Dental Record Manager Plus (DRM Plus)

User Manual

Version 6.6 **July 2015**

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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.

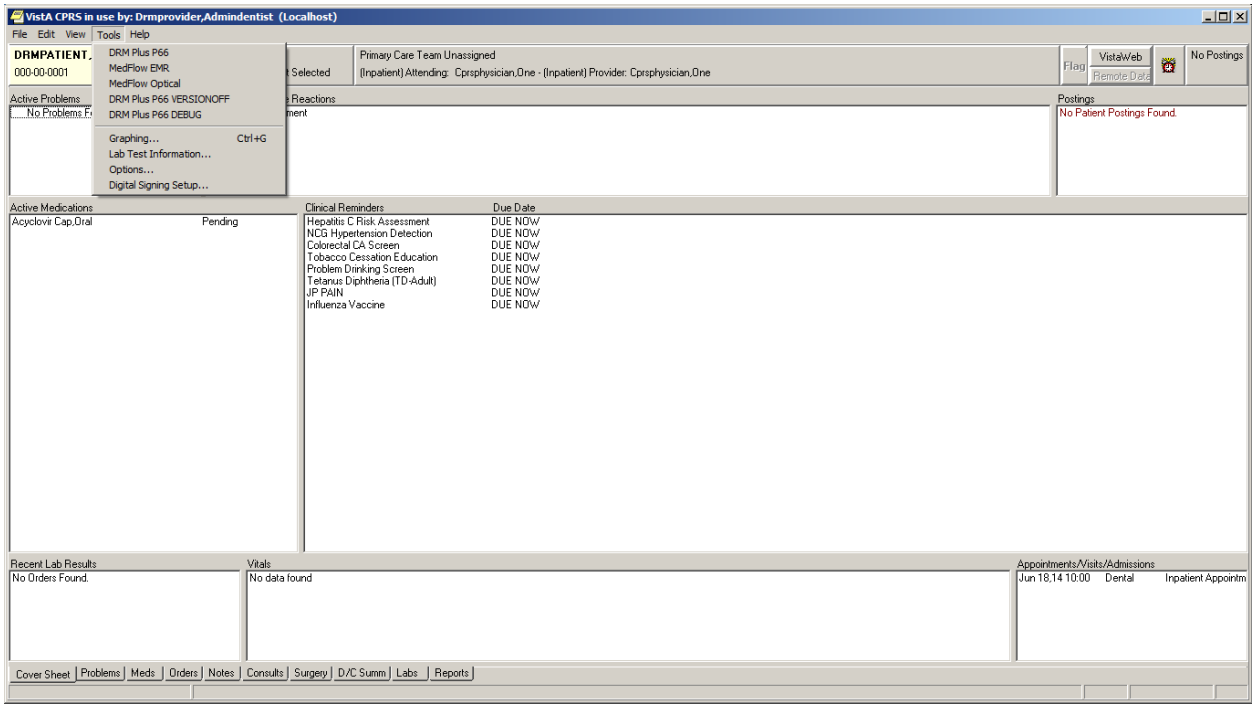


Figure 1: Access DRM Plus through CPRS

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.

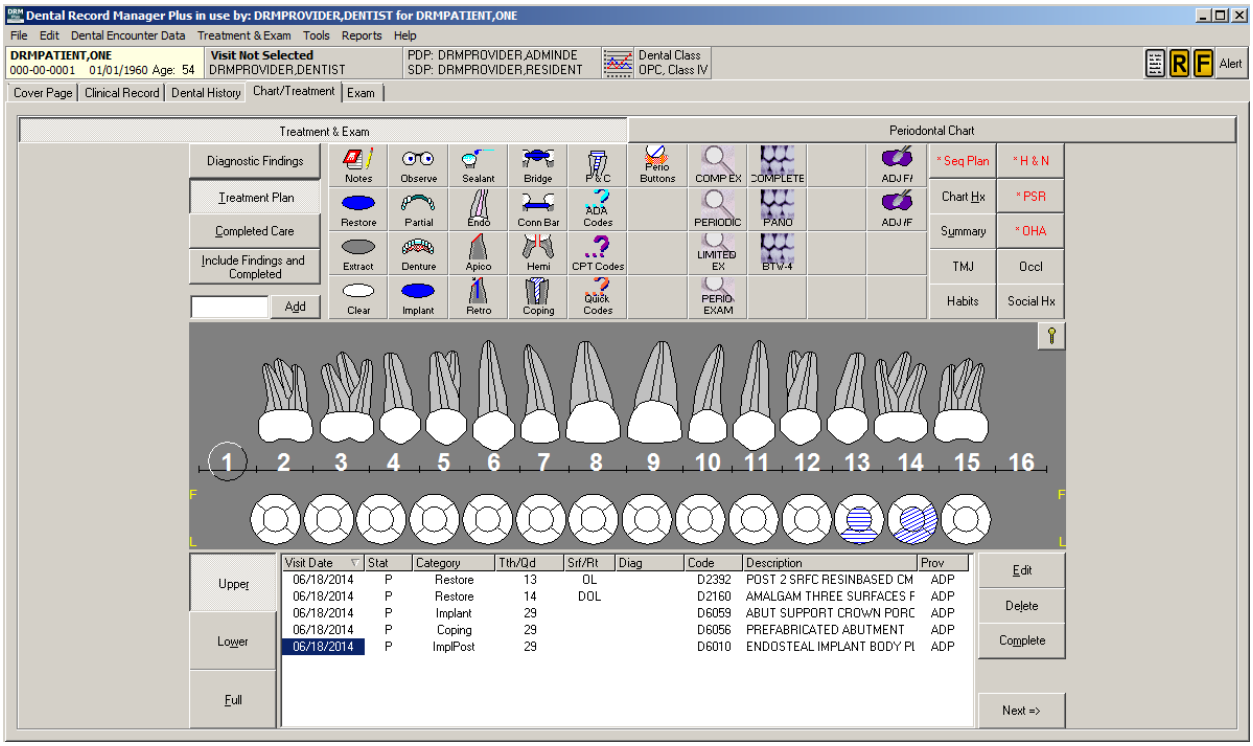


Figure 2: DRM Plus Chart/Treatment Tab

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.

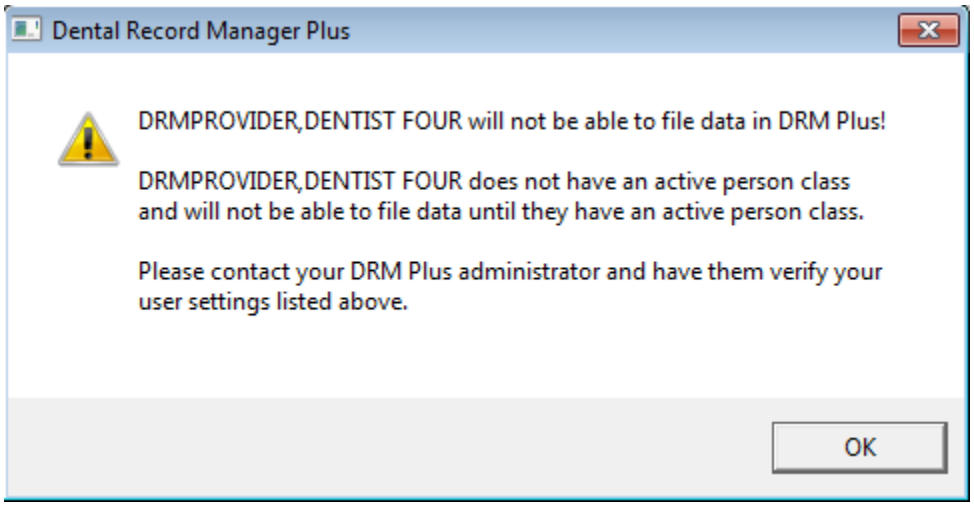


Figure 3: "!"-screen (Informational)

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.**

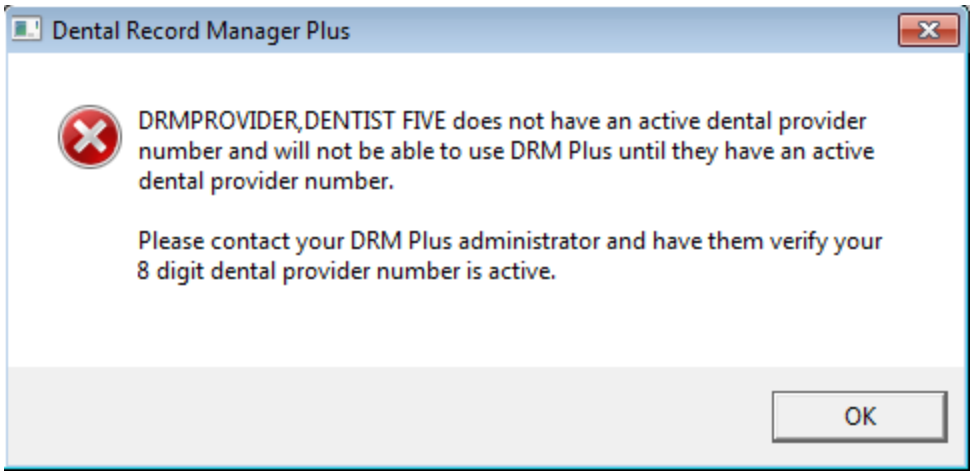


Figure 4: "Red X" –screen (Stop)

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.

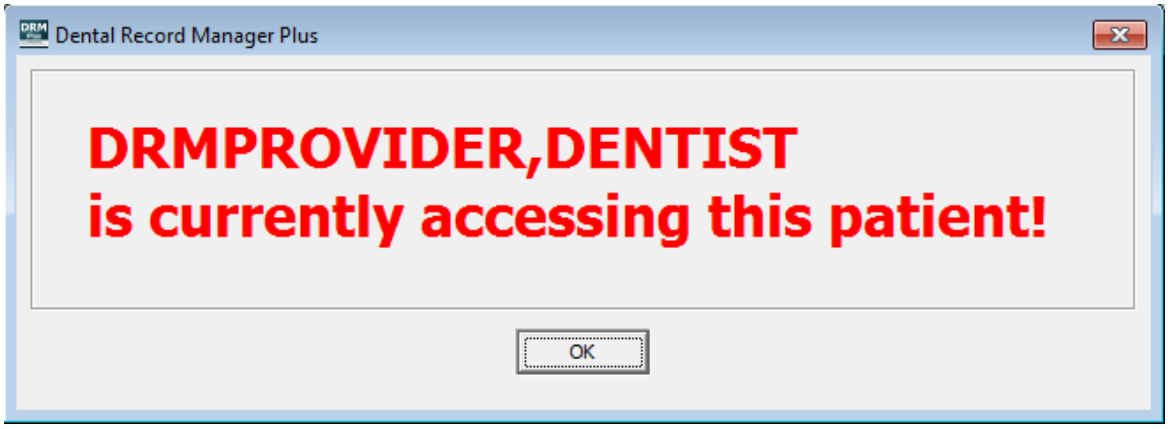


Figure 5: First Warning Informational Screen

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.

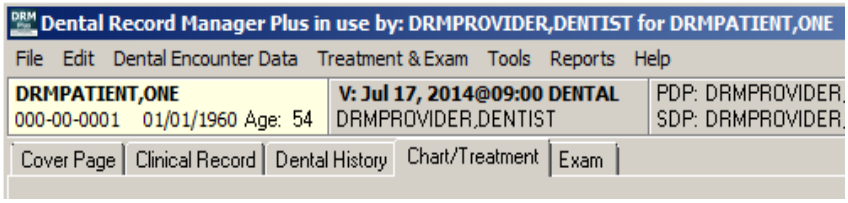


Figure 7: DRM Plus Drop-Down Menus

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.

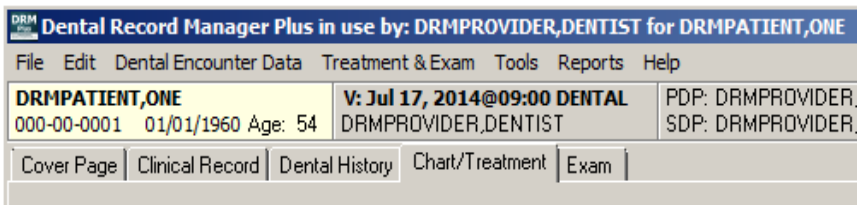


Figure 9: DRM Plus Tabs

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.**

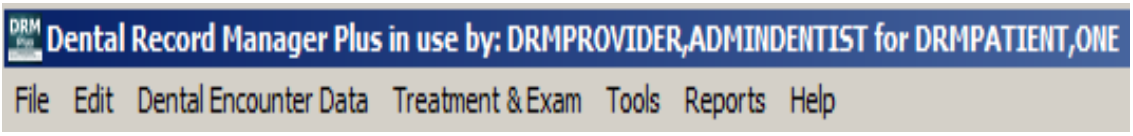


Figure 10: DRM Plus Drop-Down Menus

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** submenu is only active in the note and note addendum screens.

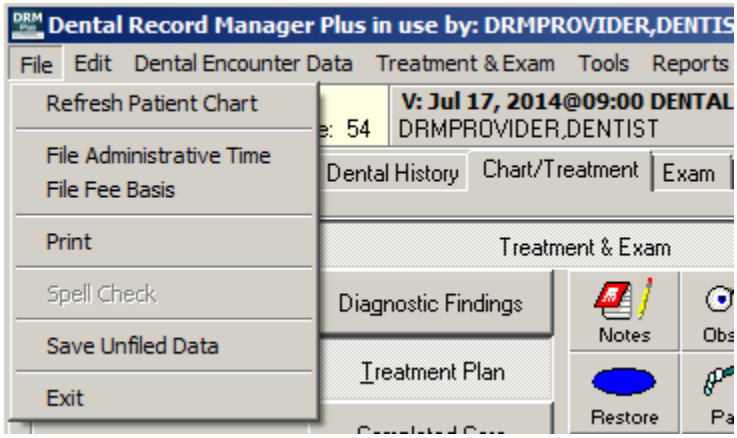


Figure 11: DRM Plus File Menu

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.

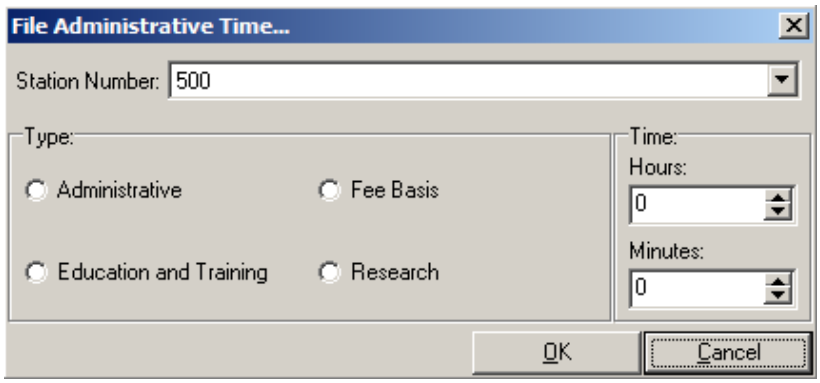


Figure 12: File Administrative Time Screen

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.

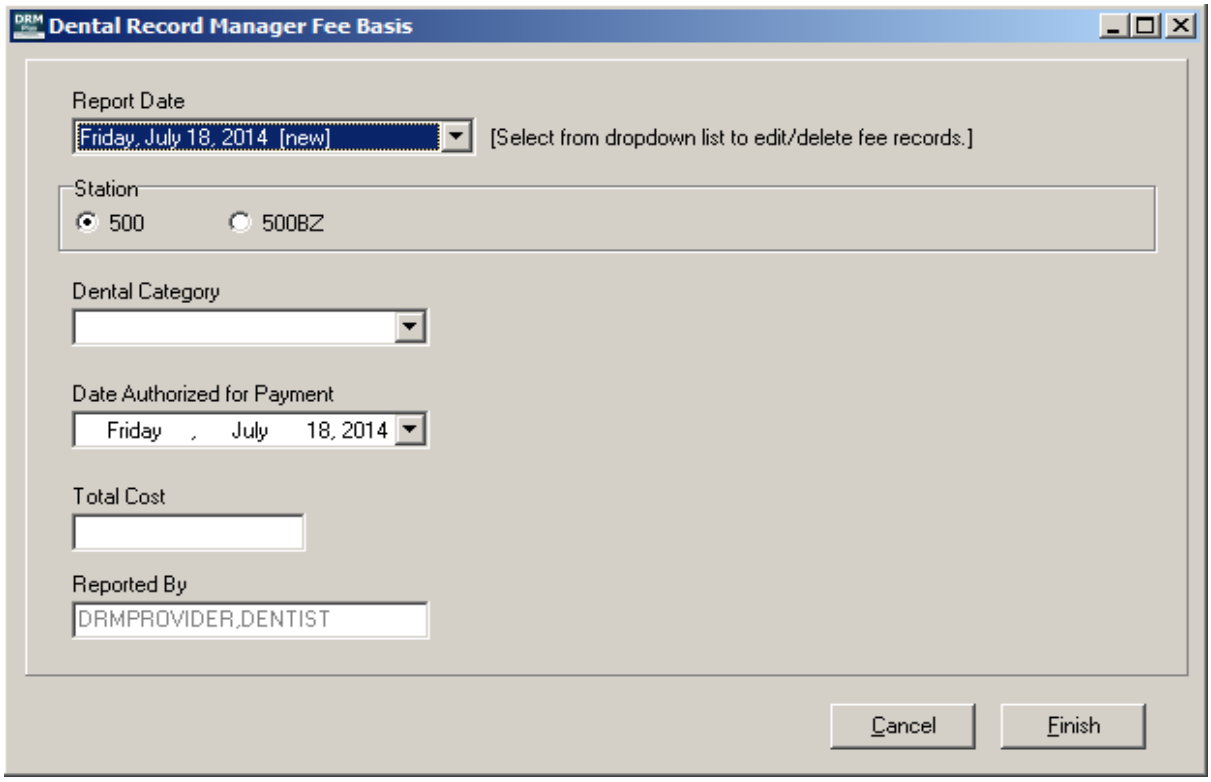


Figure 13: Dental Record Manager Fee Basis Screen

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.

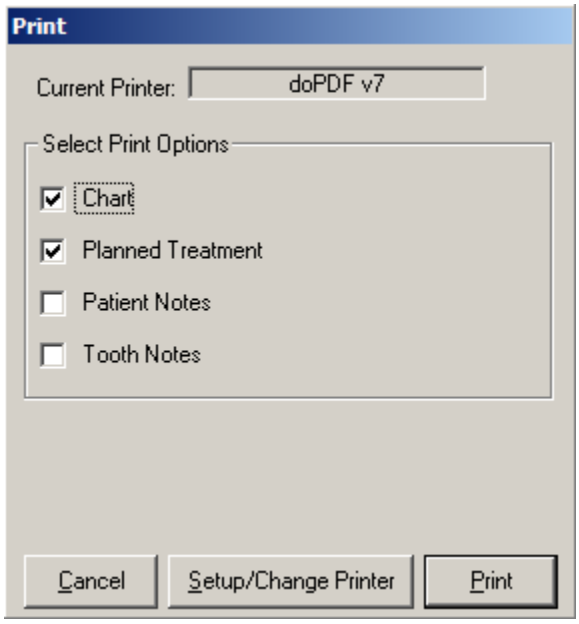


Figure 14: Print Screen

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

Spell Check

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

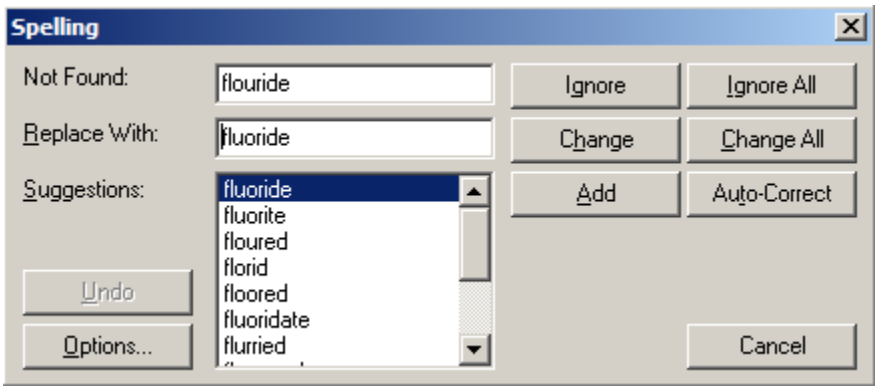


Figure 15: Spelling Screen

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.

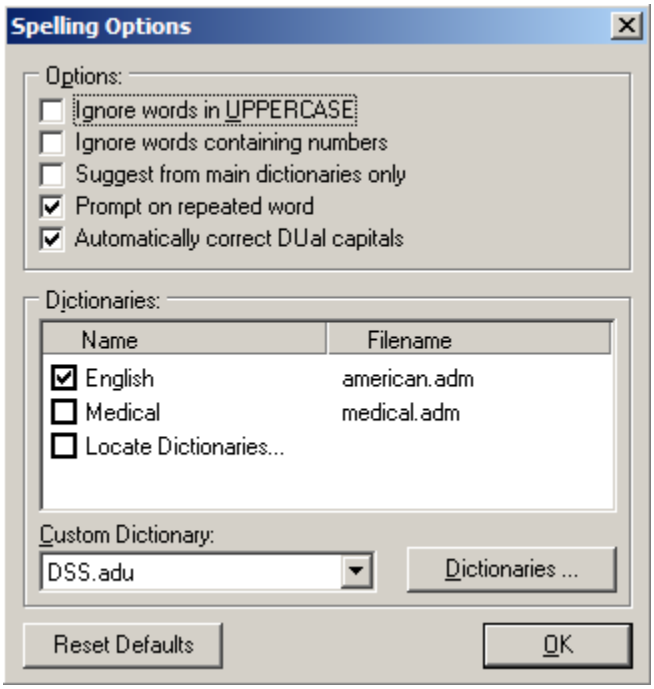


Figure 16: Spelling Options Screen

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

Save Unfiled Data

Select the **Save Unfiled Data** submenu. The **Save DRM Plus Data** screen displays. Click the **Yes** button to save the unfiled data to the listed provider. A screen displays. Click the **Yes** button again to confirm.

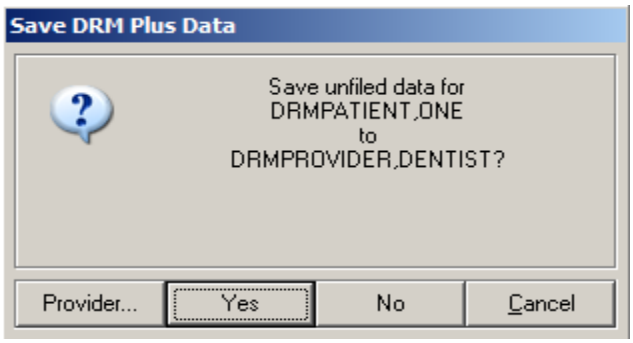


Figure 17: Save DRM Plus Data Screen

To change the save unfiled data to another provider, click the **Provider...** button.

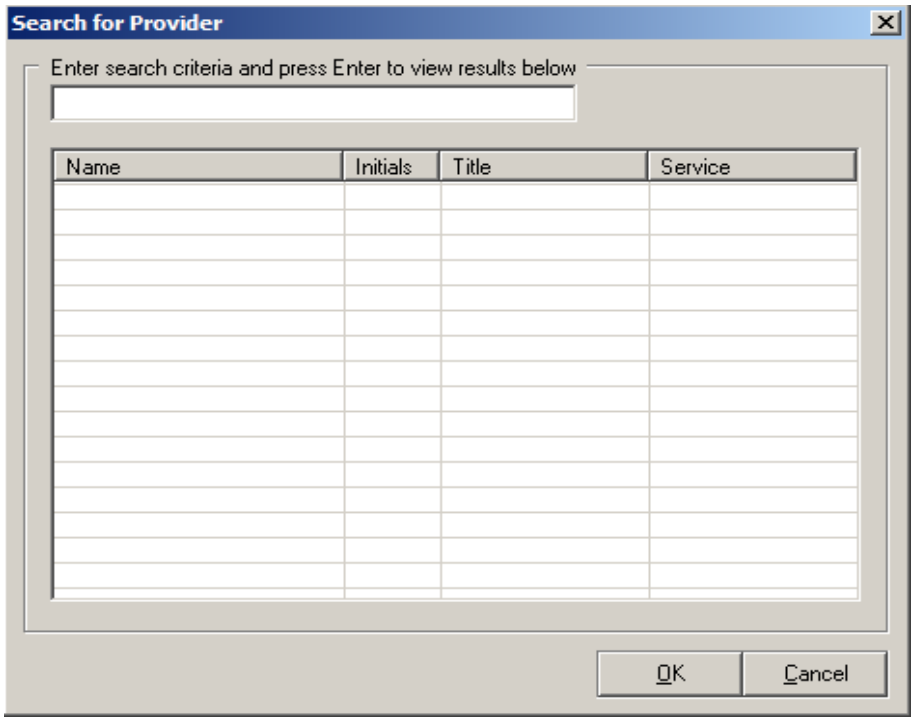


Figure 18: Search for Provider Screen

1. Enter the name or partial name of the desired provider in the **search criteria** text box.
2. Press the <**Enter**> key.
3. Click the needed provider from the list of results.
4. Click the **OK** button to change the provider. The **Save DRM Plus Data** screen displays.
5. Click the **Yes** button to save the unfiled data to the new provider.

When a dental provider is saving unfiled data and assigning it to another dental provider for a selected patient who has previously saved unfiled data that has NOT been filed, the following screen displays.

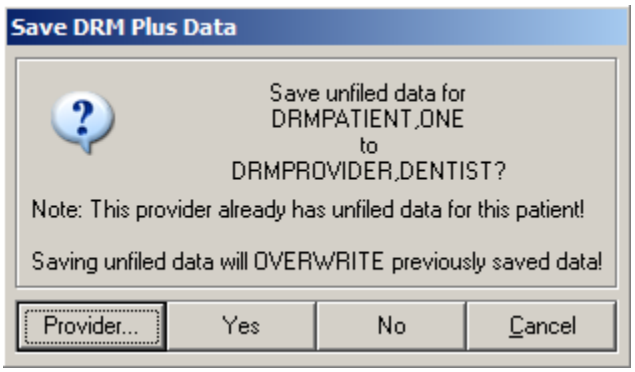


Figure 19: Provider Already Has Unfiled Data

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 **Exit** from the **File** menu. The CPRS main screen displays.

Edit

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

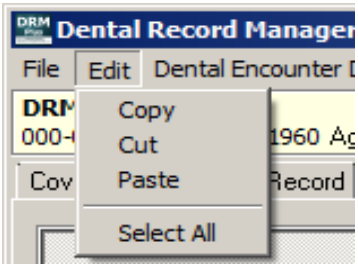


Figure 20: Edit Menu

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

Dental Encounter Data

The **Dental Encounter Data** menu has two submenus: **Create New PCE Visit** or **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 for Current Activities** 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.

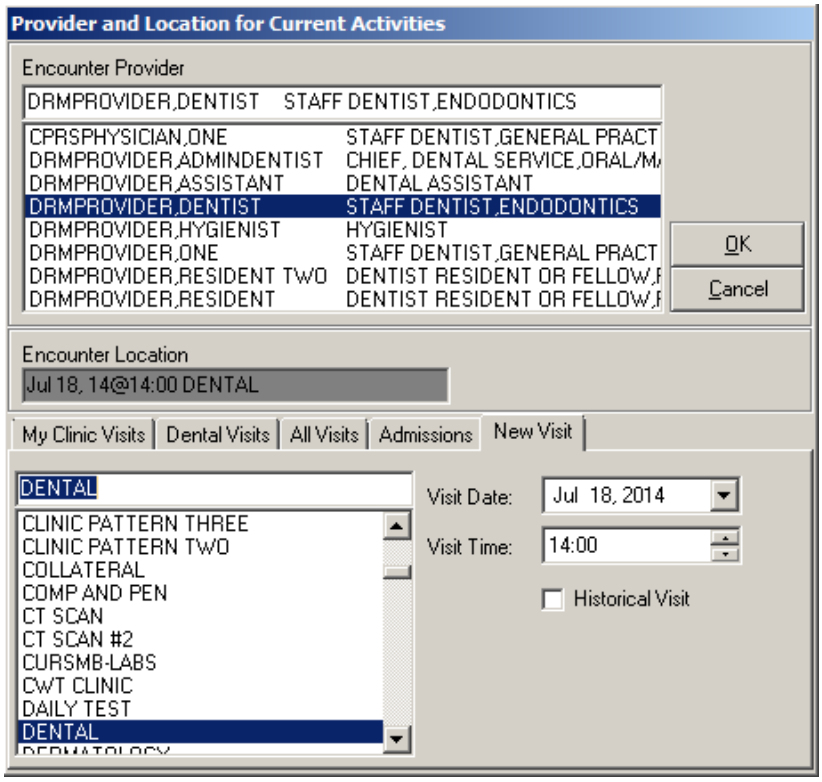


Figure 22: Provider and Location for Current Activities Screen

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.

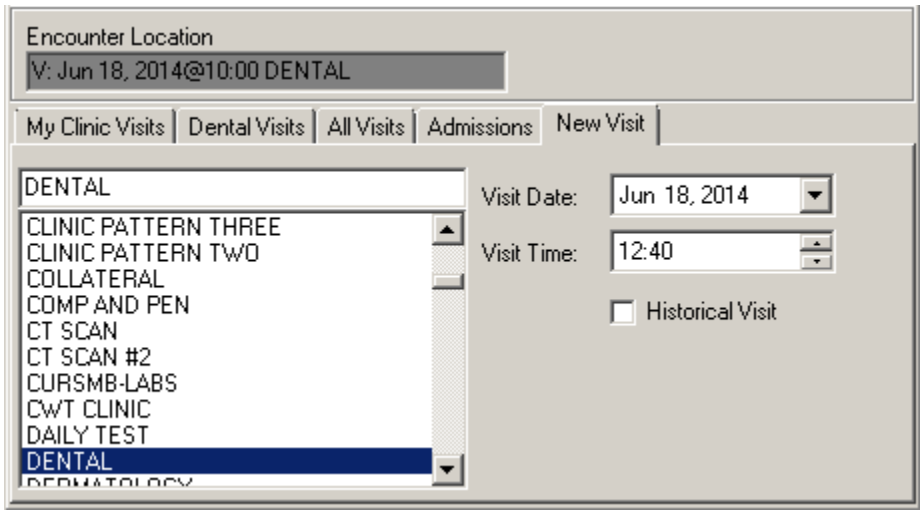


Figure 23: New Visit Tab

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.

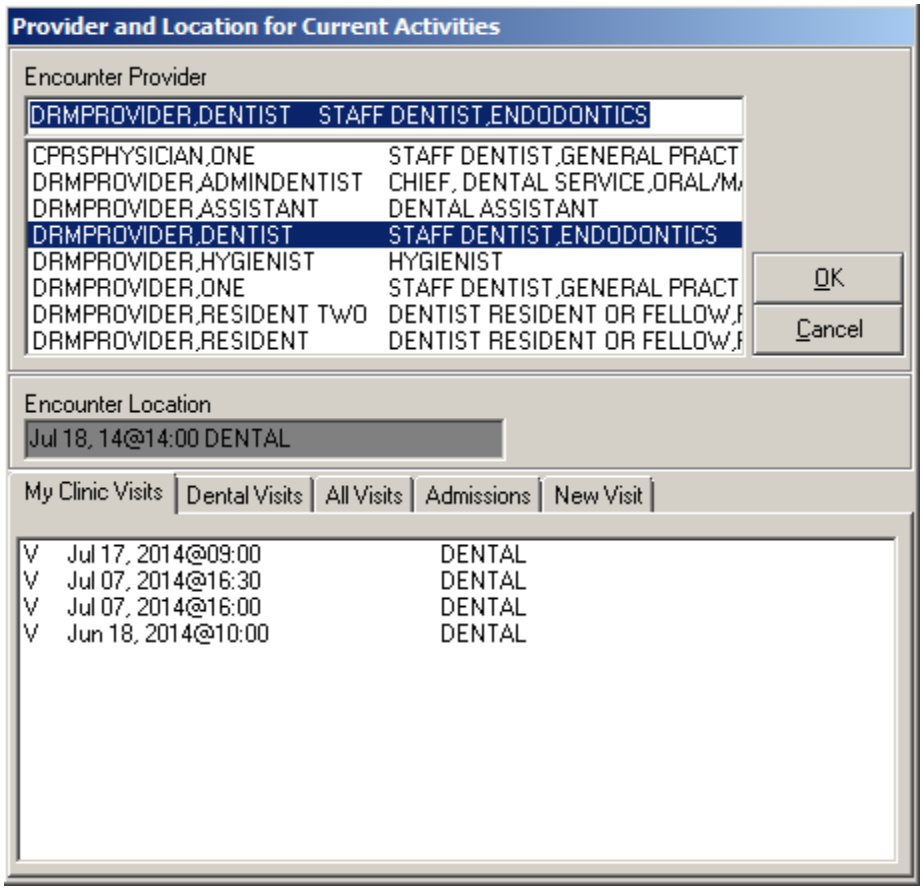


Figure 24: My Clinic Visits Tab

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

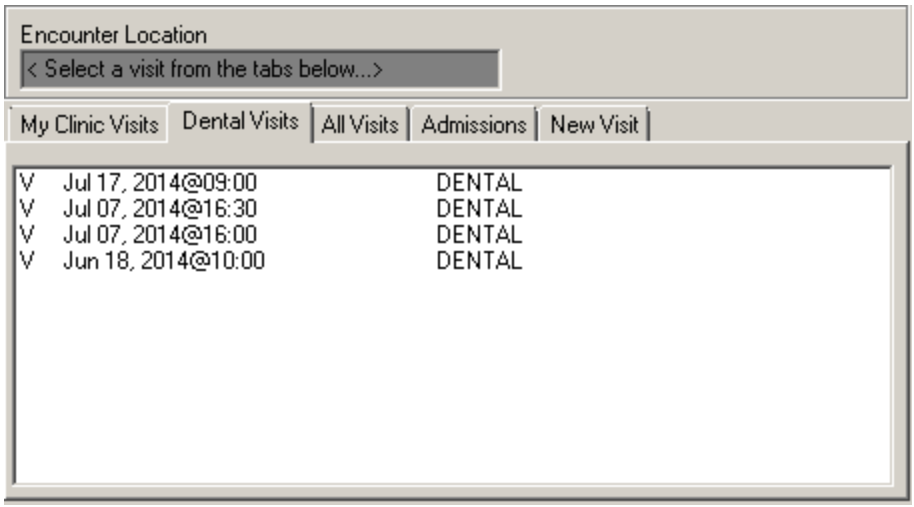


Figure 25: Dental Visits Tab

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

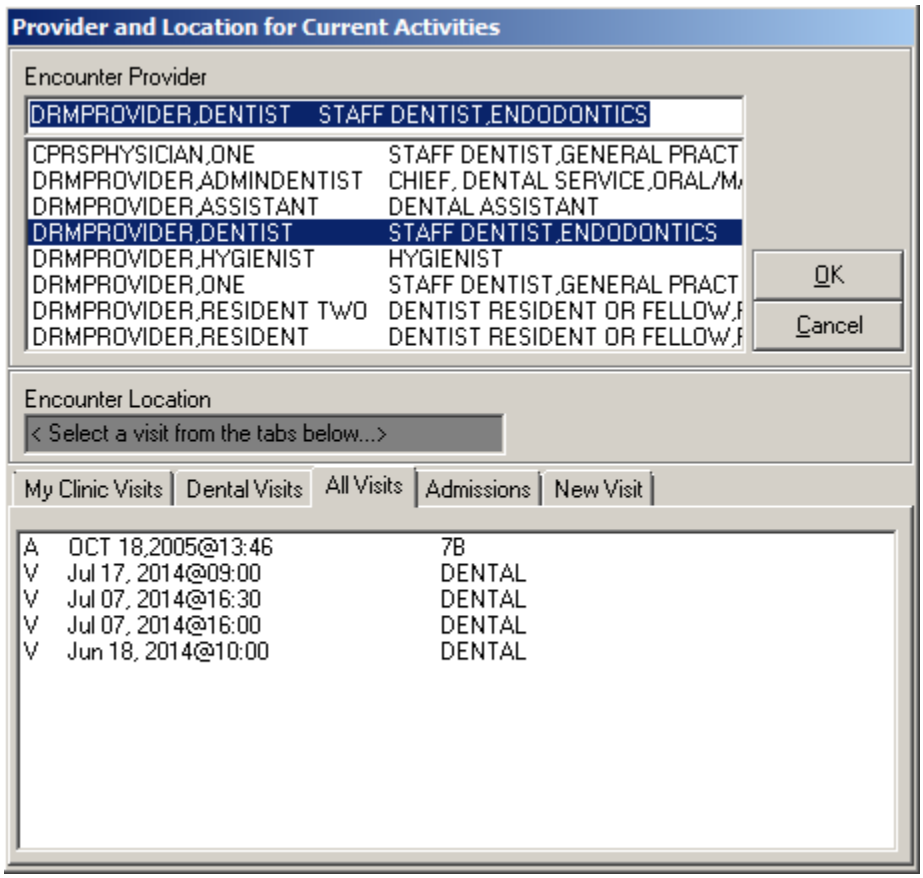


Figure 26: All Visits Tab

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

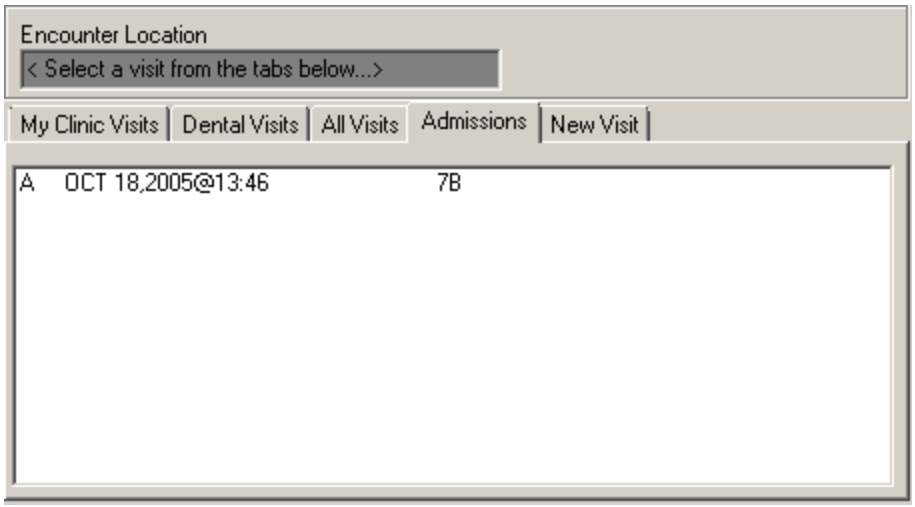


Figure 27: Admissions Tab

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 functions. Please contact a DRM Plus Administrator for more information about these submenus.

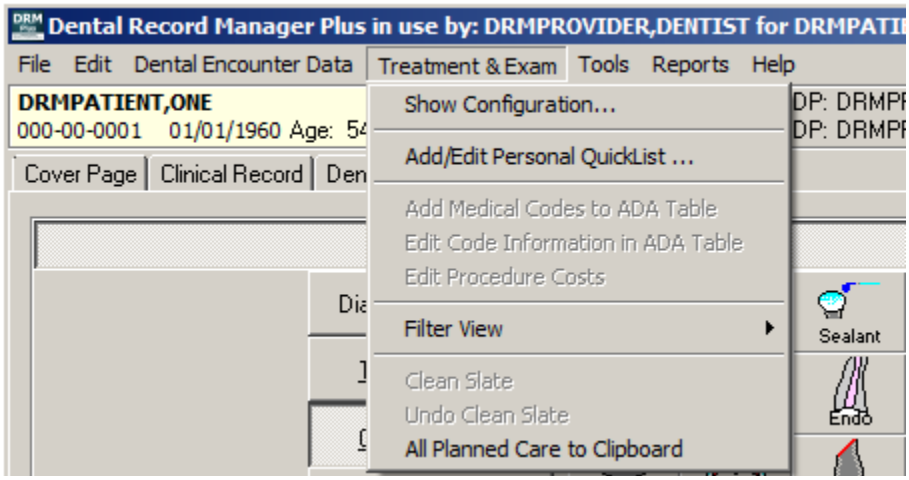


Figure 28: Treatment & Exam Menu

Show Configuration

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

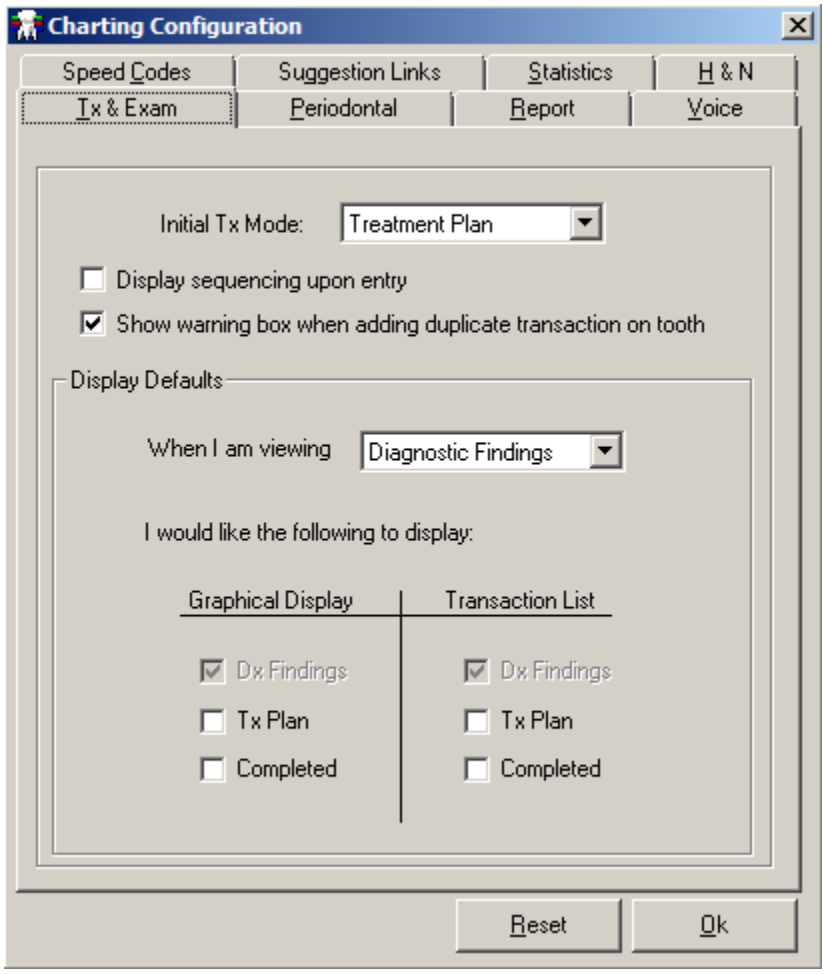


Figure 29: Charting Configuration Screen

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.

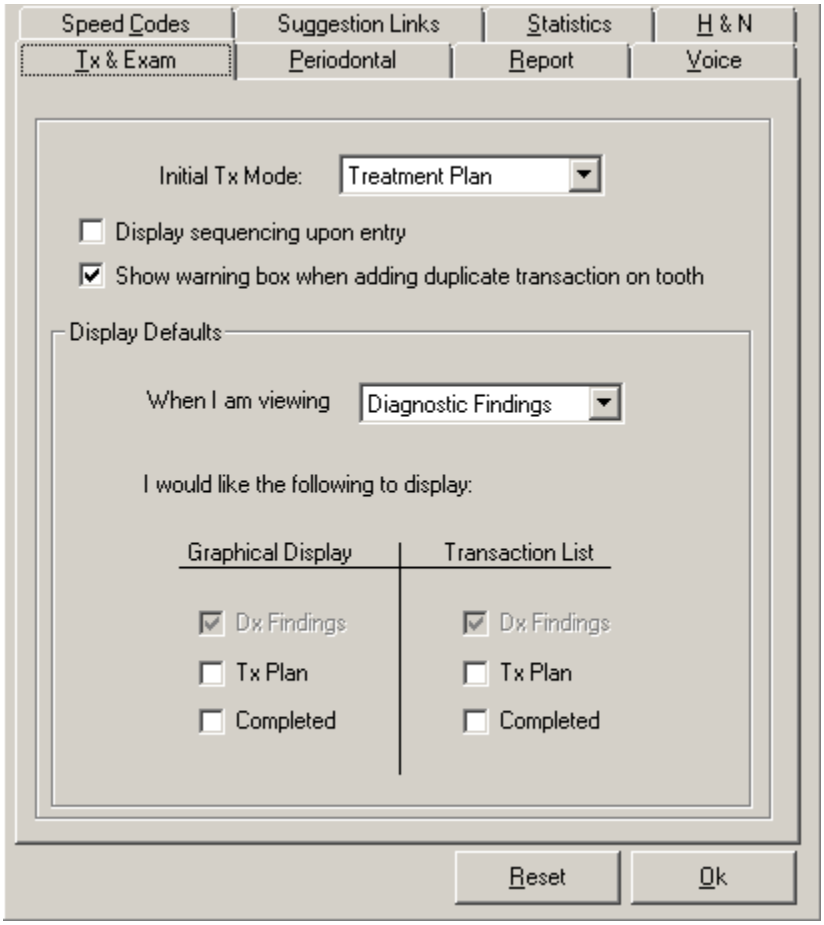


Figure 30: Tx & Exam Tab

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 options on this tab include **Show MGJ Trace** and **Exam Sequence.**

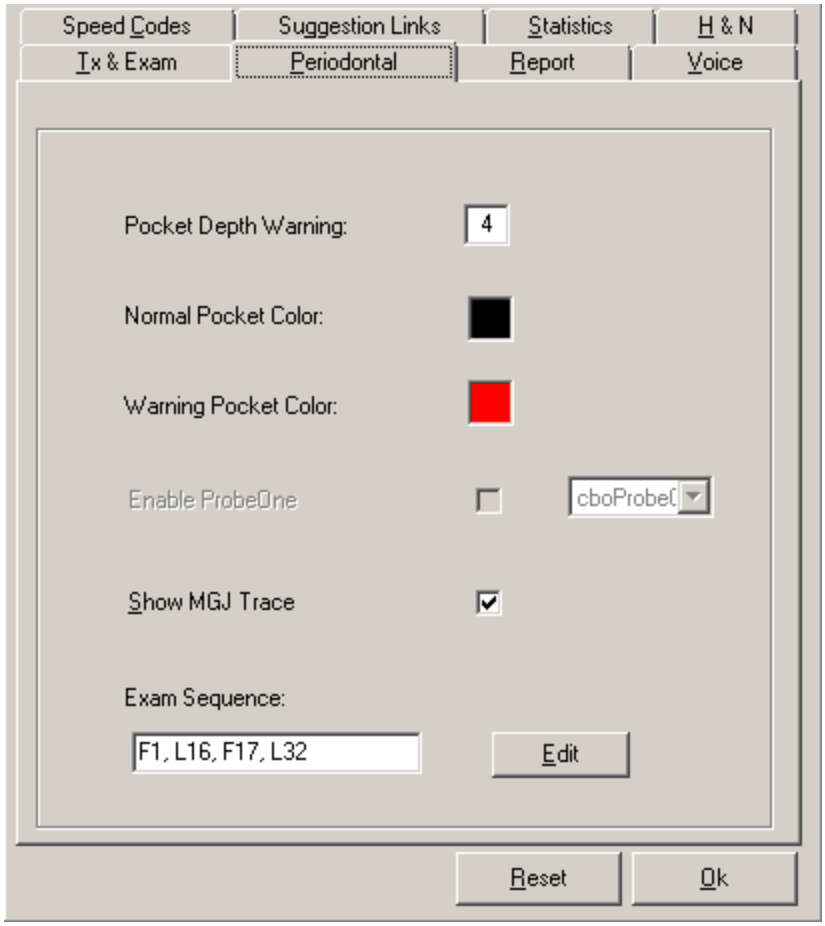


Figure 31: Periodontal Tab

To change the exam sequence:

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

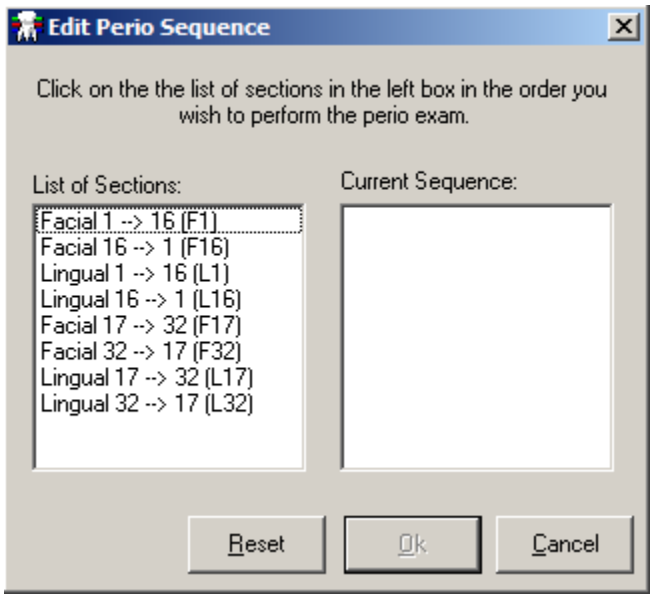


Figure 32: Edit Perio Sequence Screen

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** submenu 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.

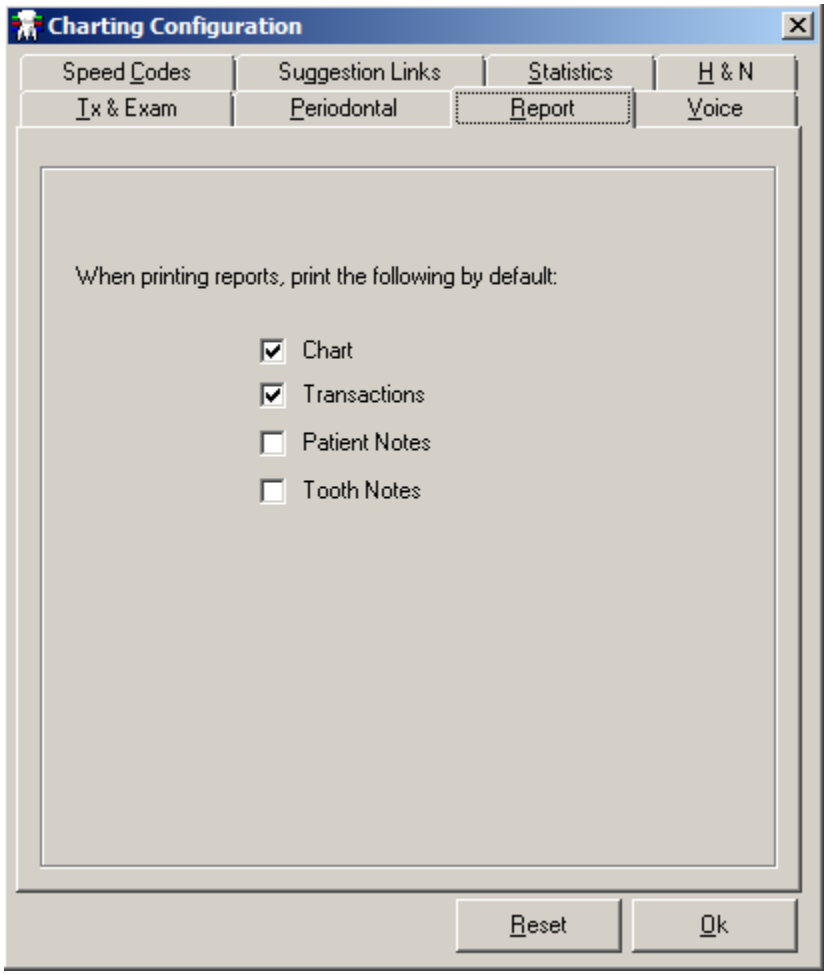


Figure 33: Report Tab

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.

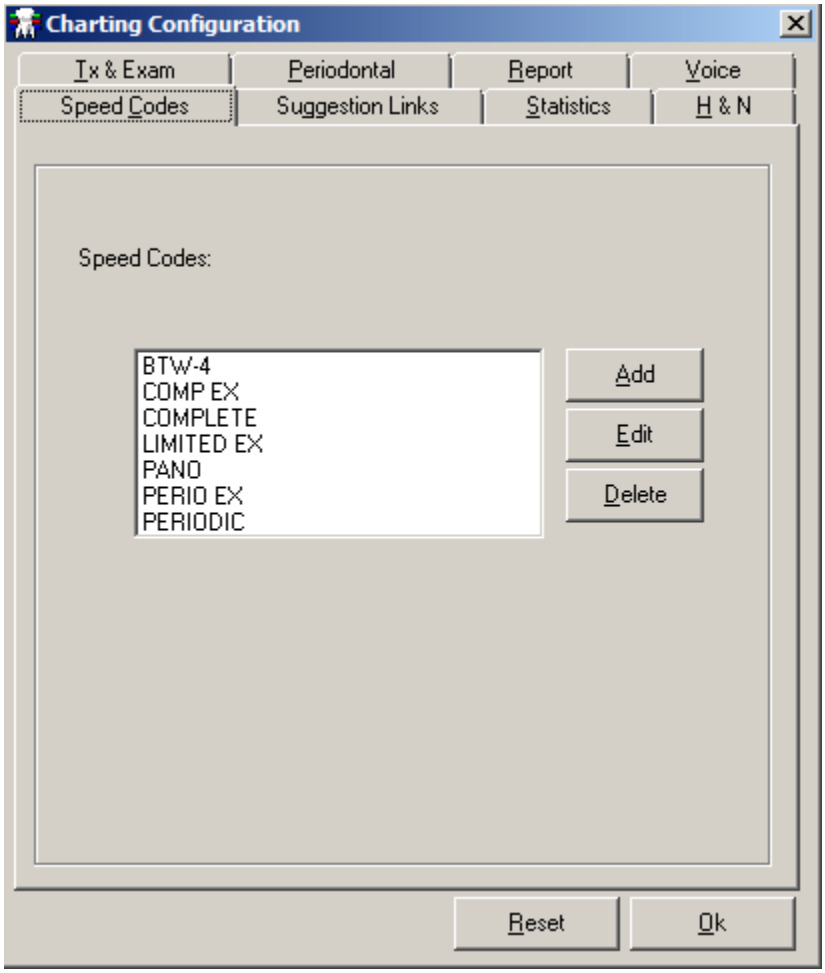


Figure 34: Speed Codes Tab

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.

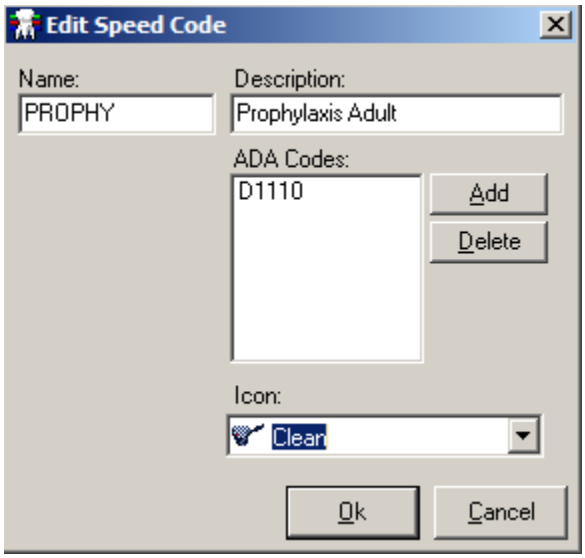


Figure 35: Edit Speed Code Screen

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.

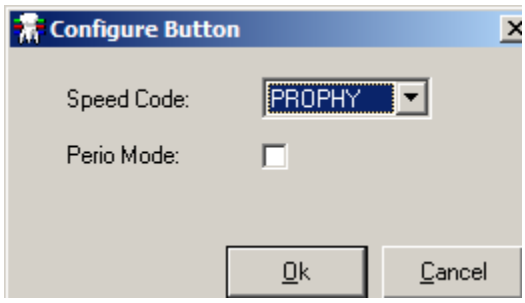


Figure 36: Configure Button Screen

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.

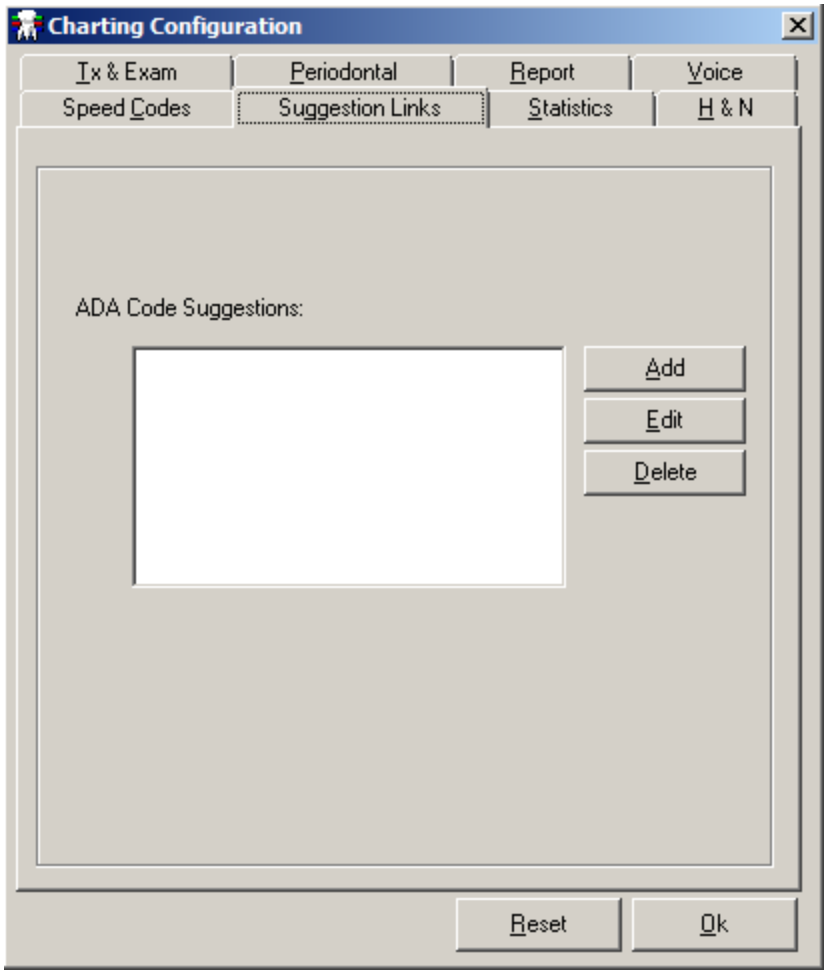


Figure 37: Suggestion Links Tab

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.

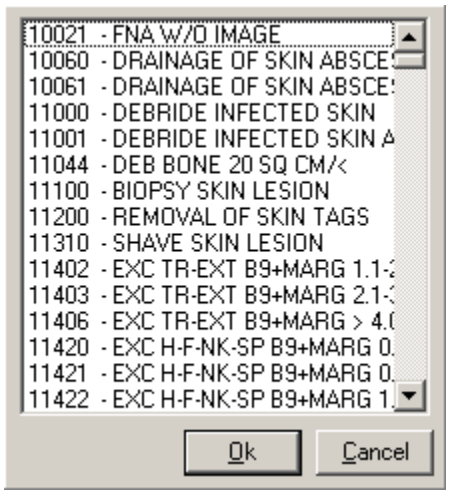


Figure 38: Suggestion Links Code List

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

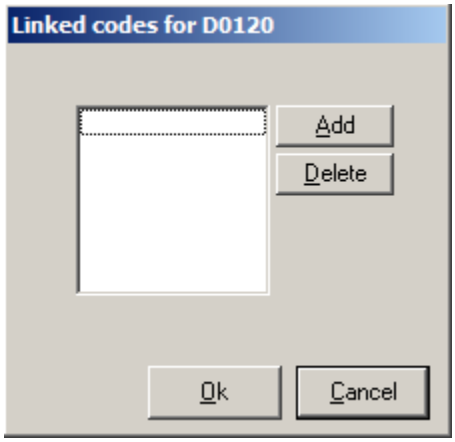


Figure 39: Linked Codes Screen

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.

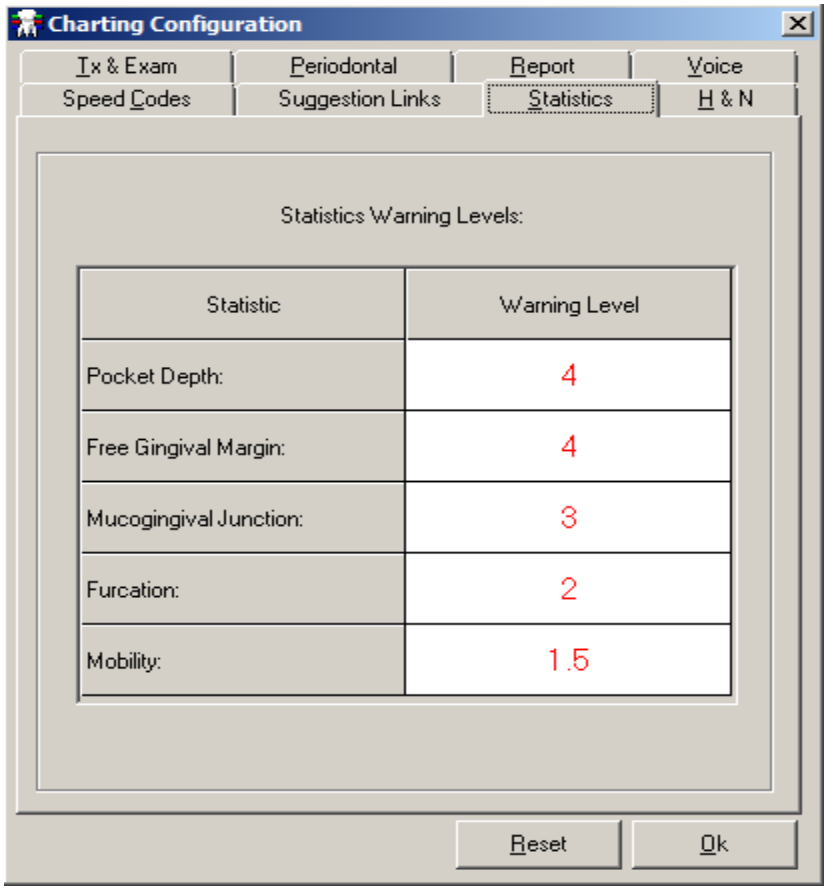


Figure 40: Statistics Tab

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.

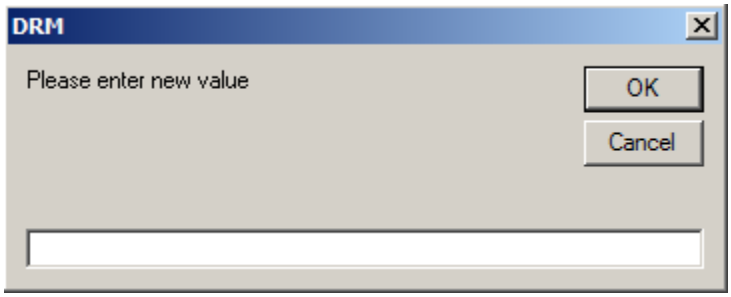


Figure 41: Adjust the Warning Level

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

H&N

The **H&N** tab can be entered by any user but only saved by DRM Plus Administrators. Please contact a DRM Plus Administrator for more information.

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.

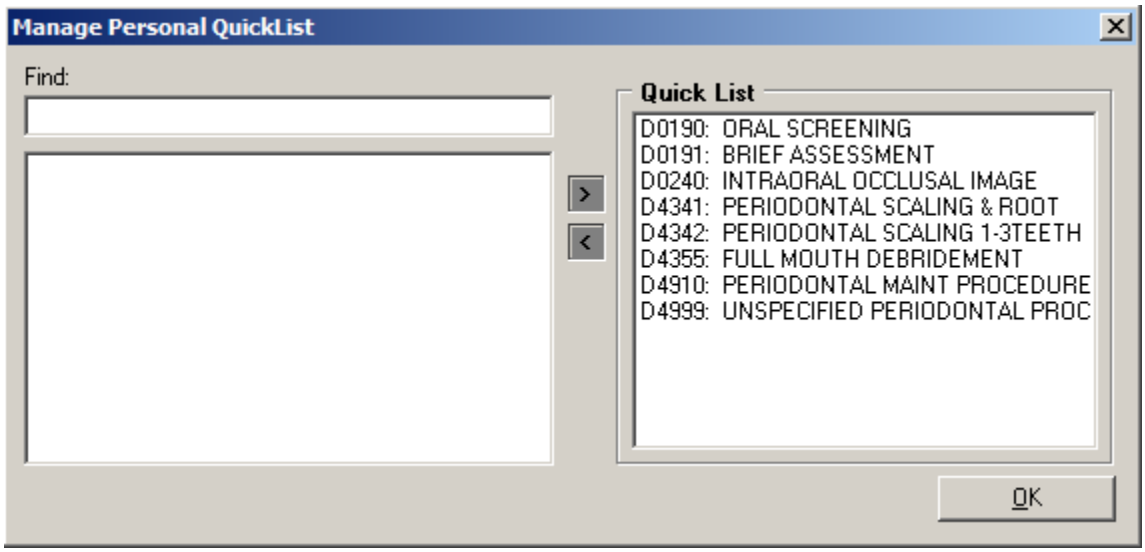


Figure 42: Manage Personal QuickList Screen

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

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Edit Code Information in the ADA Table

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Edit Procedure Costs

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Filter View

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

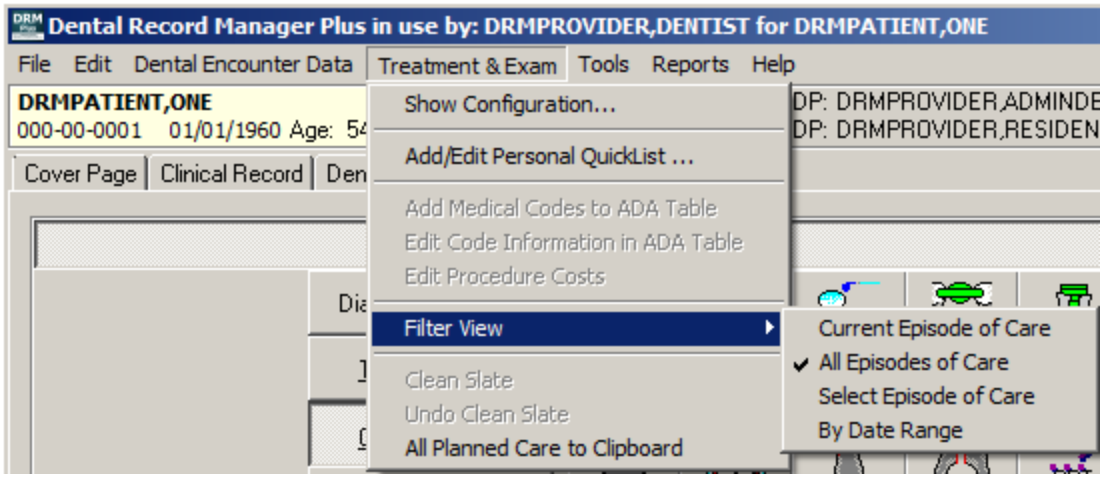


Figure 43: Filter View Submenus

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.

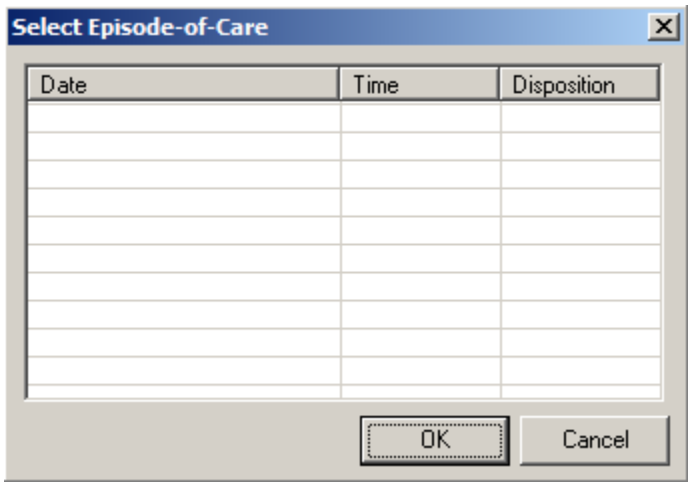


Figure 44: Select Episode of Care Screen

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.

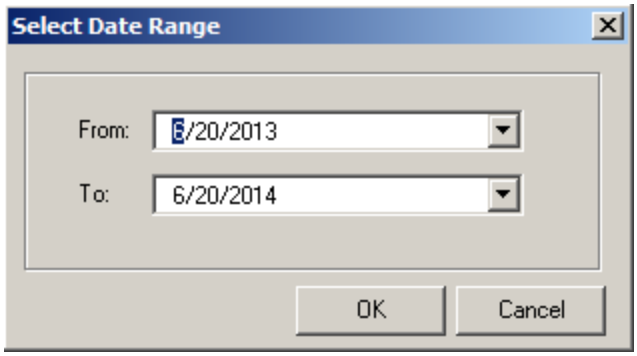


Figure 45: Select Date Range Screen

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

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Undo Clean Slate

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

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 curser 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.

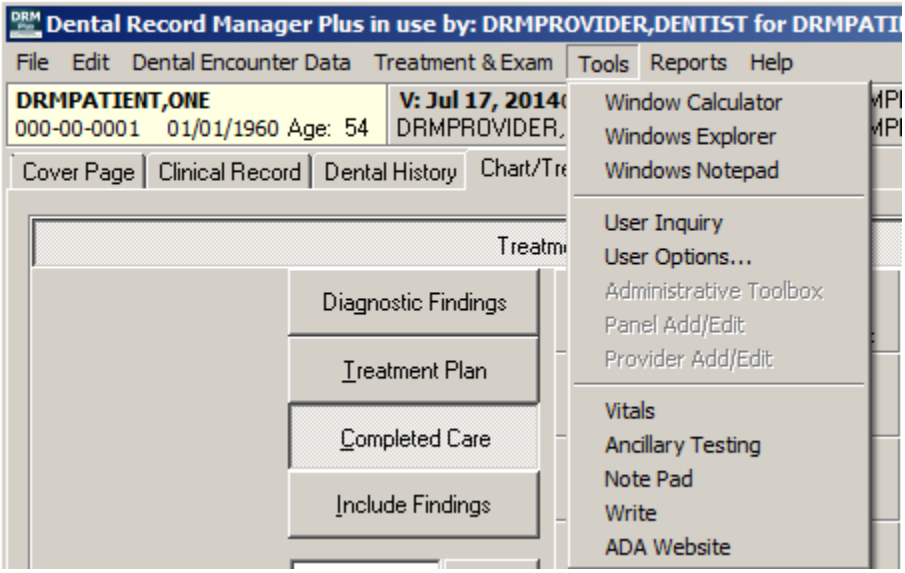


Figure 46: Tools Menu

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.

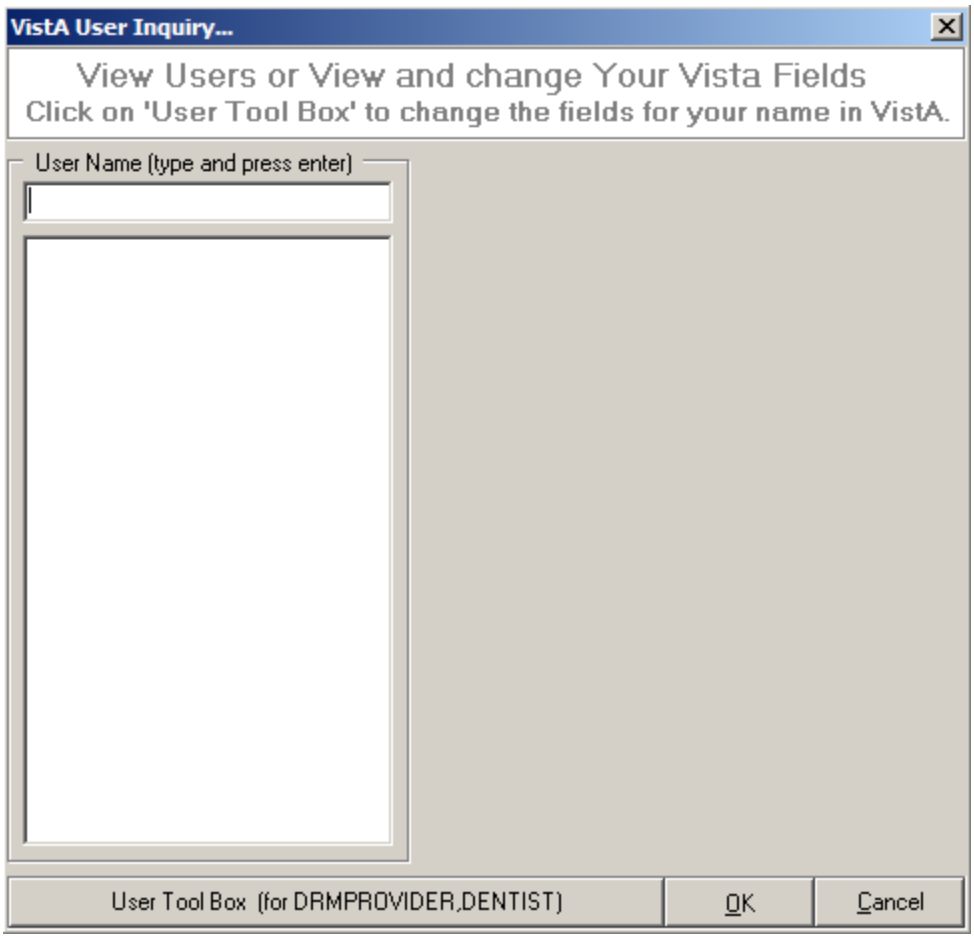


Figure 47: VistA User Inquiry Screen

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.

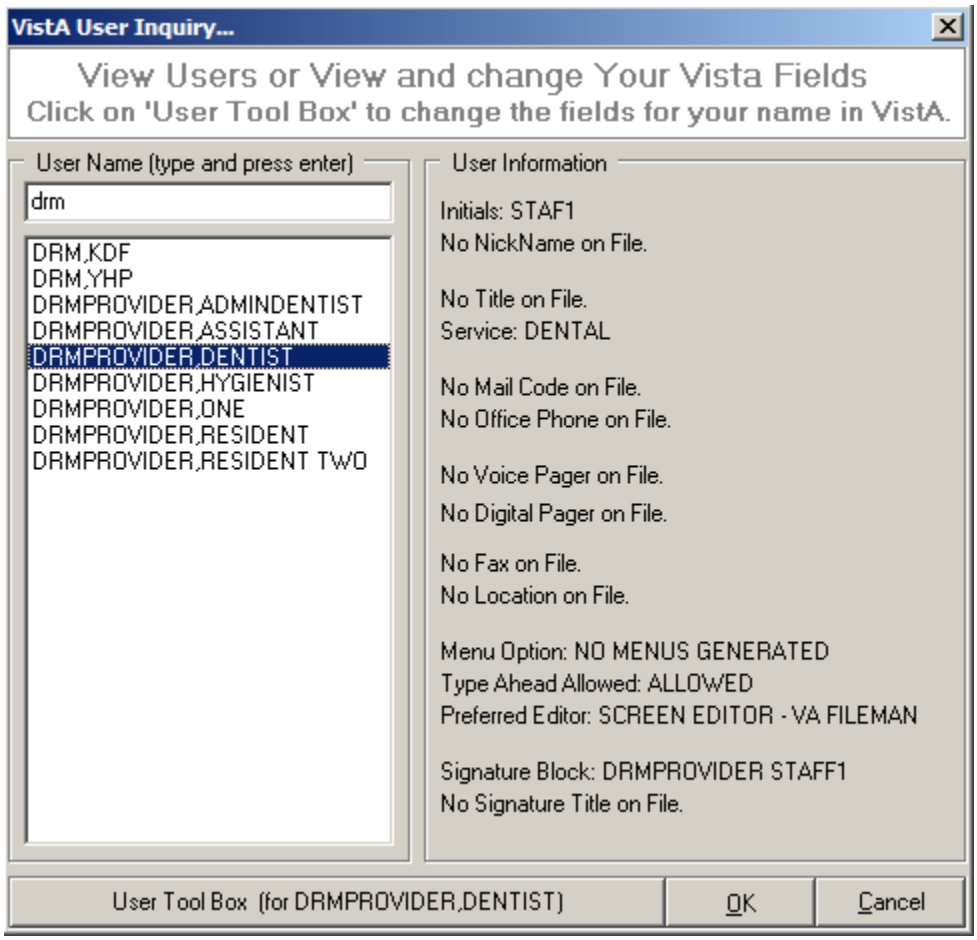


Figure 48: VistA User Entry Screen with User Information Displayed

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.

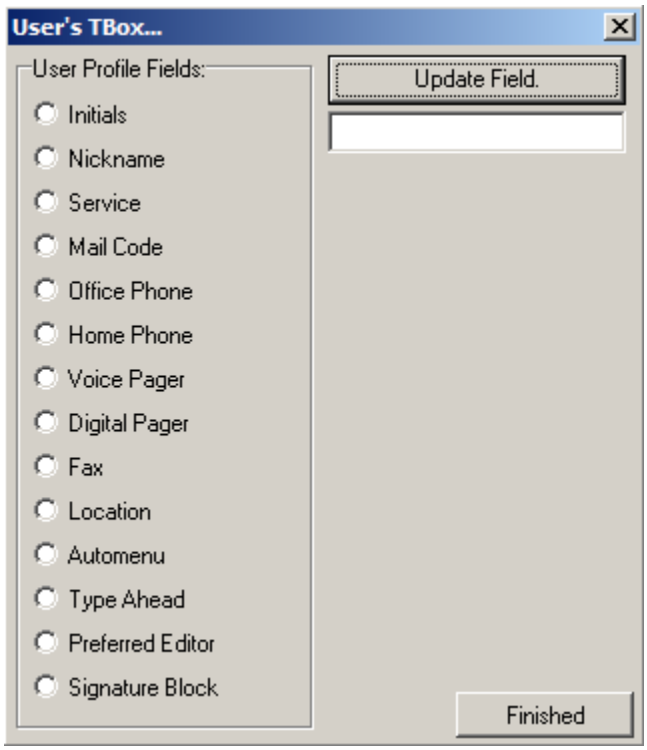


Figure 49: User's TBox Screen

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.**

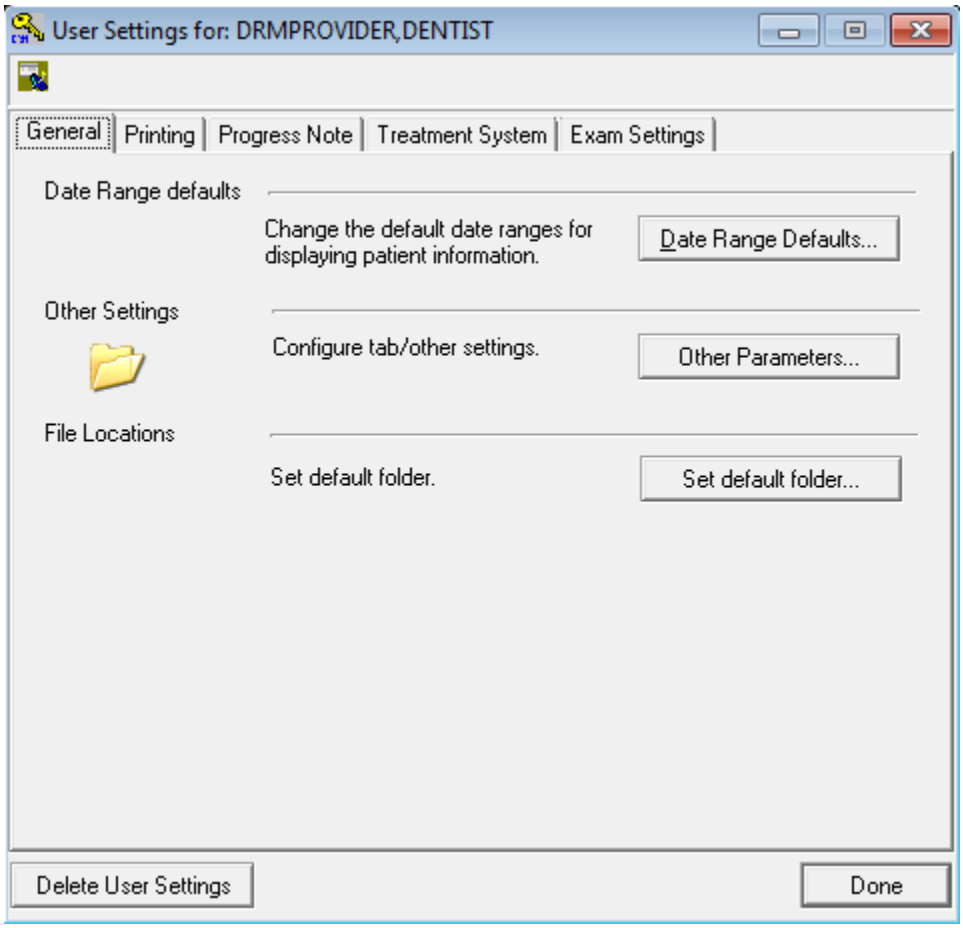


Figure 50: User Settings Screen

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.

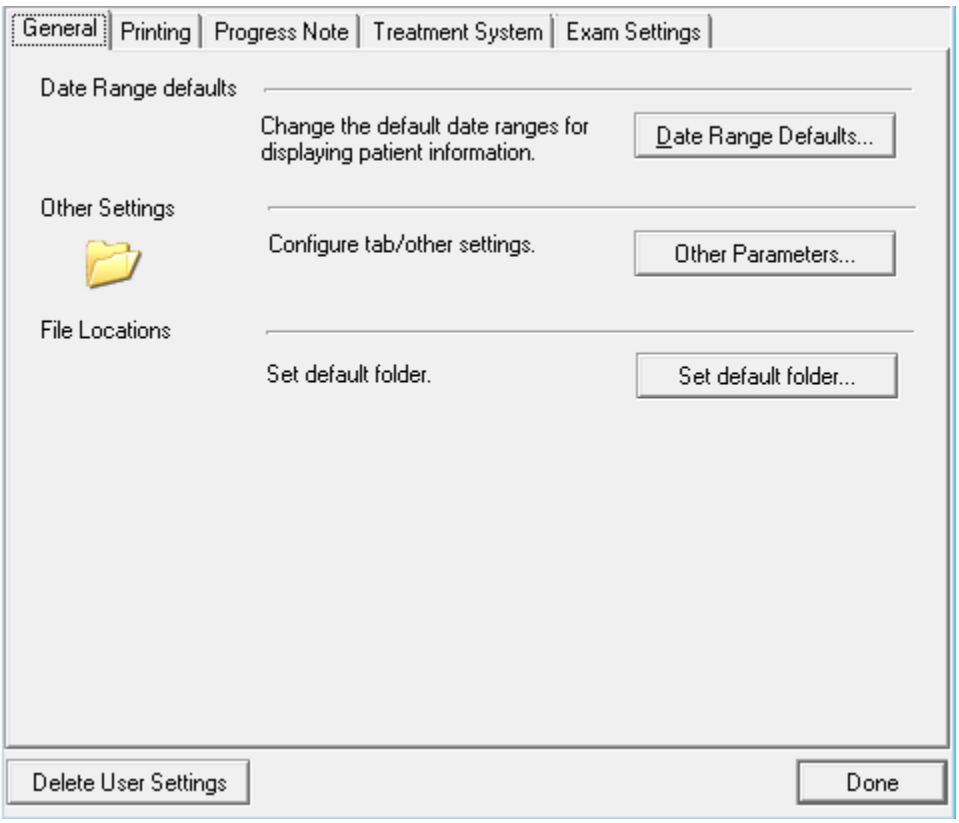


Figure 51: General Tab

To change the default date ranges:

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

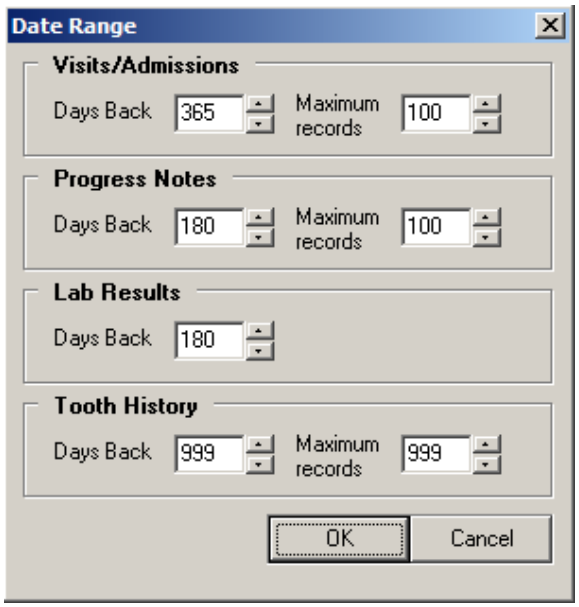


Figure 52: Date Range Screen

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.

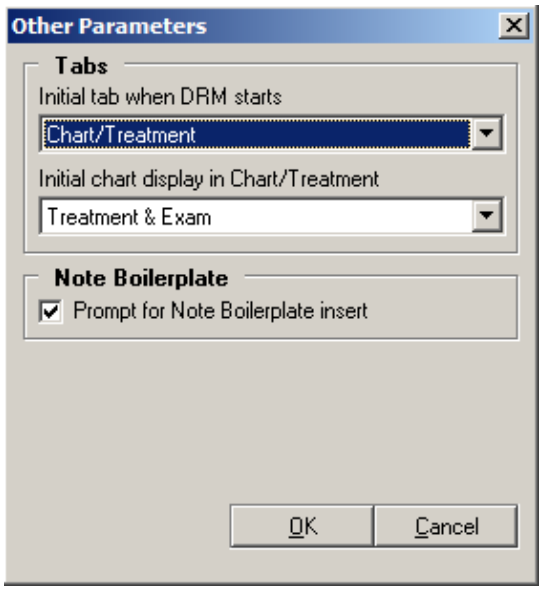


Figure 53: Other Parameters Screen

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 location:

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

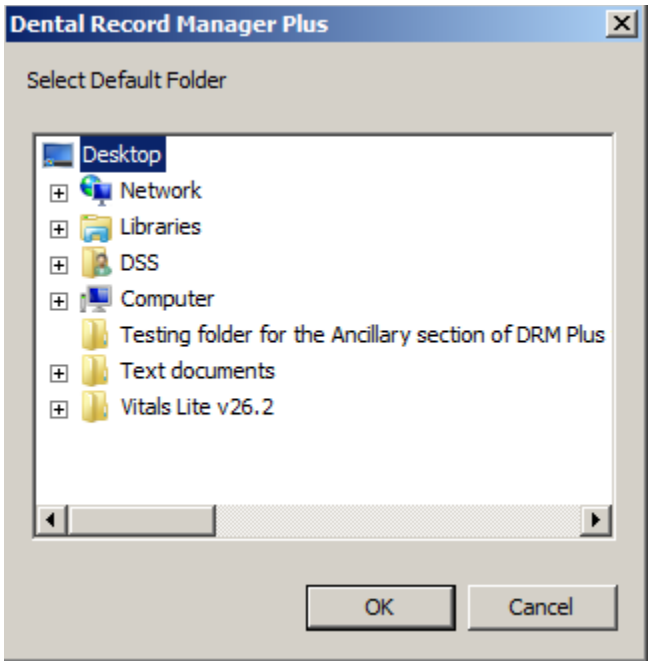


Figure 54: Select Default Folder Screen

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.

Printing

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

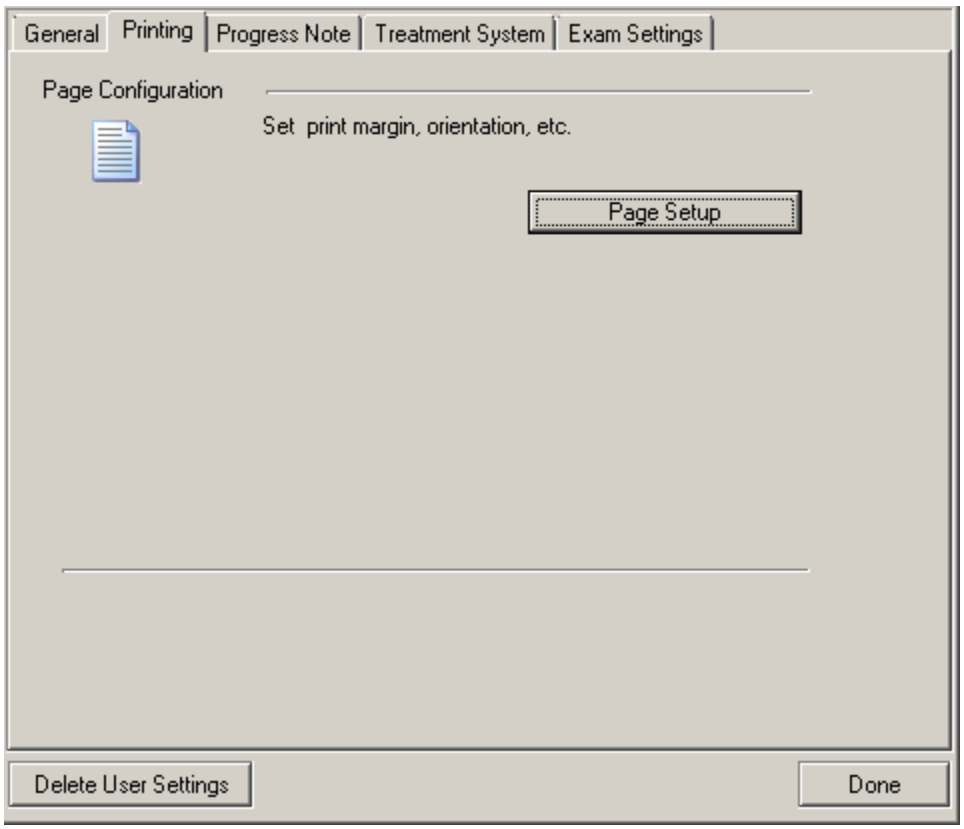


Figure 55: Printing Tab

To change the page configuration:

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

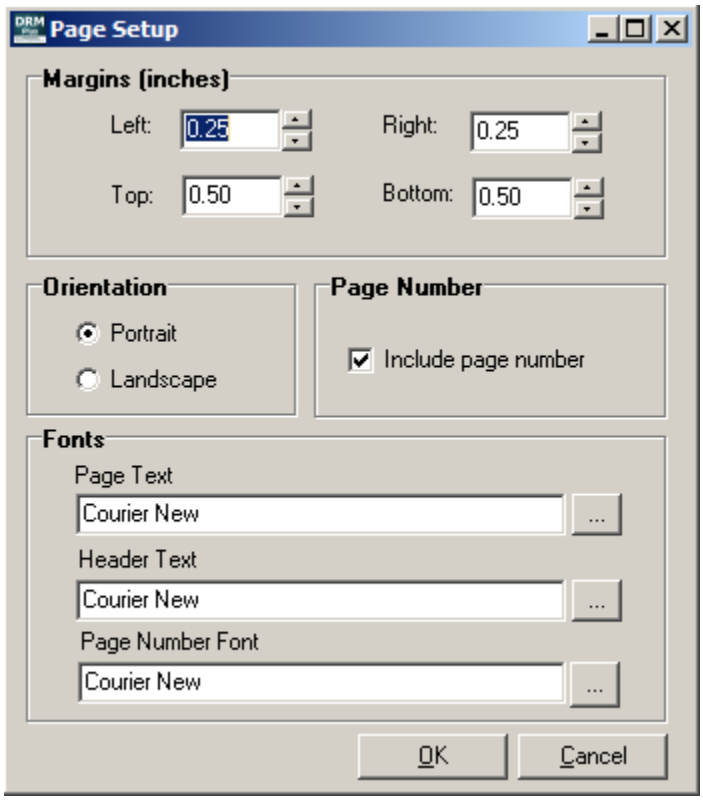


Figure 56: Page Setup Screen

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

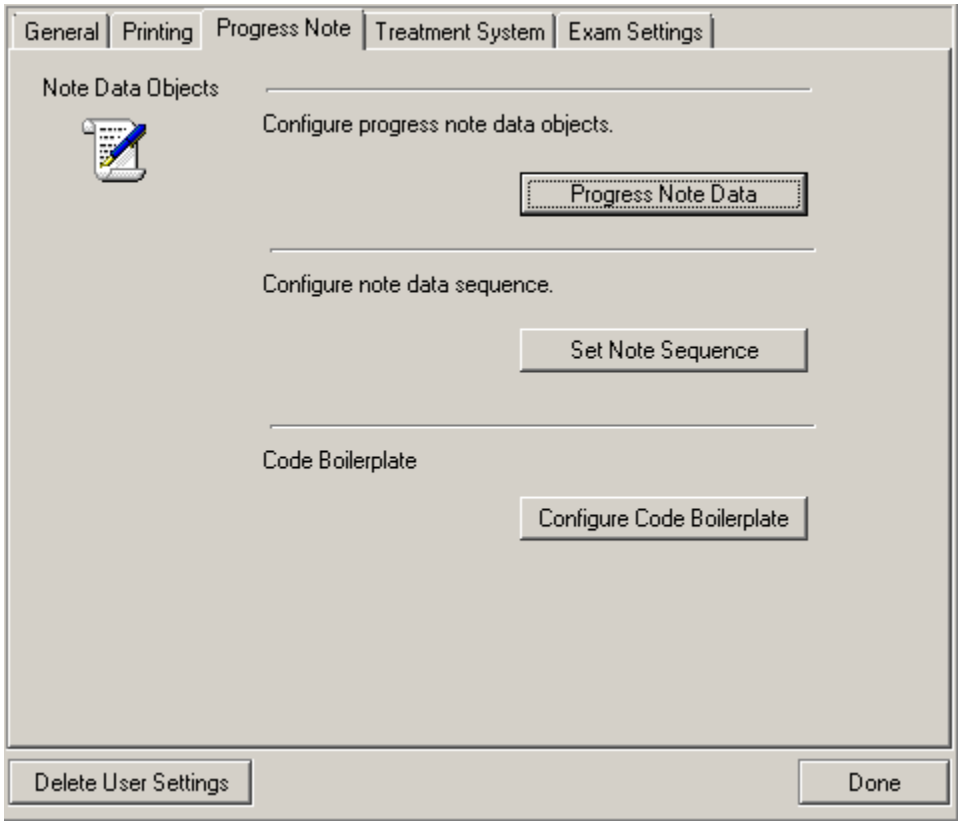


Figure 57: Progress Note Tab

To configure progress note data objects:

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

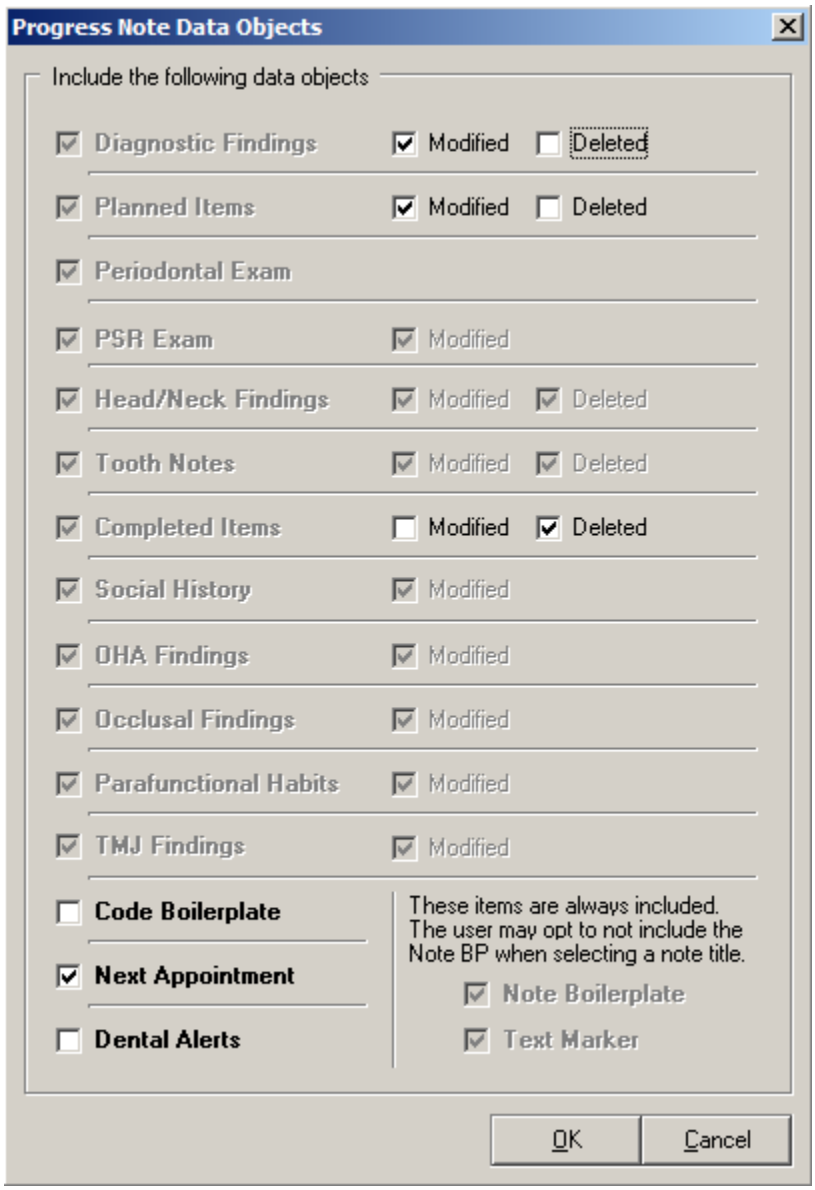


Figure 58: Progress Note Data Objects Screen

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.

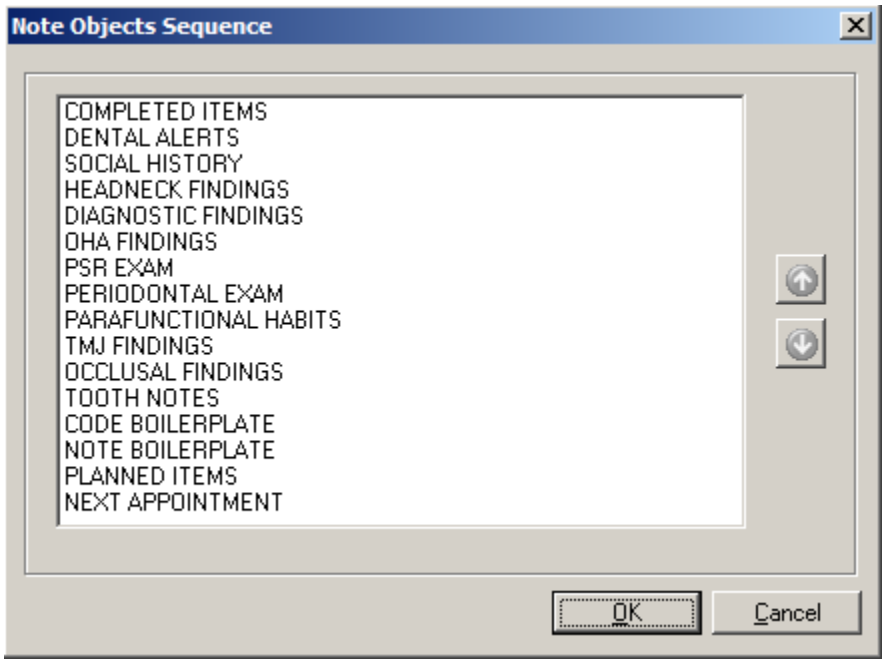


Figure 59: Note Object Sequence Screen

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.

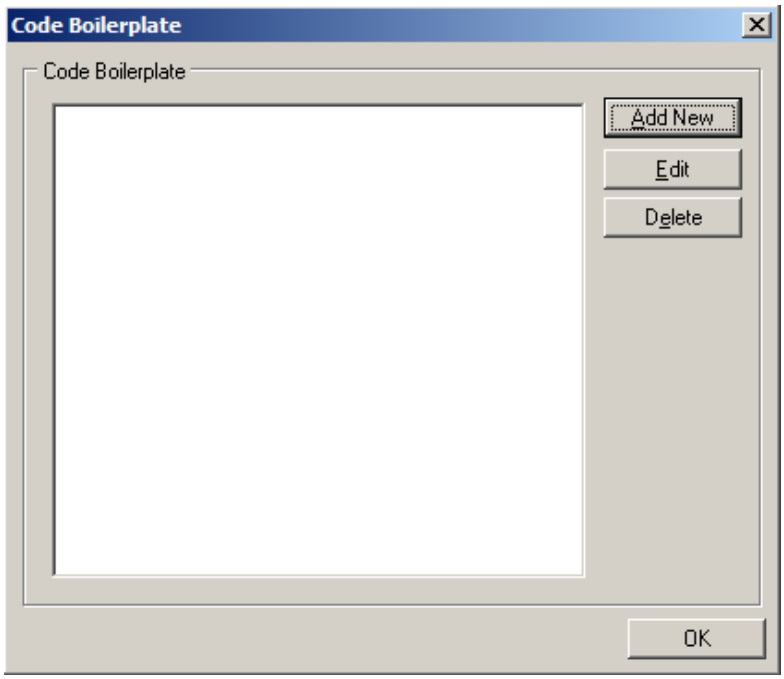


Figure 60: Code Boilerplate Screen

To add a new code boilerplate:

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

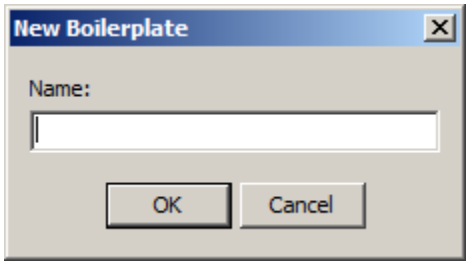


Figure 82: New Boilerplate Screen

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

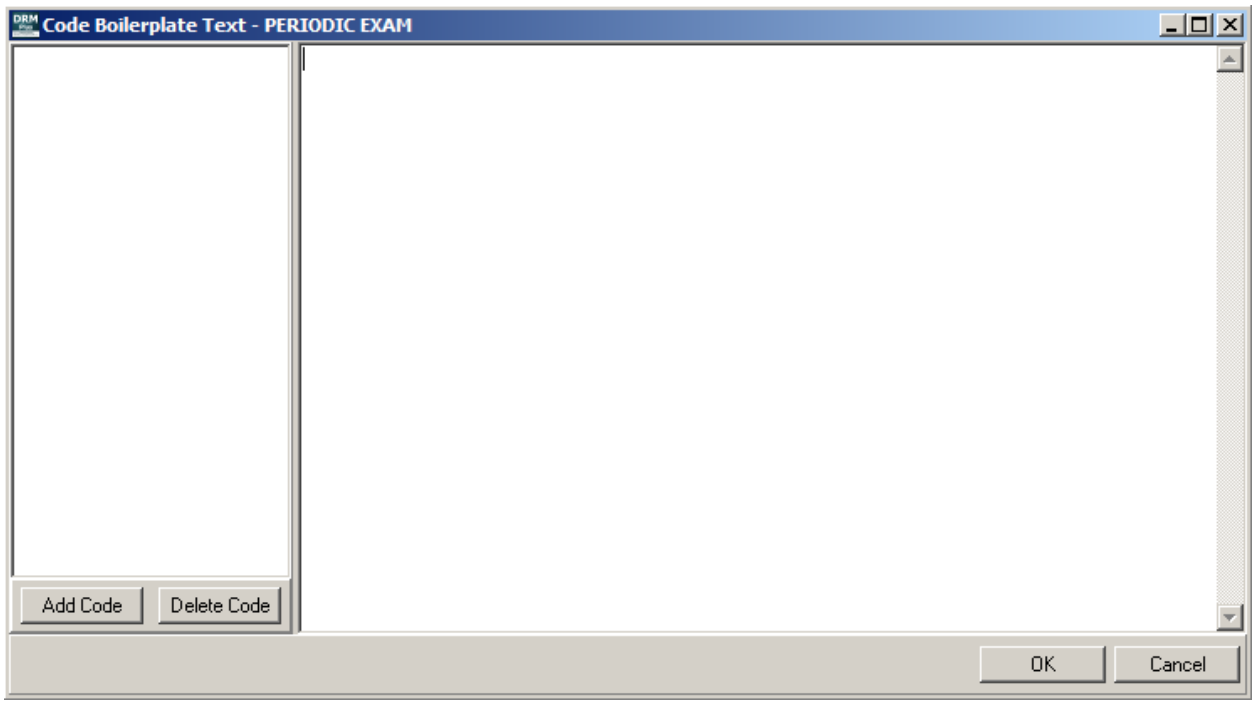


Figure 61: Code Boilerplate Text Screen

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

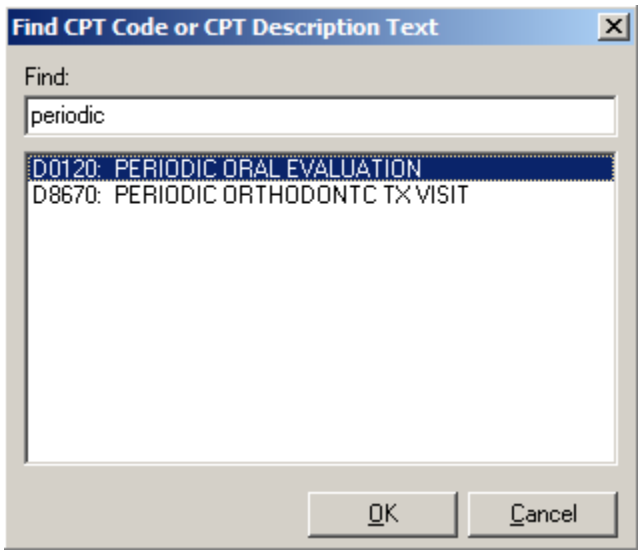


Figure 62: Find CPT Code Screen

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.

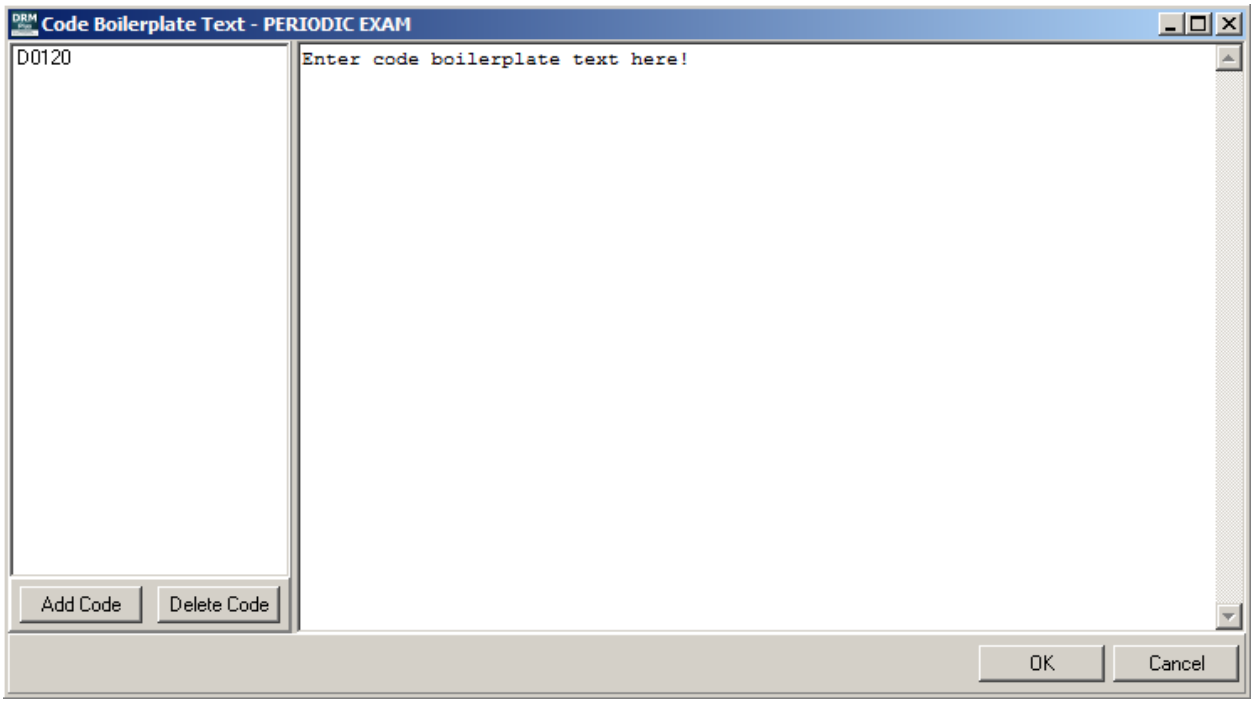


Figure 63: Code Boilerplate Text Screen

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.

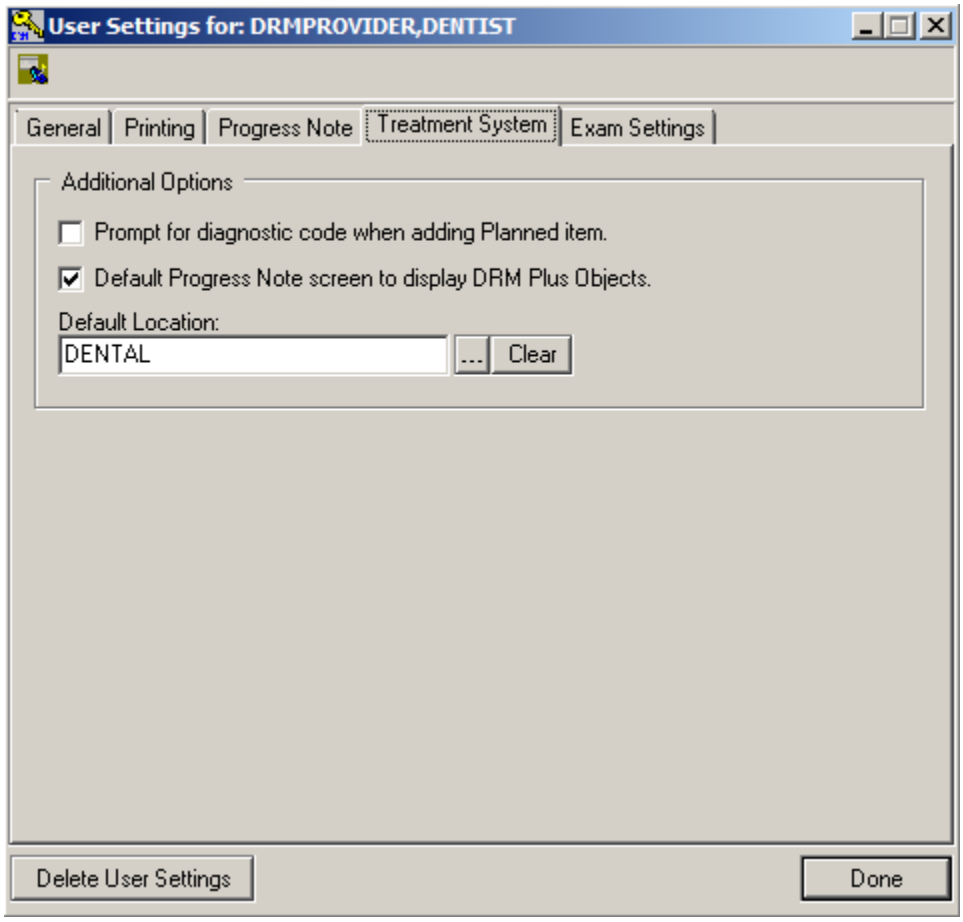


Figure 64: Treatment System Tab

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.

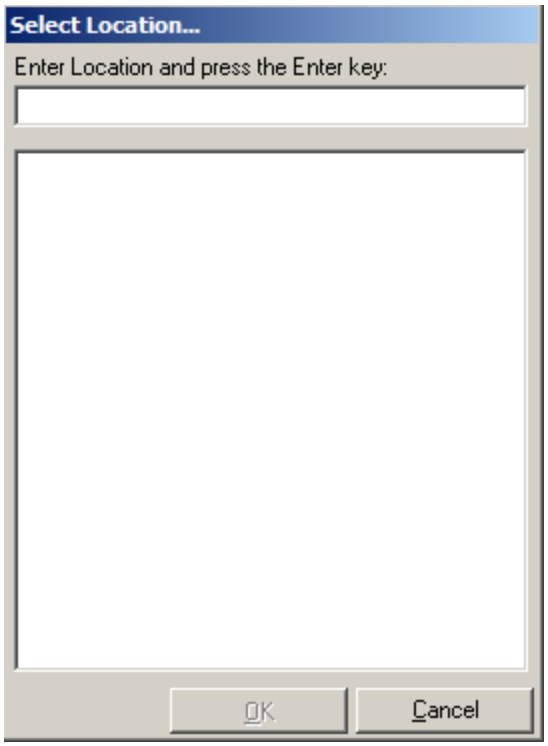


Figure 65: Select Location Screen

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.**

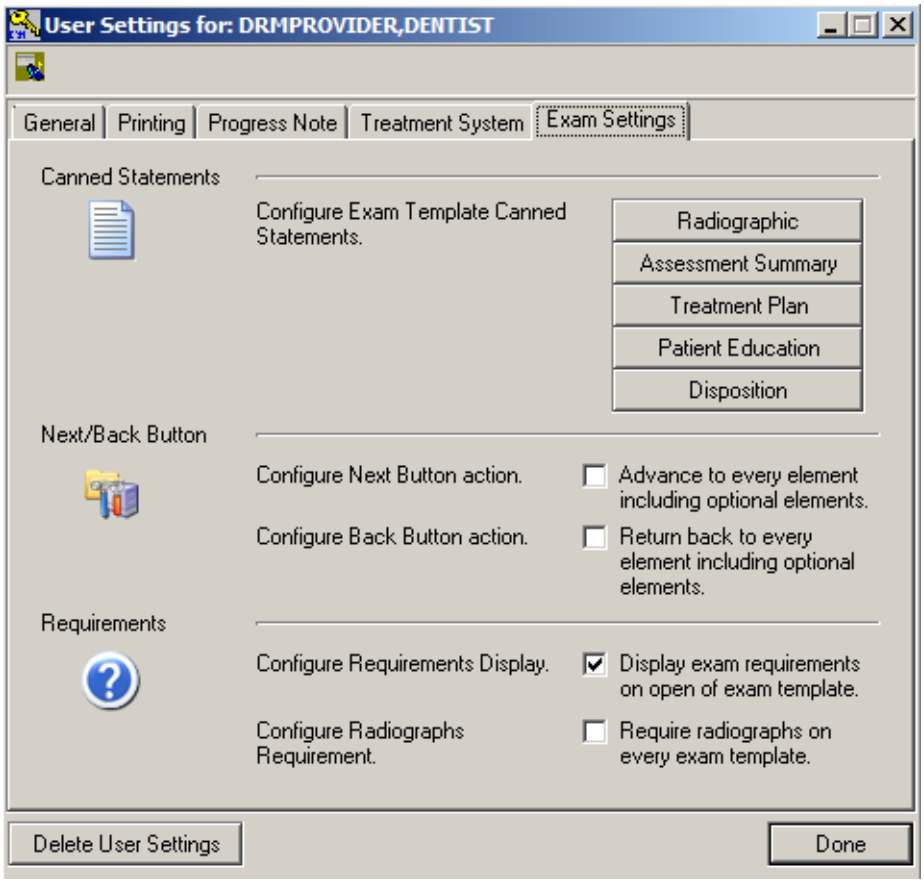


Figure 66: Exam Settings Tab

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.

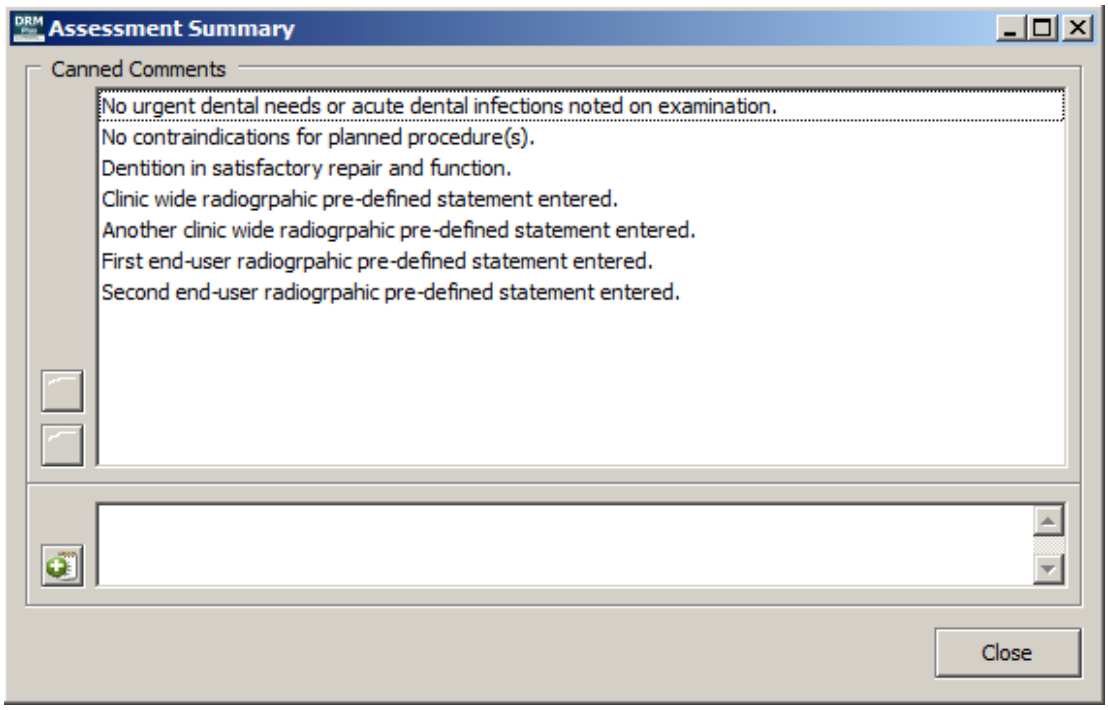


Figure 67: Assessment Summary Screen

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 **Presentation/Chief Complaint** element screen and there is no **Next** button on the last **Disposition** element screen.

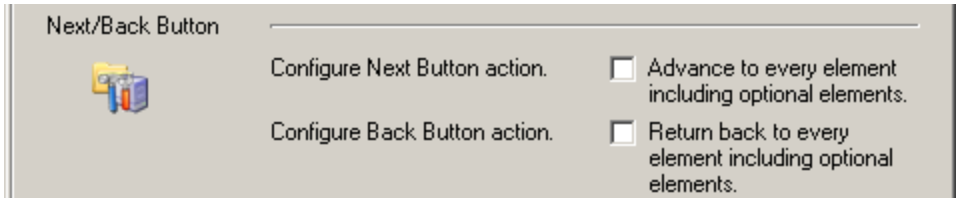


Figure 68: Next/Back Button Parameters

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.

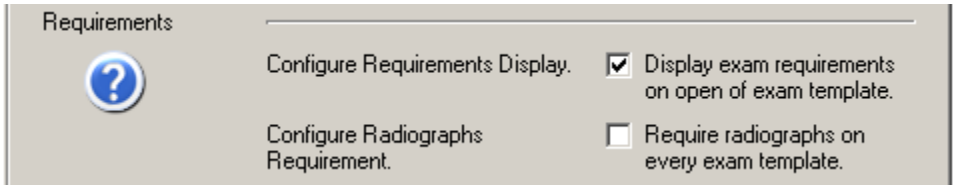


Figure 69: Requirements Parameters

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.**

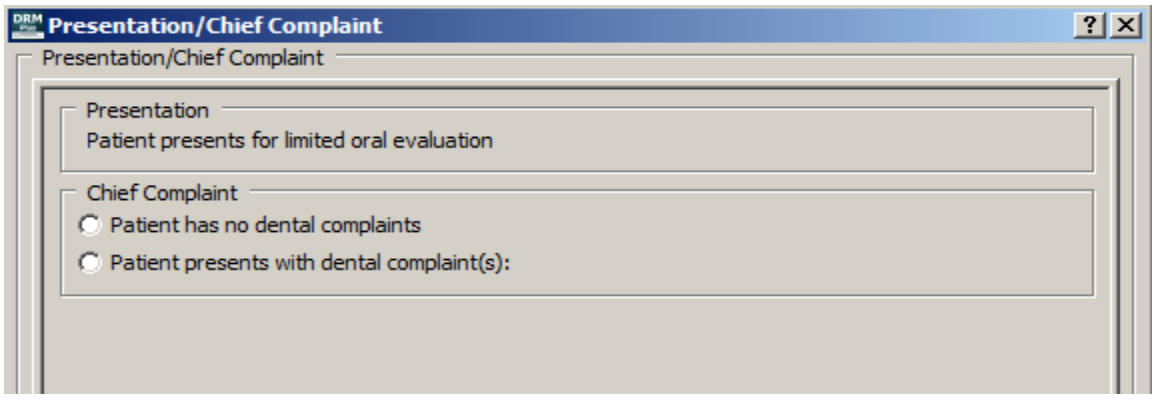


Figure 70: Presentation/Chief Complaint Element Screen

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

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Panel Add/Edit

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

Provider Add/Edit

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

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. Please see the DRM Plus Administrator for more details.

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.

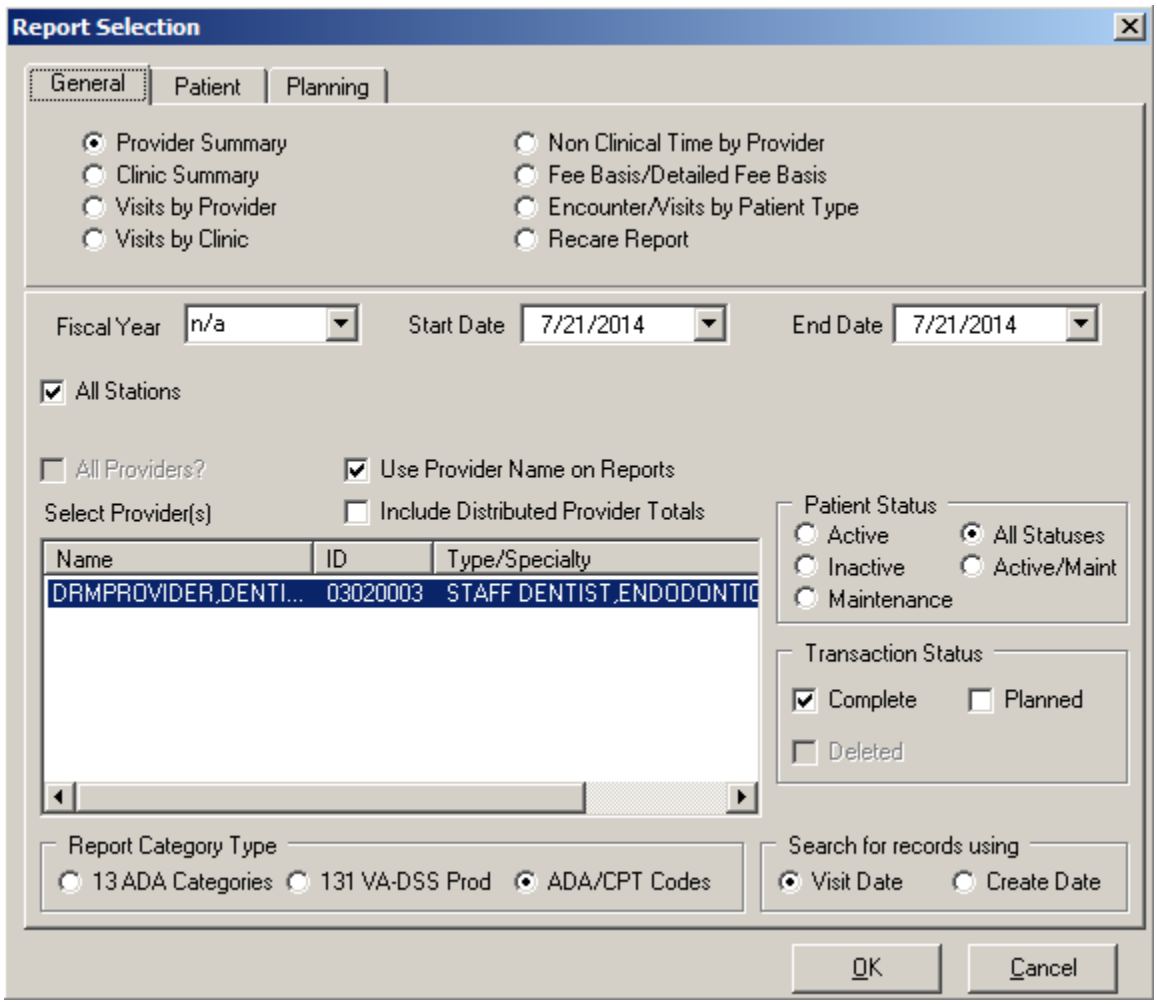


Figure 71: Report Selection Screen

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

General Tab

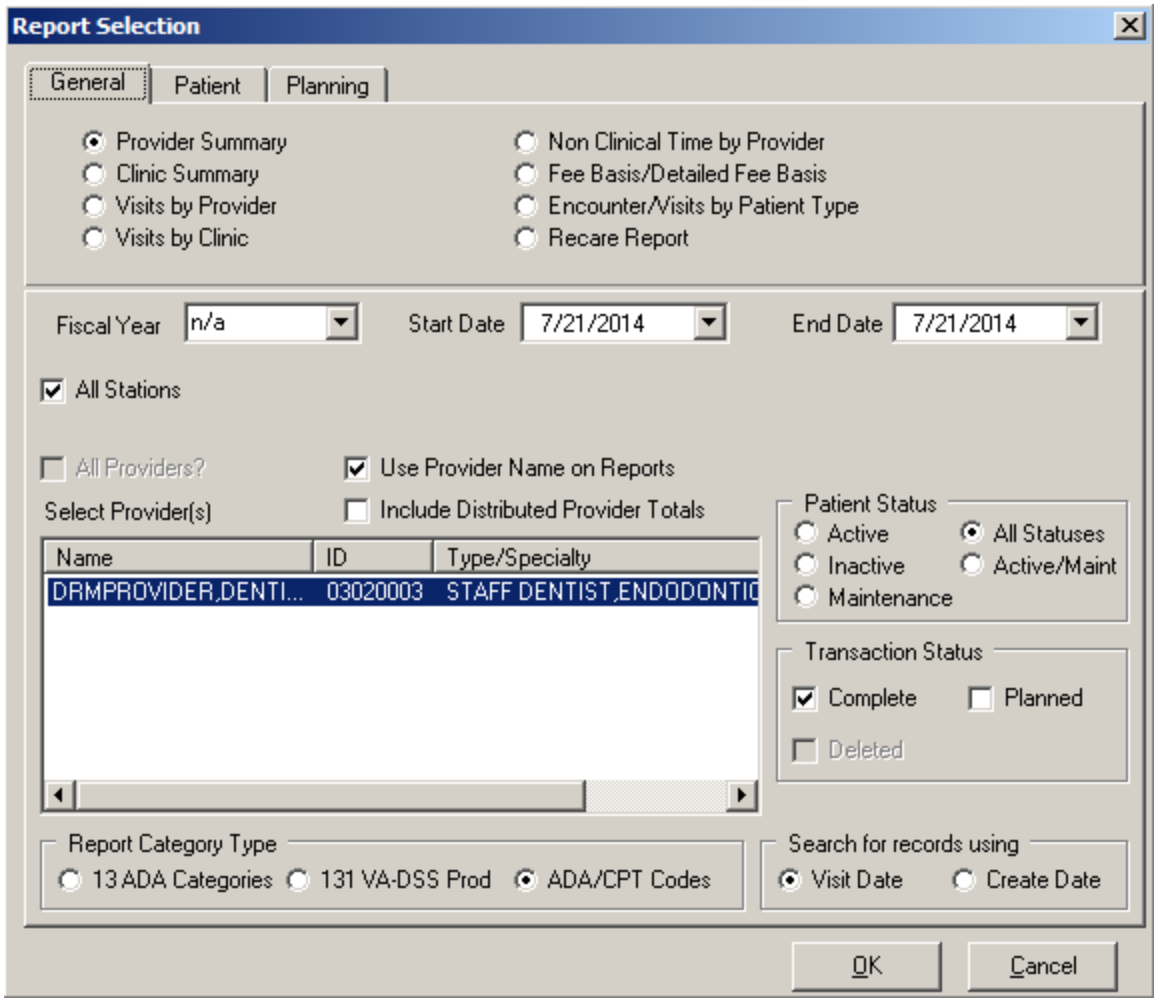


Figure 72: General Tab

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.

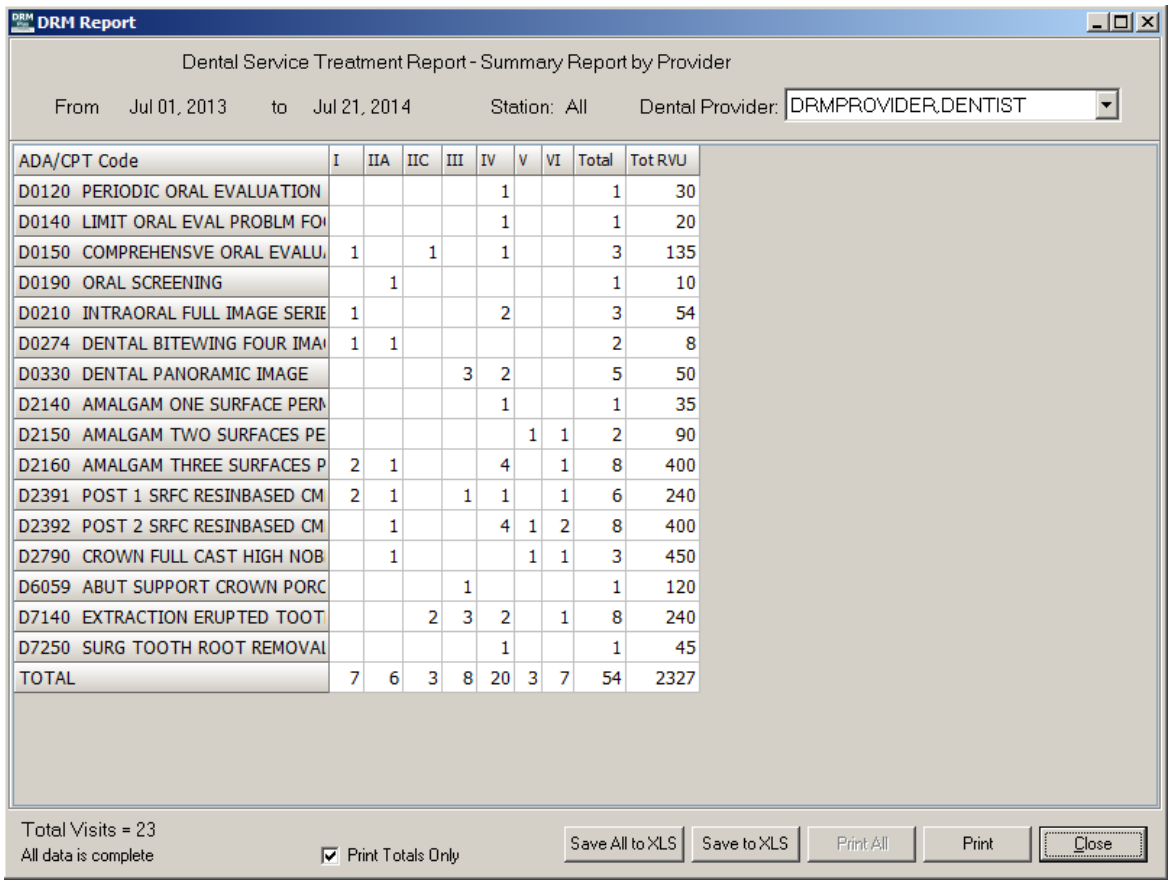


Figure 73: DRM Report Screen

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.

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.

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.

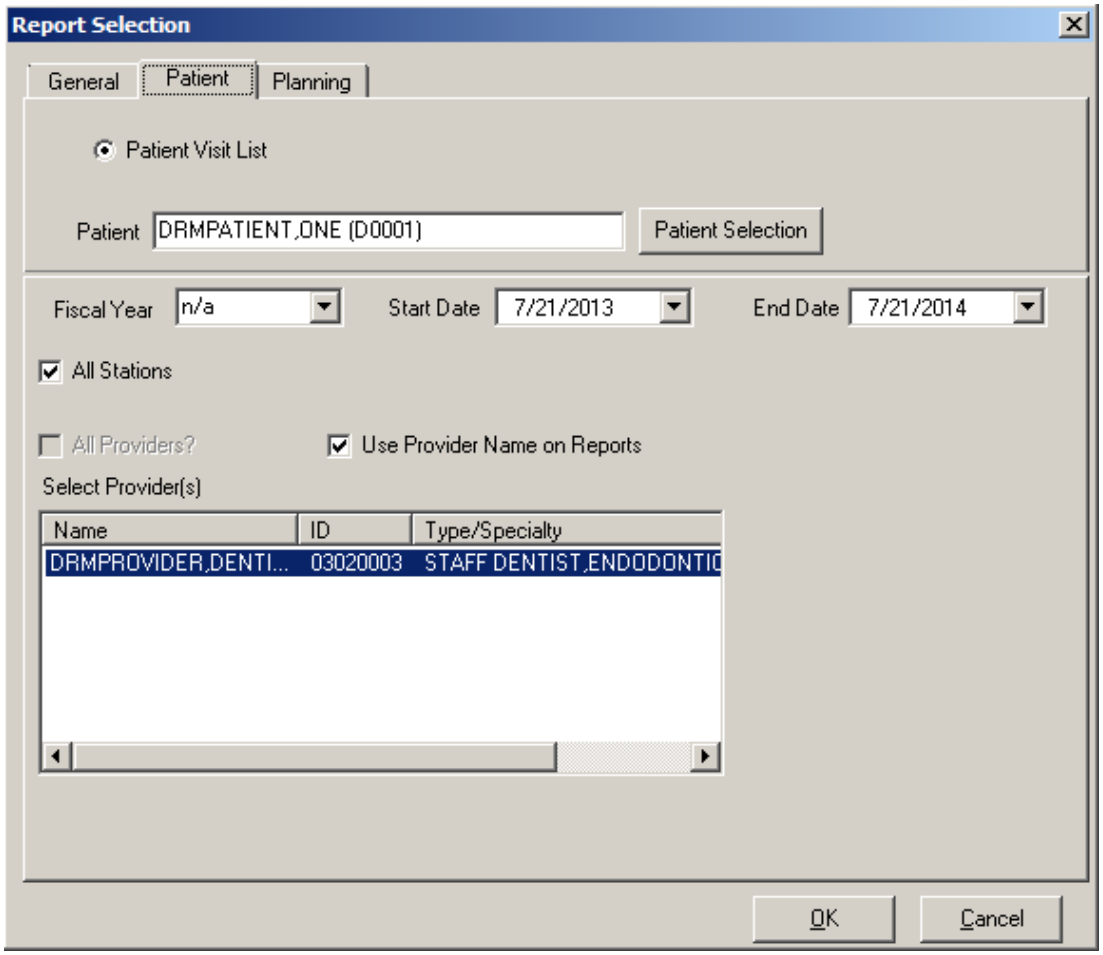


Figure 74: Patient Tab

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.

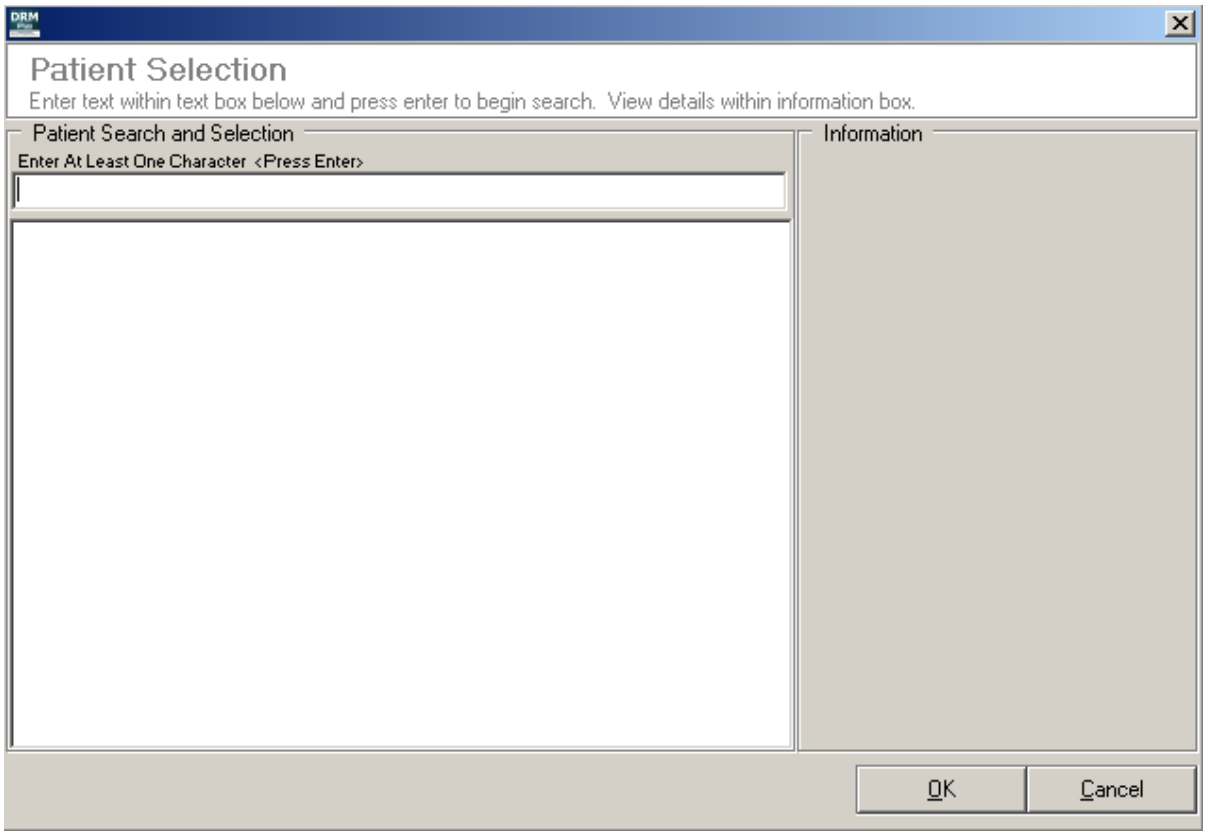


Figure 75: Patient Selection Screen

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.

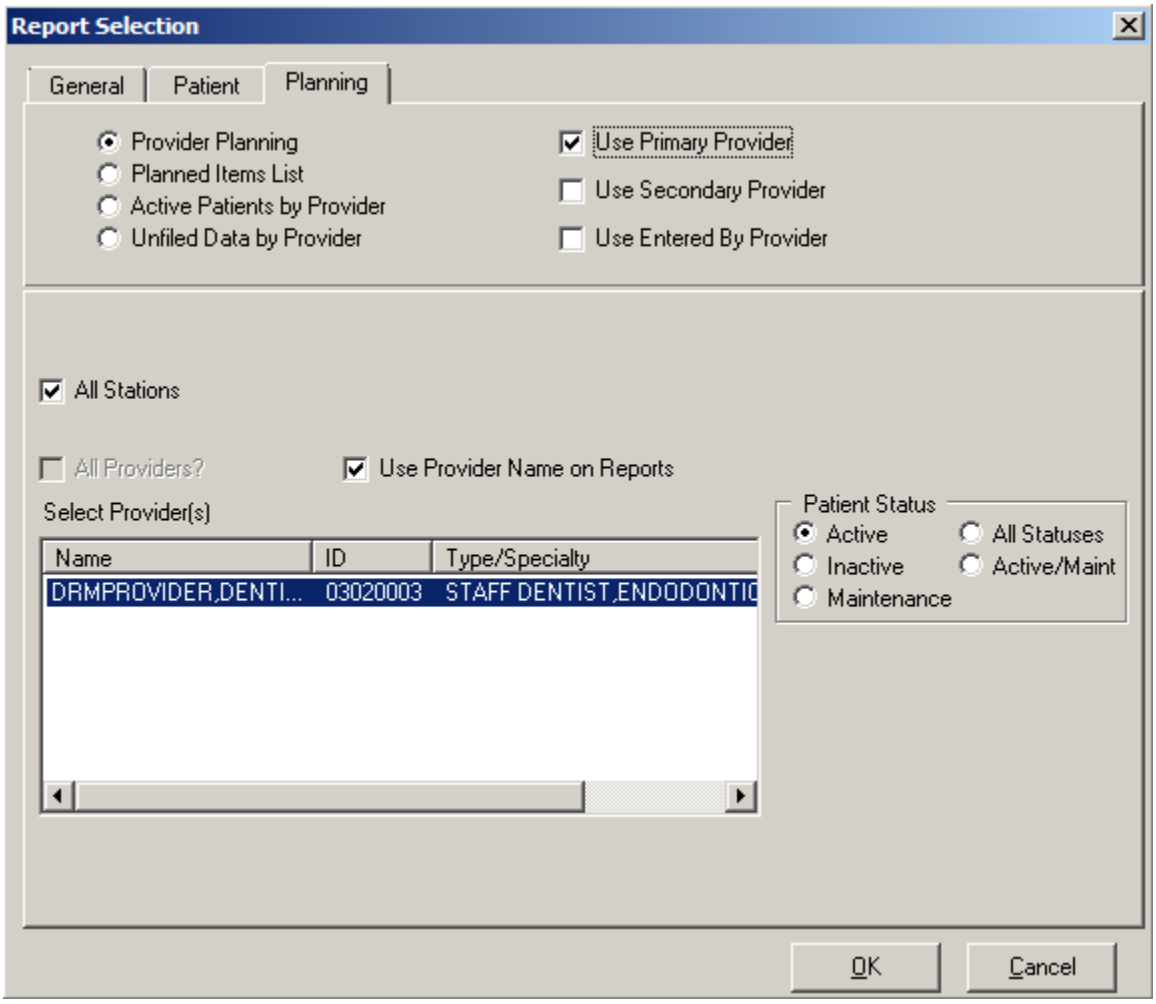


Figure 76: Planning Tab

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.**

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.

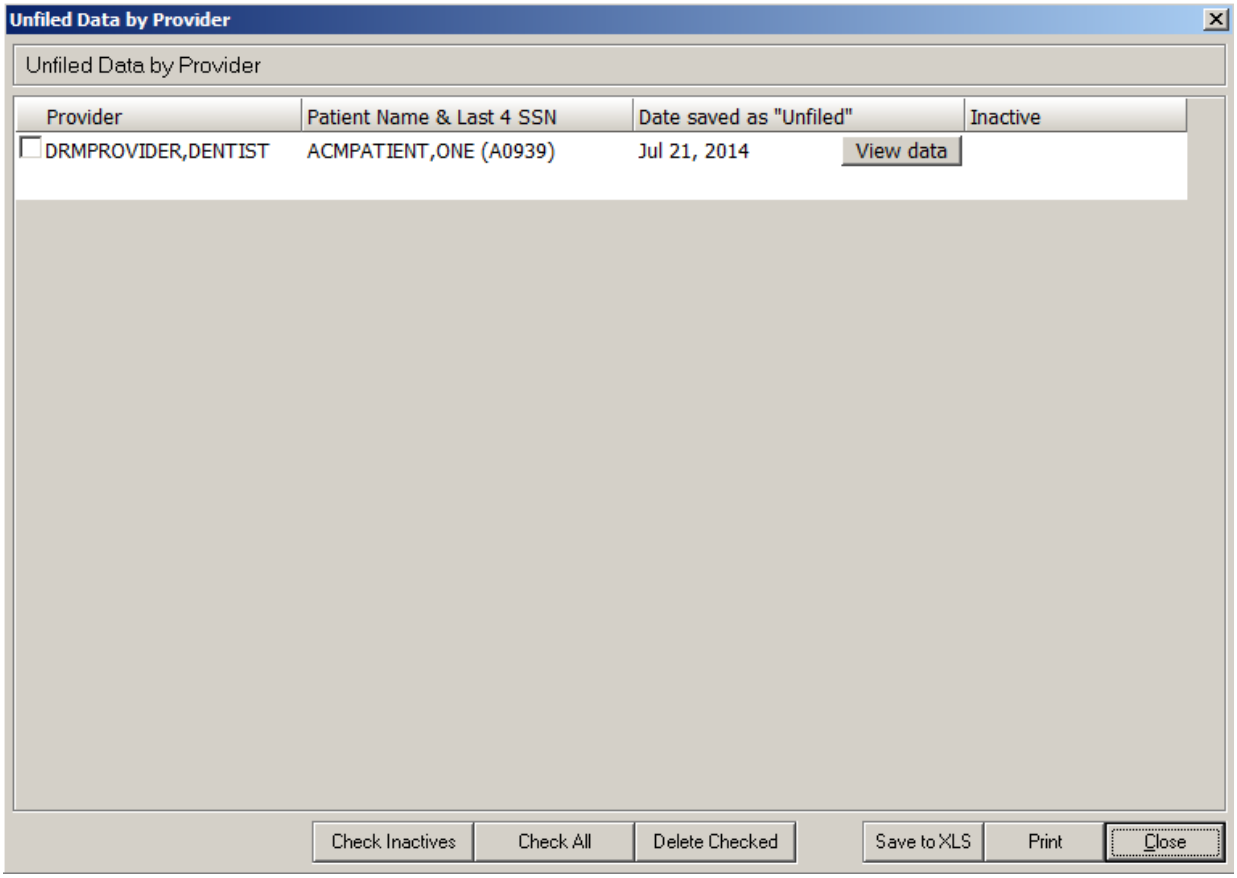


Figure 77: Unfiled Data by Provider Screen

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.

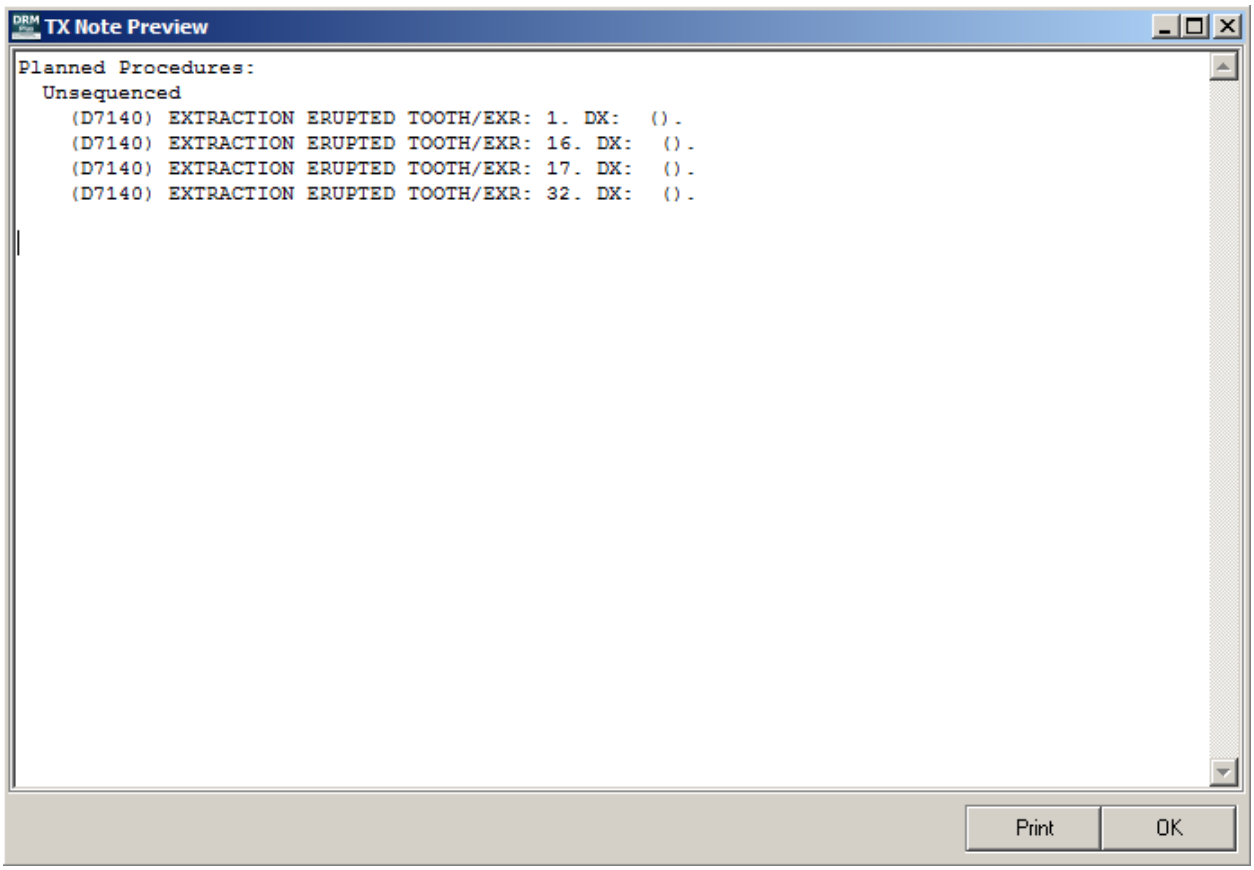


Figure 78: TX Note Preview

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.

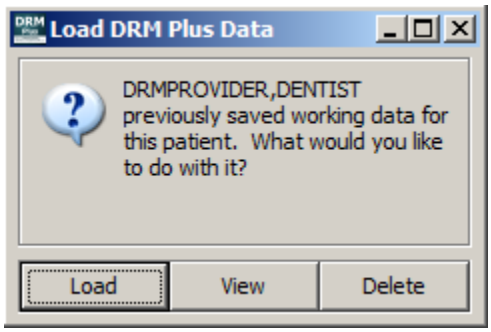


Figure 79: Load DRM Plus Data Screen

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** submenu 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.

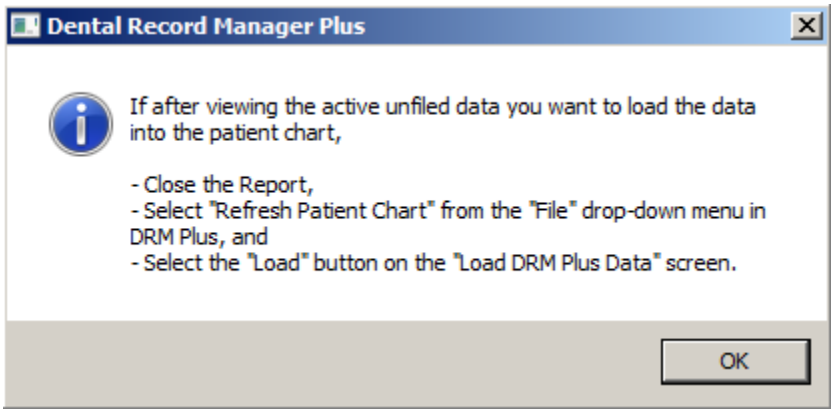


Figure 80: Instructional Steps to Load Unfiled Data

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 Plus user with access to the patient.

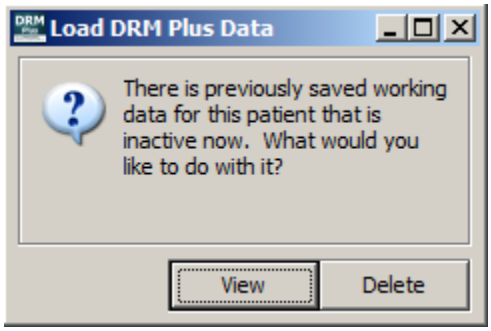


Figure 81: Previously Saved Inactive Data

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 **Report** menu to select and create a service report.

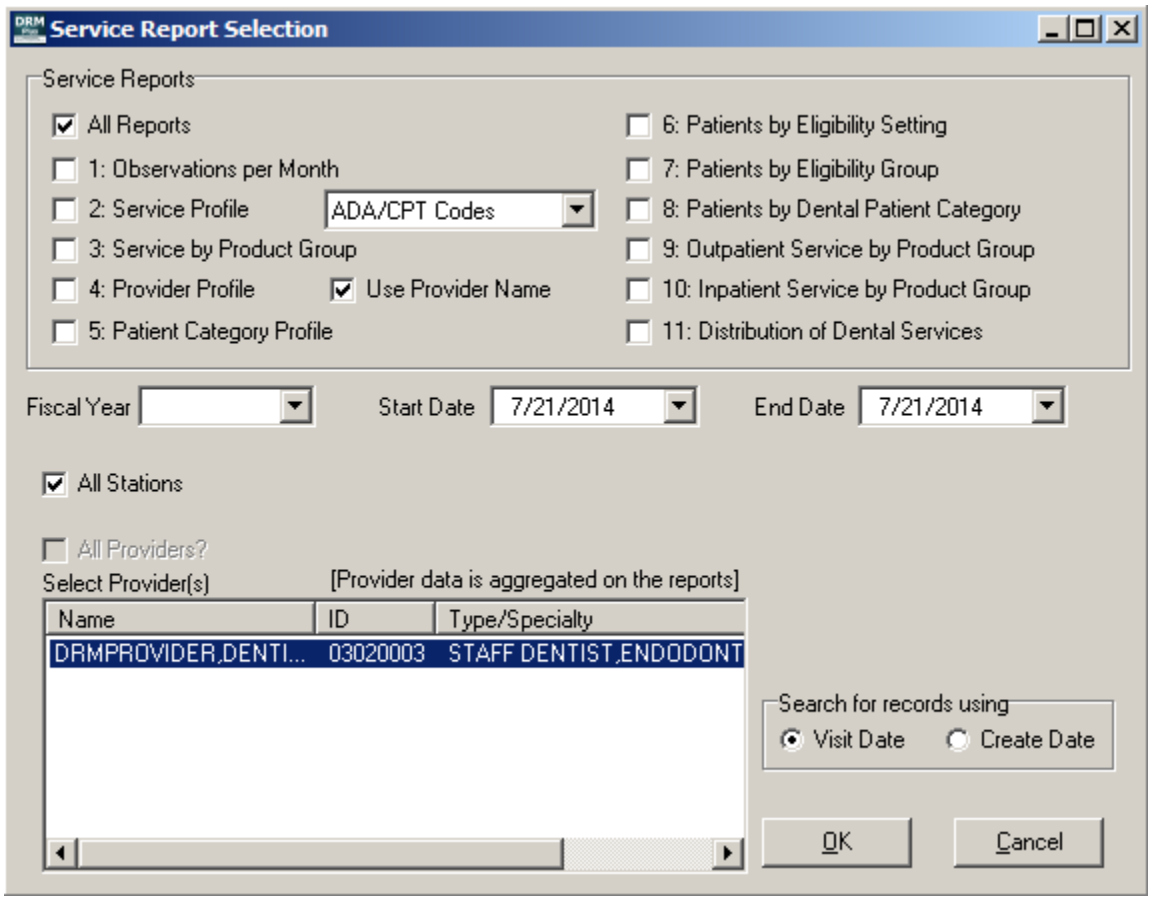


Figure 82: Service Report Selection Screen

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.

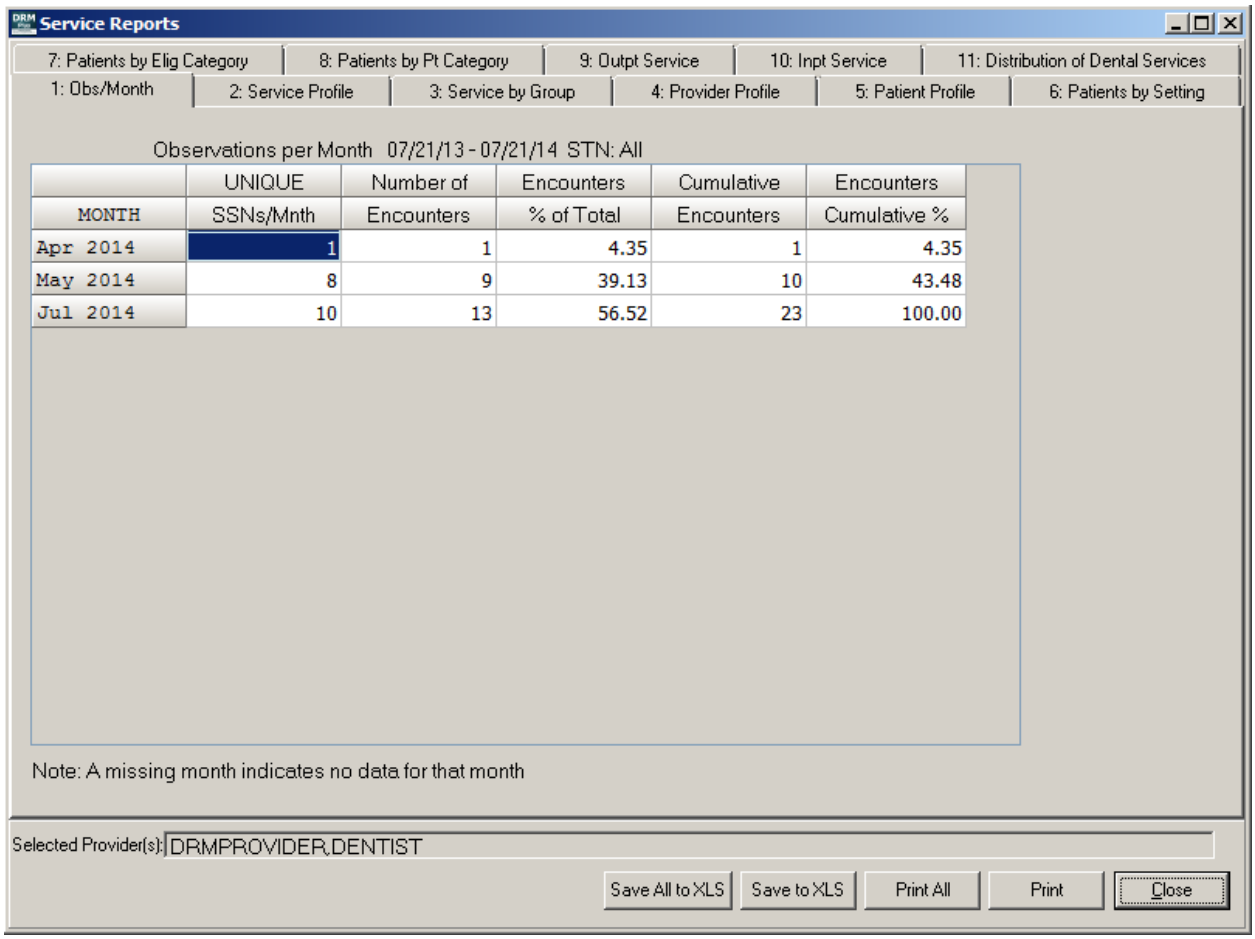


Figure 83: Service Reports Screen

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.

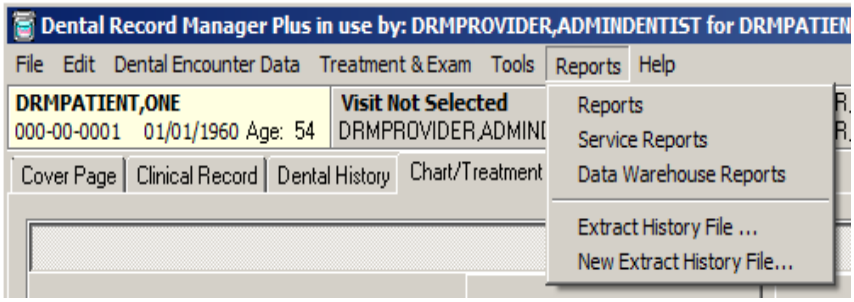


Figure 84: Reports Menu

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.

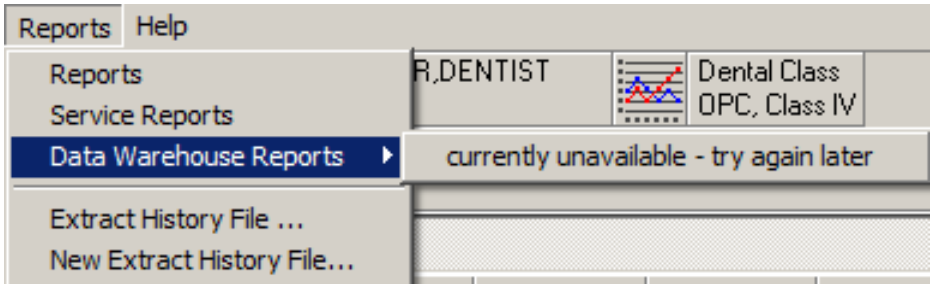


Figure 85: Data Warehouse Reports Submenu Options

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 by the DRM Plus Administrator.

Extract History File

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

New Extract History File

This is an administrative function. For more information, please see the DRM Plus Administrator Manual or speak to a local DRM Plus Administrator.

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.**

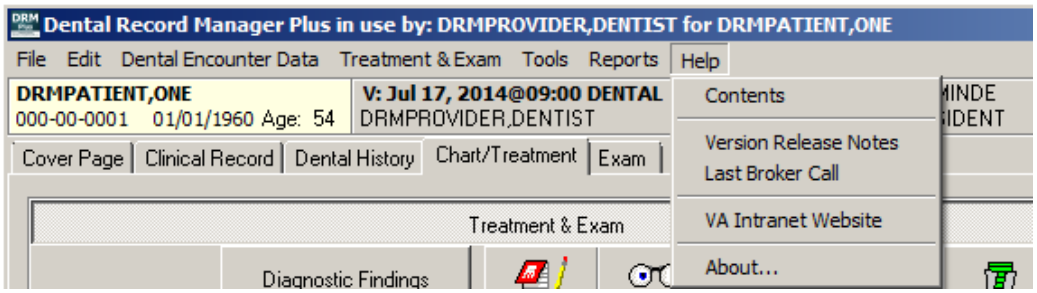


Figure 86: Help Menu

Contents

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

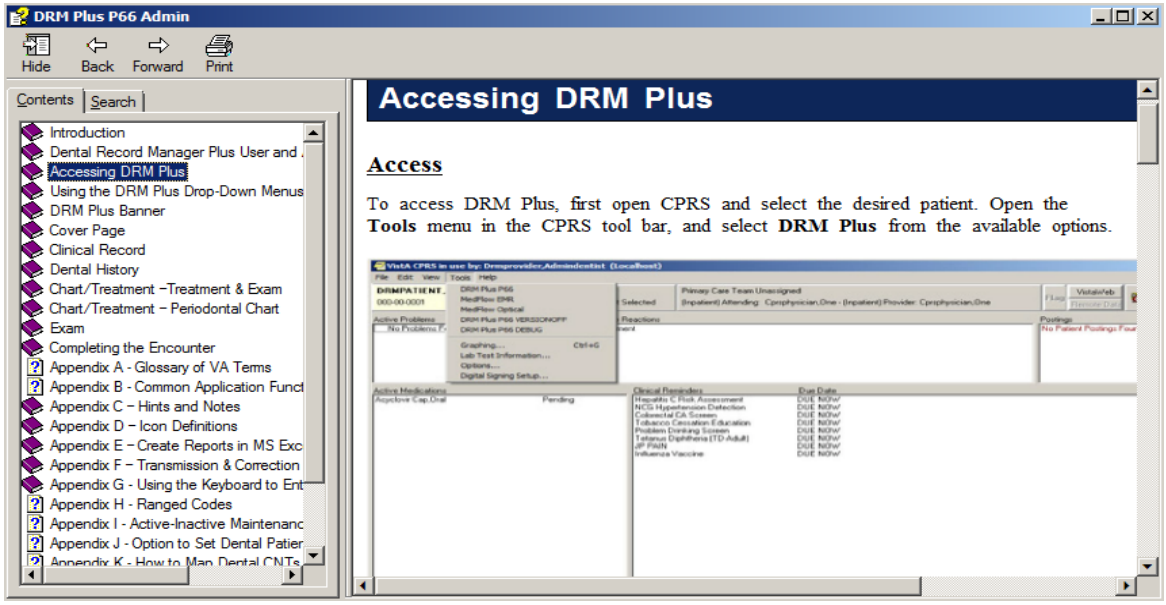


Figure 87: DRM Plus Contents Screen

Version Release Notes

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

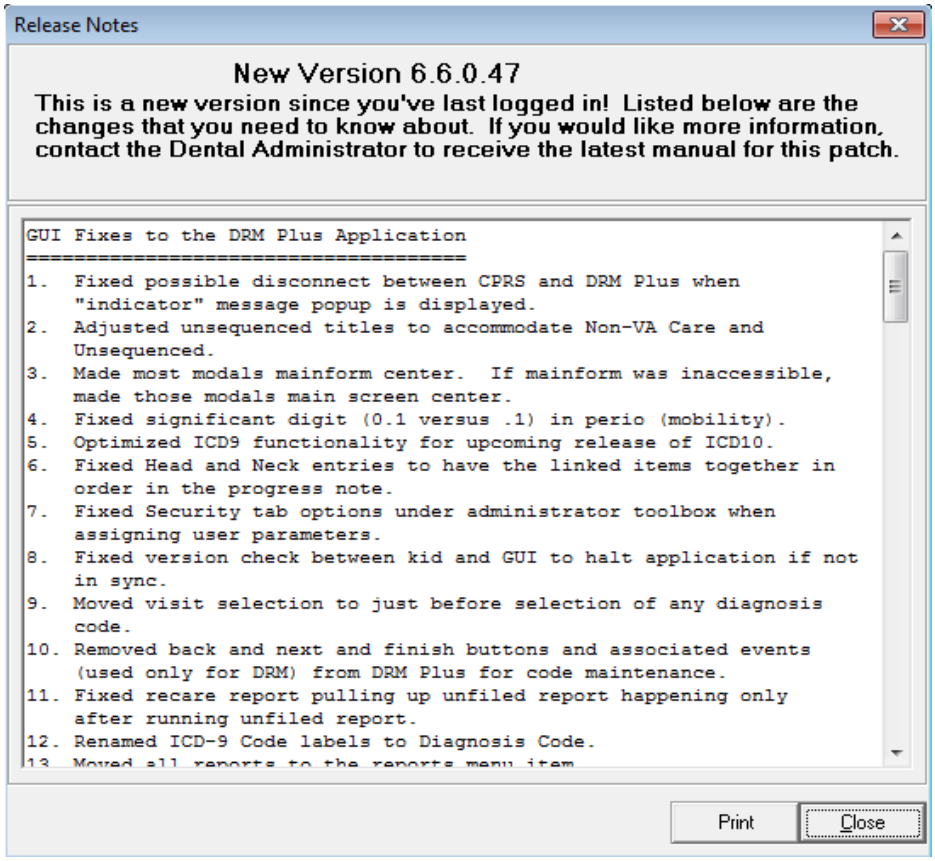


Figure 88: Release Notes Screen

Last Broker Call

Select this submenu to see the last broker call.

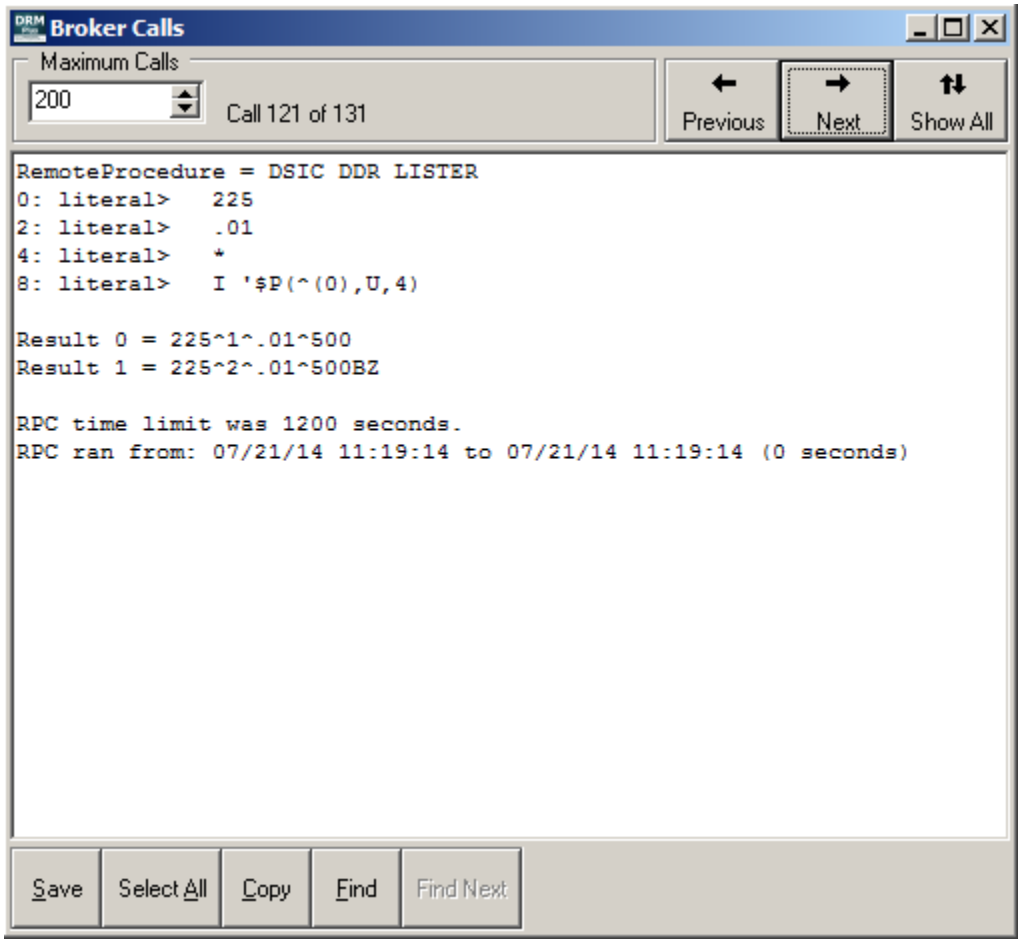


Figure 89: Broker Calls Screen

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 90: DRM Plus About Screen

DRM Plus Banner

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

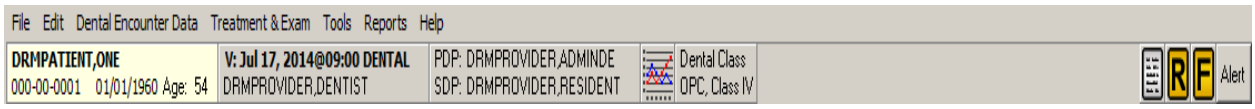


Figure 91: DRM Plus Banner

Patient Information

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

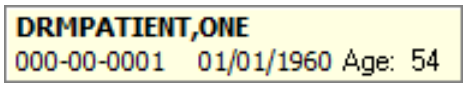


Figure 92: Patient Inquiry Button

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.

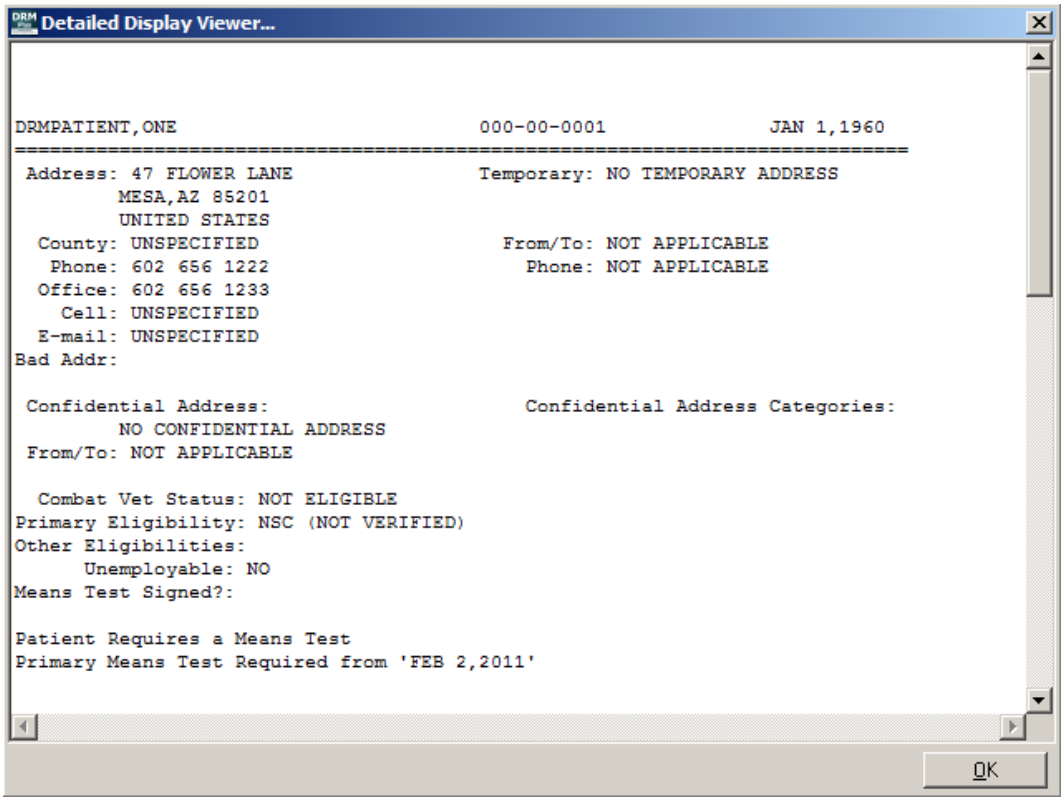


Figure 93: Patient Inquiry Screen

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 94: 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.

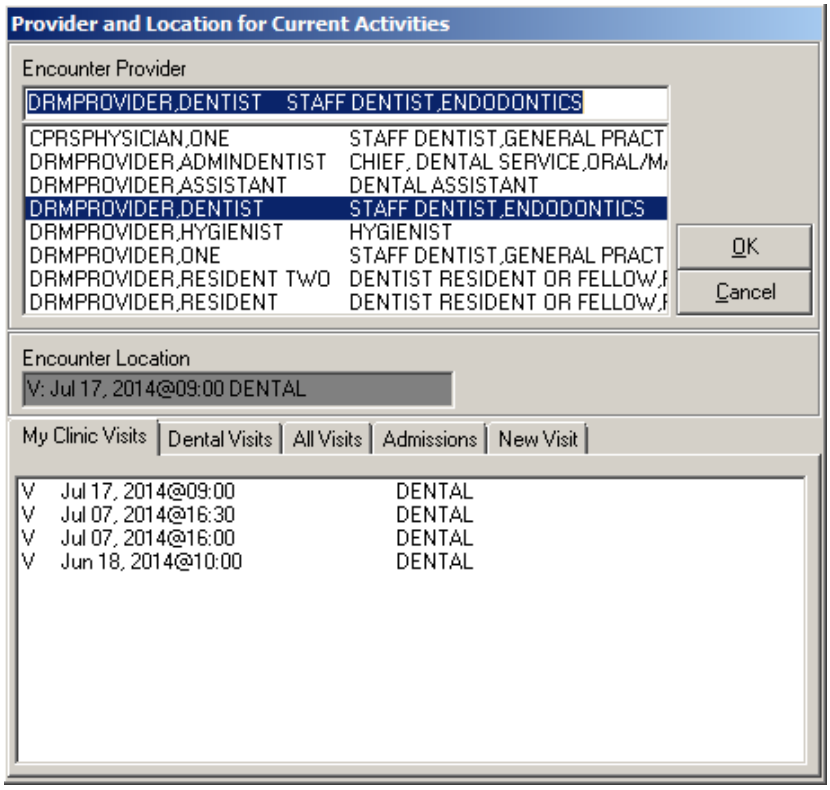


Figure 95: Provider and Location for Current Activities Screen

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.

Figure 96: Designate Dental Providers Button

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.

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.

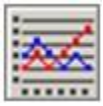


Figure 97: Vitals Lite Button

Dental Class Information

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

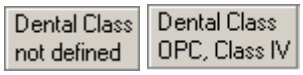


Figure 98: Dental Class Button

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 99: 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 100: 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.

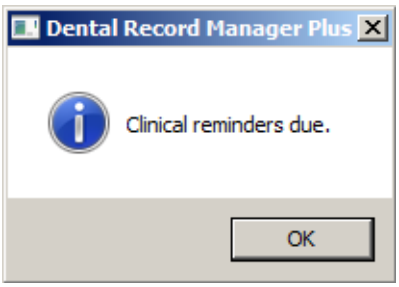


Figure 101: Clinical Reminders Due

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.

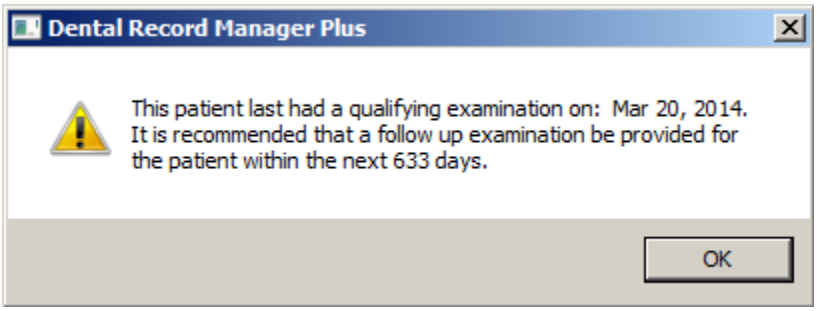


Figure 102: Exam Quality Indicator Screen

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.

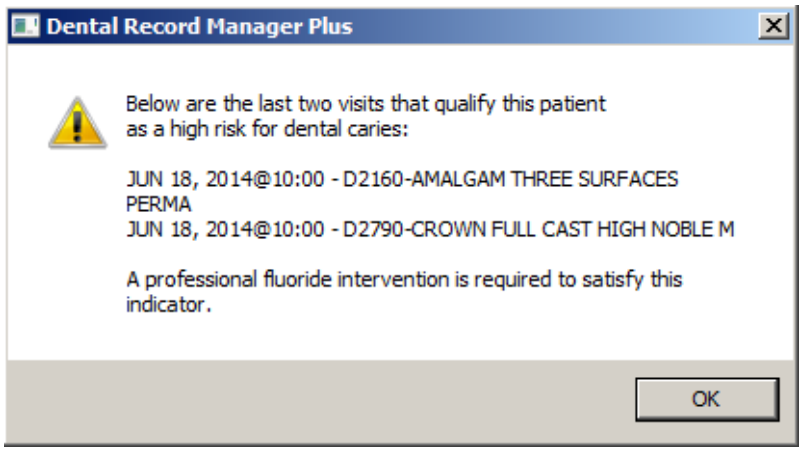


Figure 103: Fluoride Quality Indicator Screen

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 Alerts** screen displays.

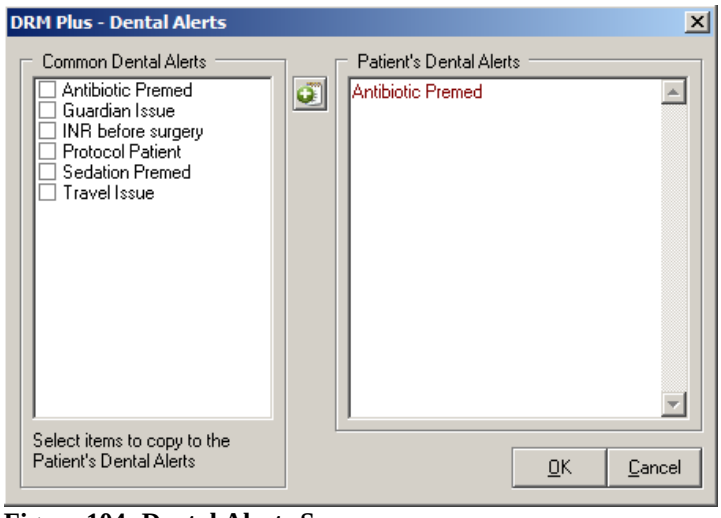


Figure 104: Dental Alerts Screen

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.

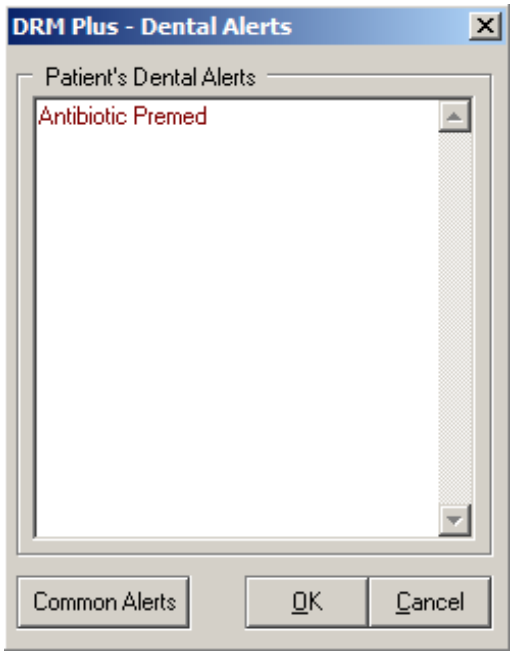


Figure 105: Patient's Dental Alerts Screen

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 **Patent'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.**

Note: Dental Eligibility is a DRM Plus administrative function. Please contact a DRM Plus Administrator for more information about this option.

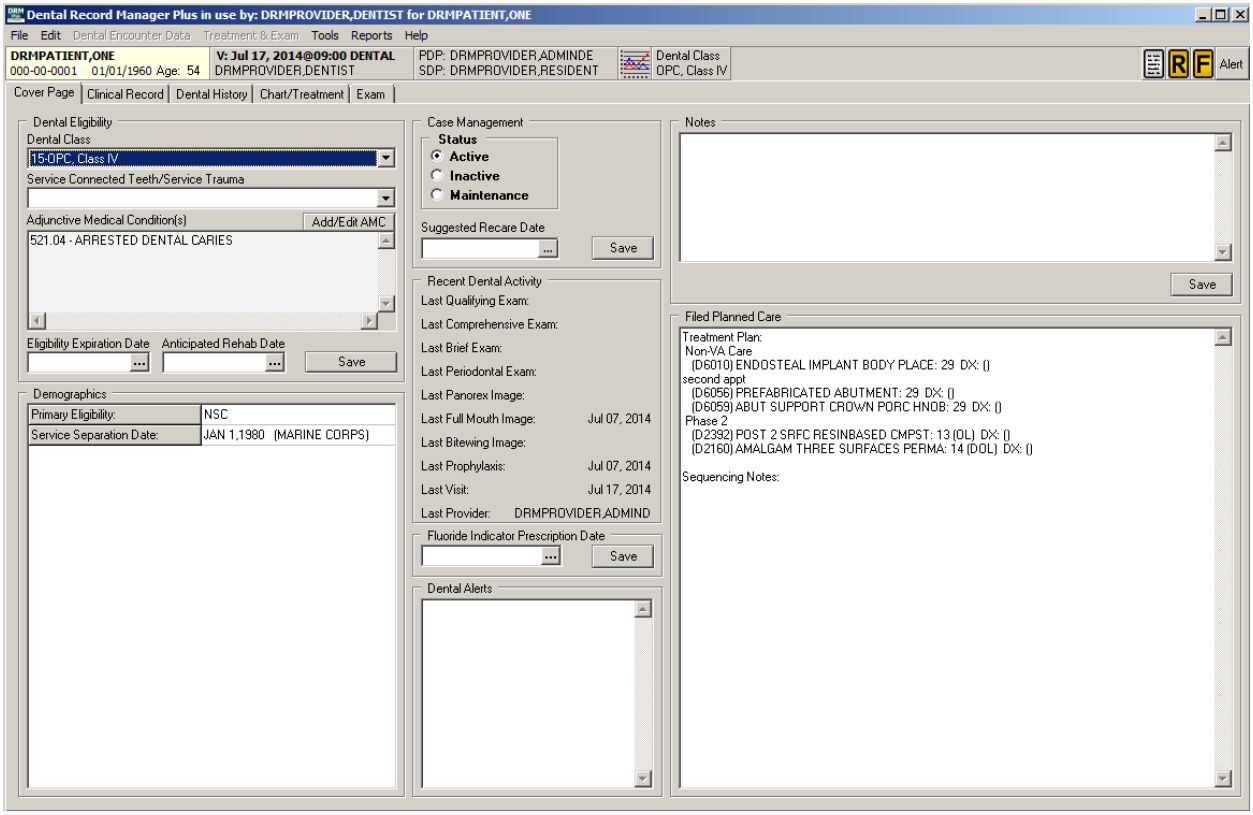


Figure 106: DRM Plus Cover Page Tab

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.

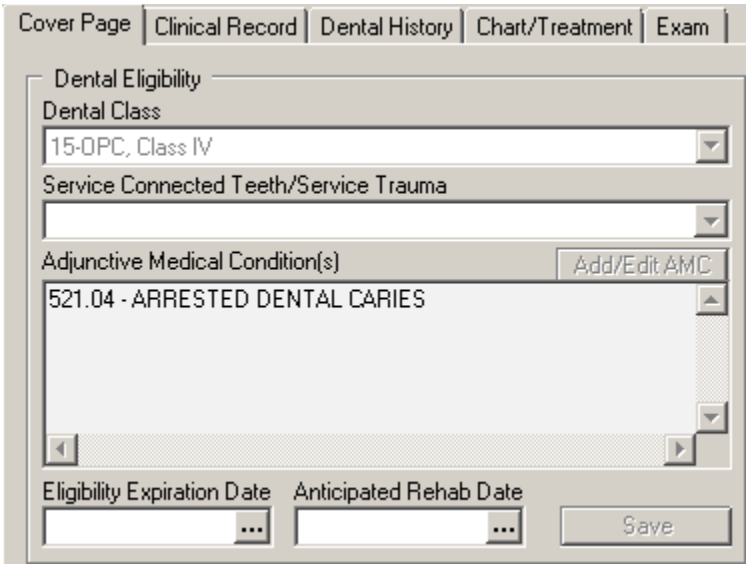


Figure 107: Dental Eligibility

Dental Class

Dental Class can only be changed by a DRM Plus Administrator or a user who has been given this administrative parameter option.

Service Connected Teeth/Service Trauma

Service Connected Teeth/Service Trauma can only be changed by a DRM Plus Administrator or user who has been given this administrative parameter option.

Adjunctive Medical Condition(s)

Adjunctive Medical Condition(s) can only be changed by a DRM Plus Administrator or user who has been given this administrative parameter option.

Eligibility Expiration Date

Eligibility Expiration Date can only be changed by a DRM Plus Administrator or user who has been given this administrative parameter option.

Anticipated Rehab Date

Anticipated Rehab Date can only be changed by a DRM Plus Administrator or user who has been given this administrative parameter option.

Demographics

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

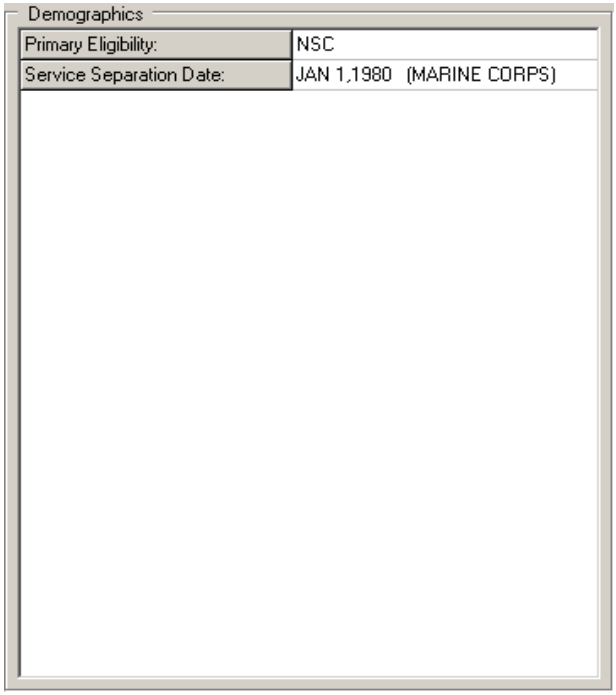


Figure 108: Demographics

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.

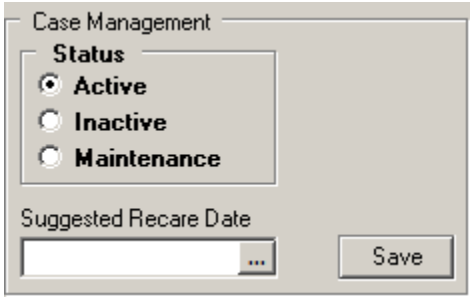


Figure 109: Case Management

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.

Figure 110: Recent Dental Activity

Fluoride Indicator Prescription Date

Add a fluoride indicator prescription date here.

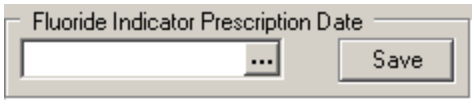


Figure 111: Fluoride Indicator Prescription Date

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.

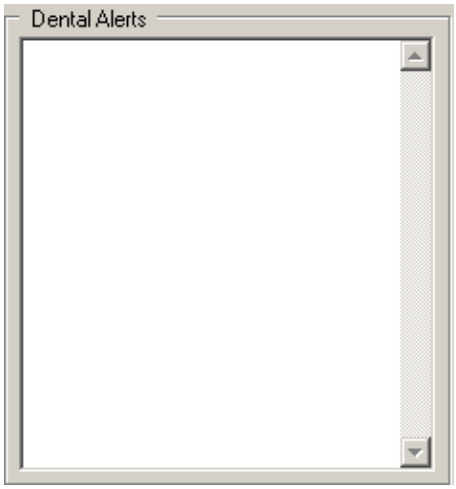


Figure 112: Dental Alerts

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.

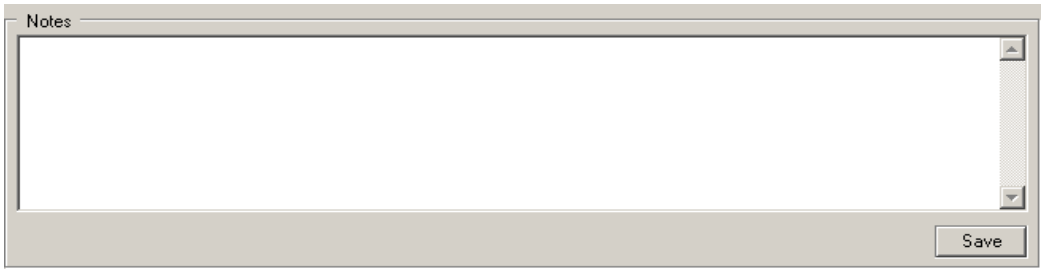


Figure 113: Notes

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

Figure 114: 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.**

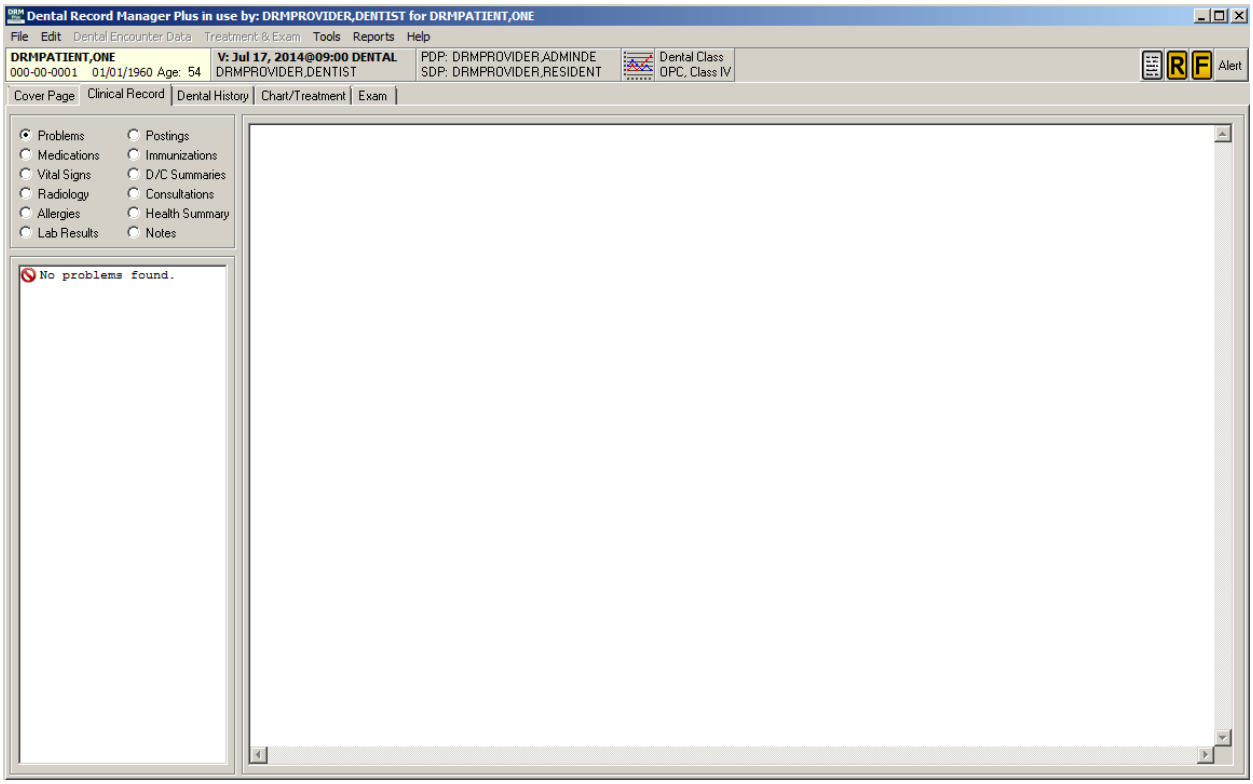


Figure 115: Clinical Record Tab

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

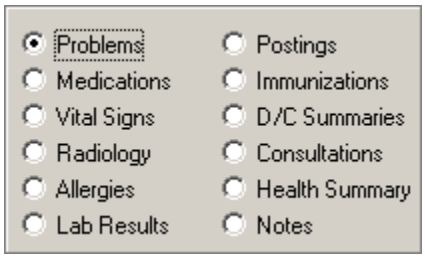
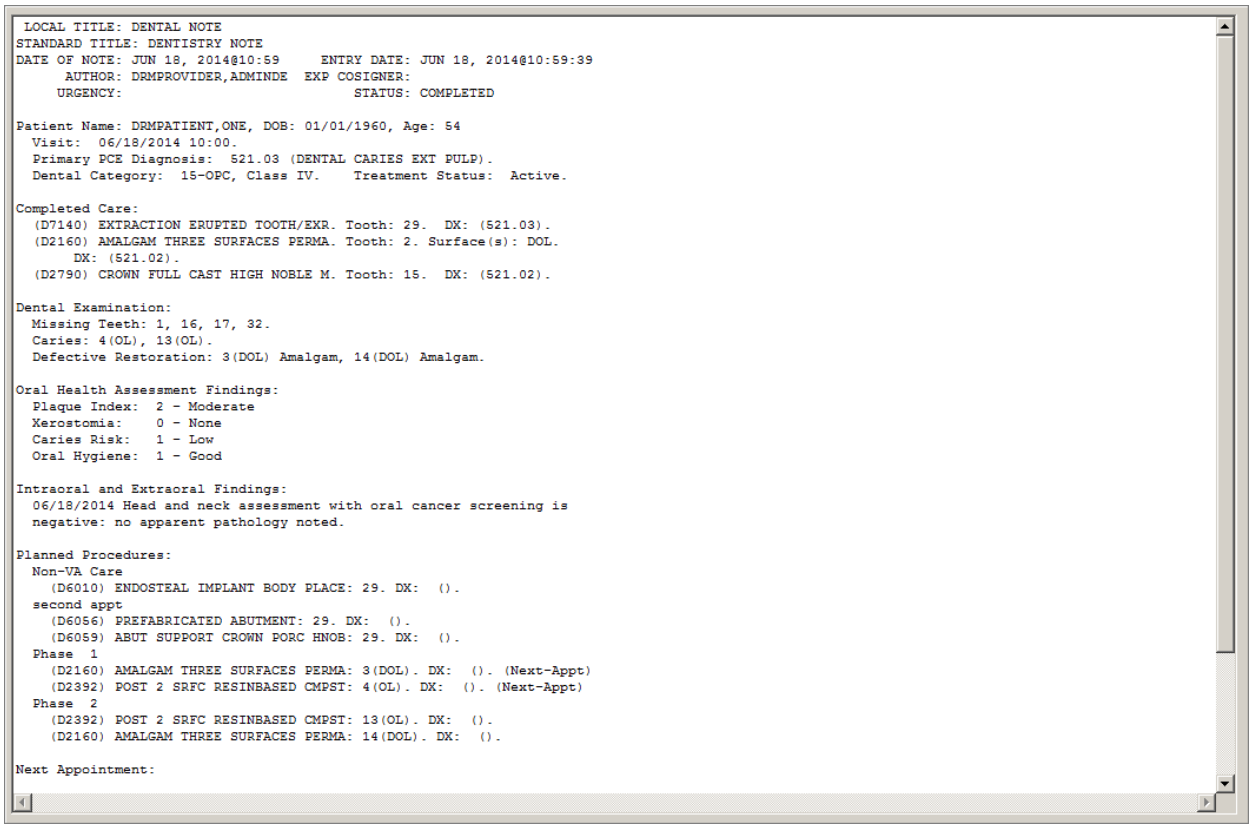


Figure 116: Clinical Record Radio Buttons

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

Figure 117: Clinical Record Entries Window

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



```
 LOCAL TITLE: DENTAL NOTE
STANDARD TITLE: DENTISTRY NOTE
DATE OF NOTE: JUN 18, 2014@10:59     ENTRY DATE: JUN 18, 2014@10:59:39
      AUTHOR: DRMPROVIDER,ADMINDE  EXP COSIGNER:
     URGENCY:                          STATUS: COMPLETED

Patient Name: DRMPATIENT,ONE, DOB: 01/01/1960, Age: 54
  Visit:  06/18/2014 10:00.
  Primary PCE Diagnosis:  521.03 (DENTAL CARIES EXT PULP).
  Dental Category:  15-OPC, Class IV.    Treatment Status:  Active.

Completed Care:
  (D7140) EXTRACTION ERUPTED TOOTH/EXR. Tooth: 29.  DX: (521.03).
  (D2160) AMALGAM THREE SURFACES PERMA. Tooth: 2. Surface(s): DOL.
       DX: (521.02).
  (D2790) CROWN FULL CAST HIGH NOBLE M. Tooth: 15.  DX: (521.02).

Dental Examination:
  Missing Teeth: 1, 16, 17, 32.
  Caries: 4(OL), 13(OL).
  Defective Restoration: 3(DOL) Amalgam, 14(DOL) Amalgam.

Oral Health Assessment Findings:
  Plaque Index:  2 - Moderate
  Xerostomia:    0 - None
  Caries Risk:   1 - Low
  Oral Hygiene:  1 - Good

Intraoral and Extraoral Findings:
  06/18/2014 Head and neck assessment with oral cancer screening is
  negative: no apparent pathology noted.

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-Appt)
    (D2392) POST 2 SRFC RESINBASED CMPST: 4(OL). DX:  (). (Next-Appt)
  Phase  2
    (D2392) POST 2 SRFC RESINBASED CMPST: 13(OL). DX:  ().
    (D2160) AMALGAM THREE SURFACES PERMA: 14(DOL). DX:  ().

Next Appointment:
```

Figure 118: 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.

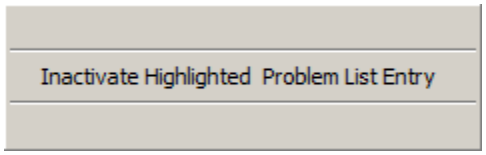


Figure 119: Inactivate Highlighted Problem List Entry Button

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 120: 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.

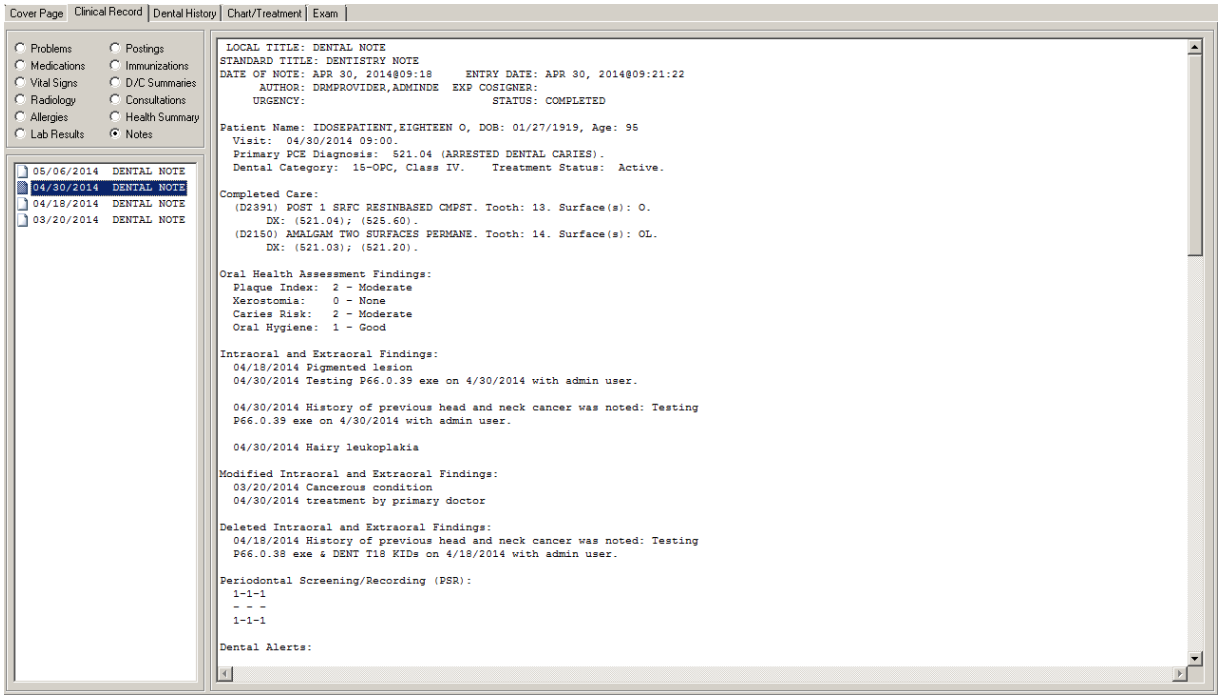


Figure 121: All TIU Completed Notes List

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

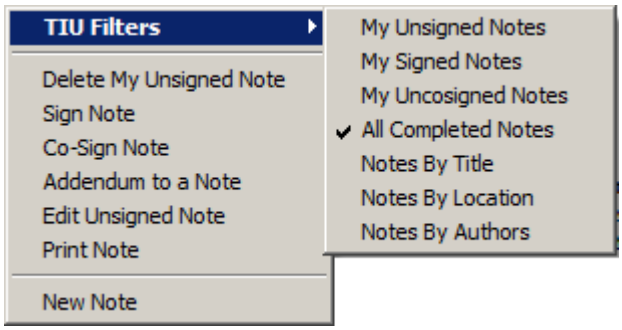


Figure 189: TIU Filters Submenus

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

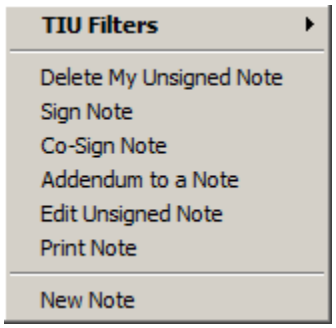


Figure 122: Note Functions Menu

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.

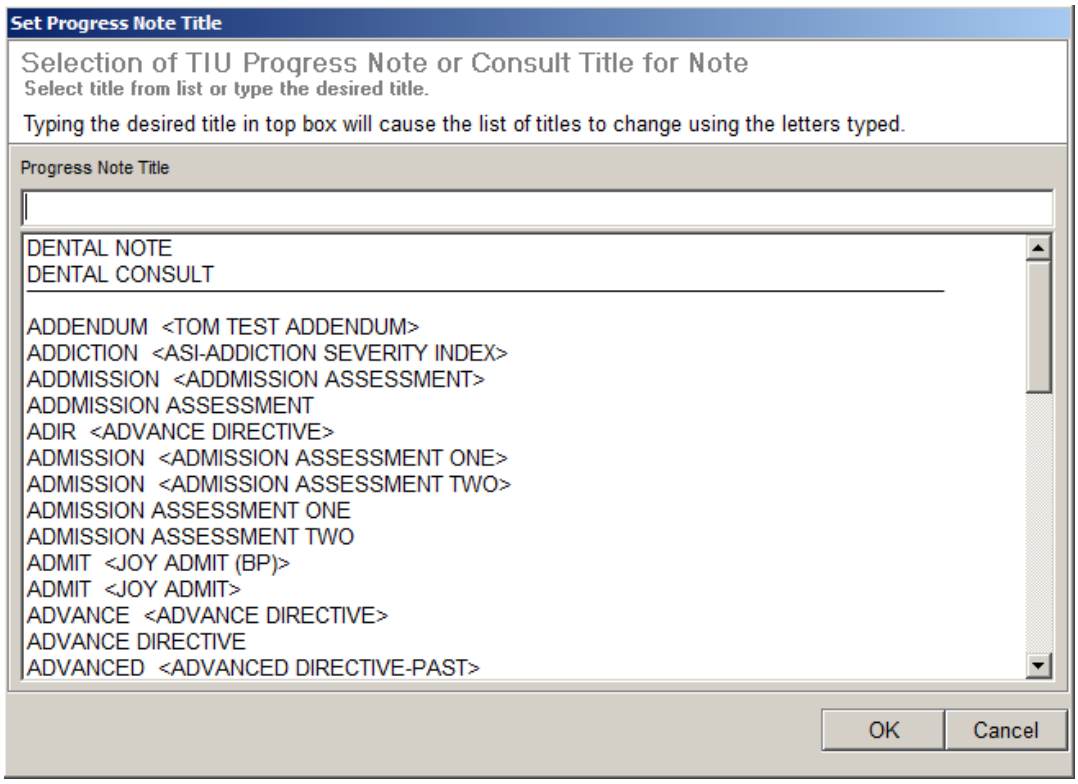


Figure 123: Set Progress Note Title Screen

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

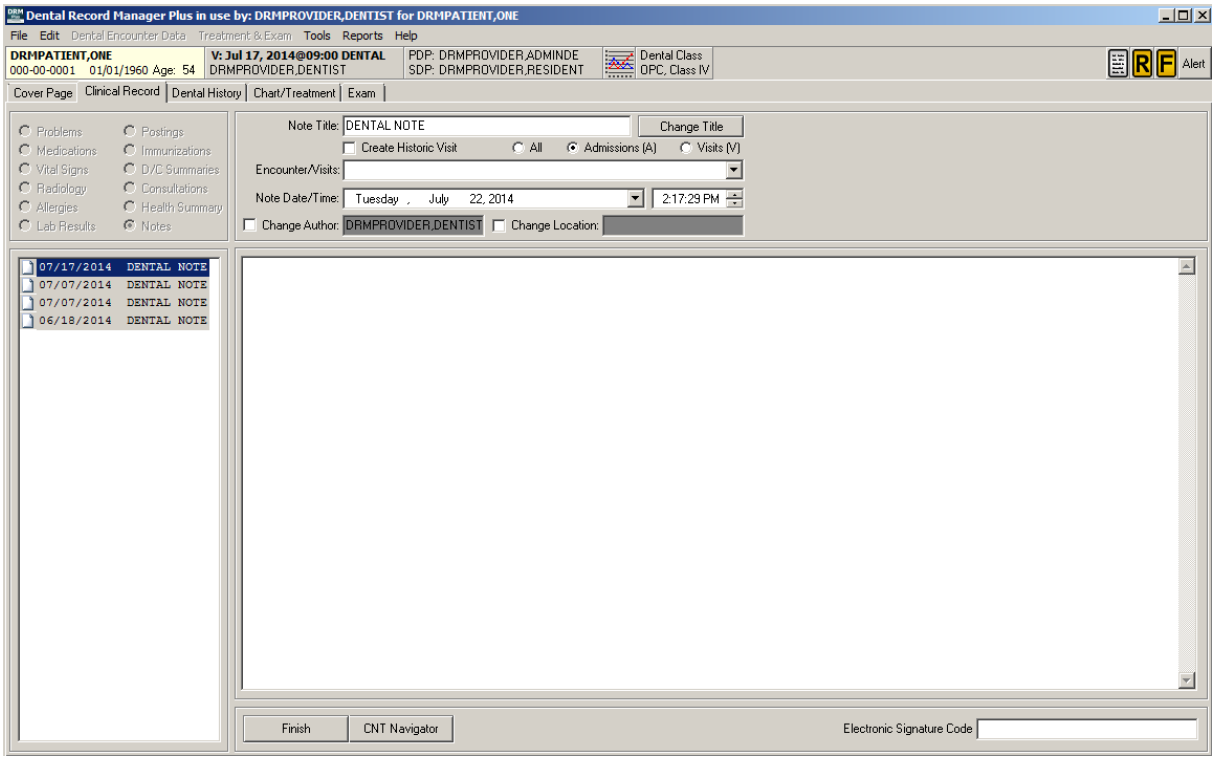


Figure 124: New TIU Progress Note without Any Procedures

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.

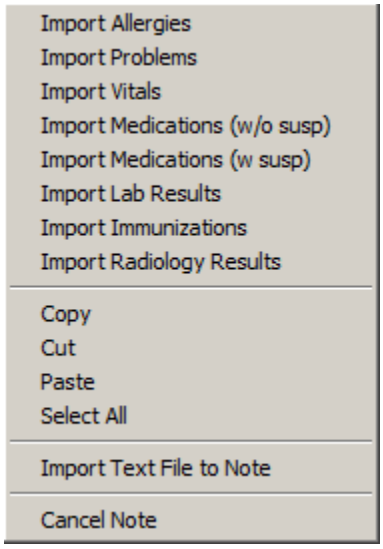


Figure 125: Import Menu Information Screen

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.

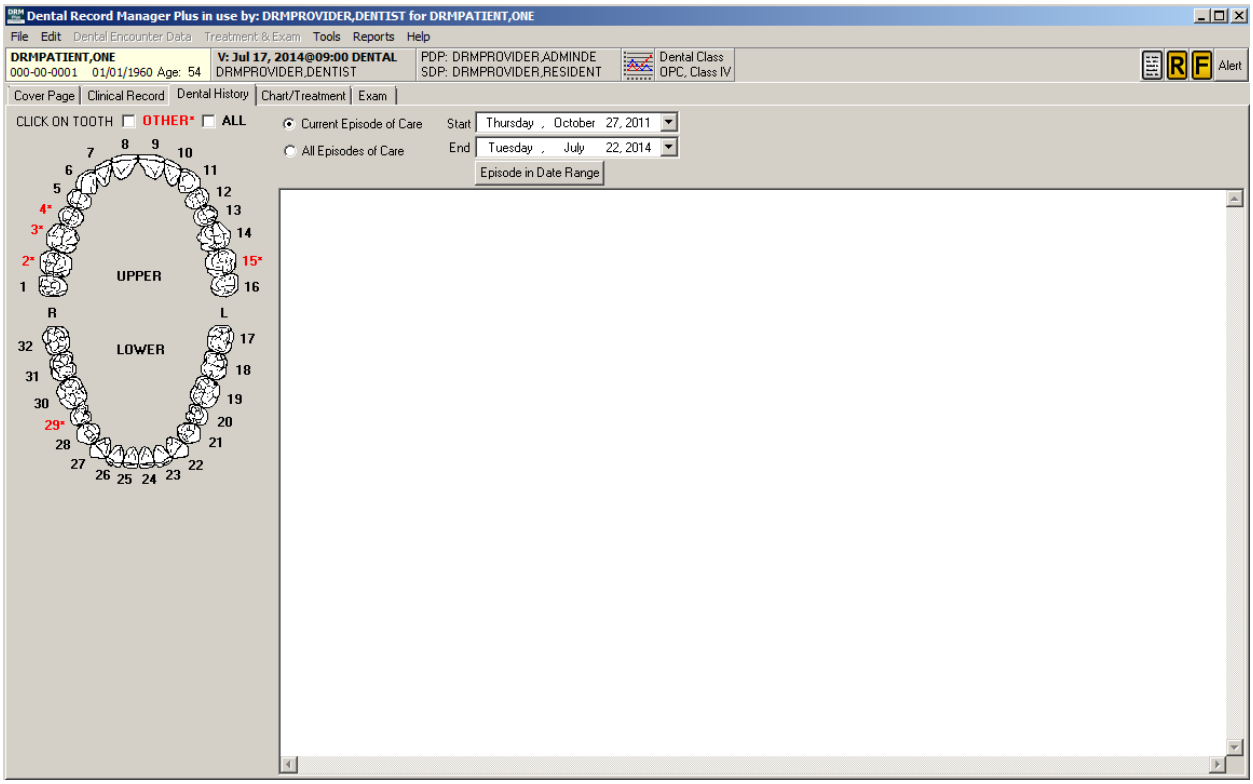


Figure 126: Dental History Tab

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.

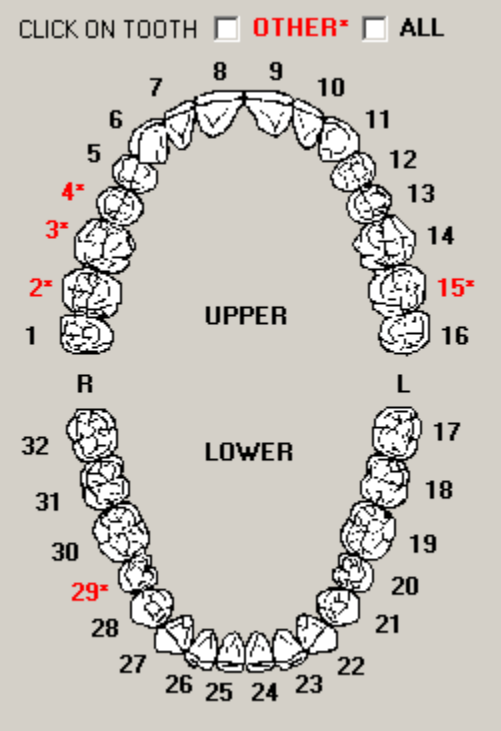


Figure 127: Dental History Teeth Diagram

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 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.

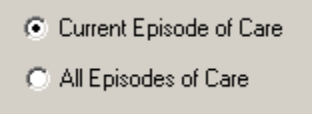


Figure 128: Episode of Care Radio Buttons

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.

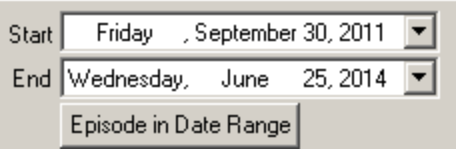


Figure 129: Episode in Date Range

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.

Chart/Treatment – Treatment & Exam

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

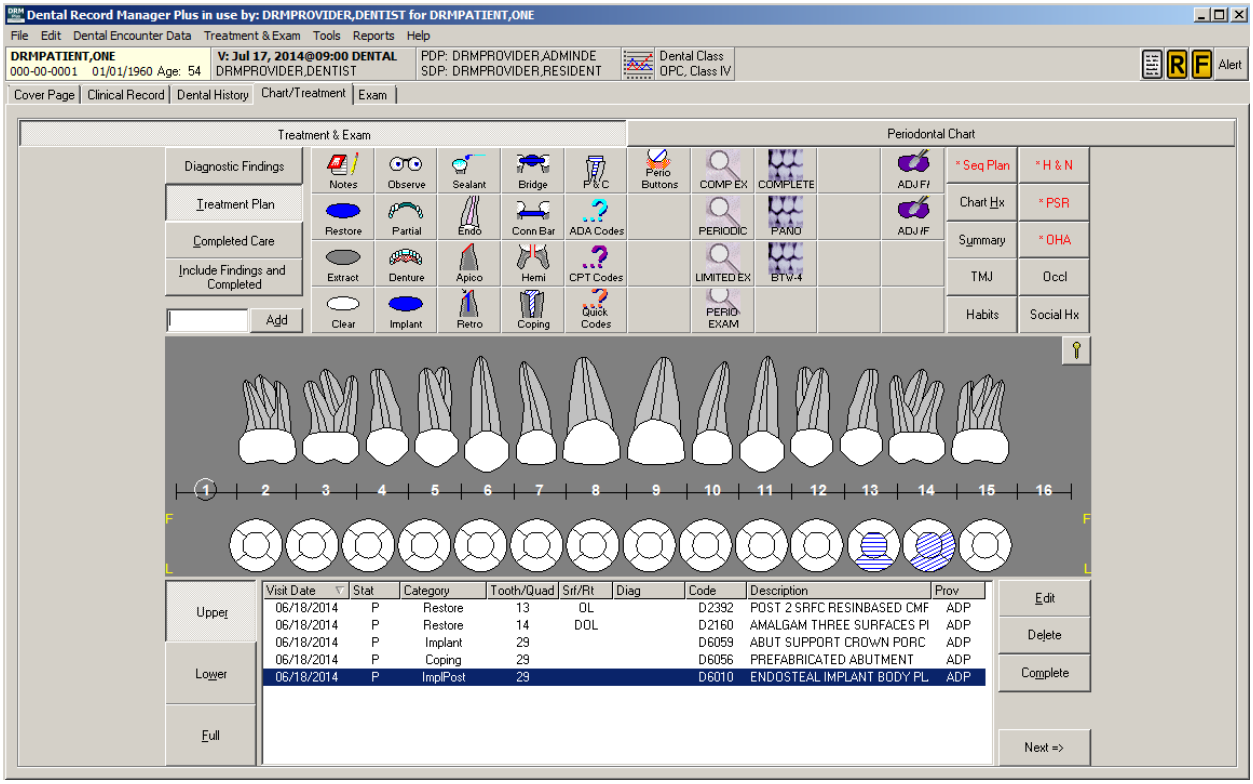


Figure 130: Chart/Treatment Tab Displaying Treatment & Exam Screen

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 131: 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.

Figure 132: 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.

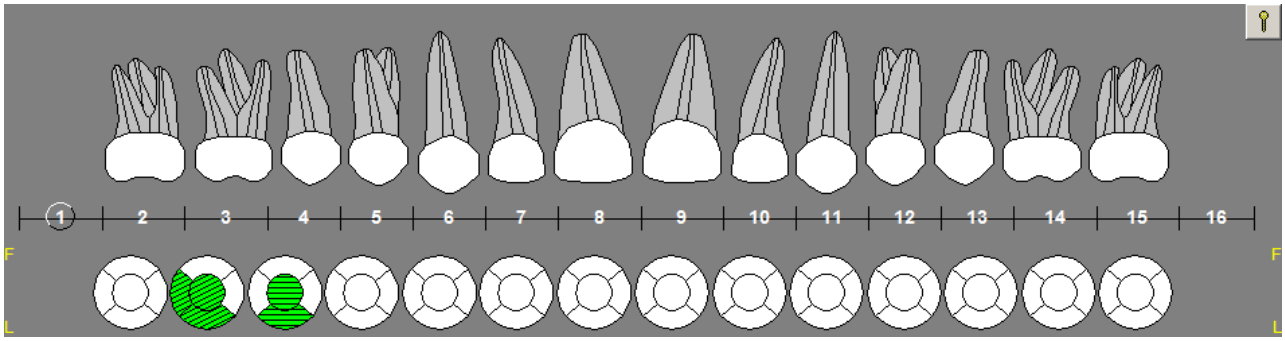


Figure 133: Completed Care Graphic Display

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.

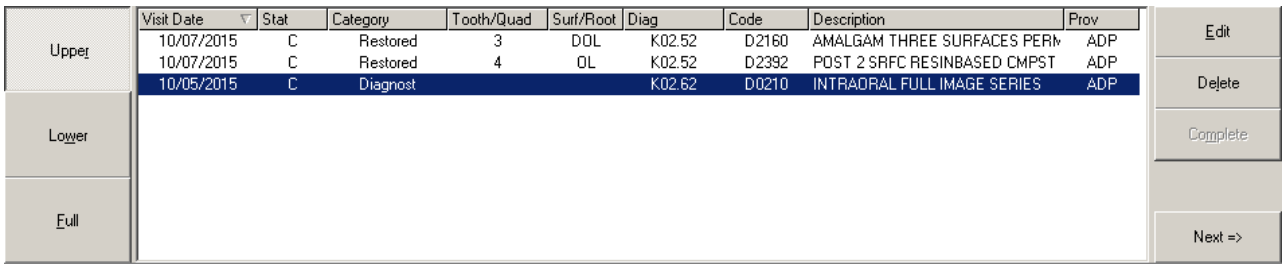


Figure 134: Completed Care Transaction Table

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.

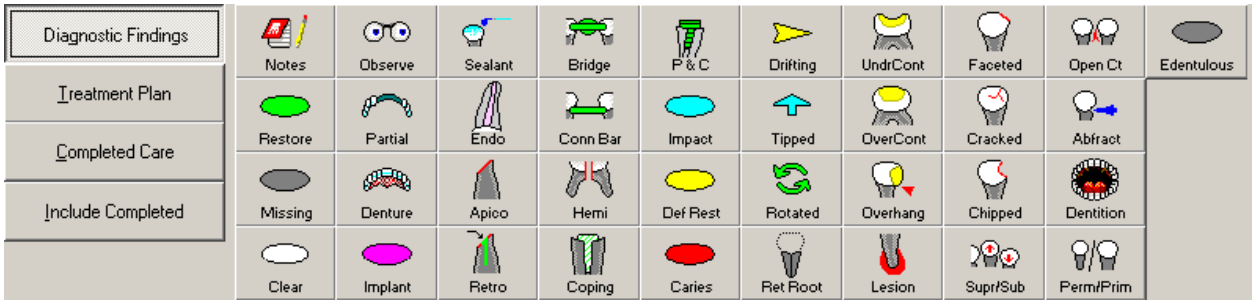


Figure 135: Diagnostic Findings Button Active with Icons

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.

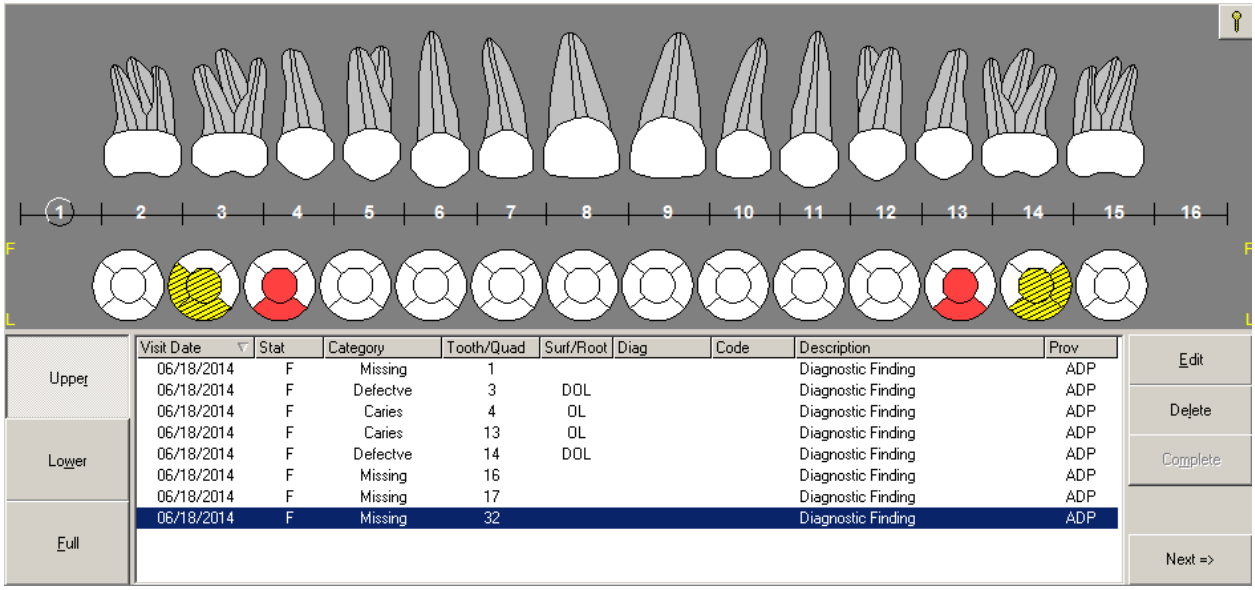


Figure 136: Diagnostic Findings Graphic Chart and Transaction Table

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 Finding 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.

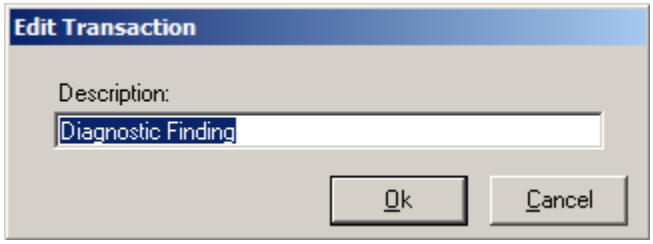


Figure 137: Edit Transaction Screen

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 138: 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.

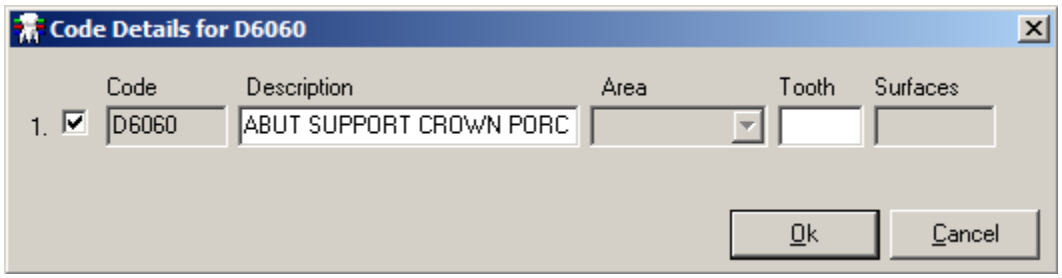


Figure 139: Code Details Screen

Enter the **Tooth** number and, if applicable, the **Area** or **Surface** 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 140: ADA, CPT and Quick Codes Icons

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

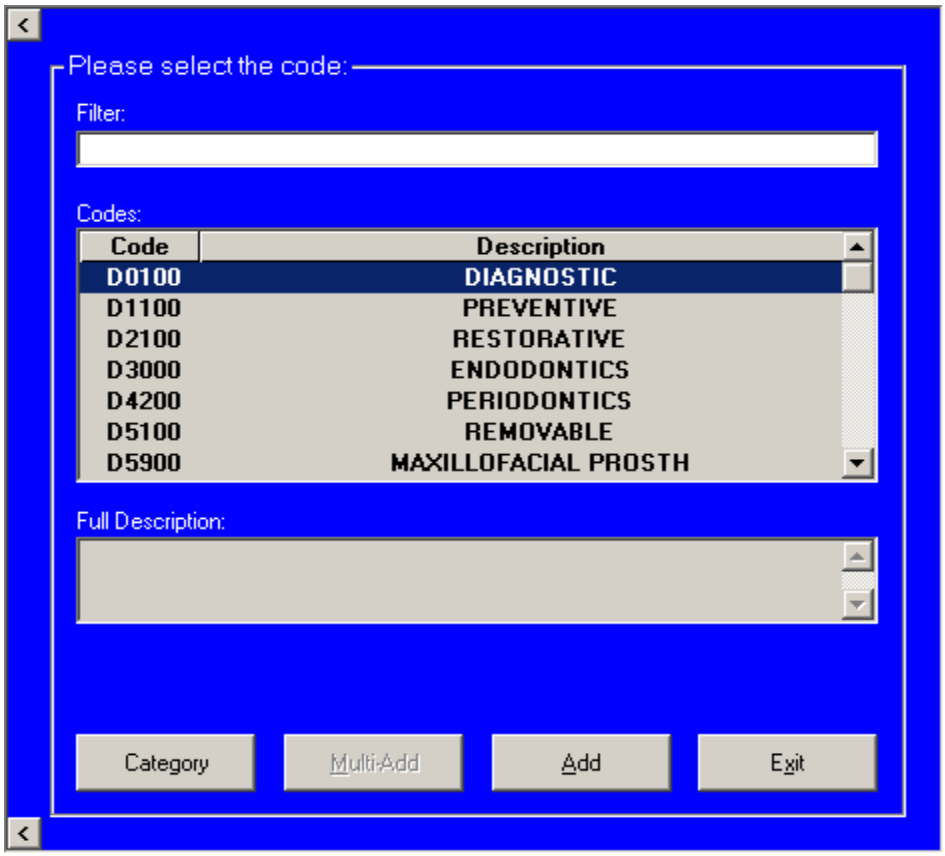


Figure 141: Procedure Code Selection Screen

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.

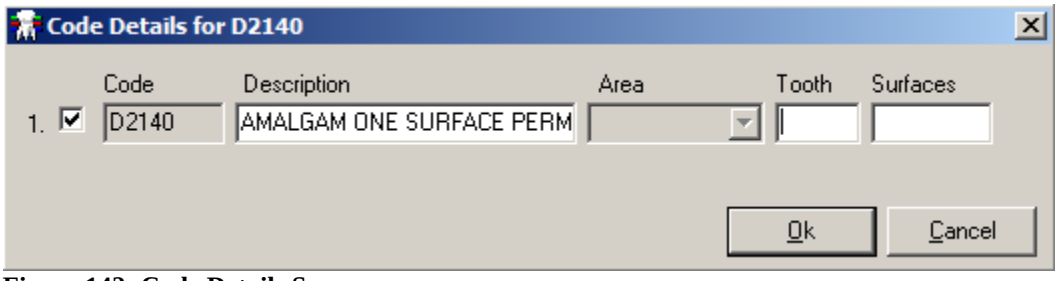


Figure 142: Code Details Screen

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** window 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 **Perio 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.

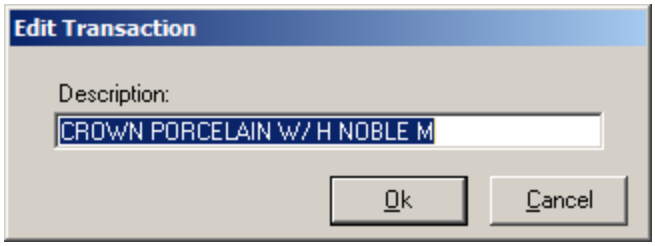


Figure 143: Edit Transaction Screen

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.

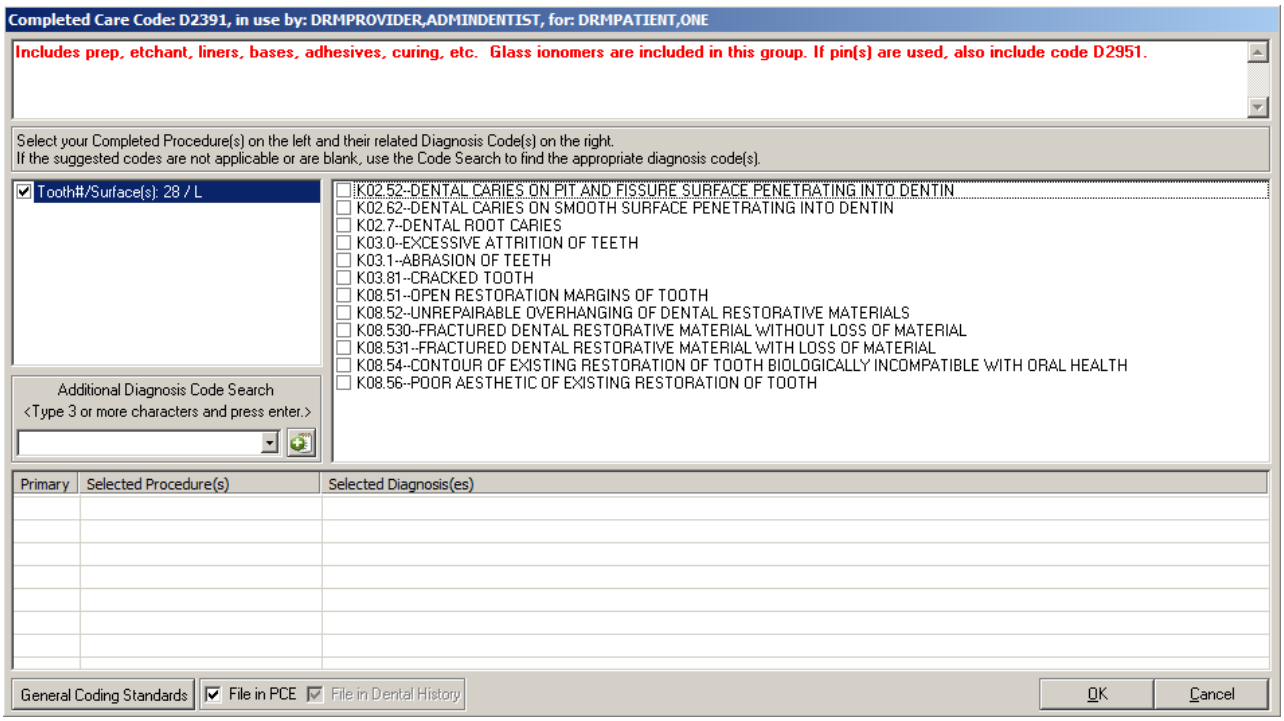


Figure 144: Diagnosis Code Screen

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** window 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.
7. 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 145: Completed Care Button Active with Icons

The rules for entering a procedure code for a completed treatment in the **Completed Care** 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 **ADA, CPT, Quick Codes** or a **Speed Code** icon.
3. The **Add** button and corresponding text box may be used interchangeably with rule 2.
4. 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:

1. Click the **Completed Care** button.
2. Select the desired associated **standard** icon.
3. Choose the appropriate tooth/area on the graphic display.
4. Complete the **Diagnosis Code** screen.
5. The entry displays in the graphical/transaction tables.
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 **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.

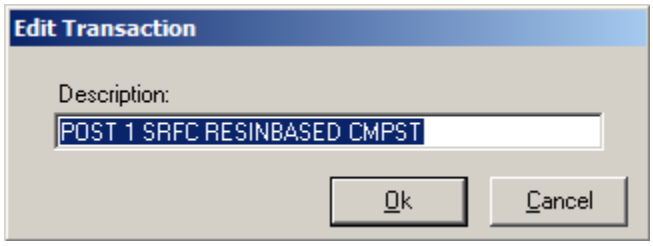


Figure 146: Edit Transaction Screen

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.

DRM Plus users are NOT allowed to delete any previously filed completed treatment. This can be performed only by DRM Plus Administrators.

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.

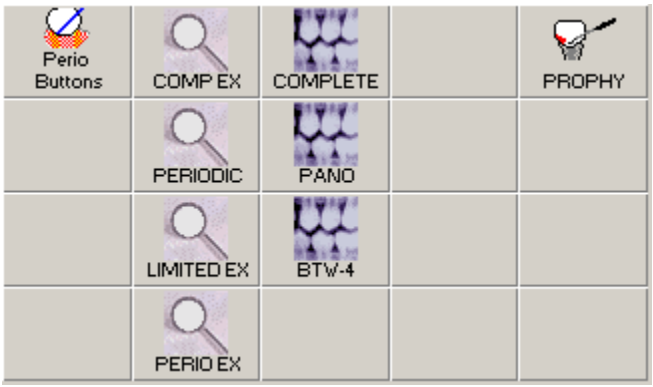


Figure 147: Perio Buttons and Speed Code Icons

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.

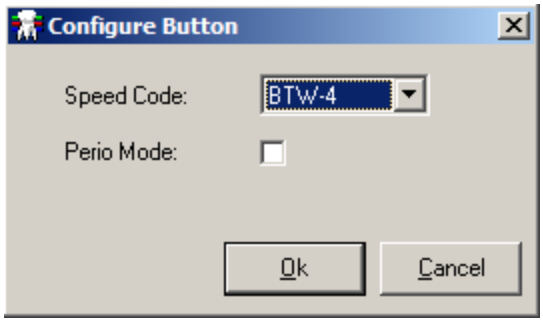


Figure 148: Configure Button Screen

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.

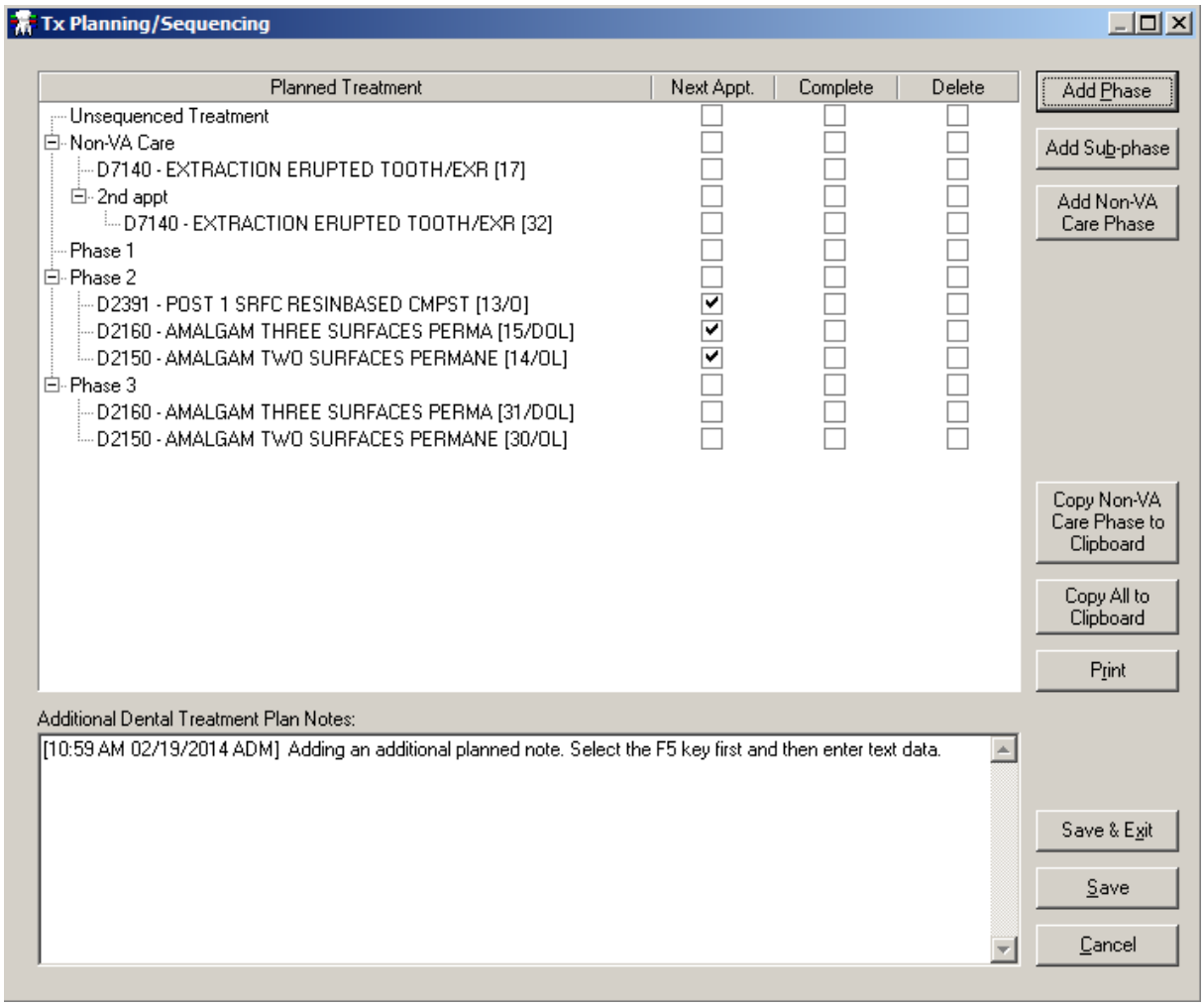


Figure 149: Tx Planning/Sequencing Screen

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.

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.

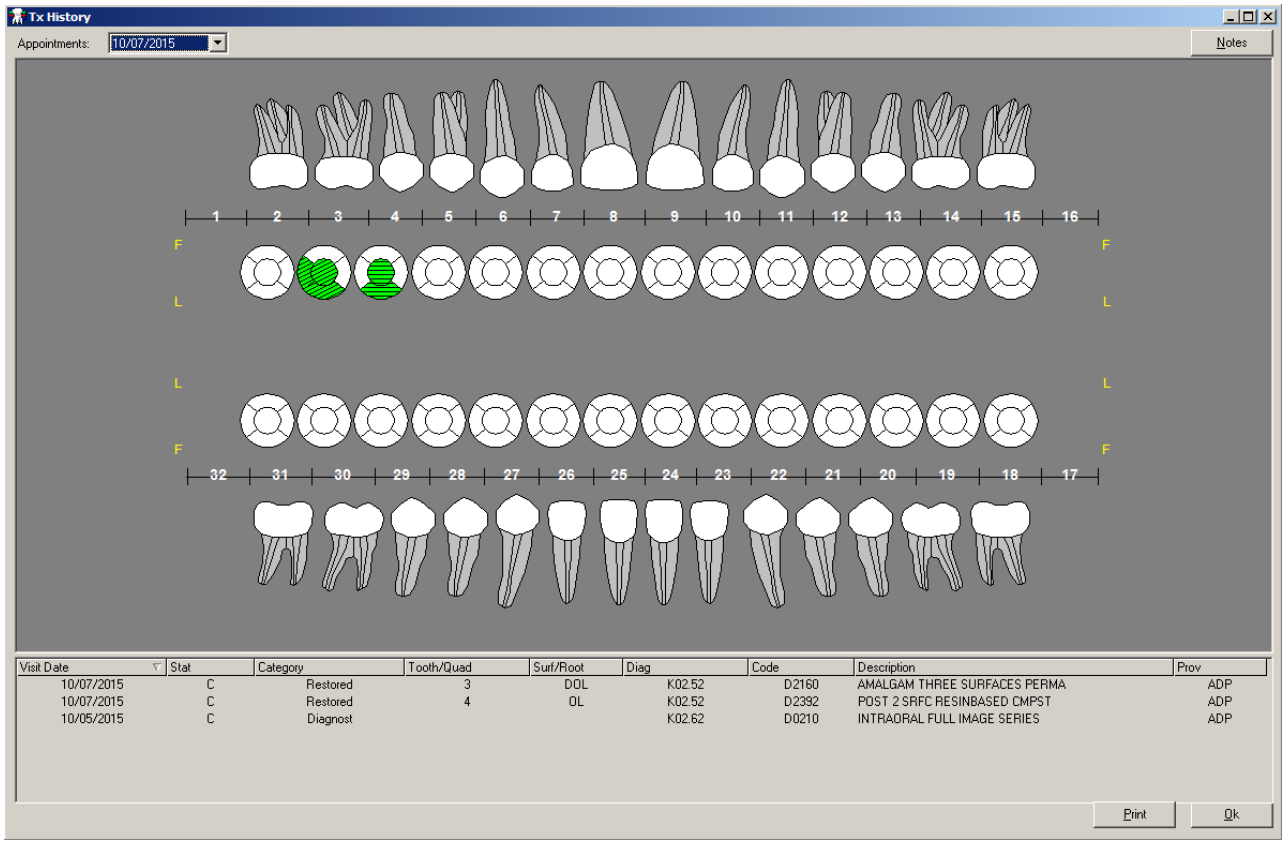


Figure 150: Tx History Screen

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.

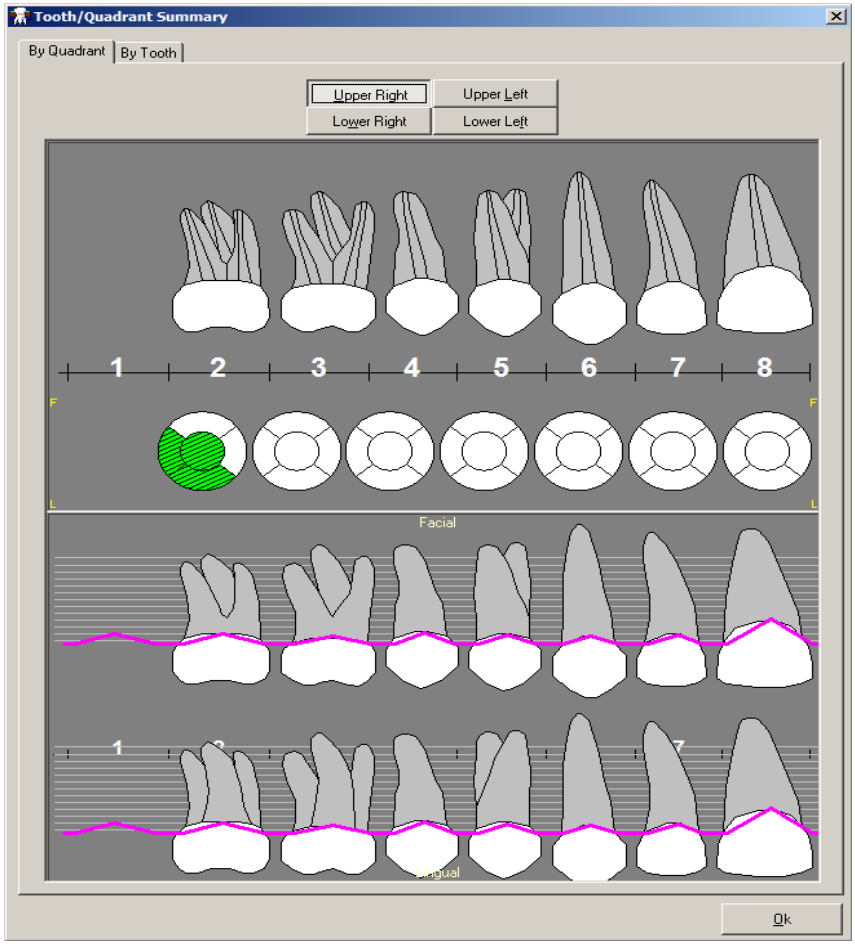


Figure 151: Tooth/Quadrant Summary Screen

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.

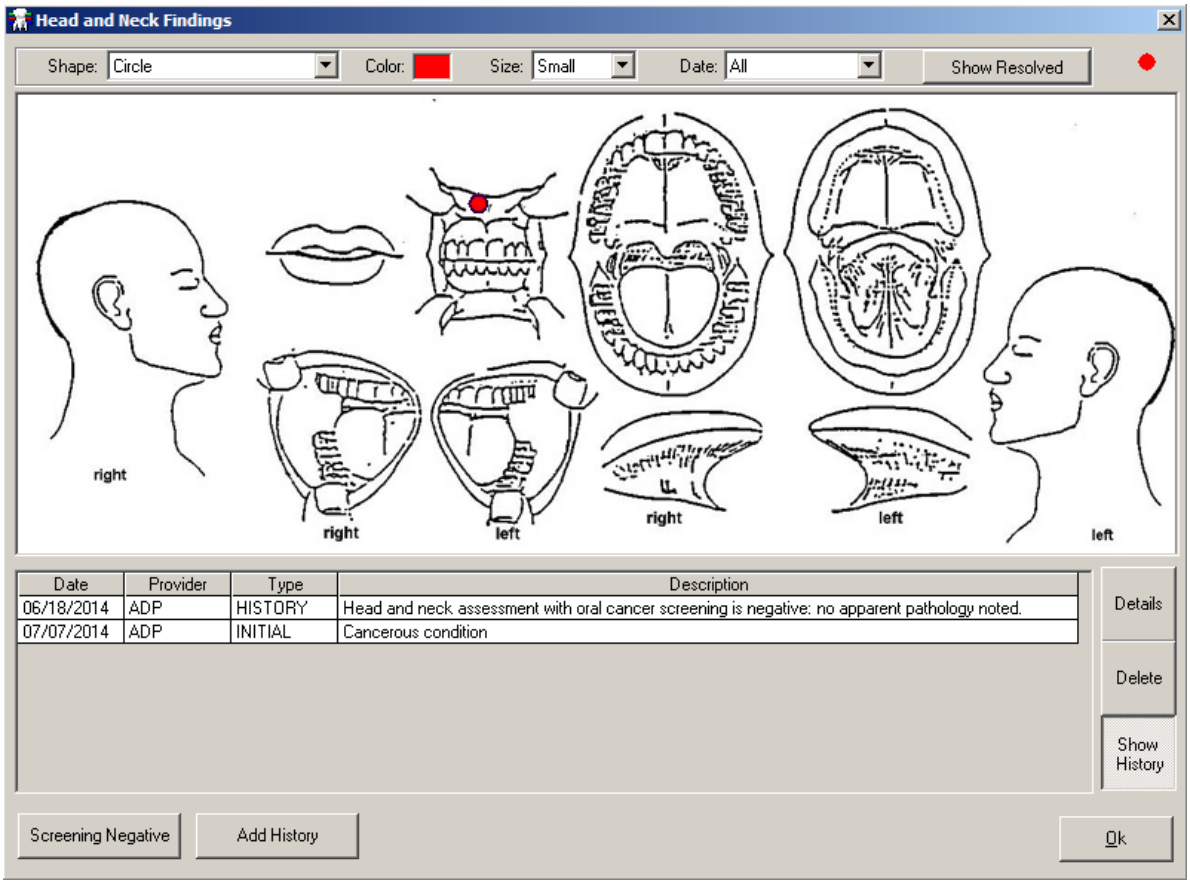


Figure 152: Head and Neck Findings Screen

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.

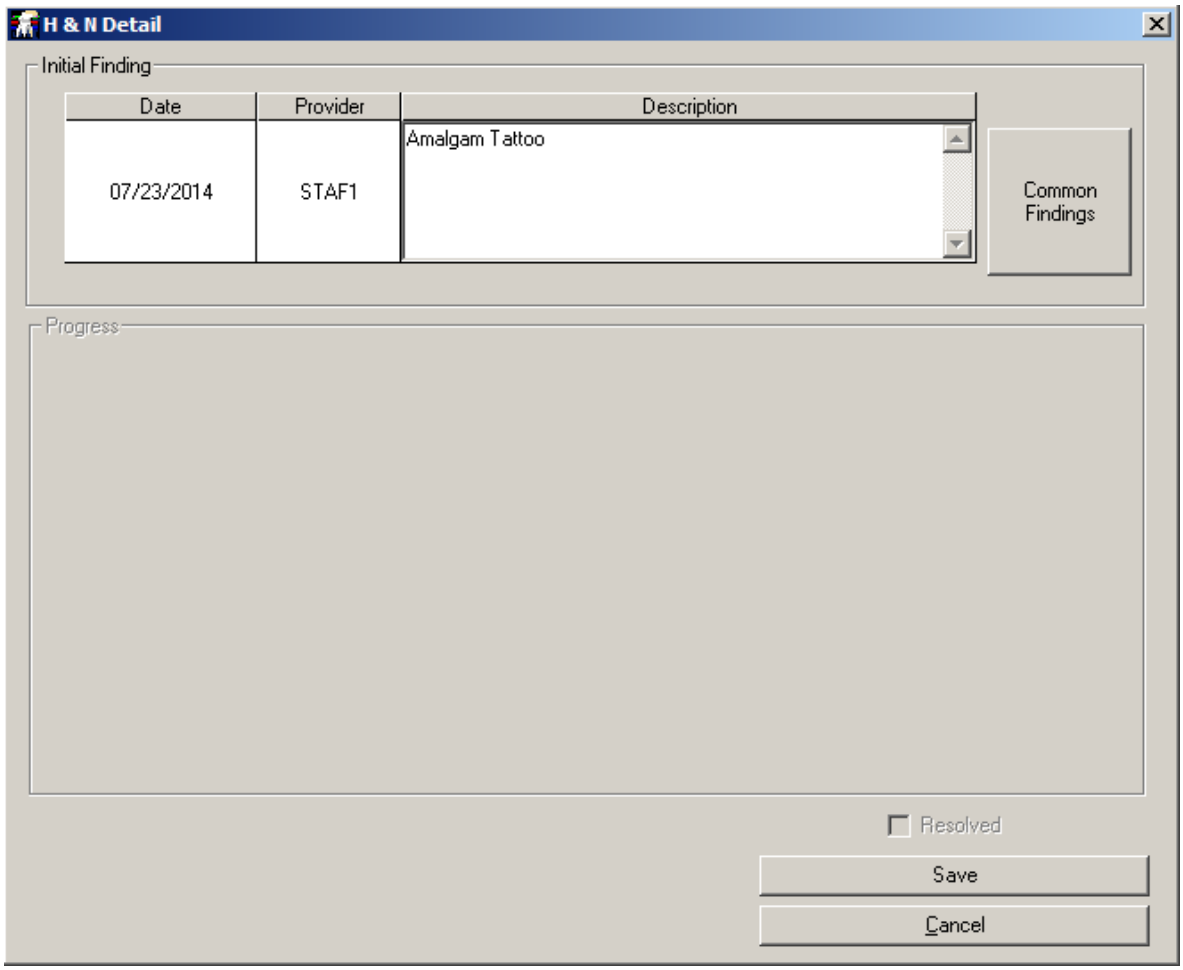


Figure 153: H&N Detail Screen

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.

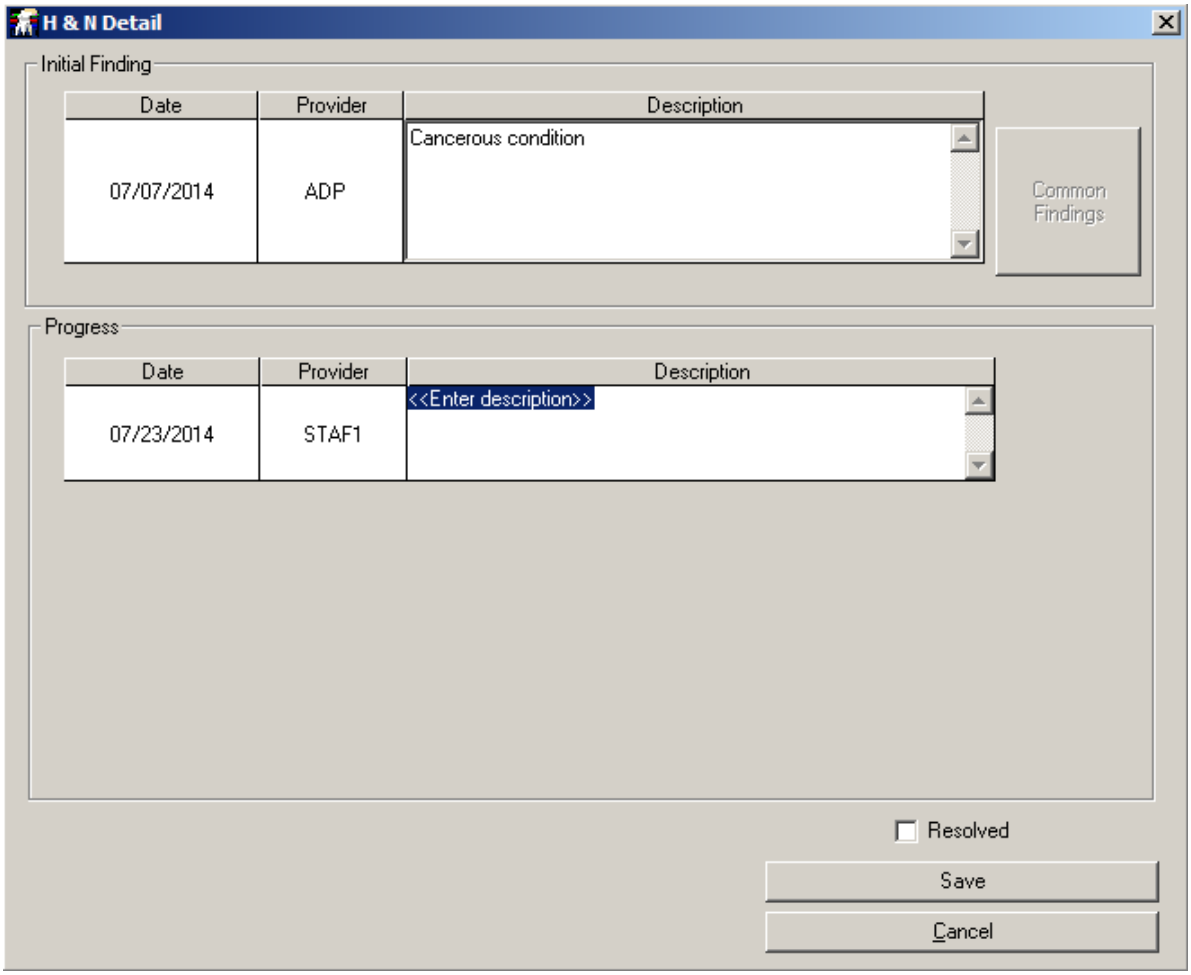


Figure 154: H&N Detail Screen with Progress Description Activated

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.

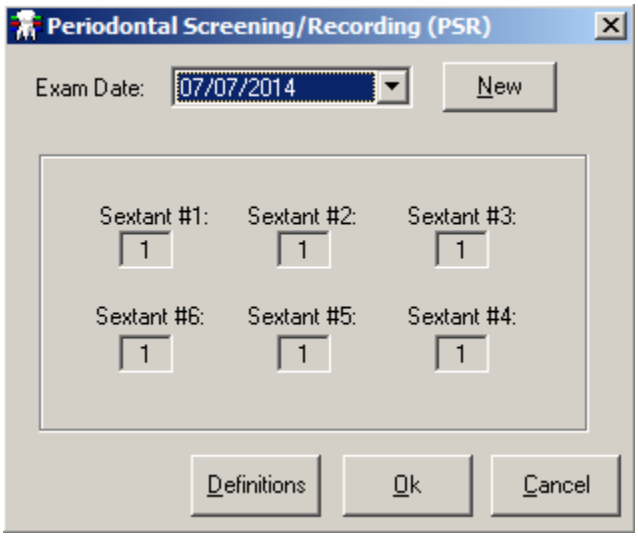


Figure 155: Periodontal Screening/Recording (PSR) Screen

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.

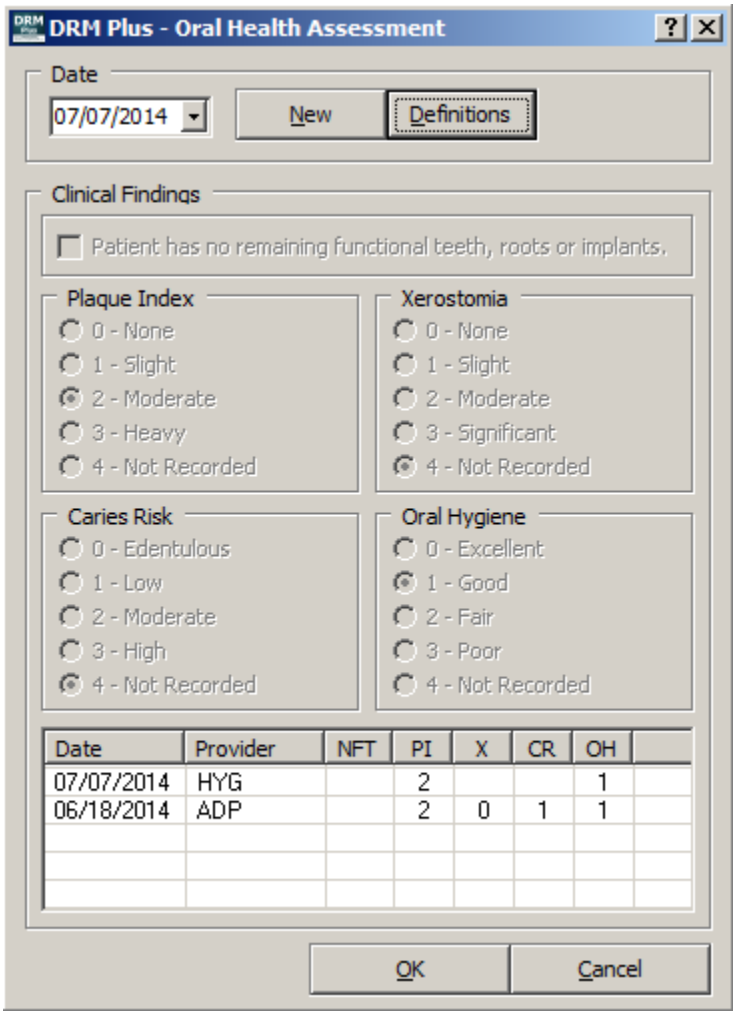


Figure 156: Oral Health Assessment (OHA) Screen

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.

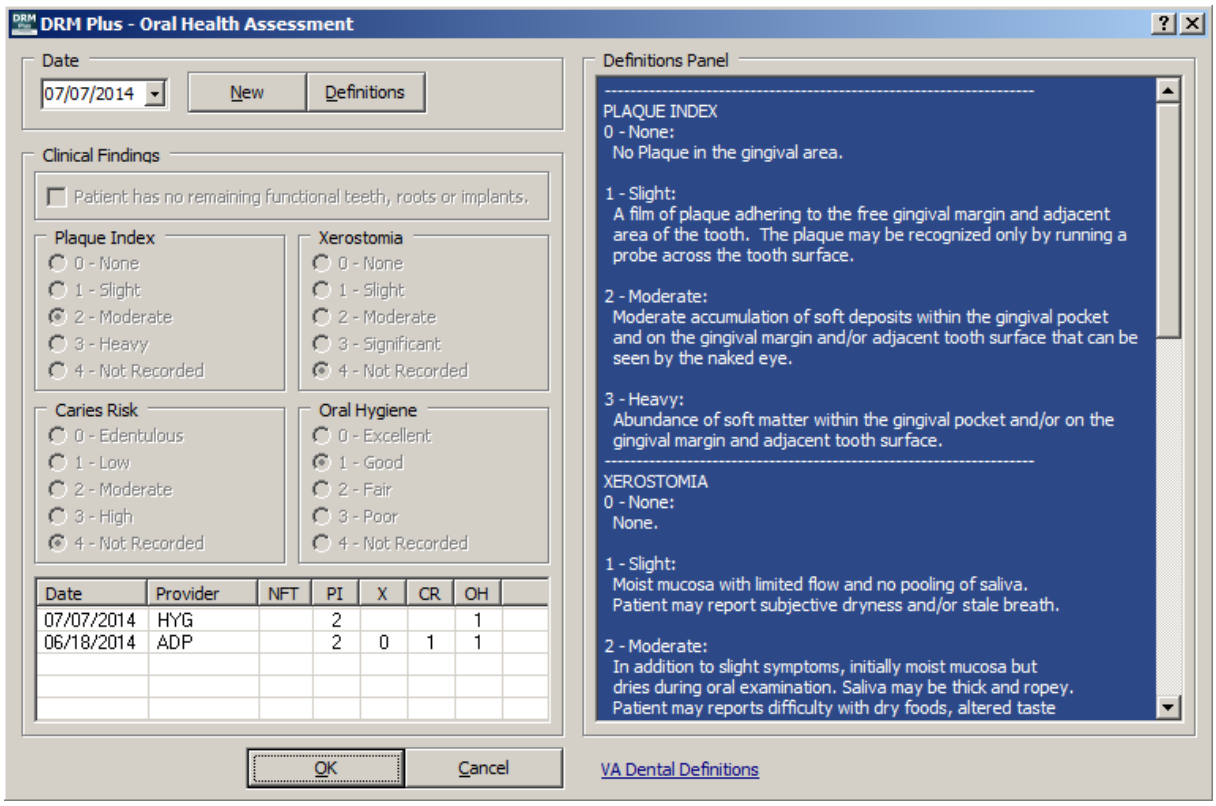


Figure 157: OHA Definitions Displaying Plaque Index/Xerostomia

The Oral Health Assessment (OHA) **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.

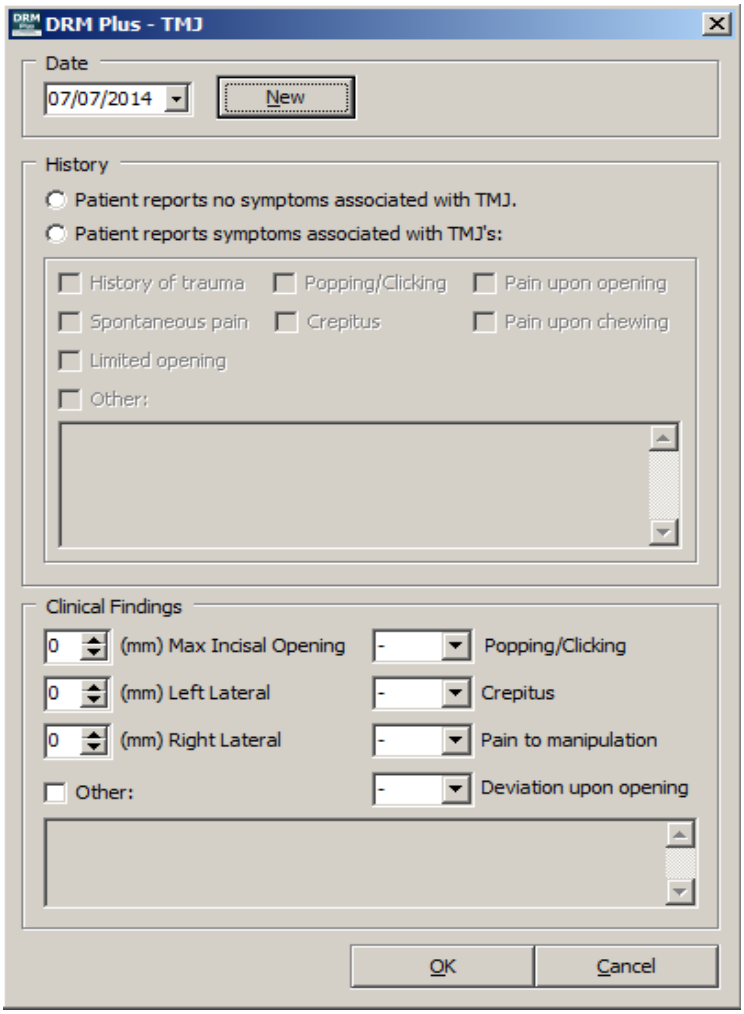


Figure 158: TMJ Screen

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.

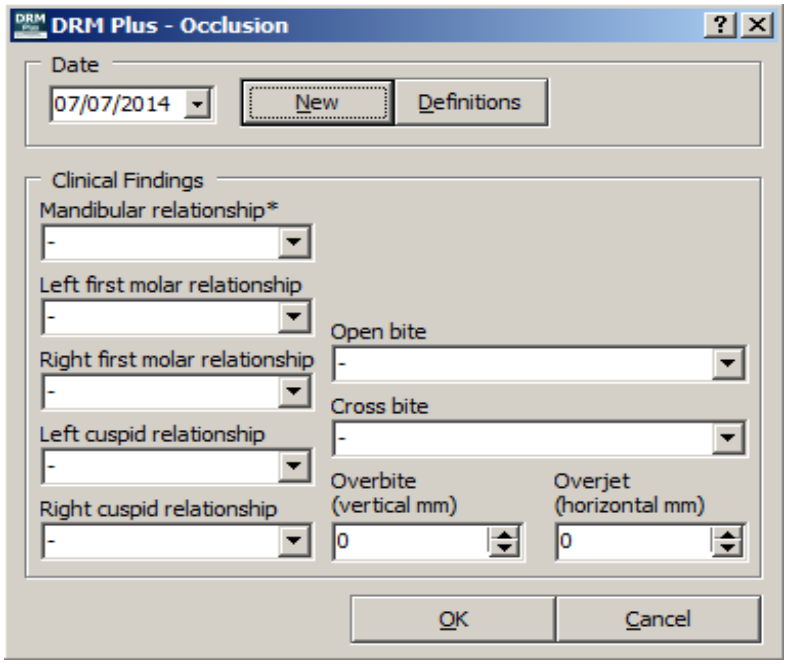


Figure 159: Occlusion Screen

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.

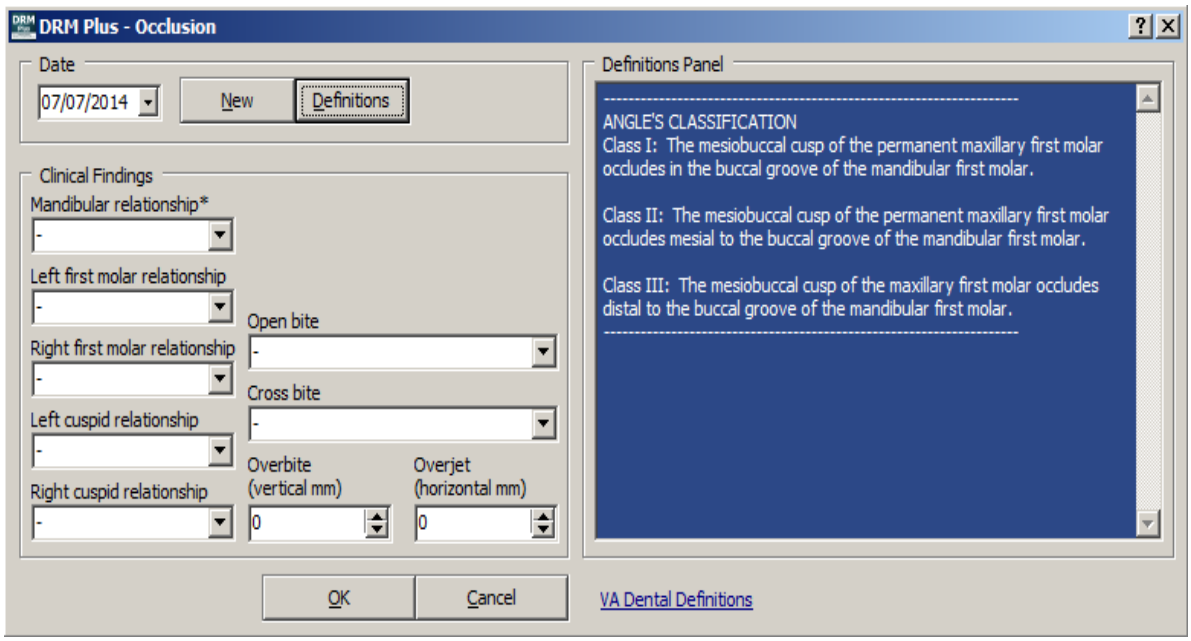


Figure 160: Occlusion Angle's Classification Definitions

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 **Parafunctional Habits** 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.

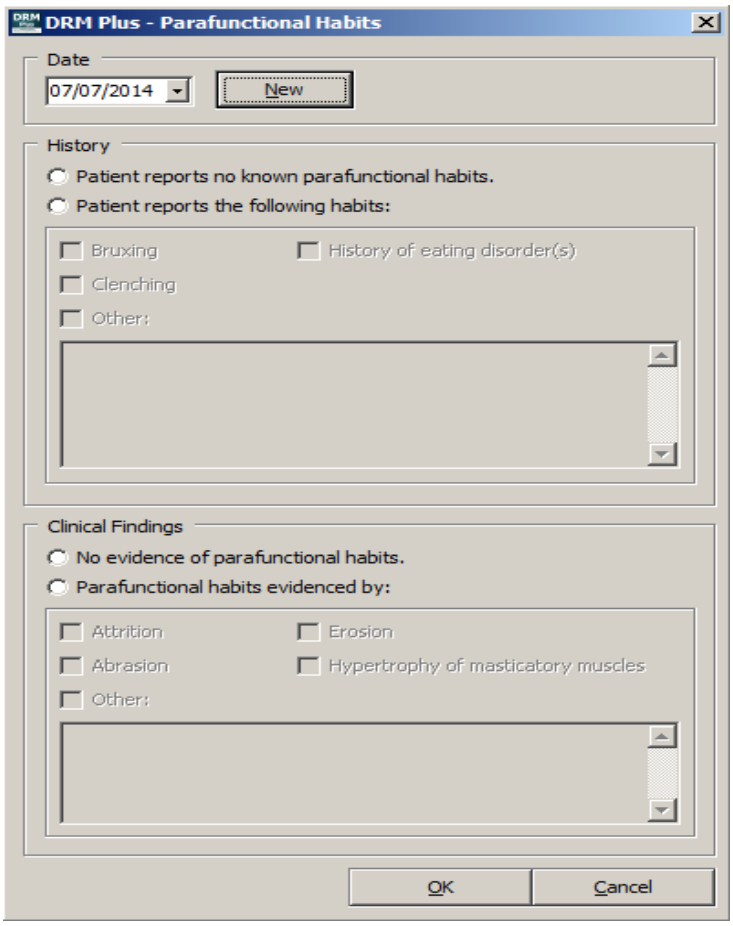


Figure 161: Parafunctional Habits Screen

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.

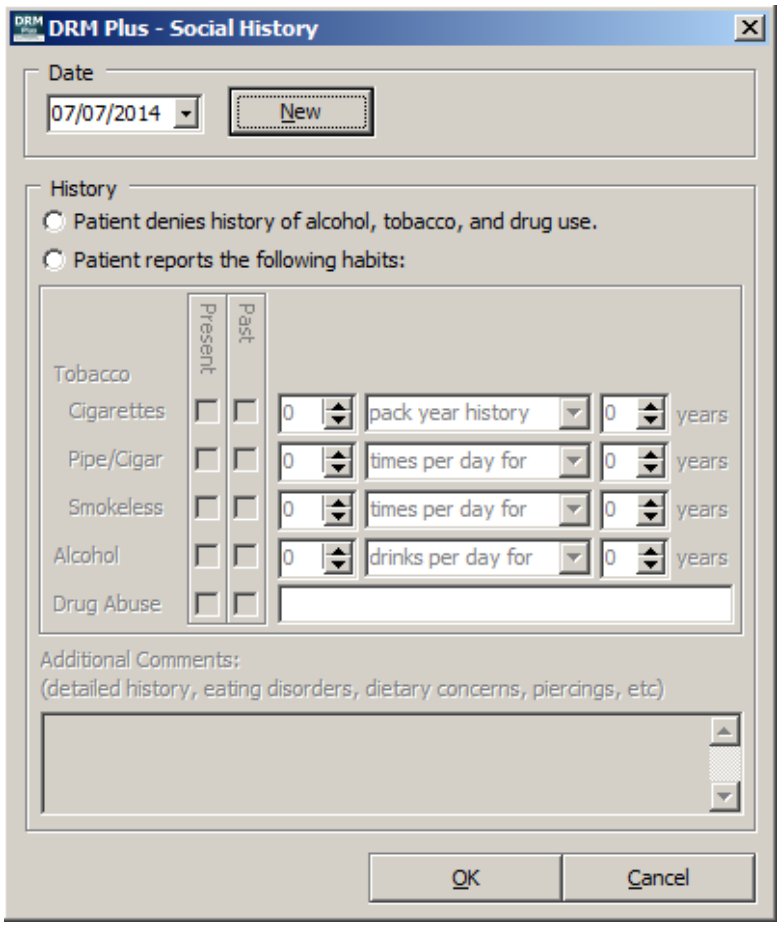


Figure 162: Social Hx (History) Screen

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.

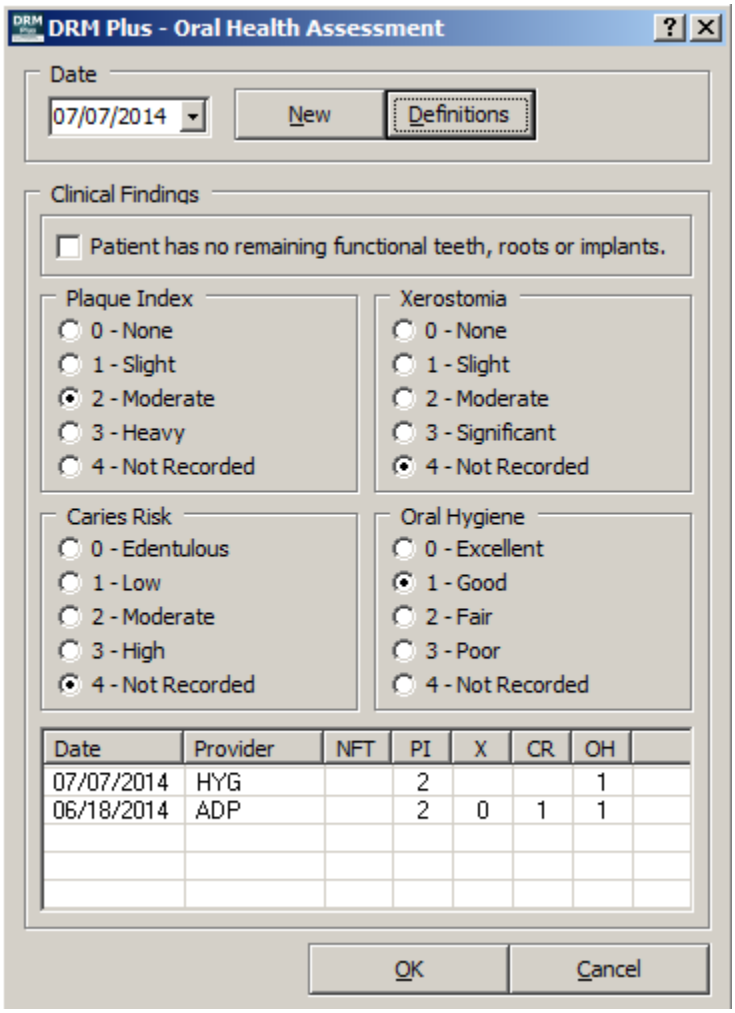


Figure 163: Provider HYG Filed OHA Data First Today

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.

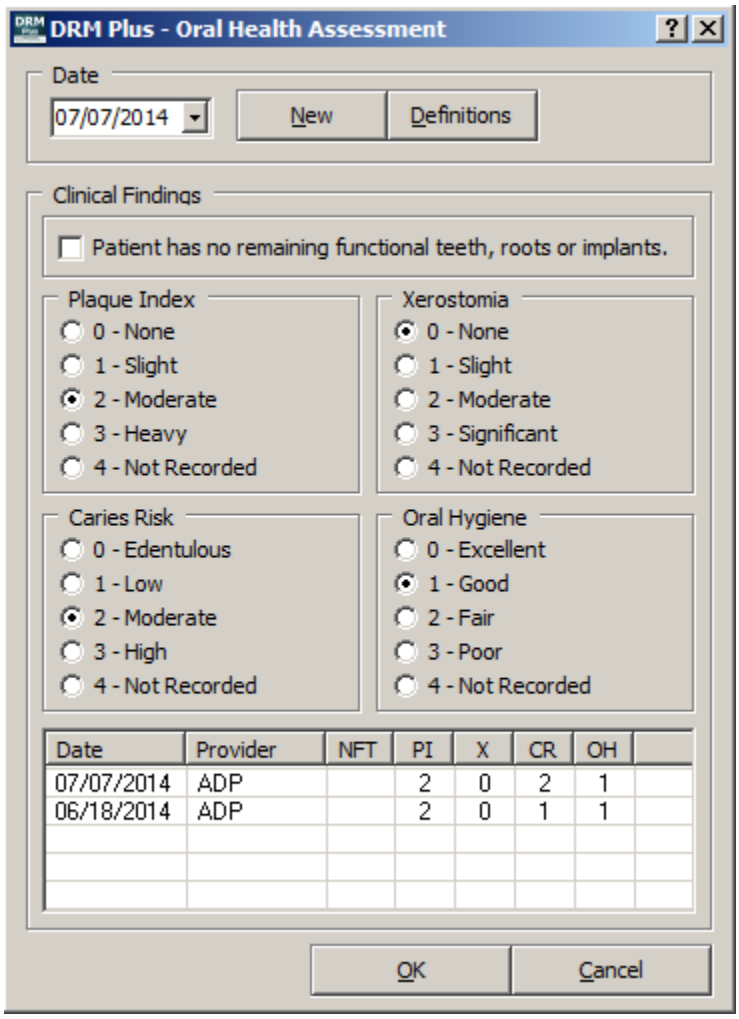


Figure 164: Provider ADP Edited and Filed OHA Data Second Today

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.

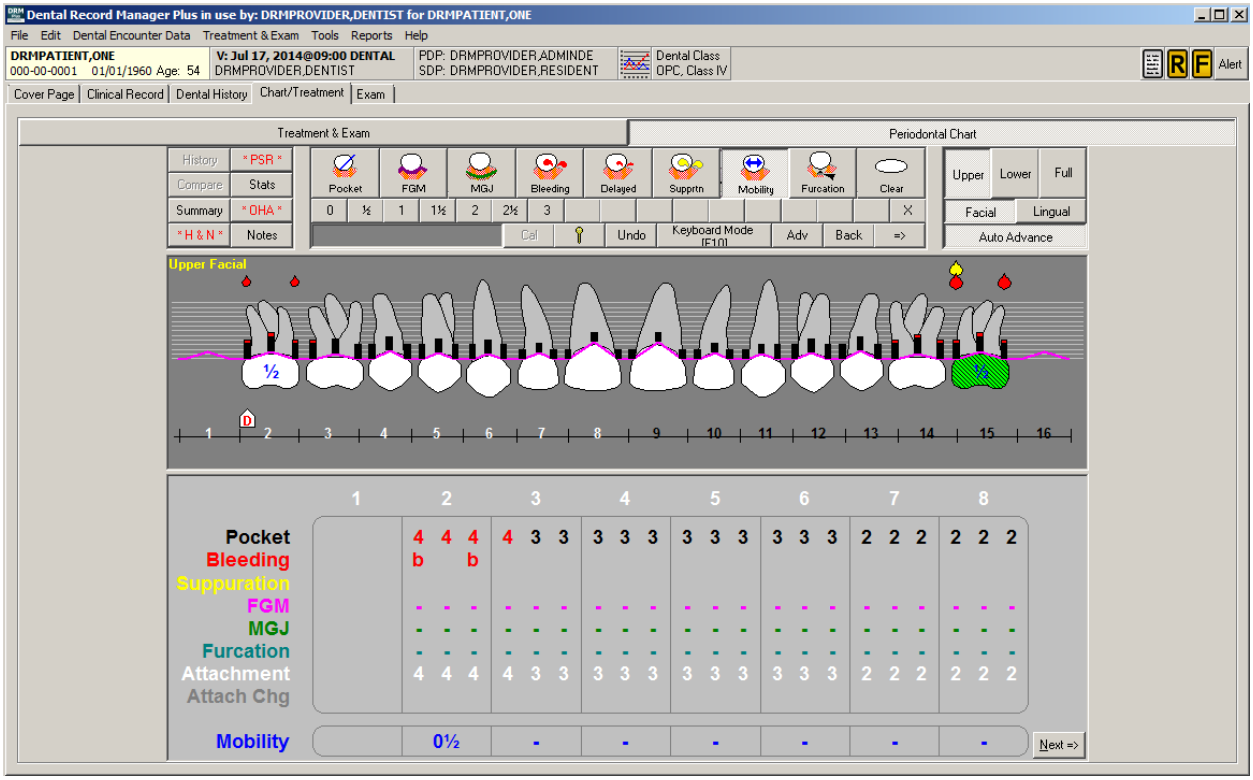


Figure 165: Periodontal Chart Screen

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.

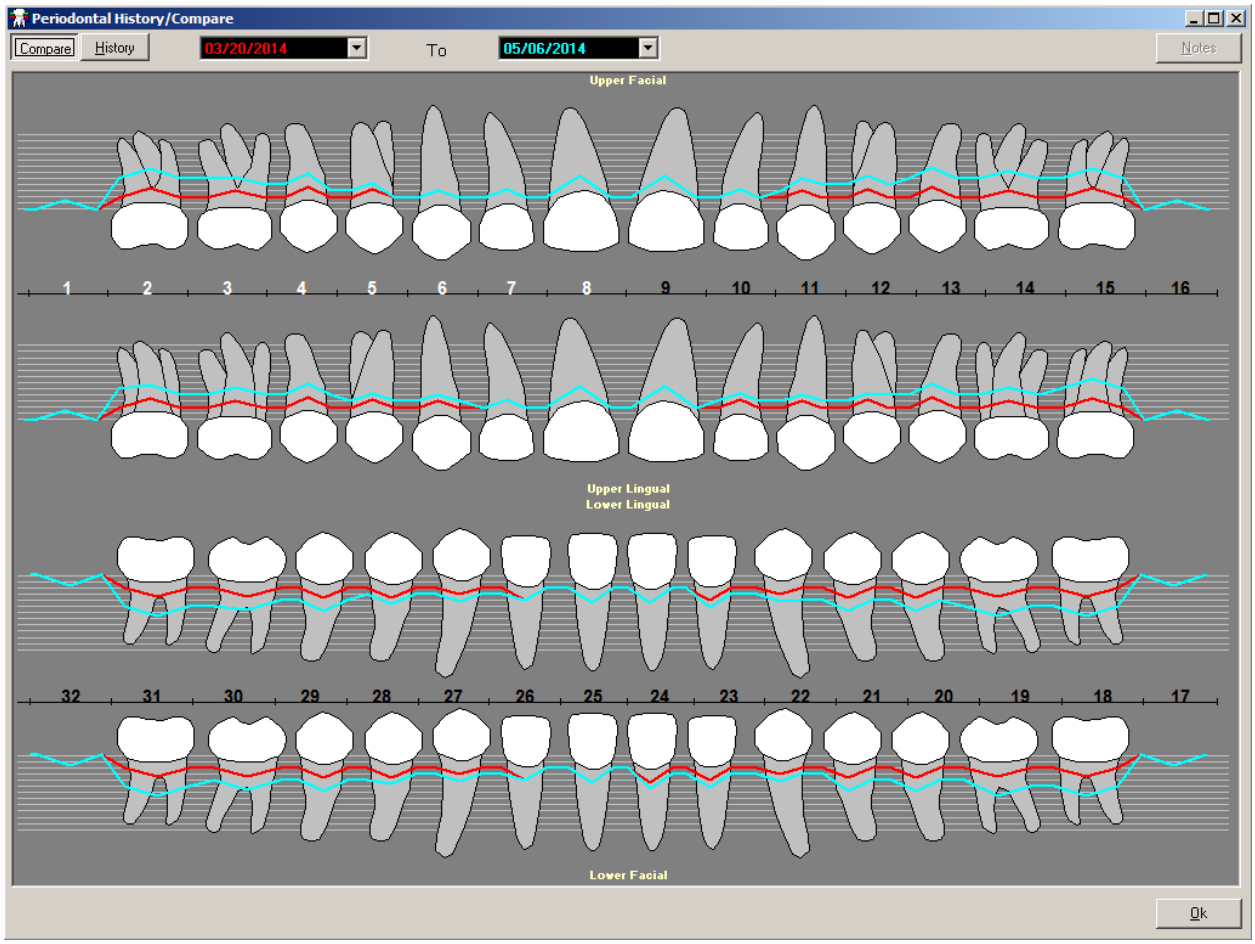


Figure 166: Periodontal History/Compare Screen – Compare Viewable

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.

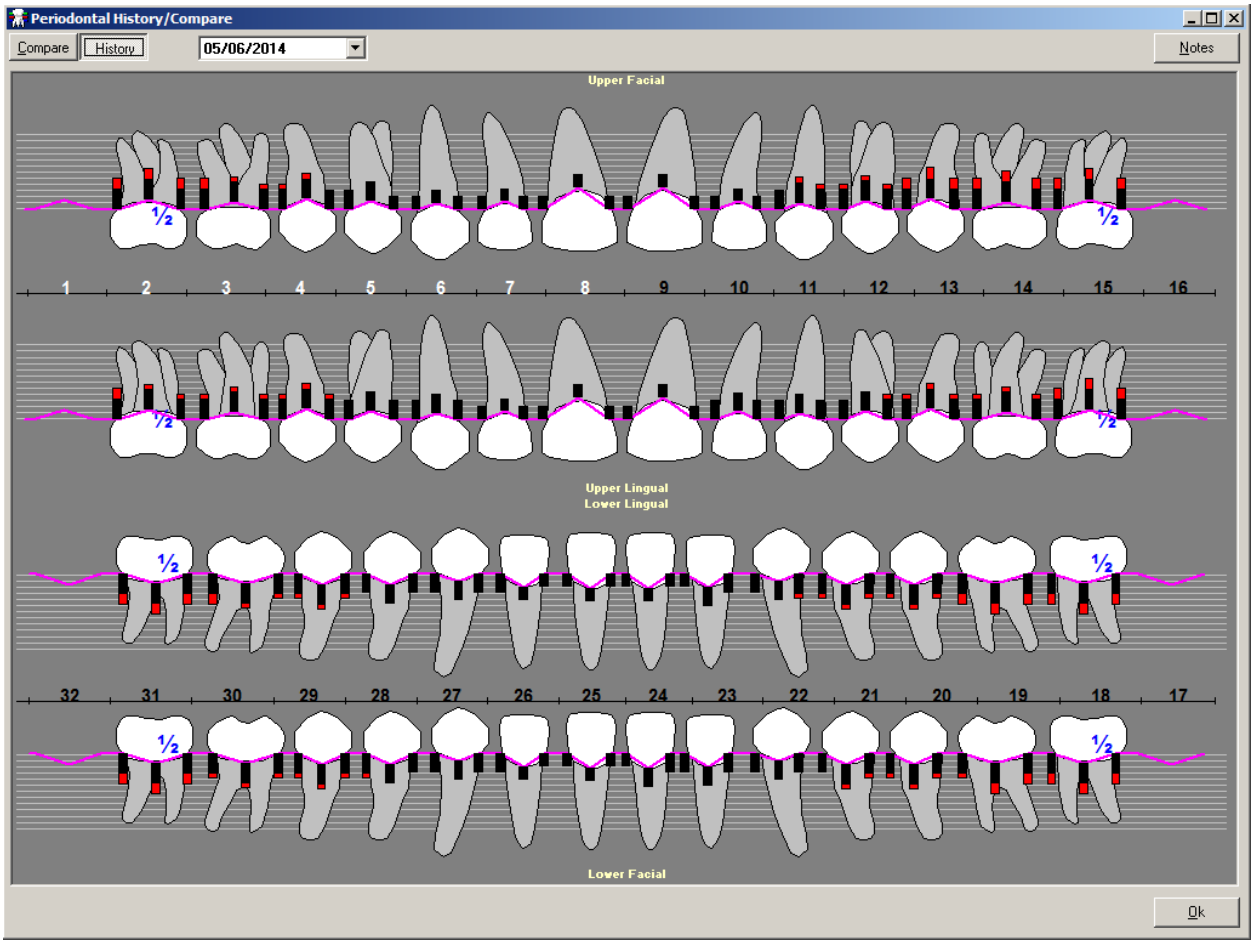


Figure 167: Periodontal History/Compare Screen - History Viewable

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

Select the **Stats** button to view the patient's total number of periodontal warning levels.

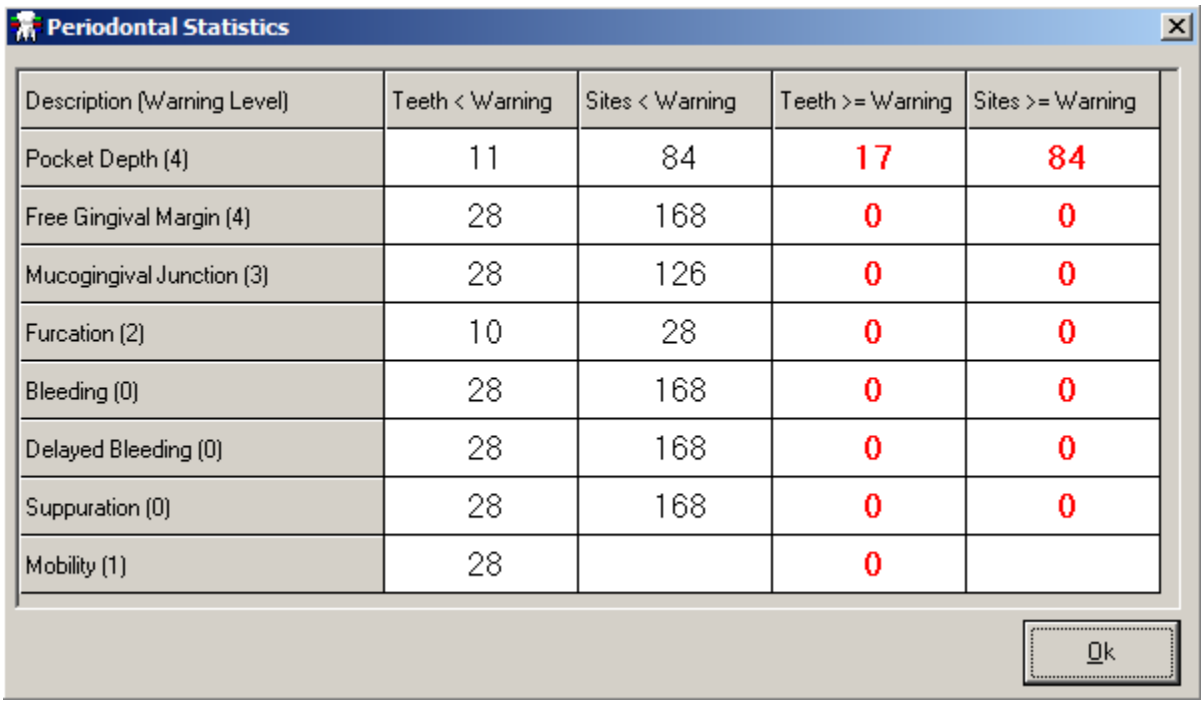


Figure 168: Periodontal Statistics Screen

OHA (Oral Health Assessment) Button

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

Notes Button

Select the **Notes** button

to enter general patient notes or tooth specific notes into the chart.

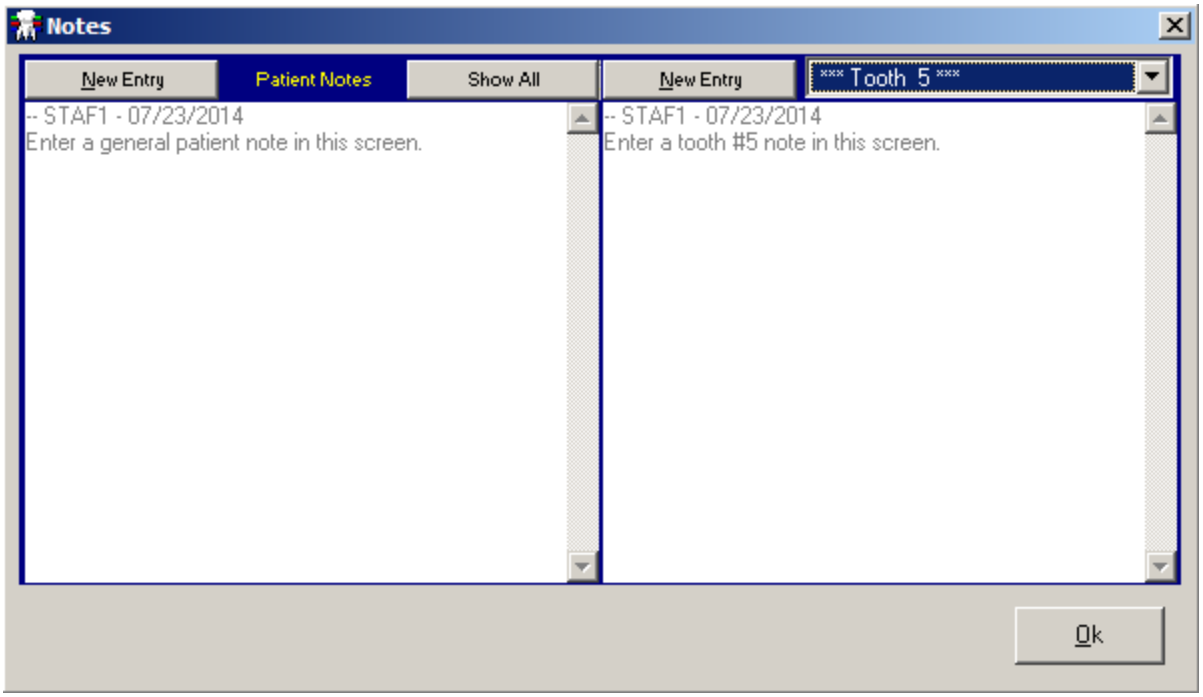


Figure 169: Notes Screen

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.

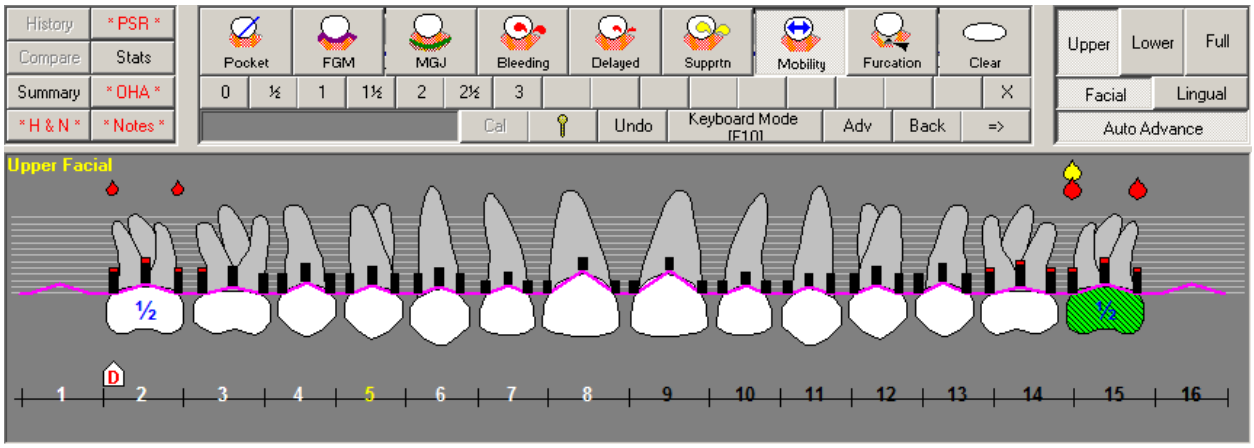


Figure 170: Periodontal Condition-Specific Icons and Periodontal Graphical Chart

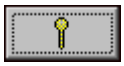
To enter periodontal information:

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

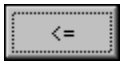
switches the program to keyboard mode.

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.

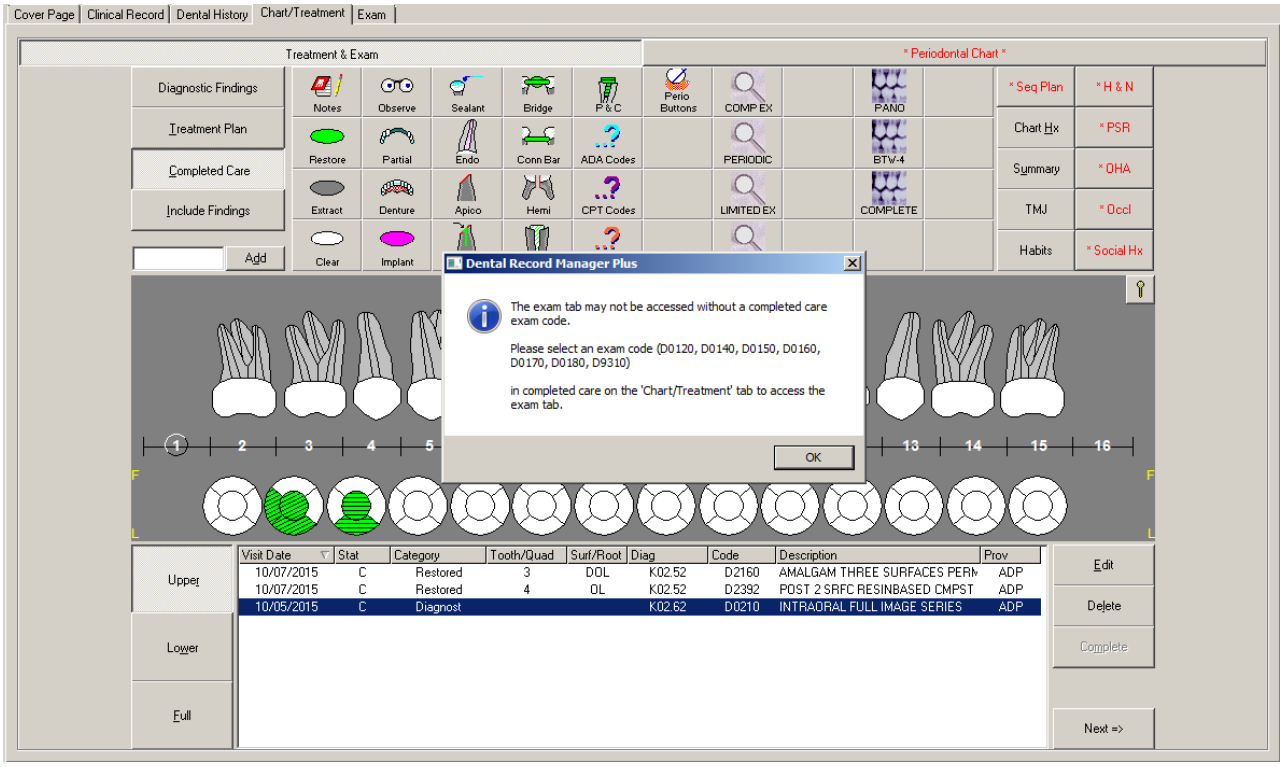


Figure 171: Exam Tab Message

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.

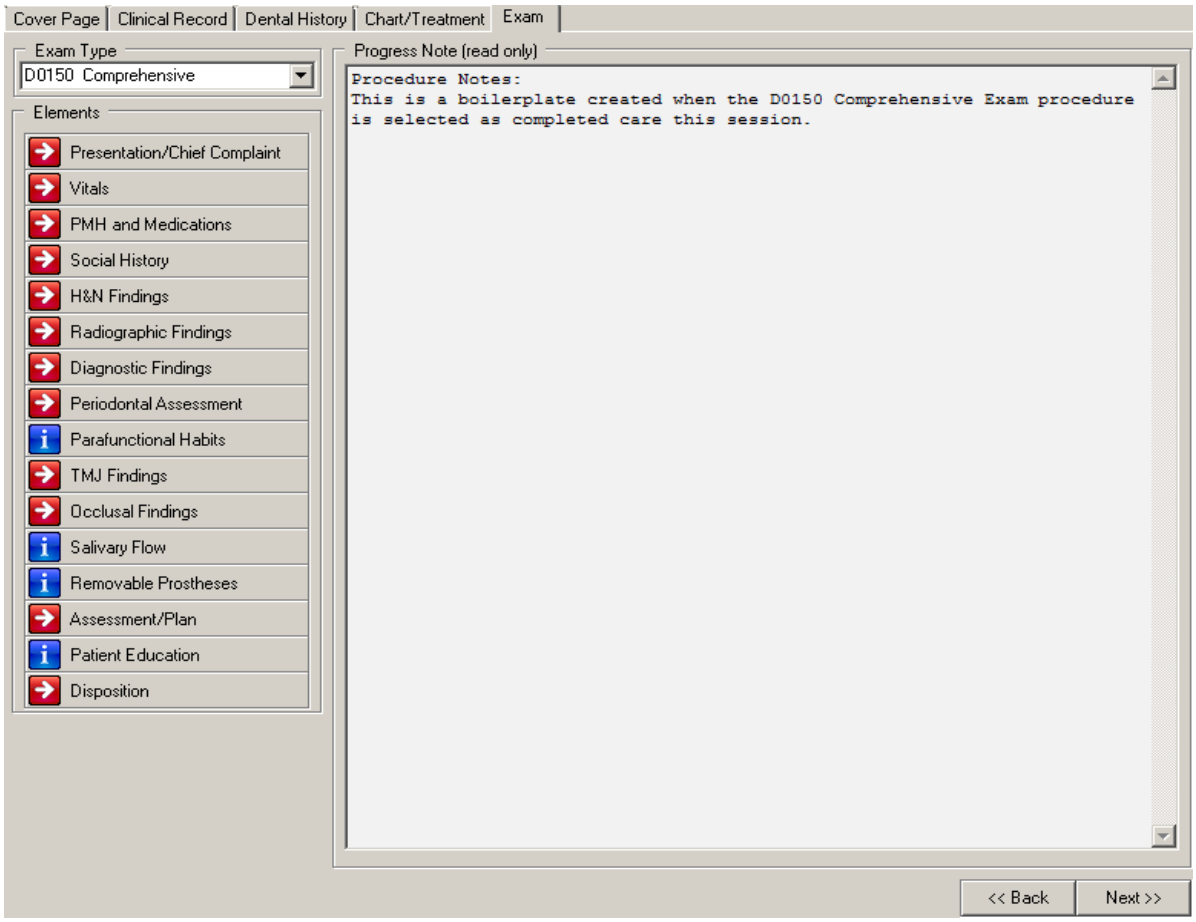


Figure 172: Exam Tab

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.

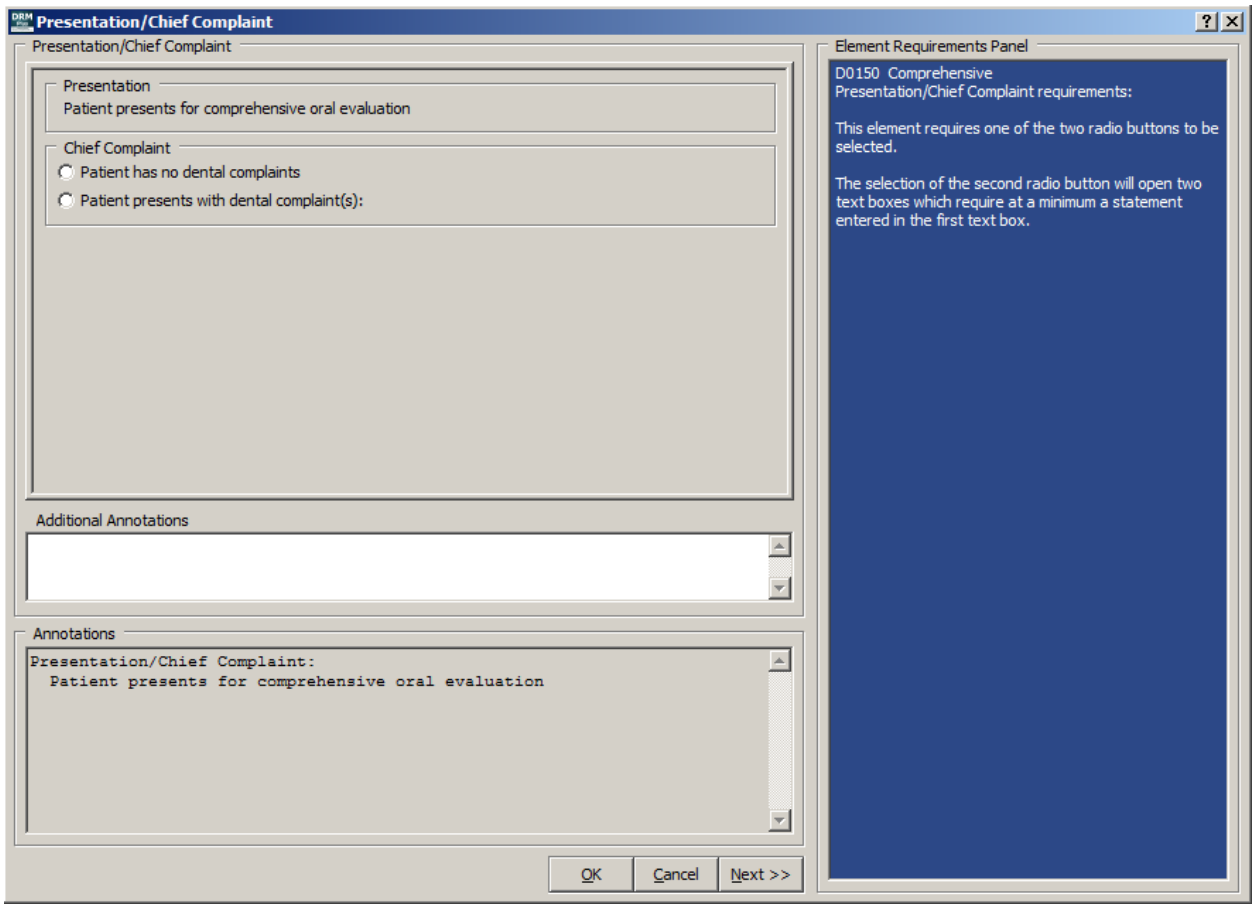


Figure 173: Presentation/Chief Complaint Element Screen

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.

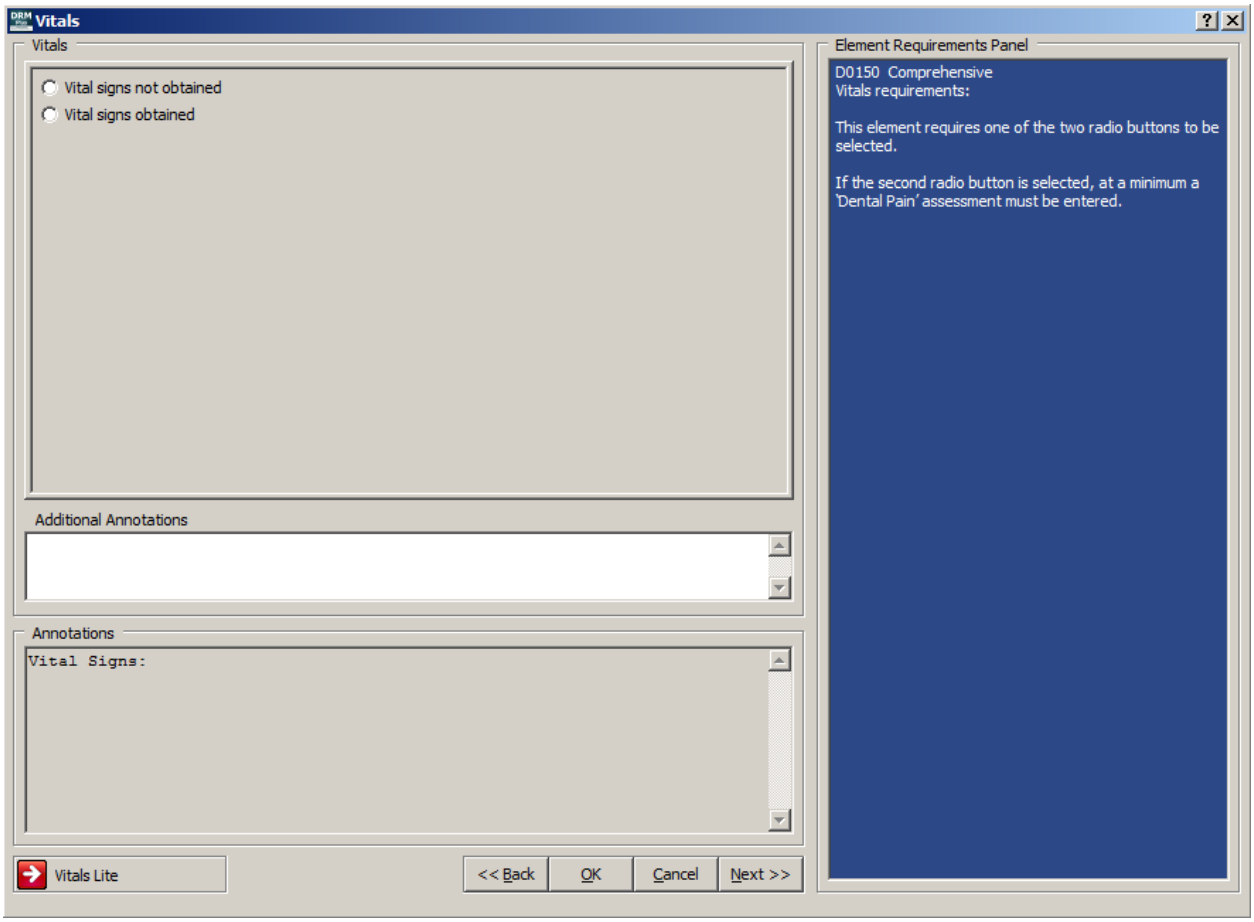


Figure 174: Vitals Element Screen

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.

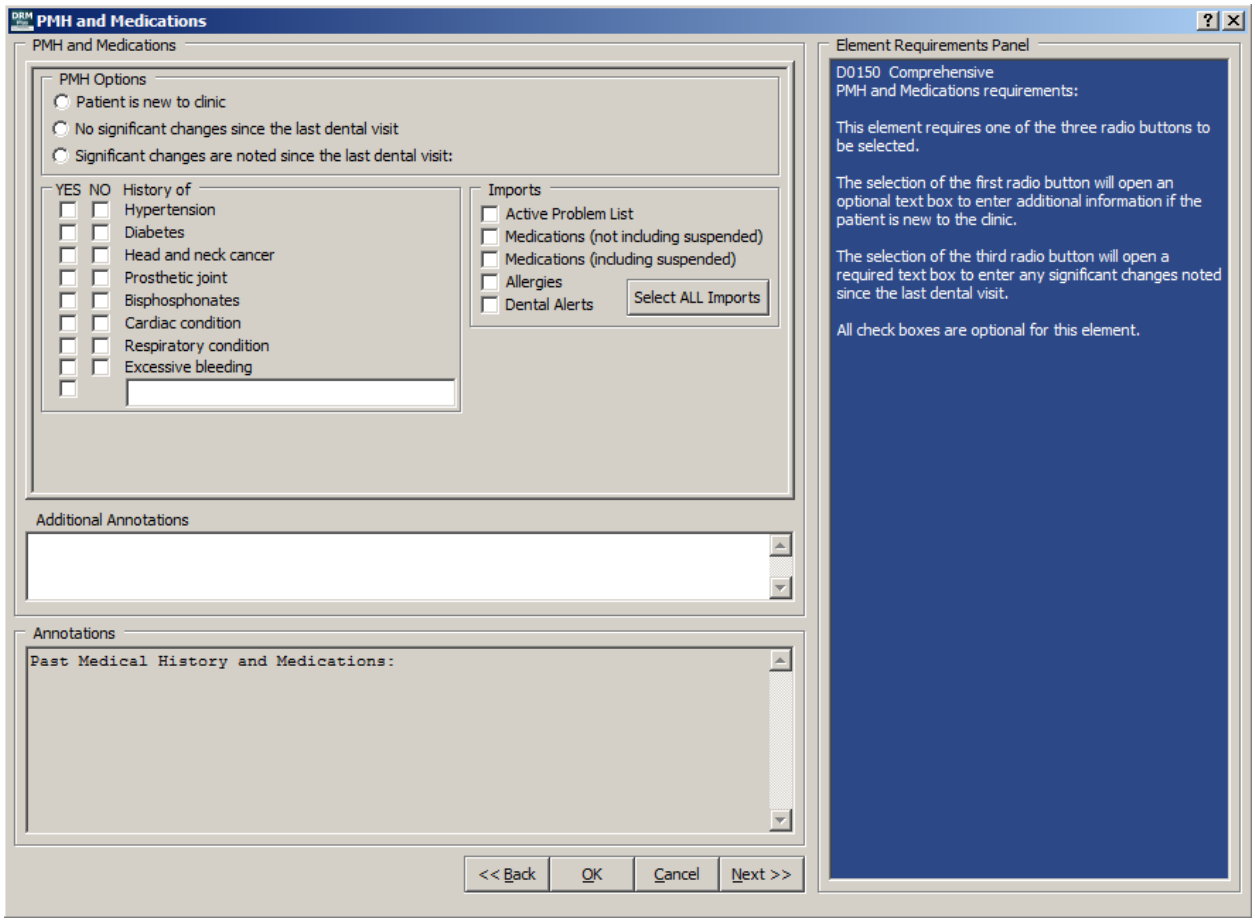


Figure 175: PMH Element Screen

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.

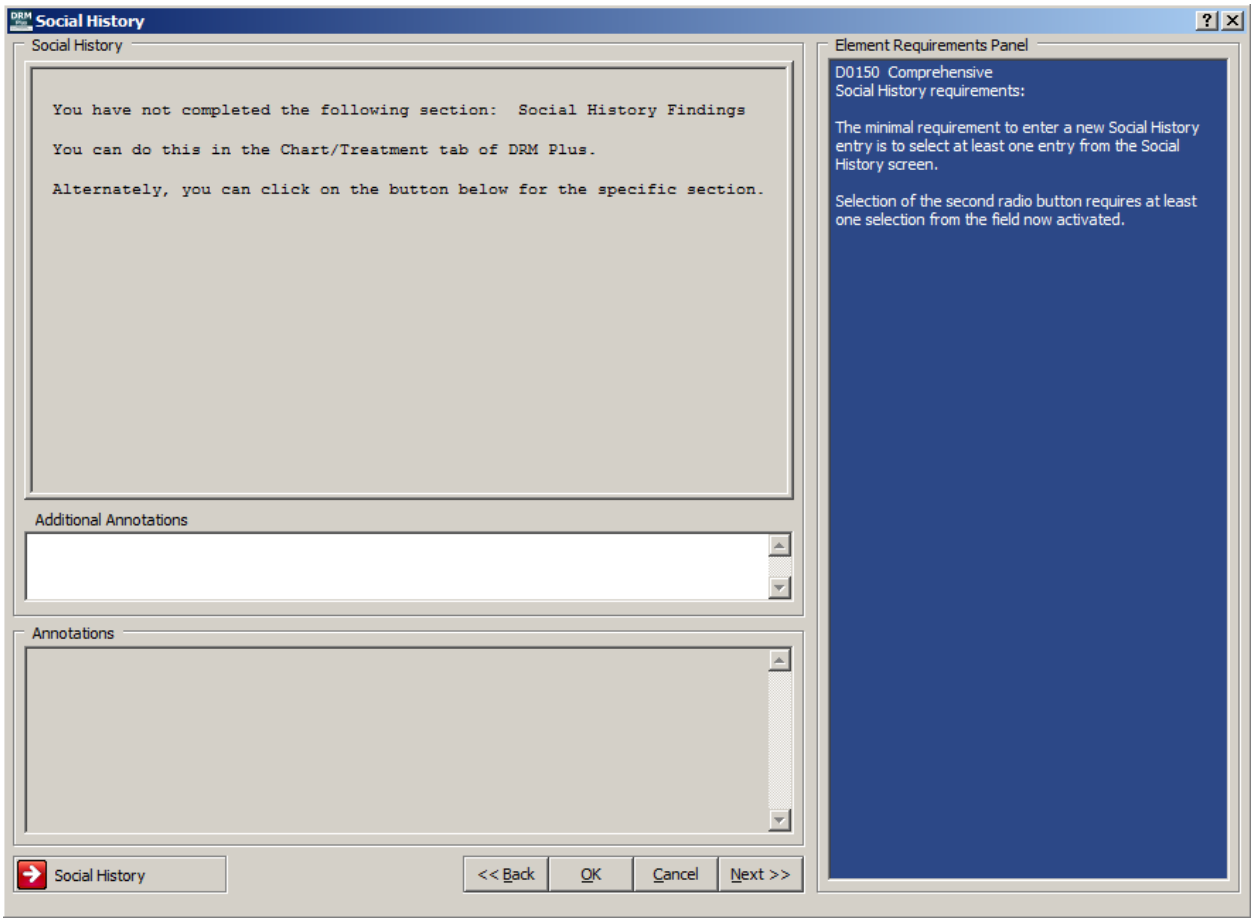


Figure 176: Social History Element Screen

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.

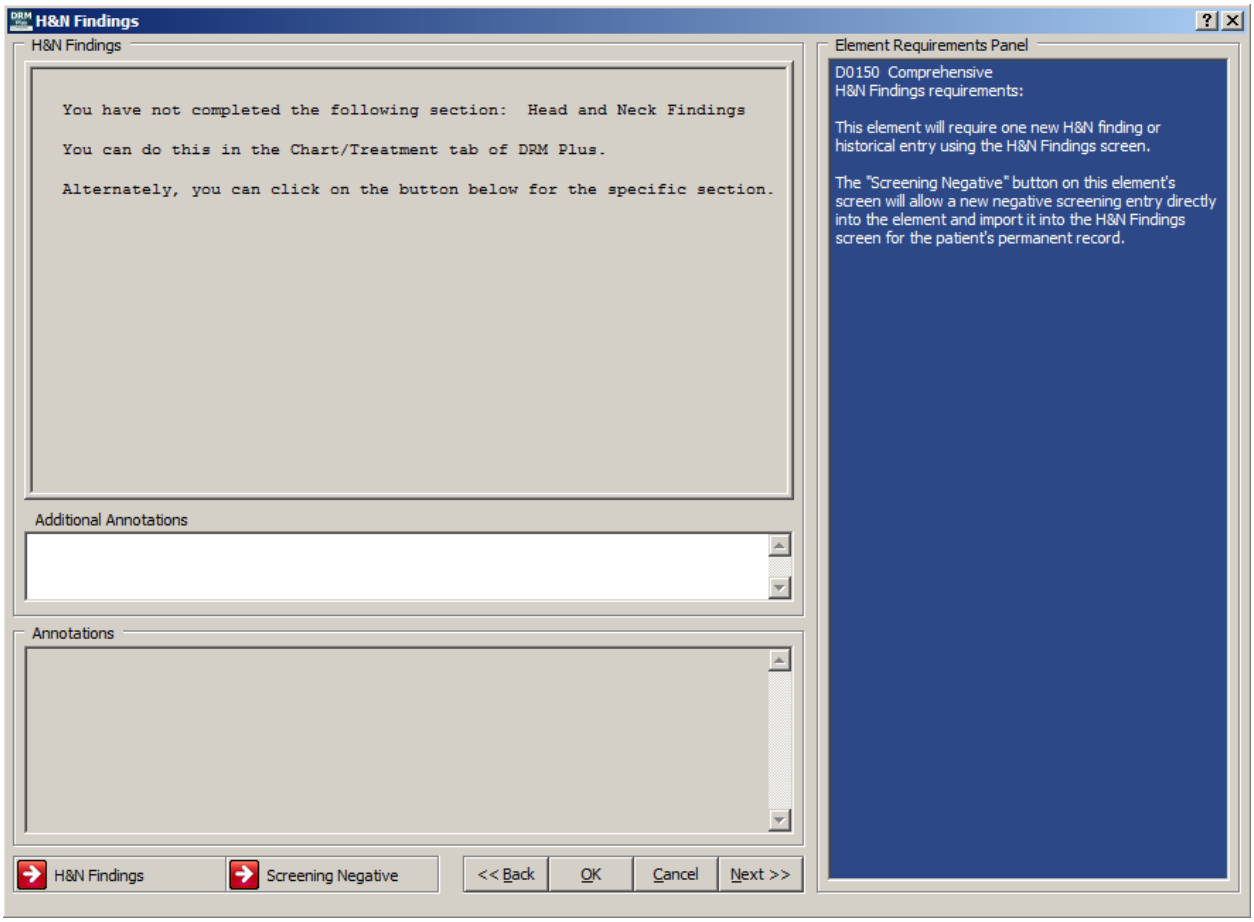


Figure 177: H&N Findings Element Screen

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 per-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.

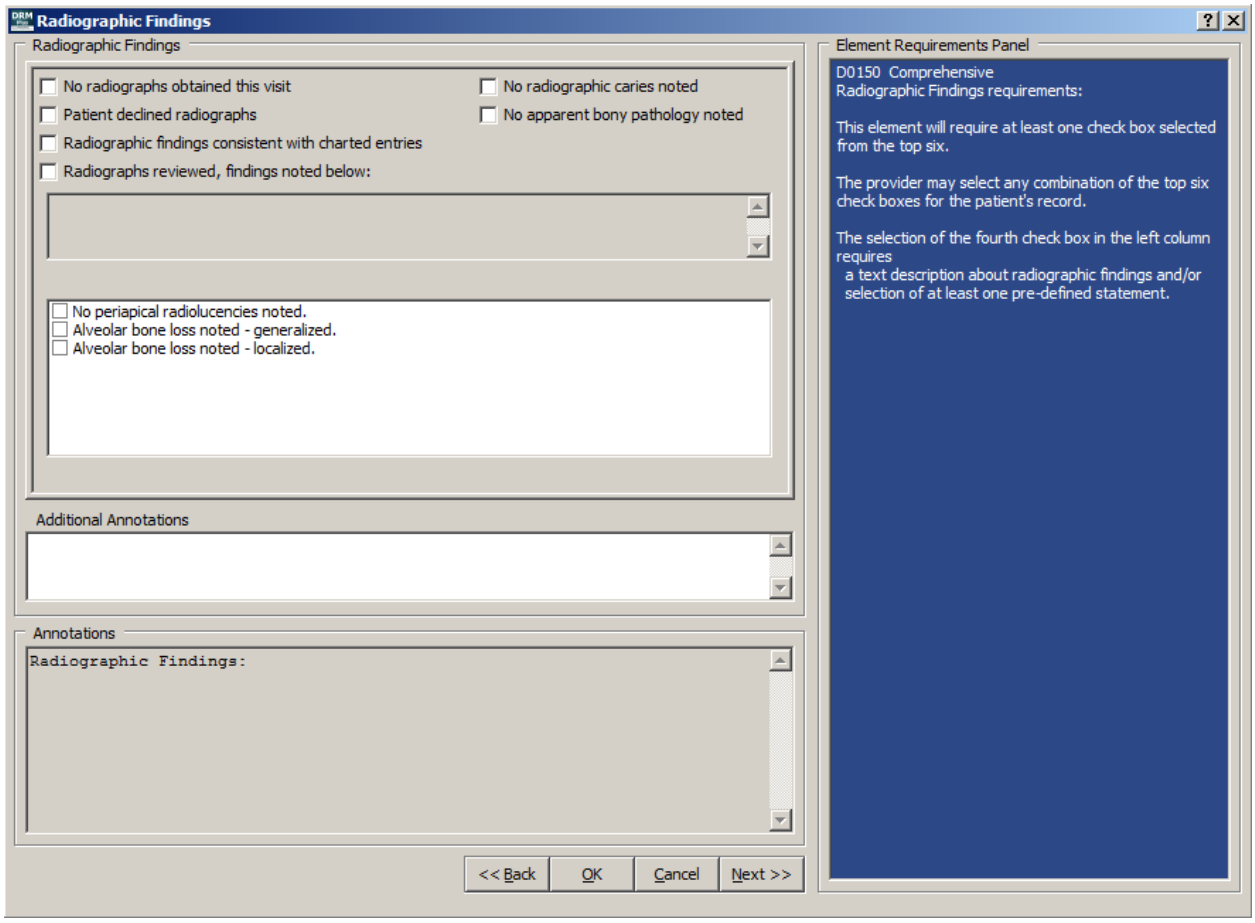


Figure 178: Radiographic Findings Element Screen

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.

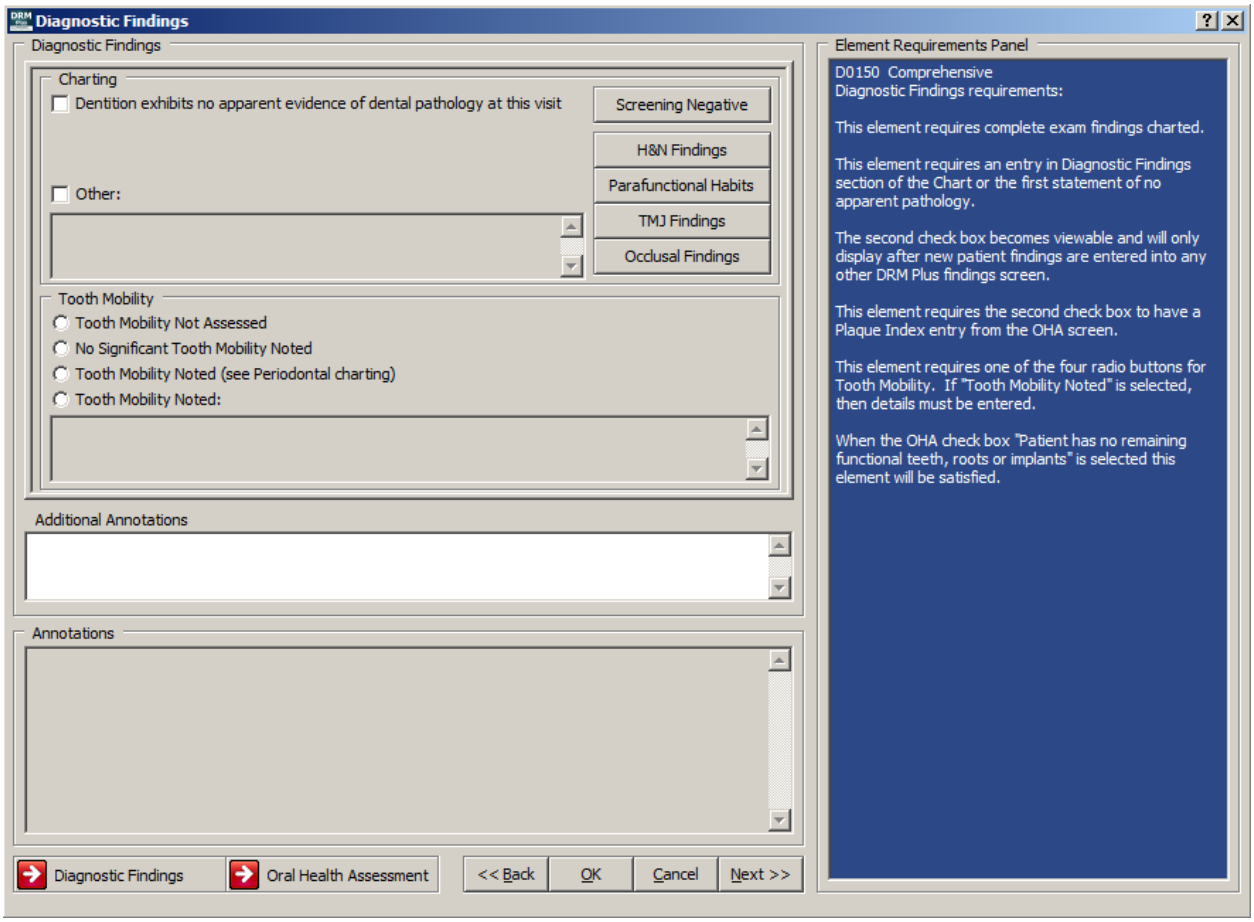


Figure 179: Diagnostic Findings Element Screen

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.

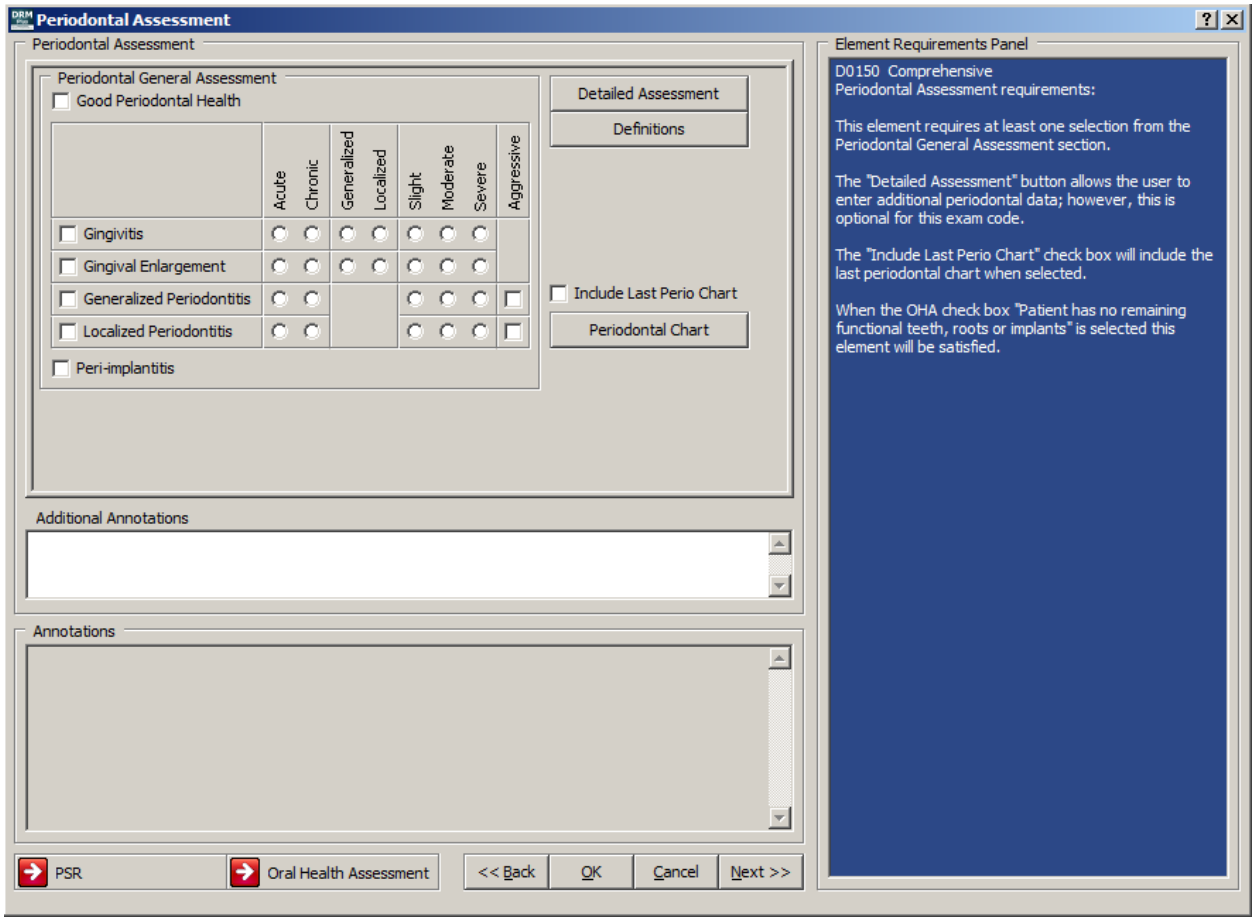


Figure 180: Periodontal Assessment Element Screen

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.

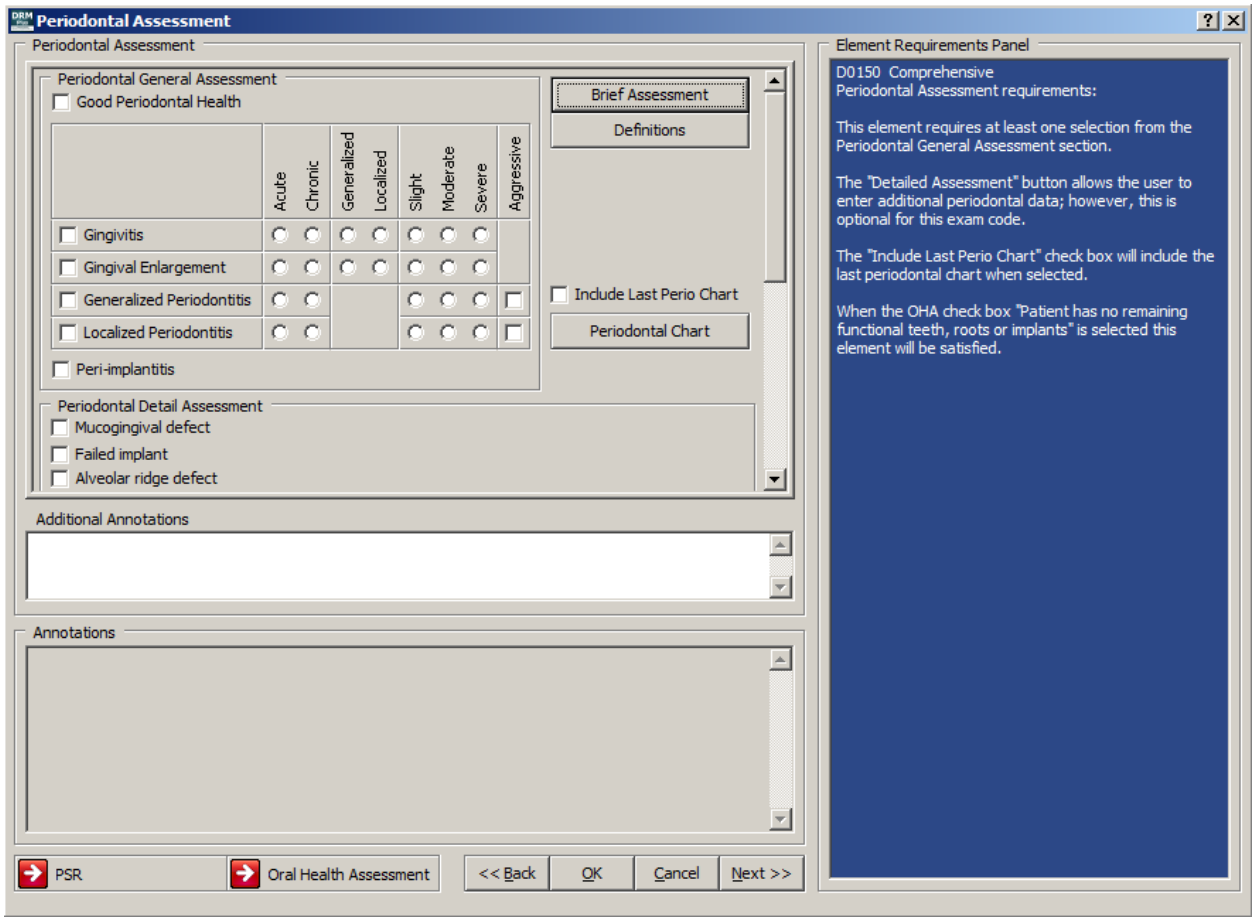


Figure 181: Periodontal Detailed Assessment Button Selected

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.

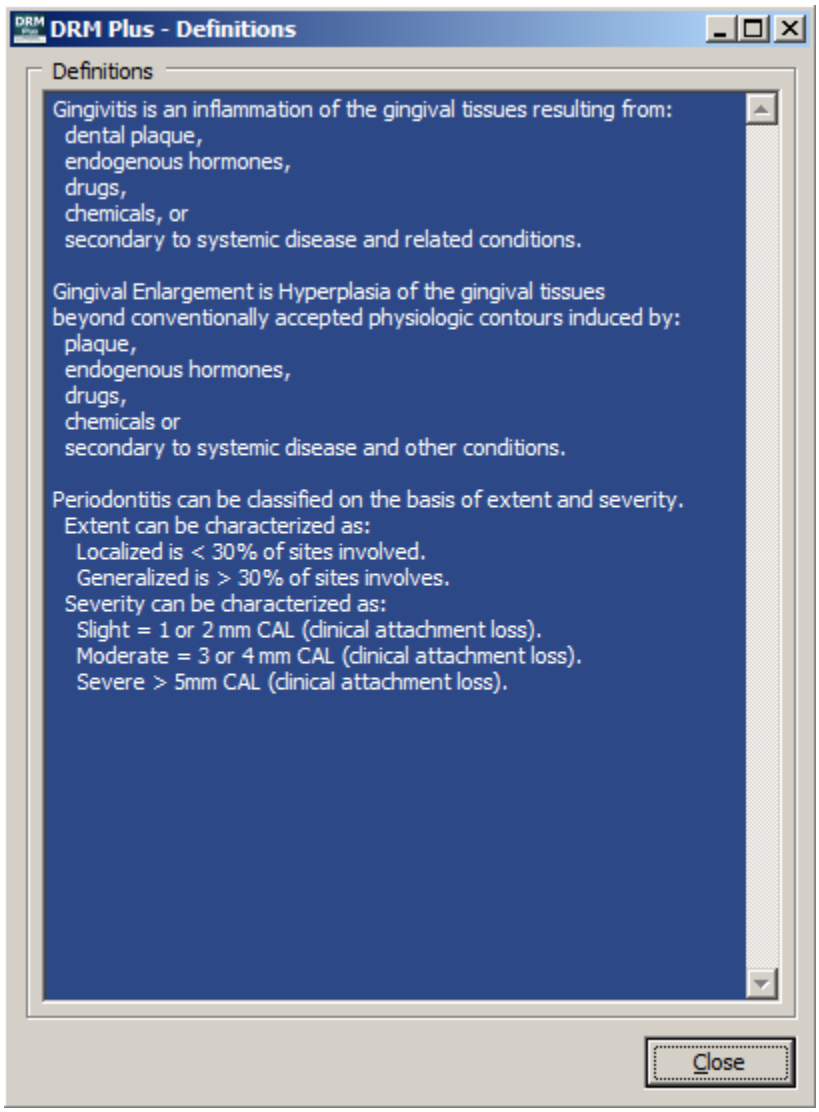


Figure 182: VA Dentistry Periodontal Definitions

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.

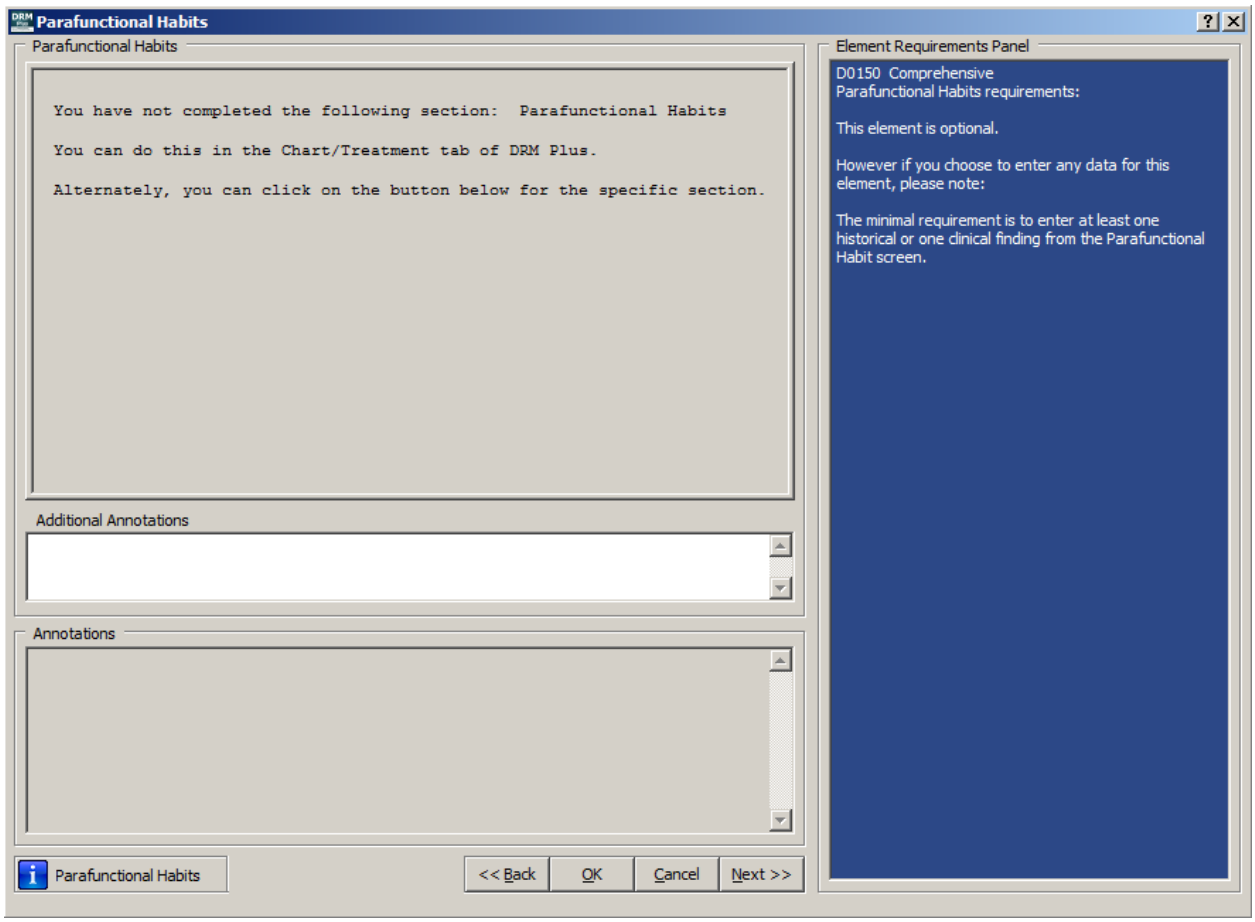


Figure 183: Parafunctional Habits Element Screen

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.

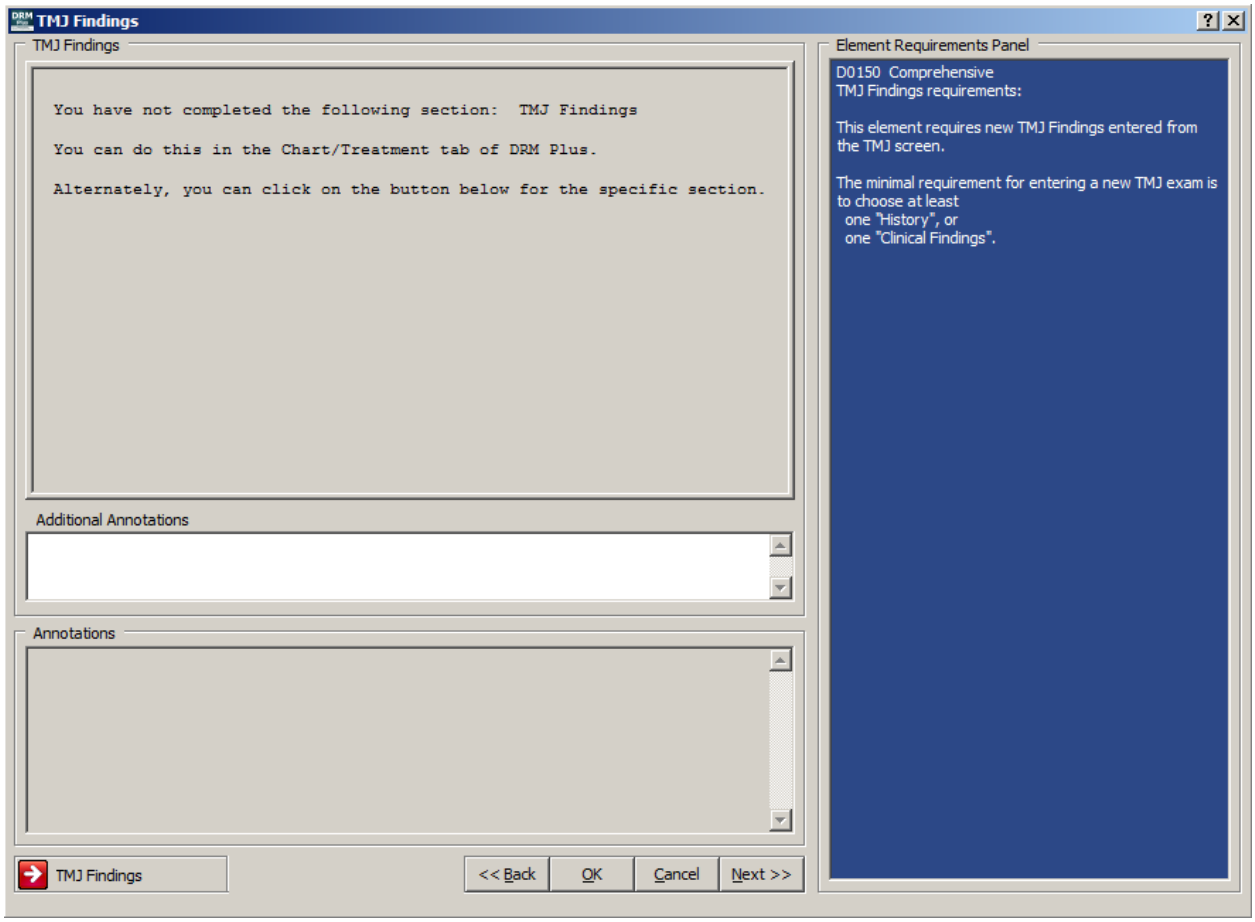


Figure 184: TMJ Findings Element Screen

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.

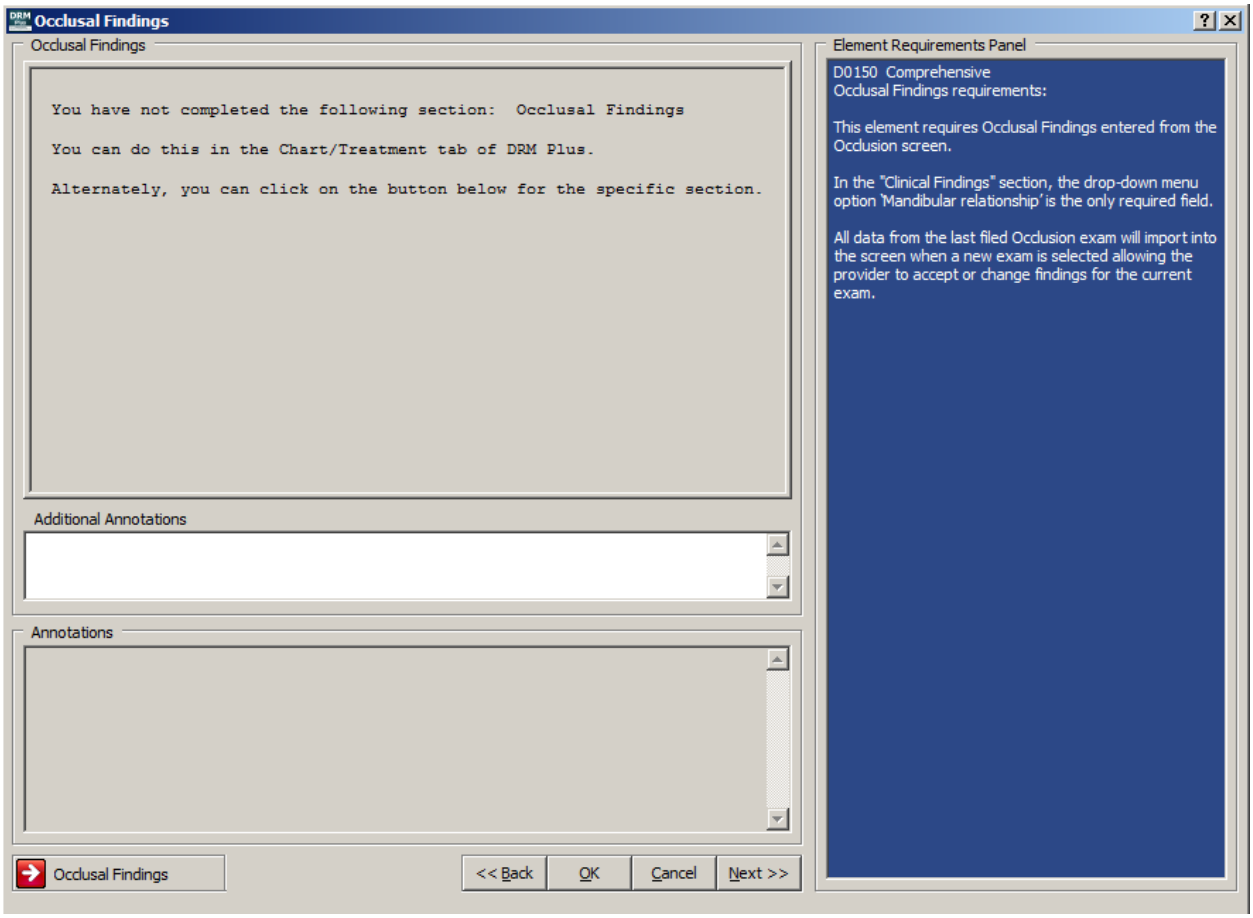


Figure 185: Occlusal Findings Element Screen

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.

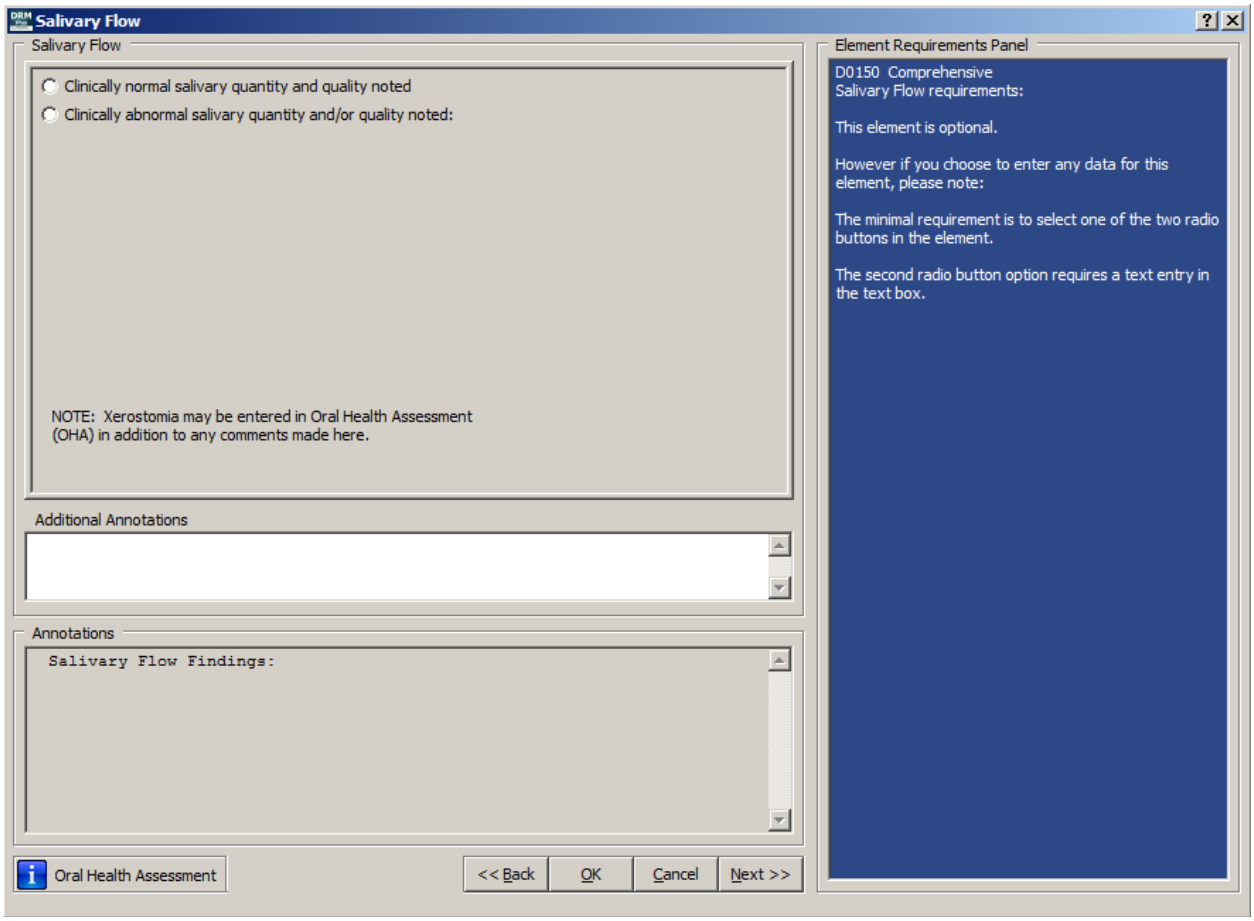


Figure 186: Salivary Flow Element Screen

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 Prostheses Element

The **Removable Prostheses** 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 prosthes(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 prostheses in the text box.

The **Other Prostheses** check box opens a required text box for any other prostheses that should be added to the TIU progress note for the patient.

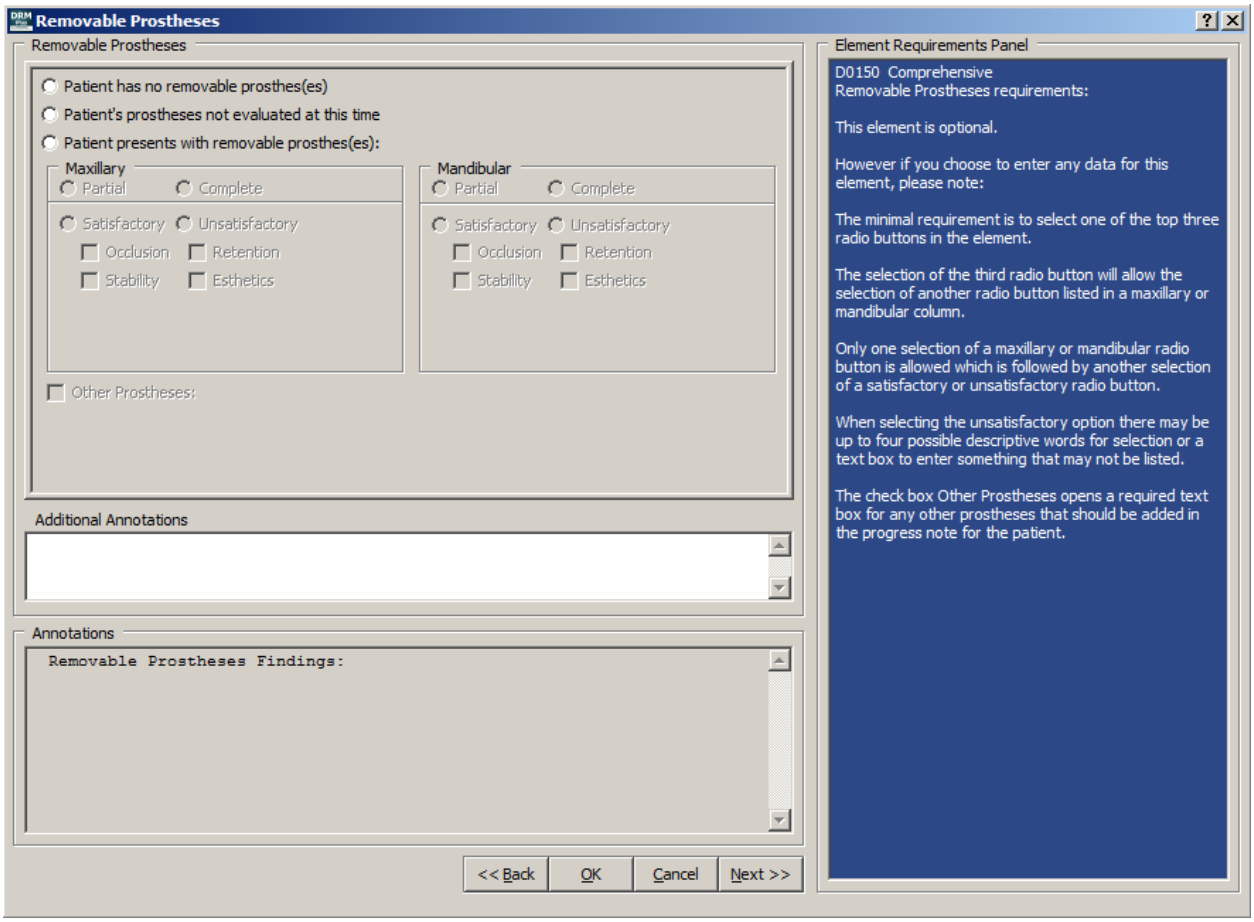


Figure 187: Removable Prostheses Element Screen

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.

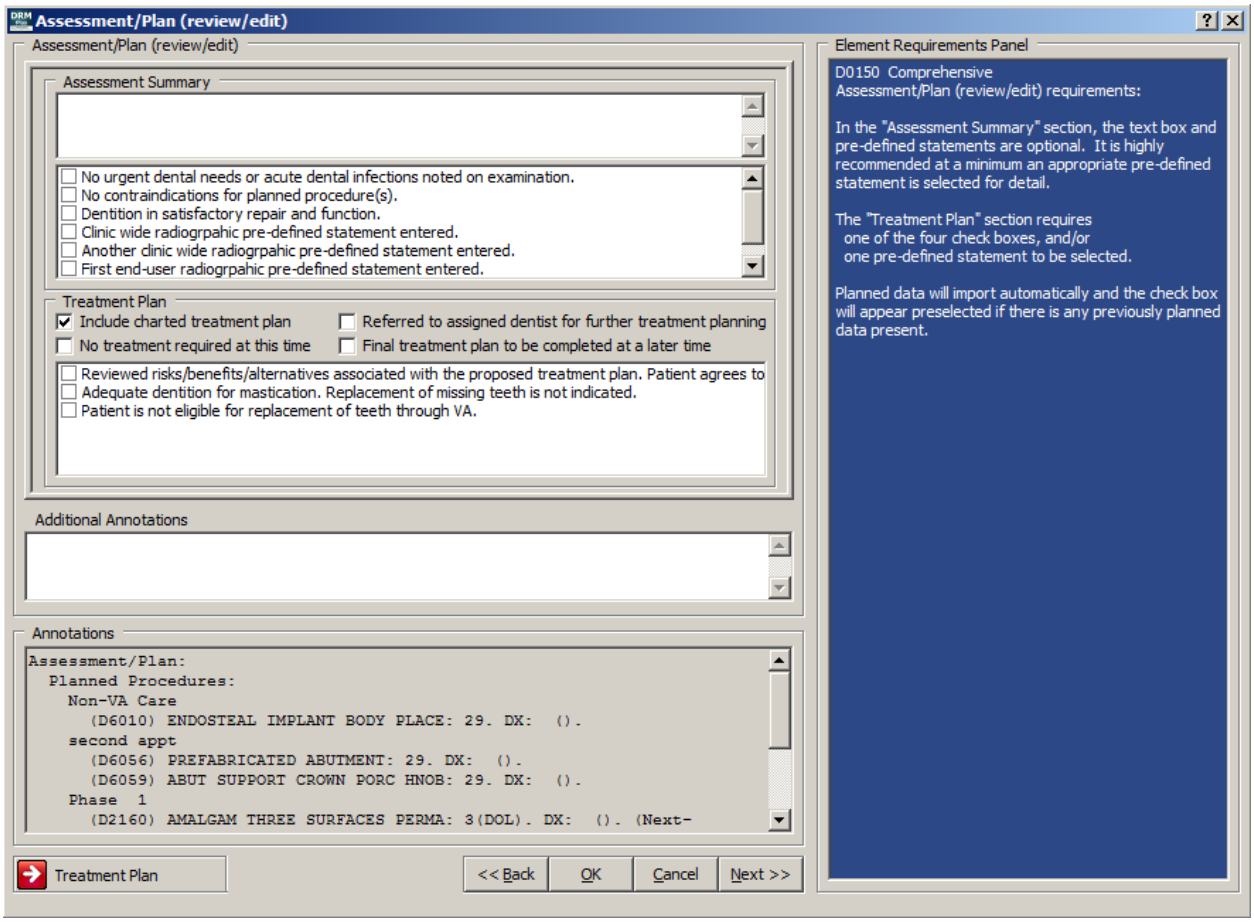


Figure 188: Assessment/Plan Element Screen

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.

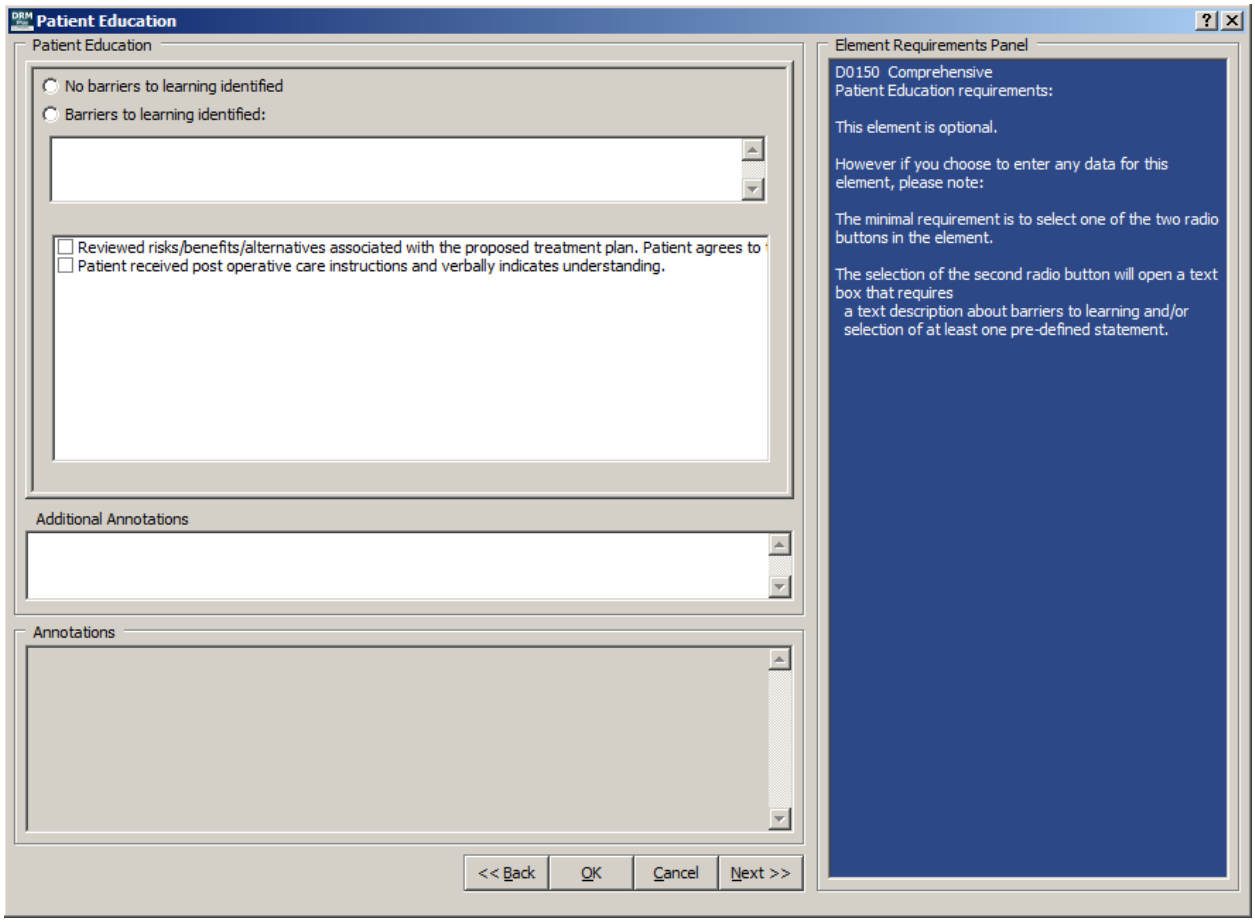


Figure 189: Patient Education Element Screen

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.

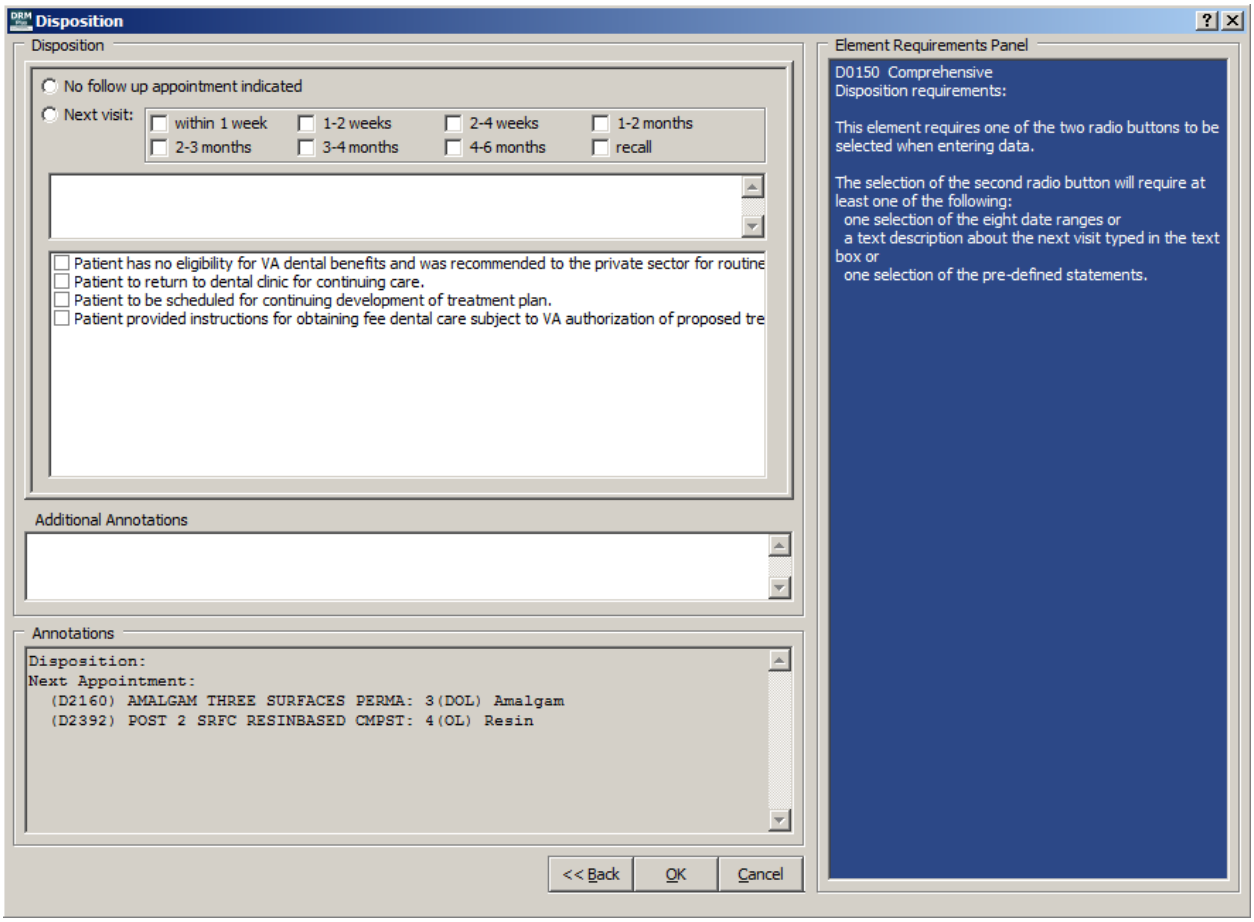


Figure 190: Disposition Element Screen

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.

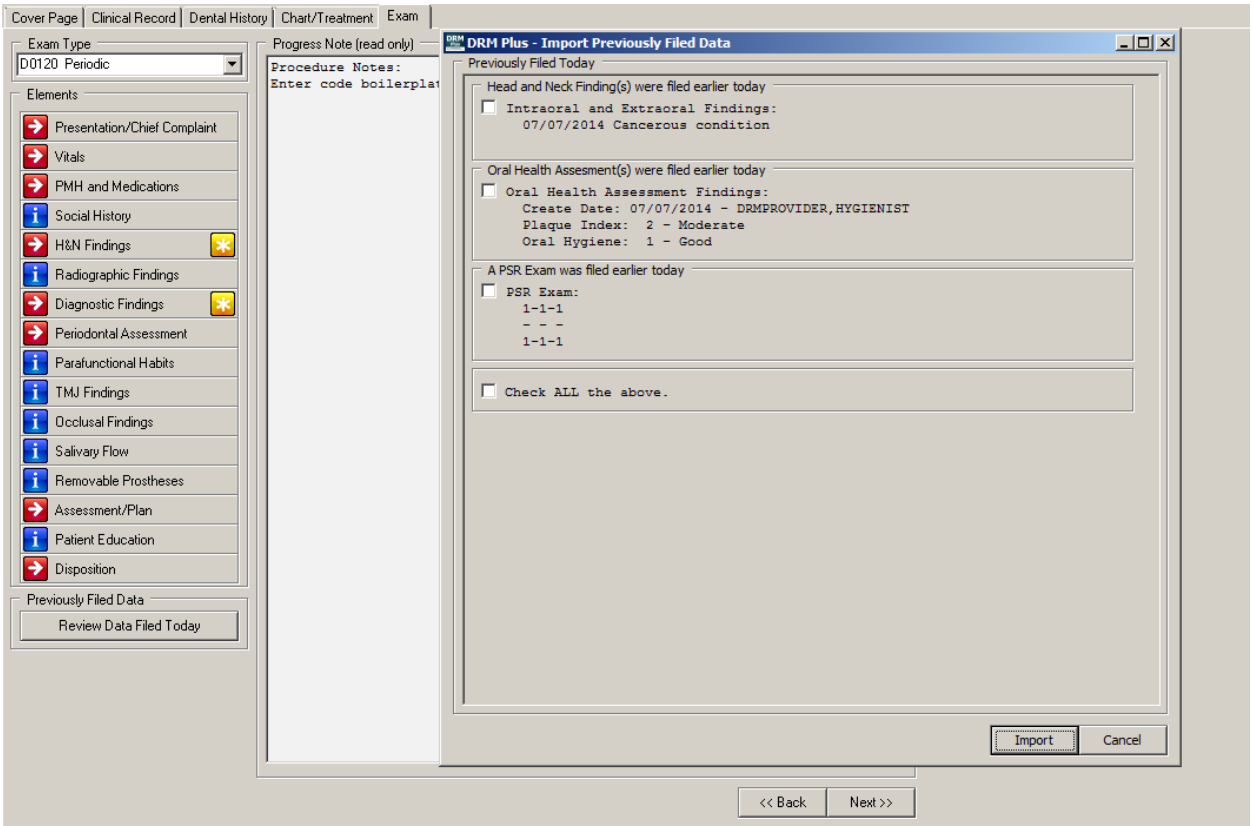


Figure 191: Import Previously Filed Data Screen

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.

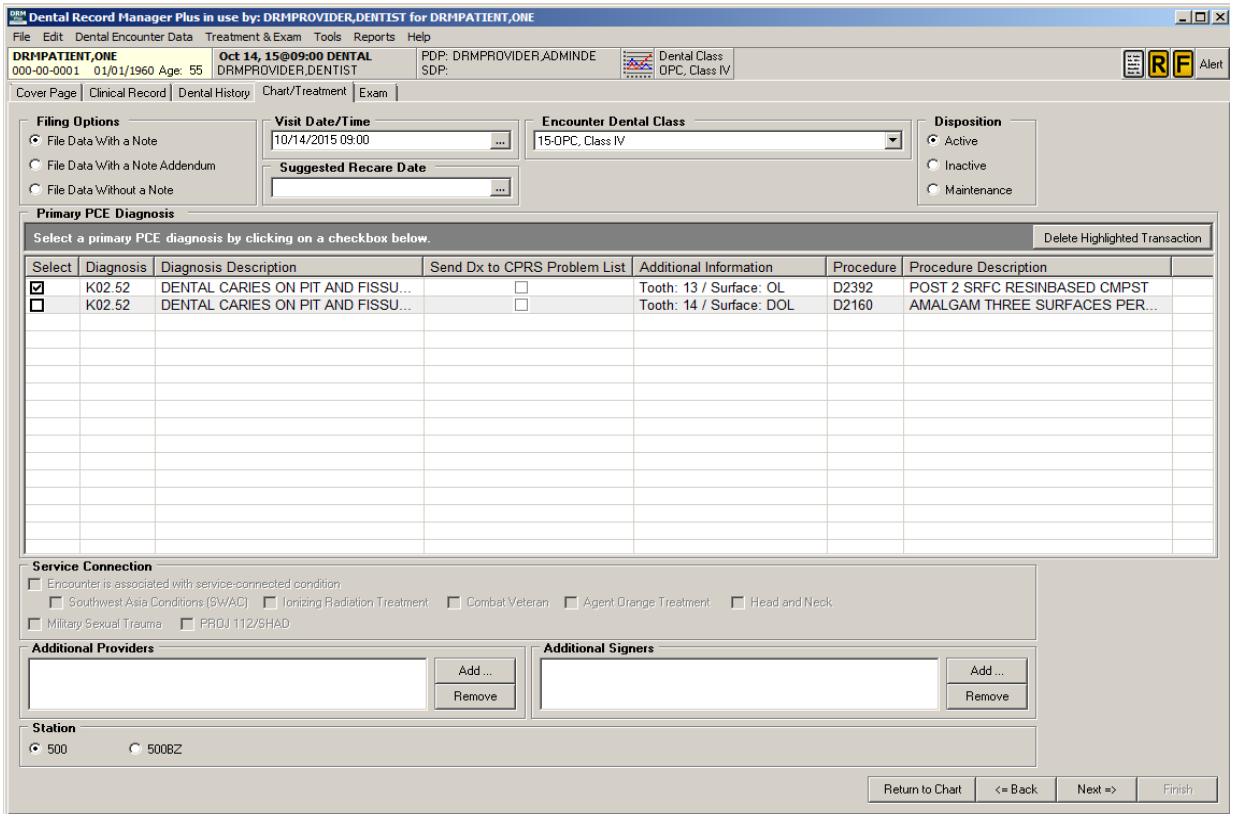


Figure 192: Filing Options Screen

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.

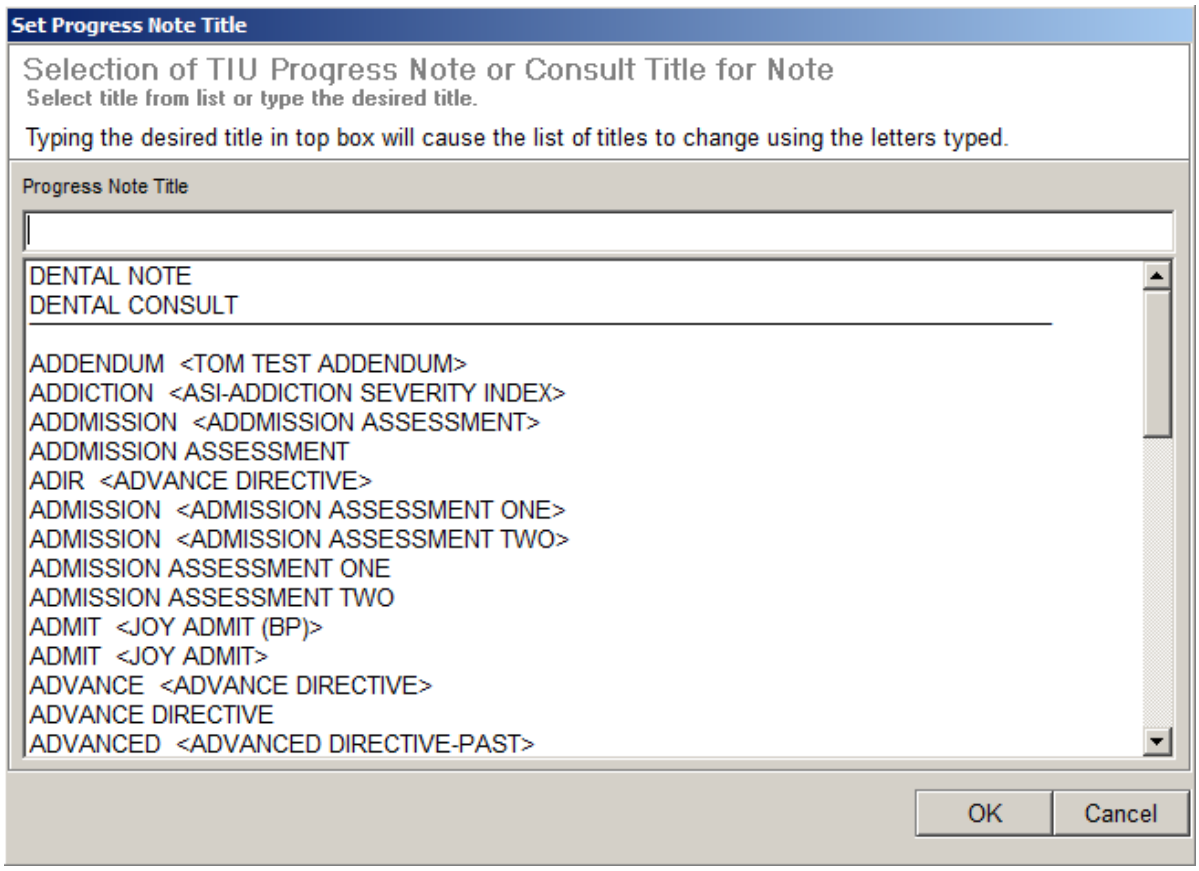


Figure 193: Set Progress Note Title Screen

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.

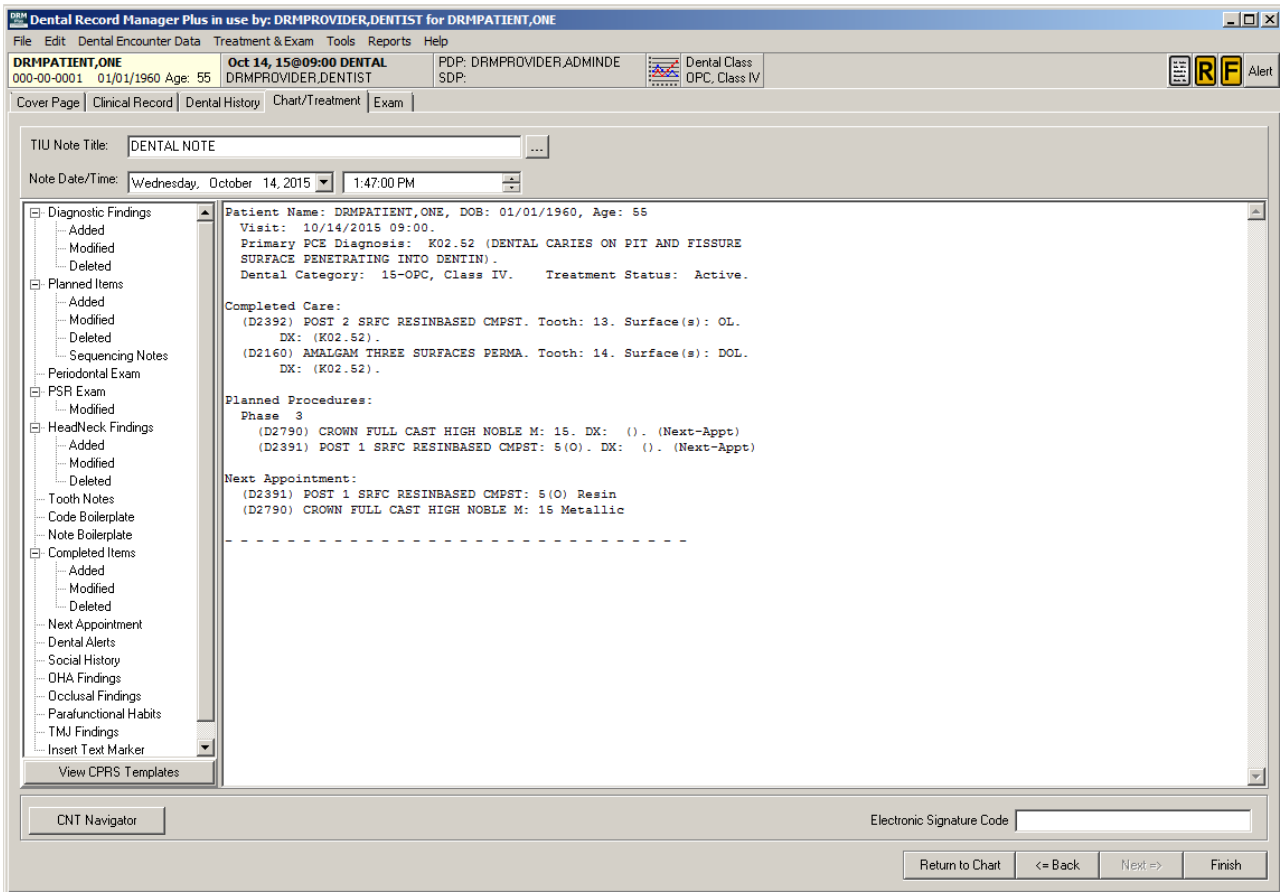


Figure 194: Progress Note Screen

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.

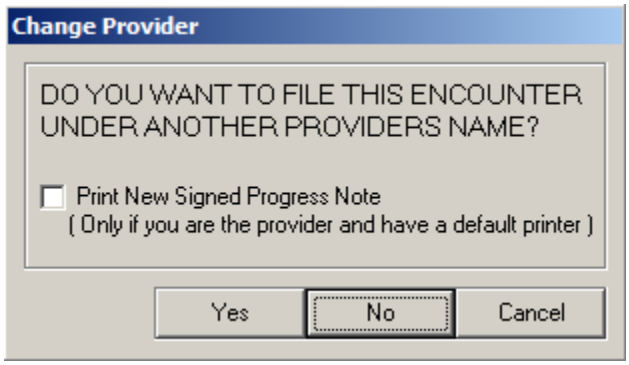


Figure 195: Change Provider Screen

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.

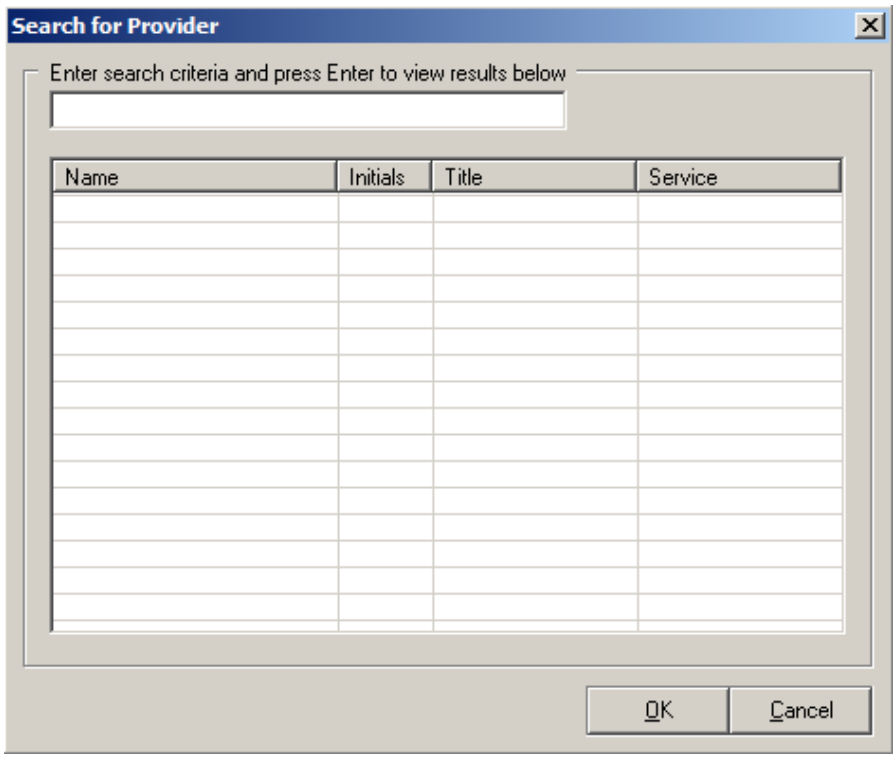


Figure 196: Search for Provider Screen

18. Enter the search information and press the <**Enter**> key. Select the provider from the list and click the **OK** button.
19. An informational screen displays stating that the encounter record has been created.

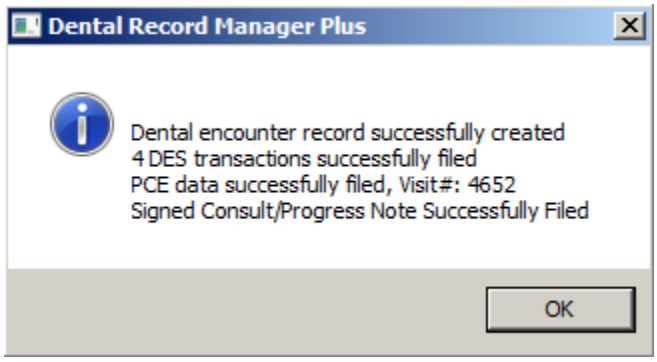


Figure 197: Dental Encounter Record Created

20. Click the **OK** button. The DRM Plus screen minimizes, and the CPRS main screen remains open, unless it has timed out.

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** screen is clicked.

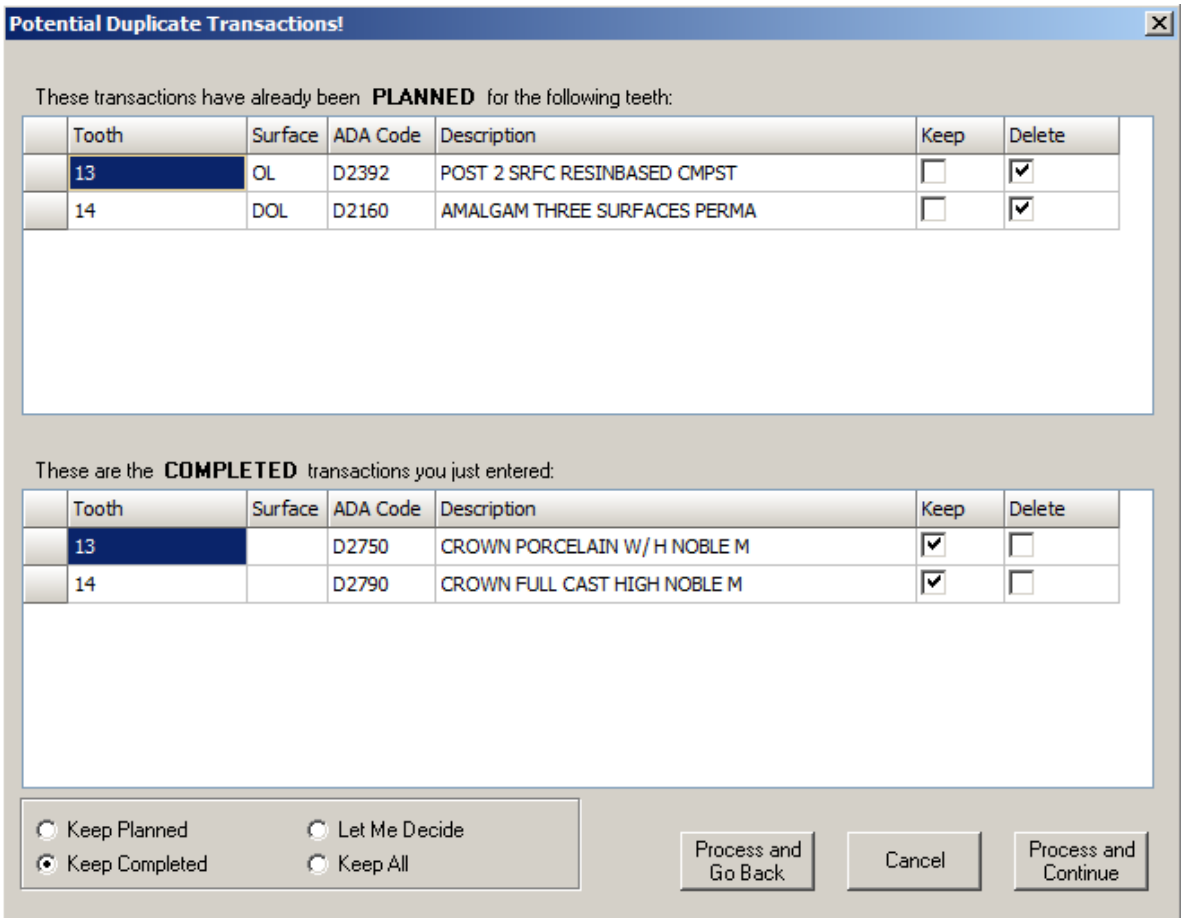


Figure 198: Potential Duplicate Transactions! Screen

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.

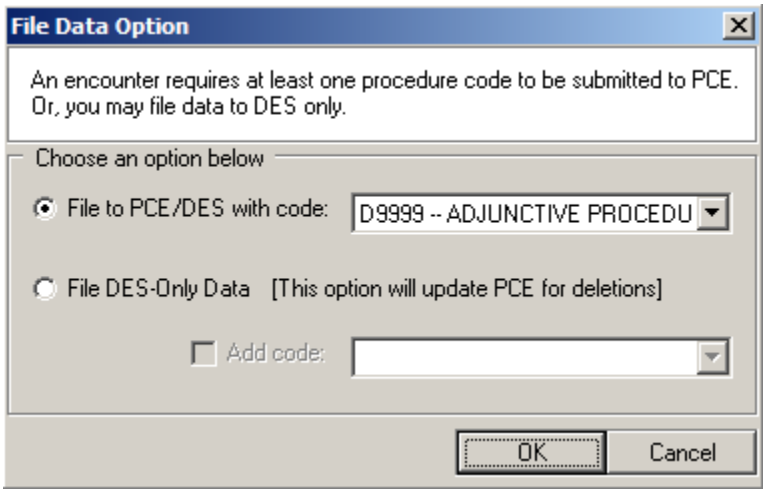


Figure 199: File Data Option Screen

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.

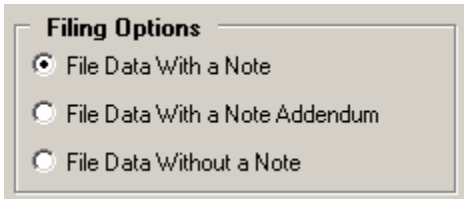


Figure 200: Filing Options

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.

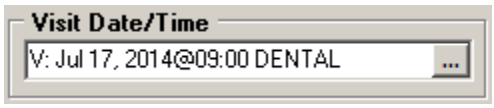


Figure 201: Visit Date/Time

To change the visit date and time:

1. Click the **Ellipsis (...)** button.
2. The **Provider and Location for Current Activities** screen displays.
3. 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.

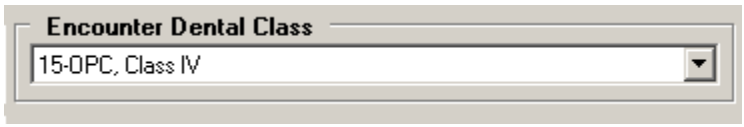


Figure 202: Encounter Dental Class

Disposition

Use the radio buttons to change the patient's **Disposition** or case management status.

Figure 203: Disposition

Suggested Recare Date

Use the **Ellipsis (...)** button to add/change the suggested recare date.

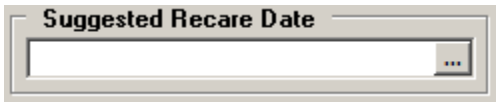


Figure 204: Suggested Recare Date

Click the **Ellipsis (...)** button to open the **Select Date** screen.

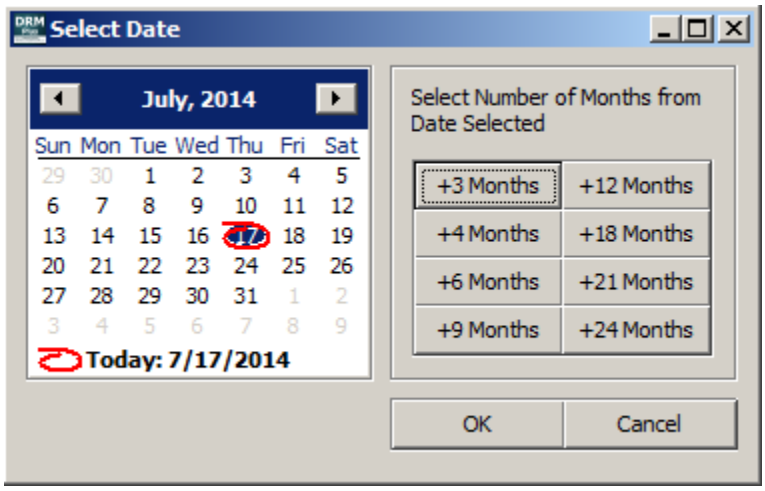


Figure 205: Select Date Screen

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.

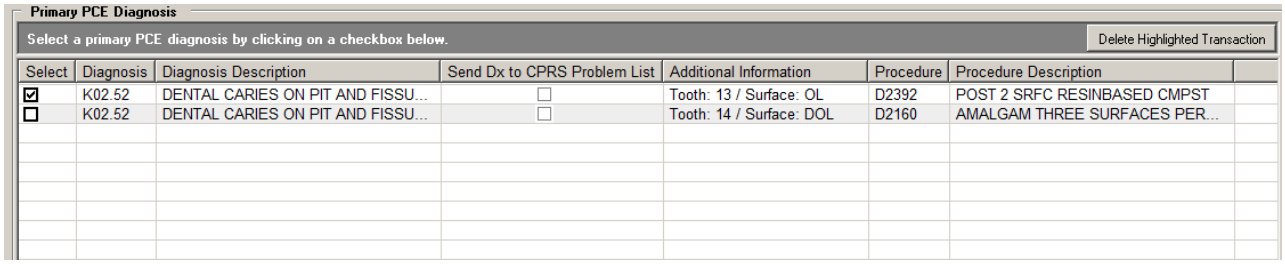


Figure 206: Primary PCE Diagnosis Window

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.

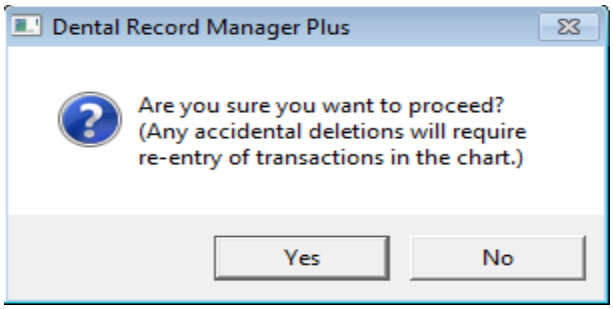


Figure 207: Transaction Deletion Screen

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.

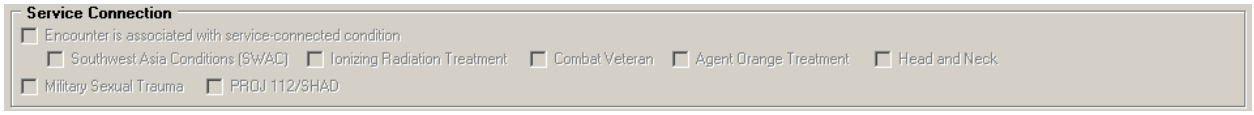


Figure 208: Service Connection

Additional Providers/Additional Signers

Add or remove providers from this patient encounter by using the tools in this area.

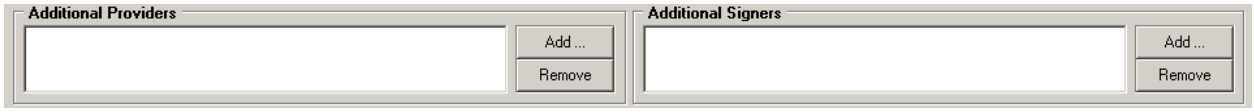


Figure 209: Additional Providers/Additional Signers

To add a provider or signer:

1. Click the **Add** button.
2. The **Search for Provider** or the **Search for Signer** screen displays.

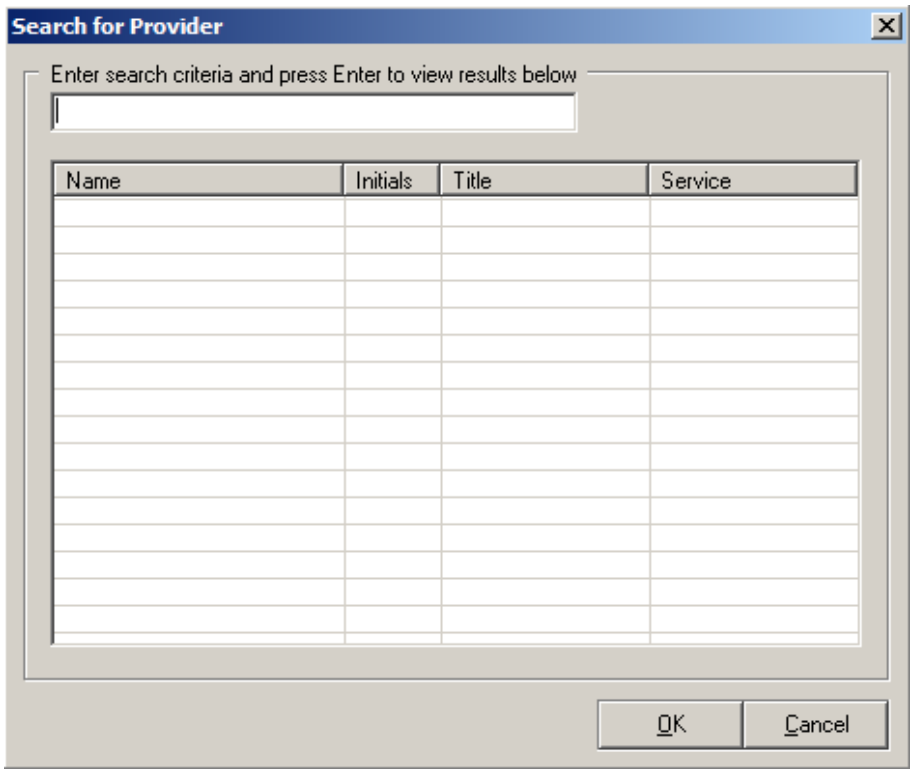


Figure 210: Search for Provider Screen

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 or 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.

Figure 211: 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.

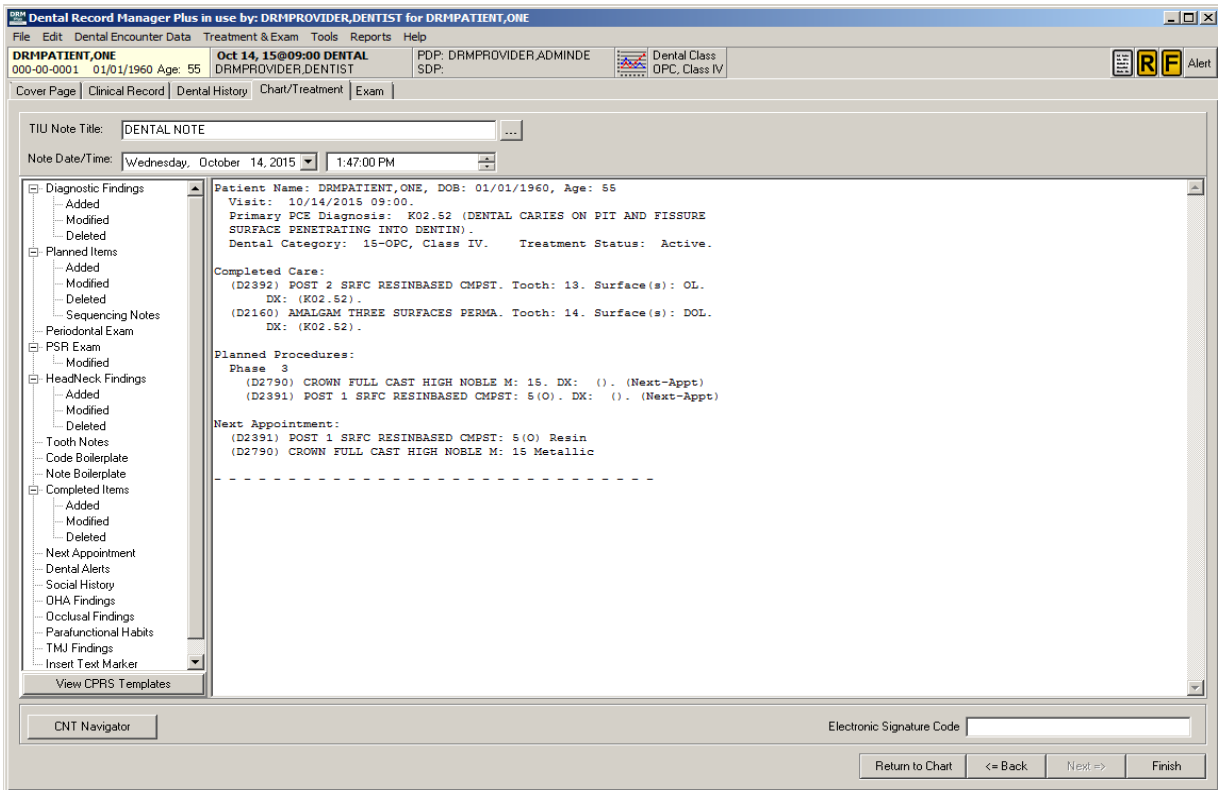


Figure 212: Progress Note Screen

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.

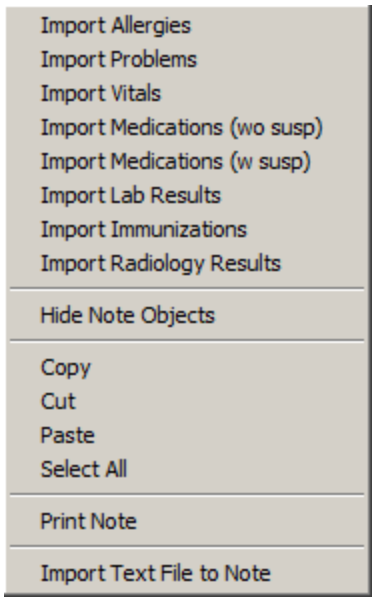


Figure 213: Import Menu Screen

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.

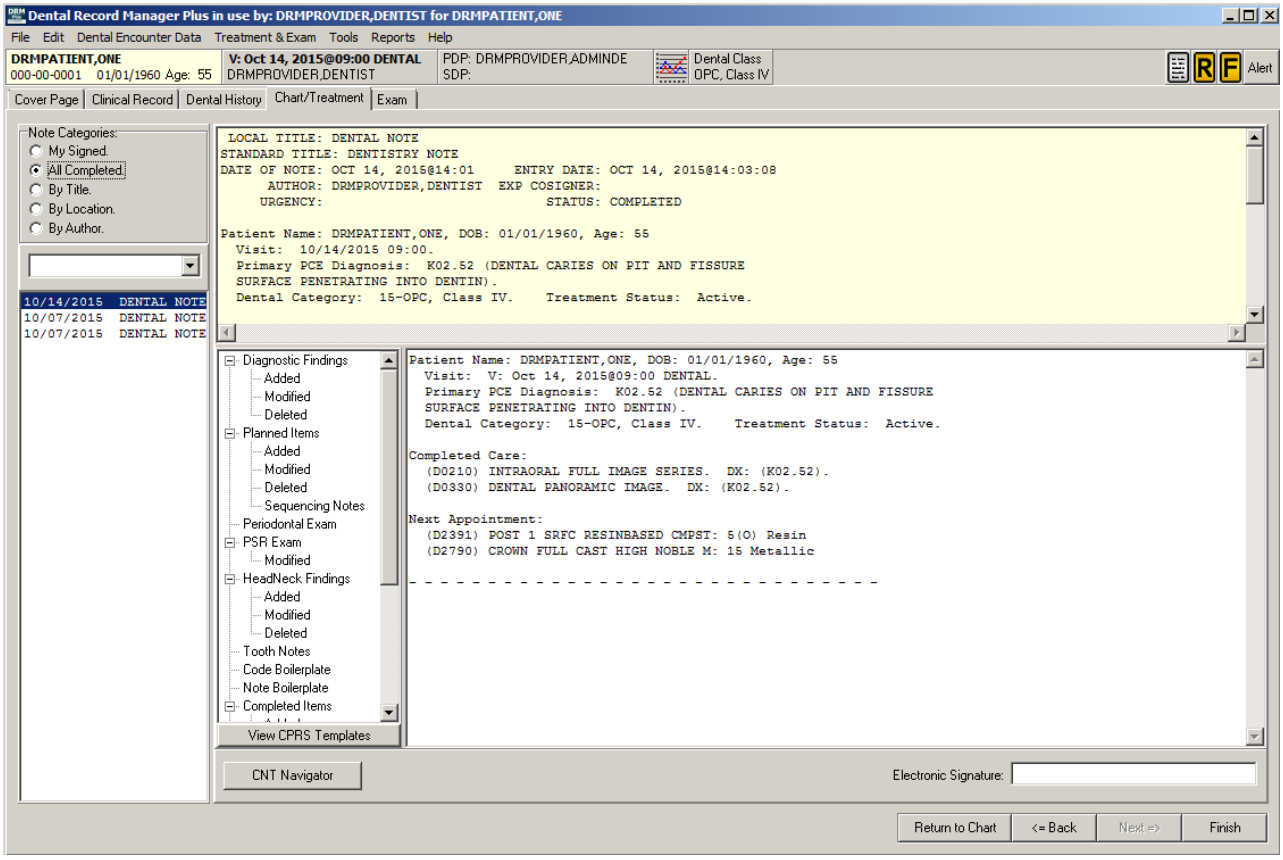


Figure 214: Progress Note Addendum Screen

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 215: 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.

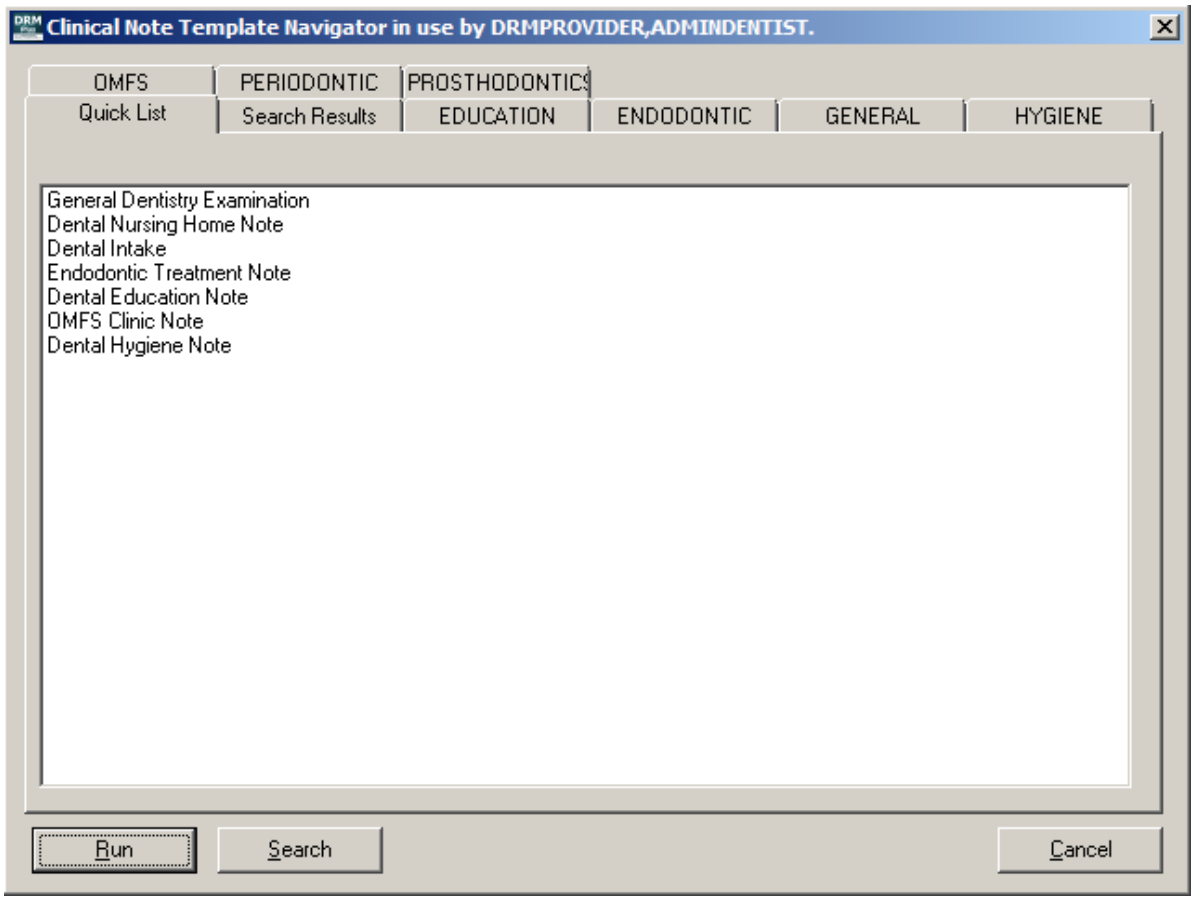


Figure 216: Clinical Note Template Navigator Screen

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.

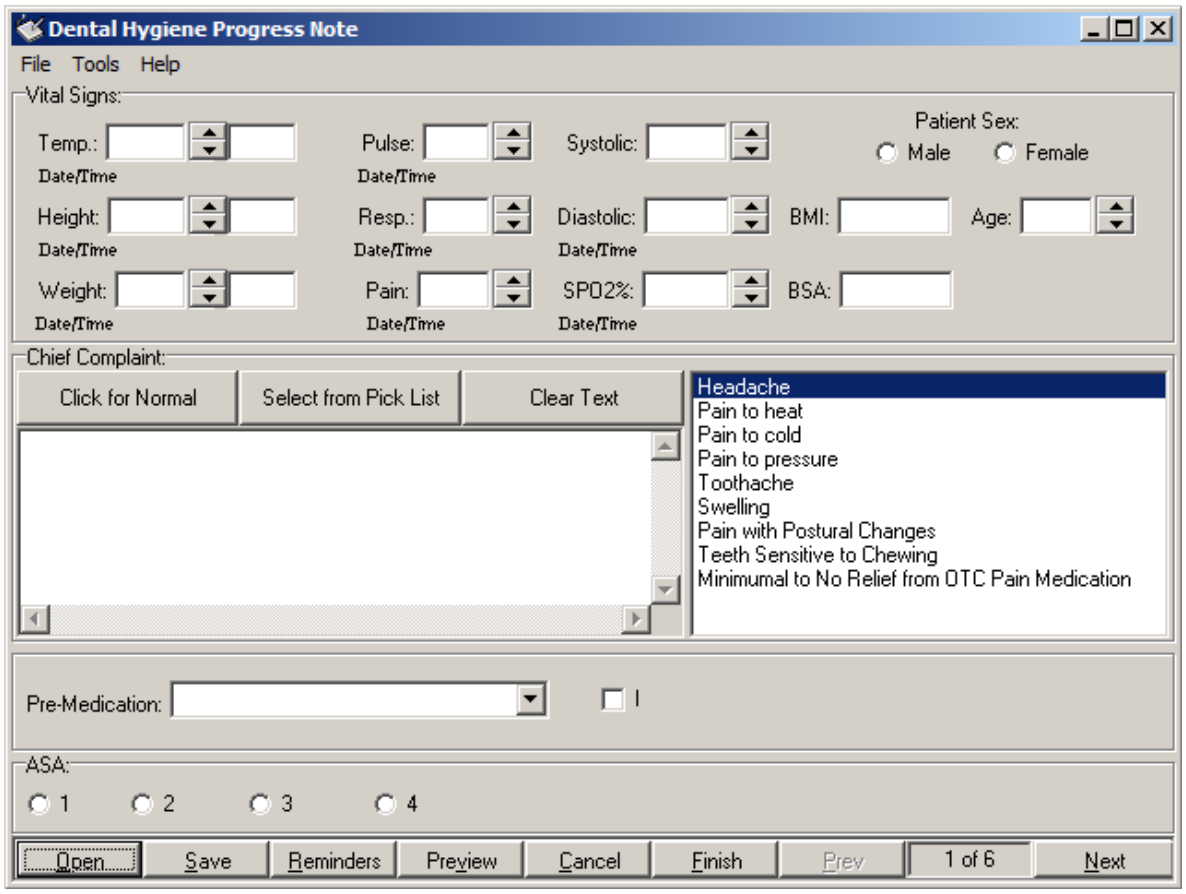


Figure 217: Navigating Within CNT

3. Click the **Return** button to continue writing the note.

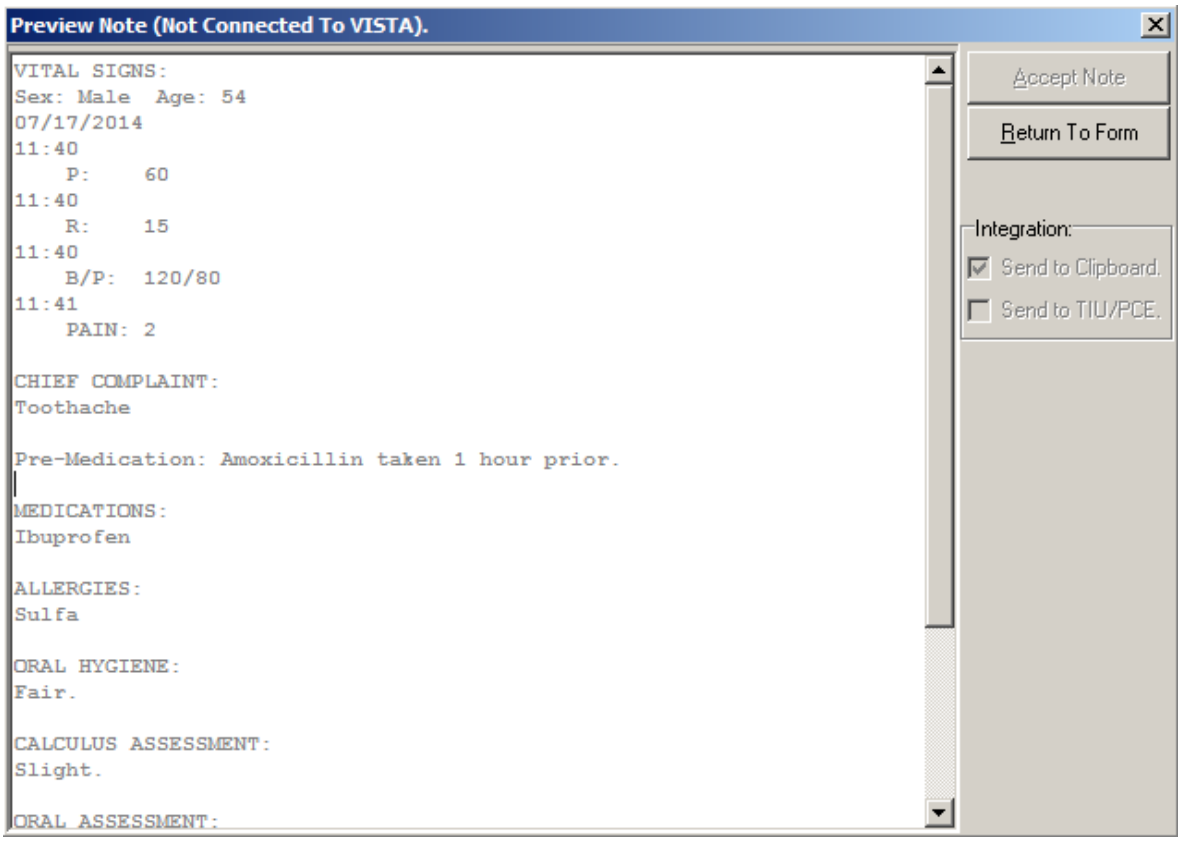


Figure 218: Preview Note

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.

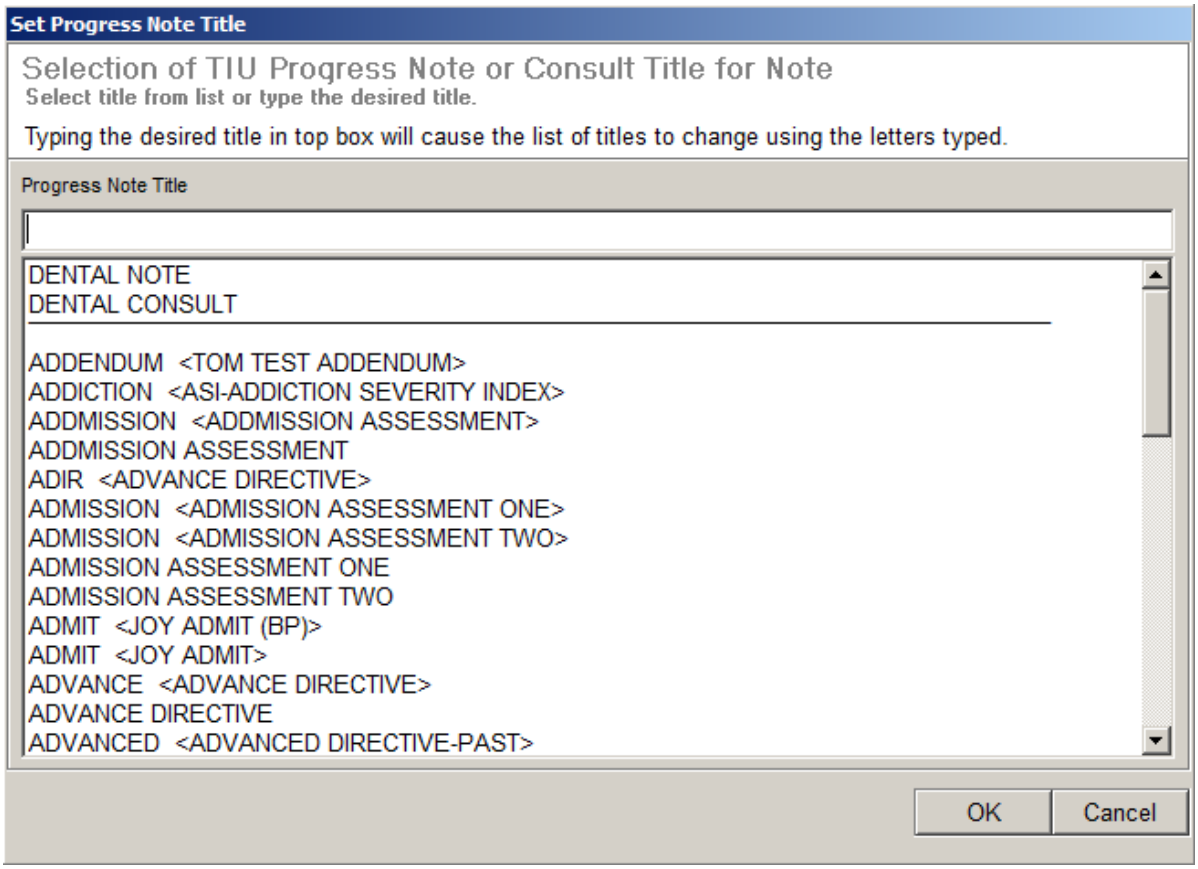


Figure 219: Set Progress Note Title Screen

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.

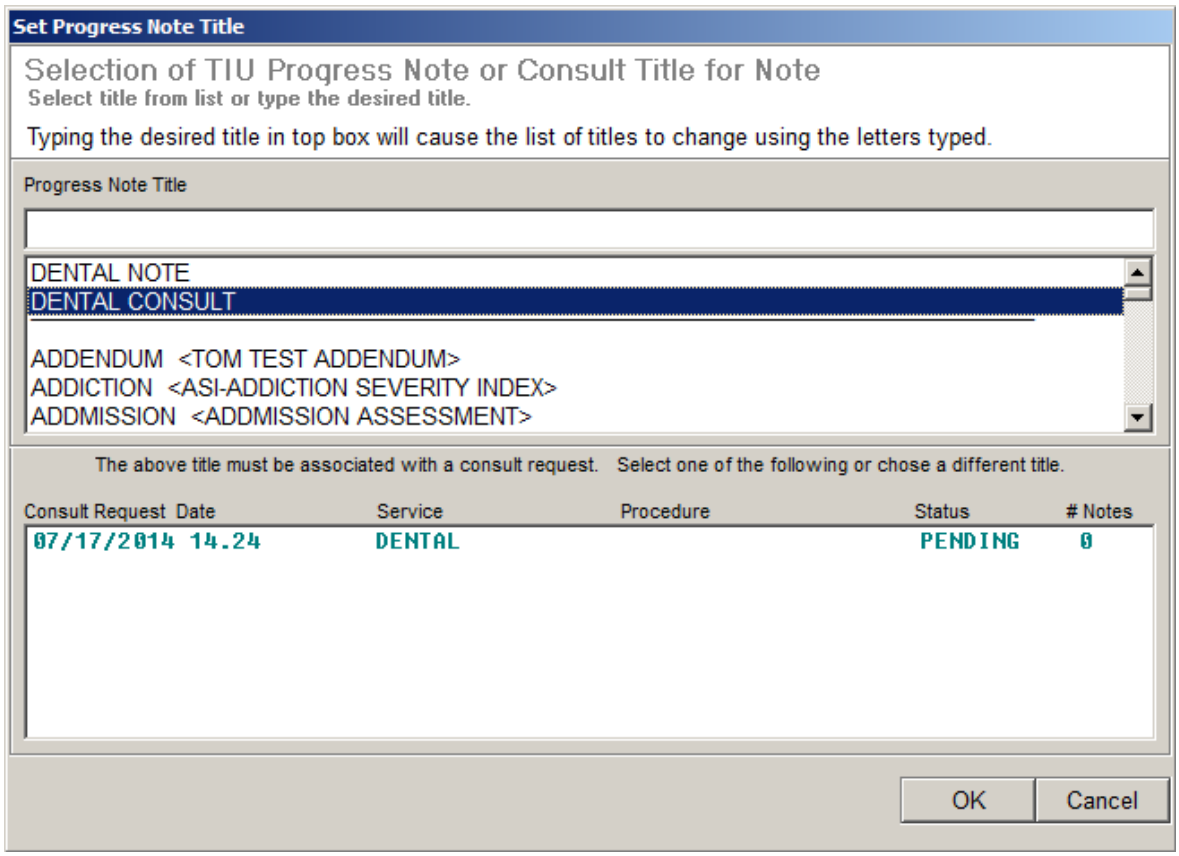


Figure 220: Set Progress Note Title with Pending Consult

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.

Resident Filing as Cosigners or Distributed Providers

A 2006 VA Directive stated that residents are users with a VistA **Person Class** of **V030300,** V11550 or V115600. All residents are required to have a distributed provider (attending) to complete the encounter with the patient. Since most sites require residents to enter a cosigner for the note, the cosigner defaults as the distributed provider in PCE. If there is no cosigner required for the resident, or the user filing data to a resident, they must enter the distributed provider before filing.

To add a distributed provider:

1. Click the **Finish** button.
2. The **Change Provider** screen displays.

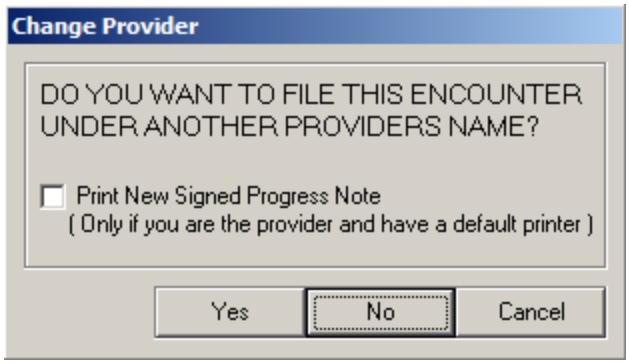


Figure 221: Change Provider Screen

3. Click the desired response. (Residents click the **No** button).
4. The **Search for Cosigner Provider** screen or the **Search for Distributed (PCE Primary) Provider** screen displays.

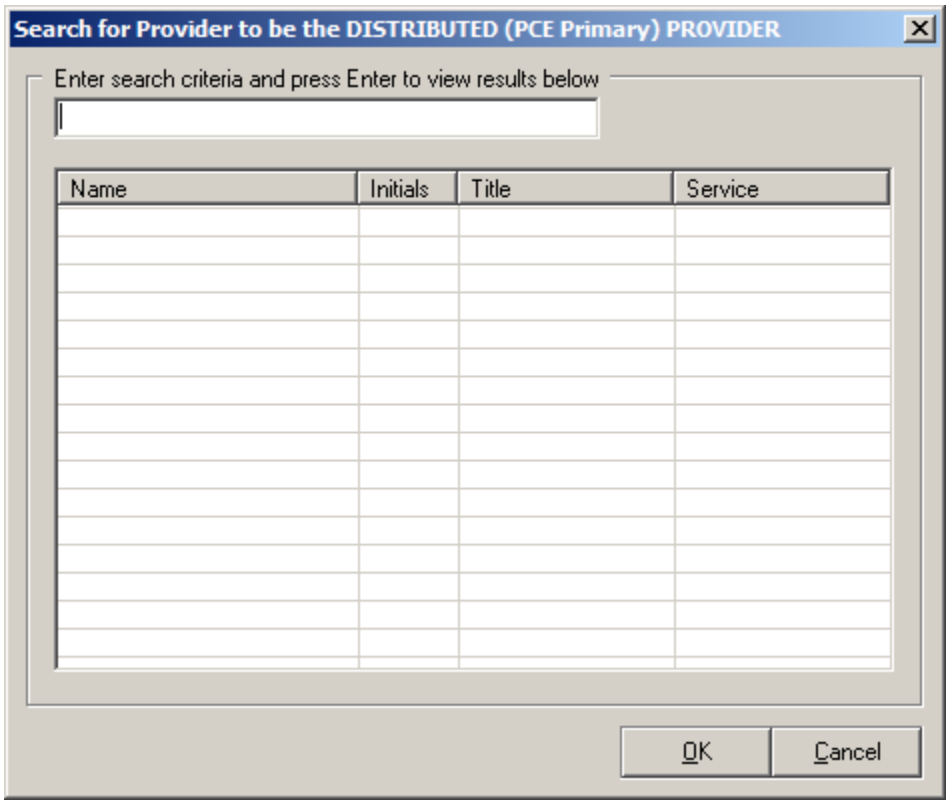


Figure 222: Search for Distributed Provider Screen

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.

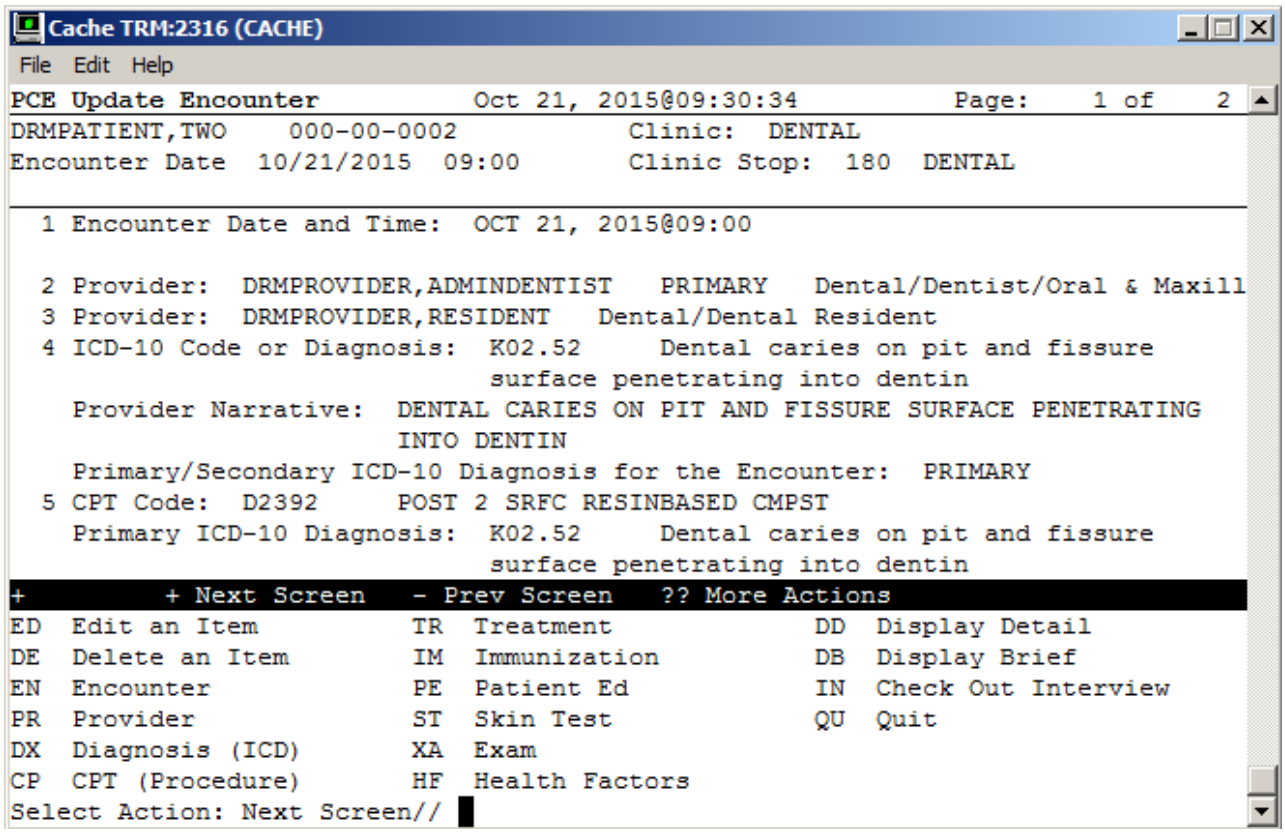


Figure 223: PCE Encounter Information in VistA

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 section 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 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-signers 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
Endentulous	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 But-tons	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 But-tons	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.

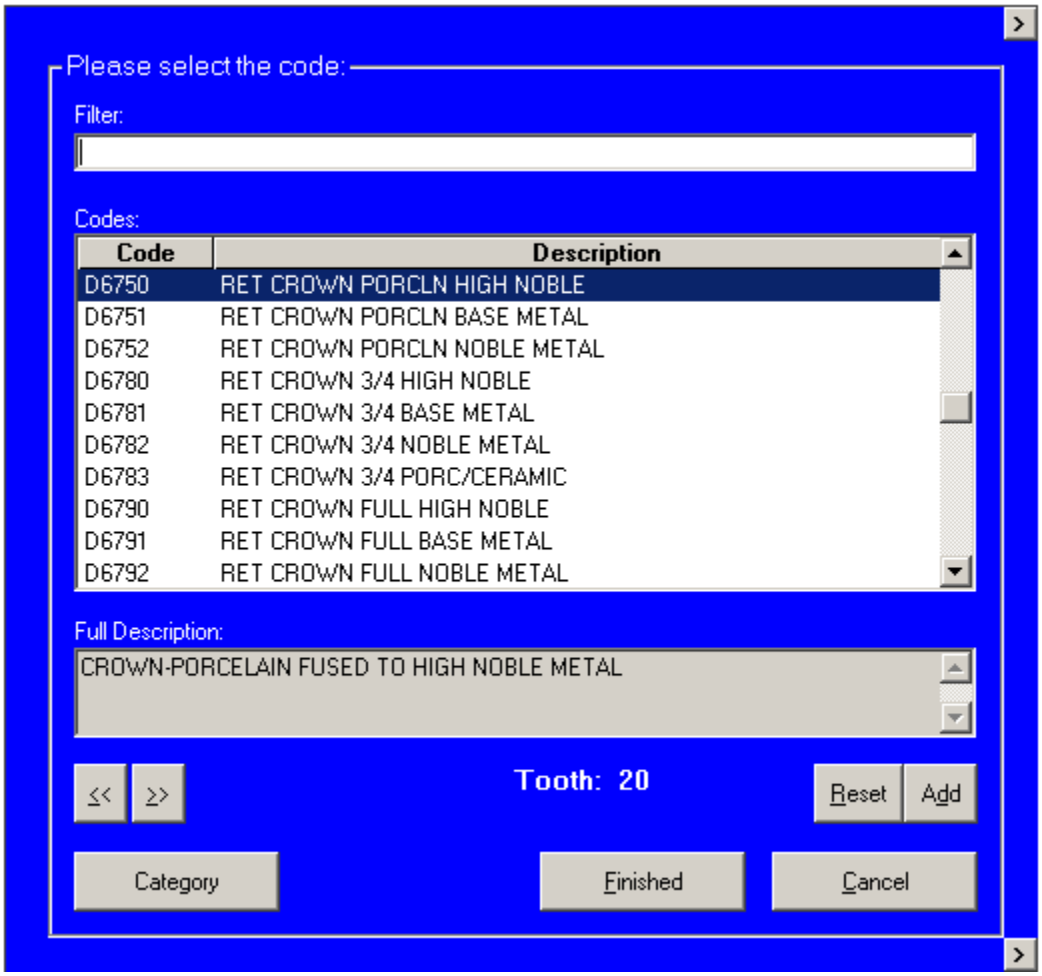


Figure 224: Procedure Code Selection Screen

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 – 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 225: 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 <**B**> 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 F – 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 Prosthodontics	Implant Services	Fixed Prosthodontics
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 G – 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).

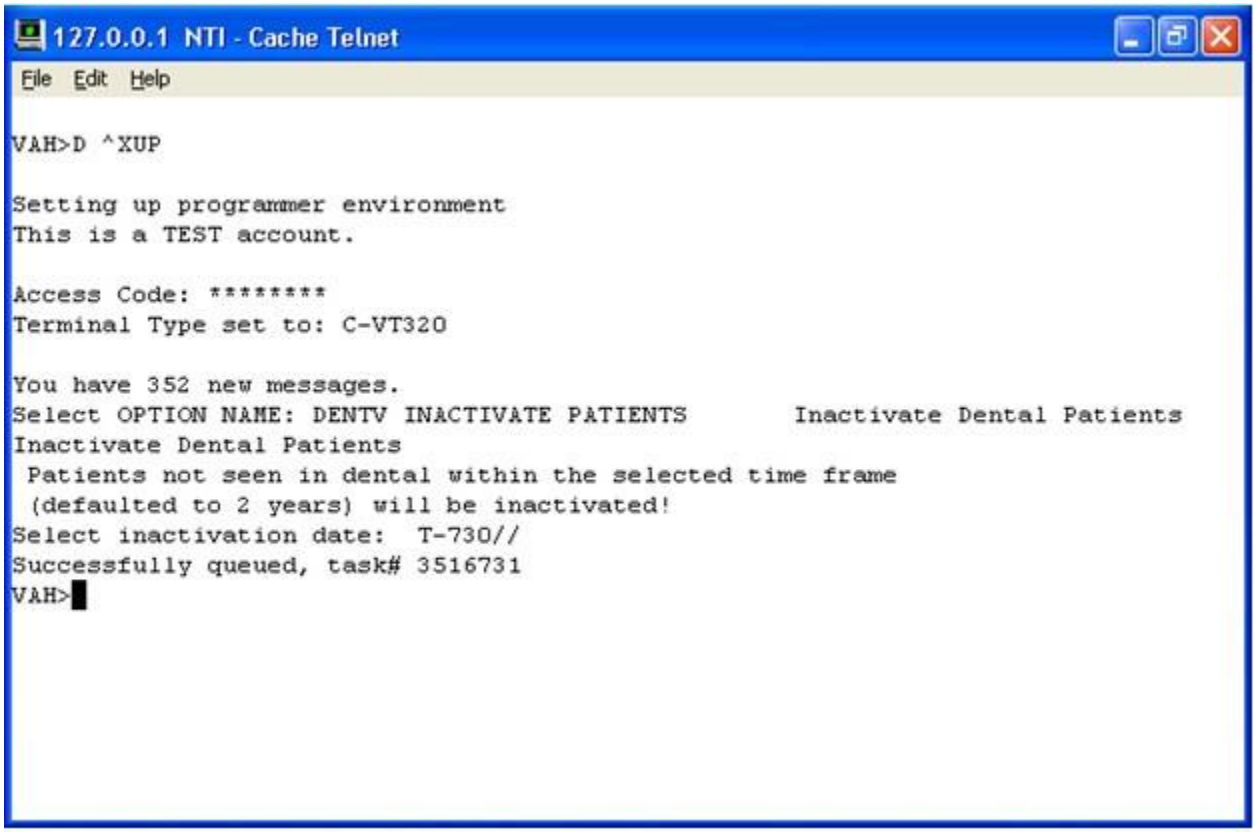


Figure 226: VistA Option to Set an Inactivation Date

Appendix H – 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.

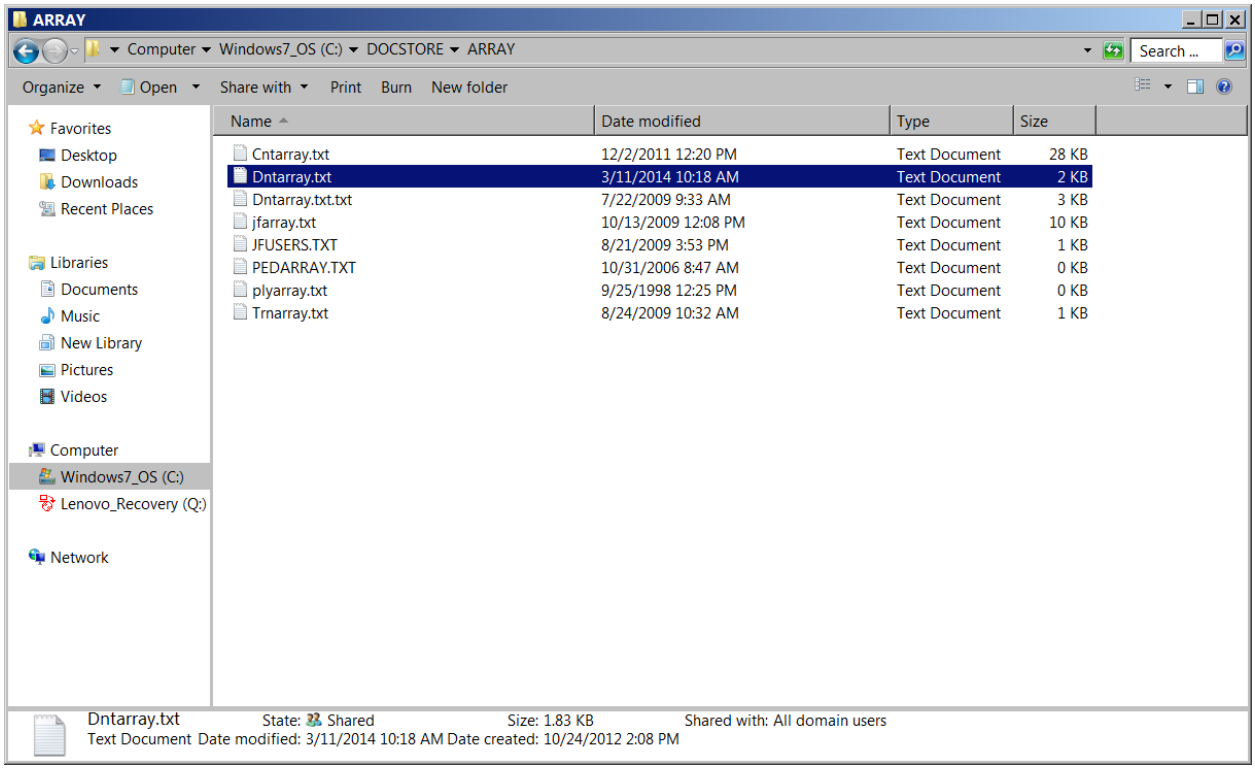


Figure 227: Map Dental CNTs from dntarrary.txt file

2. Open one of the CNT .ini files within the **\DOCSTORE\FORMS** directory (i.e., \\vhaserver-name\DOCSTORE\FORMS\160_DENT\04160001\DRMEval.ini)

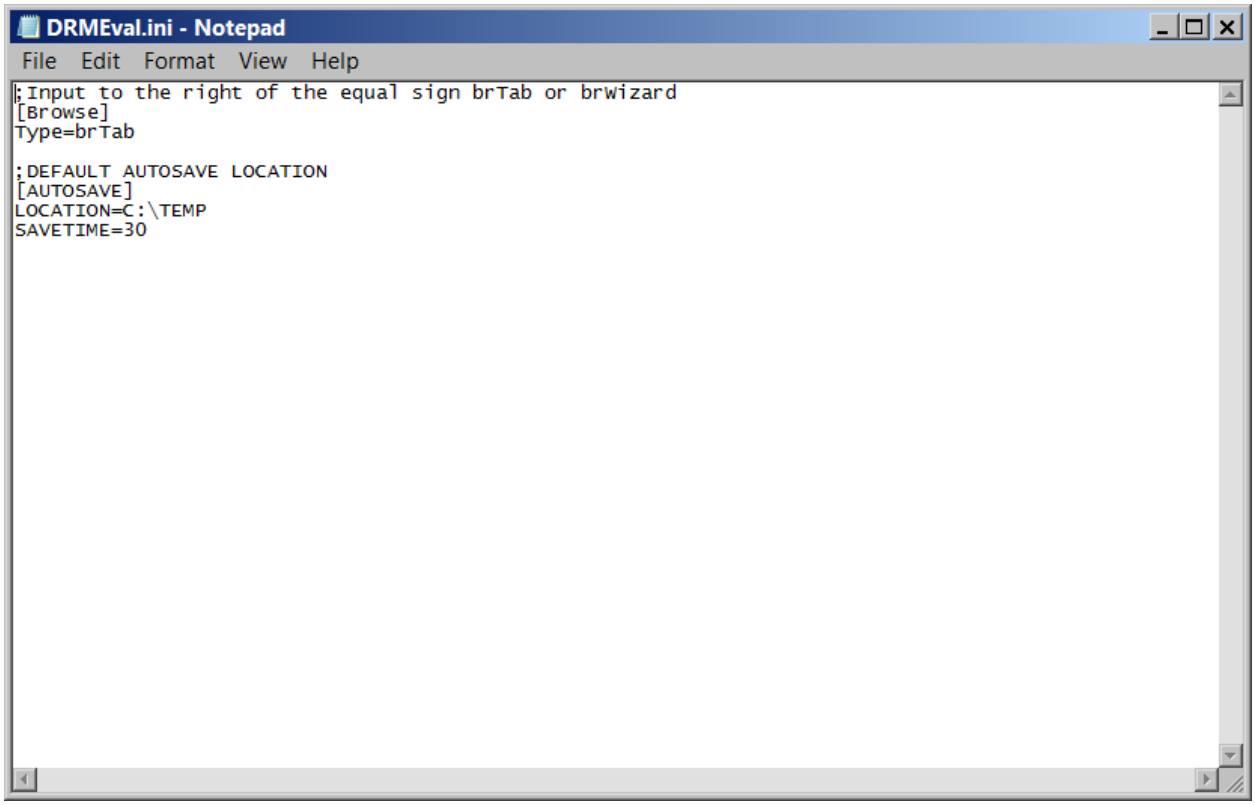


Figure 228: DRMEval.ini File

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 I – 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.

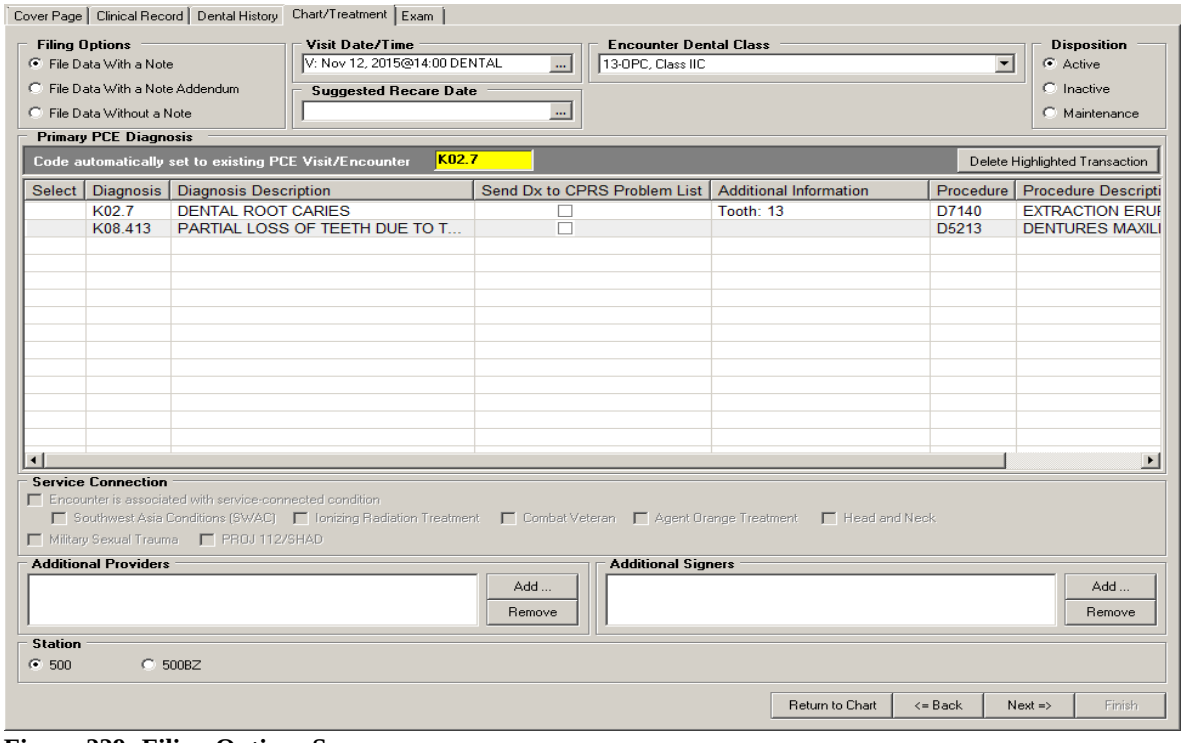


Figure 229: Filing Options Screen

4. Complete the encounter as a note addendum.

Appendix J – 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 K – 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 L – 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:

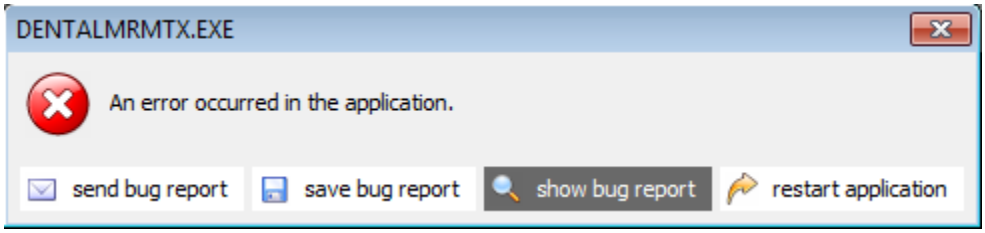


Figure 230: DENTALMRMTX.EXE Screen

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:

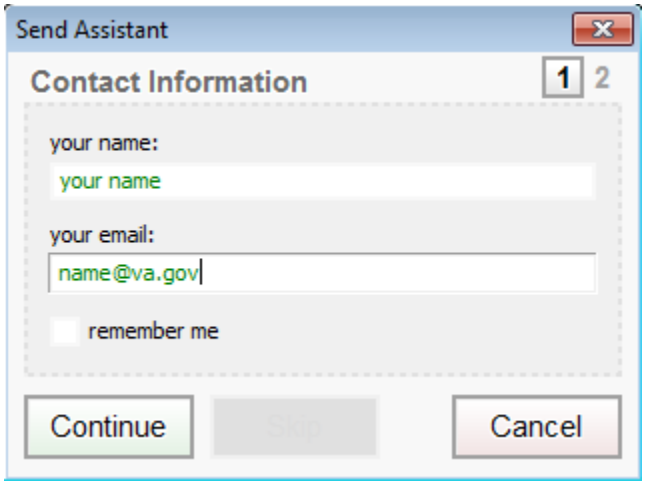


Figure 231: Contact Information Screen

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.

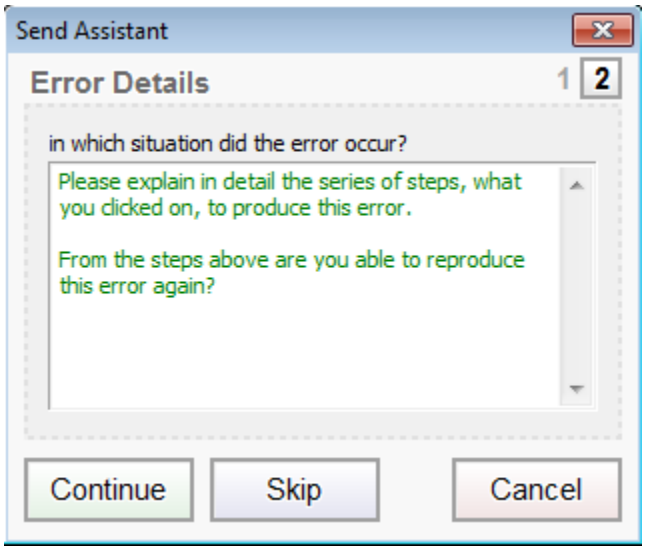


Figure 232: Error Details Screen

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:

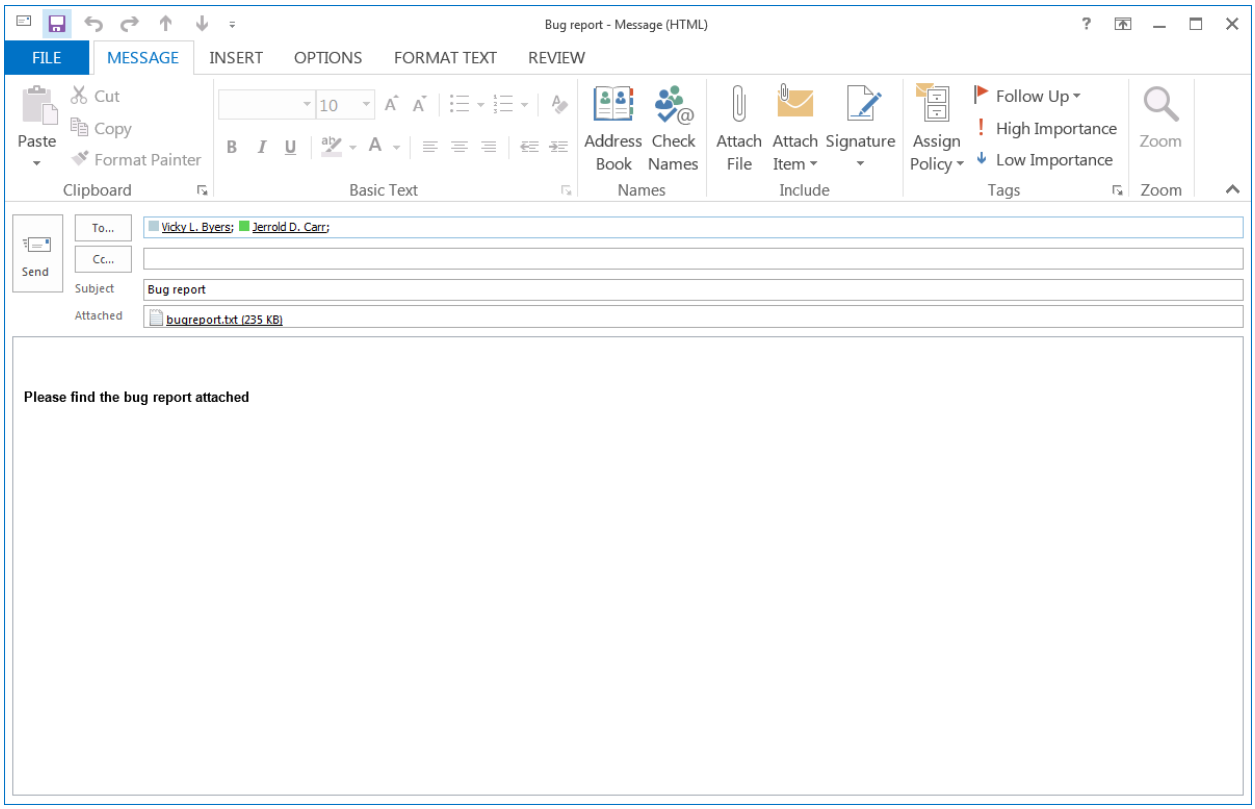


Figure 233: Outlook Window

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

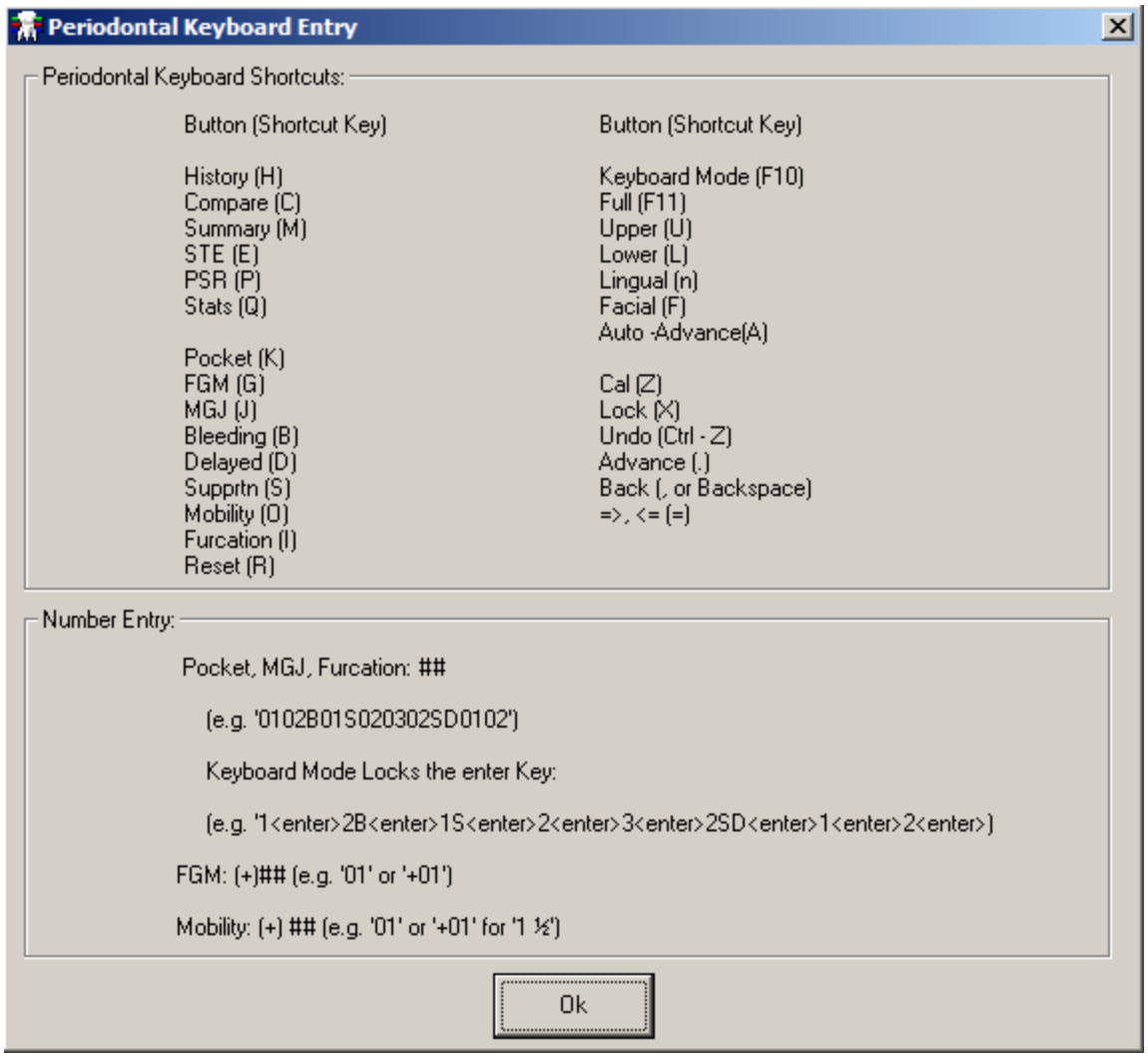


Figure 234: Periodontal Keyboard Entry Screen