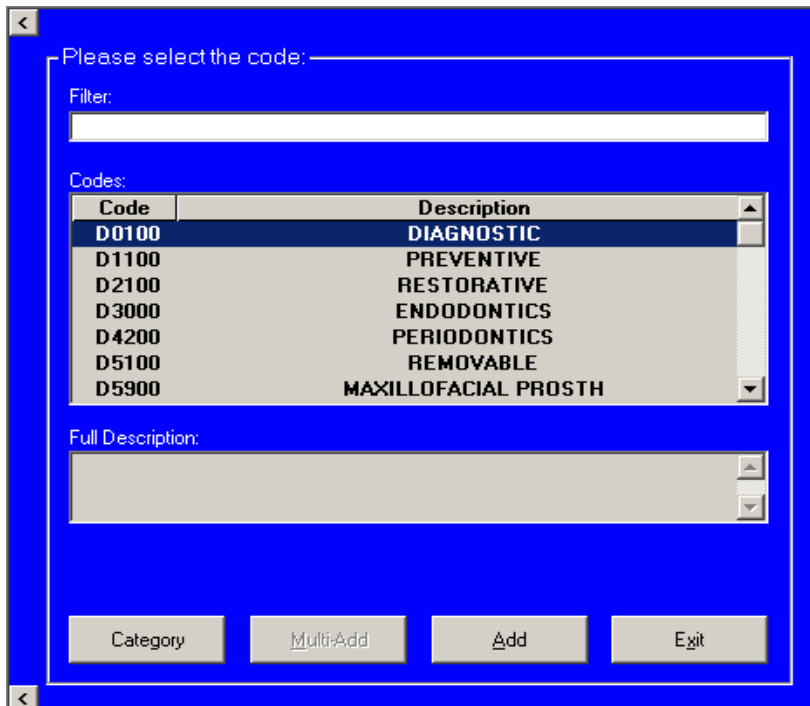


Figure 211: Procedure Code Selection Screen

3. Type the **procedure code** into the filter, or use the scroll bar to search for a code.
4. A description of the highlighted procedure code displays in the **Full Description** text box.
5. Click the **Category** button to return to the list of categories at the top of the scroll sheet. Click the **Multi-Add** button to add multiple procedure codes on other teeth.
6. When the desired code is highlighted, click the **Add** button.
7. If the procedure code needs to be attached to a specific tooth and surface modifier, the **Code Details** screen displays.

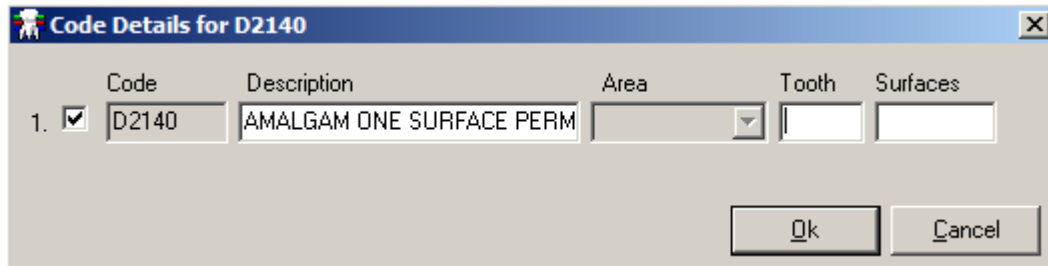


Figure 212: Code Details Screen

8. Fill in the fields with the requested information and click the **OK** button.
9. The **Diagnosis Code** screen displays if the parameter is activated.
10. Select the planned treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does **NOT** appear, use the **Additional Diagnosis Code Search** to find a different diagnosis code.
11. Click the **OK** button. The information displays in the transaction table on the graphic chart.
12. To undo any graphical entry on today's encounter, use the **Clear** icon as described in the **Diagnostic Findings** section of this chapter.

Entering a planned treatment using the **Quick Codes** icon is similar to adding a planned treatment with the **ADA Code** icon. To enter a planned treatment using the personal **Speed Code** icons, please see the **Periodic Buttons** section later in this chapter.

Editing a Treatment Plan Description

1. Select the desired planned entry in the transaction table.
2. Click the **Edit** button. The **Edit Transaction** screen displays.

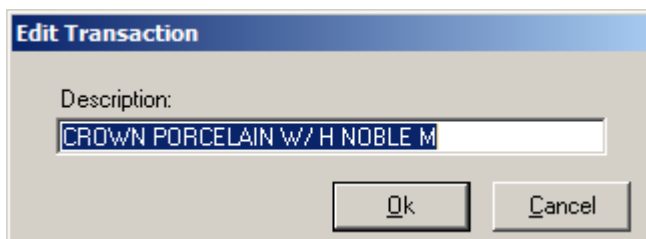


Figure 213: Edit Transaction Screen

3. Enter the new description in the text box.
4. Click the **OK** button.
5. The Description is changed in the transaction table. Note that the Code, Category and other information cannot be changed with the **Edit** button.

Deleting a Treatment Plan

1. Select the desired planned entry in the transaction table.
2. Click the **Delete** button.
3. The planned treatment is removed from the graphic and the transaction table.

Every DRM Plus user is allowed to delete any planned item, regardless of who entered it. The planned entry is removed from the graphic and transaction table in the **Treatment Plan** and **Sequencing** screens.

Completing a Treatment Plan

1. Select the planned procedure to be completed from the transaction table.
2. Click the **Complete** button.
3. The **Diagnosis Code** screen displays.

Completed Care Code: D2391, in use by: DRMPROVIDER_ADMINDENTIST, for: DRMPATIENT_ONE

Includes prep, etchant, liners, bases, adhesives, curing, etc. Glass ionomers are included in this group. If pin(s) are used, also include code D2951.

Select your Completed Procedure(s) on the left and their related Diagnosis Code(s) on the right.
If the suggested codes are not applicable or are blank, use the Code Search to find the appropriate diagnosis code(s).

Tooth#/Surface(s): 28 / L

K02.52--DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRATING INTO DENTIN
 K02.62--DENTAL CARIES ON SMOOTH SURFACE PENETRATING INTO DENTIN
 K02.7--DENTAL ROOT CARIES
 K03.0--EXCESSIVE ATTRITION OF TEETH
 K03.1--ABRASION OF TEETH
 K03.81--CRACKED TOOTH
 K08.51--OPEN RESTORATION MARGINS OF TOOTH
 K08.52--UNREPAIRABLE OVERHANGING OF DENTAL RESTORATIVE MATERIALS
 K08.530--FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL
 K08.531--FRACTURED DENTAL RESTORATIVE MATERIAL WITH LOSS OF MATERIAL
 K08.54--CONTOUR OF EXISTING RESTORATION OF TOOTH BIOLOGICALLY INCOMPATIBLE WITH ORAL HEALTH
 K08.56--POOR AESTHETIC OF EXISTING RESTORATION OF TOOTH

Additional Diagnosis Code Search
<Type 3 or more characters and press enter.>

Primary	Selected Procedure(s)	Selected Diagnosis(es)

General Coding Standards File in PCE File in Dental History

OK Cancel

Figure 214: Diagnosis Code Screen

4. Select the planned treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side of the screen. If the correct diagnosis code is **NOT** listed, use the **Additional Diagnosis Code Search** to find a different diagnosis code.
5. Notice the **File in PCE** check box. If the completed treatment is **NOT** to be filed in **PCE**, uncheck this box.
6. Click the **OK** button.

- The planned procedure is removed from the transaction table and is now part of **Completed Care** transactions for the patient.

Note: When no diagnosis code(s) are mapped to (or listed with) a procedure code on the **Diagnosis Code** screen the **Additional Diagnosis Code Search** must be used to find the appropriate diagnosis code(s) to be filed with the selected procedure code.

Note: The **PCE** check box option should only be used by advanced users. Changing this option effects the data being sent to VistA PCE. Do **NOT** change this check box unless the user does **NOT** want the data to be sent to VistA PCE.

Note: Planned procedure codes can be designated with or without a related diagnosis. The parameter change for users to acquire this functionality is **Tools menu → User Options submenu → Treatment System tab → select the top check box.**

Completed Care

Click the **Completed Care** button to see all treatments that have been previously completed in the VA for the patient, or entering any new completed treatment for today's visit.



Figure 215: Completed Care Button Active with Icons

The rules for entering a procedure code for a completed treatment in the **Completed Care** view include:

- Always use a **standard** icon, first four columns and P&C, if one is available first.
- When **NO** standard icon is available use **ADA, CPT, Quick Codes** or a **Speed Code** icon.
- The **Add** button and corresponding text box may be used interchangeably with rule 2.
- Always enter transactions in the same order they are performed on a patient.

Entering Completed Care

There are several ways to enter completed treatment. Planned treatments, which are completed (see Completing a Treatment Plan), display in the **Completed Care** transaction table. Completed treatment can also be entered manually:

- Click the **Completed Care** button.
- Select the desired associated **standard** icon.
- Choose the appropriate tooth/area on the graphic display.
- Complete the **Diagnosis Code** screen.

5. The entry displays in the graphical/transaction table.
6. To undo any graphical entry on today's encounter, use the **Clear** icon as described in the **Diagnostic Findings** section of this manual.

Completed treatment can also be entered through the **Add** button and text box; the **ADA**, **CPT** and **Quick Codes** icons, as well as the **Speed Code** icons. Please see the **Treatment Plan** section of this manual for further information on these functions.

Editing Completed Care Description

Completed Care description can only be edited if it has NOT yet been made a part of the TIU progress note. To edit a completed care entry:

1. Choose a completed care entry from the transaction table.
2. Click the **Edit** button.
3. The **Edit Transaction** screen displays.

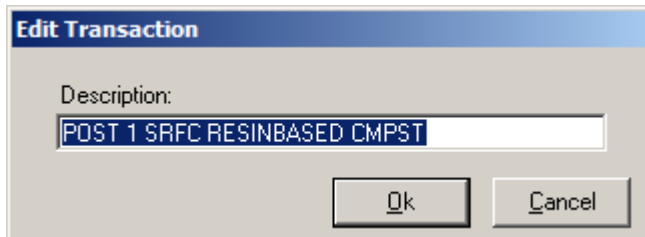


Figure 216: Edit Transaction Screen

4. Type the new description into the text box.
5. Click the **OK** button. Note that only the description can be edited.

Deleting a Completed Care

1. Click the desired completed entry in the transaction table.
2. Click the **Delete** button.
3. The completed treatment is removed from the graphic and transaction tables.
4. To finalize the deletion, the encounter with the patient must be completed and filed. See the **Completing the Encounter** chapter of this manual for further information.

Only DRM Plus Administrators may delete line item entries, and this updates only DRM Plus charting, VistA DES and VistA PCE. VistA TIU progress notes viewed in CPRS are not updated. If the deleted completed transaction was associated with the **Primary Diagnosis** for the visit in which it was originally entered, a new **Primary Diagnosis** for the encounter must be entered. The **PCE Select Primary data** screen displays after the **Electronic Signature** is entered, so that a new **Primary Diagnosis** can be chosen. Click the desired diagnosis (Dx) code/description check box, then click the **OK** button.

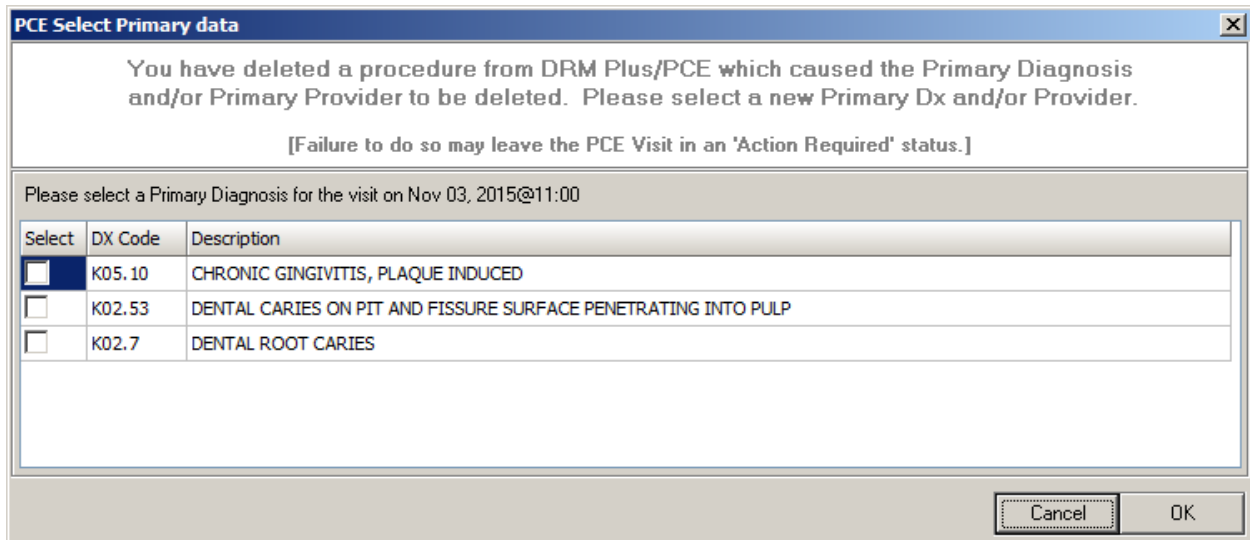


Figure 217: PCE Select Primary Data Screen

Note: The DRM Plus Administrator should follow local guidelines as to whether they append the associated TIU progress note, or have some other guideline option.

Note: To delete all entries from a dental encounter, never use the line item deletion in **Completed Care** screen. Instead, delete the entire dental encounter in the **Dental History** tab. Please see the Deleting an Encounter section in the Dental History chapter of this manual for further information.

Include “Completed”/Include “Findings and Completed”/Include “Findings”

This button can be used in conjunction with the other buttons to include more than one type of information on the display. When the **Diagnostic Findings** button is active, and the associated information is displayed in the graphic and transaction tables, clicking this button adds the **Completed Care** information to the display. If the **Treatment Plan** button is active, and the associated information is displayed, clicking this button adds the **Diagnostic Findings** and the **Completed Care** information to the graphic and transaction tables. Finally, when the **Completed Care** button is active, and the associated information is displayed, clicking this button adds the **Diagnostic Findings**.

Perio Buttons Icon

The icon table includes the **Perio Buttons** icon. Click this **Perio Buttons** icon to see the second set of speed codes associated with perio mode, if entered by the user. Please see the Speed Codes section in the Using the DRM Plus Drop-Down Menu chapter of this manual for further information.

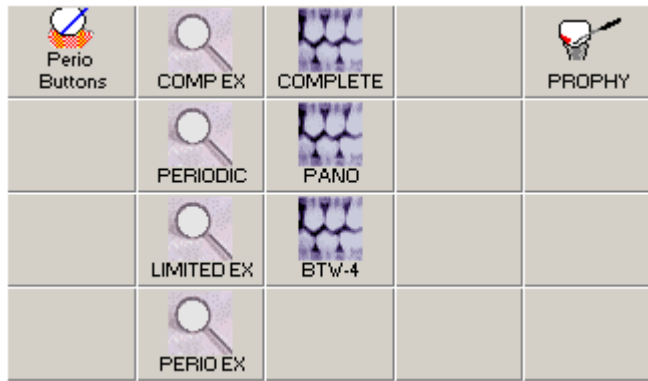


Figure 218: Perio Buttons and Speed Code Icons

This option is only available while **Treatment Plan** or **Completed Care** are active, but NOT with **Diagnostic Findings**.

Click the desired icon to add it to the planned treatment. If these buttons are clicked when **Completed Care** screen is active, the **Diagnosis Code** screen displays, which allows the selection of diagnosis codes that are mapped to that procedure code to be entered.

To change the location of the speed code icon:

1. Click one of the **blank** icons where the speed code icon is to be moved.
2. The **Configure Button** screen displays.

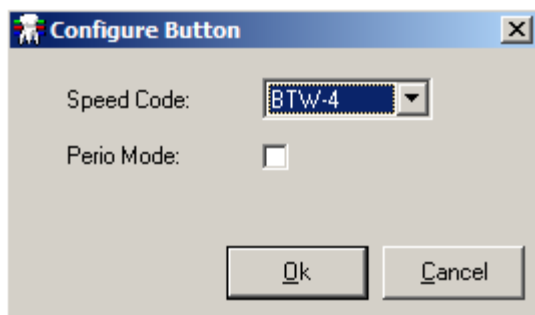


Figure 219: Configure Button Screen

3. Use the drop-down menu to assign the speed code.
4. Use the **Perio Mode** check box to link the speed code icon with the **Perio Buttons** icon.
5. Click the **OK** button. The old speed code icon location is cleared and the speed code icon is now in the new assigned icon location.

Seq Plan/Sequencing Button

Use sequencing in combination with the **Treatment Plan** screen to organize when to perform specific planned treatment. There are nine buttons on the **Tx Planning/Sequencing** screen. The nine buttons are **Add Phase**, **Add Sub-phase**, **Add Non-VA Care Phase**, **Copy Non-VA Care Phase to Clipboard**, **Copy All to Clipboard**, **Print**, **Save & Exit**, **Save** and **Cancel**. The **Tx Planning/Sequencing** screen has the nine buttons positioned or grouped on the right side of the screen.

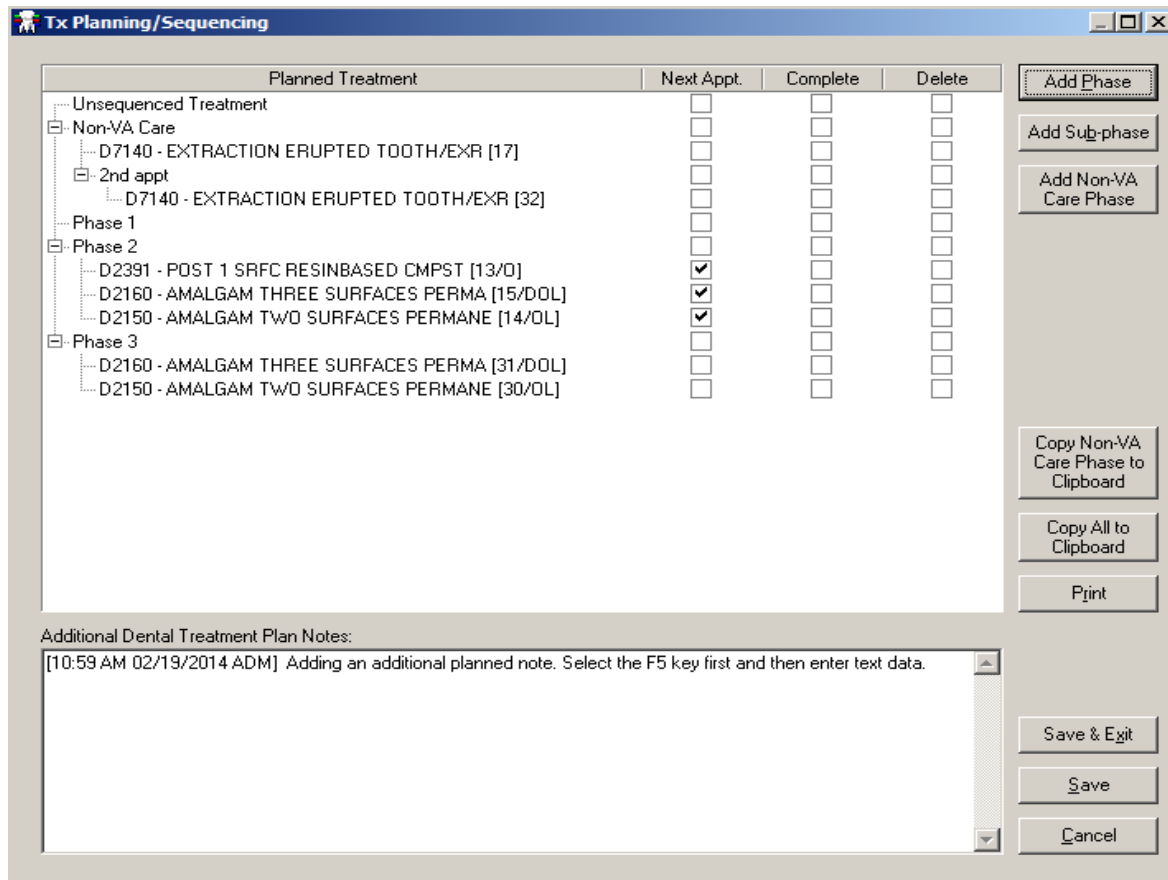


Figure 220: Tx Planning/Sequencing Screen

All planned transactions sequenced into a **Phase 1**, **Phase 2**, etc. and with all sub-phases associated with numbered phases has full functionality of **Next Appt.**, **Complete** and **Delete** check boxes.

The **Add Non-VA Care Phase** button allows only one **Non-VA Care** phase to be added. The **Non-VA Care** phase will be listed below the **Unsequenced Treatment** and above **Phase 1**. Users may add an unlimited number of sub-phases in a **Non-VA Care** phase. When trying to add a second **Non-VA Care** phase a warning message appears stating that only one **Non-VA Care** phase may be added.

The **Next Appt.** and **Complete** check boxes for the **Non-VA Care** phase are inactive; if selected, an informational screen appears stating these check boxes may **NOT** be used in the **Non-VA Care** phase. The **Delete** check box remains active for the **Non-VA Care** phase and all of **Non-VA Care** sub-phases.

Note: The DRM Plus user should delete a planned **Non-VA Care** phase, sub-phases and transactions after receiving verification from the Non-VA Care provider that the procedure(s) has/have been completed.

The two buttons of **Copy Non-VA Care Phase to Clipboard** and the **Copy All to Clipboard** when selected will allow the user to copy the planned transactions listed in the Tx Planning/Sequencing screen. The copied data includes filed and unfiled planned treatment from only the Tx Planning/Sequencing screen to paste on any word document, text document or any application window if allowed.

The end-user may use the <F5> key now in the **Additional Dental Treatment Plan Notes** to import a date/time stamp identifier before or after the text entry if desired.

Plan a Treatment Sequence

1. Click the **Seq Plan** (Sequencing) button.
2. The **Tx Planning/Sequencing** screen displays.
3. Information from the **Treatment Plan** transaction table is shown on the screen. Use the **Add Phase, Add Sub-phase** or **Add Non-VA Care Phase** buttons to add a new phase and/or sub-phase. Highlight the desired phase listed in the screen to add the sub-phase under this phase.
4. Change the sequence of the planned treatments by dragging and dropping them into the correct phase.
5. If the planned treatment is to be completed at the next appointment, click the corresponding check box. **Non-VA Care** phase is NOT allowed a next appointment.
6. Add **Additional Dental Treatment Plan Notes** in the text box.
7. Click the **Save & Exit** button if only planned items have been added or sequenced for this patient. This option requires that NO new data be entered as completed transactions, Perio, H&N or any other modal at the same time for the option to work.
8. Click the **Save** button to save the progress in sequencing and keep working on this encounter.

Note: Always enter planned treatment in the same order they are performed on a patient.

Note: The **Save & Exit** button from the sequencing screen files any changes and minimize DRM Plus. Any new planned entries added have the same **Visit** date as the latest TIU progress note filed on this patient. The most recent dental encounter must have an **Active** status for this feature to work.

Complete a Planned Treatment in the Sequencing Screen

1. Click the **Seq Plan** (Sequencing) button.
2. The **Tx Planning/Sequencing** screen displays.
3. Choose the planned treatment that is to be completed by checking the corresponding check box in the **Complete** column. **Non-VA Care** phase is NOT allowed to be completed in the **Tx Planning/Sequencing** screen.
4. Click the **Save** button.
5. The **Diagnosis Code** screen displays. Please see the Completing a Treatment Plan portion in the Treatment Plan section of this chapter for further information.

Deleting a Planned Treatment in the Sequencing Screen

1. Click the **Seq Plan** (Sequencing) button.
2. The **Tx Planning/Sequencing** screen displays.
3. Choose the planned treatment that is to be deleted by checking the corresponding check box in the **Delete** column. The DRM Plus user should delete a planned **Non-VA Care** phase, sub-phases and transactions after receiving verification from the Non-VA Care provider that the procedure(s) has/have been completed.
4. Click the **Save** button.
5. The planned treatment is deleted from the sequencing screen, the transaction table and the graphical chart on the **Treatment Plan** screen.

Chart Hx (History) Button

Click the **Chart Hx** button to see a completed care chart of the patient's dental history. The transaction table includes the text details of the **Visit Date, Stat, Category, Tooth/Quadrant, Surface/Root** modifiers, **Codes, CPT Description** and **Provider** initials.

The screenshot shows the 'Tx History' window with an appointment date of 10/07/2015. The dental chart displays teeth 1-16 (upper) and 17-32 (lower). Teeth 2 and 3 in the upper arch are highlighted in green. Below the chart is a table of transactions:

Visit Date	Stat	Category	Tooth/Quad	Surf/Root	Diag	Code	Description	Prov
10/07/2015	C	Restored	3	DOL	K02.52	D2160	AMALGAM THREE SURFACES PERMA	ADP
10/07/2015	C	Restored	4	DL	K02.52	D2392	POST 2 SRFC RESINBASED CMPST	ADP
10/05/2015	C	Diagnost			K02.62	D0210	INTRADURAL FULL IMAGE SERIES	ADP

Figure 221: Tx History Screen

Use the **Appointments** drop-down menu to see the patient's history by different appointment dates. View tooth notes on the patient's file by clicking the **Notes** button tied to the note's appointment date.

Note: To display any past tooth-specific note, click the **Chart Hx** button. Continue by clicking the drop-down arrow of the **Appointment** field, in the top left corner of the **Tx History** screen, and selecting the appropriate date the tooth-specific note was entered. Once the date is selected, the tooth numbers in the graph displays in yellow. Once the desired tooth is found, click the **Notes** button. Then use the drop-down arrow to select the tooth-specific note of interest and view its contents.

Summary Button

Click the **Summary** button to view a summary of a patient’s chart. Periodontal information displays in the summary as well.

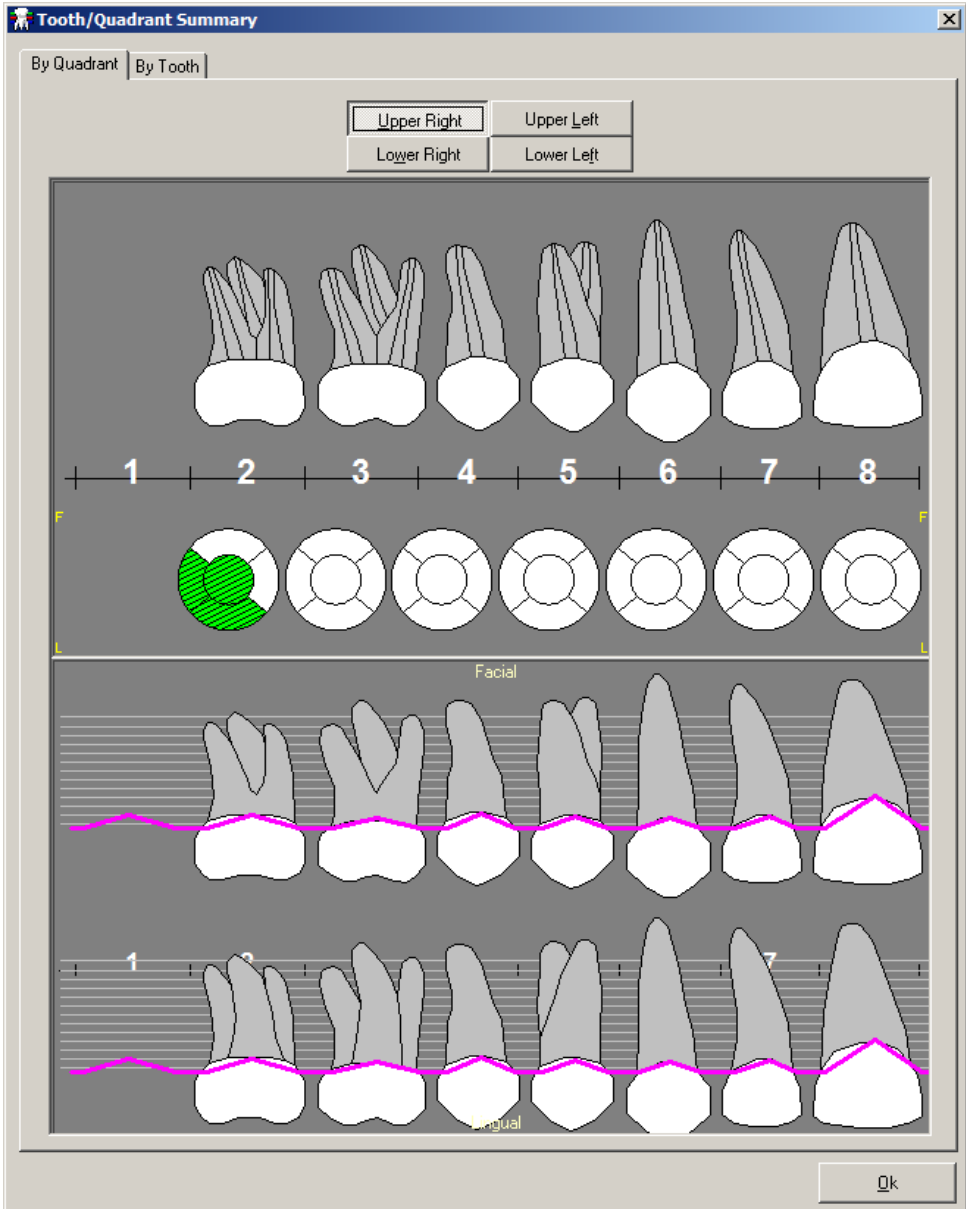


Figure 222: Tooth/Quadrant Summary Screen

Use the tools on the screen to view the information by quadrant or by tooth.

Note: On the **Treatment & Exam** screen, with the following views: **Diagnostic Findings**, **Treatment Plan** or **Completed Care**, clicking the **Summary** button displays the history of the selected primary view. The upper half of the window shows the summary of the primary view that is active when the **Summary** button is selected. Only the activated primary view, with all of its entries, displays in the restorative top window. The lower half of the screen displays the periodontal summary, which includes the latest exam in periodontal history with filed **Diagnostic Findings** and **Completed Care**; however, NOT including surfaces or roots.

H&N Button

Use the functions in the **H&N** (Head and Neck) button to enter and view diagnostic information on the patient's head and neck.

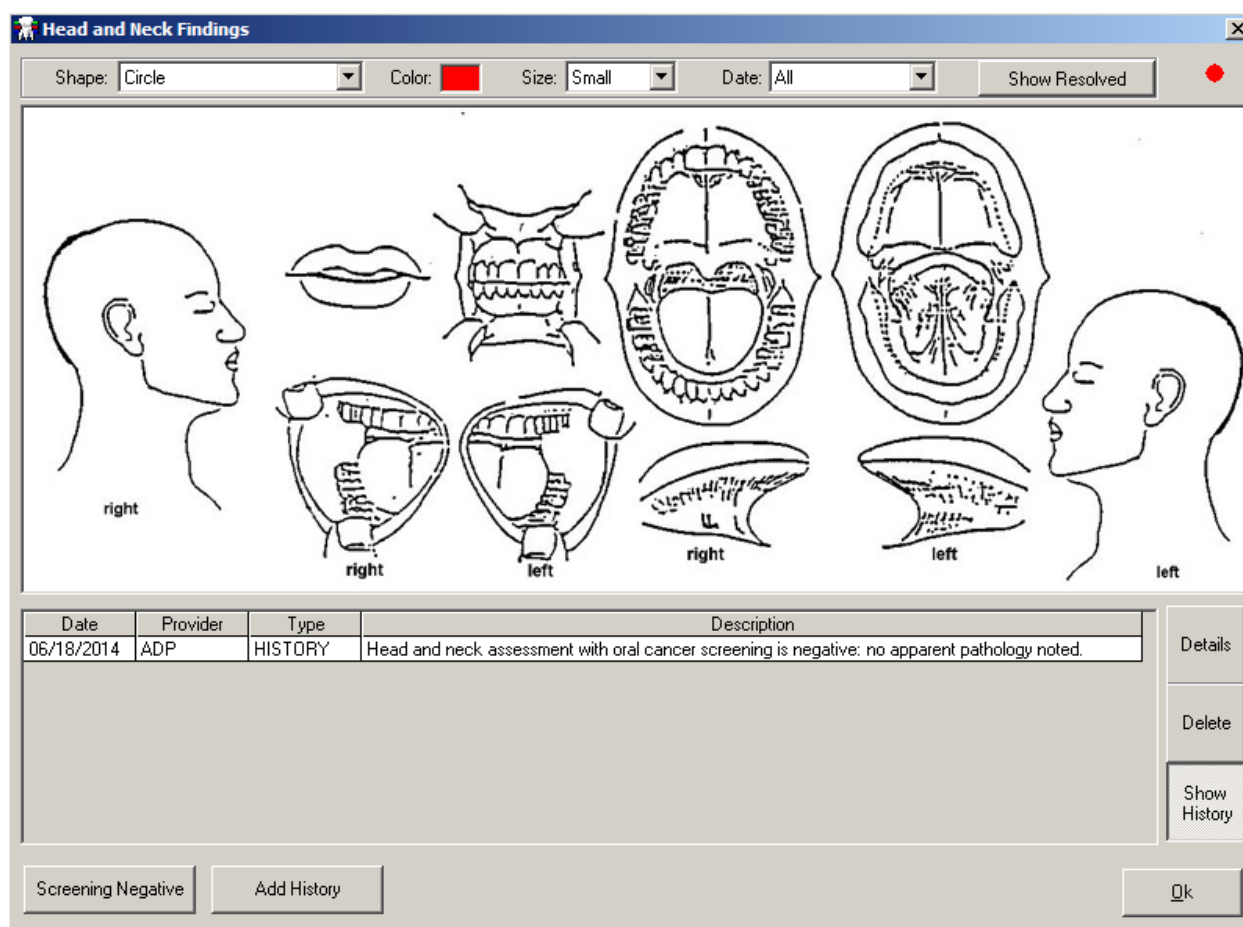


Figure 223: Head and Neck Findings Screen

To enter an H&N finding:

1. Select the graphic shape that best represents the finding by using the **Shape** drop-down menu.
2. Select the contrasting color for the finding by clicking the **Color** box. A visual list of possible colors displays.
3. Select the size of the graphic by using the **Size** drop-down menu.

4. The date box defaults to **Today**, which is required for new data entries. After the first filed TIU progress note entry of H&N, the date box defaults to **All**. The user may click the drop-down arrow and highlight a previous exam to view the entries on a previous date.
5. Click the graphic to show where the lesion is located on the patient.
6. The **H&N Detail** screen displays.

Date	Provider	Description
07/07/2014	ADP	Cancerous condition

Common Findings

Progress

Resolved

Save

Cancel

Figure 224: H&N Detail Screen

7. Enter the description of the lesion in the **Description** column, or click the **Common Findings** button to see a list of commonly appearing lesions and add the description to the finding.
8. Click the **Save** button. The finding displays on the **H&N Findings** transaction table.

To add new details of an H&N finding:

1. Click the desired **finding** in the **H&N Findings** transaction table and click the **Details** button.
2. The **H&N Detail** screen displays with progress information to be entered.

The screenshot shows a window titled "H & N Detail" with two main sections: "Initial Finding" and "Progress".

Initial Finding: A table with columns "Date", "Provider", and "Description". The data row shows "07/07/2014", "ADP", and "Cancerous condition". To the right of the table is a button labeled "Common Findings".

Progress: A table with columns "Date", "Provider", and "Description". The data row shows "07/07/2014", "ADP", and "<<Enter description>>".

At the bottom right of the window, there is a checkbox labeled "Resolved" (which is unchecked), a "Save" button, and a "Cancel" button.

Figure 225: H&N Detail Screen with Progress Description Activated

3. Enter information in the **Description** column of the **Progress** window.
4. Click the **Save** button to save the entered information and return to the **H&N Findings** screen.

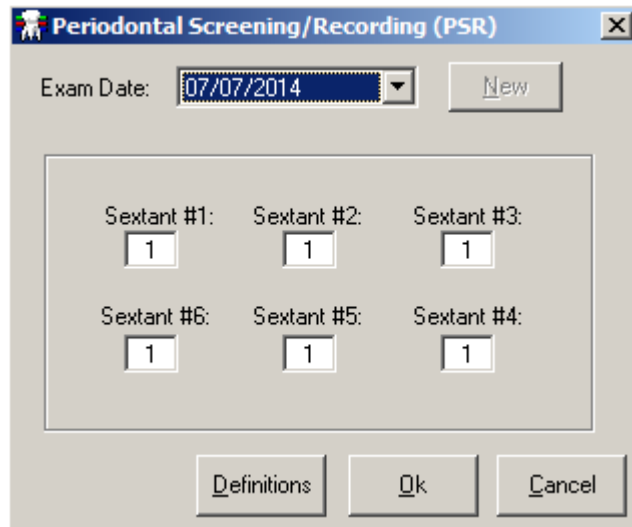
To delete a lesion:

1. Highlight the **finding** entry on the **H&N Findings** transaction table.
2. Click the **Delete** button.
3. A screen confirming that the entry is to be deleted displays. Click the **OK** button. Note that this screen only displays if the finding entry is made during this session.
4. The entry and the mark on the **H&N Findings** graphic is removed if entered this session.

Note: Clicking the **Delete** button deletes the highlighted finding entry(s) during the same session the **H&N Findings** transaction was entered. Deleting any filed **H&N Findings** transaction by any DRM Plus end-user results in a line through the entry, and it remains in the transaction table.

PSR Button

Click the **PSR** button to view the **Periodontal Screening/Recording (PSR)** screen. Use this screen to view previously entered PSR information if present, or to enter new PSR information.



The screenshot shows a dialog box titled "Periodontal Screening/Recording (PSR)". At the top left, there is a label "Exam Date:" followed by a dropdown menu showing "07/07/2014" and a "New" button. Below this is a large rectangular area containing six text boxes arranged in two rows of three. The top row is labeled "Sextant #1:", "Sextant #2:", and "Sextant #3:". The bottom row is labeled "Sextant #6:", "Sextant #5:", and "Sextant #4:". Each text box contains the number "1". At the bottom of the dialog box are three buttons: "Definitions", "Ok", and "Cancel".

Figure 226: Periodontal Screening/Recording (PSR) Screen

Use the **Exam Date** drop-down menu to view past periodontal screening information.

To enter new information:

1. Click the **New** button. All the **Sextant** text boxes will default to a 0 dental value.
2. Enter the desired national dental value in each **Sextant** text box. Entering an "*" requires a number added with the symbol to be saved (i.e., "3*").
3. Click the **Definitions** button to view PSR definitions of national dental values.
4. Click the **OK** button to complete.

Note: The **PSR** modal allows two providers to enter a PSR exam on the same day; however, it only displays the last PSR exam that was entered on that day. The first entered PSR exam is only viewable in the TIU progress note of the provider that filed the encounter. The second provider's filed note has a different header, which includes the word 'modified' in the PSR exam of the TIU progress note.

OHA (Oral Health Assessment) Button

The specialty **Plaque** button was combined with **Xerostomia**, **Caries Risk** and **Oral Hygiene** to create the **OHA** button. This also applies to the **Plaque** button on the **Periodontal Chart** screen.

To enter new data in the **Oral Health Assessment (OHA)** screen, click the **New** button. Today's date is imported into the **Date** field on the screen.

Date	Provider	NFT	PI	X	CR	OH
06/18/2014	ADP		2	0	1	1

Figure 227: Oral Health Assessment (OHA) Screen

The **NFT** check box, **Patient has no remaining functional teeth, roots or implants;** may be selected in the event the patient meets these criteria and no findings can be entered in the **Diagnostic Findings** chart.

Checking this box automatically completes the **Diagnostic Findings** element and the **Periodontal Assessment** element when filing any exam/consult code during a dental encounter. It also automatically selects the **0-Edentulous** radio button in the **Caries Risk** section.

The radio buttons default to **4 – Not Recorded** in all four fields. This selection does NOT import any clinical finding into the TIU progress note, nor does it display in the transaction table of the **OHA** screen. The provider has the option of selecting the appropriate radio button (0-3) for each of **Plaque Index**, **Xerostomia**, **Caries Risk** and **Oral Hygiene**, or simply leaving the default setting.

The entry of date, provider's initials and each field value entered is captured in the transaction table at the bottom of the screen. The provider has to enter at least one value (between 0-3) in one of the four fields to save and file an oral health assessment.

The **Definitions** button has the American Dental Association definitions for field values when entering **Plaque Index**, **Xerostomia Risk** and **Caries Risk**. The rest of the **Xerostomia** and **Caries Risk** definitions may be viewed using the scroll bar on the right side of the screen.

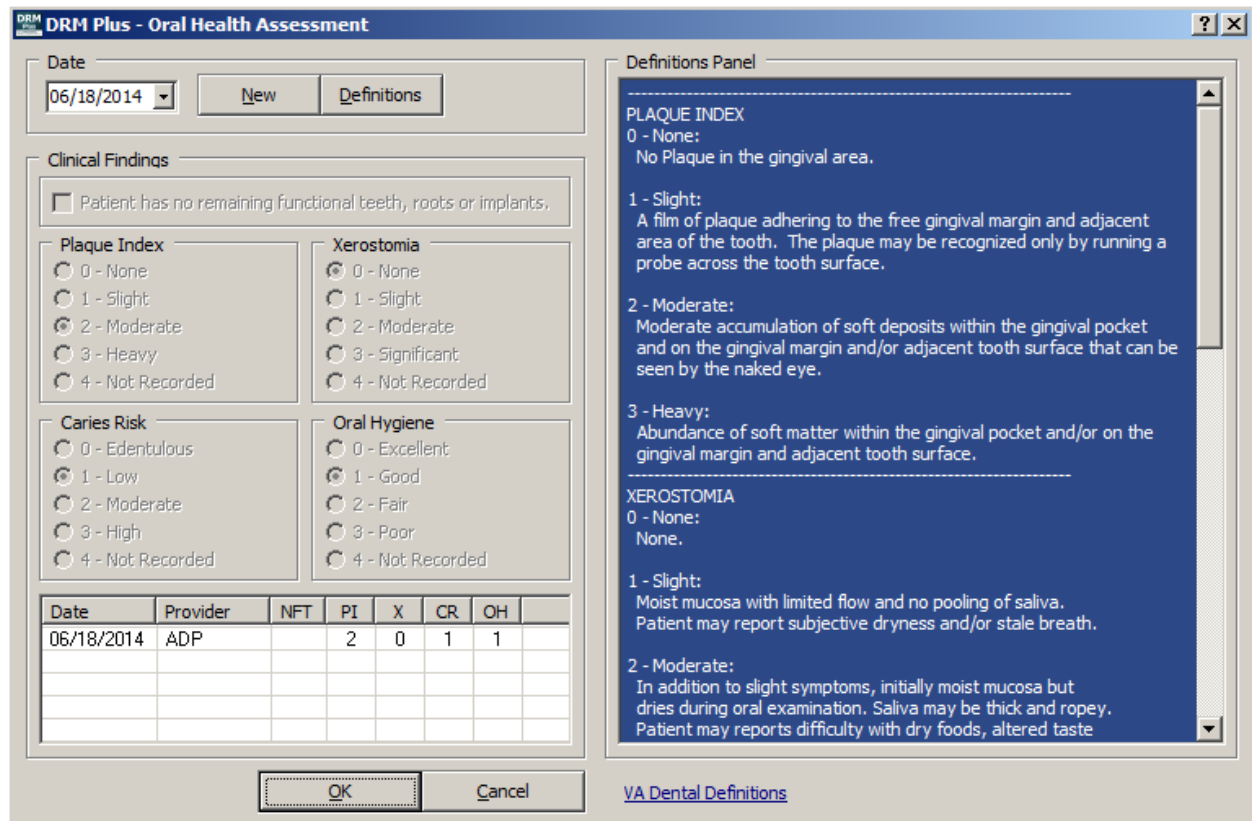


Figure 228: OHA Definitions Displaying Plaque Index/Xerostomia

The OHA (Oral Health Assessment) **Definitions Panel** is displayed in the previous screen. The **Definitions Panel** may be automatically expanded due to the parameter selection that is defaulted when first loaded. The user may change this parameter by navigating to **Tools** menu → **User Options** submenu → **Exam Settings** tab → uncheck the **Requirements**.

At the bottom of the OHA definitions panel the **VA Dental Definitions** hyperlink takes the provider to the VA dental website to view current OHA definitions. This hyperlink should be changed by the DRM Plus Administrator when instructed to do so by the VA Dental Informatics and Analytics Director.

Note: If not immediately directed to the website when selecting the hyperlink, please notify the Help Desk.

Note: The **Plaque Index** definitions have been reprogrammed and only allow whole number entries. Most **Plaque Index** values filed before the loading of the exam template patch retain the decimal value, if entered with one, and is located in the **PI** column of the **OHA** transaction table.

TMJ Button

The **TMJ** modal functions similar to the **OHA** modal when entering a new exam. Click the **New** button and today's date imports into the **Date** field.

At least one entry in either the **History** or **Clinical Findings** sections from this **TMJ** screen requires data to be selected in order to save. Selecting the second **History** radio button, **Patient reports symptoms associated with TMJ's**; allows multiple check box selections and at least one is required for this option to save.

The text windows below the **Other** check box in **History** or **Clinical Findings** only opens if the check box has been selected and each requires a text entry. The **Other** text boxes allow an unlimited text field.

The screenshot shows the 'DRM Plus - TMJ' window. It features a 'Date' field with a dropdown menu showing '07/07/2014' and a 'New' button. The 'History' section contains two radio buttons: 'Patient reports no symptoms associated with TMJ.' (selected) and 'Patient reports symptoms associated with TMJ's:'. Under the second radio button, there are several checkboxes: 'History of trauma', 'Popping/Clicking', 'Pain upon opening', 'Spontaneous pain', 'Crepitus', 'Pain upon chewing', 'Limited opening', and 'Other:'. Below the 'Other:' checkbox is a text area. The 'Clinical Findings' section has four rows, each with a numerical spinner (set to 0), a label in parentheses, and a drop-down menu. The rows are: '(mm) Max Incisal Opening' with 'Popping/Clicking', '(mm) Left Lateral' with 'Crepitus', '(mm) Right Lateral' with 'Pain to manipulation', and 'Other:' with 'Deviation upon opening'. Below the last row is another text area. At the bottom are 'OK' and 'Cancel' buttons.

Figure 229: TMJ Screen

The **Clinical Findings** section has three numerical fields to enter a millimeter value and four drop-down menu options in selecting popping/clicking, crepitus, pain to manipulation, and deviation upon opening. The **Other** check box allows an unlimited text field for additional text information if selected.

The minimum requirement to enter a new **TMJ** finding is the selection of only one historical or clinical finding from this screen.

Occl (Occlusion) Button

The **Occl** (Occlusion) button functions are different from the other modals when entering a new occlusion finding. Click the **New** button and today's date imports into the **Date** field. When there is previous filed data present then all that filed data imports into the new exam. The user needs to add/delete any new occlusion findings and click the **OK** button to save.

The screenshot shows a software window titled "DRM Plus - Occlusion". At the top left, there is a "Date" field with a dropdown menu showing "07/07/2014". To the right of the date field are two buttons: "New" and "Definitions". Below the date field is a section titled "Clinical Findings". This section contains several dropdown menus: "Mandibular relationship*" (with an asterisk indicating it is required), "Left first molar relationship", "Right first molar relationship", "Left cuspid relationship", and "Right cuspid relationship". To the right of these dropdowns are four more fields: "Open bite", "Cross bite", "Overbite (vertical mm)", and "Overjet (horizontal mm)", each with a numerical input field. At the bottom of the window are two buttons: "OK" and "Cancel".

Figure 230: Occlusion Screen

The **Clinical Findings** drop-down menu option **Mandibular relationship*** is the only required (*) field on this screen. The six other drop-down menu options and the two numerical box selections are optional entries.

The **Definitions Panel** displays the **Angle's Classification** definitions. These angle's classifications are for the selections displayed in the left bottom four drop-down menus. The **Definitions Panel** maybe reduced to display only the **Occlusion** screen by selecting the **Definitions** button.

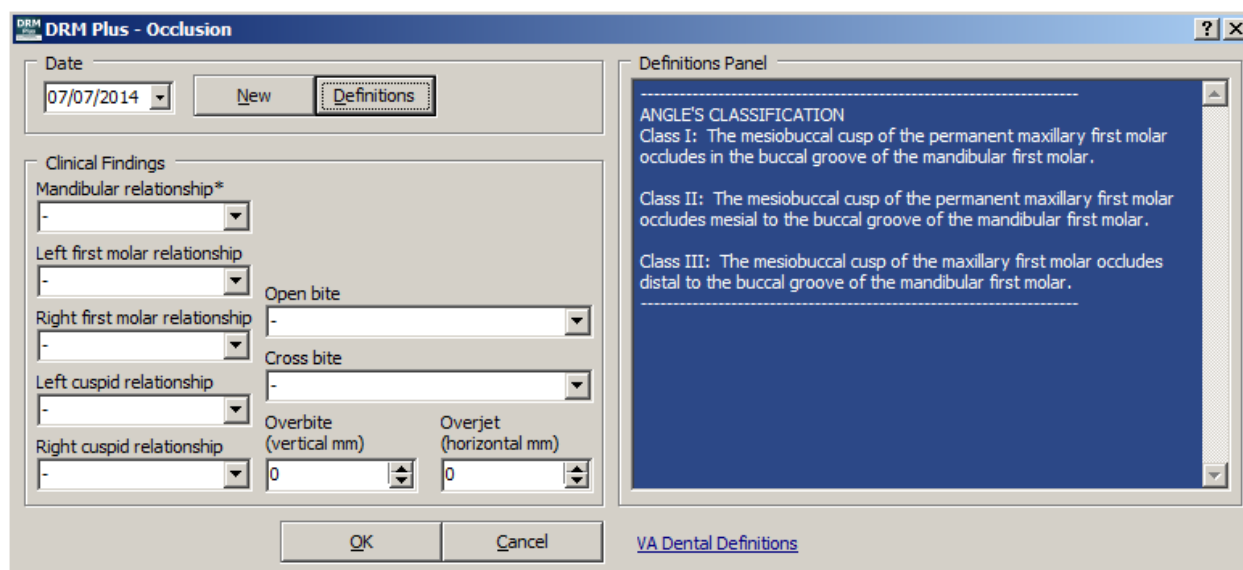


Figure 231: Occlusion Angle's Classification Definitions

The **Definitions Panel** may be expanded due to the parameter selection that is defaulted when first loaded. The user may change this parameter by going to the **Tools** menu → **User Options** submenu → **Exam Settings** tab → uncheck the **Requirements**.

At the bottom of the occlusion **Definitions Panel**, the **VA Dental Definitions** hyperlink takes the provider to the VA dental website to view current occlusion definitions. This hyperlink should be changed by the DRM Plus Administrator when instructed to do so by the VA Dental Informatics and Analytics Director.

Note: If NOT immediately directed to the website when selecting the hyperlink, please notify the Help Desk.

Habits (Parafunctional) Button

The **Habits (Parafunctional)** modal functions similar to the **OHA** modal when entering a new exam. Click the **New** button and today's date imports into the **Date** field.

The **History** and **Clinical Findings** fields each have two radio buttons for selection. When the second radio button is selected in each field, multiple options become active for selection. The **Other** check box allows an unlimited text field for additional text information.

The minimum requirement to enter a new parafunctional habit finding is to select only one historical or clinical finding from the **Parafunctional Habits** screen.

The screenshot shows a dialog box titled "DRM Plus - Parafunctional Habits". It features a "Date" field with a dropdown menu showing "07/07/2014" and a "New" button. Below this is the "History" section, which has two radio buttons: "Patient reports no known parafunctional habits." and "Patient reports the following habits:". Under the second radio button, there are checkboxes for "Bruxing", "Clenching", "Other:", and "History of eating disorder(s)". A text area is provided for additional information. The "Clinical Findings" section also has two radio buttons: "No evidence of parafunctional habits." and "Parafunctional habits evidenced by:". Under the second radio button, there are checkboxes for "Attrition", "Abrasion", "Other:", "Erosion", and "Hypertrophy of masticatory muscles". A second text area is provided for additional information. At the bottom of the dialog are "OK" and "Cancel" buttons.

Figure 232: Parafunctional Habits Screen

Social Hx (Social History) Button

The **Social History** modal functions similar to the **OHA** modal when entering a new exam. Click the **New** button and today's date imports into the **Date** field.

The minimum requirement is the selection of one of the two **History** radio buttons. When selecting the second radio button then at least one check box option is required to save the new historical data.

Any combination of check boxes maybe selected for **Present/Past**. The tobacco and alcohol drop-down options are per day, per week, per month, and per year except for cigarettes. **Cigarettes** have only the drop-down options of pack year history, per day, and per week. The text box with the **Drug Abuse** selection is optional when one of the check boxes is selected. The bottom text box is optional and allows an unlimited text field of formation if selected to enter data about eating disorders, dietary concerns, piercings, etc.

	Present	Past			
Tobacco					
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	0	pack year history	0 years
Pipe/Cigar	<input type="checkbox"/>	<input type="checkbox"/>	0	times per day for	0 years
Smokeless	<input type="checkbox"/>	<input type="checkbox"/>	0	times per day for	0 years
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	0	drinks per day for	0 years
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>			

Figure 233: Social Hx (History) Screen

Note: All entries made into the **Social History**, **OHA**, **Occlusion**, **Parafunctional Habits** and **TMJ** modals NOT filed are cleared by selecting the **Cancel** button.

Multiple Filings to Same Modal on Same Day

The following occurs when any modal has multiple filed findings and/or history during the same day on the same patient's chart; subsequent filings may be changed/edited or remain the same as the previous filing.

The last modal filing during one calendar day is the only record present from the date drop-down menu of that modal screen. The TIU progress notes filed that day will have the record of the modal data entered that session/encounter.

The first provider (HYG) may file findings in the **OHA** modal and that data displays in the screen for every other user of DRM Plus to review.

DRM Plus - Oral Health Assessment

Date: 07/07/2014 [New] [Definitions]

Clinical Findings

Patient has no remaining functional teeth, roots or implants.

Plaque Index

- 0 - None
- 1 - Slight
- 2 - Moderate
- 3 - Heavy
- 4 - Not Recorded

Xerostomia

- 0 - None
- 1 - Slight
- 2 - Moderate
- 3 - Significant
- 4 - Not Recorded

Caries Risk

- 0 - Edentulous
- 1 - Low
- 2 - Moderate
- 3 - High
- 4 - Not Recorded

Oral Hygiene

- 0 - Excellent
- 1 - Good
- 2 - Fair
- 3 - Poor
- 4 - Not Recorded

Date	Provider	NFT	PI	X	CR	OH
07/07/2014	HYG		2			1
06/18/2014	ADP		2	0	1	1

[OK] [Cancel]

Figure 234: Provider HYG Filed OHA Data First Today

If the second provider (ADP) changes/edits the filed **OHA** findings from the first provider (HYG) on the same calendar day; modifies the findings in the **OHA** modal. The modified **OHA** findings filed by the second provider will be the data viewed by the local clinical providers in the patient's **OHA** screen.

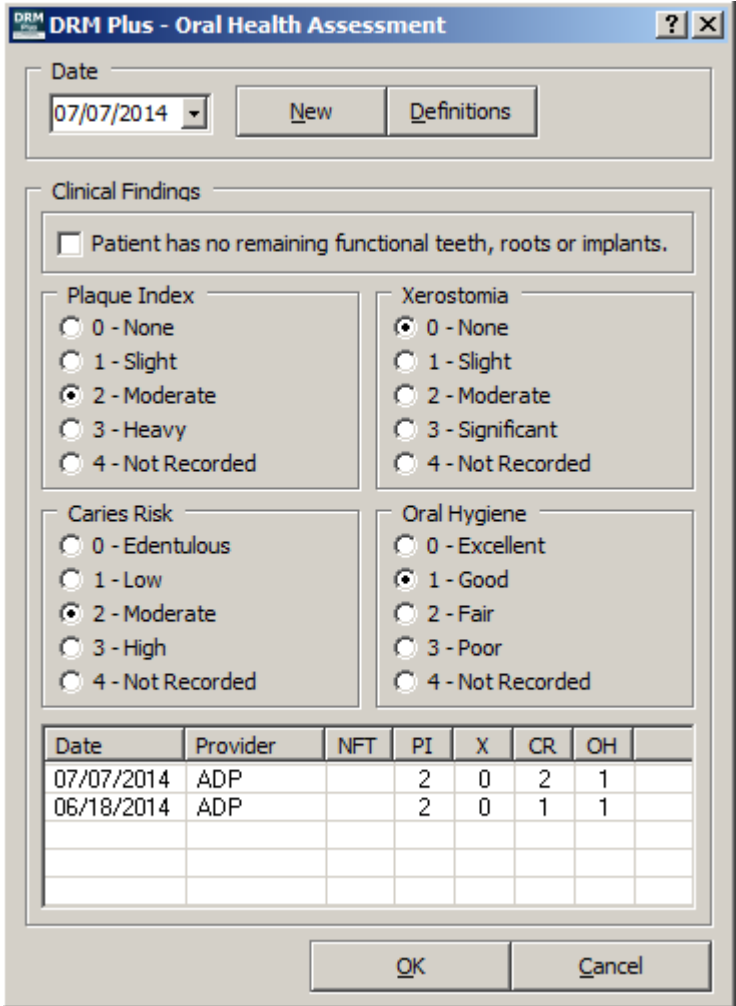


Figure 235: Provider ADP Edited and Filed OHA Data Second Today

Note: The first provider’s **OHA** findings are only present in their filed TIU progress note.

Note: The **OHA** and **H&N** modals are the only screens that displays the date and the provider’s initials filed with the findings and/or history data.

Chart/Treatment – Periodontal Chart

Enter periodontal information on the patient from the **Periodontal Chart** screen, within the **Chart/Treatment** tab.

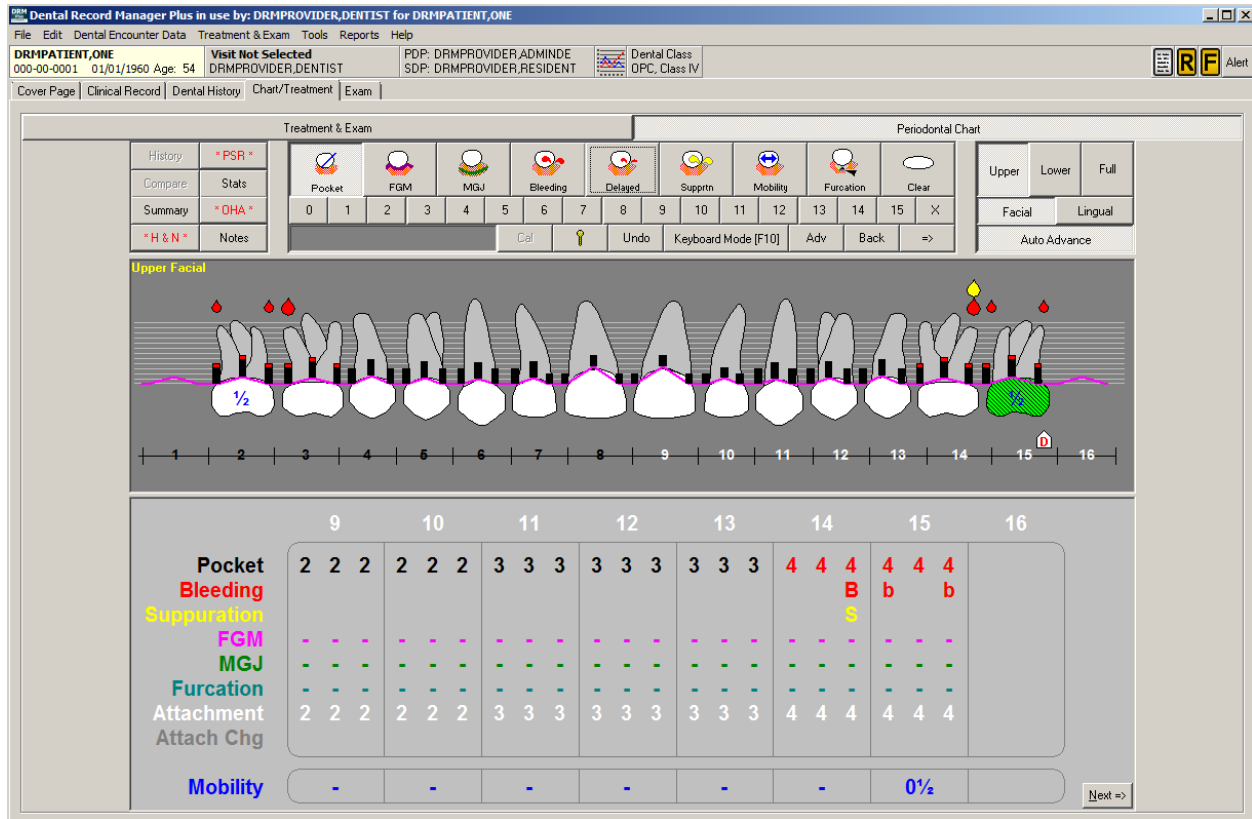



Figure 236: Periodontal Chart Screen

The upper left side of the screen shows the **History**, **Compare**, **Summary**, **H&N**, **PSR**, **Stats**, **OHA** and **Notes** buttons. The top center of the screen displays various periodontal condition-specific icons. Use these to mark periodontal findings on the patient's chart.

Use the options on the upper-right side of the screen to adjust the view of the tooth/arch graphic.

The center of the screen features the tooth/arch graphic. Clicking various areas in combination with the condition-specific icons located in the top center of the screen enters information into the patient's chart.

The bottom of the screen shows text (only a quadrant is viewable depending where the cursor shield  is located) of the periodontal information entered using the graphic and the condition-specific icons in the top center of the screen.

Note: The **Periodontal Chart** screen allows two providers to enter perio data on the same day. However, it only displays the last perio data that was filed on that day. The first entered perio data is only viewable in the TIU progress note of the provider that filed the first encounter.

History and Compare Buttons

Clicking the **History** or **Compare** buttons display similar screens. Use the **Compare** function to see two periodontal charts for a patient.

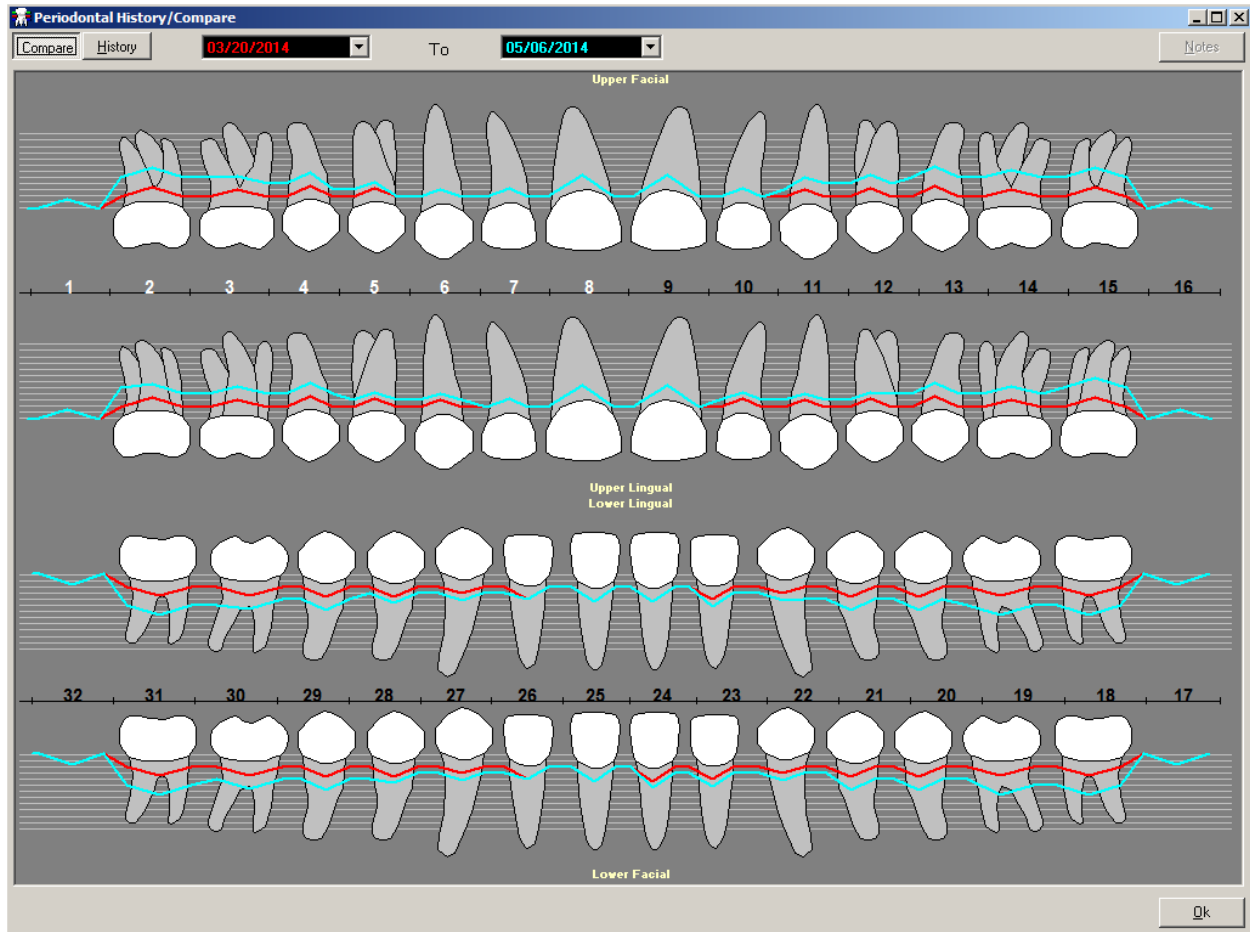


Figure 237: Periodontal History/Compare Screen – Compare Viewable

The information is color-coded. The data from the first date is displayed in red, while the data from the second date is displayed in blue. Use the drop-down menus to change the dates.

Click the **History** button to view a graphic of the patient's history.

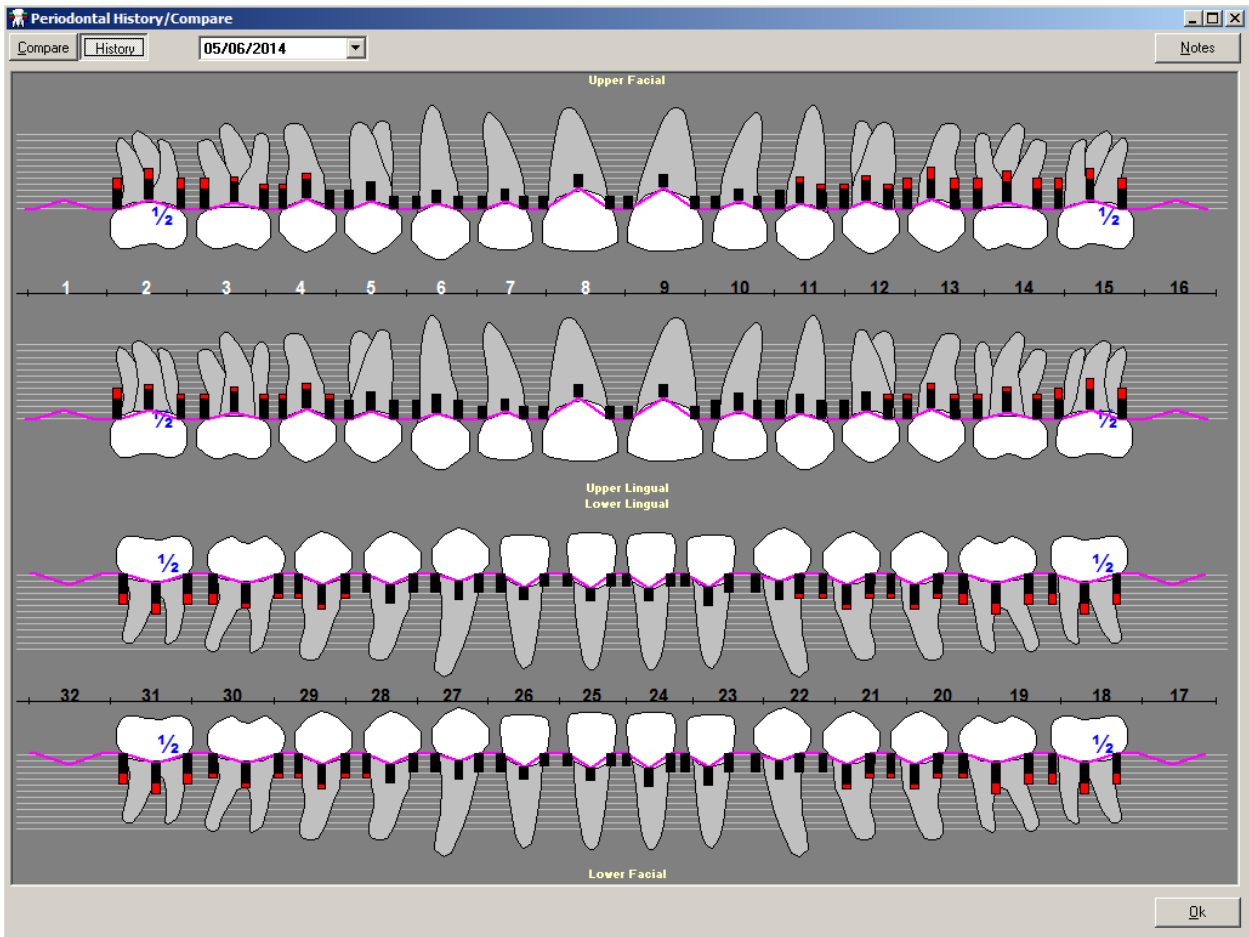


Figure 238: Periodontal History/Compare Screen - History Viewable

Use the drop-down menu to change the date. Use the **Notes** button to view previously entered notes concerning the patient's periodontal history.

Summary Button

See the **Summary Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

H&N Button

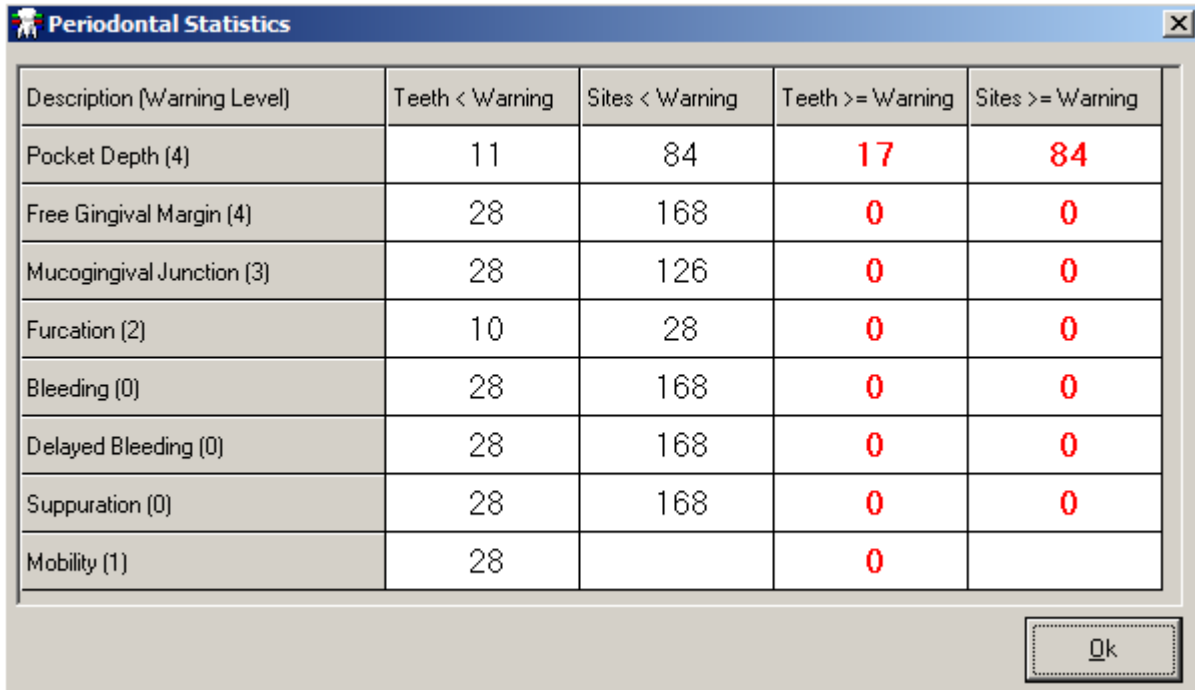
See the **H&N Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

PSR Button

See the **PSR Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

Stats Button

Use the **Stats** function to view the patient's total number of periodontal warning levels.



Description (Warning Level)	Teeth < Warning	Sites < Warning	Teeth >= Warning	Sites >= Warning
Pocket Depth (4)	11	84	17	84
Free Gingival Margin (4)	28	168	0	0
Mucogingival Junction (3)	28	126	0	0
Furcation (2)	10	28	0	0
Bleeding (0)	28	168	0	0
Delayed Bleeding (0)	28	168	0	0
Suppuration (0)	28	168	0	0
Mobility (1)	28		0	

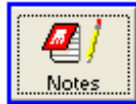
Ok

Figure 239: Periodontal Statistics Screen

OHA (Oral Health Assessment) Button

See the **OHA Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

Notes Button



Use the **Notes** button to enter general patient notes or tooth specific notes into the chart.

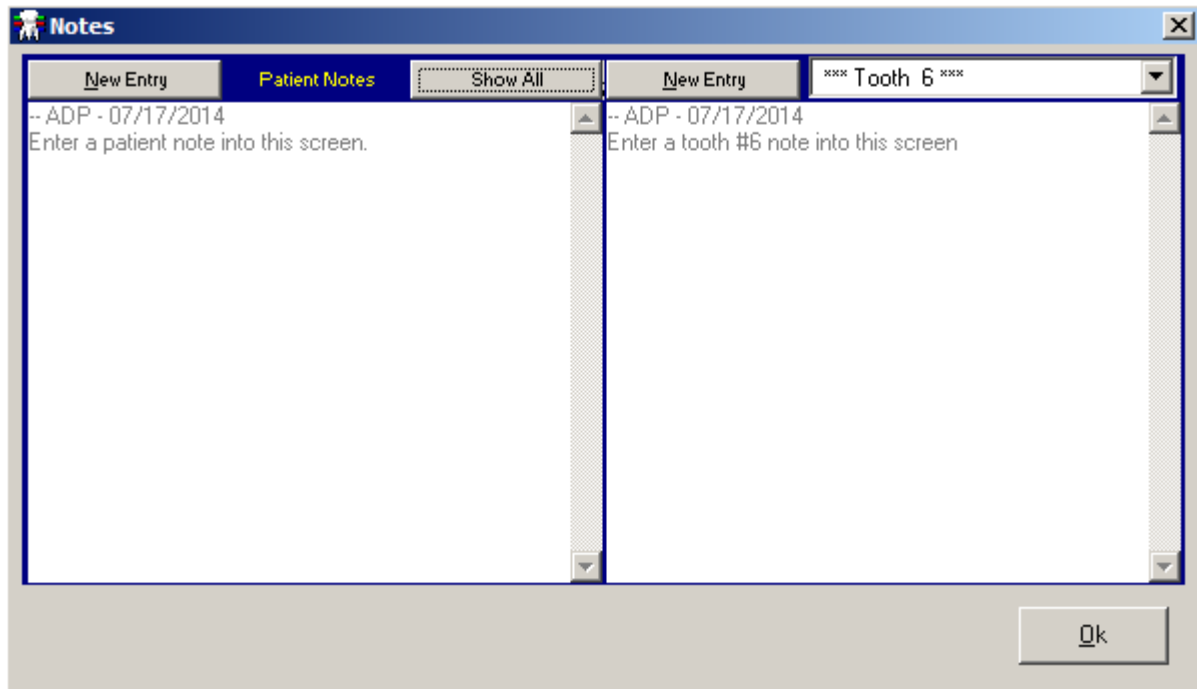


Figure 240: Notes Screen

Choose between creating a more general note on the patient by using the tools on the left side of the screen, or a note about a specific tooth on the right side of the screen.

- To create a new note, click the **New Entry** button.
- To view all general patient notes in the patient's chart, click the **Show All** button.
- To make an entry about a specific tooth, use the drop-down menu on the right side of the screen to select a tooth before making a new entry.

To view any tooth-specific note that has been entered during the past year into the patient's chart, click the **History** button. View the note by clicking the selected history's **Notes** button, according to the appropriate visit date. Note that this is the same screen that displays if the **Notes** icon is clicked on the **Treatment & Exam** screen.

Entering Periodontal Information

The condition-specific icons in the top center of the screen works in combination with the tooth/arch graphic.

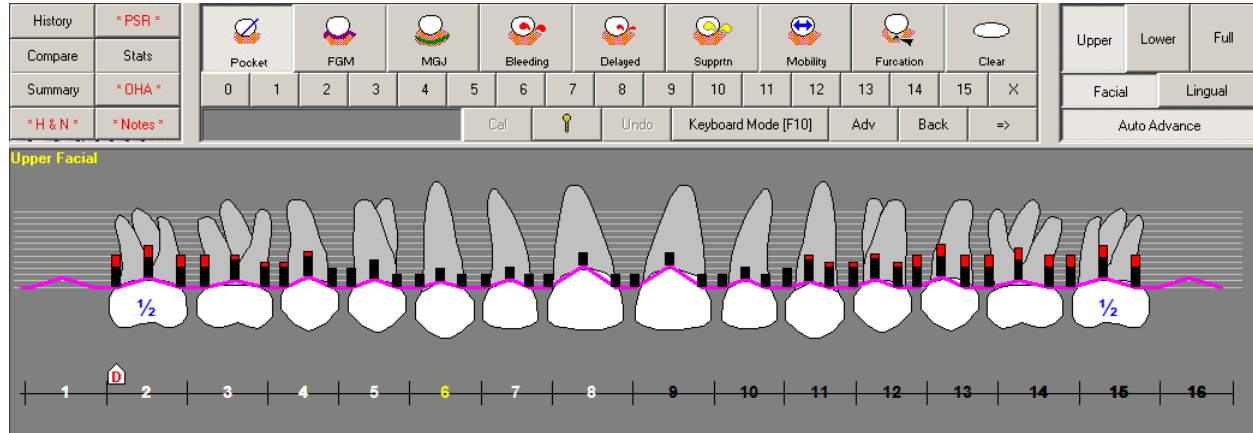



Figure 241: Periodontal Condition-Specific Icons and Periodontal Graphical Chart


To enter periodontal information:


1. Click the desired condition-specific icon (**Pocket, FGM, Bleeding, Mobility, etc.**).
2. On the graphic, the cursor shield  is the graphical pocket location for perio data entry.
3. Click the desired **number** below the list of condition icons (if applicable). **Bleeding, Delayed Bleeding** and **Suppuration** do NOT require any clicks on a number.
4. Use the buttons on the top right of the screen to view different areas of the tooth/arch, or to change the view.
5. The condition and location displays on the graphic and on the transaction table below the graphic. The transaction table only displays a quadrant of the upper/lower arch.

Note: Only one periodontal chart exam should be completed per day, per patient. When a second exam is completed during the same day, the periodontal chart history only saves the second exam. TIU progress notes in VistA still have all the data entered.


Other Tools

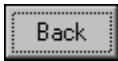
The last line of buttons in the top center of the screen features several tools.

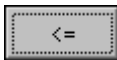
Key button  displays keyboard shortcuts.

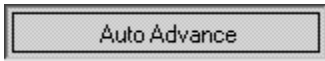
Undo button  undoes the last action performed on the screen. This action is limited to the last nine actions performed.

Keyboard Mode button  switches the program to keyboard mode.

Advance button  moves the cursor shield on the graphic forward due to the direction of the arrow.

Back button  moves the cursor shield on the graphic back due to the direction of the arrow.

Direction button  shows the direction the cursor shield moves on the graphic. The direction of advancement depends on the orientation of this button.

Auto Advance button  when the button is active, the cursor shield automatically moves in the way designated for the perio exam entry of the condition-specific icons. It does **NOT** allow **Bleeding**, **Delayed Bleeding** or **Suppuration**, to automatically move.

The auto exam sequence is a parameter adjustment that may be redesigned by each provider. For more information, please see the Treatment & Exam/Show Configuration/Periodontal section of the Using the DRM Plus Drop-Down Menus chapter of this manual.

Exam

Providers have the ability to file required data using a national standard exam style format for each exam/consult code (**D0120, D0140, D0150, D0160, D0170, D0180 and D9310**) in conjunction with the **Exam** tab in DRM Plus. Mandatory elements for each exam/consult code and requirements for each element are based on the user's exam/consult code selection. Initially, each element is marked with required or optional icon. The **Exam** tab interfaces automatically with existing DRM Plus modals (i.e. Head & Neck) for easy data entry. The **Exam** tab, when activated, generates a TIU progress note associated with a specific visit containing the entire exam or consult's required information, along with other DRM Plus note objects (i.e. dental alerts, etc.).

To proceed to the **Exam** tab, the user is prompted to select one of the six exam or consult procedure codes from the **Chart/Treatment** tab's **Completed Care** screen.

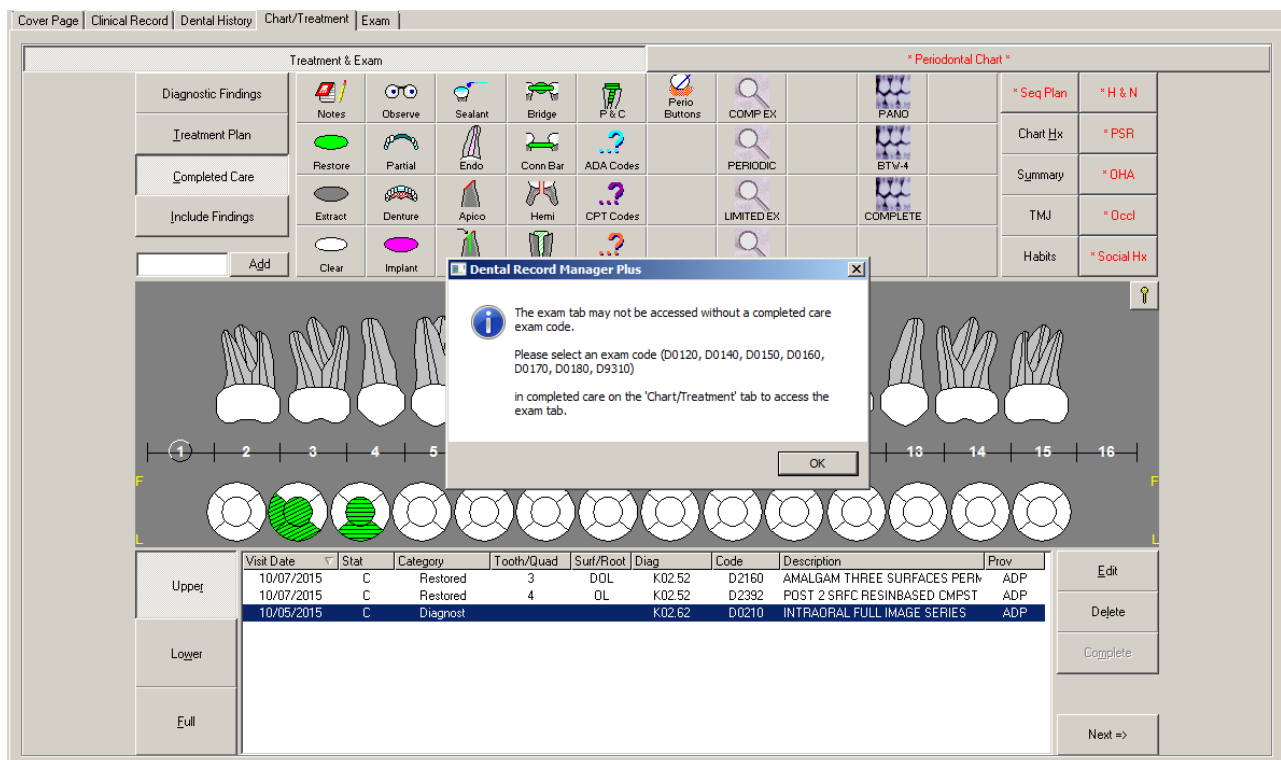





Figure 242: Exam Tab Message

Entering the exam/consult procedure activates the **Exam** tab and displays the procedure in the **Exam Type** drop-down menu. One way to change the exam/consult procedure after selecting it and determining it was incorrect is to use the drop-down menu located on the **Exam** tab. Another way to change the exam/consult procedure is by deleting the procedure from the **Completed Care** screen and entering a new one.

Selecting the exam/consult code from the **Completed Care** screen triggers all of the elements on the **Exam** tab with a required  icon or optional  icon. When these elements are satisfied, a completed  icon displays. Some elements automatically pull data from the modals when entered from the **Chart/Treatment** tab.

Note: Users may enter additional optional information in each element, if desired, for the selected exam/consult code.

In the following example, the **D0150**, comprehensive exam, was selected from the **Treatment & Exam/Completed Care** screen. Upon selecting the **Exam** tab, **D0150 Comprehensive** displays in the **Exam Type** drop-down menu. Twelve of the sixteen elements require data entry by the provider when selecting the D0150, comprehensive exam.

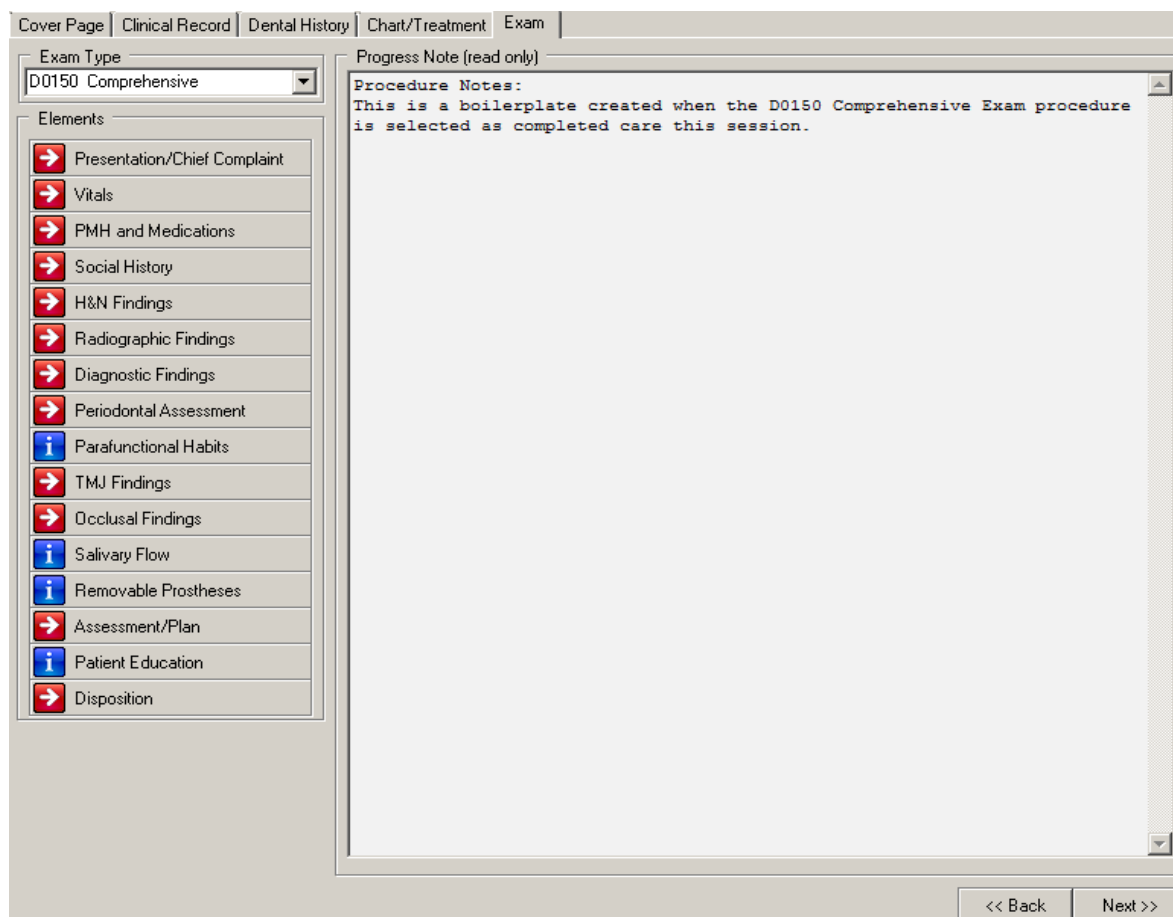


Figure 243: Exam Tab

The seven exam/consult codes each have a different set of required and optional elements activated when selecting a specific code. The dialogue found in each element section that follows are those that would display if the user selected D0150, comprehensive exam, during a session.

The **Back** button located on the **Exam** tab screen returns the end-user to the **Chart/Treatment** tab.

The **Next** button located on the **Exam** tab allows the end-user to proceed to the **Filing Options** screen, which is the next screen when completing the encounter. This **Next** button also opens any required element if that element has NOT been completed.

The **Back/Next** buttons located on each element screen only move backward or forward to other element screens. The buttons allow the provider to move to the next required element for this exam type depending on the parameter the user selected. Usage of the **Back** button is NOT dependent on the element's completion.

Exam Elements

Presentation/Chief Complaint Element

The **Presentation/Chief Complaint** element is required for all seven exam/consult procedure codes and defaults open when the **Exam** tab is selected. The presentation of the exam/consult code is automatically imported and displayed at the top of the element. This element requires one of the two radio buttons to be selected. The selection of the second radio button, **Patient presents with dental complaint(s)** opens two text boxes which require a text entry only in the first text box intended for the dental complaint of the patient. The second text box (optional text entry) allows data entry for the history of the patient's present illness.

The screenshot shows a software window titled "Presentation/Chief Complaint" with a standard Windows-style title bar. The main area is divided into several sections. At the top, there's a "Presentation" section with a text box containing "Patient presents for comprehensive oral evaluation". Below that is a "Chief Complaint" section with two radio buttons: "Patient has no dental complaints" (which is selected) and "Patient presents with dental complaint(s)". Underneath the radio buttons is a large empty text area. Below the main form is an "Additional Annotations" section with a text box and scroll arrows. At the bottom left is an "Annotations" section with a text box containing "Presentation/Chief Complaint: Patient presents for comprehensive oral evaluation". At the bottom right are three buttons: "OK", "Cancel", and "Next >>". To the right of the main window is a smaller "Element Requirements Panel" with a blue background. It contains the following text: "D0150 Comprehensive Presentation/Chief Complaint requirements: This element requires one of the two radio buttons to be selected. The selection of the second radio button will open two text boxes which require at a minimum a statement entered in the first text box."

Figure 244: Presentation/Chief Complaint Element Screen

The following information is the same with all sixteen elements except the **Presentation/Chief Complaint** does NOT have a **Back** button, and **Disposition** does NOT have a **Next** button.

Additional Annotations is a free text window, which allows the provider to enter additional information about the patient's chief complaint. It offers right-click functionality for importing .txt files, if desired.

Annotations is view-only, and captures everything entered into this element. Select the **OK** button to save all required information entered and close the element, or click the **Next** button to move to the next required element, depending on the selected parameter.

Vitals Elements

The **Vitals** element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected. The second radio button, **Vital signs obtained**, defaults to any vitals that have been entered, using **Vitals Lite**, during 24 hours of the visit date. The **Visit/Date** for this encounter also must be entered in the banner for this feature to work. Entering the **Visit/Date** should be the first action taken when opening any patient's chart for a new encounter.

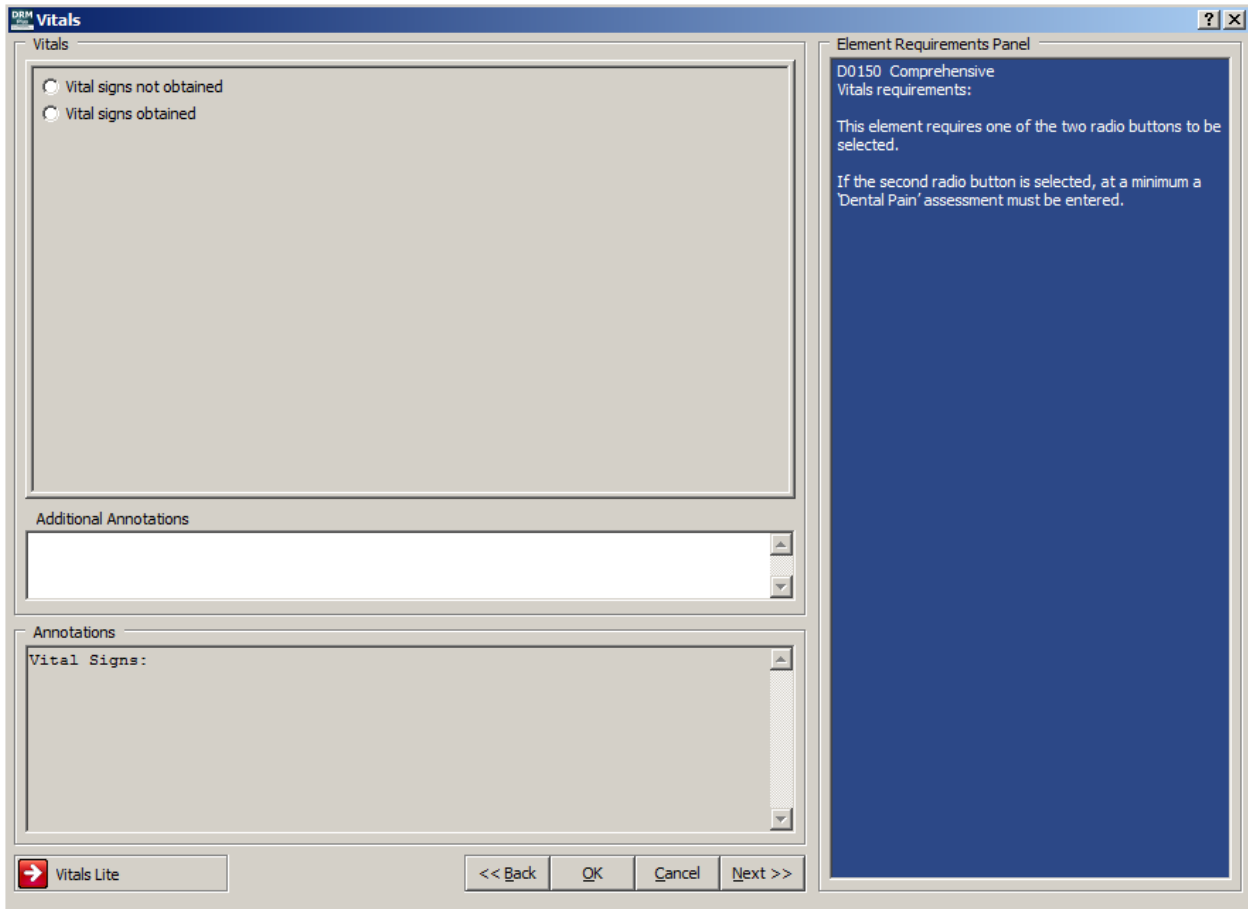


Figure 245: Vitals Element Screen

If no vitals have been entered using **Vitals Lite**, the information can be entered manually; however, no date is attached to these entries. **Dental Pain** is the only required vital sign.

To enter vitals, first select the scheduled appointment, visit or admission. Then click the **Vitals Lite** button located on the DRM Plus banner. The user can also click the **Vitals Lite** button in the lower left portion of the **Vitals** element screen.

Specific vitals information can be entered into the **Additional Annotations** free text window. Right-click this window to import text files, if desired. All information entered into the **Vitals** element appear in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move to the next element, or the **OK** button to close the element. The **Back** button moves to the previous required element, depending on the selected parameter, and is NOT dependent on the element's completion.

Note: The only vital sign, **Dental Pain**, may be saved as unfiled data for this element.

PMH (Past Medical History) and Medications Element

The **PMH** element is required for all seven exam/consult procedures. This element requires one of the three radio buttons to be selected. The selection of the first radio button opens an optional text box to enter additional information if the patient is new to the clinic. The selection of the third radio button opens a required text box to enter any significant changes noted since the last dental visit.

The eight positive/negative check box conditions, one free text positive condition or the five **Imports** check boxes are optional entries of patient information for this element. The user may select one import such as the patient's medications or use the **Select ALL Imports** button to import all four previously filed medical histories about the patient which are being stored in a VistA Fileman database.

The screenshot shows the 'PMH and Medications' dialog box. It is divided into several sections:

- PMH Options:** Three radio buttons for selecting the patient's status relative to their last dental visit.
- History of:** A table with 'YES' and 'NO' columns and checkboxes for various medical conditions.
- Imports:** Checkboxes for importing specific data types, with a 'Select ALL Imports' button.
- Additional Annotations:** A text area for entering extra information.
- Annotations:** A text area containing the text 'Past Medical History and Medications:'.
- Element Requirements Panel:** A blue sidebar on the right providing instructions on how to use the radio buttons and checkboxes.
- Navigation:** Buttons for '<< Back', 'OK', 'Cancel', and 'Next >>' at the bottom.

Figure 246: PMH and Medications Element Screen

Additional Annotations is a free text window, which allows the provider to enter additional information about the patient's past medical history. It offers right-click functionality of import text files, if desired. **Annotations** is view-only, and captures everything entered into this element.

Once the element is complete, click the **Next** button to move to the next element, or the **OK** button to close the element. The **Back** button moves to the previous required element, depending on the selected parameter, and is NOT dependent on the element's completion.

Social History Element

The **Social History** element is required for the D0150 and D0180 exams. This element requires new social history findings entered with the **Social History** screen when completing one of the two required exams. The **Social History** screen may be opened with the specialty button located on the **Chart/Treatment** tab, or by the **Social History** button located in the lower left corner of this screen. The minimum requirement to enter a new social history entry is to select at least one historical finding from the **Social History** screen.

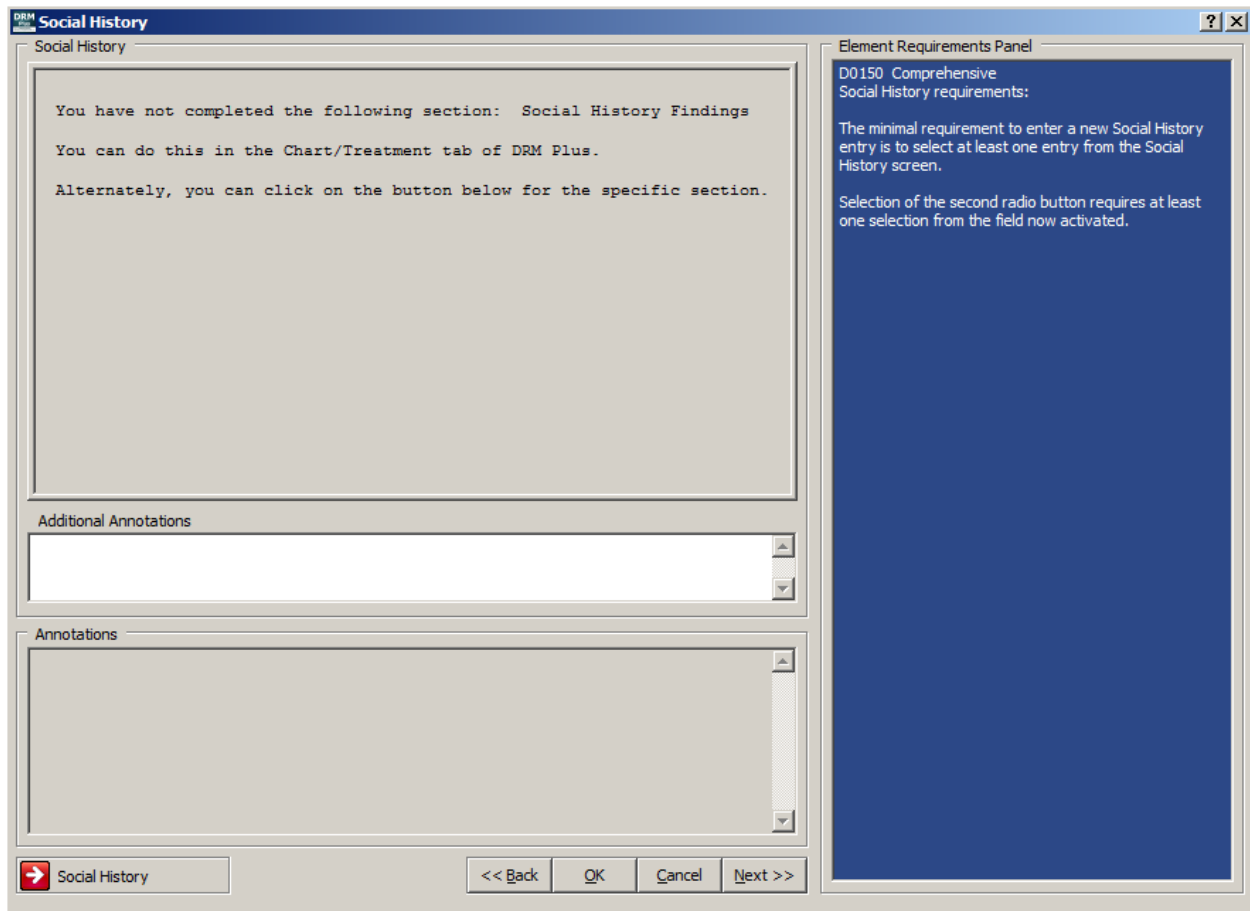


Figure 247: Social History Element Screen

Additional information regarding the patient can be entered into the **Additional Annotations** window. Right-click in this window to import text files, if desired. All information added to this element displays in the read-only **Annotations** window. Once this element is complete, click the **Next** button to move on to the next element.

H&N (Head and Neck) Findings Element

The **H&N Findings** element is required for the D0120, D0150 and D0180 exams. This element requires a new H&N finding or historical entry using the **H&N Findings** screen. This element imports data entered from the **H&N Findings** screen. The **Screening Negative** button on this element's screen allows a new screening negative entry directly into the element and import it into the **H&N Findings** screen for the patient's permanent record.

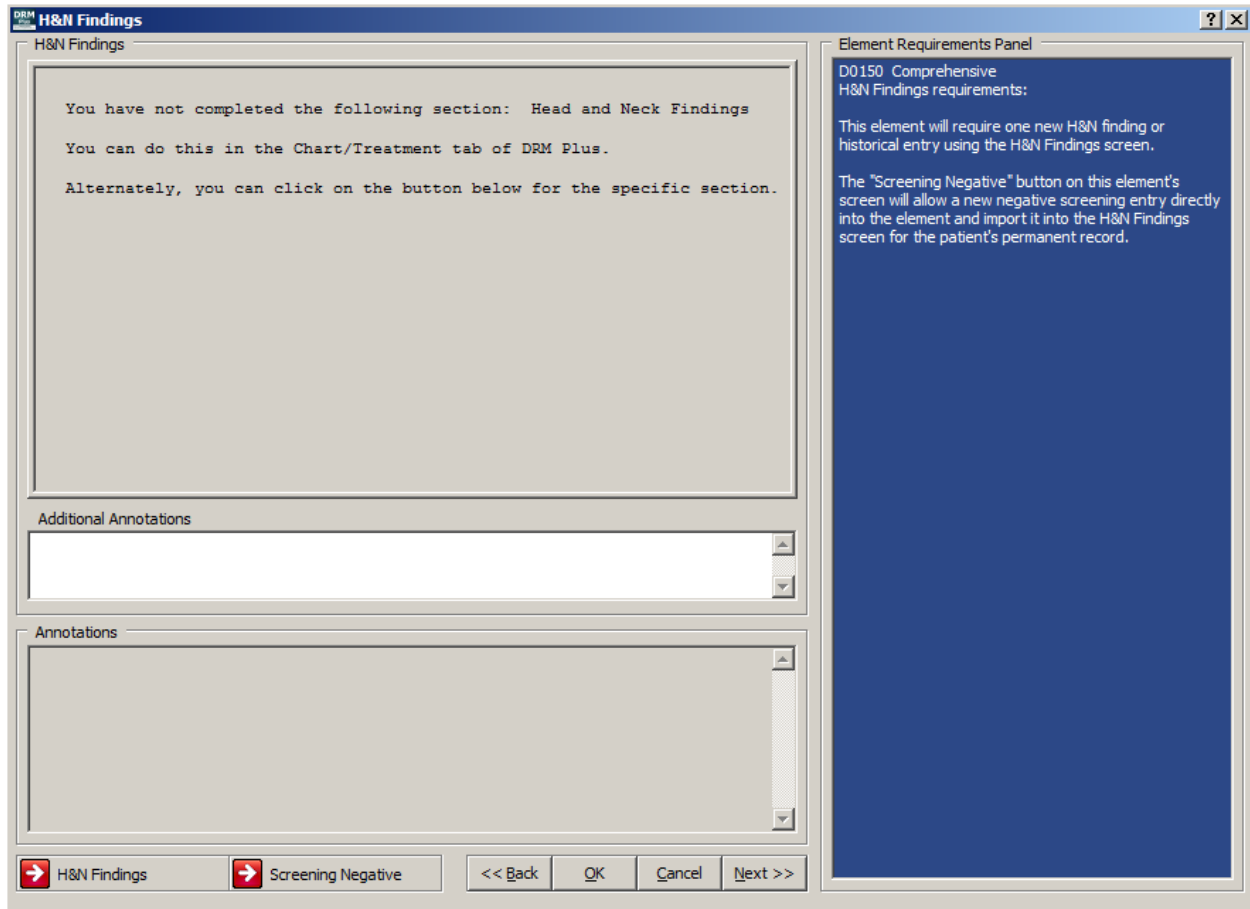


Figure 248: H&N Findings Element Screen

The **H&N Findings** screen can be accessed by either clicking the specialty button from the **Chart/Treatment** tab, or clicking the **H&N Findings** button in the left bottom corner of this element. Once the H&N findings are added to this element, additional information regarding the patient can be entered in the **Additional Annotations** free text window. Right-click this window to import text files, if desired. All information entered into this element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Radiographic Findings Element

The **Radiographic Findings** element is required for the D0150 and D0180 exams. The radiographic element requires at least one selected check box from the top six options. The provider may select any combination of the top six check boxes for the patient's TIU progress note. The fourth check box down the left column requires some data entry in the text box or at least one pre-defined statement to satisfy the requirements.

The **Exams Settings** tab located using the **Tools** menu → **User Options** submenu → **Exam Settings** tab → **Configure Radiographs Requirement** parameter that allows each user to require a radiographic finding for all exam/consult codes with mandatory entries in the **Exam** tab.

The screenshot shows a software window titled "Radiographic Findings" with a blue header bar. The main content area is divided into several sections. At the top, there are six checkboxes arranged in two columns. The first four are on the left, and the last two are on the right. Below these is a text box with a scroll bar. Underneath that is another section with three checkboxes. Below this is a text box labeled "Additional Annotations" with a scroll bar. At the bottom of the main area is a section labeled "Annotations" with a scrollable list containing the text "Radiographic Findings:". At the very bottom of the window are four buttons: "<< Back", "OK", "Cancel", and "Next >>". To the right of the main window is a smaller panel titled "Element Requirements Panel" with a blue background. It contains text explaining the requirements for the D0150 Comprehensive Radiographic Findings element, stating that at least one check box must be selected and that the fourth check box requires a text description or pre-defined statement.

Figure 249: Radiographic Findings Element Screen

Up to twelve pre-defined statements on radiographic findings can be selected from this screen. The check boxes found in the pre-defined statements window have three national radiographic findings statements pre-loaded; however, all twelve statements can be created locally.

The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

Additional information regarding the patient can be added in the **Additional Annotations** free text window. The user can right-click to import a text file, if desired. All information entered into this element displays in the **Annotations** read-only window. Once the element is complete, click the **Next** button to move on to the next element.

Diagnostic Findings Element

The **Diagnostic Findings** element is required for all seven exam/consult procedures. All exam/consult codes are required as appropriate for new and updated findings. The second check box only displays after data is entered from at least one **Chart/Treatment** findings screen that satisfies this option. Informational screens advise the user of any missing requirements for a specific exam code.

The **NFT**, no functional teeth, check box when selected in the **OHA** screen, bypasses all requirements in this element for all exam/consult procedures. The **OHA** screen may be opened from the **Chart/Treatment** tab or by selecting the **OHA** button in the lower left area of this screen.

- **D0120:** Requires a **Plaque Index** entry from the **OHA** screen. Also requires the selection of a **Mobility** radio button, as it pertains to the patient.
- **D0150:** Requires at least one entry from the **Diagnostic Findings** screen or the first check box of no apparent pathology selected. Requires a **Plaque Index** entry from the **OHA** screen. Also requires the selection of a **Mobility** radio button, as it pertains to the patient.
- **D0180:** Requires an **Oral Hygiene** entry from the **OHA** screen.

Figure 250: Diagnostic Findings Element Screen

The user can enter any additional information regarding the patient into the **Additional Annotations** free text window. Right-click this window to import a text file, if desired. All information entered into this element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Periodontal Assessment Element

The **Periodontal Assessment** element is required for the D0120, D0150 and D0180 exams. The D0120 and D0150 exams required at least one selection from the **Periodontal General Assessment** section. The **Detailed Assessment** button allows the user to enter additional perio data; however, this is optional for the D0120 and D0150 exam codes.

The **Include Last Perio Chart** check box defaults as unchecked if the provider wants to import the last filed periodontal chart into this element. The **Include Last Perio Chart** check box, when selected, satisfies the requirements for this **Periodontal Assessment** element for the D0140, D0160, D0170, and D9310 procedures. When any new perio data has been added to the perio chart during this session, that data imports into this element and satisfies the same four exam/consult procedures as stated previously.

The **NFT**, no functional teeth, check box when selected in the **OHA** screen, bypasses all requirements for the D0120, D0150 or D0180 exams in the periodontal element. The user may access the **Periodontal Chart** screen, **OHA** screen or **PSR** screen using the buttons found on this **Periodontal Assessment** element screen.

Periodontal Assessment

Periodontal Assessment

Periodontal General Assessment

Good Periodontal Health

	Acute	Chronic	Generalized	Localized	Slight	Moderate	Severe	Aggressive
<input type="checkbox"/> Gingivitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Gingival Enlargement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Generalized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
<input type="checkbox"/> Localized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
<input type="checkbox"/> Peri-implantitis								<input type="checkbox"/>

Include Last Perio Chart

Detailed Assessment

Definitions

Periodontal Chart

Additional Annotations

Annotations

PSR Oral Health Assessment << Back OK Cancel Next >>

Element Requirements Panel

D0150 Comprehensive Periodontal Assessment requirements:

This element requires at least one selection from the Periodontal General Assessment section.

The "Detailed Assessment" button allows the user to enter additional periodontal data; however, this is optional for this exam code.

The "Include Last Perio Chart" check box will include the last periodontal chart when selected.

When the OHA check box "Patient has no remaining functional teeth, roots or implants" is selected this element will be satisfied.

Figure 251: Periodontal Assessment Element Screen

The D0180 exam requires one selection from the **Periodontal General Assessment** section as well. The **Periodontal Detailed Assessment** section is optional and has optional text boxes with each selection if more descriptive detail is needed.

The D0180 exam also requires the first four rows in the **Additional Periodontal Detail** section to have at least one selection. The **Additional Periodontal Comments** text box is optional in this section. When the **Other** check box is selected from the **Past Periodontal Tx History** options, data entry is required in the **Additional Periodontal Comments** text box.

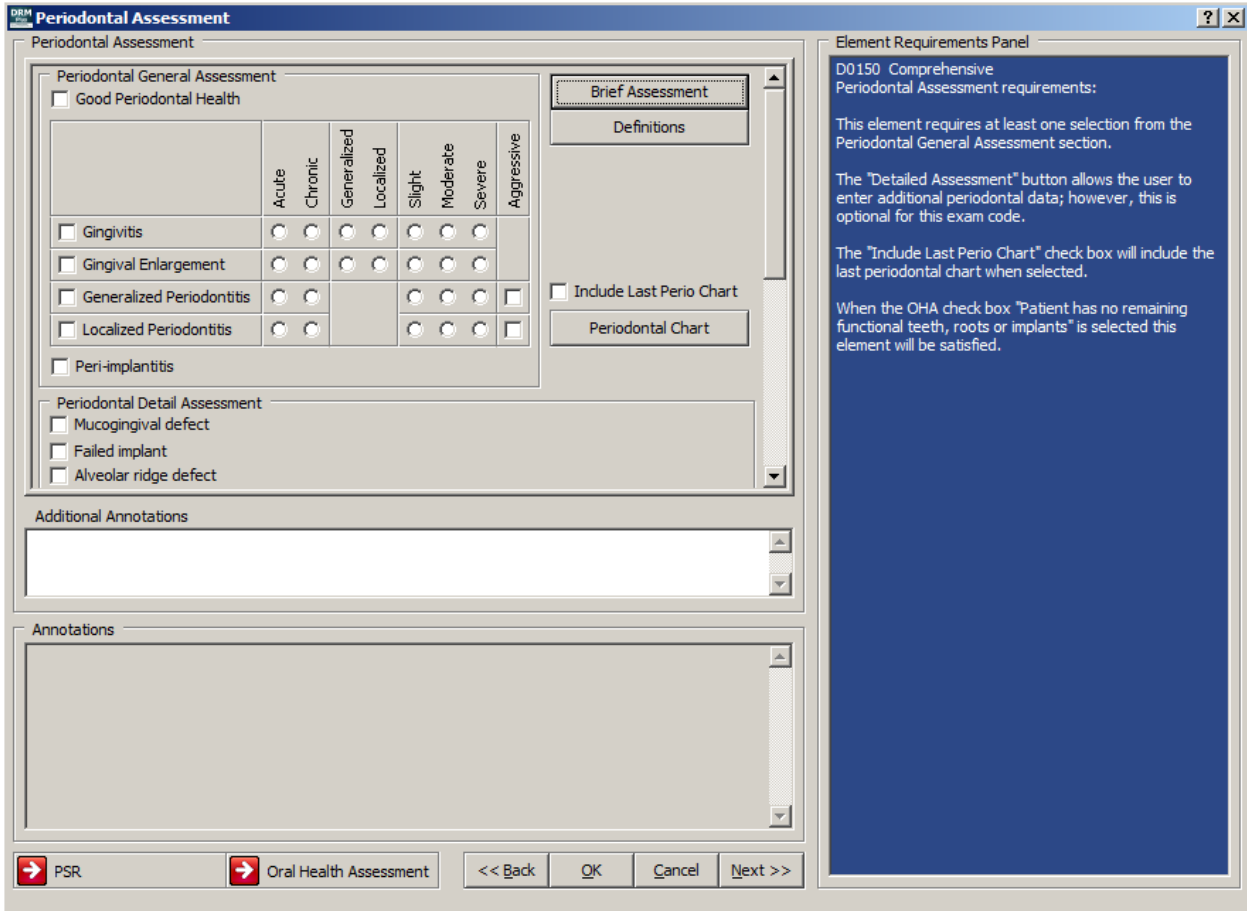


Figure 252: Periodontal Detailed Assessment Button Selected

Note: The D0180 exam code does NOT allow the user to select the **Brief Assessment** button from this screen.

Additional information regarding the patient may be entered into the **Additional Annotations** free text window. The user may right-click in this window to import a text file, if desired. All information entered into this element appears in the read-only **Annotations** window. Once this element is complete, click the **Next** button to move on to the next element.

The provider may open the **OHA** screen or the **PSR** screen using the buttons in the lower left area of this screen or the **Chart/Treatment** tab to enter an OHA finding or a PSR exam. The **Periodontal Chart** button on the middle right side of this screen allows access to that chart to enter any new findings for this session.

The following dialog displays the VA Office of Dentistry perio definitions when selecting the **Definitions** button.

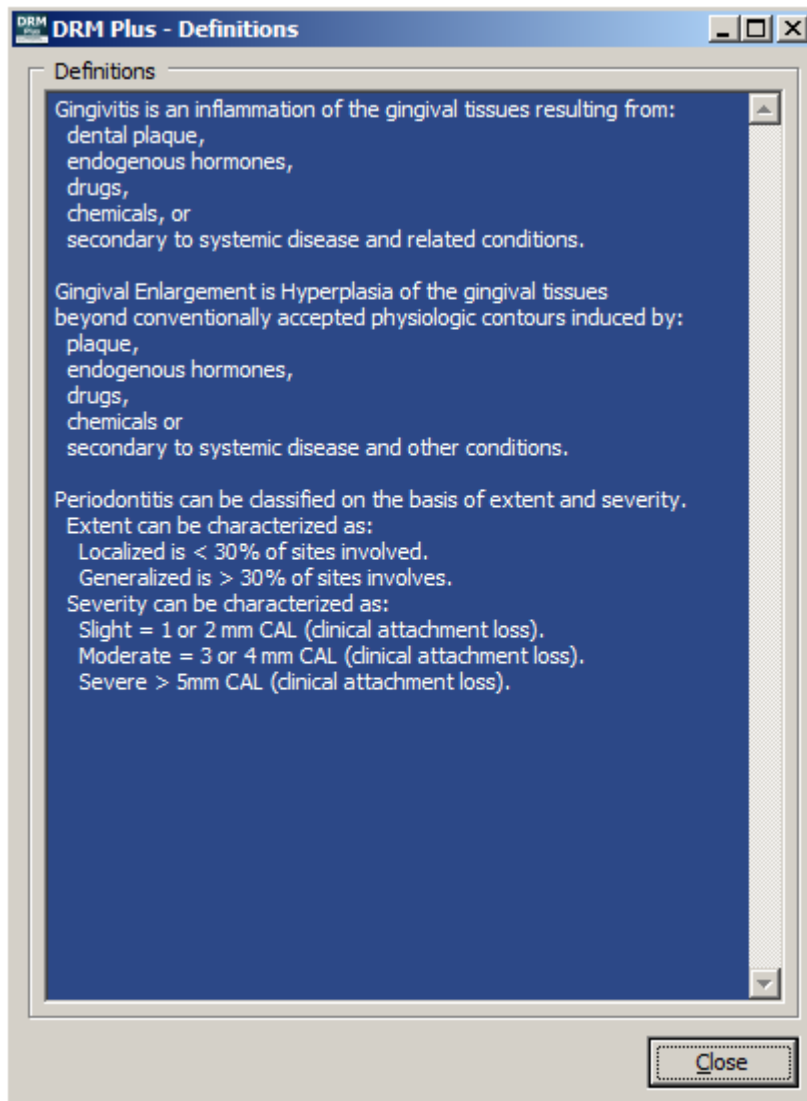


Figure 253: VA Dentistry Periodontal Definitions

Parafunctional Habits Element

This element is optional for all seven exam/consult types. It imports all data entered in this session from the **Parafunctional Habits** screen, or simply is left blank. The **Parafunctional Habits** screen can be opened by clicking the **Habits (Parafunctional)** button from the **Chart/Treatment** tab, or by clicking the **Parafunctional Habits** button in the bottom left portion of this element.

The minimum requirement to enter a new parafunctional habit finding is to select at least one history or one clinical finding from the **Parafunctional Habits** screen.

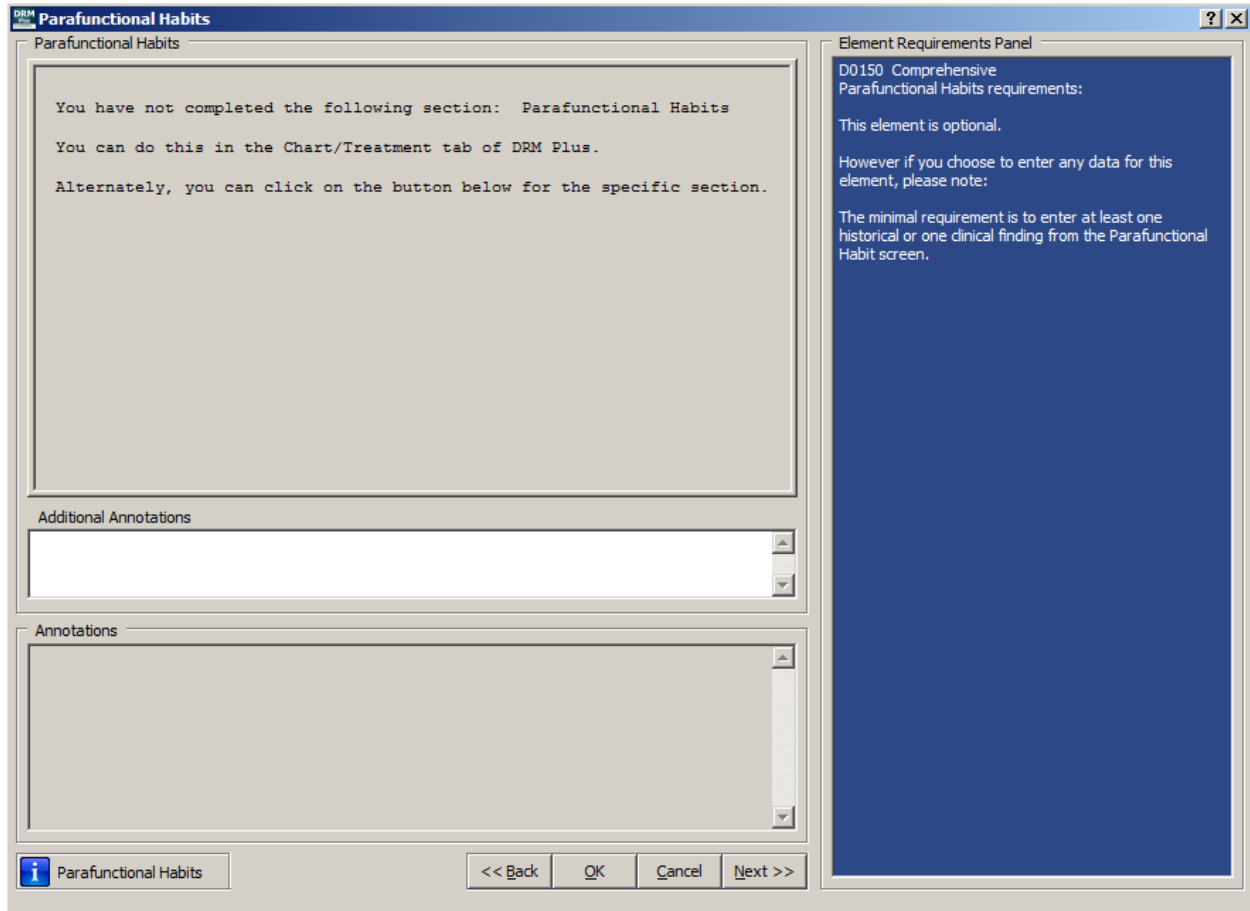


Figure 254: Parafunctional Habits Element Screen

Additional information regarding the patient may be entered into the **Additional Annotations** free text window. The user can right-click in this window to import a text file, if desired. All information entered into this element displays in the read-only **Annotations** window. Once this element is complete, click the **Next** button to move on to the next element.

TMJ Findings Element

This element is required for the D0120, D0150 and D0180 exams. It requires new TMJ findings entered from the **TMJ** screen, which can be opened either by clicking the **TMJ** button from the **Chart/ Treatment** tab, or the **TMJ Findings** button located in the bottom left portion of this element.

The minimum requirement to enter a new TMJ exam finding is to select at least one historical or clinical finding from the **TMJ** screen. Additional information regarding the patient can be entered into the **Additional Annotations** free text window. The user can right-click in this window to import a text file, if desired.

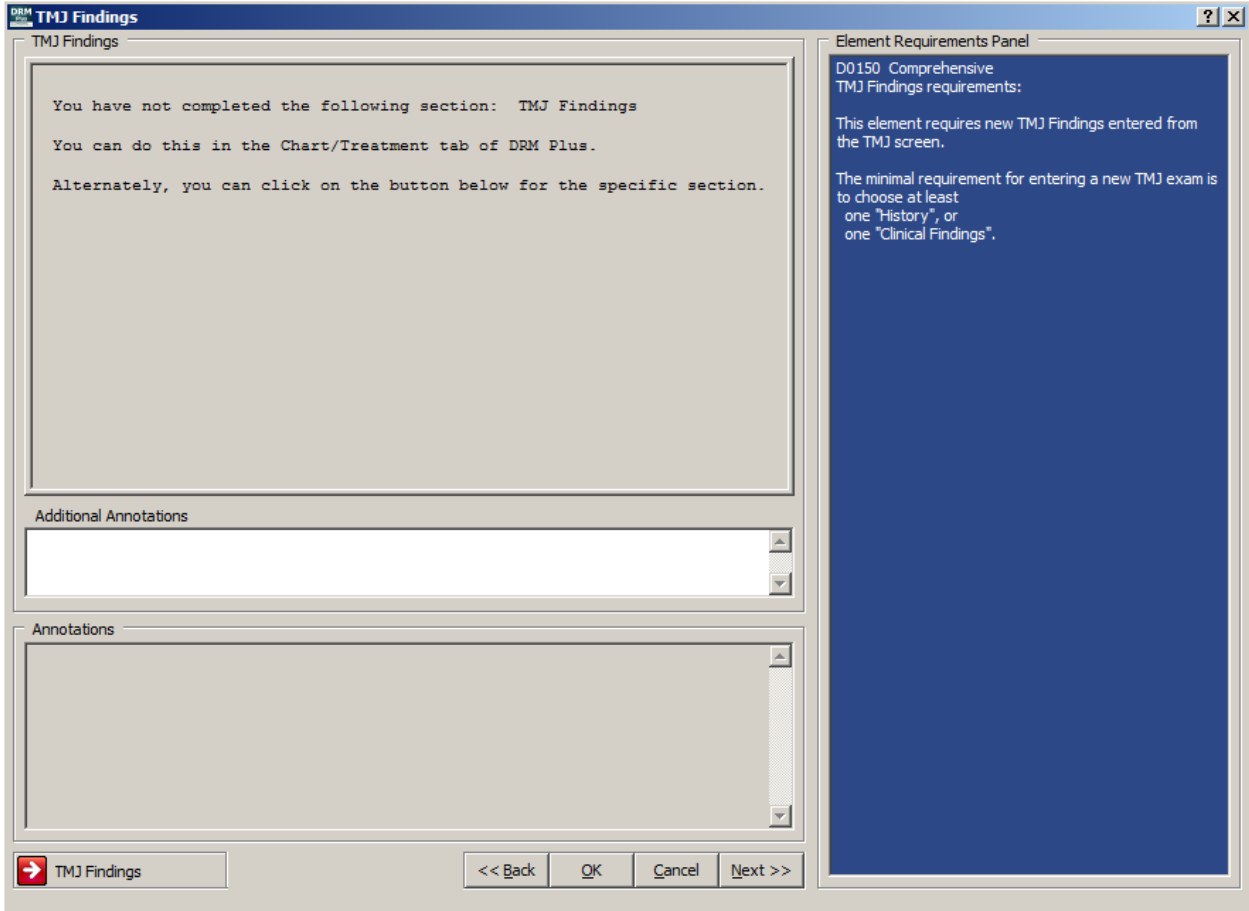


Figure 255: TMJ Findings Element Screen

All information entered in this element appears in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Occlusal Findings Element

The **Occlusal Findings** element is required for every D0150 and D0180 exams. Occlusal findings must be entered into, and imported from the **Occlusion** screen when completing one of these exams. The **Occlusion** screen can either be opened by clicking the **Occl** (Occlusion) button from the **Chart/Treatment** tab, or by clicking the **Occlusal Findings** button in the bottom left corner of this screen.

From the **Clinical Findings** section, the **Mandibular relationship*** is the only required field. All data from the last filed occlusion exam imports into the screen with a new exam, which requires the provider to remove and/or add correct data for the new exam.

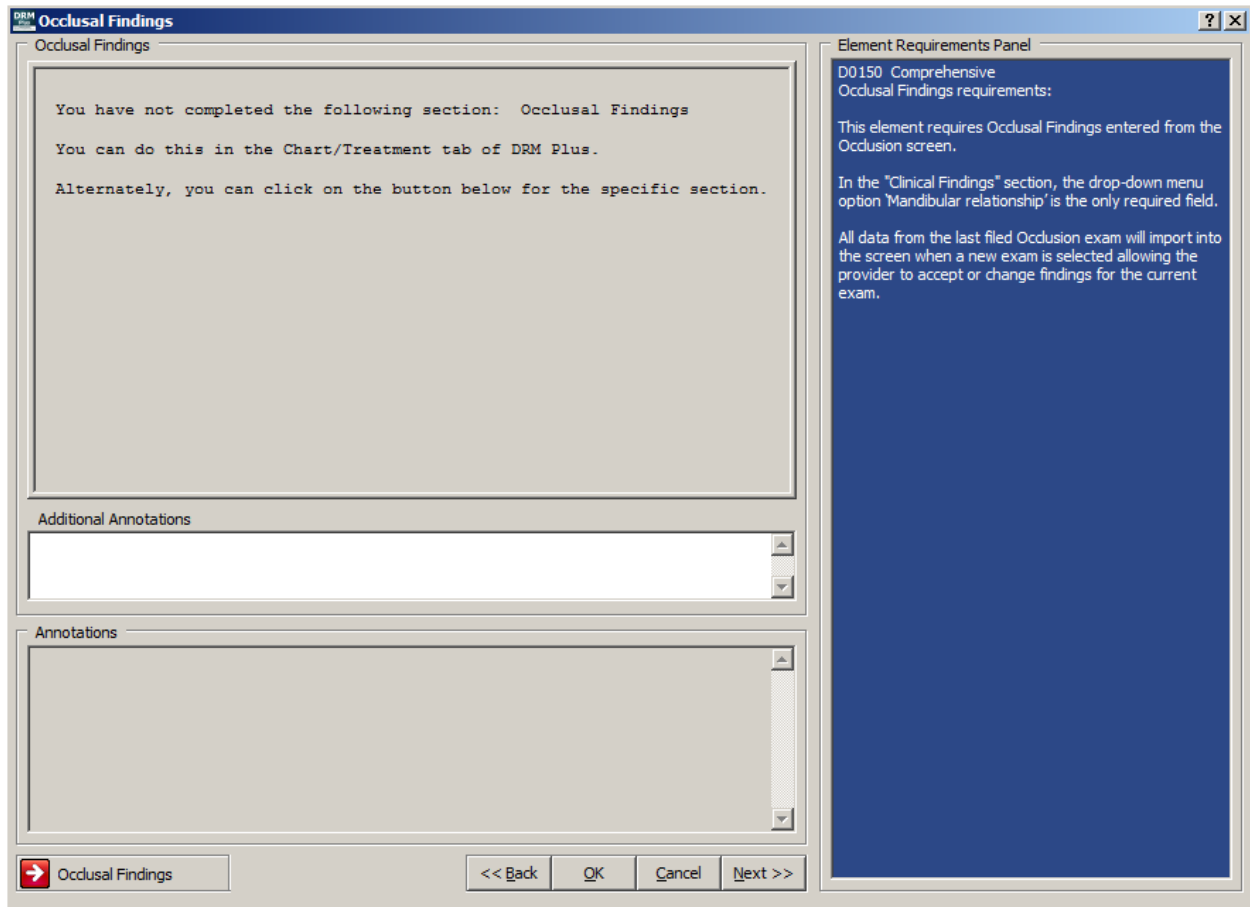


Figure 256: Occlusal Findings Element Screen

Enter additional information regarding the patient in the **Additional Annotations** free-text window, which offers right-click functionality to import text files, if desired. All information entered into this element displays in the read-only **Annotations** window. When the element is complete, click the **Next** button to move on to the next element.

Salivary Flow Element

The **Salivary Flow** element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The second radio button; **Clinically abnormal salivary quantity and/or quality noted**, requires a statement to be entered in the text box.

The **Xerostomia** value and description imports for viewing on this **Salivary Flow** element screen if entered from the **OHA** screen during this session.

The screenshot displays the 'Salivary Flow' element screen. The main area contains two radio buttons: 'Clinically normal salivary quantity and quality noted' (selected) and 'Clinically abnormal salivary quantity and/or quality noted:'. Below the radio buttons is a text box for additional information. A note states: 'NOTE: Xerostomia may be entered in Oral Health Assessment (OHA) in addition to any comments made here.' There are sections for 'Additional Annotations' and 'Annotations' (containing 'Salivary Flow Findings:'). At the bottom are buttons for '<< Back', 'OK', 'Cancel', and 'Next >>'. An 'Element Requirements Panel' on the right provides instructions: 'D0150 Comprehensive Salivary Flow requirements: This element is optional. However if you choose to enter any data for this element, please note: The minimal requirement is to select one of the two radio buttons in the element. The second radio button option requires a text entry in the text box.' A status bar at the bottom left shows 'Oral Health Assessment'.

Figure 257: Salivary Flow Element Screen

The user can enter additional information regarding the patient into the **Additional Annotations** free text window. This window offers right-click functionality to import text files, if desired. All information entered into the element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Removable Protheses Element

The **Removable Protheses** element is optional for all seven exam/consult types. This element requires one of the top three radio buttons to be selected when entering data. If the user selects the third radio button, **Patient presents with removable prothes(es)**, the user must then select one of either the **Maxillary** or **Mandibular** radio buttons: **Partial** or **Complete**. Only one is required and, once selected, it pens two more radio buttons: **Satisfactory** or **Unsatisfactory**.

If the user selects **Unsatisfactory**, four check boxes (**Occlusion**, **Retention**, **Stability** and **Esthetics**) and a text box become active. The user needs to check any box pertaining to the patient, and note any additional protheses in the text box.

The **Other Protheses** check box opens a required text box for any other protheses that should be added to the TIU progress note for the patient.

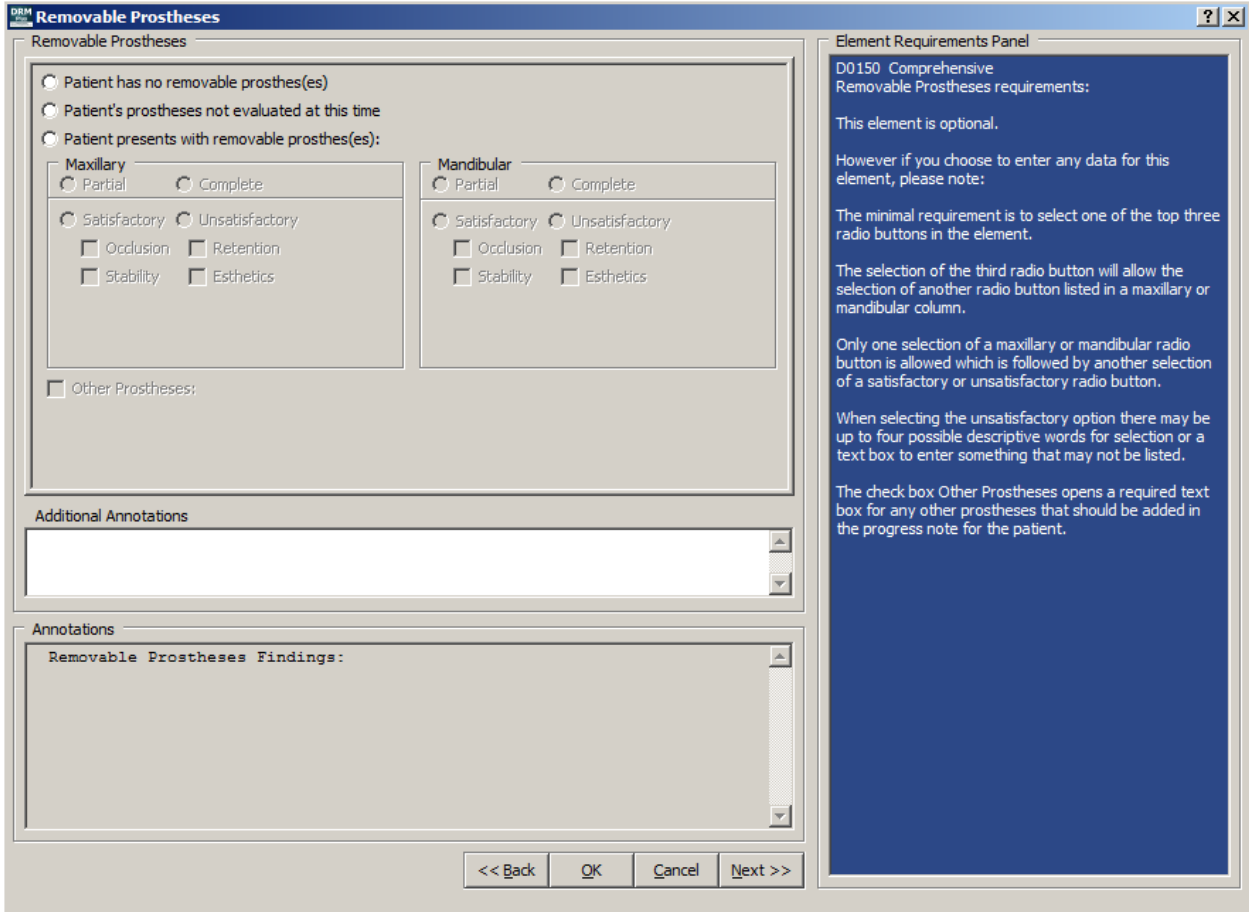


Figure 258: Removable Protheses Element Screen

The user may enter any additional information regarding the patient into the **Additional Annotations** text window. This window offers right-click functionality to import text files, if desired. All information entered into the element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Assessment/Plan Element

The **Assessment/Plan** element, comprised of an assessment and planned section, is required for all seven exam/consult procedures. The top assessment section is optional for the completion of this element.

The **Treatment Plan** section requires one of the four check boxes or only one pre-defined statement to be selected to complete the element. The first check box, **Include charted treatment plan**, loads automatically and imports the patient's newly entered and/or past planned treatment.

Up to twelve pre-defined statements for the **Assessment Summary** and twelve **Treatment Plan** statements can be selected from this screen. The check boxes found in the pre-defined statement windows have three national assessment and three national planned statements pre-loaded; however, all twelve statements from either can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

The screenshot shows the 'Assessment/Plan (review/edit)' window. The 'Assessment Summary' section contains the following checkboxes:
 No urgent dental needs or acute dental infections noted on examination.
 No contraindications for planned procedure(s).
 Dentition in satisfactory repair and function.
 Clinic wide radiographic pre-defined statement entered.
 Another clinic wide radiographic pre-defined statement entered.
 First end-user radiographic pre-defined statement entered.

The 'Treatment Plan' section contains the following checkboxes:
 Include charted treatment plan
 Referred to assigned dentist for further treatment planning
 No treatment required at this time
 Final treatment plan to be completed at a later time
 Reviewed risks/benefits/alternatives associated with the proposed treatment plan. Patient agrees to
 Adequate dentition for mastication. Replacement of missing teeth is not indicated.
 Patient is not eligible for replacement of teeth through VA.

The 'Annotations' section shows the following text:
Assessment/Plan:
Planned Procedures:
Non-VA Care
(D6010) ENDOSTEAL IMPLANT BODY PLACE: 29. DX: ().
second appt
(D6056) PREFABRICATED ABUTMENT: 29. DX: ().
(D6059) ABUT SUPPORT CROWN PORC HNOB: 29. DX: ().
Phase 1
(D2160) AMALGAM THREE SURFACES PERMA: 3 (DOL). DX: (). (Next-

The 'Element Requirements Panel' on the right contains the following text:
D0150 Comprehensive
Assessment/Plan (review/edit) requirements:
In the "Assessment Summary" section, the text box and pre-defined statements are optional. It is highly recommended at a minimum an appropriate pre-defined statement is selected for detail.
The "Treatment Plan" section requires one of the four check boxes, and/or one pre-defined statement to be selected.
Planned data will import automatically and the check box will appear preselected if there is any previously planned data present.

Figure 259: Assessment/Plan Element Screen

The user may enter additional information regarding the patient into the **Additional Annotations** free text window. This window offers right-click functionality to import text files, if desired. All information entered into this element appears in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is NOT dependent on the element's completion.

Note: The **Assessment/Plan** element imports incomplete when it is saved as unfiled data and reloaded. The provider is required to review/edit this element again at this time.

Patient Education Element

The **Patient Education** element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button opens a text box that requires specific information regarding the patient or one pre-defined statement may be selected.

Up to twelve pre-defined statements on patient education can be selected from this screen. The check boxes found in the pre-defined statements window have two national patient education statements pre-loaded; however, all twelve statements can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

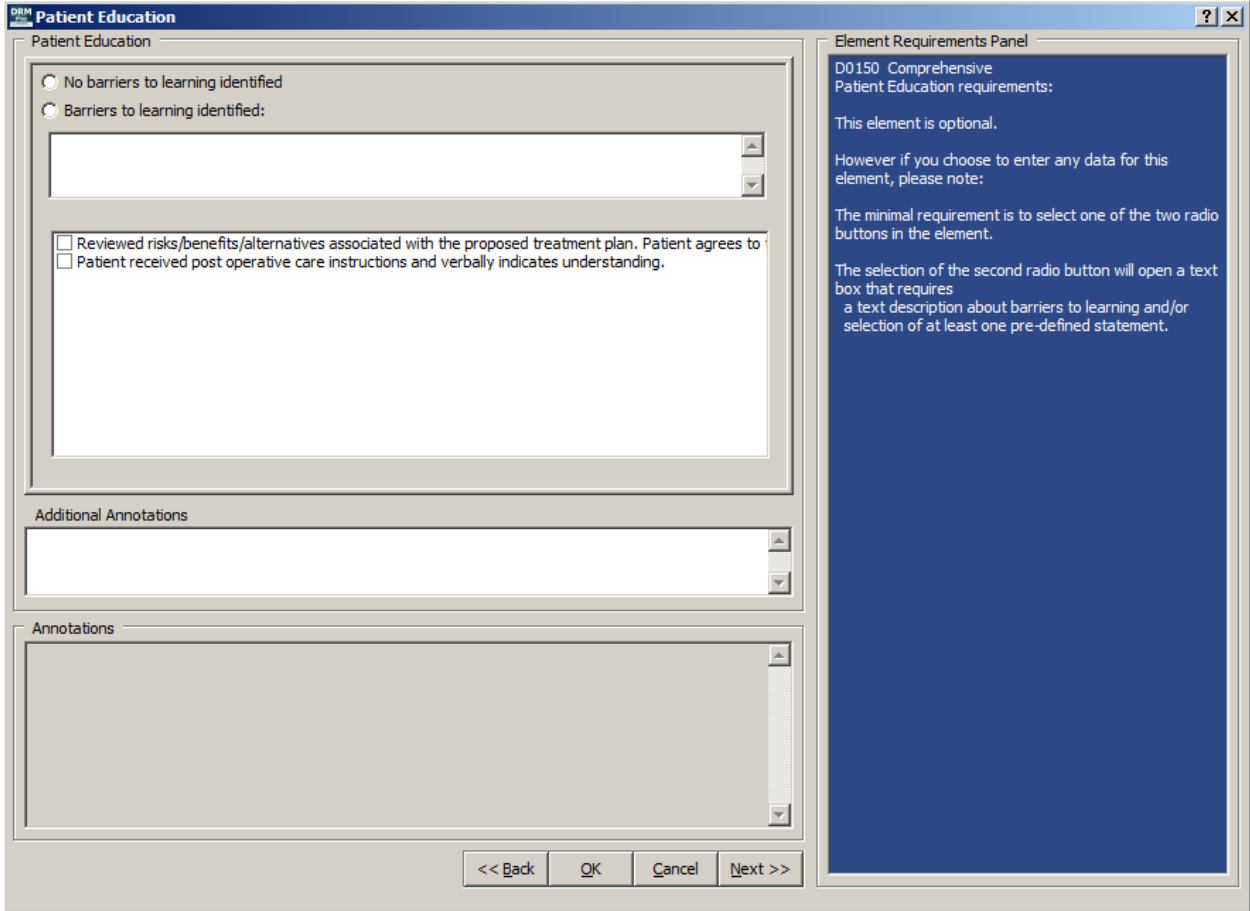


Figure 260: Patient Education Element Screen

The user may enter additional information regarding the patient into the **Additional Annotations** free text window. This window offers right-click functionality to import text files, if desired. All information entered into this element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Disposition Element

The **Disposition** element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button, **Next visit**, requires at least one of the following; one selection of the eight date ranges, a text description about the next visit typed in the text box, or one selection from the pre-defined statements.

The **Next Appointment** check boxes, if selected in the **Tx Planning/Sequencing** screen, import automatically into the **Annotations** view window of this element.

Up to twelve pre-defined statements on disposition can be selected from this screen. The check boxes found in the pre-defined statements window have four national disposition statements pre-loaded; however, all twelve statements can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

The screenshot shows the 'Disposition' window with the following content:

- Disposition**
 - No follow up appointment indicated
 - Next visit:
 - within 1 week
 - 1-2 weeks
 - 2-4 weeks
 - 1-2 months
 - 2-3 months
 - 3-4 months
 - 4-6 months
 - recall
- Text box for additional notes
- Pre-defined statements:
 - Patient has no eligibility for VA dental benefits and was recommended to the private sector for routine
 - Patient to return to dental clinic for continuing care.
 - Patient to be scheduled for continuing development of treatment plan.
 - Patient provided instructions for obtaining fee dental care subject to VA authorization of proposed tre

- Additional Annotations**: Text box
- Annotations**:

```
Disposition:  
Next Appointment:  
(D2160) AMALGAM THREE SURFACES PERMA: 3 (DOL) Amalgam  
(D2392) POST 2 SRFC RESINBASED CMPST: 4 (OL) Resin
```
- Buttons: << Back, OK, Cancel

Element Requirements Panel (right side):

D0150 Comprehensive
Disposition requirements:
This element requires one of the two radio buttons to be selected when entering data.
The selection of the second radio button will require at least one of the following:
one selection of the eight date ranges or
a text description about the next visit typed in the text box or
one selection of the pre-defined statements.

Figure 261: Disposition Element Screen

The user may enter additional information regarding the patient into the **Additional Annotations** free text window. This window offers right-click functionality to import text files, if desired. All information entered into this element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is NOT dependent on the element's completion.

Import Previously Filed Data Screen

When any provider has filed patient dental data previously that day in any of the following screens: **Social History, OHA, TMJ, Parafunctional Habits, Occlusion, Diagnostic Findings, Head and Neck Findings, PSR or Periodontal Chart**; then that data may be imported by a second provider entering an exam encounter that same day. The second provider, after selecting an exam code and then selecting the **Exam** tab, has the following **Import Previously Filed Data** screen display. This screen allows the provider an option to import the data into his exam template to satisfy some possible requirement from the exam code that they may have selected.

Selecting the check boxes of any or all previously filed data that day imports that data into their present exam template session. There is a **Check ALL the above** check box at the bottom of the screen which allows all that day's filed data to be imported into this new TIU progress note. After selecting the desired check boxes, the provider click the **Import** button to incorporate this data into the current exam template. If none of the data should be imported into the current exam template, then select the **Cancel** button.

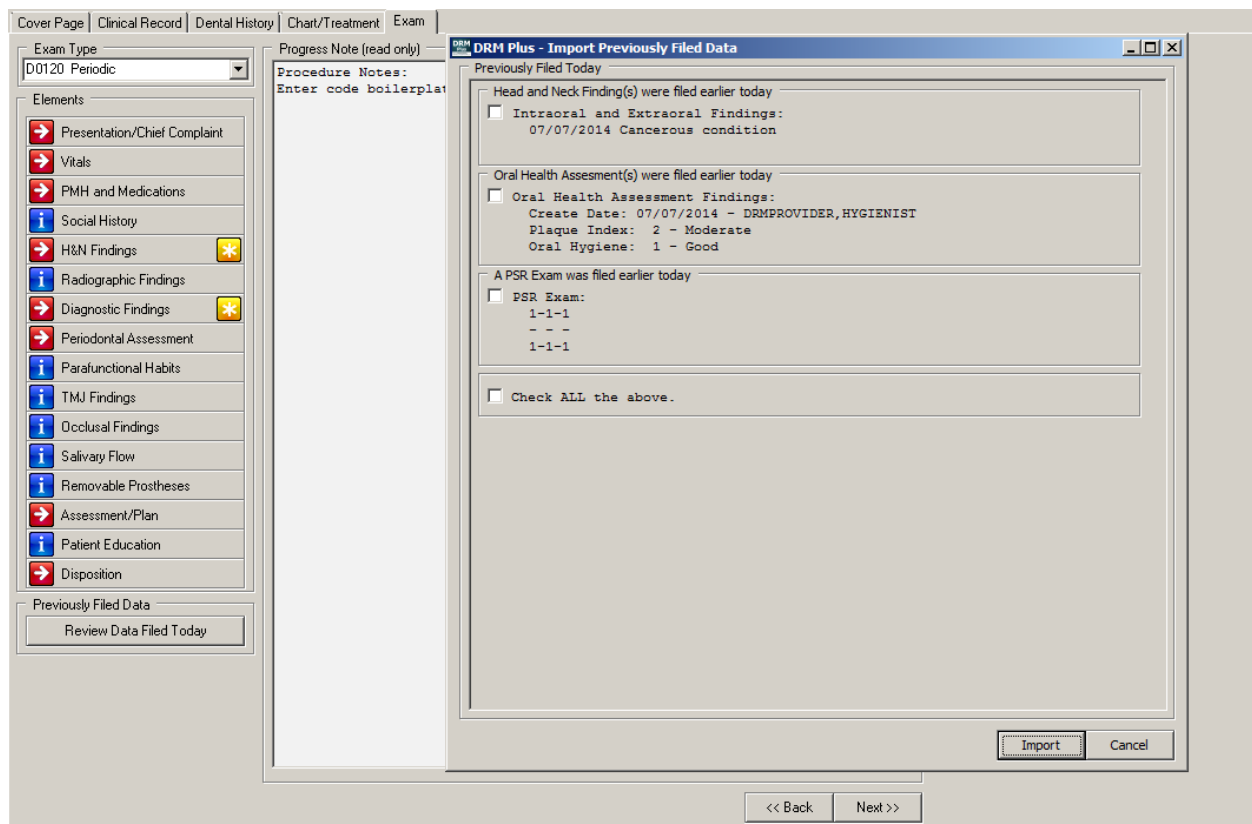




Figure 262: Import Previously Filed Data Screen

The  icon on the right of the element button displays when there was previously filed data that day and that data is associated with the element. The **Diagnostic Findings** element informs the provider, by displaying the  icon, there is one or any combination of diagnostic findings, OHA or PSR filed earlier that day by another provider.

Below the element icons located on the left side of the **Exam** tab, there is a **Review Data Filed Today** button. This button only displays when data was filed to VistA TIU earlier that day by all providers working with this patient. This button allows the provider to open the **Import Previously Filed Data** screen to make edits or corrections by the present provider on what was filed previously that day.

Note: The **yellow asterisk** icon will always display when vitals have been entered for this patient during a 24 hours range from the **Visit** date and taken anywhere in the hospital for this patient.

Completing the Encounter

Click the **Next** button, located in the bottom right corner of both the **Treatment & Exam** and **Periodontal Chart** screens, to begin completing the encounter for the patient's chart. If there was no provider/visit/date in the banner, imported or selected, when the patient's chart was opened and **NOT** one completed transaction selected; then clicking the **Next** button brings up the **Provider and Location for Current Activity** screen to select/enter a visit. After selecting one procedure code the **File Data Option** screen displays, which is explained later in this chapter. In addition, if the system finds possible duplicate procedure codes in the planned and completed transactions, the **Potential Duplicate Transaction** screen displays.

To complete the patient encounter with completed transactions:

1. Click the **Next** button on the bottom right corner of either the **Treatment & Exam** or **Periodontal Chart** screens.
2. The **Filing Options** screen displays.

The screenshot shows the 'Filing Options' screen in the Dental Record Manager Plus application. The window title is 'Dental Record Manager Plus in use by: DRMPROVIDER,ADMINIDENTIST for DRMPATIENT,ONE'. The patient information banner includes: DRMPATIENT,ONE (000-00-0001), 01/01/1960, Age: 55, Oct 07, 15@09:00 DENTAL, DRMPROVIDER,ADMINIDENTIST, PDP: DRMPROVIDER,ADMINDE, SDP: DRMPROVIDER,ADMINDE, and Dental Class: DPC, Class IV. The 'Filing Options' section has three radio buttons: 'File Data With a Note' (selected), 'File Data With a Note Addendum', and 'File Data Without a Note'. The 'Visit Date/Time' is 10/07/2015 09:00, and the 'Encounter Dental Class' is 15-OPC, Class IV. The 'Disposition' section has three radio buttons: 'Active' (selected), 'Inactive', and 'Maintenance'. The 'Primary PCE Diagnosis' section has a table with columns: Select, Diagnosis, Diagnosis Description, Send Dx to CPRS Problem List, Additional Information, Procedure, and Procedure Description. Two rows are visible, both with 'K02.52' as the diagnosis and 'DENTAL CARIES ON PIT AND FISSU...' as the description. The first row is selected. The 'Service Connection' section has several checkboxes, none of which are checked. The 'Additional Providers' and 'Additional Signers' sections each have an 'Add ...' and 'Remove' button. The 'Station' section has two radio buttons: '500' (selected) and '500BZ'. At the bottom right, there are buttons for 'Return to Chart', '<= Back', 'Next >=', and 'Finish'.

Select	Diagnosis	Diagnosis Description	Send Dx to CPRS Problem List	Additional Information	Procedure	Procedure Description
<input checked="" type="checkbox"/>	K02.52	DENTAL CARIES ON PIT AND FISSU...	<input type="checkbox"/>	Tooth: 3 / Surface: DOL	D2160	AMALGAM THREE SURFACES PER...
<input type="checkbox"/>	K02.52	DENTAL CARIES ON PIT AND FISSU...	<input type="checkbox"/>	Tooth: 4 / Surface: OL	D2392	POST 2 SRFC RESINBASED CMPST

Figure 263: Filing Options Screen

3. Select the correct **Filing Option**. The information displayed in the **Visit Date/Time** and the **Disposition** defaults can be changed. The **Encounter Dental Class** defaults if saved on the cover page. Select the **Suggested Recare Date** if applicable to the patient.
4. Select the **Primary PCE Diagnosis** for the encounter, unless there is only one no matter how many transactions there are which defaults checked.
5. Provider may select the diagnosis to be sent to the patient's problem list.

6. Enter the locally required information for service connection.
7. Enter the optional information of **Additional Providers** or **Additional Signers** on this screen. Please see the **Additional Providers/Additional Signers** section, found later in this chapter, for more information.
8. Select the appropriate facility (station) by clicking the appropriate radio button.
9. Click the **Next** button.
10. The **Dental Class Discrepancy** screen may display, if the encounter dental class and cover page dental class do **NOT** match. This does **NOT** stop the user from completing the encounter.
11. The **Set Progress Note Title** screen displays. Note that this screen does **NOT** display if the **File Data with a Note Addendum** or **File Data Without a Note** options were selected from the filing options.

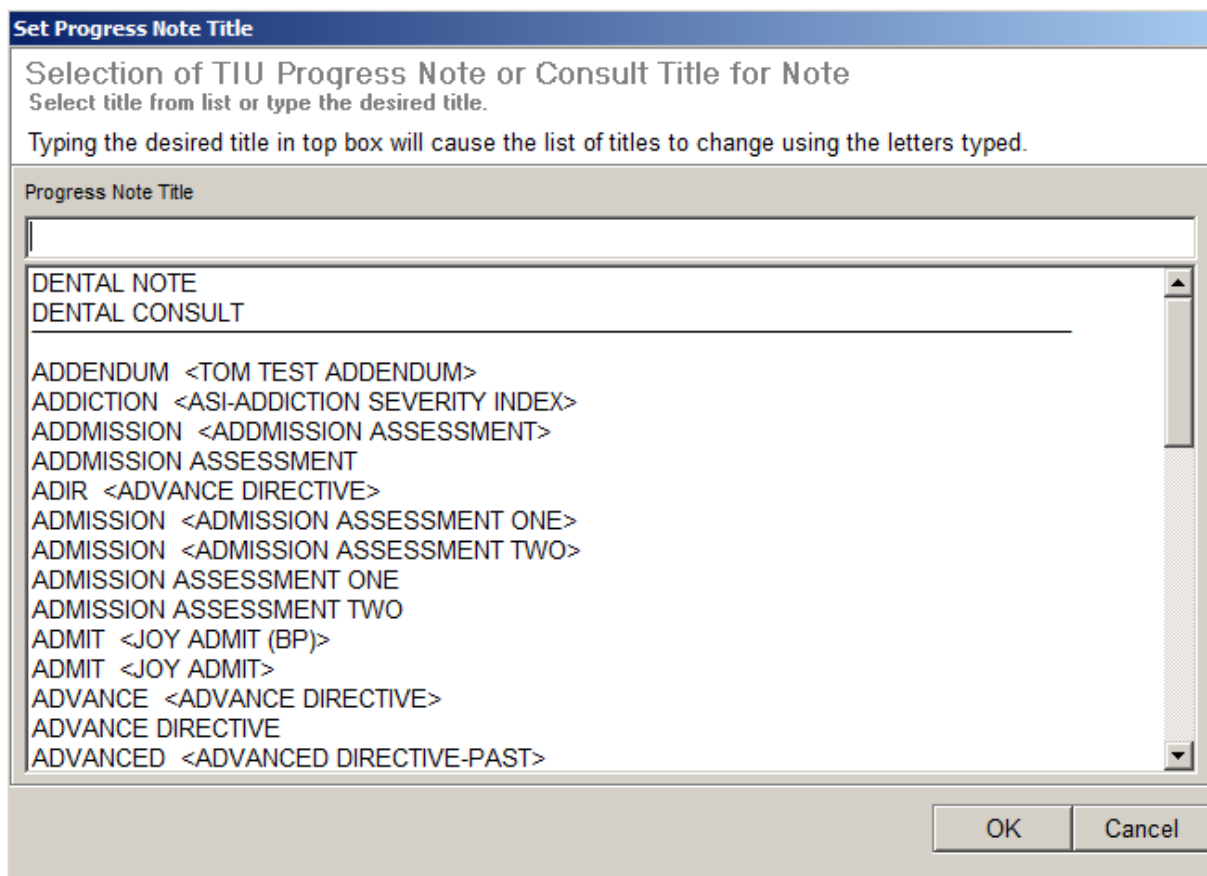


Figure 264: Set Progress Note Title Screen

12. Search for the title using the **Progress Note Title** search box, or use the scroll bar to select the desired title from the list. Default TIU progress note titles at the top of the list are set in the **CPRS Tools** menu → **Options** submenu → **Notes** tab → **Document Titles** button.
13. Click the **OK** button.
14. The progress note screen displays.

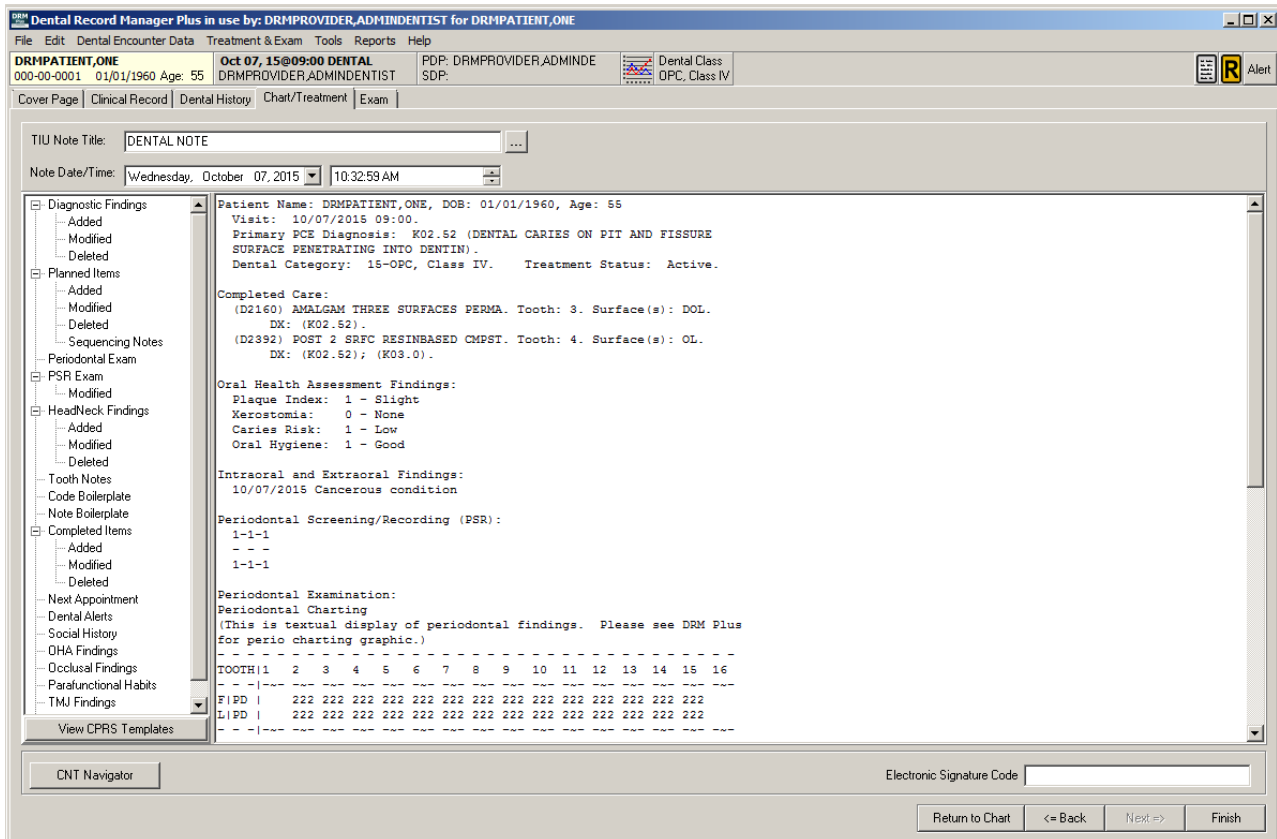


Figure 265: Progress Note Screen

15. Ensure the information on the screen is correct. Enter the electronic signature and click the **Finish** button. An electronic signature is NOT required to file the note as unsigned. Please see the **Electronic Signature** section, found later in this chapter, for more information.
16. The **Change Provider** screen displays.

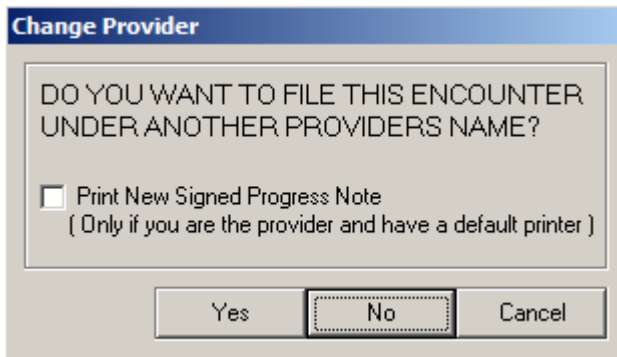


Figure 266: Change Provider Screen

17. Click the **Yes** button to change the provider. The **Search for Provider** screen displays. If **No** is selected, a screen displays. Please see step 19.

Potential Duplicate Transactions Screen

If the system detects that a possible duplicate transaction exists, the **Potential Duplicate Transactions** screen displays, when the **Next** button on the **Treatment & Exam** or **Periodontal Chart** screens is clicked.

These transactions have already been **PLANNED** for the following teeth:

Tooth	Surface	ADA Code	Description	Keep	Delete
13	OL	D2392	POST 2 SRFC RESINBASED CMPST	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14	DOL	D2160	AMALGAM THREE SURFACES PERMA	<input type="checkbox"/>	<input checked="" type="checkbox"/>

These are the **COMPLETED** transactions you just entered:

Tooth	Surface	ADA Code	Description	Keep	Delete
13		D2750	CROWN PORCELAIN W/ H NOBLE M	<input checked="" type="checkbox"/>	<input type="checkbox"/>
14		D2790	CROWN FULL CAST HIGH NOBLE M	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Keep Planned Let Me Decide
 Keep Completed Keep All

Figure 269: Potential Duplicate Transactions! Screen

A list of planned transactions for a tooth, along with the procedure code and the description, are listed in the top portion of the screen. Completed transactions taken during this encounter are listed in the bottom portion of the screen, with elements that match other planned transactions for the same tooth.

The radio buttons on the lower left portion of the screen designate which information is kept or discarded. The **Keep Planned** radio button keeps the planned transaction and deletes the conflicting completed transaction entered during the encounter. The **Keep Completed** radio button keeps the completed transaction entered during this encounter and deletes the planned transaction. The **Let Me Decide** radio button clears all check boxes and allows for picking and choosing among the planned and completed transactions. **Keep All** allows all conflicting procedure codes that are planned and completed to be processed.

After clicking the desired radio button and selecting, if necessary, which transactions are kept and/or discarded, click the **Process and Go Back**, **Cancel** or **Process and Continue** buttons to continue completing the encounter. **Process and Go Back** processes the procedure codes and returns to the **Treatment & Exam** or **Periodontal Chart** screen. **Cancel** displays the **Periodontal Chart** or **Treatment & Exam** screen without processing any information. **Process and Continue** processes the procedure codes and continues updating the TIU progress note. The **Filing Options** screen displays. Continue completing the encounter from this point, as outlined previously in this chapter.

Note: The system does NOT present a user with the **Potential Duplicate Transactions** screen when the potential duplicate is a tooth-related radiographic procedure.

File Data Option Screen

If no procedure code has been entered as completed treatment on the **Completed Care** screen and the user clicks the **Next** button, the **Provider and Locations for Current Activities** screen displays if no visit is present in the banner. When the visit is present or after one has been selected then the **File Data Option** screen displays.

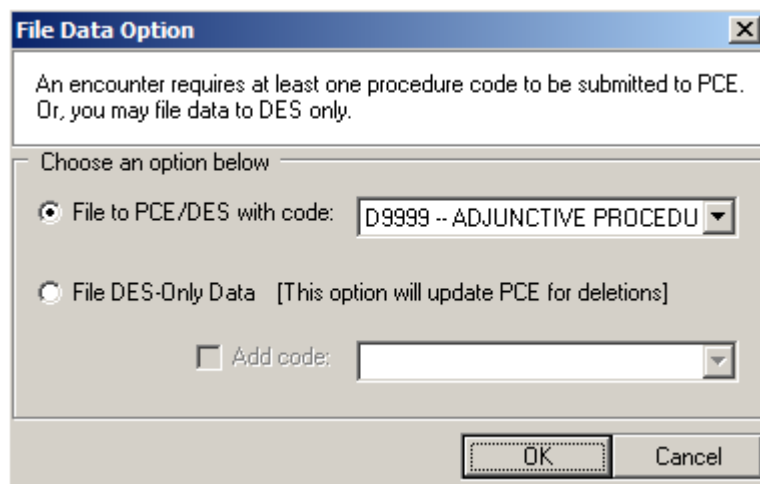


Figure 270: File Data Option Screen

Click the appropriate radio button to designate whether the data is to be filed to PCE/DES with a procedure code, or to file to DES-Only data.

File to PCE/DES with Code

To file data to PCE/DES with a procedure code:

1. The **Provider and Location for Current Activities** screen displays. Select the correct visit.
2. Click the **File to PCE/DES with code** radio button on the **File Data Option** screen.
3. The program defaults to **D4999** if entering this screen from the **Periodontal Chart**, and **D9999** if entering from **Treatment & Exam**.
4. If the default procedure code is incorrect, click the code drop-down menu and select the desired procedure code.
5. Click the **OK** button.
6. The **Diagnosis Code** screen displays.
7. Select the procedure code on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does NOT appear, use the **Additional Diagnosis Code Search** to find a different diagnosis code.

File to DES-Only Data

To file to DES-Only data:

1. The **Provider and Location for Current Activities** screen displays. Select the correct visit.
2. Click the **File to DES-Only Data** radio button.
3. If a procedure code is desired (NOT required), check the **Add code** check box and use the drop-down menu to select a procedure code.
4. The **Diagnosis Code** screen displays.
5. Select the procedure code on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does NOT appear, use the **Additional Diagnosis Code Search** to find a different diagnosis code.

Filing Options Screen

The **Filing Options** screen is divided into ten main sections: **Filing Options, Visit Date/Time, Encounter Dental Class, Disposition, Suggested Recare Date, Primary PCE Diagnosis & Send DX to CPRS Problem List, Service Connection, Additional Providers, Additional Signers and Station.**

Filing Options

Use the **Filing Options** radio buttons to choose how the encounter is to be filed.

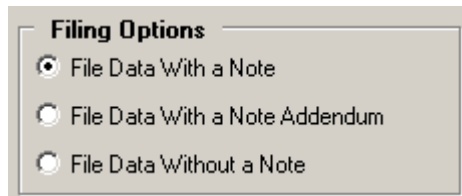


Figure 271: Filing Options

The options are: **File to Data with a Note, File Data With a Note Addendum** and **File Data Without a Note**. The **File Data Without a Note** creates no TIU progress note.

Visit Date/Time

Adjust the **Visit Date/Time** using this function. The program defaults to whatever was entered on the **Provider and Location for Current Activities** screen.

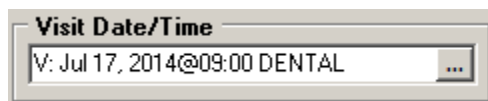


Figure 272: Visit Date/Time

To change the visit date and time:

1. Click the **Ellipsis (...)** button.
2. The **Provider and Location for Current Activities** screen displays.

- Choose the correct provider and appointment from the **Provider and Location for Current Activities** screen and click the **OK** button. Please see the Dental Encounter Data section in the Using DRM Plus Drop-Down Menus chapter of this manual, for further information.

Encounter Dental Class

Use the drop-down menu to change the **Encounter Dental Class** for this encounter.



Figure 273: Encounter Dental Class

Disposition

Use the radio buttons to change the patient's **Disposition** or case management status.



Figure 274: Disposition

Suggested Recare Date

Use the **Ellipsis (...)** button to add/change the suggested recare date.

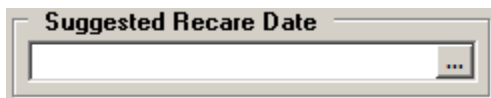


Figure 275: Suggested Recare Date

Click the **Ellipsis (...)** button to open the **Select Date** screen.

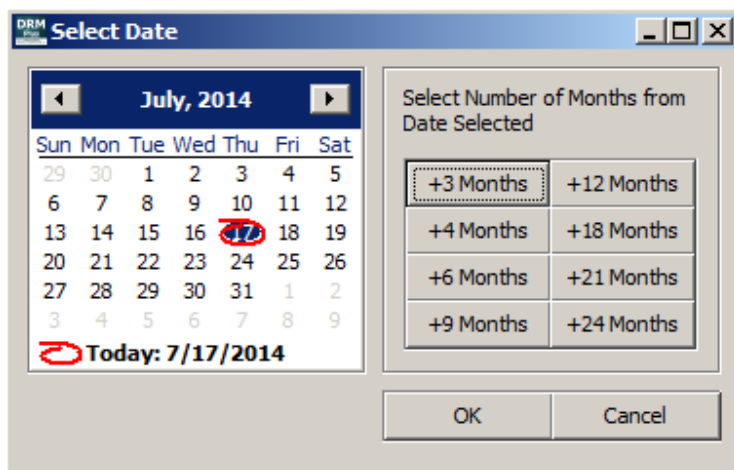


Figure 276: Select Date Screen

Select the date from the calendar or select the number of additional months from the date selected first on the calendar and then click the **OK** button.

Primary PCE Diagnosis & Send Dx to CPRS Problem List

This window features a list of the diagnosis codes with descriptions, selections to send diagnosis to CPRS problem list, procedure codes with descriptions, and additional information.

Select the primary PCE diagnosis by clicking the check box under the **Select** column in the **Primary PCE Diagnosis** window. If there is only one diagnosis, or several of the exact same diagnosis, the selection is checked by default. All encounters require only one primary diagnosis filed to VistA PCE.

Select diagnoses to **Send Dx to CPRS Problem List** by clicking the check box in that column.

Select	Diagnosis	Diagnosis Description	Send Dx to CPRS Problem List	Additional Information	Procedure	Procedure Description
<input checked="" type="checkbox"/>	K02.52	DENTAL CARIES ON PIT AND FISSU...	<input type="checkbox"/>	Tooth: 3 / Surface: DOL	D2160	AMALGAM THREE SURFACES PER...
<input type="checkbox"/>	K02.52	DENTAL CARIES ON PIT AND FISSU...	<input type="checkbox"/>	Tooth: 4 / Surface: OL	D2392	POST 2 SRFC RESINBASED CMPST

Figure 277: Primary PCE Diagnosis Window

The **Primary PCE Diagnosis** window allows one completed transaction at a time to be deleted when using the **Delete Highlighted Transaction** button.

First highlight the completed transaction that should be deleted and then select the **Delete Highlighted Transaction** button located in the upper right corner of the window.

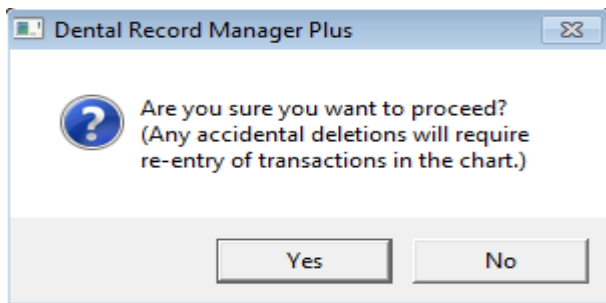


Figure 278: Transaction Deletion Screen

The resulting pop-up will display asking are sure you want to proceed. Selecting the **Yes** button will delete that completed transaction.

Service Connection

Use the check boxes to denote service connection, if applicable.

Service Connection

Encounter is associated with service-connected condition

Southwest Asia Conditions (SWAC) Ionizing Radiation Treatment Combat Veteran Agent Orange Treatment Head and Neck

Military Sexual Trauma PRQJ 112/SHAD

Figure 279: Service Connection

Additional Providers/Additional Signers

Add or remove providers from this patient encounter by using the tools in this area.

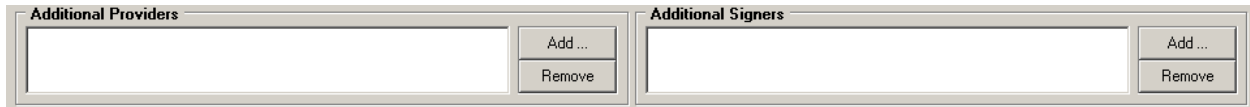


Figure 280: Additional Providers/Additional Signers

To add a provider or signer:

1. Click the **Add** button.
2. The **Search for Provider** or the **Search for Signer** screen displays.

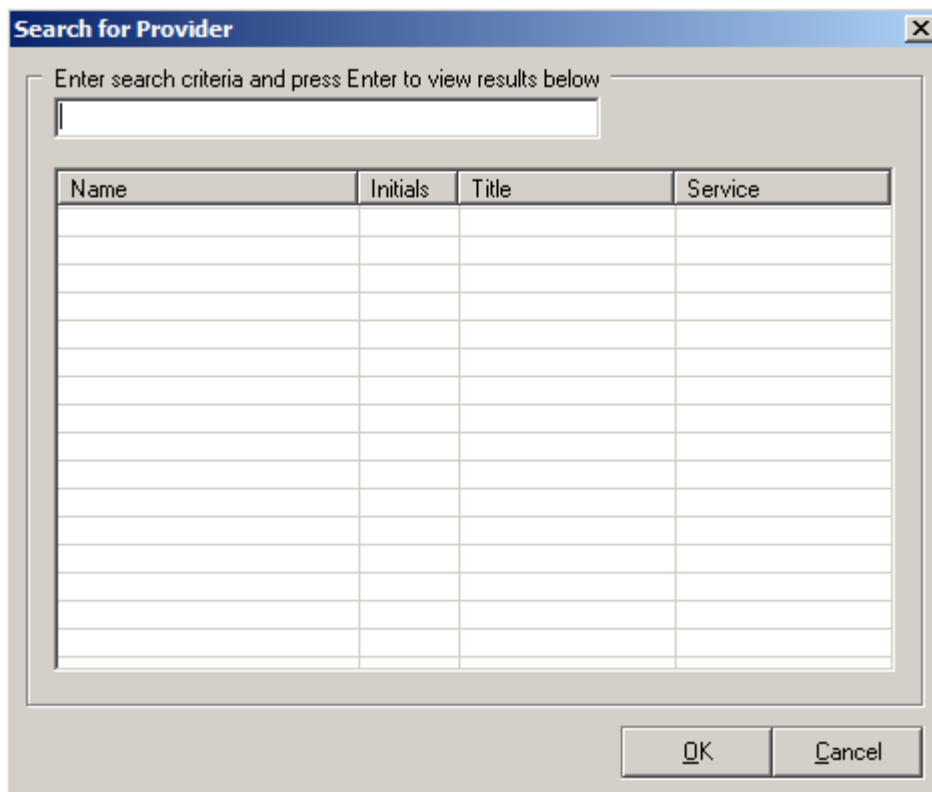


Figure 281: Search for Provider Screen

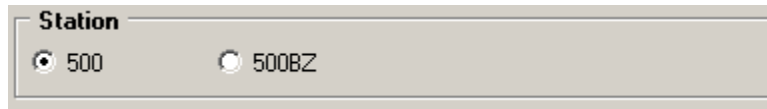
3. Enter the name into the text box and press <**Enter**>.
4. Select the correct name from the results and click the **OK** button.
5. The provider displays on the **Additional Provider/Signer** window. Repeat as necessary.

To remove a Provider/Signer:

1. Highlight the provider or signer name.
2. Click the **Remove** button.
3. A confirmation screen displays. Click the **Yes** button.
4. The name is removed from the **Additional Provider/Signer** window.

Station

Select the appropriate **Station** (facility) by clicking the appropriate radio button, if applicable.

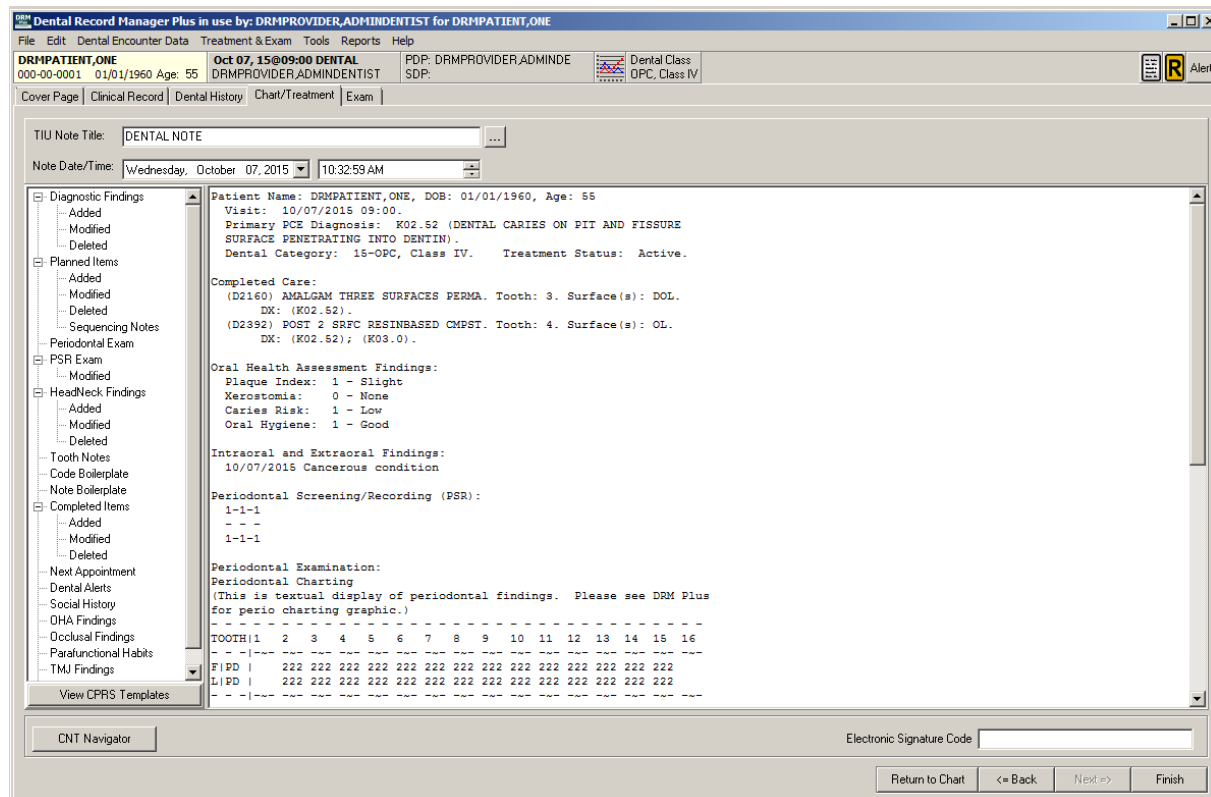


The image shows a window titled "Station" with two radio buttons. The first radio button is selected and is labeled "500". The second radio button is unselected and is labeled "500BZ".

Figure 282: Station

Progress Note Screen

The **Progress Note** screen has several major areas and functions. This is the final screen in completing an encounter with the patient, and has different incarnations depending on how the transaction is to be filed: **File Data With a Note**, **File Data With a Note Addendum** or **File Data Without a Note**. The following screen displays when the transaction is filed using the **File Data With a Note** option.



The screenshot shows the "Progress Note Screen" in the Dental Record Manager Plus application. The window title is "Dental Record Manager Plus in use by: DRMPROVIDER,ADMINIDENTIST for DRMPATIENT,ONE". The menu bar includes File, Edit, Dental Encounter Data, Treatment & Exam, Tools, Reports, and Help. The patient information is displayed as DRMPATIENT,ONE, 000-00-0001, 01/01/1960, Age: 55, on Oct 07, 15@09:00 DENTAL, DRMPROVIDER,ADMINIDENTIST, PDP: DRMPROVIDER,ADMINDE, SDP: DRMPROVIDER,ADMINDE, Dental Class: OPC, Class IV. The TIU Note Title is "DENTAL NOTE" and the Note Date/Time is "Wednesday, October 07, 2015 10:32:59 AM". The left sidebar contains a tree view of categories such as Diagnostic Findings, Planned Items, PSR Exam, HeadNeck Findings, Tooth Notes, Code Boilerplate, Note Boilerplate, Completed Items, Next Appointment, Dental Alerts, Social History, OHA Findings, Occlusal Findings, Parafunctional Habits, and TMJ Findings. The main content area displays patient information, visit details, primary PCE diagnosis (K02.52), dental category (15-OPC, Class IV), completed care for teeth 3 and 4, oral health assessment findings (Plaque Index: 1 - Slight, Xerostomia: 0 - None, Caries Risk: 1 - Low, Oral Hygiene: 1 - Good), intraoral and extraoral findings (10/07/2015 Cancerous condition), and periodontal screening/recording (PSR) results (1-1-1). A periodontal examination table is shown with columns for TOOTH (1-16) and rows for F|PD and I|PD, all containing the value 222. The bottom of the screen features a "CNT Navigator" button, an "Electronic Signature Code" field, and "Return to Chart", "< Back", "Next >", and "Finish" buttons.

Figure 283: Progress Note Screen

Use the **Ellipsis (...)** button to change the TIU progress note title here if needed. Use the **up** and **down arrows** to change the **Note Date/Time** if desired. From this screen, the user can also: view and/or import DRM Plus objects, view and import CPRS templates, launch the **CNT Navigator** (DSS clinical note templates), view the patient's TIU progress note, import VistA medical information, and add an electronic signature.

In addition to the imports that can be made into a TIU progress note, free-texting for narrative may also be entered prior to filing the note by the user.

Viewing/Importing DRM Object/Progress Note

To view/import DRM objects:

1. Click the **View DRM Plus Objects** button (defaulted) below the tree on the left side of the screen.
2. Double-click the DRM object and it displays in the viewer on the right side of the screen. The DRM object imports where the cursor is positioned.
3. Information can be added or deleted by typing directly into the progress note on the right side of the screen.

Viewing/Importing CPRS Templates

To view/import CPRS templates:

1. Click the **View CPRS Template** button below the tree on the left side of the screen.
2. The shared/personal templates tree, if expanded, displays on the left side of the screen. Most functionality of CPRS templates in DRM Plus is the same as in CPRS.
3. Click the **View DRM Plus Objects** button to return to the DRM object tree.

Importing VistA Medical Information

To import VistA medical information into the patient's TIU progress note:

1. Right-click in the progress note area.
2. The **Import Menu** displays.

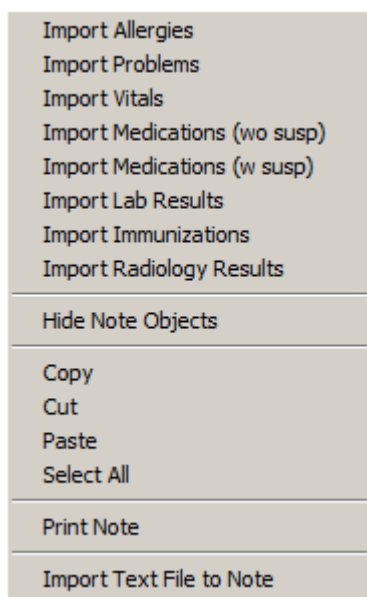


Figure 284: Import Menu Screen

3. Choose the information that is to be imported from the top half of the menu.
4. The information displays in the progress note where the cursor was positioned.

Other Options in the Import Menu

- **Hide Note Objects:** Hides or closes the objects tree on the left side of the screen and enlarges the progress note viewer.
- **View Note Objects:** Undoes the hide note objects.
- **Copy:** Copies selected text in the progress note.
- **Cut:** Cuts selected information in the progress note.
- **Paste:** Pastes information into the progress note.
- **Select All:** Selects all text in the progress note.
- **Print Note:** Prints the progress note.
- **Import Text File to Note:** Navigates to a text file to import into a note. See the User Options section in the Using DRM Plus Drop-Down Menus chapter of this manual for more information on automatically setting the location for this text file.

Accessing Dental CNTs

Click the **CNT Navigator** button to access dental CNTs. These are DSS product clinical note templates. The dental CNTs may NOT be mapped for DRM Plus at the user's site; it would require IT assistance. Please see the CNT Navigator section, further in this chapter.

Electronic Signature

Enter the **Electronic Signature Code** and click the **Finish** button to complete the TIU progress note. Clicking the **Finish** button without entering an electronic signature leaves the patient TIU progress note status as unsigned.

Progress Note Addendum

When the **File Data With Note Addendum** option has been chosen, the **Progress Note** screen displays slightly different. The functions are the same as in the previously shown progress note screen with the additions of selecting the **Note Categories** radio button options and with the parent note displaying in the upper right window.

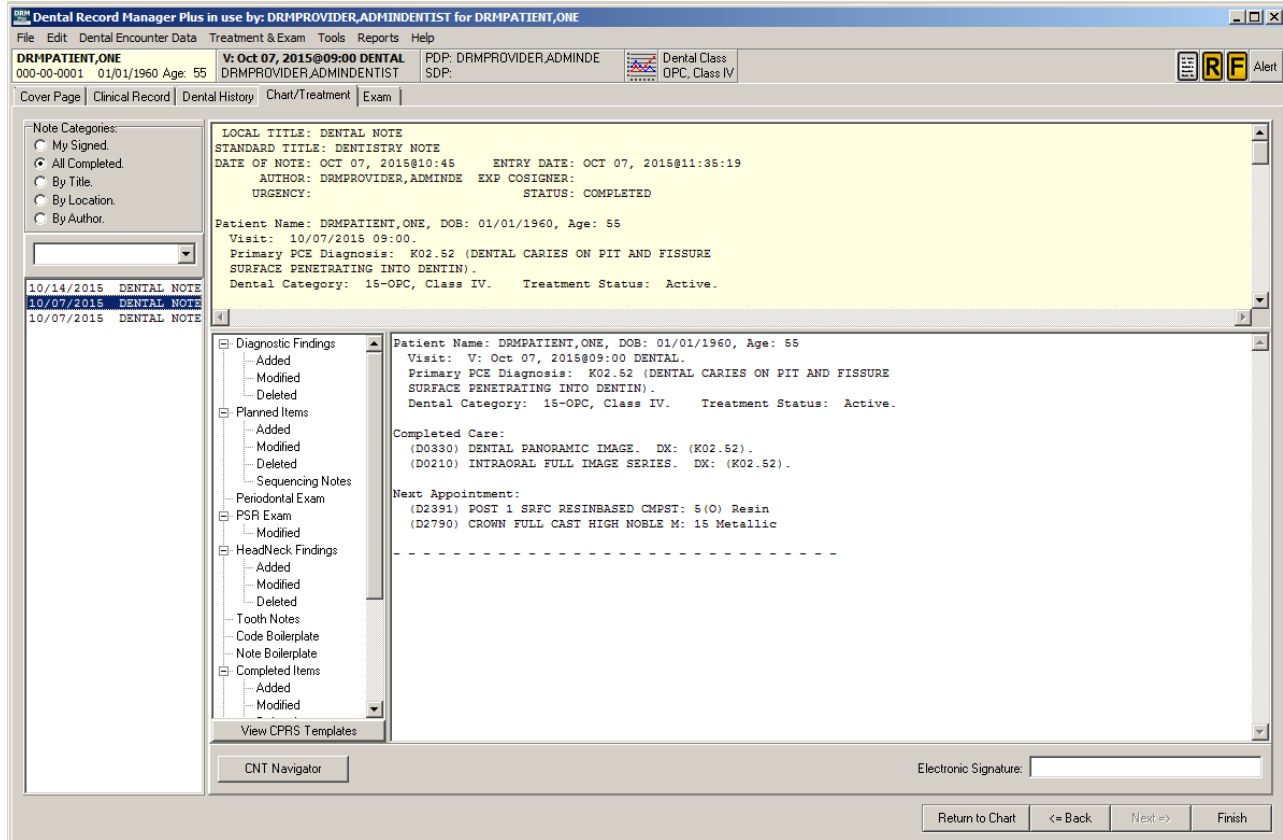


Figure 285: Progress Note Addendum Screen

The notes associated with the selected **Note Categories** appear in the narrow window below the note categories area. Use the drop-down menu below the note categories to filter the results. Click a parent note to view details in the upper right window of the screen.

Finish the process of filing the encounter with a note addendum, which displays in the lower right window of the screen.

CNT Navigator

Clicking the **CNT Navigator** button displays up a directory of clinical note templates in use, as a tool, to assist the user in writing a note, or additional information to a note. The **CNT Navigator** button is located on the bottom left side of the **Progress Note** screen. These are Document Storage Systems (DSS) product clinical note templates, and may NOT function unless they are mapped correctly, which requires IT assistance.

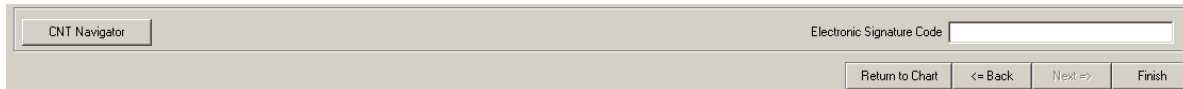


Figure 286: CNT Navigator Button

Using the mouse, point and click to select pre-determined text in the development of a note. Type the text within the CNT if the pre-determined text or statement does NOT contain the necessary verbiage.

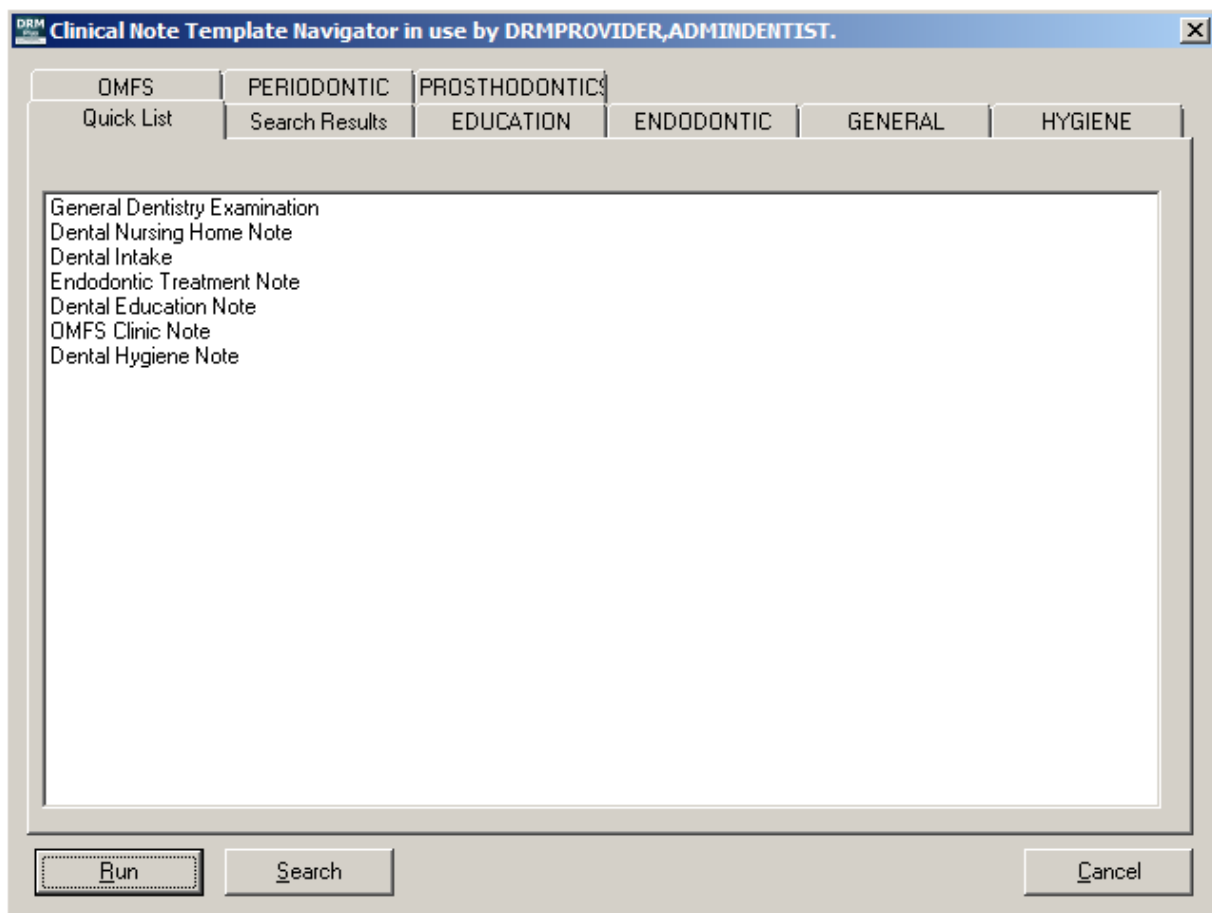


Figure 287: Clinical Note Template Navigator Screen

To access a CNT:

1. Click any of the tabs.
2. A listing of CNTs specific to the selected tab displays. Either double-click the desired template, or click once to select it and then click the **Run** button.

Navigating Within CNTs

To navigate within a CNT:

1. Point and click within the windows, tabs, drop-down arrows, check boxes, and radio buttons. Each navigational method provides the user with a different method of entering or selecting information.
2. Preview the note by clicking the **Preview** button.
3. Click the **Return** button to continue writing the note.

The screenshot shows a software window titled "Dental Hygiene Progress Note" with a menu bar (File, Tools, Help). The window is divided into several sections:

- Vital Signs:** A grid of input fields for Temp., Pulse, Systolic, Diastolic, Resp., Pain, SP02%, Height, Weight, BMI, Age, and BSA. Each field includes a date/time dropdown and a numeric spinner. Patient Sex is indicated by radio buttons for Male and Female.
- Chief Complaint:** A text area with a scroll bar and a list of options: Headache, Pain to heat, Pain to cold, Pain to pressure, Toothache, Swelling, Pain with Postural Changes, Teeth Sensitive to Chewing, and Minimal to No Relief from OTC Pain Medication. Buttons for "Click for Normal", "Select from Pick List", and "Clear Text" are present.
- Pre-Medication:** A dropdown menu and a checkbox.
- ASA:** Radio buttons for ASA classes 1, 2, 3, and 4.
- Footer:** A row of buttons: Open, Save, Reminders, Preview, Cancel, Finish, Prev, 1 of 6, Next.

Figure 288: Navigating Within CNT

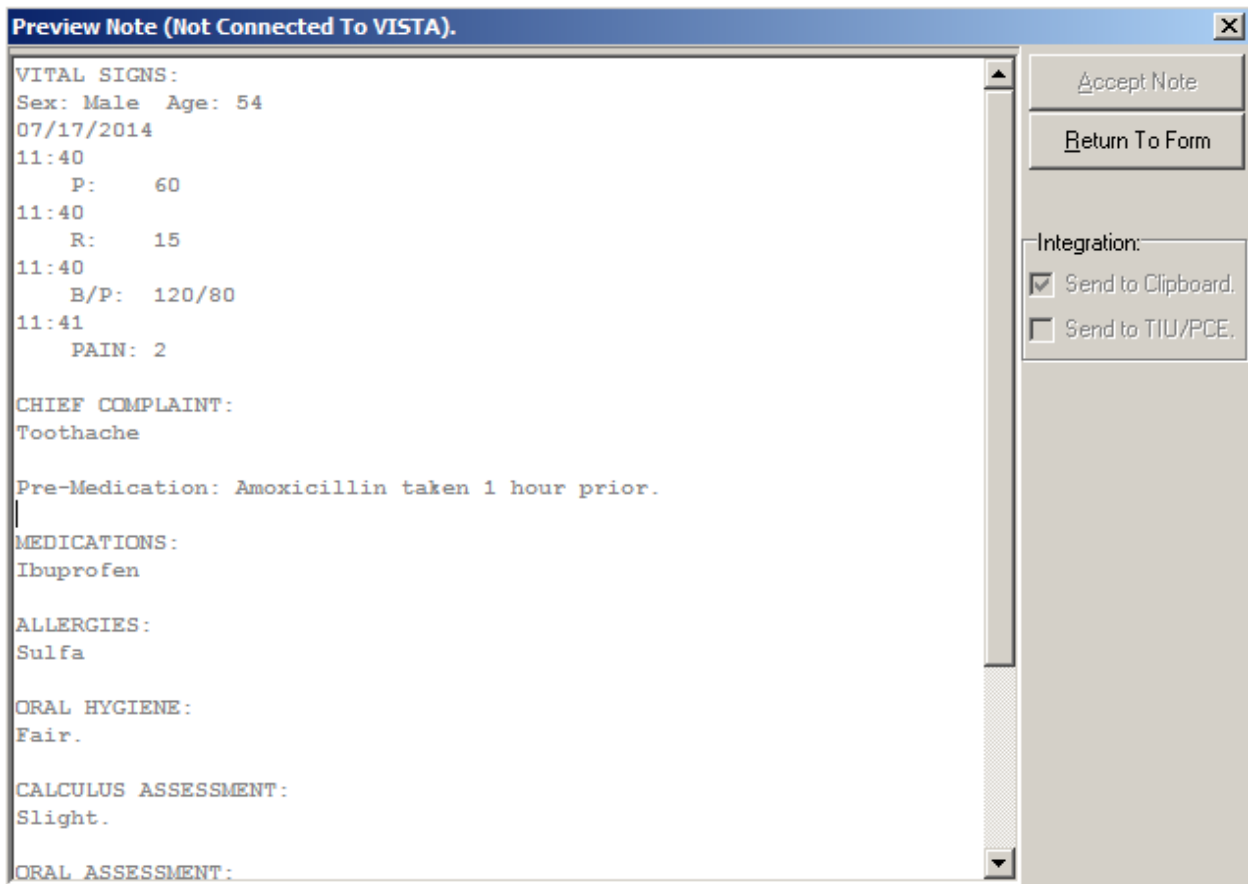


Figure 289: Preview Note

When the note is complete, click the **Finish** button. Then click the **Accept Note** button.

Consult Notes

The option to complete a consult displays after the **Filing Options** screen, during the process of completing a patient encounter, when the **Set Progress Note Title** screen displays.

Set Progress Note Title

Selection of TIU Progress Note or Consult Title for Note
Select title from list or type the desired title.

Typing the desired title in top box will cause the list of titles to change using the letters typed.

Progress Note Title

DENTAL NOTE
DENTAL CONSULT

ADDENDUM <TOM TEST ADDENDUM>
ADDICTION <ASI-ADDICTION SEVERITY INDEX>
ADMISSION <ADMISSION ASSESSMENT>
ADMISSION ASSESSMENT
ADIR <ADVANCE DIRECTIVE>
ADMISSION <ADMISSION ASSESSMENT ONE>
ADMISSION <ADMISSION ASSESSMENT TWO>
ADMISSION ASSESSMENT ONE
ADMISSION ASSESSMENT TWO
ADMIT <JOY ADMIT (BP)>
ADMIT <JOY ADMIT>
ADVANCE <ADVANCE DIRECTIVE>
ADVANCE DIRECTIVE
ADVANCED <ADVANCED DIRECTIVE-PAST>

OK Cancel

Figure 290: Set Progress Note Title Screen

To complete the consult:

1. Choose the consult title from the **Set Progress Note Title** screen.
2. The patient's pending consults display on the screen.

Set Progress Note Title

Selection of TIU Progress Note or Consult Title for Note
 Select title from list or type the desired title.

Typing the desired title in top box will cause the list of titles to change using the letters typed.

Progress Note Title

DENTAL NOTE
DENTAL CONSULT
 ADDENDUM <TOM TEST ADDENDUM>
 ADDICTION <ASI-ADDICTION SEVERITY INDEX>
 ADMISSION <ADMISSION ASSESSMENT>

The above title must be associated with a consult request. Select one of the following or chose a different title.

Consult Request	Date	Service	Procedure	Status	# Notes
07/17/2014	14.24	DENTAL		PENDING	0

OK Cancel

Figure 291: Set Progress Note Title with Pending Consult

3. Select the consult from the list.
4. The consult is added to the progress note on the **Progress Note** screen. Once the electronic signature is entered on the **Progress Note** screen, the consult is complete.

5. Enter the search terms in the text box and press the <Enter> key.
6. Choose the provider from the search results and click the **OK** button.
7. An information screen displays confirming that the information was filed.

Note: VA dental gives credit/RVU time to the resident actually performing the procedures, all of which is filed to DES; to meet the VA requirement that the attending (distributed) gains credit for the encounter, this has to be filed in PCE.

When the encounter is filed to PCE, the resident becomes the secondary provider, and the distributed provider becomes the primary provider for the PCE encounter. All procedures and diagnoses are assigned to the distributed provider in VistA PCE.

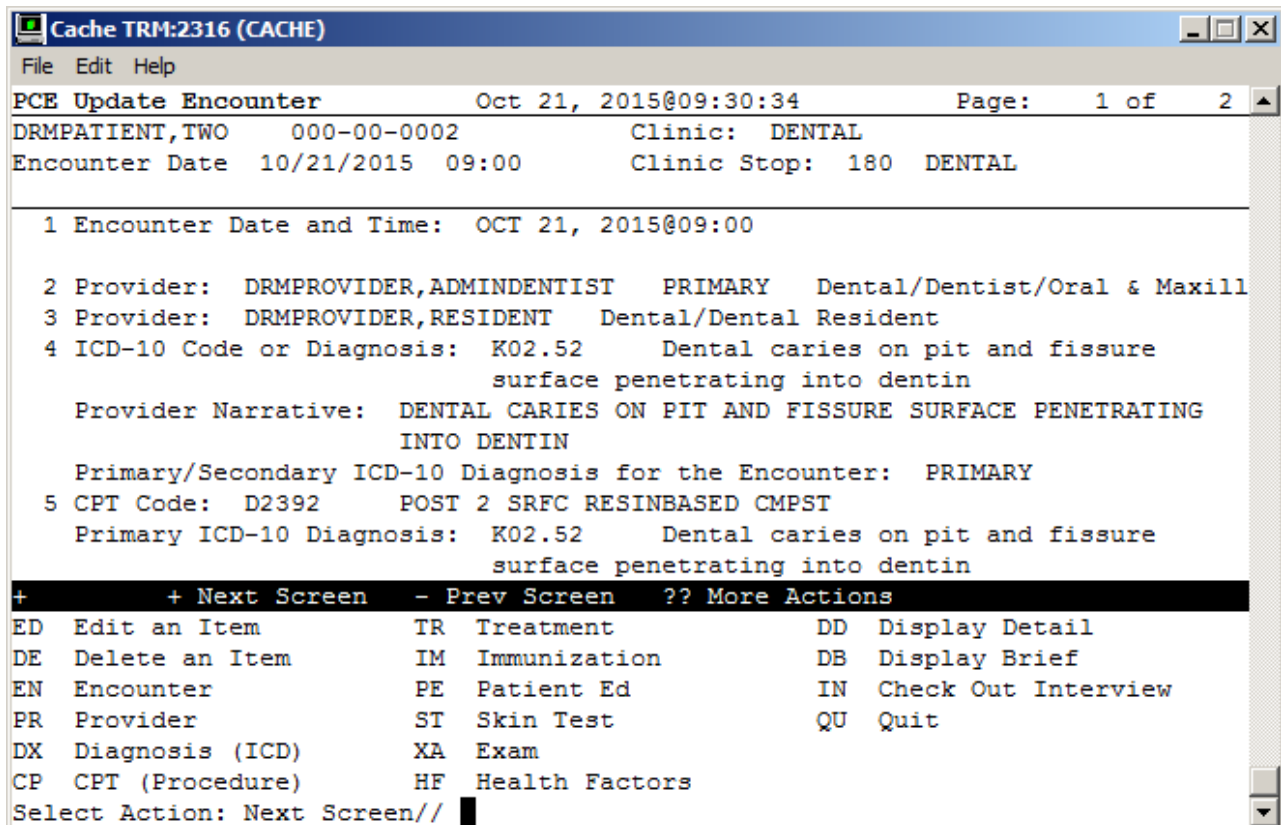


Figure 294: PCE Encounter Information in VistA

Appendix A – Glossary of VA Terms

ADPAC	Automated Data Processing Applications Coordinator
AICS	Automated Information Collection System, formerly Integrated Billing, the program that manages the definition, scanning and tracking of Encounter Forms.
APPOINTMENT	A scheduled meeting with a provider at a clinic; an appointment can include several encounters involving other providers, tests, procedures, etc.
CBOC	Community Based Outpatient Clinic
CC	Coordinating Committee
CFO	Chief Financial Officer
CHECKOUT PROCESS	Part of the Medical Administration (PIMS) appointment processing. The checkout process documents administrative and clinical data related to the appointment.
CIO	Chief Information Officer
CIR	Corporate Information Repository
CIRN	Clinical Information Resource Network
CLINICIAN	A doctor or other provider in the medical center authorized to provide patient care.
CNT	Clinical Note Template (Used to format TIU progress notes)
CPR	Cardiopulmonary Resuscitation
CPRS	Computerized Patient Record System
CPT	Common Procedure Terminology
CQI	Continuous Quality Improvement
DAS	Dental Activity System (also called AMIS)
DES	Dental Encounter System (also called DES)
DHCP	Decentralized Hospital Computer Program (See: VistA)
DNR	Do Not Resuscitate
DOD	Department of Defense
DRG	Diagnostic Related Group
DSS	Decision Support System
DSS	Document Storage Systems, Inc.

DVA	Department of Veterans Affairs
EDI	Electronic Data Interchange
ELC	Executive Leadership Council
EMR	Electronic Medical Record
ENCOUNTER	A contact between a patient and a provider who has responsibility for assessing and treating the patient at a given contact, exercising independent judgment. A patient can have multiple encounters per visit.
ENCOUNTER FORM	A paper form used to display and collect data pertaining to an outpatient encounter, developed by the AICS package.
EPISODE OF CARE	Many encounters for the same problem constitute an episode of care. An outpatient episode of care may be a single encounter, or can encompass multiple encounters over a long period of time.
FEMA	Federal Emergency Management Agency
FIM	Federal Independence Measure
FRP	Federal Response Plan
GAF	Global Assessment of Functioning
GPRA	Government Performance and Results Act
GUI	Graphic User Interface
HEALTH SUMMARY	A Health Summary is a clinically-oriented, structured report that extracts multiple kinds of data from VistA and displays it in a standard format.
HR IGA	Human Resources Office of Intergovernmental Affairs
INPATIENT VISIT	Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient.
IOM	Institute of Medicine
ISDA	Intensity Severity Admission Discharge (criteria)
IT	Information Technology
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LAN	Local Area Network
MVV	Mission Vision Values
MAC	Management Assistance Council
MCCR	Medical Care Cost Recovery
MDS	Minimum Data Set

NHCU	Nursing Home Care Unit
OERR	Order Entry Results Reported
OSHA	Occupational Safety & Health Administration
OUTPATIENT ENCOUNTER	Outpatient encounters include scheduled appointments and walk-in unscheduled visits
OUTPATIENT VISIT	The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician's office, hospital medical center) within one calendar day.
PACS	Picture Archiving and Communications System
PAI	Patient Assessment Instruction
PCE	Patient Care Encounter
PI	Prevention Index
PM	Performance Management
PROCEDURE	A test or action done for or to a patient that can be coded with the CPT coding process.
PROVIDER	The entity which furnishes health care to a consumer.
PSA	Patient Service Area
PTSD	Post Traumatic Stress Disorder
RM	Risk Management
RPM	Resource Planning Methodology
SD	Standard Deviation
SMI	Seriously Mentally Ill
SSC	Shared Service Center
TIU	Text Integrated Utility
TQI	Total Quality Management
UM	Utilization Management
UNC	Universal Naming Convention. Used in place of Drive letters.
VA	Department of Veteran Affairs
VAVS	Veterans Administration Voluntary Service
VHA	Veterans Healthcare Administration
VISN	Veterans Integrated Service Network
VISIT	The visit of a patient to one or more units of a facility within one calendar day.

VistA	Veterans Information System Technology Architecture, the new name for DHCP.
VSO	Veterans Service Organization

Appendix B – Common Application Functions

Microsoft Windows tools are used in DRM Plus. Left-clicking, right-clicking, double-clicking, drop-down arrows, radio buttons, check boxes, text boxes, highlighting and scroll bars are used throughout DRM Plus. Certain buttons and clicking options are common to most screens and are discussed below.

OK: Clicking the **OK** button is used to finalize a selection or end a process. The open screen is closed, and the user is moved to another screen.

Cancel: Clicking the **Cancel** button cancels the action taken on a screen and returns the user to the previous screen.

Next: Clicking the **Next** button moves the user to the next screen.

Back: Clicking the **Back** button moves the user to the previous screen.

Add: Clicking the **Add** button adds a selected item to a function.

Edit: Clicking the **Edit** button allows the user to edit a selection.

Delete: Clicking the **Delete** button allows the user to delete a selection.

Reset: Clicking the **Reset** button resets changed settings to their original settings during this session.

Finish: Same as the **OK** button.

Browse Buttons: Clicking the **Browse** button moves the user to a previously-programmed selection screen.

Radio Buttons: Clicking a **radio button** displays a dot in the button, designating a specific option. Only one radio button is allowed for a section in a group.

Check boxes: Clicking a **check box** works the same as a radio button, however multiple selections may be added from one group.

Text Boxes: Clicking in a text box allows the user to type text into the box.

Drop-Down Arrows: Clicking these **arrows** displays a menu of selections.

Selection Arrows: Clicking these **arrows** allows a selected item to be moved from one dialogue box to another.

Search Boxes: Typing selection criteria in a search box causes the criteria to be matched to a master file. Matches are displayed, allowing the user to highlight the desired selection for further action. DRM Plus requires the user to press the <Enter> key after entering the criteria.

Sorting: Clicking a Transaction table column heading sorts the table, usually in ascending order, depending on the current view. Clicking the column heading a second time returns the table to its original view.

Highlighting: Clicking an item results in its being highlighted, and selected for the next action to be completed.

Shift Key: Generally, holding the <Shift> key down allows for selection of multiple consecutive items in Windows applications.

Control Key: Generally, holding the <Ctrl> key down allows for selection of multiple items in Windows applications.

Keyboard Use: When a letter or a button name is underlined (Add or Speed Code) the keyboard can be used to activate the button. The action required is to press and hold the <Alt> key, then press the underlined letter.

Appendix C – Hints and Notes

Save Unfiled Data

If the user has entered any data and attempts to close DRM Plus, or switch to a different patient, DRM Plus displays a screen prompting the user to save the current patient's entries. Clicking the **Yes** button initiates the save unfiled data function.

When the user has saved unfiled data and no longer needs this data for the patient, there are two options to eliminate this saved, unfiled data. The first is to select the **Delete** button when opening the patient's chart; a dialogue screen asks the user if they want to load the saved data. The second option is to delete the saved unfiled data from the **Unfiled Data by Provider** report.

Dental Class Displayed on Banner

The patient's **Dental Class** displays in the banner area, only if the information was entered on the cover page in the **Dental Eligibility/Dental Class** field by a DRM Plus Administrator. As soon as the **Dental Class** is selected, it displays in both fields: the dental class field on the **Cover Page** tab screen, and the **Dental Class** box in the DRM Plus banner.

Diagnostic Findings

Diagnostic Findings are NOT updated automatically from **Completed Care** entries for any encounter. Any **Completed Care** entries that are filed need to be entered as **Diagnostic Findings** during a patient's future dental examination.

Always mark teeth missing in **Diagnostic Findings** before entering **Partials, Dentures, Implants** or **Bridge** findings. DRM Plus works best when missing teeth or edentulous arch(es) are entered before any other findings. **Dentition** is always entered first on a new patient before any dental data is entered in DRM Plus, if the patient is a juvenile.

Diagnostic Findings may be deleted after the encounter has been filed by a user. If this happens after the encounter has been filed, the deleted findings are removed from the graphic; however, the text entry remains in the transaction table with a line through it. DRM Plus Administrators can completely remove any **Diagnostic Finding** entry from the transaction table, unless the entry was already deleted by a user.

Treatment Plan

For implant procedures entered in the **Treatment Plan** screen, and if a related finding of **Missing** has NOT been entered, DRM Plus does NOT allow this corrective planned treatment procedure to be entered.

It is recommended to use the **Include Findings and Completed** button to temporarily combine screens of the planned treatment with the findings and NOT use the automatic **Include** parameter in DRM Plus. The automatic **Include** parameter is the original default in DRM Plus when the user is viewing the **Treatment Plan** screen. End-users may edit this parameter by accessing the **Treatment & Exam** menu → **Show Configuration** submenu → **Tx & Exam** tab → **Display Defaults** drop-down menu → remove check marks in check boxes.

Multi-Add Screen

Small buttons [<] and [>] have been added to the **Procedure Code** selection screen to enable the user to move the screen to the other half of the graphic chart. This may be necessary to see what is beneath, especially when entering multi-add codes.

Missing teeth display as white text on a blue background. This can help the user visualize the mouth while entering multi-add codes. The missing teeth are still selectable if needed for the procedures partial, denture, implant or bridge.

Ranged Codes

Certain codes, designated as ranged codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted and can only be used with hard coded DRM Plus icons. These icons are **Partial, Bridge, Conn Bar** and some **Denture** procedure codes. These icons are only found with the **Treatment Plan** and **Completed Care** screens. When other options are utilized for selecting these CPT procedure codes, when using the **ADA Codes** icon or **Add** box, the ranged codes are disabled and cannot be selected.

Speed Codes

Speed Codes do NOT have multi-add or suggestion links functionality. The multi-add and suggestion links functionalities work with the **Quick Codes** icon, **ADA Codes** icon, **CPT Codes** icon, using the **Add** box to select a procedure code. Some of the DRM Plus standard icons allow multi-add functionality. Speed codes are only used with the **Treatment Plan** and **Completed Care** view screens for selecting a procedure code.

Speed Codes that include codes violating coding compliance rules need to be edited or deleted.

Tx Planning/Sequencing Screen

There is a maximum of nine phases which may be added to the sequenced planned treatment for one patient. There are an unlimited number of sub-phases possible in each phase. There is only one **Non-VA Care** phase that may be added however with an unlimited number of sub-phases.

Ranged codes, mostly prosthetics, move as a block when one code is highlighted, by left-clicking the item, holding and dragging to the proper phase.

End-users are able to re-size and move the **Tx Planning/Sequencing** screen in all directions. DRM Plus allows users to drag and drop multiple procedures at one time by pressing the <Shift> and <Ctrl> keys.

Users may add or modify the **Treatment Plan** and **Tx Planning/Sequencing** screen and file the changes without having to click the **Next** button and create a TIU progress note as long as no new completed transactions, perio, PSR or Head & Neck data are entered. In addition, the most recent dental encounter must have an **Active** status for this feature to work. Clicking the **Save & Exit** button from the **Tx Planning/Sequencing** screen files any changes made, and minimizes DRM Plus. Any new planned entries added have the same visit date as the latest active TIU progress note filed for the patient.

If the completed care screen is set as the display default in DRM Plus, transactions completed from the sequencing screen may require a refresh for those transactions to display in the **Completed Care** screen. Selecting the **Diagnostic Findings** button or the **Treatment Plan** button and then reselecting the **Completed Care** button refreshes the application.

Completed Care

Completed procedures that have been filed can only be deleted by a DRM Plus Administrator. If an end-user, who does NOT have this administrative parameter option, highlights an entry in the **Completed Care** transaction table and clicks the **Delete** button, a screen stating that the transaction cannot be deleted displays. When a DRM Plus Administrator deletes an entry from DRM Plus, appropriate procedures must be followed to correct any associated entry filed in VistA TIU or possible VistA PCE.

In those rare cases where pre-existing charted care does NOT allow the user to click and select a procedure code via the graphic chart, the user may enter the desired code via the **ADA Codes** icon.

If one or more of the procedures entered with multi-add functionality require an assignment of a different diagnosis code, deselect the procedure code by clicking the check box of the procedure description located on the upper left side of the **Diagnosis Code** screen. The deselected procedure code no longer appears highlighted, and is removed from the table at the bottom of the screen, indicating that it does NOT associate with the selected diagnosis code. Click the **OK** button at the bottom of the screen, and the remaining unchecked procedure code(s) recycle and appear highlighted in the **Diagnosis Code** screen for the user to assign a diagnosis code. This process of recycling continues until all procedure codes added with the multi-add functionality have a diagnosis code assigned by the user.

Periodontal Chart

The **History** button maintains graphical entries from previous perio examinations; therefore, any prior perio exam graph may be viewed with the **History** button, selected from the **Periodontal Chart** screen. The **Periodontal History/Compare** screen may be vertically extended to view any data that is NOT visible.

To use the **Furcation** icon, the cursor shield must be positioned at the root location where an entry in the graphics would be appropriate.

The **X** button located at the end of the pre-defined measurement scale results in a null entry in the transaction table for **Pocket, FGM, MGJ, Mobility** and **Furcation** entries. This null entry only works when the specific icon is active for **Pocket, FGM, MGJ, Mobility** and/or **Furcation**. The null entry remains as a “-” mark in the transaction table, and there is no entry in the TIU progress note.

If the error is recognized immediately, the **Undo** button may be clicked. Otherwise, place the cursor shield on the pocket where the incorrect value was entered. If the value is for **Pocket, FGM, MGJ, Mobility** or **Furcation**; the incorrect value can be replaced by entering the correct value.

A zero entry results in no graphical view; however, it results in a zero entry in the transaction table and TIU progress note, since it is a measurement. If no recording should be present for a given icon, a null entry can be created by clicking the **X** button. If the incorrect entry is for **Bleeding, Delayed Bleeding** or **Suppuration**; click the identical icon again to remove the graphic display and transaction table entry.

When perio data is imported into the TIU progress note, it has each tooth displayed with each surface and condition shown in the vertical column, under the tooth number. The key at the bottom of the perio data explains certain symbols. There may be a statement at the bottom of the perio data, which informs other providers that this TIU progress note contains perio data from the current exam, as well as data that has NOT changed from at least one previous exam. If the **Clear** icon was used at the beginning of the perio exam, then only data from this current exam is imported into the note.

Warning levels can be changed by the end-user and then displayed. The pocket depth warning level should be the same for the perio chart graphics, and for the pocket depth warning level listed on the **Statistics** tab. The pocket depth warning level on the **Statistics** tab must be the same as the pocket depth warning level in the **Periodontal** tab. Both of these tabs are found by utilizing the **Treatment & Exam** menu → **Show Configurations** submenu.

Completing the Encounter

Selecting any **Service Connection** check box sends a flag to PCE for the encounter.

DRM Plus is now aligned with CPRS for patients who are **Combat Veteran** service connected. If appropriate, the Combat Veteran option defaults to a check (**Yes**) in DRM Plus. To remove the check (change to **No**), click the check box to the left of the **Combat Veteran** field. The check is removed.

VistA has co-signature functionality, and is checked by CPRS and DRM Plus. Both GUIs also have additional signer functionality. Additional signers are NOT required, but may be added to a TIU progress note by a provider. Do NOT confuse additional signers with co-signers. Co-signers are built into VistA by facility management based on business rules. If the software detects that a co-signer is required, a screen displays, requesting a co-signature. A provider may need a co-signer for one or all TIU progress notes.

Since most sites require residents to enter a co-signer, the co-signer defaults as the distributed provider in PCE. If there is no co-signer (i.e., no note exists when using **File Data Without a Note**, or the resident is NOT required to have a co-signer) then the resident, or user filing resident data, must enter the distributed provider prior to filing. When the encounter is filed to VistA PCE, the resident becomes the secondary provider and the distributed (attending) provider becomes the primary provider for the encounter. All procedures and diagnoses are assigned to the distributed provider in VistA PCE.

VA Dental wants to give credit/RVU time, etc. to residents who actually perform the procedures, and all of this is filed to VistA DES. However, to meet the VA requirement that gives credit for the encounter to the attending (distributed), requires this to be filed in VistA PCE.

DRM Plus users may import a **TIU Note Boilerplate** into a patient's TIU progress note. If the **Note Boilerplate** parameter is set with a check mark, an informational screen displays when selecting a TIU progress note or consult title, if that title has a note boilerplate associated with it. The informational screen allows a user to select **Yes** or **No** to the question of importing the note boilerplate. If this parameter is NOT set with a check mark then the note boilerplate imports into the patient's TIU progress note without an opportunity to decline this action. This parameter is located under the **Tools** menu → **User Options** submenu → **General** tab → **Other Parameters** button.

CPRS templates automatically import into a patient's TIU progress note if the TIU note/consult title selected is associated with a CPRS template and there is no option for the user to decline this template import. When the template displays or opens, complete or fill-in the appropriate information on the template and close or finish it. The information entered on the template imports into the patient's TIU progress note. **Please note:** DRM Plus does NOT support **Reminder Dialog** or **COM objects** CPRS templates.

There are generally two types of TIU progress notes created using DRM Plus: 1) using the **Exam** tab or 2) NOT using the **Exam** tab. A TIU progress note created using the **Exam** tab sequences DRM Plus objects in the order designed and approved by the VA Dental Exam Committee. The sequencing of DRM Plus objects in the **Note Objects Sequence** parameter screen is overwritten by the **Exam** tab sequence design when the **Exam** tab is used. TIU progress notes created without using the **Exam** tab sequence DRM Plus objects in the order set by the user in the **Note Objects Sequence** parameter screen. This parameter is located by selecting the following: **Tools** menu → **User Options** submenu → **Progress Note** tab → **Set Note Sequence** button. The **Note Boilerplate** in the list of **Note Objects Sequence** parameter screen includes both TIU **Note Boilerplates** and supported CPRS templates.

All DRM Plus data objects displayed in the left narrow window of the **Progress Note** screen may be imported into the TIU progress note automatically. This depends on whether the parameters are activated by the end-user. However, most of the data objects are NOT allowed to be de-selected by the end-user for the automatic importing process. These parameters are located by selecting **Tools** menu → **User Options** submenu → **Progress Note** tab → **Progress Note Data** button.

DRM Plus **Code Boilerplates** are listed individually with the DRM Plus objects on the **Progress Note** screen. DRM Plus users who have created code boilerplates can now import them into a TIU progress note by clicking the desired **Code Boilerplate** object, listed with DRM Plus objects. Using the cursor, set the object where it is sequenced in the TIU progress note, then double-click to import the object.

Text files may be created and saved in a preferred directory. Right-click in a **Progress Note** window and click **Import Text File** option to navigate to and open the saved file. The file is then placed in the TIU progress note as designated by the cursor placement.

Follow these steps to set up a file for importing:

1. Create a folder in an appropriate directory (usually a server drive).
2. From the **Tools** menu → **User Options** submenu → **Set File Folder** button, navigate to the folder created in Step 1. Set the folder by double-clicking it.
3. Create a text file from the **Tools** menu → **Windows Notepad** submenu and save it as a .txt file in the designated folder from Step 1.

If the user clicks the **Finish** button before the provider's electronic signature is entered, the dental data is filed in VistA (PCE, DES and TIU) as an unsigned progress note, and may be viewed with CPRS. If the electronic signature is entered before clicking the **Finish** button, the dental data is filed as a signed progress note in VistA (PCE, DES and TIU).

When the user clicks the **Finish** button, a prompt may display if there are no planned items, and if the patient status is **Active**. Correctly identifying the patient's status is important for reporting. The user should click the proper radio button (**Active**, **Inactive** or **Maintenance**) and then click the **OK** button.

Reports – Non-Clinical Time by Provider

The **Non-Clinical Time by Provider** report displays an approximate numerical unit of days (1 day = 8 hours). Accumulation of less than 4 hours results in rounding down to the nearest whole number day, and accumulation of 4 or greater hours round up to the nearest whole number day.

Code Boilerplates

Multiple boilerplates may be added for a single code, or multiple codes may be associated with the same boilerplate. The user may establish as many boilerplates and related codes as necessary.

If a DRM Plus Administrator creates a code boilerplate in their **Administrative Toolbox** submenu, then every user may use the code boilerplate by entering the name of that code boilerplate to their parameter. Enter the name precisely as it was entered by the DRM Plus Administrator and click the **OK** button in the end-user's **User Settings** screen. This action imports the administrative code boilerplate to the end-user's code boilerplates.

Last Broker Call

The **Last Broker Call** submenu is used by the IT or ADPAC personnel to document problems. It is not usually accessed by providers.

Recent Dental Activity

This section on the **Cover Page** tab displays the most recent date for selected types of procedure codes. Hover the cursor over the heading to display all of the ADA procedure codes, which comprise the data for that heading.

- **Last Qualifying Exam** = D0120, D0150 or D0180
- **Last Comprehensive Exam** = D0150 or D0160
- **Last Brief Exam** = D0120, D0140 or D0170
- **Last Periodontal Exam** = D0180
- **Last Panorex Image** = D0330
- **Last Full Mouth Image** = D0210
- **Last Bitewing Image** = D0270, D0272, D0273, D0274 or D0277
- **Last Prophylaxis** = D1110, D4341, D4342, D4355 or D4910
- **Last Visit** = the last dental date encounter was filed on.
- **Last Provider** = the provider that filed the last encounter.

Appendix D – Icon Definitions

Diagnostic Findings

The following table explains the actions required to enter a **Diagnostic Finding**:

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore	As many as required	As many as required	No	Material or surfaces	Graphic in green
Missing	As many as required	No	As many as required	Selected Roots	Graphic for roots is outlined
Observe	As many as required	No	As many as required	Selected Roots	Tooth outlined in red
Partial	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	None	Graphic allows root condition graphics to show. Graphic in purple.
Implant	As many as required	No	No	None	Graphic in violet
Sealant	No	As many as required	No	None	Graphic in green
Endo	No	No	Yes	Materials and roots	Graphic color denotes material
Apico	No	No	Yes	Select roots	Graphic in red
Retro	No	No	Yes	Selected roots and materials	Requires Apico to be present. Graphic denotes material
Bridge					See special instructions
Conn Bar					See Special Instructions
Hemi	No	No	As many as required	Selected roots	Graphic in dark gray

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Coping	Yes	No	No	None	Graphic in green
P&C	No	No	As many as required	Selected roots and materials	Graphic in green and denotes material
Impact	As many as required	As many as required	As many as required	Selected surfaces and roots	Graphic in light blue, roots in blue-green
Def Rest	Yes	As many as required	Yes	Selected surfaces, roots and materials	Graphic in yellow, denotes material
Caries	Yes	As many as required	As many as required	Selected surfaces and roots	Graphic in red, root caries initiates description box
Drifting	Yes	No	No	Direction	Graphic is yellow arrow to the left of tooth
Tipped	Yes	No	No	Direction	Graphic is light blue arrow to left of tooth
Rotated	Yes	No	No	Direction	Graphic is green arrow to left of tooth
Ret Root	No	No	As many as required	None	Graphic removes crown
UndrCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow
OverCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Overhang	No	As many as required	No	Selected surface	Graphic is red and yellow
Lesion	No	No	As many root surfaces as required	Selected roots	Can also click implant. Graphic is a red circle.
Faceted	No	As many as required	No	Selected surfaces	Graphic is red and yellow

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Cracked	No	As many as required	As many as required	Selected surfaces and roots	Graphic is red and yellow
Chipped	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Supr/Sub	Yes	No	No	Direction	Graphic is red arrow
Open Ct	Yes	No	No	None	Graphic is red arrow to right of tooth
Abfract	No	Facial or lingual	No	None	Graphic is blue arrows
Dentition	No	No	No	Dentition box	Converts graphic to juvenile. Must be done before other entries
Perm/Prin	Yes	No	No	Dentition Box	Designate selected tooth as primary or permanent
Edentulous	Any tooth	No	No	None	Graphic removes all teeth and roots in arch

Note: Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, display graphically on all screen views. These items are, if entered from the **Diagnostic Findings** screen: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen: extract, hemi section, implant and observe.

Treatment Plan

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection box	Graphic in Blue
Extract	Yes	No	Yes	Code Selection Box	Graphic in shadow
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show
Denture	Any tooth	No	No	Code Selection box	Graphic allows root condition graphics to show.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in blue, no root graphic
Endo	No	No	Yes	Code Selection Box	Graphic in blue
Apico	No	No	Yes	Code Selection Box	Graphic in red
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in blue.
Bridge (1)				Code Selection Box	See special instructions.
Conn Bar (1)				Code Selection Box	See special instructions

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Hemi	No	No	As many as required	Code Selection Box	Graphic in gray
Coping	Yes	No	No	Code Selection Box	Graphic in blue
P&C	No	No	As many as required	Code Selection Box	Graphic in blue
Perio Buttons	No	No	No	None	No Graphic. See Speed Code instructions.

Certain codes associated with these icons are defined as ranged codes. Ranged codes can only be entered by clicking the proper icon button. The **ADA Codes** icon, **CPT Codes** icon, **Quick Codes** icon or **Speed Code** icons are NOT allowed for entering ranged codes.

To designate a root restoration, click the **Restore** icon. Click the tooth surface that corresponds to the root surface. Using a tooth note, or the description edit feature in the transaction table, explain the root restoration.

Note: Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, appear graphically on all screen views. If these items are entered from the **Diagnostic Findings** screen, they are: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen, they are: extract, hemi section, implant, and observe.

Completed Care

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection Box	Graphic in Green
Extract	Yes	No	Yes	Code Selection Box	Tooth disappears. Root graphic in dark gray.
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete. Then Code Selection box.	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	Code Selection Box	Graphic allows root condition to show. Graphic in blue-purple.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in green. No root graphic.
Endo	No	No	Yes	Code Selection Box	Graphic in pink.
Apico	No	No	Yes	Code Selection Box	Graphic in red.
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in green.
Bridge (1)				Code Selection Box	See Special Instructions

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Conn Bar (1)				Code Selection Box	See Special Instructions
Hemi	No	No	As many as required	Code Selection Box	Graphic in gray
Coping	Yes	No	No	Code Selection Box	Graphic in green
P&C	No	No	As many as required	Code Selection Box	Graphic in green
Perio Buttons	No	No	No	None	No Graphic. See Speed Code instructions.

Certain codes associated with these icons are defined as ranged codes. Ranged codes can only be entered by clicking the proper icon button. The **ADA Codes** icon, **CPT Codes** icon, **Quick Codes** icon or **Speed Code** icons are NOT allowed for entering ranged codes.

To designate a root restoration, click the **Restore** icon. Click the tooth surface that corresponds to the root surface. Using a tooth note, or the description edit feature in the transaction table, explain the root restoration.

Note: Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, appear graphically on all screen views. If these items are entered from the **Diagnostic Findings** screen, they are: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen, they are: extract, hemi section, implant, and observe.

Special Descriptions – Bridge Icon

Place the cursor on the first abutment and drag to the second abutment. The **Procedure Code** selection screen displays, with the lowest number tooth selected, as shown below.

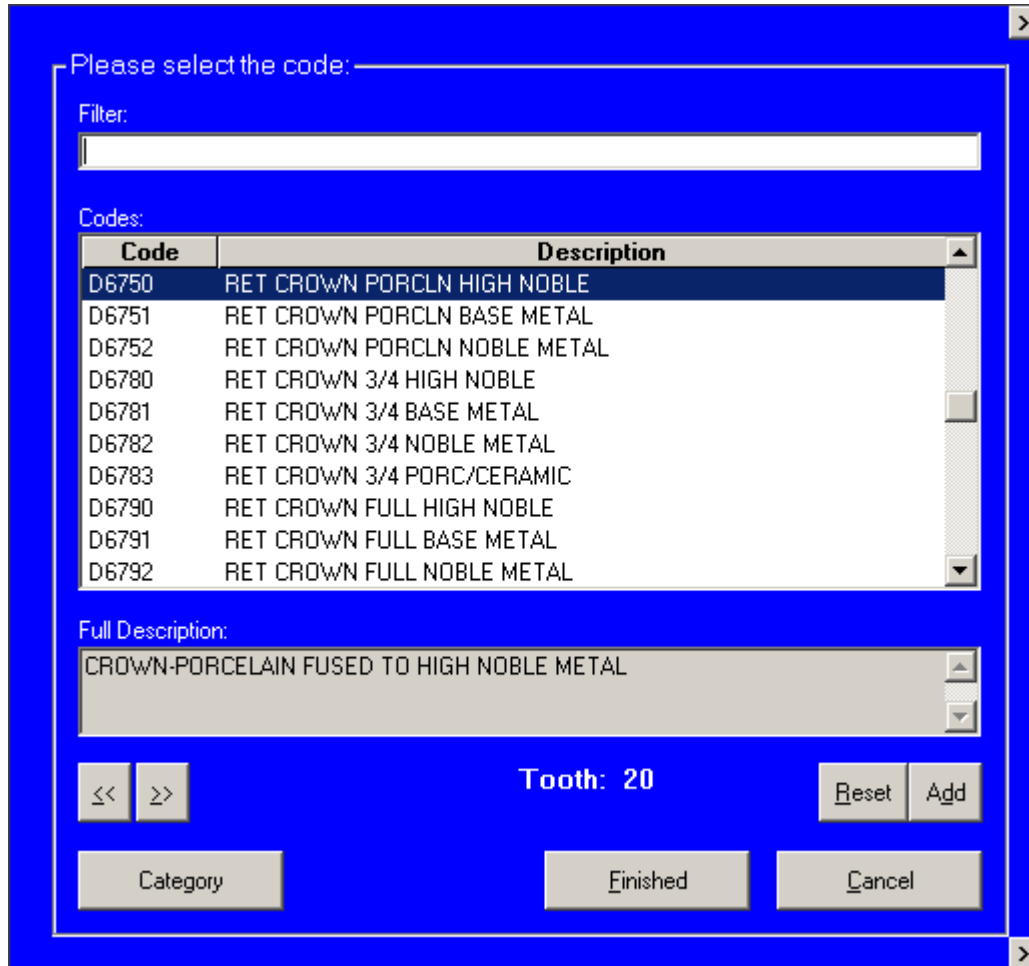


Figure 295: Procedure Code Selection Screen

Select the appropriate code and click the **Add** button. The **Procedure Code** selection screen moves to the first pontic tooth. Select the appropriate code and click the **Add** button again. Continue this process until all required teeth and codes have been selected. Click the **Finished** button once the selection process is complete.

Note: The << and >> buttons may be clicked to move backward or forward to different teeth for code selection. The **Reset** button, when activated by using the << and >> buttons, clears all previously entered codes for the selected tooth.

Special Descriptions – Conn Bar Icon

This functionality works for all three view screens of **Diagnostic Findings, Treatment Plan** and **Completed Care**. Place the cursor on the first tooth location and drag it to the final tooth location. When entering a connector bar from the **Treatment Plan** screen or the **Completed Care** screens, the **Procedure Code** selection screen displays, with no tooth selected. DRM Plus defaults to the correct connector procedure code, depending on what conditions the connector bar was entered on. Click the **OK** button to complete the connector bar entry.

Special Descriptions – Notes Icon

Please see the **Notes** section in the Chart/Treatment – Periodontal Chart chapter of this manual. This icon works the same for all three **Treatment & Exam** screen views.

Items to consider on tooth notes:

- Teeth designated as primary show in the tooth drop-down menu with the appropriate letter without a number. A tooth designation for **Supernumerary** teeth is displayed after tooth #32 in the drop-down menu.
- When a tooth-specific note has been entered, the tooth number in the graphical chart on the **Diagnostic Findings, Treatment Plan, Completed Care** and **Periodontal Chart** screens displays in yellow.
- Previously entered notes (tooth/patient note) appear disabled. The note appears disabled if it was saved as unfiled data and DRM Plus is closed and reopened. It also becomes disabled when an assistant saves unfiled data to a provider. When the provider re-opens DRM Plus to complete the encounter, they may edit-delete the note (tooth/patient note) by clicking the **New Entry** button. This activates the disabled entry so the provider is able to modify or delete the note before the encounter is finished.
- After entering any new dental data into **Patient Notes** or **Tooth Notes** windows select the **Notes** icon to save and close the **Notes** screen. Closing the **Notes** screen before opening any other screen in DRM Plus is the only action that saves the data entered into the **Notes** screen.

Appendix E – Create Reports in MS Excel and Access

Developing Excel Reports

To open Excel:

1. Click the **Excel** shortcut (if available) If unavailable;
2. Click the **Start** button.
3. Click the **Programs** button.
4. Click **Microsoft Office**.
5. Click **Microsoft Excel**. A blank Excel workbook opens.

To open a saved file:

1. Select the **File** menu from the top menu bar.
2. Click the **Open** option.
3. Navigate to the directory/network where the extract file is saved.
4. Navigate to the saved .txt file and click **Open** or double-click the file name.
5. A screen similar to the one below is displayed.

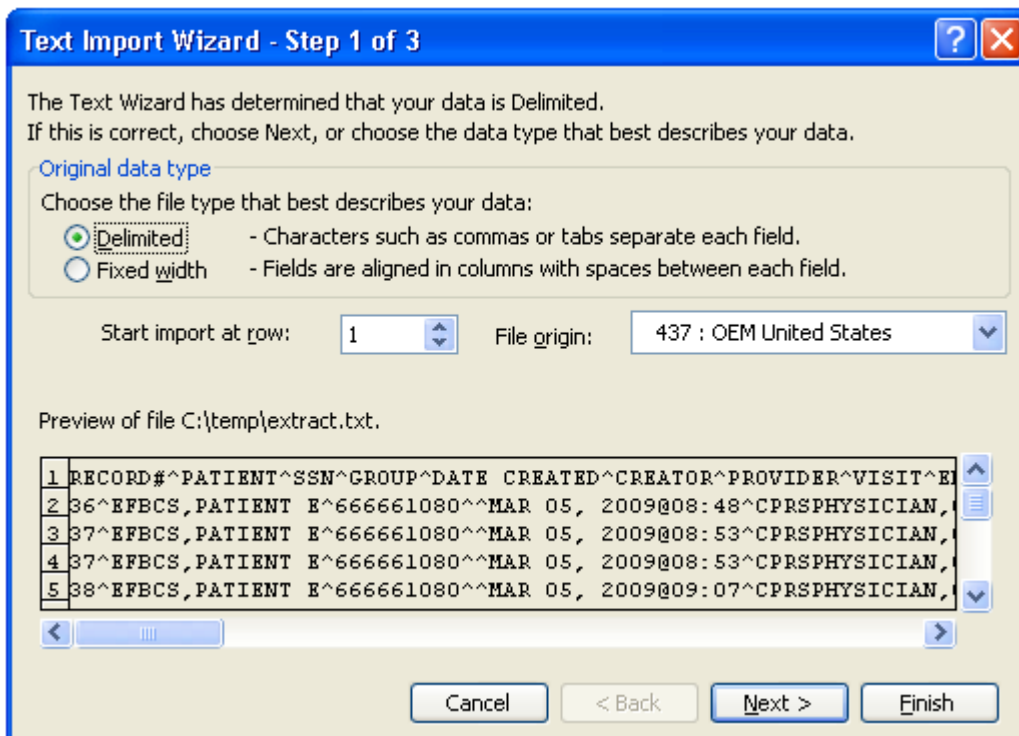


Figure 296: Developing Excel Spreadsheet Reports

6. Click the **Delimited** radio button.

7. Click the **Next** button. Another screen displays.

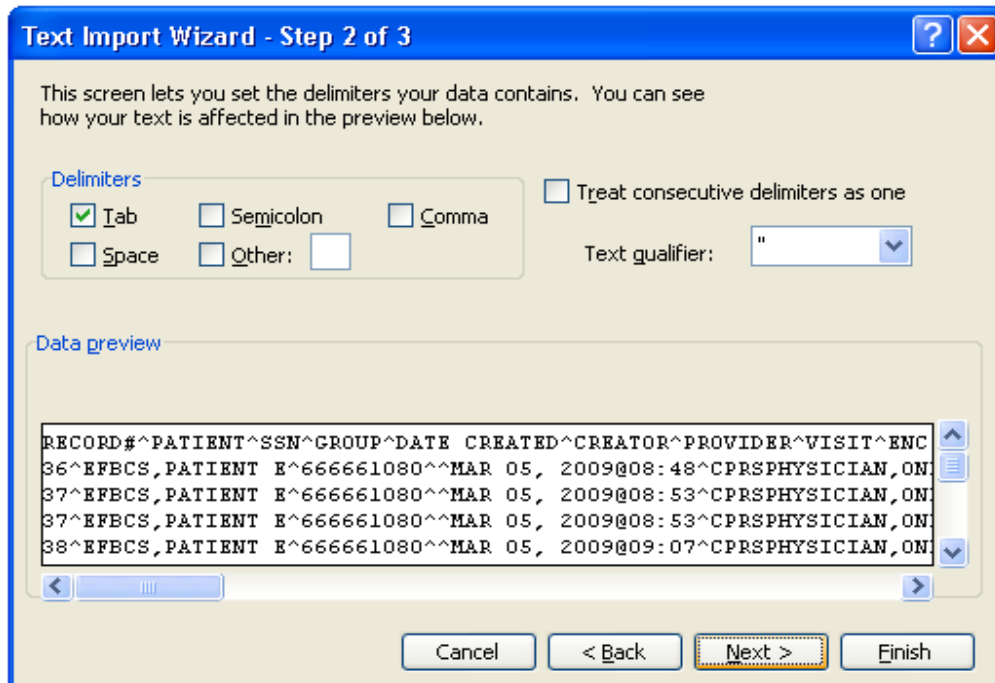


Figure 297: Delimiters Options

8. The **Tab** check box is checked by default.
9. Click the **Other** check box.
10. Type a ^ (<Shift> + <F6>) within the window beside **Other**. Then click the **Next** button.

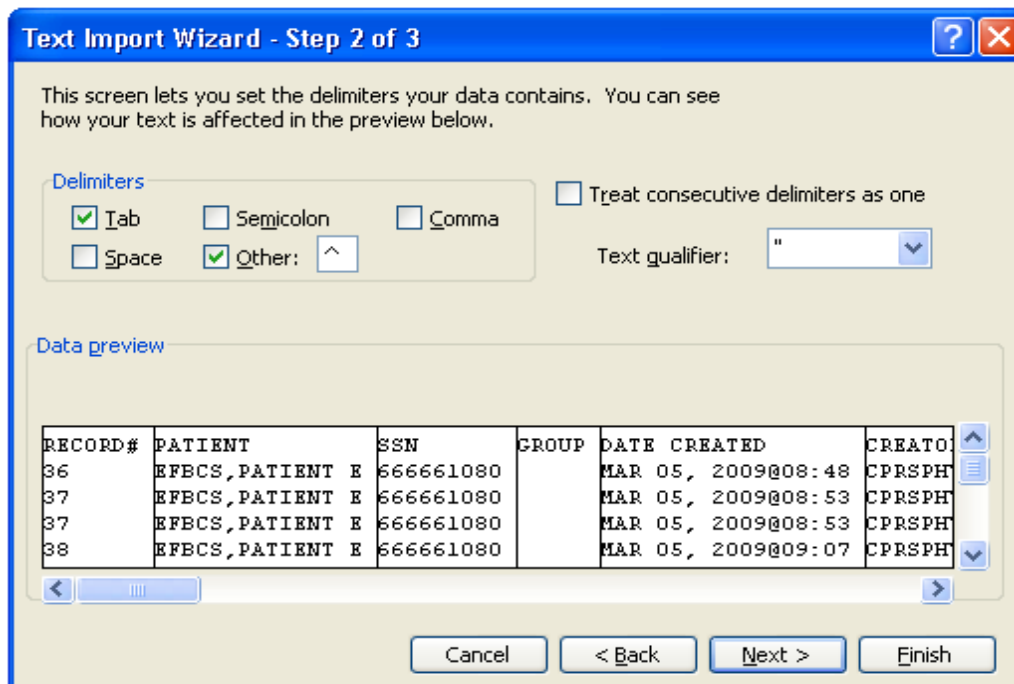


Figure 298: Preview Text

11. Click the **Next** button. A similar screen displays.

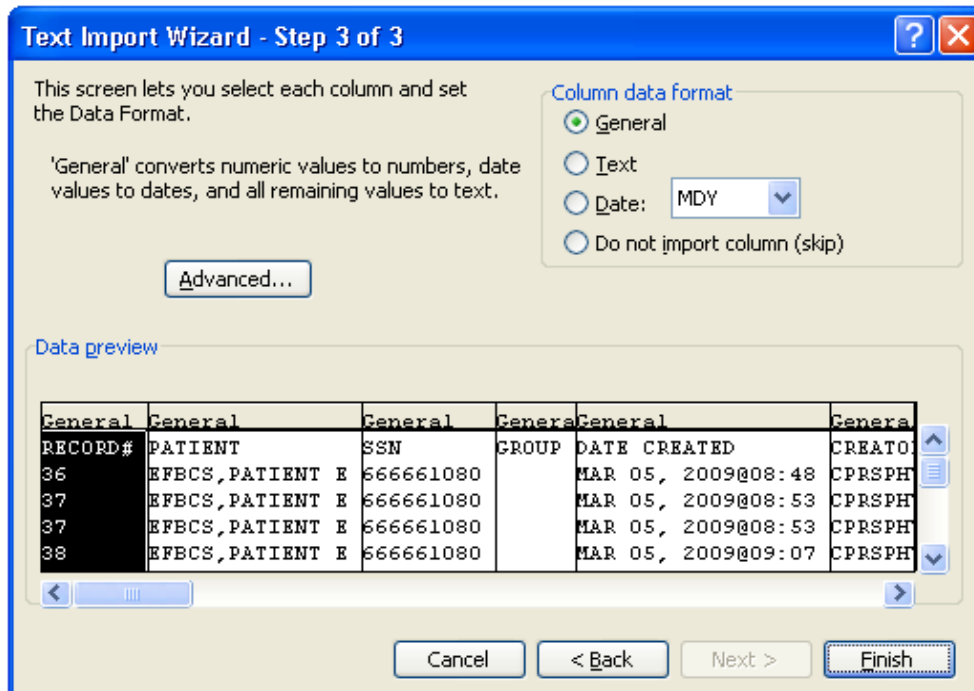


Figure 299: Text Import Wizard Final Screen

12. Click the **Finish** button. The extracted data displays in Excel.

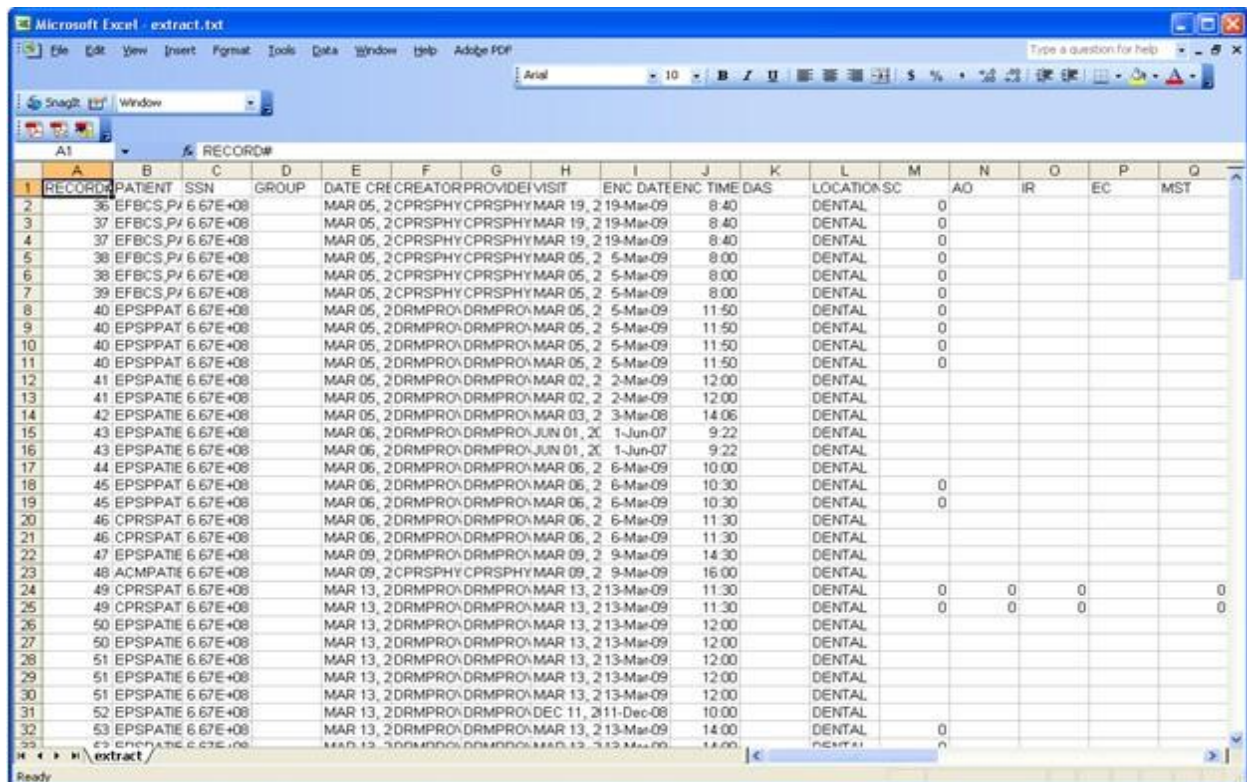


Figure 300: Report Preview

13. The text file can now be saved in an Excel format (.xls file). Select **File** from the top menu bar, then choose the **Save As** option. Rename the file and save with the .xls suffix.
14. The Excel worksheet can now be modified to create any number of custom reports to meet specific needs. The Excel tools are powerful, and numerous report types can be created depending on the user's level of Excel proficiency.

Examples of possible reports include:

- All Procedures by Provider
- All Procedures by Patient
- All Procedures by Clinic
- Reports by ADA Code
- Specific ADA Codes by Provider
- Reports by Diagnosis

Creating Custom Reports Using Excel

Reports can be customized using a variety of Excel functions including: deleting, expanding, formatting, sorting and subtotaling fields. Data may also be copied to other Excel worksheets to create numerous separate reports.

Deleting Columns or Rows

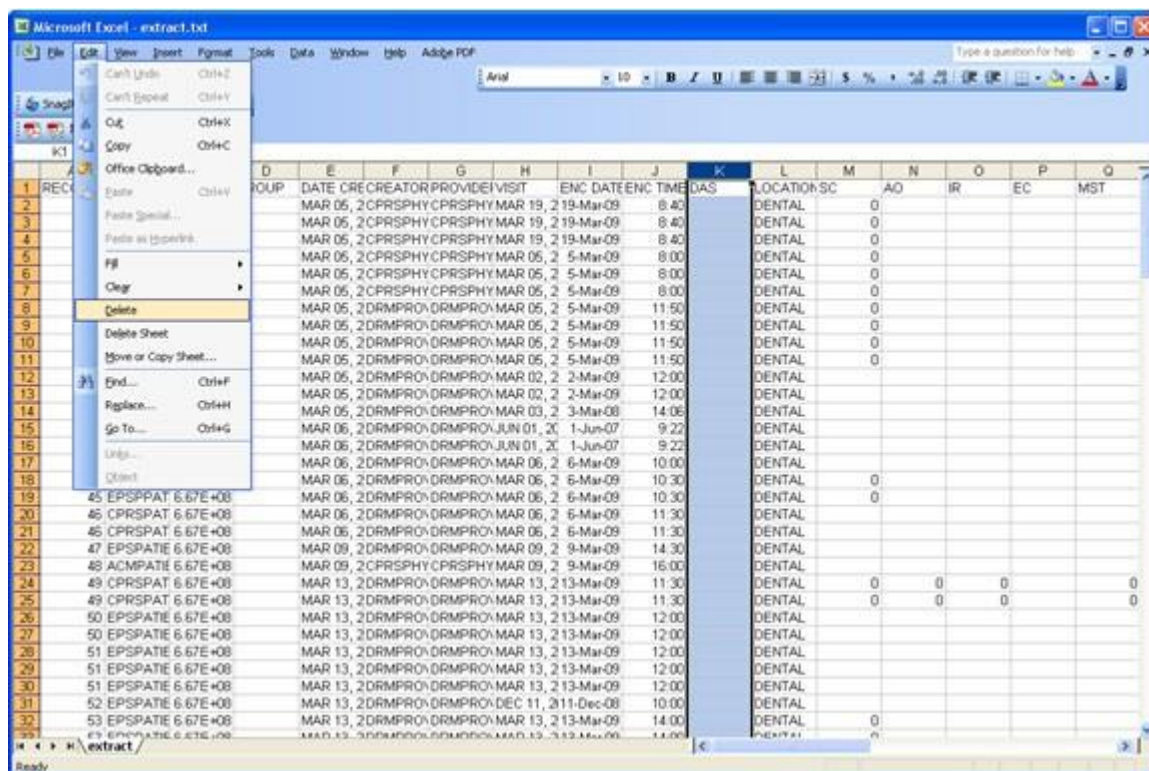


Figure 301: Creating Custom Reports in Excel - Deleting Columns or Row

To delete a column or row:

1. Click the column or row header. This highlights the column or row for deletion.
2. Click the **Edit** button.
3. Click the **Delete** button. This function can be initiated by right-clicking with the cursor in the highlighted area.

Expanding Columns or Rows

Put the cursor on the line between the column heading letters. The cursor turns into a cross with two arrows. Holding the left mouse button down and dragging right or left expands or contracts the column or row. Double-clicking automatically expands or contracts the column or row to fit the contents.

Field Formatting Options

Click the **Format** menu. The following is displayed.

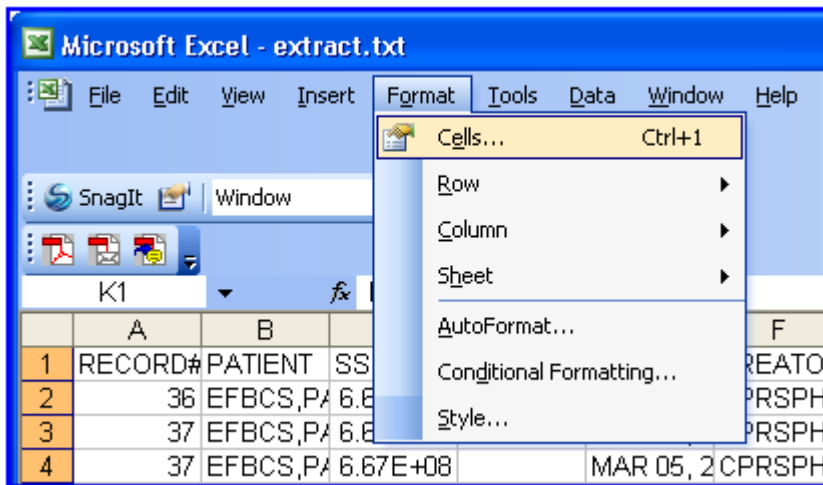


Figure 302: Field Formatting Options

Click **Cells**. The following screen displays.

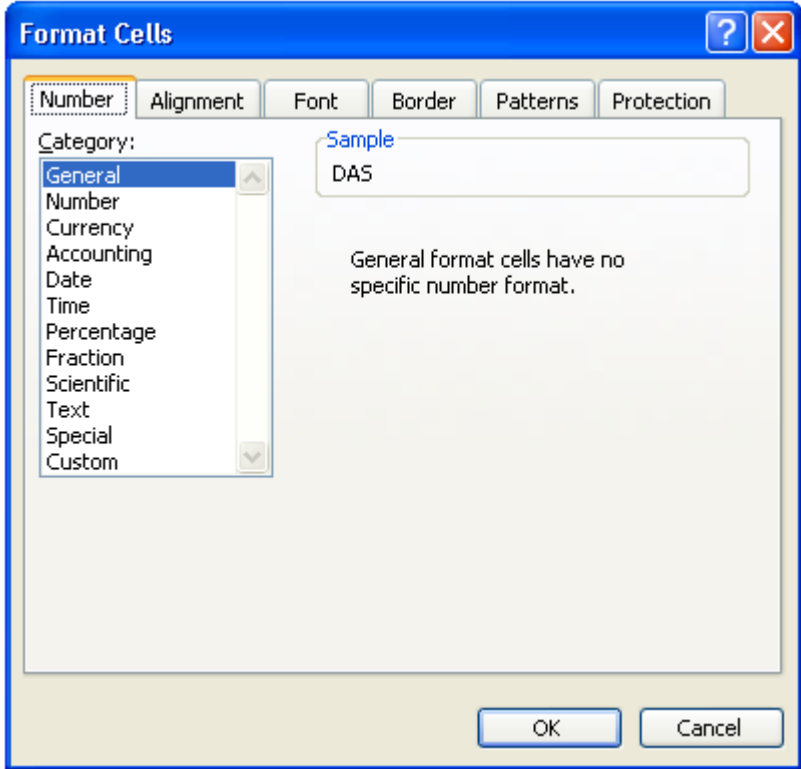


Figure 303: Format Cells

Select the desired option, then enter the desired changes.

Set Horizontal/Vertical settings to make the report easier to read. Setting the text control to wrap text automatically wraps the text within the space allotted for the cell. The height of the cells in a row or column changes. Click the **Alignment** tab to display the following screen.

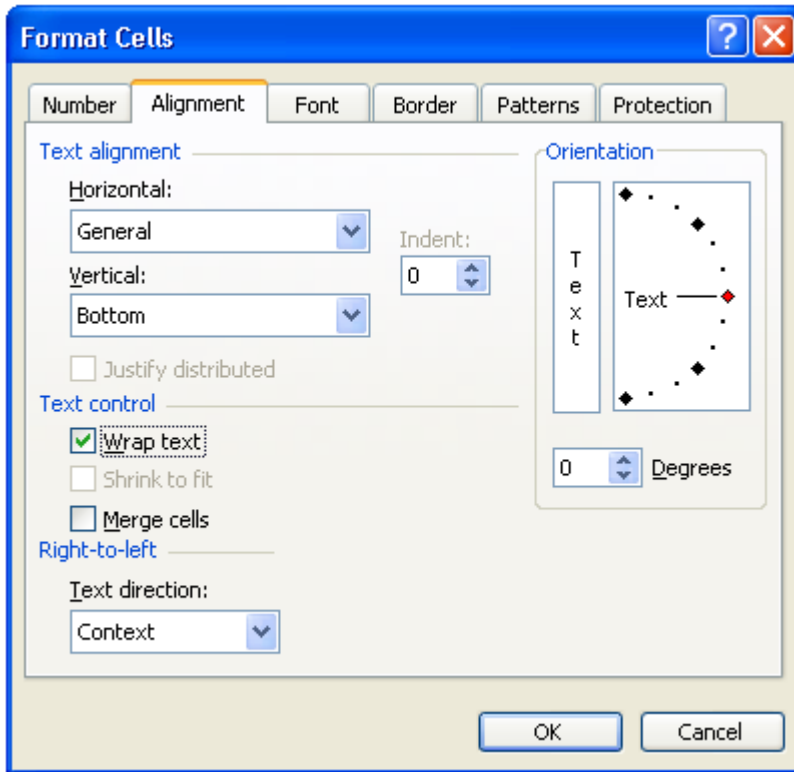


Figure 304: Text Alignment Options

Click the **Wrap text** check box. Click the **OK** button to complete the process.

Creating a Header For a Report

- 1. Click the drop-down **View** menu.
- 2. Click **Header and Footer**.
- 3. Click **Custom Header** or **Custom Footer**.

Place the cursor within the appropriate section and either type the Header or click one of the icons to bring in the date, time or to format the entered text (select the text to be formatted before selecting the icon to format the text).

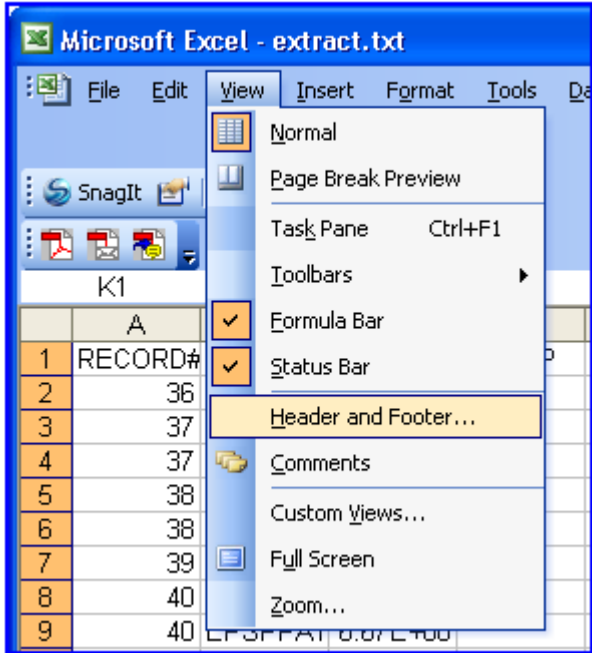


Figure 305: Header and Footer Option

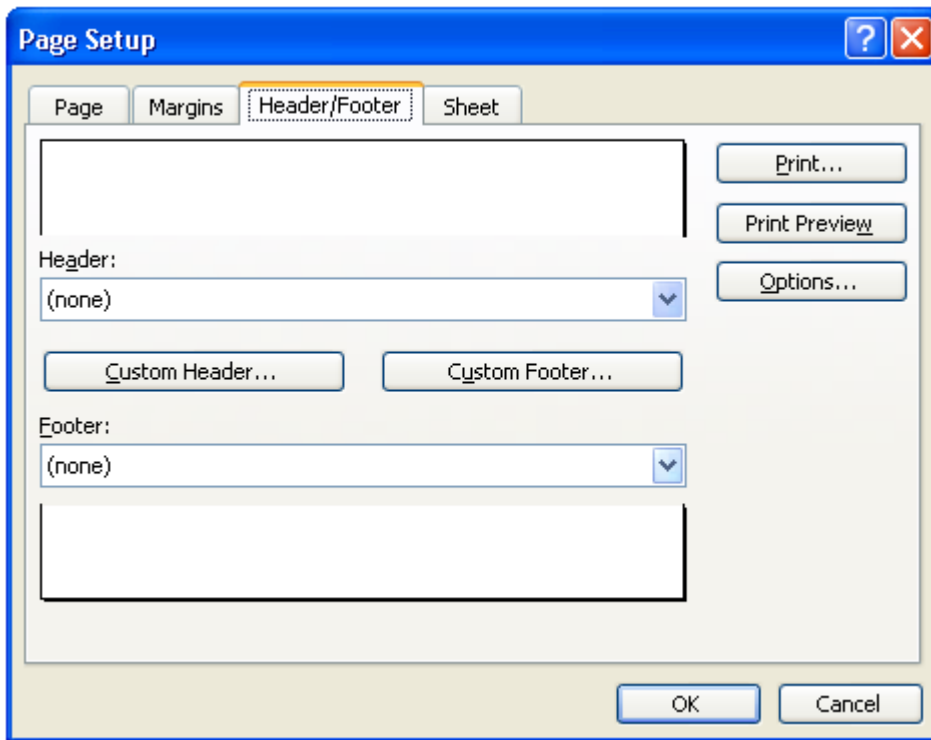


Figure 306: Page Setup Screen

The screen below displays.

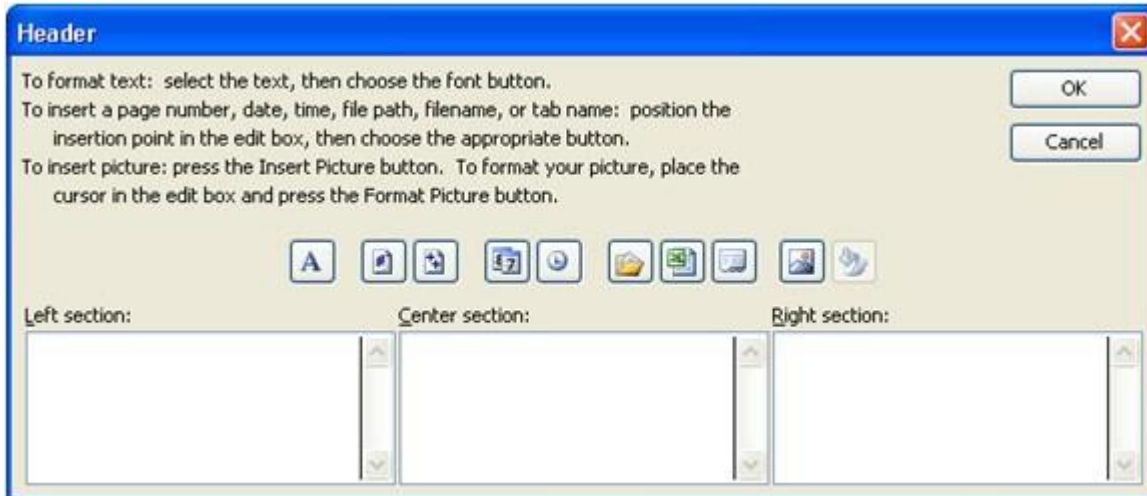


Figure 307: Header Formatting Screen

Sorting Data

To sort data:

1. Highlight the fields to include in the sort.
2. Click the **Data** button.
3. Click the **Sort** button.

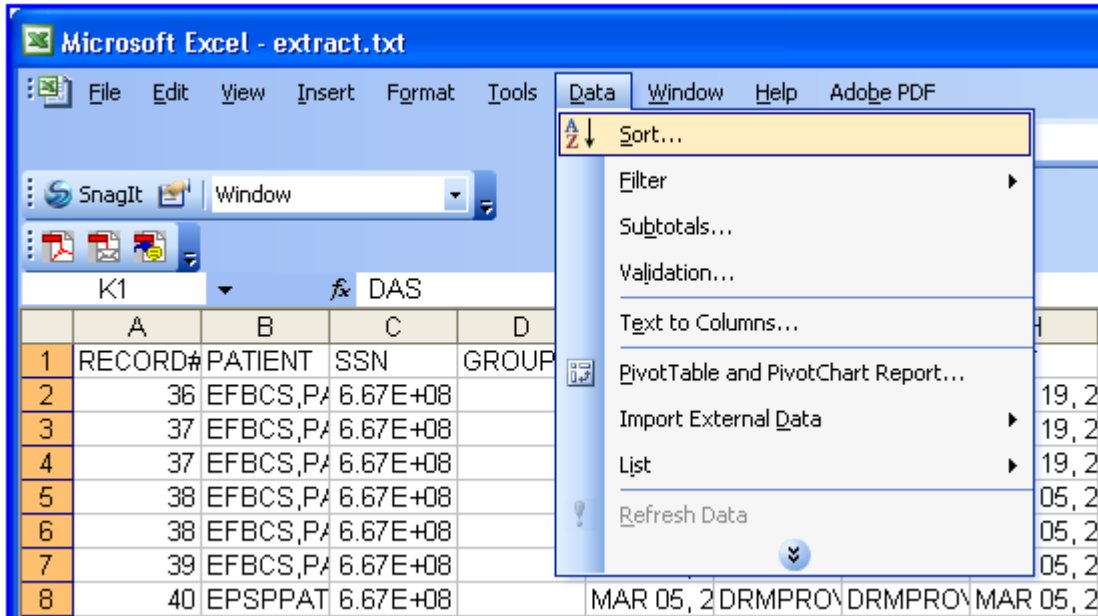


Figure 308: Sorting Data

The Sort screen displays.



Figure 309: Data Sort Options

Choose the sorting options by clicking the drop-down menus and selecting the desired options.

Subtotaling Data

To subtotal data:

1. Highlight the fields to be included in the sub-total. Then click **Data** menu from the menu bar.

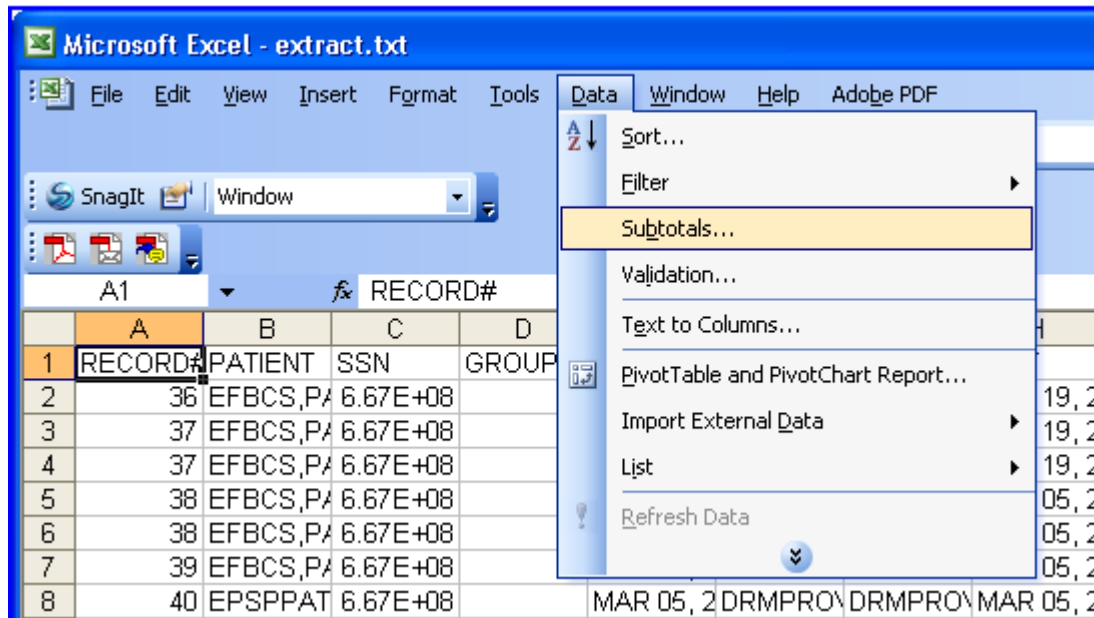


Figure 310: Subtotaling Data

2. Click **Subtotals...** The following screen displays.

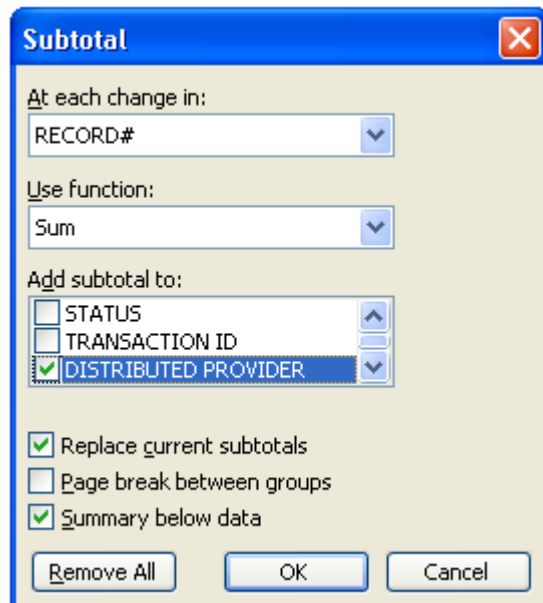


Figure 311: Subtotal Options

Pull Down Options

- **At Each Change In:** Select an item to perform subtotals when a change occurs. The example uses CPT code.
- **Use Function:** This example counts the number of times a provider performs a CPT Procedure in a given time frame.
- **Add Subtotal To:** Location subtotals displays.

Below is a sample report:

RECORD	PATIENT	SSN	GROUP	DATE	CREATOR	PROVIDER	VISIT	ENC DATE	ENC TIME	DAS	LOCATION	SC	AO	IR	EC	MS
36	EPFBSP	P/ 6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 19, 2	19-Mar-09	8:40		DENTAL		0			
36	Total												0			
37	EPFBSP	P/ 6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 19, 2	19-Mar-09	8:40		DENTAL		0			
37	Total												0			
38	EPFBSP	P/ 6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 05, 2	5-Mar-09	8:00		DENTAL		0			
38	Total												0			
39	EPFBSP	P/ 6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 05, 2	5-Mar-09	8:00		DENTAL		0			
39	Total												0			
40	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	5-Mar-09	11:50		DENTAL		0			
40	Total												0			
41	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	5-Mar-09	11:50		DENTAL		0			
41	Total												0			
42	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	5-Mar-09	11:50		DENTAL		0			
42	Total												0			
43	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	5-Mar-09	11:50		DENTAL		0			
43	Total												0			
44	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 03, 2	3-Mar-09	14:06		DENTAL					
44	Total															
45	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 06, 2	6-Mar-09	10:00		DENTAL					
45	Total															
46	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 06, 2	6-Mar-09	10:30		DENTAL		0			
46	Total												0			
47	EPSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 06, 2	6-Mar-09	10:30		DENTAL		0			
47	Total												0			
48	CPRSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	6-Mar-09	11:30		DENTAL					
48	Total															
49	CPRSPAT	6.67E+08		MAR 05, 2	DRMPRO	DRMPRO	MAR 05, 2	6-Mar-09	11:30		DENTAL					
49	Total															

Figure 312: Sample of History File

Importing the DRM Plus Extract Text File into an Access Report

After creating a .txt file through the extract function, and saving this information in a preset folder, this information can be placed in Microsoft Access for reporting purposes.

To import a DRM Plus extract file into Microsoft Access:

1. Open Microsoft Access. Click the **File** drop-down menu and choose the **Open** option.

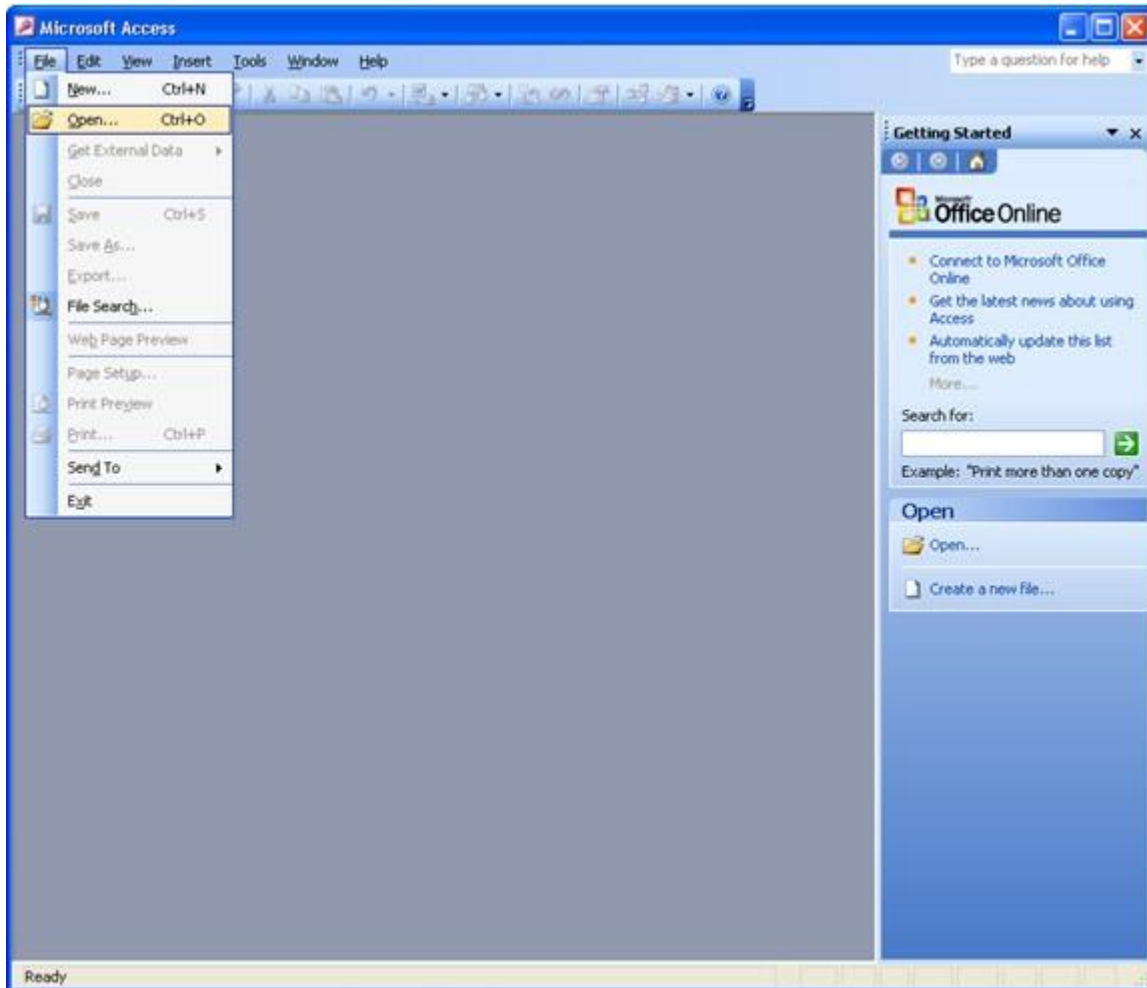


Figure 313: Import Extract File into Microsoft Access

2. The Open window displays. Using the drop-down menu, search and highlight the area where the preset extract folder is located. The preset extract folder contains the information previously extracted from DRM Plus.

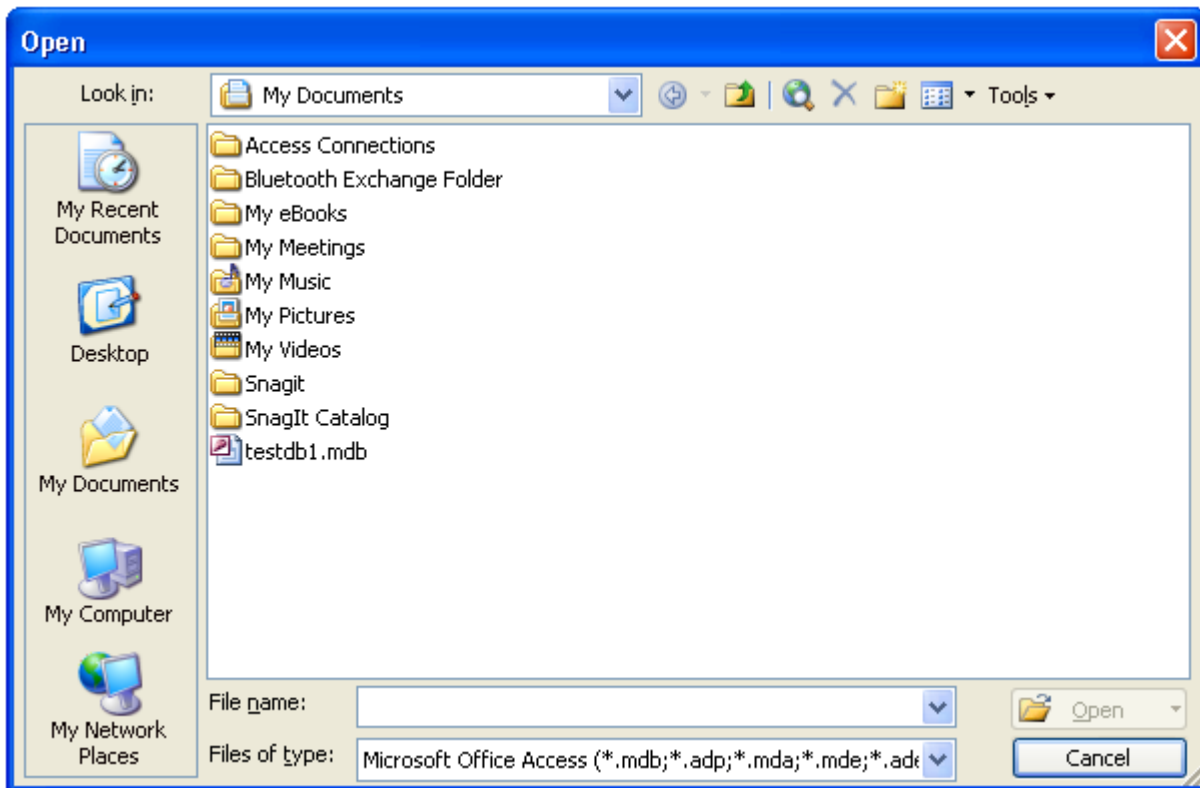


Figure 314: Open File

3. Once the folder is located in the Open screen, click and highlight it.
4. Click the **Files of type:** drop-down menu and choose All Files (*.*) as the extension.
5. Click and highlight the .txt file extraction. To access the file, choose one of the following options: double-click the .txt file; or, with the .txt file highlighted, click the **Open** button.
6. The following wizard screen displays, and the radio button preceding **Delimited...** must be selected. Select the **Next** button to continue the process.

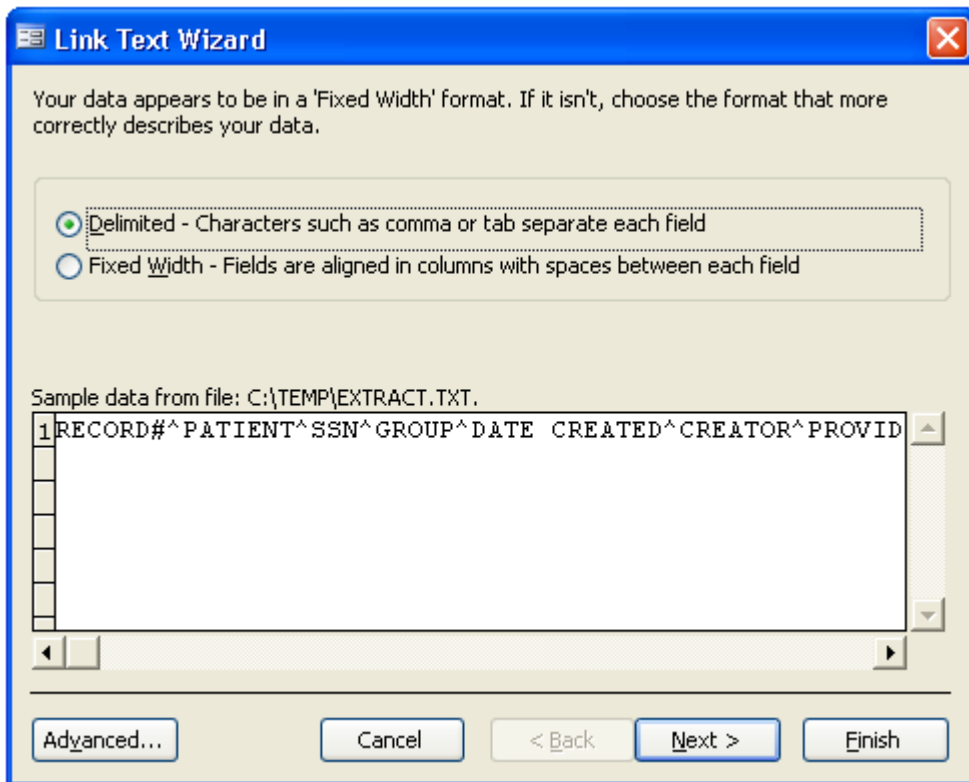


Figure 315: Link Text Wizard

7. Click the **Next** button to continue the process.

8. Within the Link Text Wizard screen, select the **Other** radio button and in the text area beside it, type a ^ (<Shift> + <F6>).

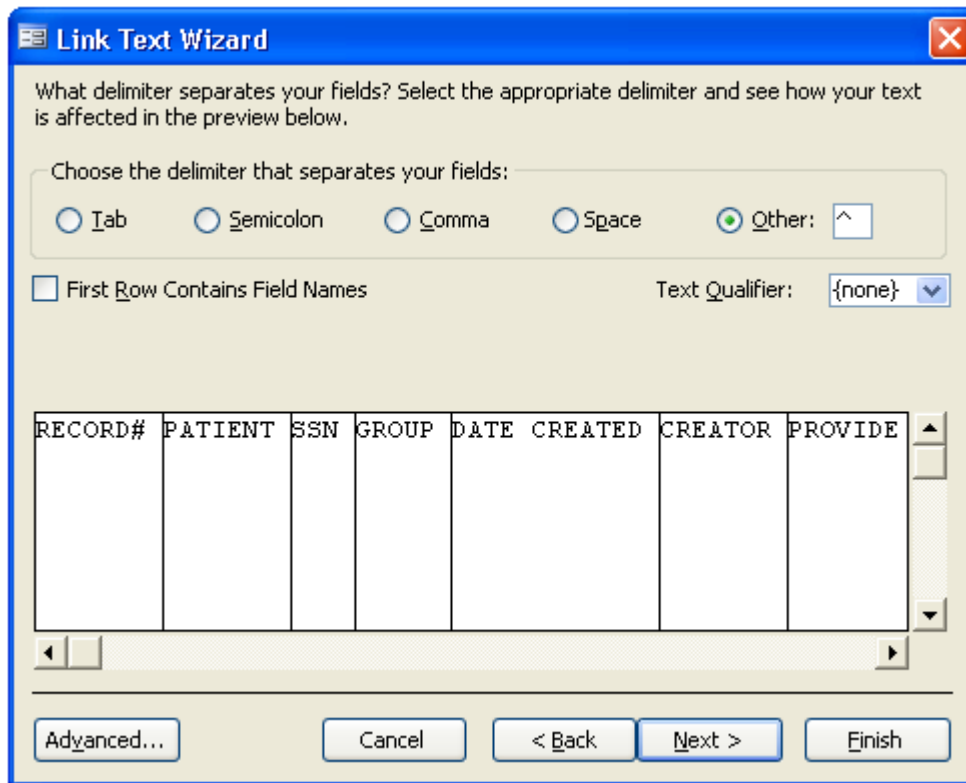


Figure 316: Link Text Wizard

9. To continue, click the **Finish** button.
10. When the Finished linking table... screen displays, click the **OK** button.
11. The file displays in the Access Database screen.

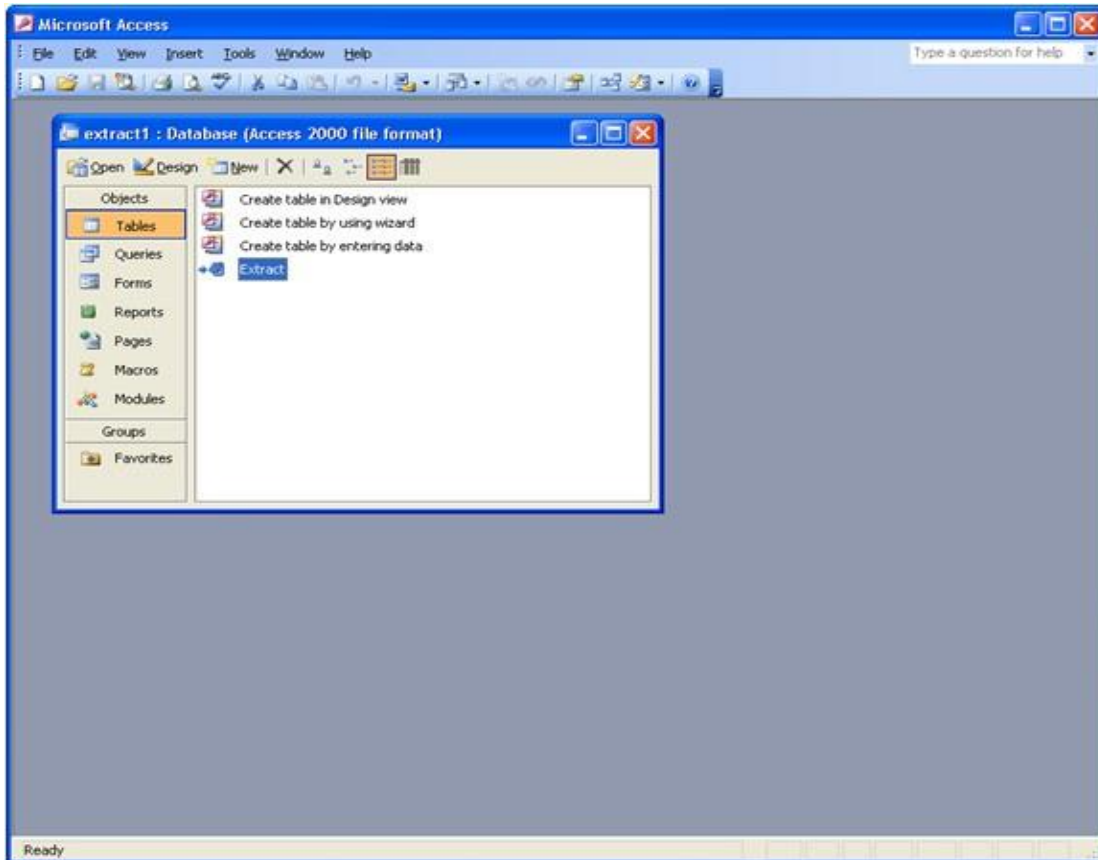


Figure 317: File in Access Database Screen

12. Click the **Reports** option, which displays on the remaining screen.
13. Highlight and double-click the **Create report by using wizard** feature.

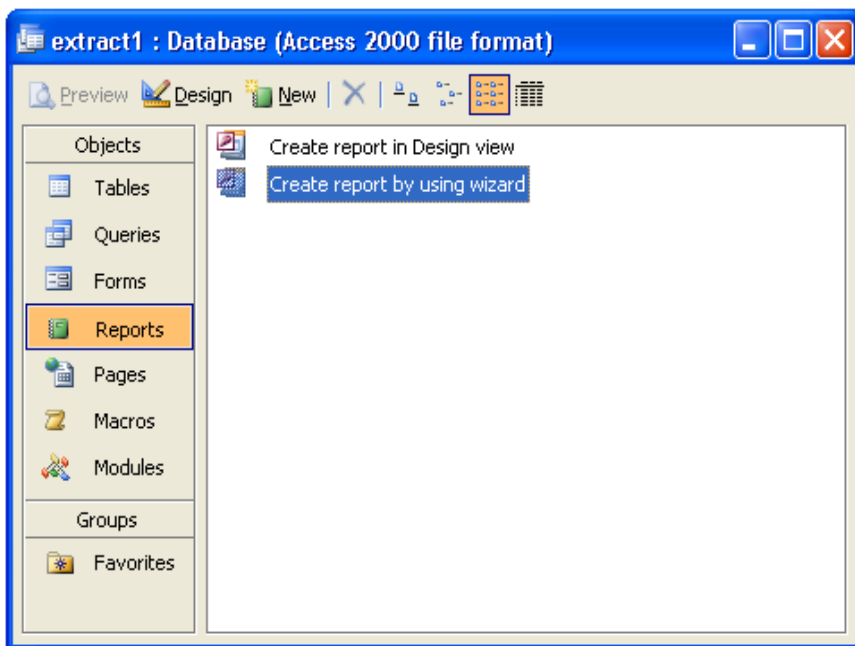


Figure 318: Create Report By Using Wizard

14. The Report Wizard window displays. Indicate the desired fields in the report by choosing by highlighting the field and moving it to the selected fields area using the double arrow (>>) buttons located in the center of the screen. Once all desired fields are selected, click the **Next** or **Finish** button to continue (or finish).

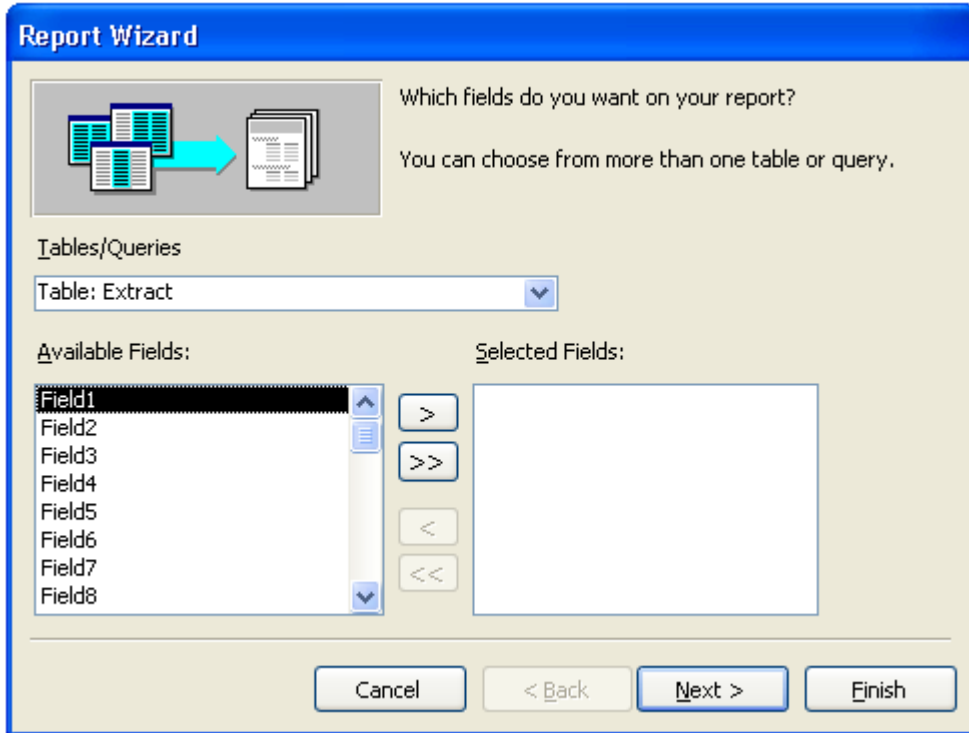


Figure 319: Choose Desired Fields for Report

15. Customized Microsoft Access reports display with the selected field information.

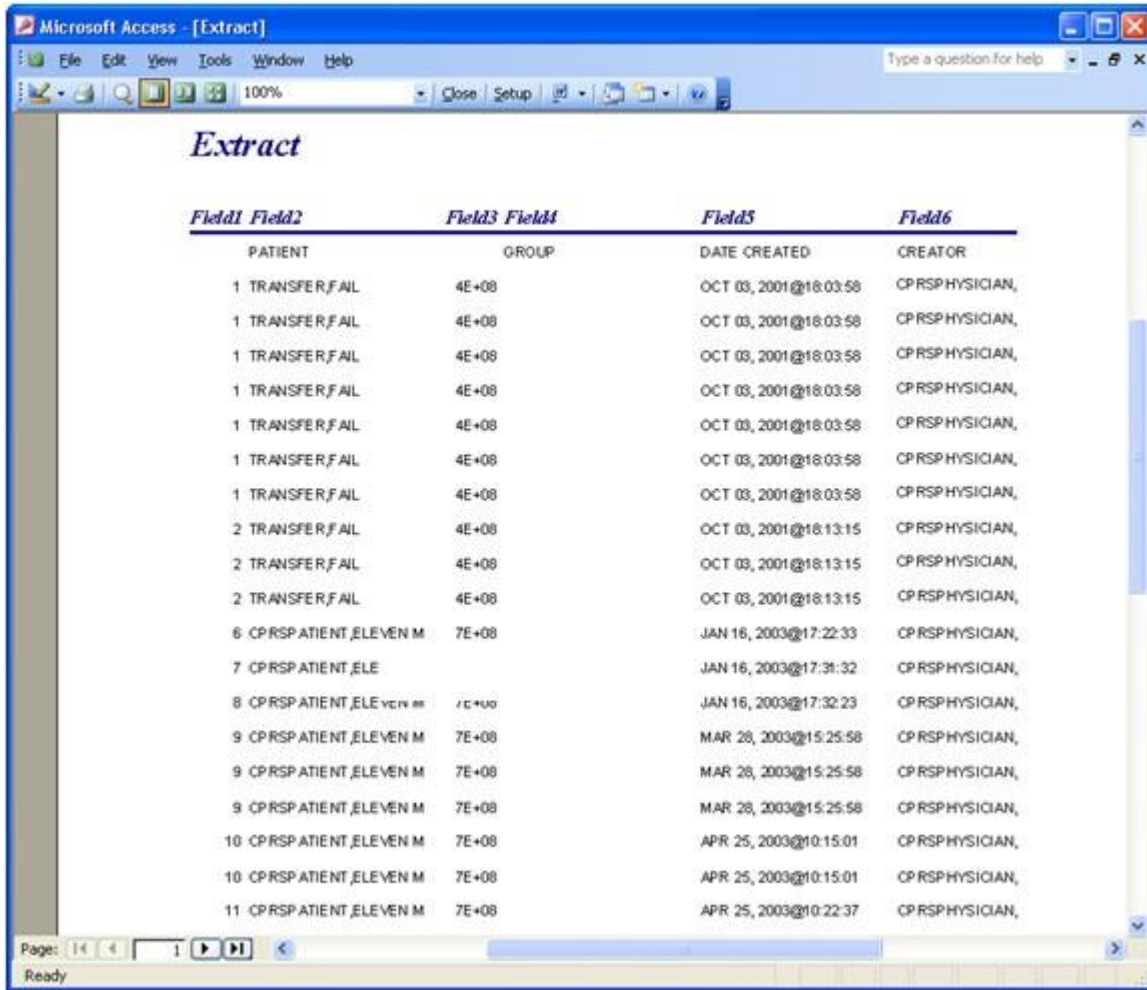


Figure 320: Customized Microsoft Access Report

The number of pages for any report depends on the number of fields selected. Total viewing of the Access report may require the use of the **Page** arrow buttons, which display on the bottom left of the screen.

Importing the DRM Plus Extract Excel File into Access Database

To import the DRM Plus extract file (Excel spreadsheet) into a new Microsoft Access database:

1. Open **Microsoft Access**.
2. Create a new database.

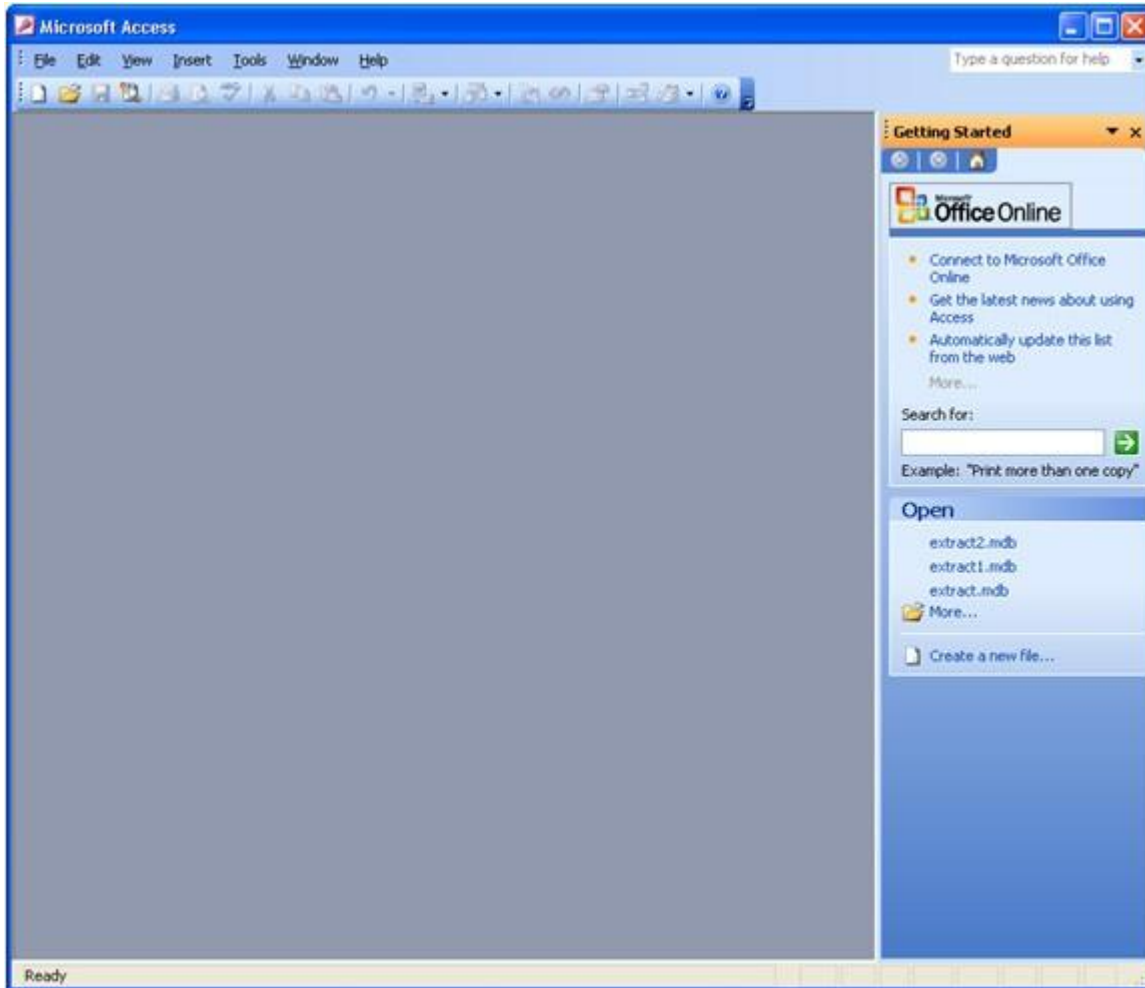


Figure 321: Import Excel File in Microsoft Access

3. Select **Create a blank database**.
4. **Save** the new database.

Upon saving the database, the following screen displays.

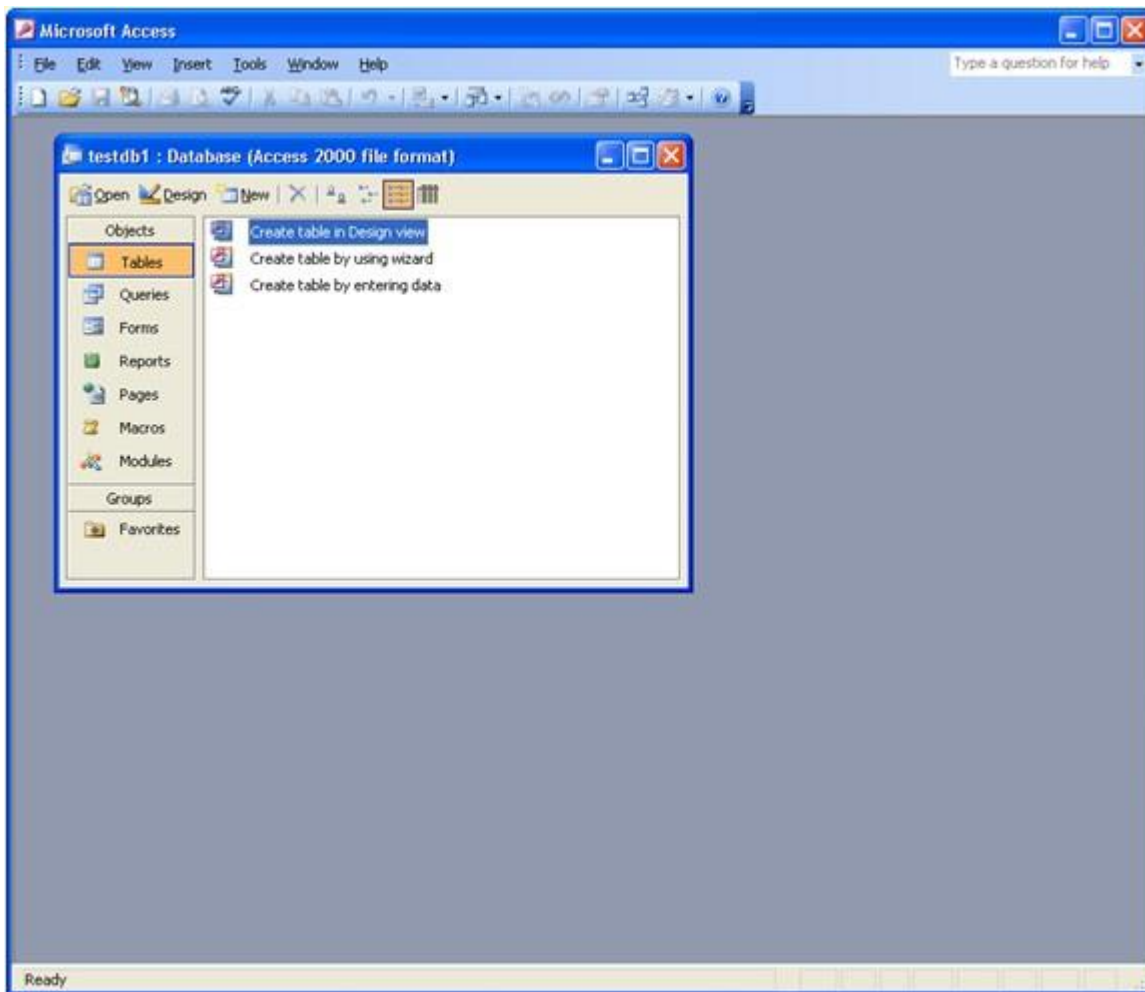


Figure 322: Microsoft Access Tables Window

To import an extract Excel file:

1. Click the **File** drop-down menu.
2. Click the **Get External Data** option.
3. Click the **Import** option.
4. Select the desired Excel file to import.

5. Click the **Import** button, and the Import Spreadsheet wizard displays. In the event that this wizard is not installed, contact local IT for additional support.

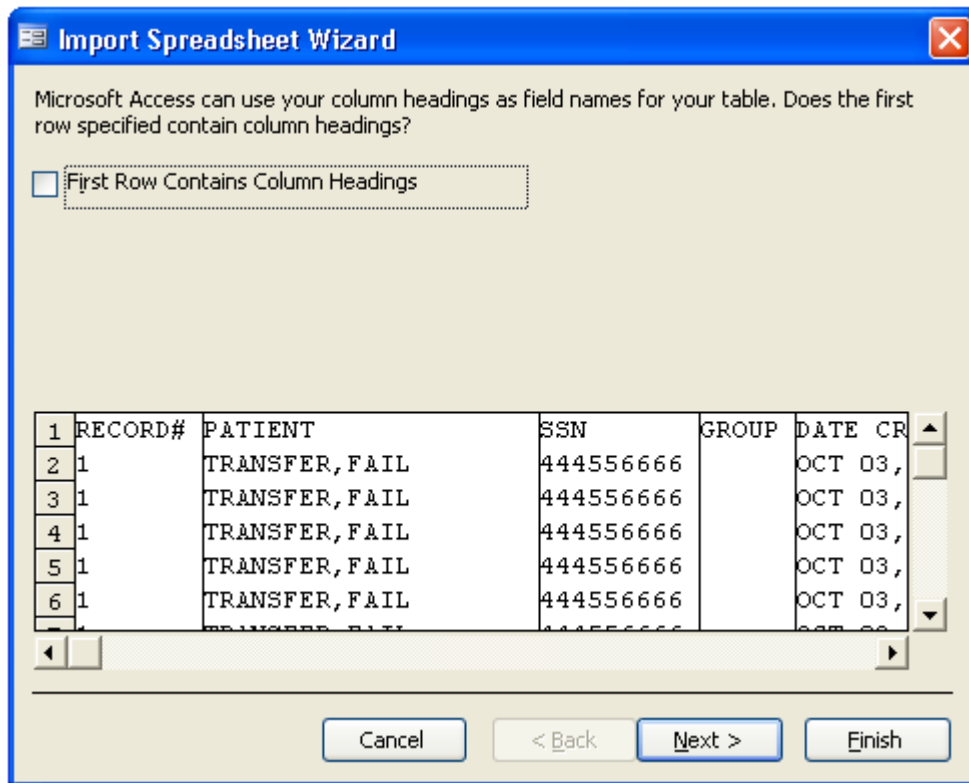


Figure 323: Import Spreadsheet Wizard

6. Select the defaults, then click the **Next** button to continue.

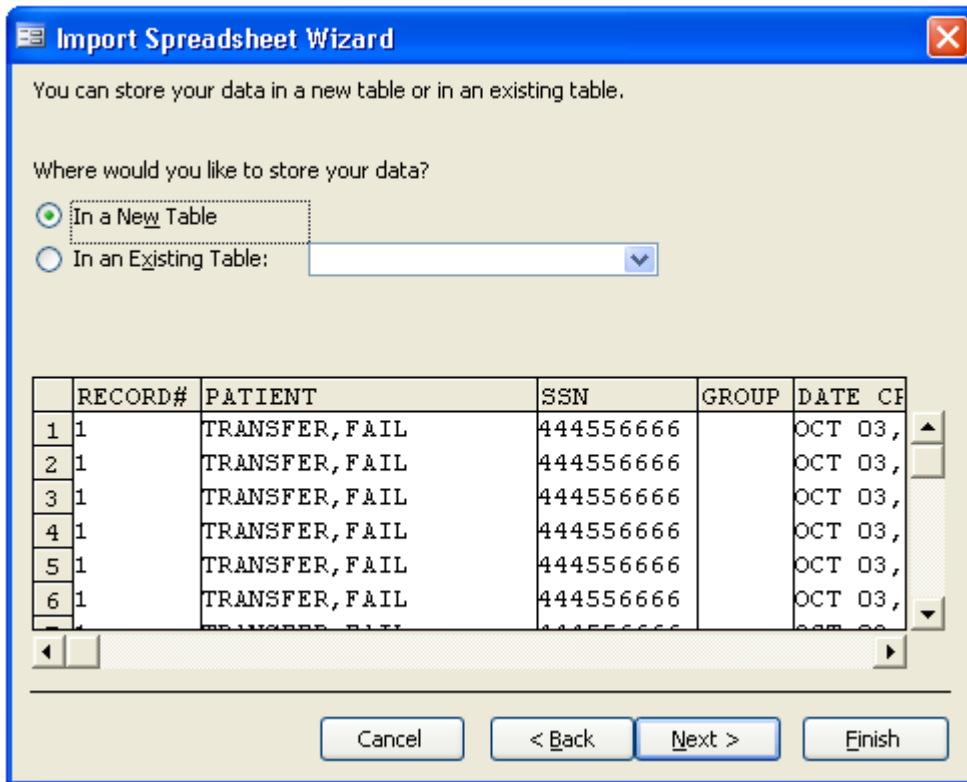


Figure 324: Select Defaults for Storing Data

7. Continue to select defaults until the following screen displays.

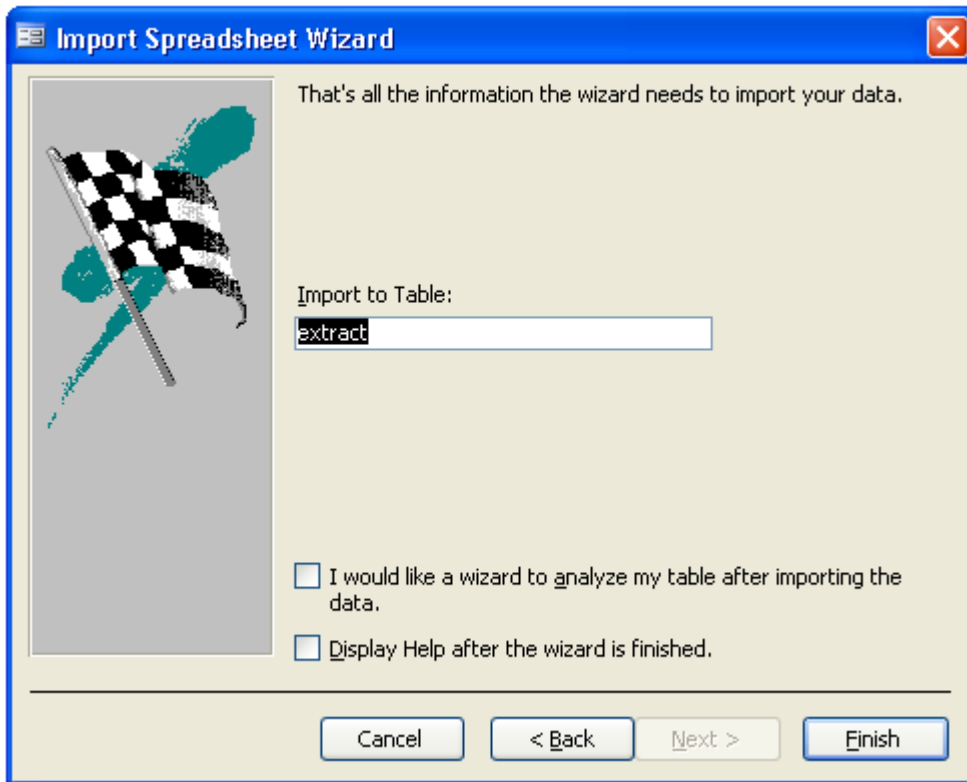


Figure 325: Import to Table

8. The extract spreadsheet is now in a Microsoft Access database.

Note: Microsoft Access training may be available. Contact local IT for further information.

Appendix F – Transmission & Correction of Processed DES Data

This was effectively discontinued in FY 14, superseded by dental data being captured at the VA Corporate Data Warehouse using a direct VistA extract process.

Sending DES data to the Austin Corporate Data Center Operations (CDCO) site is a weekly process. The CDCO receives this transmission of DES records in the form of standard HL7 messages from the site, through the Vitria Interface Engine (VIE).

Errors should not be anticipated during this process; however, in the event that the data is corrupted, the software warns users that the data cannot be sent. Also, the software informs users if sent data was not received accurately.

There are two types of errors that may occur during transmission:

- The first is generated by the dental application on VistA when the DES data is being validated, prior to being sent to the CDCO.
- The second is generated by the CDCO when attempting to validate the data within the HL7 message.

Note: Both error types are rare, particularly those generated by the CDCO.

The dental application on VistA attempts to verify DES data before sending it to the CDCO. A new mail group has been added called DENTV HL7 MESSAGES. When missing or invalid data is found, a Mailman message generates and is sent to members of the DENTV HL7 MESSAGES mail group. Members of this group should include a DRM Plus Administrator, and someone from the local IT staff, in order to research the cause of the error.

The following is an example of a transaction with an invalid RVU value:

```
Subj: Dental Transaction Error [#844] 10/18/04@13:16 2 lines
From: POSTMASTER (Sender: [redacted]) In 'IN' basket. Page 1 *New*
-----
An error was reported for a dental transaction HL7 message.
Invalid data for PATIENT,TEST transaction 42220, file TREATMENT PLAN
TRANSACTION/EXAM field RVU.

Enter message action (in IN basket): Delete//
```

Figure 326: Transaction with Invalid RVU Value

Local IT staff may be asked to use FileMan to view the record 42220 in file Treatment Plan Transaction/Exam (file 228.2) to see what the field RVU contains. The RVU should be a numeric value between 0-9999 (based on the data dictionary definition).

To repair the data, the DRM Plus Administrator should delete the transaction from the patient's transaction list, and re-enter it with the correct information. In order to find the correct transaction to delete, the DRM Plus Administrator may need additional information from the transaction, such as date entered, ADA code, etc., which can be retrieved via the FileMan Inquire option. Again, receiving these messages and having to repair data should be an exceedingly rare occurrence. These messages were designed to ensure that all workload data is transmitted to the CDCO, and to alert all users in the event this does not occur.

HL7 messages sent to the CDCO may also be rejected due to missing or invalid data. This is also a rare occurrence, due to system checks previously performed by VistA. These checks are performed on the CDCO side as a safety measure, in the event that a problem occurs with the transmission batch, or the transmission process itself.

Due to the nature of the HL7 message, along with the rejection received from the CDCO, this type of message is more difficult to decipher. In order to successfully decipher HL7 messages, some knowledge of HL7 segments and fields is required.

The following is an example of a transaction with a required field missing.

```
Subj: Dental Transaction Error [#721] 08/23/04@12:14 5 lines
From: POSTMASTER (Sender: [redacted]) In 'HL7' basket. Page 1
-----
Application error or reject for HL7 message 4638449599-3
received from Austin Automation Center.
Error code: [redacted] Error text:
SEG: PID SEQ: 03
FLD: 01 Code: 101&REQUIRED FIELD MISSING

Enter message action (in HL7 basket): Ignore//
```

Figure 327: Transaction with Required Field Missing

The HL7 message ID is contained in the dental DES/HL7 TRANSMISSION (#228.25) file. This ID can be used to look up the HL7 transmission entry. At that point, it can be used to find the transaction ID for the Dental Encounter (file 228.2) rejected message.

In addition to adding members to the VistA mail group, an Exchange Group (Distribution Group) must also be created on the exchange server (should have been created when Patch 40 was installed) so that it appears in the Outlook Global Address List (GAL) as follows: VHAUserSiteVIEMessages, i.e., VHABHHCS VIE MESSAGES (Black Hills Health Care).

This group provides the Vitria Interface Engine (VIE) Team with an address to send error messages to. Since all HL7 messaging eventually are directed through local VIEs, it is vital that this group includes persons on site with knowledge of HL7 functionality.

The SEGment, SEQuence, FiELD and Error Code values are used to show which piece of data was missing or invalid. Repairing the data follows the same procedures as those performed by VistA.

HL7 Transaction Data from Dental will be Automatically Resent

During the weekly transmission of dental encounter/transaction data, a process checks whether the CDCO has received and acknowledged the transactions. If there are no acknowledgments for two weeks, the data is resent during the next week's transmission. This should prevent the manual re-transmissions that IT performs when data does not reach the national database.

Additional Reporting Data will be Sent to CDCO

Additional reporting data has been added to the HL7 message sent to the CDCO for national reporting. This data includes the primary and secondary provider designations for the patient, the patient's **Dental Class** and **Recare Date** from the DRM Plus Cover Page, and up to five **Adjunctive Medical Conditions** (AMC). The AMC data now includes the diagnosis code, in addition to the text, so that the code data may be sent to the CDCO.

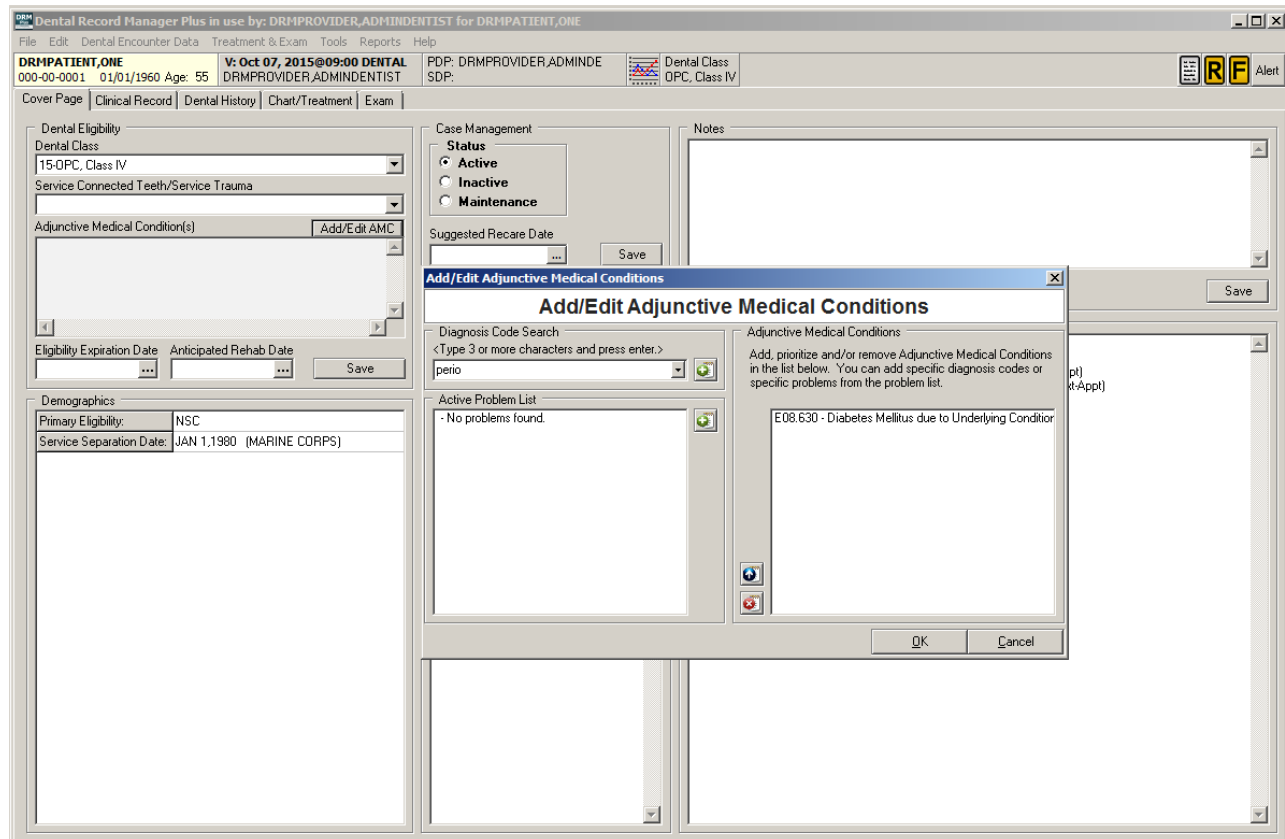


Figure 328: Add/Edit Adjunctive Medical Conditions Screen

For more information, please see the Adjunctive Medical Conditions section in the Cover Page chapter of this manual.

Appendix G – Using the Keyboard to Enter Periodontal Data

Overview

The Periodontal screen is designed for data entry using the mouse. Data entry using the keyboard is also an option. Clicking the **Keyboard Mode** key, <F10>, initiates keyboard navigation and data entry on this screen.

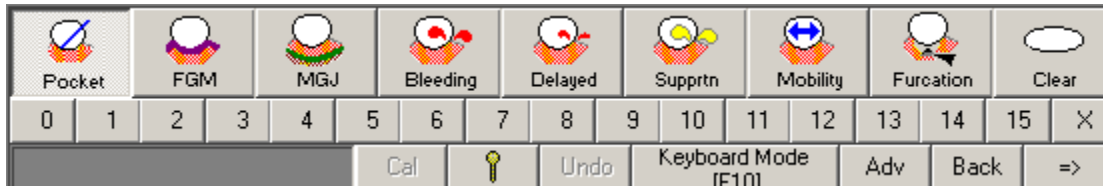


Figure 329: Keyboard Mode Button on Periodontal Chart Screen

When this button is clicked, all of the icons are disabled and the keyboard is activated. The keyboard functions are described in this section.

Navigating the Periodontal Screen

Use the following key strokes to change the screen views.

Arch Views

The screen moves from the existing view to any of the other views by using the following keys:

- U = Upper
- L = Lower
- N = Lingual
- F = Facial
- F11 = Full (This screen must be closed by using the mouse.)

Cursor Movement

There are four options for moving the cursor to select a tooth/surface.

- Enter:** Moves the cursor one surface in the direction of the higher numbered tooth.
- Backspace:** Moves the cursor one surface in the direction of the lower numbered tooth.
- ">" with or without the <Shift> key:** Moves the cursor one surface in the direction of the higher numbered tooth.
- "<" with or without the <Shift> key:** Moves the cursor one surface in the direction of the lower numbered tooth.

Press the <A> key to toggle the **Auto Advance** function on or off.

Entering Data

Entering data from the keyboard requires the cursor to be placed on the desired tooth/surface. The user must then select the desired condition and enter the data values in the appropriate manner.

Note: All numeric values must be entered with two digits (1 = 01, 2 = 02 and 10 = 10). Entering FGM and Mobility require the values to have a prefix (see below).

K = Pocket: Press the <K> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

G = FGM: Press the <G> key and with the cursor in the correct position, enter a plus sign (+) and a two digit value, or just a two digit value. Then move the cursor to the next surface.

J = MGJ: Press the <J> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

B = Bleeding: Press the key with the cursor in the correct position.

D = Delayed Bleeding: With the cursor in the correct position, press the <D> key.

S = Suppuration: With the cursor in the correct position, press the <S> key.

O = Mobility: Press the <O> key with the cursor in the correct position and enter a two digit value. For a value of 1 1/2, 2 1/2, etc., enter the two digit value preceded by a plus sign “+”.

I = Furcation: Press the <I> key with the cursor in the correct position and enter a two digit value. Move the cursor to the next surface.

R = Reset: Pressing the <R> key resets all values to zero (use this functionality with extreme caution).

Ctrl Z = Undo.

Special Buttons

Viewing the Special Buttons screen requires pressing the following keys:

H = History

C = Compare

M = Summary

E = Head & Neck

P = PSR

Q = Stats

Note: Displaying these screens using the keyboard turns off the keyboard function for these screens. The mouse is required to navigate these screens.

Other Functions

Z = Cal and **X = Lock**

For convenience, a tear-out of the **Periodontal Keyboard** shortcut chart is available on the last page of this manual.

Appendix H – Ranged Codes

Using the graphic icon on the **Treatment Plan** and **Completed Care** screens is not only straightforward, it minimizes the potential for errors. Certain codes, designated as ranged codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted to icon use only for procedure entry. These codes are listed below.

Removable Prosthetics	Implant Services	Fixed Prosthetics
5130	6054	6205
5140	6055	6210
5211	6068	6211
5212	6069	6212
5213	6070	6214
5214	6071	6240
5225	6072	6241
5226	6073	6242
5281	6074	6245
5820	6075	6250
5821	6076	6251
5863	6077	6252
5864	6078	6253
5865	6079	6545
5866	6194	6448
		6600
		6601
		6602
		6603
		6604
		6605
		6606
		6607
		6608
		6609
		6610
		6611
		6612
		6613
		6614
		6615
		6624
		6634
		6710
		6720
		6721
		6722
		6740
		6750
		6751
		6752
		6780

Maxillofacial Prosthetics	Fixed Prosthodontics
5934	6781
5935	6782
	6783
	6790
	6791
	6792
	6793
	6794
	6920

Appendix I – Active-Inactive Maintenance Control

With the introduction of DRM Plus, the direct entry of [Completed] or [Terminated] cases was removed from the program. Instead, the concept of **Patient Disposition** was introduced. The provider can choose between an [Active] and [Inactive] status, and if no planned items remain, the case records as [Completed]. If the provider changed the patient from [Active] to [Inactive] status, and planned items remained, the case records as [Terminated]. The **Current Episode of Care** is defined as that interval from when the patient was last updated from [Inactive] to [Active], then back to [Inactive].

A need has been recognized to account for patients who may not be active under care (i.e., have currently planned dental procedures) but may be in a maintenance status, pending future diagnostic or preventive dental care. Effective with Patch 47, DRM Plus now allow providers to choose the status of [Active], [Inactive] or [Maintenance] for their patient.

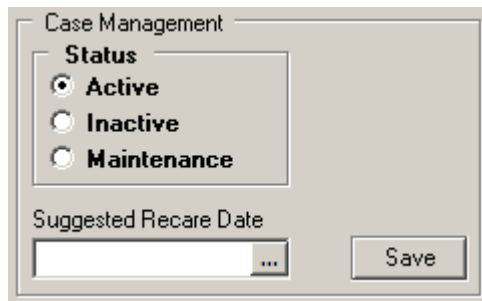


Figure 330: Case Management Status

By design, whenever a new dental patient is created in the **Dental Patient** file that patient's status is set to [Active]. As before, if the provider changes the patient from an [Active] to [Inactive] status, and there are no planned items remaining, the case is recorded as [Completed]. If the provider changes the patient from an [Active] to [Inactive] status, and there were planned items remaining, the case is recorded as [Terminated]. Now additionally, if the provider changes the patient's status from [Active] to [Maintenance], and there are no planned items remaining, the case is recorded as [Completed] and the episode of care ends. If the provider changes the patient's status from [Active] to [Maintenance], and there are planned items remaining, the case remains ongoing with no changes to the episode of care. No matter what the patient's previous status, a patient's status is set to [Active] if an entry is made for additional planned care.

The provider also now has the option of entering a **Recommended Recare Date** for the patient, which provides a date flag for reporting and re-evaluation purposes. (As CPRS re-engineering continues, this flag eventually is used for setting a clinical reminder in CPRS).

Effective with Patch 47, the install routine traverses the **Dental Patient** file and cross reference the most recent dental care for each patient. If there are no transactions on file for the patient in the last 24 months, the patient's status is set to [Inactive]. Then, on a monthly basis, a maintenance routine is set [Inactive] those patients that have an [Active] status that have no transactions on file in the last 24 months and no **Recommended Recare Date** set, or those patients with an [Active] or [Maintenance] status where 24 months have elapsed past their **Recommended Recare Date**.

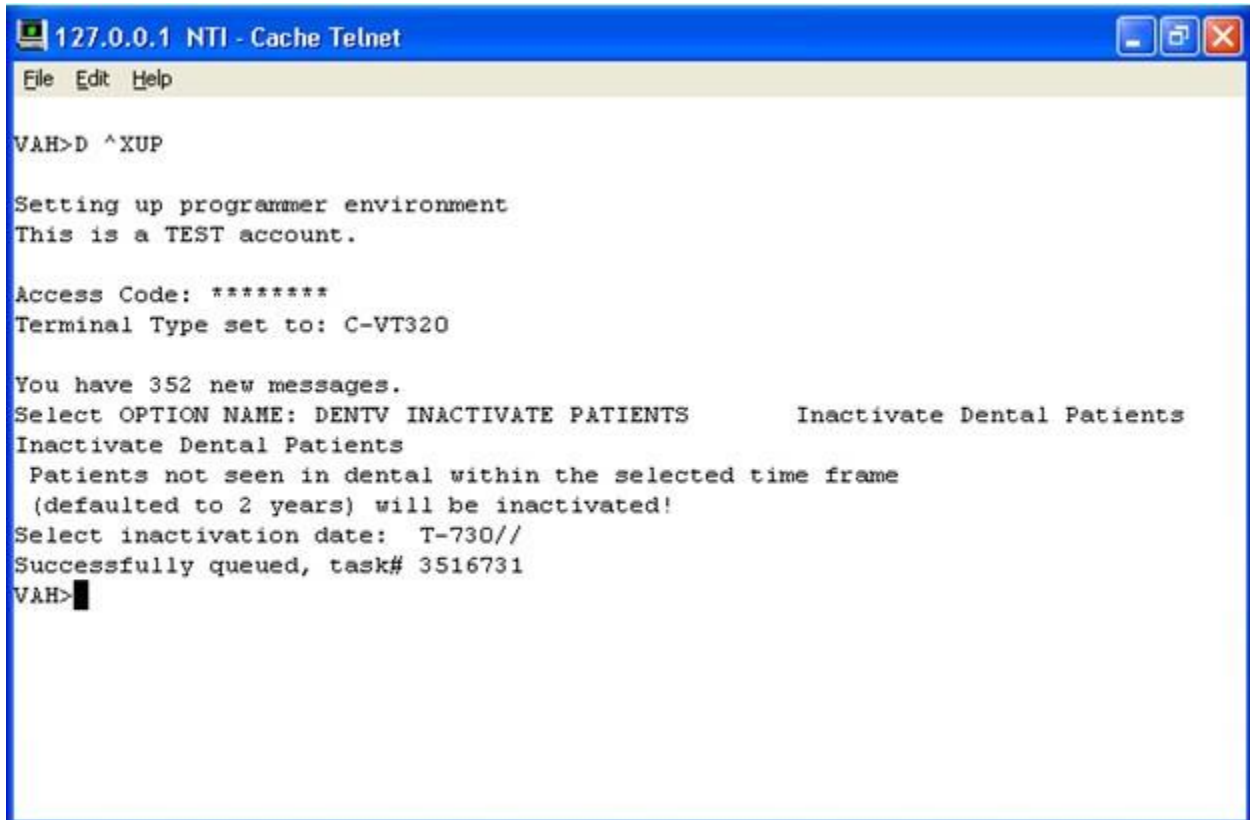
Here are some likely scenarios and the recommended use of this control:

- A newly enrolled Veteran is eligible for dental care and the patient is new to the dental clinic. Their case is automatically set to [**Active**] without user intervention upon the first time opening the patient in DRM Plus.
- A **Class II** patient has had their post-discharge dental care episode finished. Upon completion of care, their status is changed to [**Inactive**].
- A **Class I/II/IV** patient has had all of their restorative and periodontal care complete. They should be seen in four months for a periodontal checkup. Upon completion of the restorative and periodontal care, their status is changed to [**Maintenance**] with the **Recommended Recare Date** set four months from today. There is no statutory requirement for the VA to meet that recommendation, but if the patient calls in for an appointment and an appointment cannot be scheduled within the later of 30 days of that recommended date or the patient's call, they should be placed on the EWL.
- A **Class III/VI** patient has had their adjunctive care completed. Upon completion of the adjunctive care, their status is changed to [**Inactive**]. The provider can choose whether or not to recommend and enter a re-care date; there is no statutory requirement for the VA to meet that recommendation.
- A **Class V** patient has had their necessary dental care completed. Upon completion of care, their status is changed to [**Inactive**]. The provider can choose whether or not to recommend and enter a re-care date; there is no statutory requirement for the VA to meet that recommendation.
- A newly enrolled Veteran is eligible for dental care. Limited capacity requires they be placed on the EWL. Their dental eligibility information should be entered in DRM Plus and thus by opening the patient in DRM Plus as a new patient their status is set to [**Active**]. Patients on the EWL should always be recorded as [**Active**] until their care is complete. If it is likely the patient may have a significant wait for care, it is suggested the **Recommended Recare Date** be set to the approximate date the patient's dental care is initiated to avoid automatic inactivation of the patient after 24 months.
- A **Class I/II/IV** patient has failed to keep appointments and not followed through with their care. The provider makes a progress note of the patient's failure to adhere to medical recommendations and change the patient's status to [**Inactive**]. The provider can choose whether or not to recommend and enter a re-care date; there is no statutory requirement for the VA to meet that recommendation. The patient's status is changed to [**Active**] upon a new application for care.
- Necessary emergent care has been provided a patient with no other dental eligibility. Once all clinically proper follow-up care is complete, the patient's status is changed to [**Inactive**].

Appendix J – Option to Set Dental Patients to Inactive Status

A new option that IT may run (or may give as a secondary VistA option to DRM Plus users) allows the user to check the system for patient activity, and set patients without current encounters to **Inactive** status.

Use the **OPTION NAME: DENTV INACTIVE PATIENTS** and then select an inactivate date (defaulted to 2 years).



```
127.0.0.1 NTI - Cache Telnet
File Edit Help
VAH>D ^XUP
Setting up programmer environment
This is a TEST account.
Access Code: *****
Terminal Type set to: C-VT320
You have 352 new messages.
Select OPTION NAME: DENTV INACTIVATE PATIENTS          Inactivate Dental Patients
Inactivate Dental Patients
Patients not seen in dental within the selected time frame
(defaulted to 2 years) will be inactivated!
Select inactivation date: T-730//
Successfully queued, task# 3516731
VAH>
```

Figure 331: VistA Option to Set an Inactivation Date

Appendix K – How to Map Dental CNTs

Note: These procedures require IT assistance. The dental staff should provide these instructions to IT.

In order to confirm that the CNTs are mapped correctly:

1. Open the `\DOCSTORE\Array\dntarray.txt` file located on the server to confirm that within the `dntarray.txt` file, the patch for each CNT is correct.

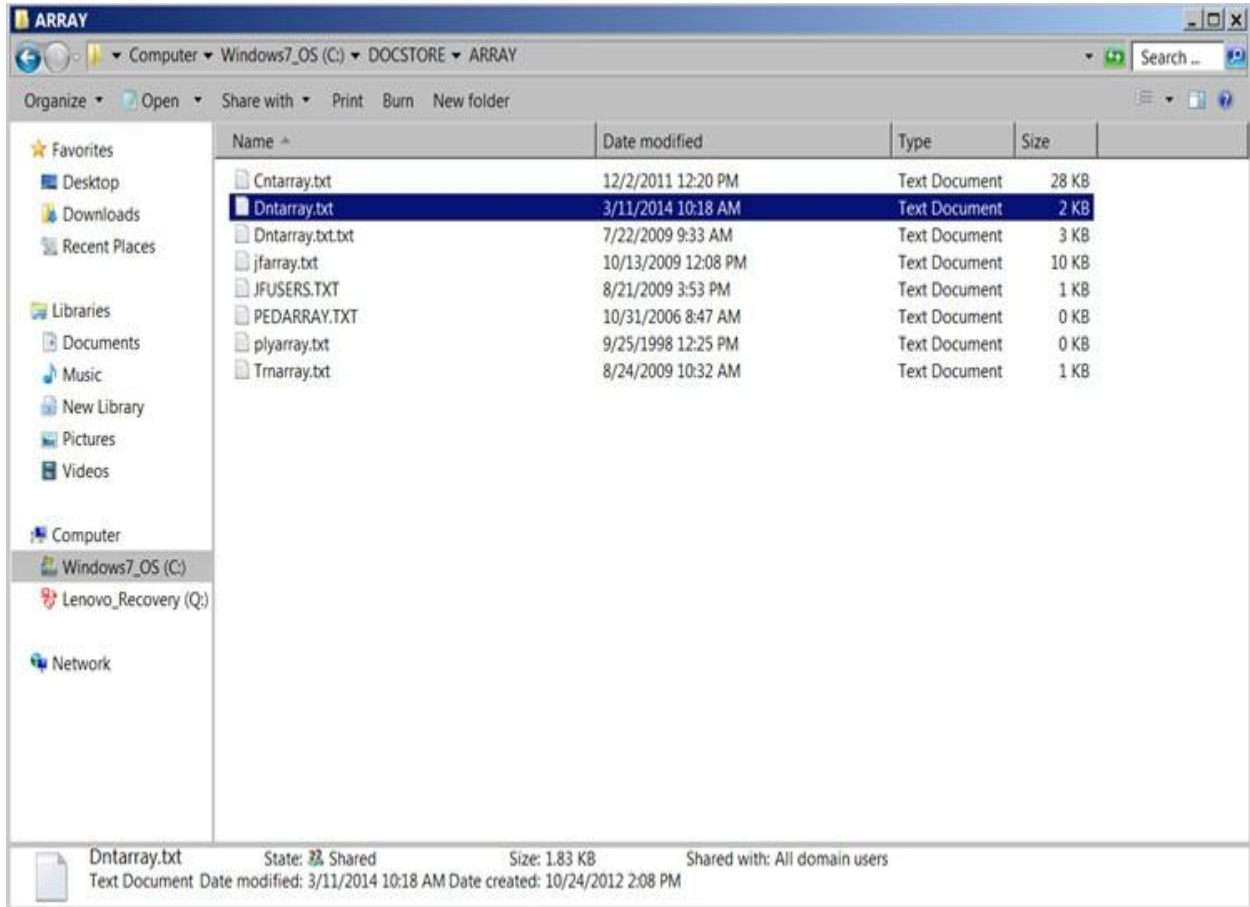


Figure 332: Map Dental CNTs from dntarray.txt file

2. Open one of the CNT .ini files within the **\DOCSTORE\FORMS** directory (i.e., \\vhaserver-name\DOCSTORE\FORMS\160_DENT\04160001\DRMEval.ini)

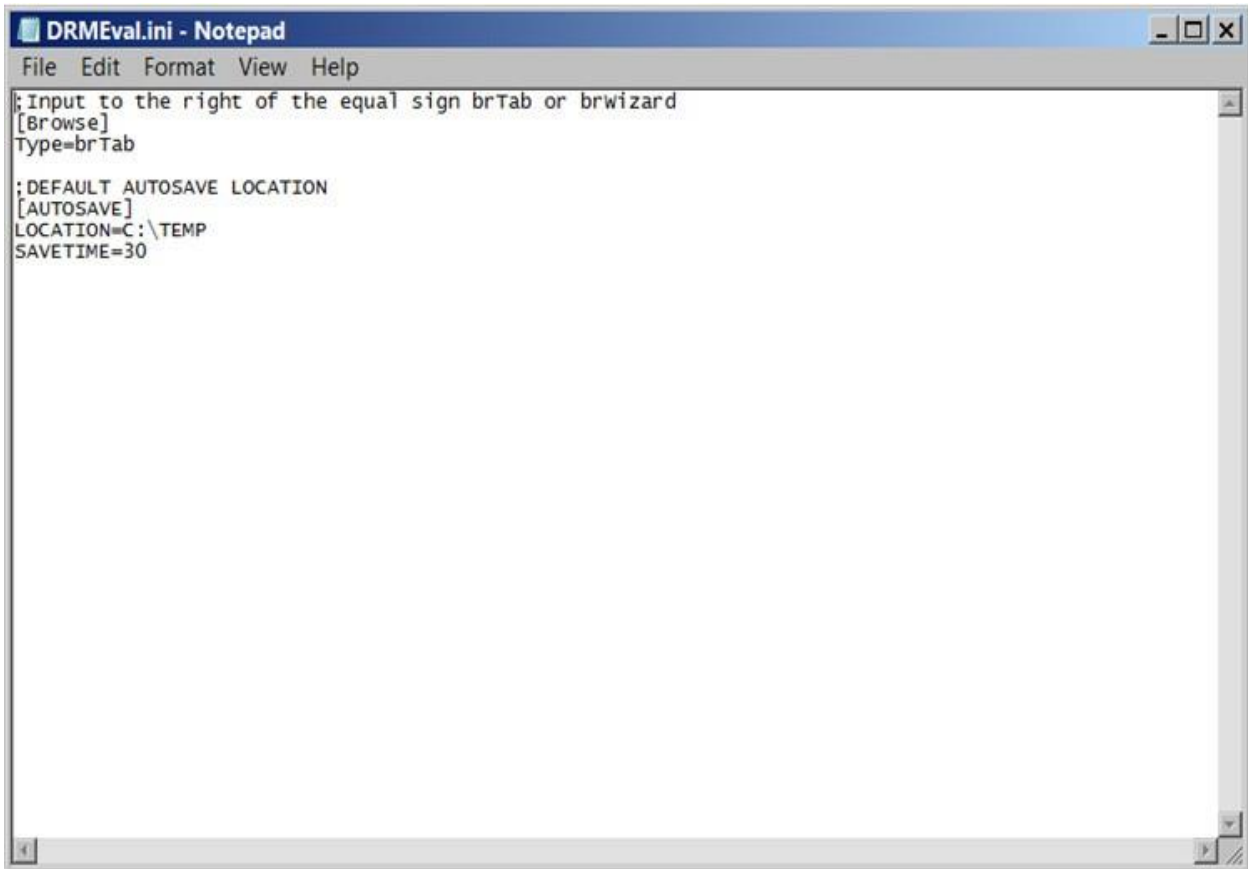


Figure 333: DRMEval.ini File

3. Confirm that the VHAservername path matches what was in the **\Array\dntarray.txt** file and is correct.
4. If the VHAservername within any of the **\FORMS\160_DENT\#####\ini** files does NOT match the directory shown above (in the ARRAY folder) then each .ini file within the **FORMS** directory need to be opened and edited to reflect the correct path.

Appendix L – Recommendations for Coding of Prosthetic Appliance

Coding for prosthetic appliances is to be done at the time when the prostheses are delivered to the patient and/or home care instructions are provided and documented.

Taking workload credit for the undeliverable prosthetic appliances should occur:

1. After death.
2. After 6 months and 3 attempted telephonic contacts. Attempts to reach patient should occur at a timely interval (i.e., at least one week apart).
3. No response to a final letter to patient's last known address.
4. CPRS documentation to insure no citation for patient abandonment.

To take workload credit with no associated patient visit (i.e., phone contact):

1. Follow local policies for documentation of telephonic contact. Codes for phone contacts in DRM Plus are listed under the CPT codes (99441, 99442 and 99443).

To file workload credit:

1. Enter code(s) in the **Completed Care** screen.
2. Select the correct previously filed **Visit Date/Time** associated with this addendum.
3. Click the **Next** button and select the **File Data With a Note Addendum** radio button.

Appendix M – Business Use of DRM Plus

As important as it is to know how to use DRM Plus, it is equally important to be aware of how to enter codes, fees and similar DRM Plus business considerations.

Entering DRM Plus business information may be viewed in three different components:

- Local policy and practice
- National policy and practice
- National business practice

Adhering to the following guidelines for each is essential and critical to the success of treating our Veterans. Entering valid data can provide important information on the allocation of VA resources on a local and national level, clarify current and future funding issues, and determine how to provide even better care to patients.

Review this information carefully. If the user has any questions about this software or the accompanying business policies, contact the local DRM Plus Subject Matter Expert on site. If this person cannot answer the question, s/he knows who to contact to find the correct solution.

Local Policy and Practice

This includes the workflow process addressing the provider's data entries for the following:

- Diagnostic Findings
- Observations
- Approval for proposed Patient Treatment Plans are to be established by the local dental manager.

National Policy and Practice Coding Standards

All completed procedures on site must be entered into the DES through DRM Plus. This includes the following:

- Procedures by staff
- Fee-basis on site
- Sharing on site
- Contract on site
- Residents
- Without compensation
- Students
- Hygienists

For example, if a surgeon goes to the OR and enters the procedure into PCE through the surgery package, or through an encounter, that procedure must be entered into DES through DRM.

Coding standards should be followed in an attempt to calibrate providers, in the event that the same encounters are observed at two separate clinics. This ensures that the encounters are coded the same.

Appendix N – Data Security

As a VA computer user, one of the best and most important ways to contribute to good computer security is to know all data, its level of sensitivity, that it is virus-free, what would happen if it were unavailable, how long it could be done-without, and the effect of another user changing it without approval.

Classifying data involves determining how sensitive and valuable it is, and what protection it needs. Information is classified according to sensitivity, which is based on its need for:

- **Confidentiality:** The information must be kept private as its owner instructs.
- **Integrity:** The information must not be inappropriately changed or destroyed.
- **Availability:** The information must be ready for use, as needed.

The amount of information and the context in which it is found can affect its value. Some information is confidential only at certain times (i.e., contracting or economic forecast information, which is sensitive until its publication or release date, after which it is made public). Current information is generally more valuable than older information.

When protecting data, all employees and contractors have a responsibility to:

- Be familiar with VA security policies, procedures, rules and regulations (i.e., know what to do, how to do it and why).
- The user should ask a supervisor or ISO any questions about these security responsibilities.

The user is responsible for:

- Reporting known or suspected incidents immediately to the ISO.
- Using VA computers only for lawful and authorized purposes.
- Choosing good passwords and changing them every 90 days. Do not write down or share log-in information with anyone, including Help Desk.
- Complying with safeguards, policies and procedures to prevent unauthorized access to VA computer systems.
- Recognizing the accountability assigned to the user's UserID and password. Each user must have a unique ID to access the VA systems. Recognize that UserIDs are used to identify an individual's actions on VA systems and the Internet. Individual user activity is recorded, including sites and files accessed on the Internet (recorded as the files go through the firewall).
- Ensuring that data is backed up, tested and stored safely.
- Not generating or sending offensive or inappropriate email messages, graphical images or sound files. Limit distribution of email to only those who need to receive it. Realize that the user is identified as a user of the VA computer systems when logged on to the Internet.
- Using authorized virus scanning software on the workstation or PC and home computer. Know the source before using discs or downloading files. Scan files for viruses before execution.
- Complying with terms of software licenses and only using VA-licensed and authorized software. Do not install single-license software on shared hard drives or servers.
- Complying with terms of software licenses and using only VA-licensed and authorized software. Do not install single-license software on shared hard drives or servers.

- Knowing data and properly classifying and protecting it, as well as inputs and outputs, according to their sensitivity and value. Label sensitive media, use a screen saver with a password, logoff when leaving the work area, and secure that sensitive information is removed from hard disks sent out for maintenance. Do not send sensitive information over the Internet unless it has been encrypted.
- Learning as much as possible about information security to assist the user's ISO. Numbers alone make users the most important security asset. Compared to one ISO for a system, users offer a chance for numerous eyes and ears to remain alert to potential threats to information systems.

Appendix O – madExcept Application

The **madExcept** application is a tool that has been added to DRM Plus to assist with error reporting from the field and implementing a fix in the application. In order to be prepared to use this tool if an error occurs while using DRM Plus, please review the following directions:

Select all the **OK** buttons from any traditional error screen that may display in DRM Plus. There may be more than one traditional error screen or there may be none, but no matter how many, select the **OK** button on all. If any informational screen displays asking if the user would like to view the last broker call, select the **No** button from that screen and continue through this process.

As soon as the **DENTALMRMTX.EXE** error screen appears, select the ‘**send bug report**’ button (first button from the left) as displayed:

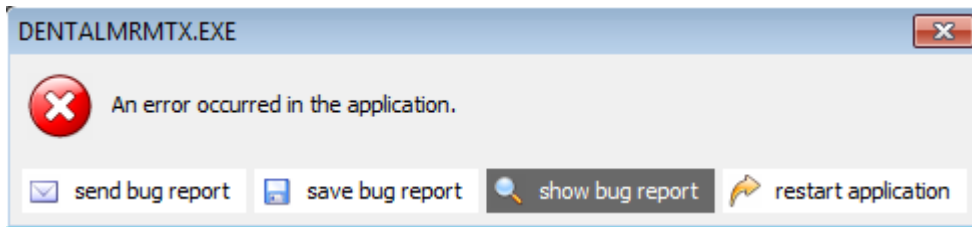


Figure 335: DENTALMRMTX.EXE Screen

After selecting the ‘**send bug report**’ button, the **Contact Information** screen will appear. Enter a user name and VA email address and select the **Continue** button on the **Contact Information** screen:

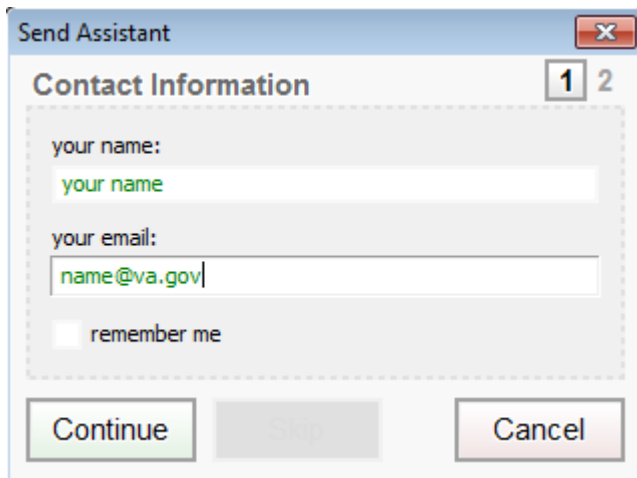


Figure 336: Contact Information Screen

The **Error Details** screen will immediately appear. Add information in the in the **Error Details** screen providing as much information as possible. If known, list every click that occurred prior to the error message. The more details listed; the easier it will be to reproduce the error and fix it.

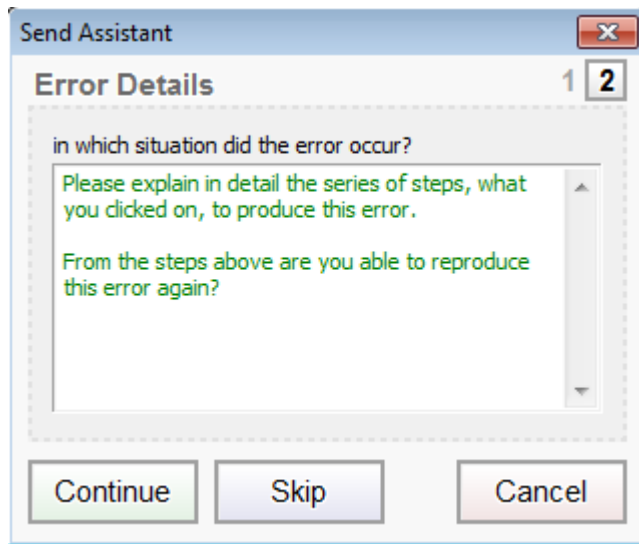


Figure 337: Error Details Screen

Select the **Continue** button from the **Error Details** screen.

The screen that follows will open the users email screen. The example used is MS Outlook. The email address of both Vicky Byers and J.D. Carr and the error/bug report will populate the 'To' field:

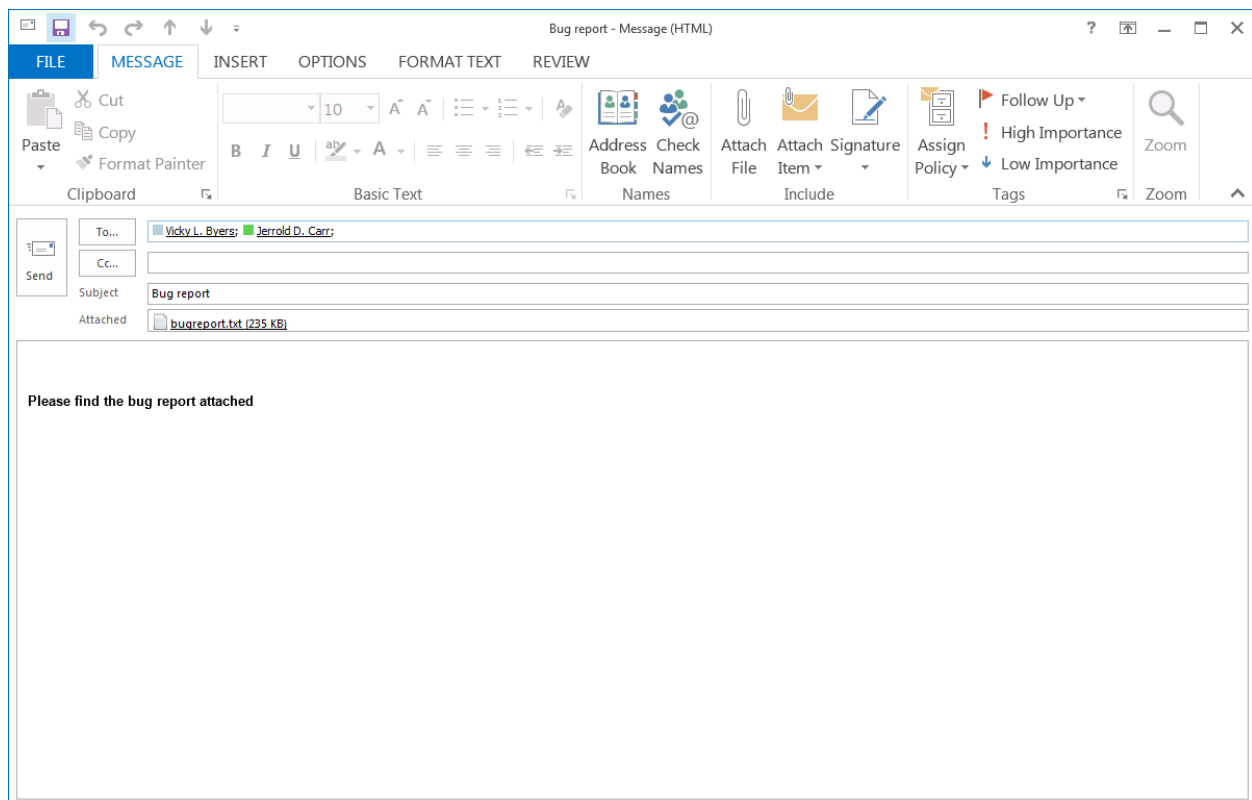


Figure 338: Outlook Window

Enter the name and location (include city and state) of the VA dental clinic where the error occurred. For example, if the error occurred at the Daytona Beach Dental Clinic, enter Daytona Beach, Florida and do NOT enter Gainesville, Florida, even though Daytona Beach is a Gainesville satellite clinic. Also include, if known, the person class or provider type/specialty and the phone number that may be used to contact the person reporting the error. Enter all this data in the email address window.

The user may add any other individuals as recipients (To and CC) in the email address fields as appropriate. Additional information may be included by entering that information in the email address window.

Click on the **Send** button from the email screen.

Select the '**restart application**' button (bottom button on the right) from the **DENTALMRMTX.EXE** screen. This will close the **madExcept** tool and restart DRM Plus.

Note: After an error occurs while using DRM Plus, please reboot the computer before continuing.

Periodontal Keyboard Shortcuts Tear-Out



Figure 339: Periodontal Keyboard Entry Screen