DRM Plus

Admin Manual

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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 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 Veteran 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 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 IRM 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.

DRM Plus Setup Requirements

User Setup

The following are requirements for a DRM Plus User:

1. The user must be defined in the Dental Provider file (file 220.5).
2. The user must have a Dental Person Class and Provider Type in the VistA Provider file.
3. The user must have the secondary menu option DENTV DSS DRM GUI assigned in VistA.

Note: DRM Plus providers filing data must have an eight (8) digit provider number in the Dental Provider file (see item #1).

Administrator Setup

The following are the requirements for a DRM Plus administrator:

1. All of the above setup procedures must be included.
2. Administrative users (including those with the authority to edit transactions):

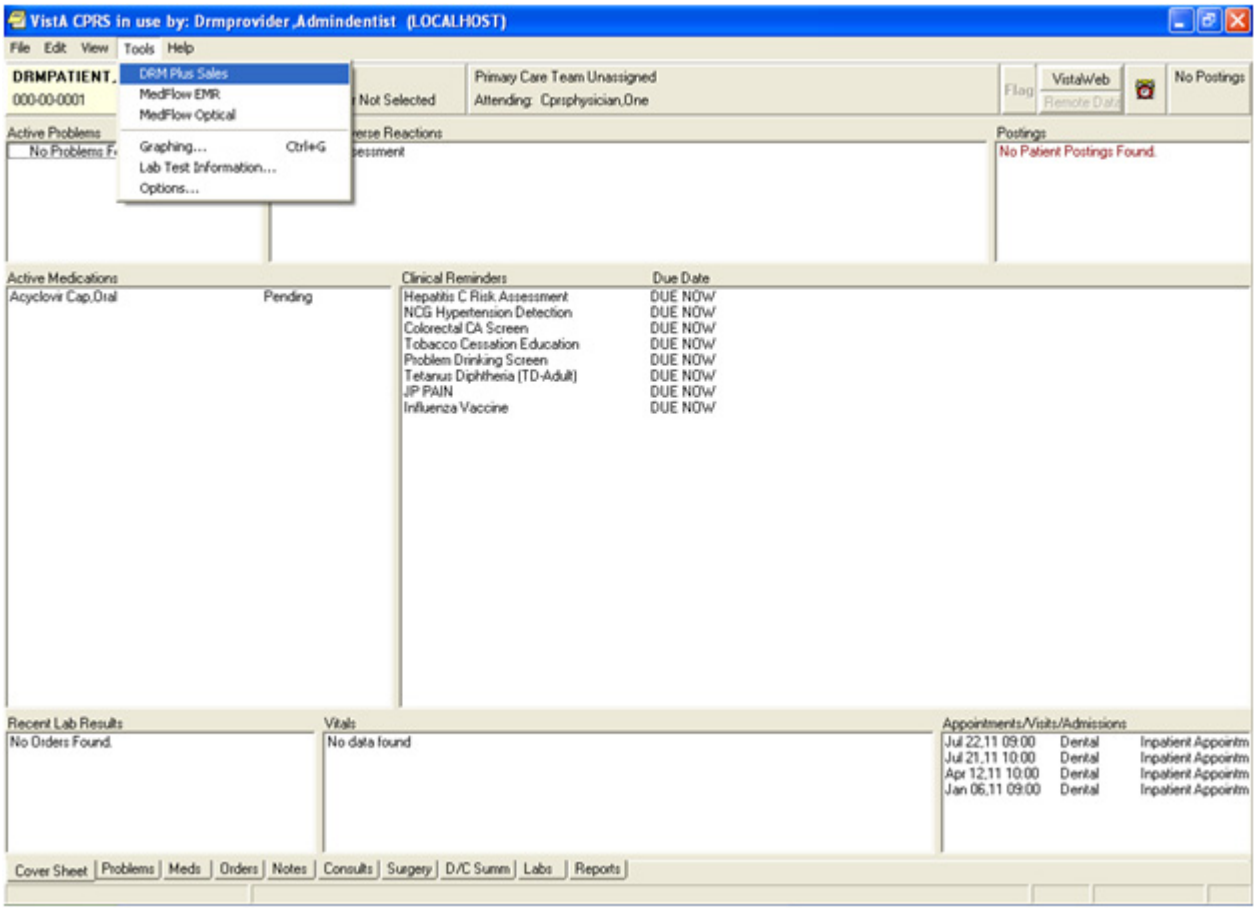
   OPTION NAME: XPAR EDIT PARAMS PARAMETER DEFINITION NAME: DENTV DRM ADMINISTRATOR -- must be turned to Yes.

Note: Each site must have at least one DRM Plus administrator.

Accessing DRM Plus

Access

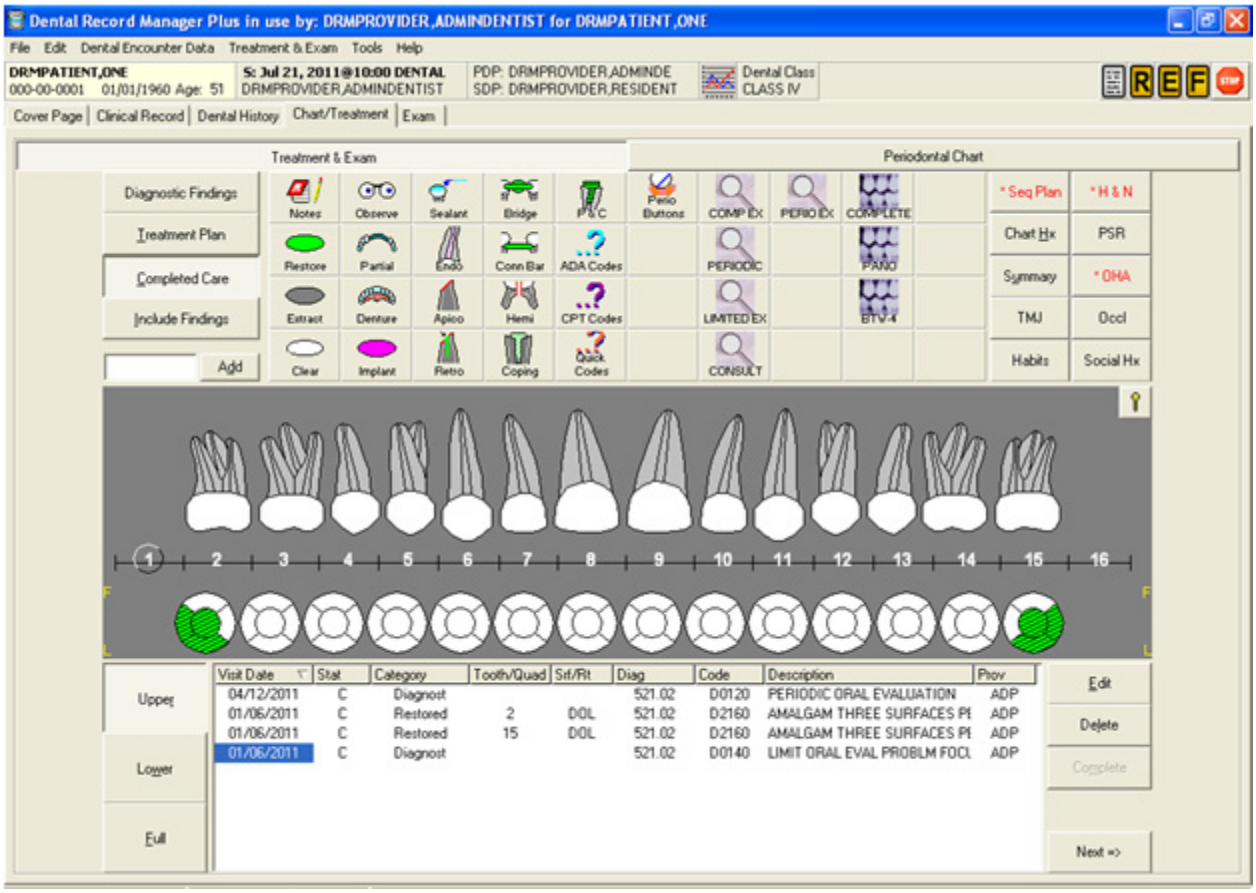
To access DRM Plus, first open CPRS and select the desired patient. Open the **Tools** menu in the CPRS tool bar, and select **DRM Plus** from the available options.



Access DRM Plus through CPRS

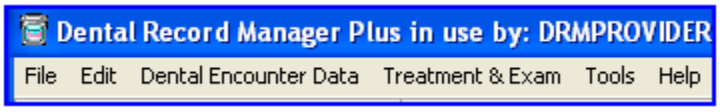
DRM Plus opens with the patient information loaded.

Note: Users may be required to re-enter Verify/Access Codes when opening DRM Plus. The default opening settings of DRM Plus is the Treatment Plan screen on the Chart/Treatment tab.



DRM Plus Chart/Treatment Tab

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 grayed out when the tab is open.

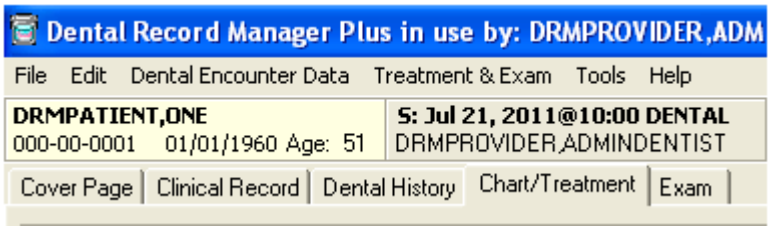


DRM Plus Drop-Down Menus

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

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, create a text note or a text note addendum. All providers may perform a myriad of tasks by simply clicking through each of the tabs and adding the pertinent information that is allowed in the appropriate place.

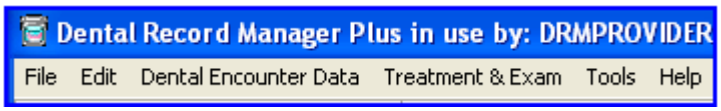


DRM Plus Tabs

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

Using the DRM Plus Drop-Down Menus

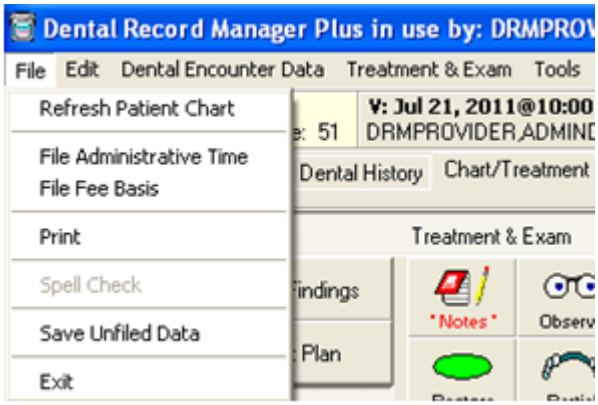
The DRM Plus drop-down menus consists of six menus: **File, Edit, Dental Encounter Data, Treatment & Exam, Tools** and **Help**.



DRM Plus Drop-Down Menus

File

The File menu contains seven options: **Refresh Patient Chart**, **File Administrative Time, File Fee Basis, Print, Spell Check, Save Unfiled Data** and **Exit**. The Spell Check is only active in Notes and Note Addendums.



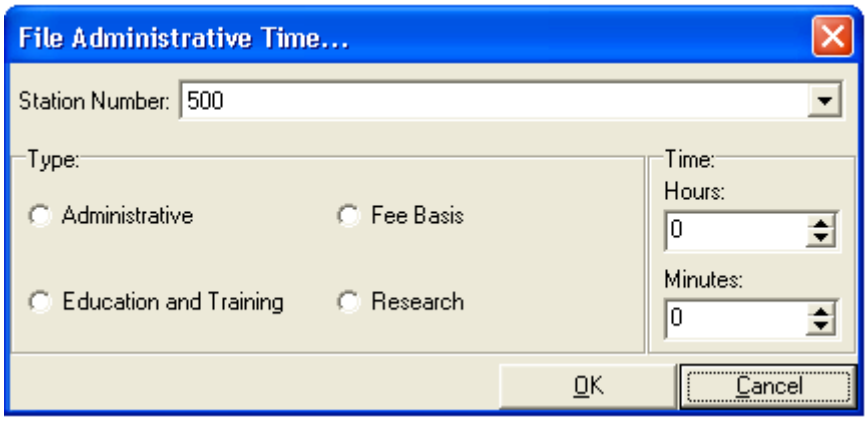
DRM Plus File Menu

Refresh Patient Chart

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

File Administrative Time

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



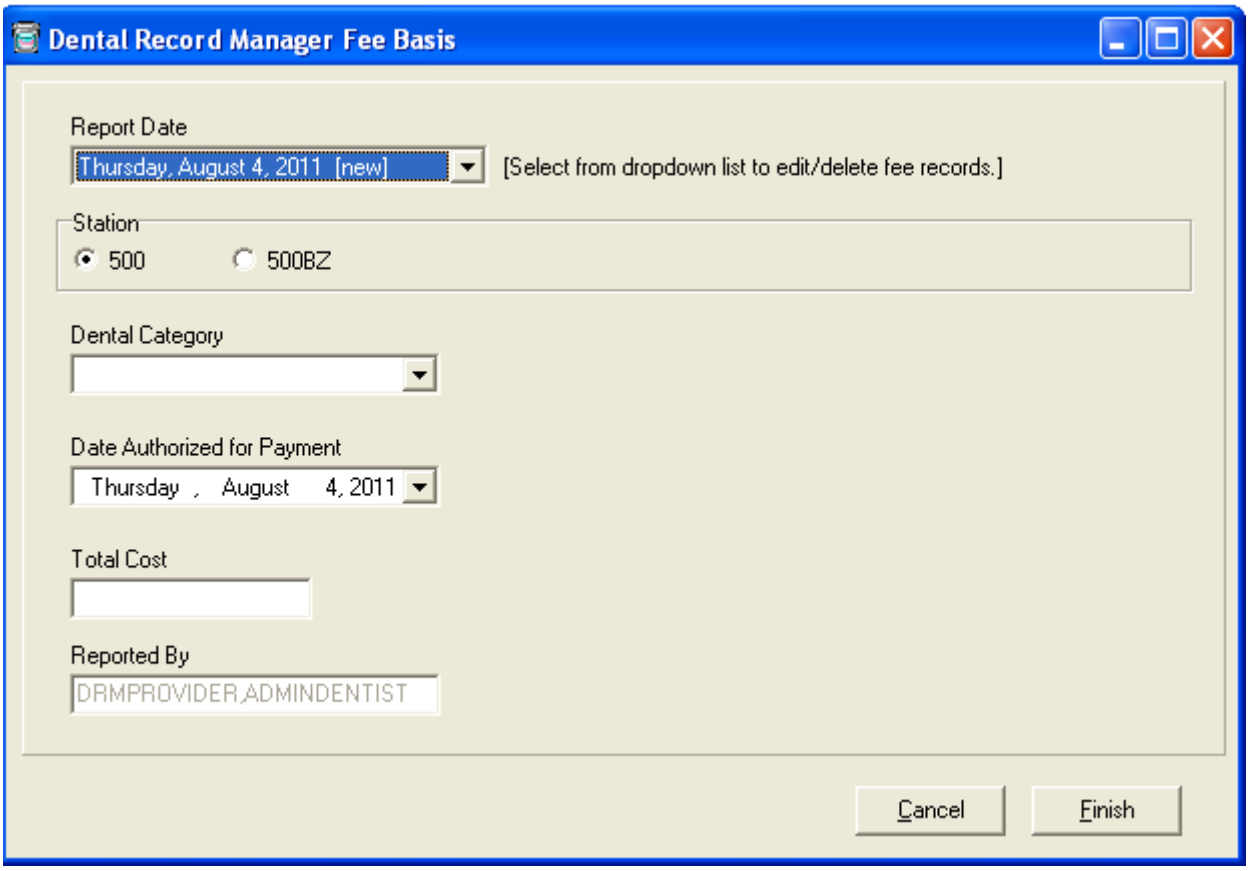
File Administrative Time Screen

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 **OK**. 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-DSS Labor Mapping Access Database Program.

File Fee Basis

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



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 **OK**.

End-users criteria required that allows one to enter fee basis data within DRM Plus includes:

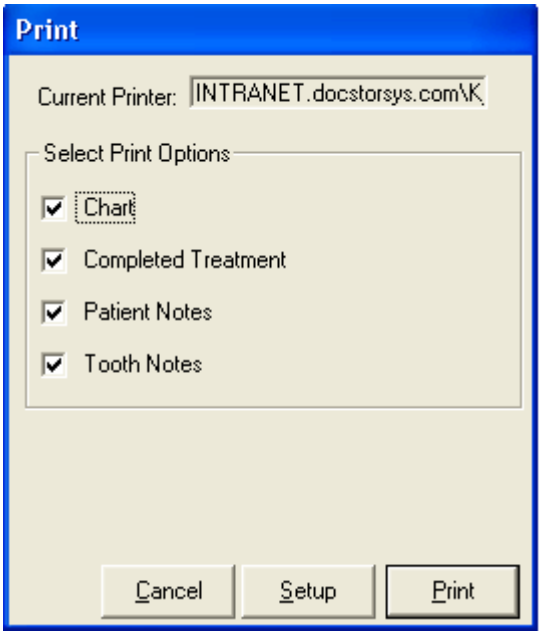
- Does not need to be in the Dental Provider file
- Does not need a Person Class in VistA
- Does need access to CPRS
- Does need access to DRM Plus (DENTV DSS DRM GUI secondary menu option)
- Does not need DRM Plus administrative access

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: Dental HL7 fee basis data no longer transmits to the CFD; however, the data is still available in DRM Plus for any site to enter the information and run a local report.

Print

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

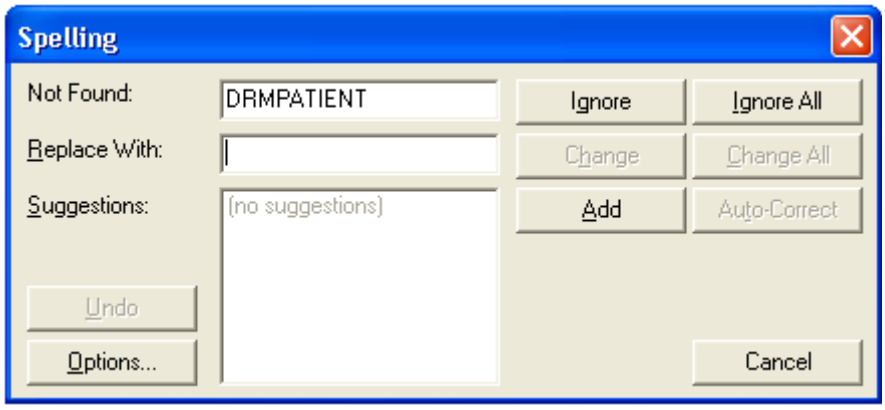


Print Screen

Select the **check box** that corresponds to what are to be printed. The designated printer is listed at the top of the screen.

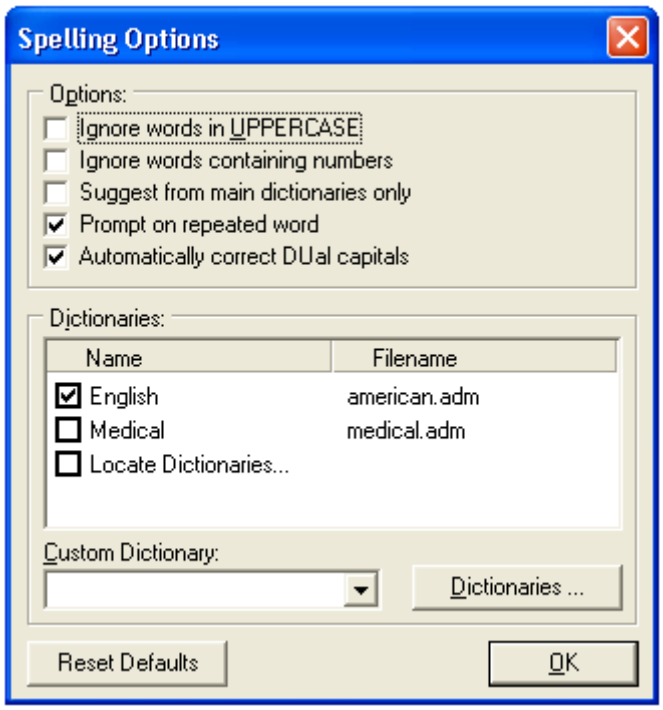
Spell Check

Select **Spell Check** to correct possible spelling errors. This feature is only active in Notes and Note Addendums.



Spelling Screen

The program goes through the text and highlights words that may have been misspelled and suggest 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.

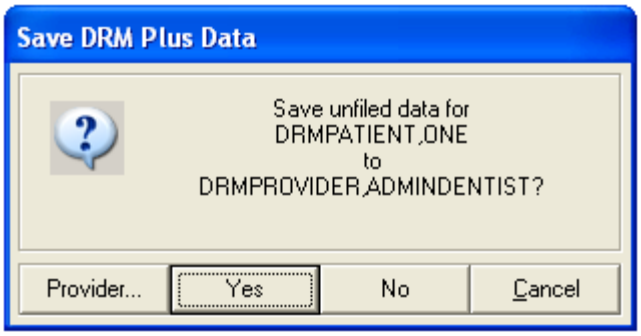


Spelling Options Screen

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

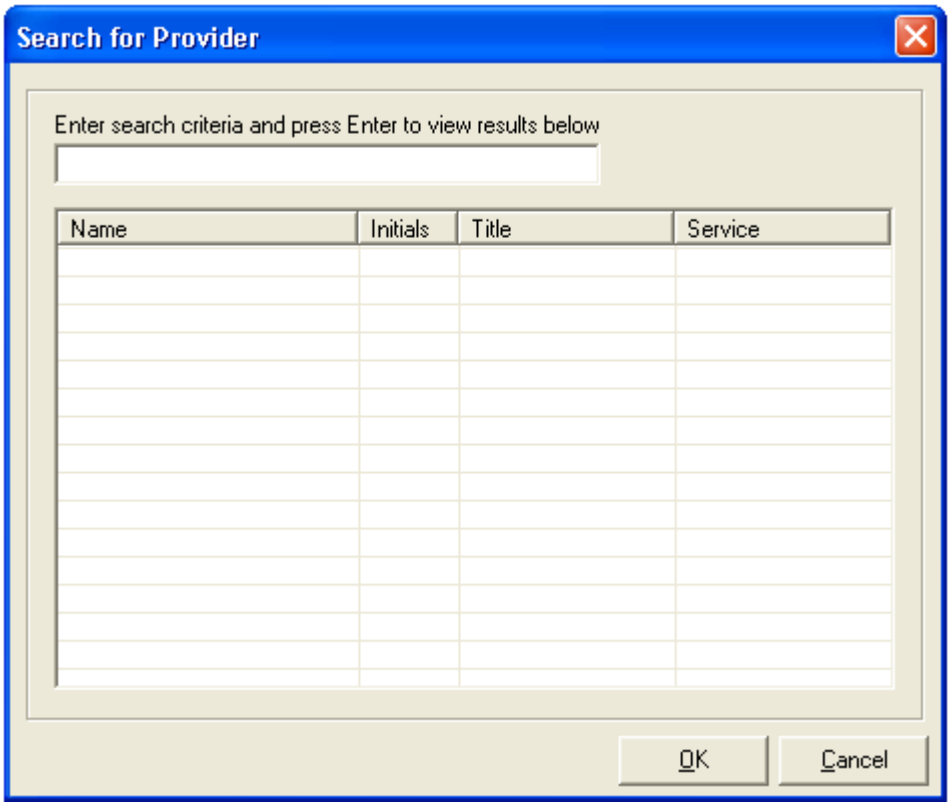
Save Unfiled Data

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



Save DRM Plus Data Screen

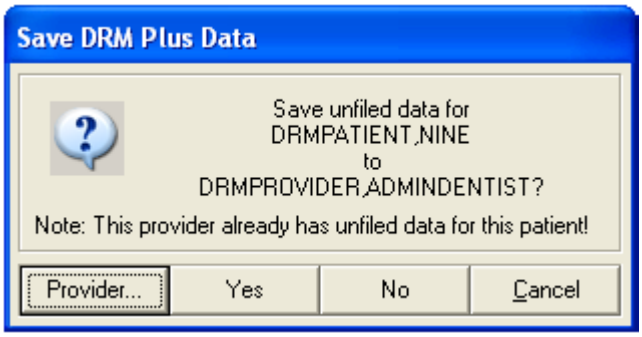
To change the save unfiled data to another provider, click the **Provider...** button.



Search for Provider Screen

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

When a DRM Plus user is saving unfiled data for another DRM Plus user or dental provider for a selected patient, who has previously saved unfiled data that has not been filed for the same selected patient, the user receives the following screen stating "This provider already has unfiled data for this patient!"



Save DRM Plus Data

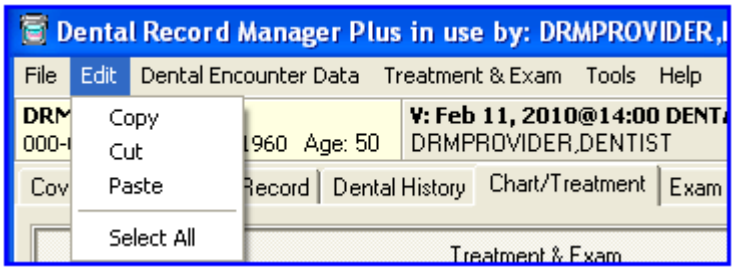
If the user clicks the **Yes** button, previously saved unfiled data originally saved by another dental provider, or this provider, is overwritten. Only one unfiled data entry may be maintained by a single provider, per patient.

Exit

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

Edit

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



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

Place the cursor at the area where the copy or cut text is to be replaced. Select the **Paste** option to add the text to the chosen area.

Select All

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

Dental Encounter Data

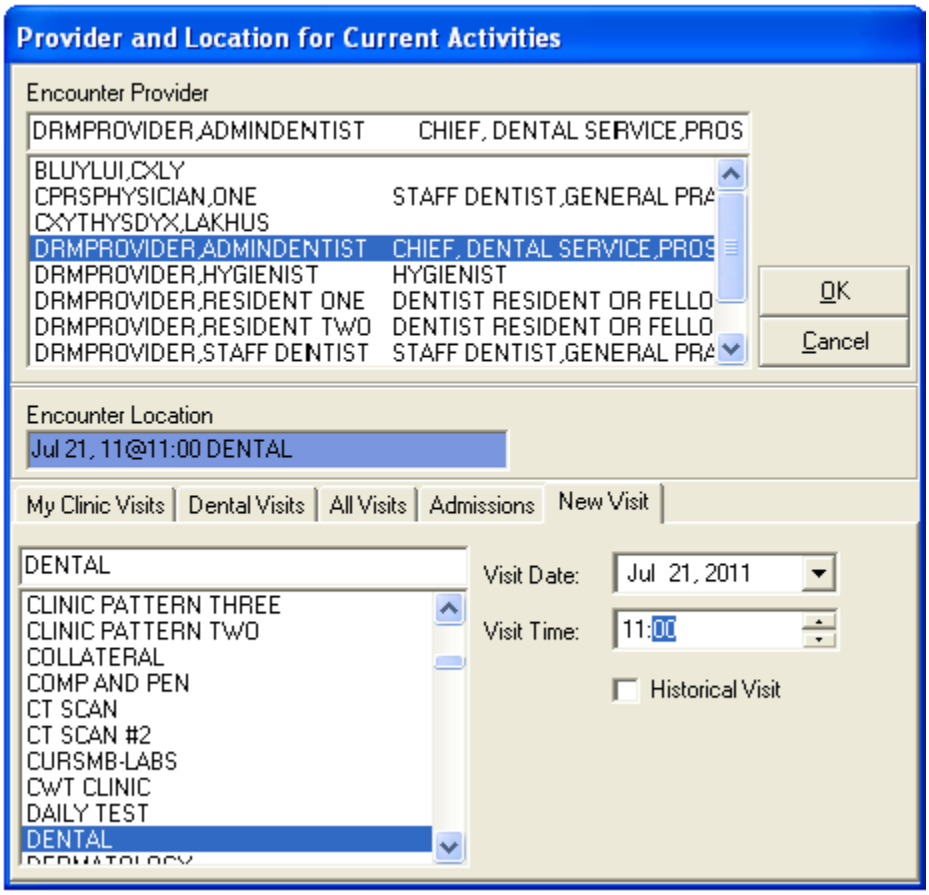
The Dental Encounter Data menu has two options: **Create New PCE Visit** or **View Scheduled Appointments and Historical Visits**.

Dental Encounter Data Menu

Create New PCE Visit

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

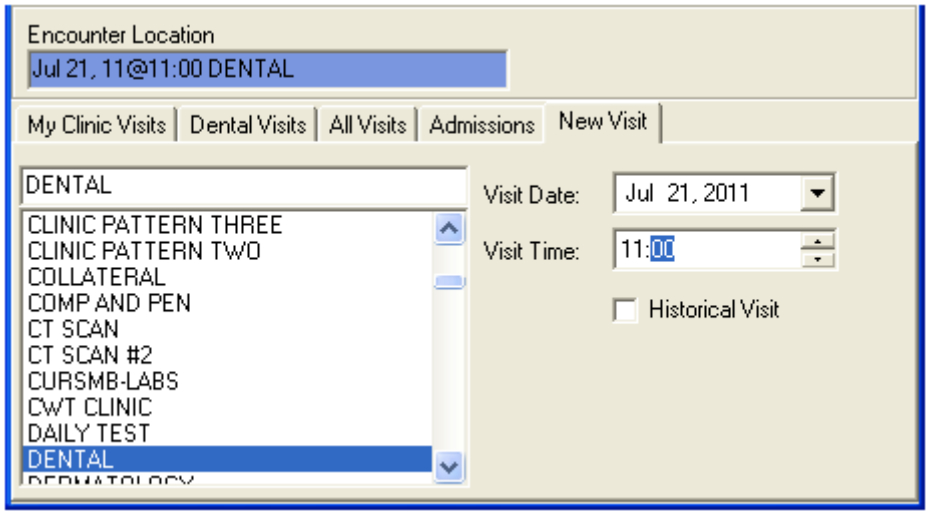
Note: This option is only active or available if the DRM Plus administrator allows New PCE Visits to be created in the DRM Plus application. The opening default tab is the **New Visit** tab.



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 under the chapter entitled Using the DRM Plus Drop-Down Menus in 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.



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 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 Historical visit if applicable.
6. Click the **OK** button to create the new PCE Visit.

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

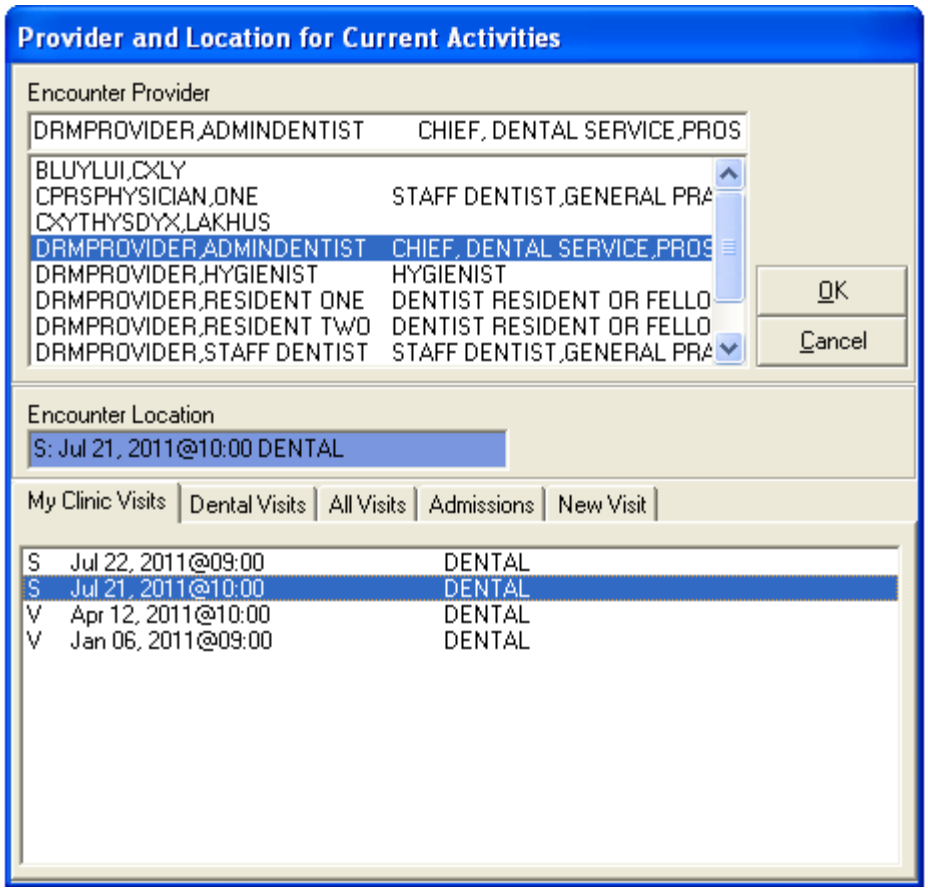
Note: Creating a new PCE Visit in DRM Plus does not update Appointment Manager in VistA.

View Scheduled Appointments and Historical Visits

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

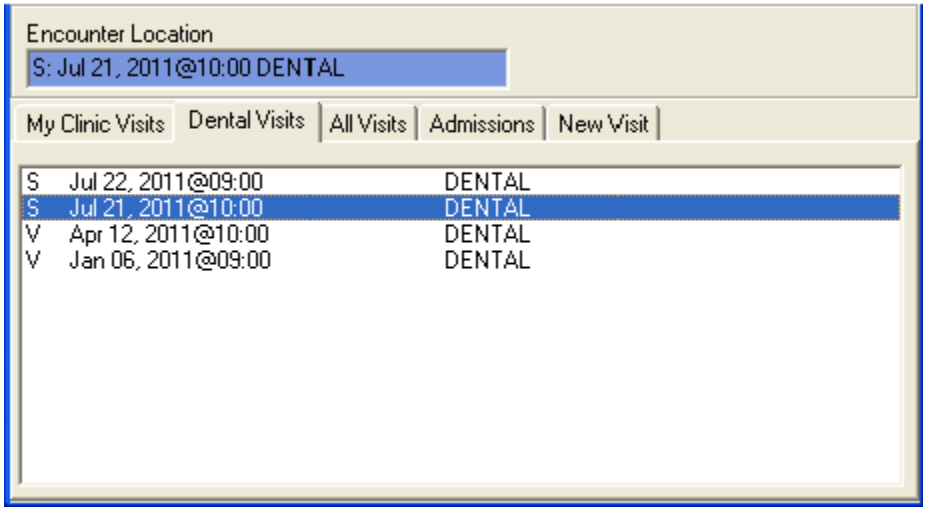
To record the scheduled appointment for the patient:

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 **OK** and the provider/location is set for the scheduled visit.



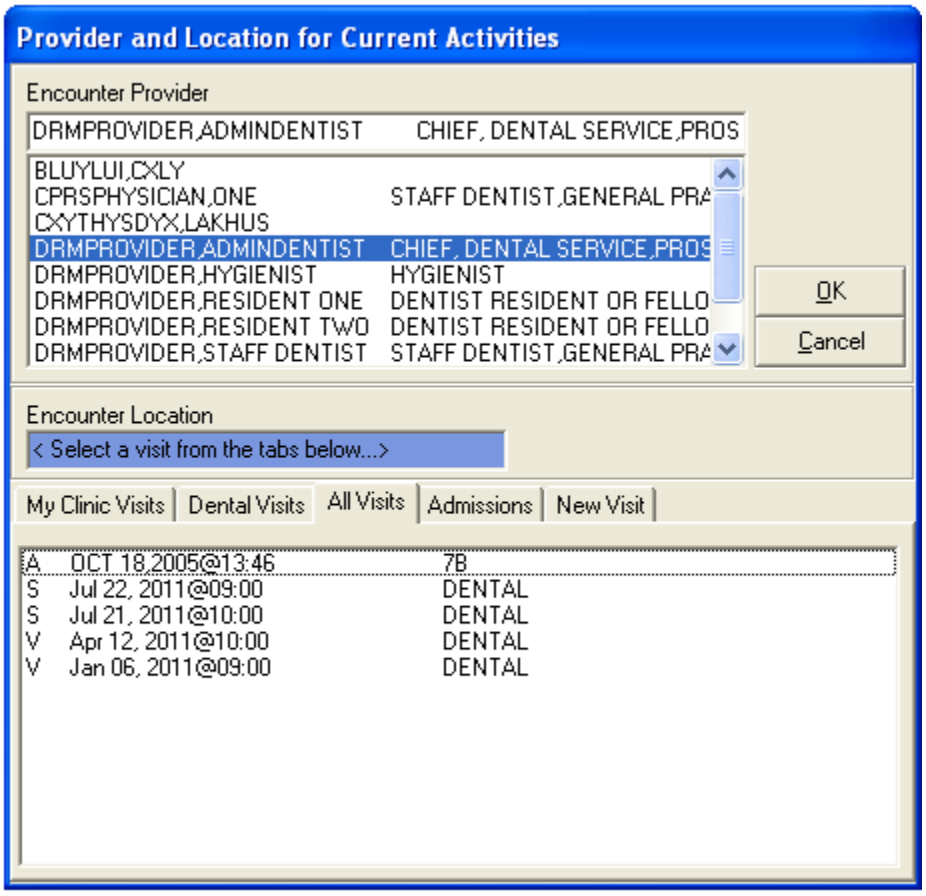
My Clinic Visits Tab

The Dental Visits tab lists all the dental clinic visits.



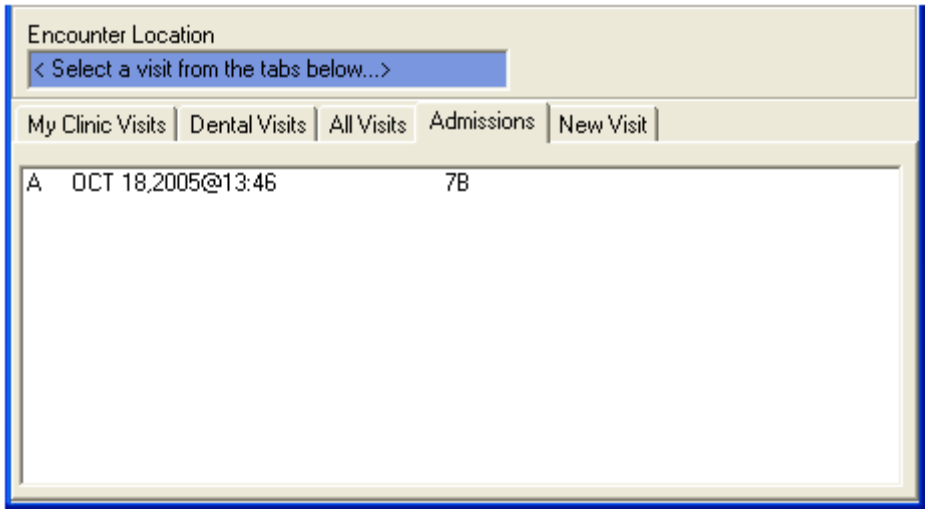
Dental Visits Tab

The All Visits tab lists all the clinic visits for the selected patient.



All Visits Tab

The Admissions tab lists the admissions for the selected patient.

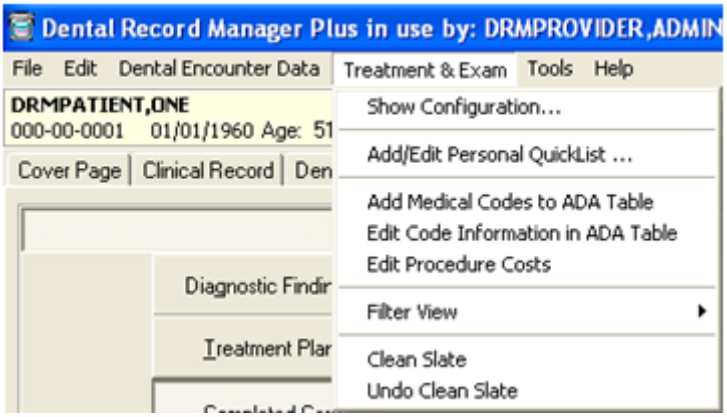


Admission Tab

Treatment and Exam

The Treatment & Exam menu has eight options: Show Configuration, Add/Edit personal QuickList, Add Medical Codes to ADA table, Edit Code Information in ADA Table, Edit Procedure Costs, Filter View, Clean Sate and Undo Clean Slate.

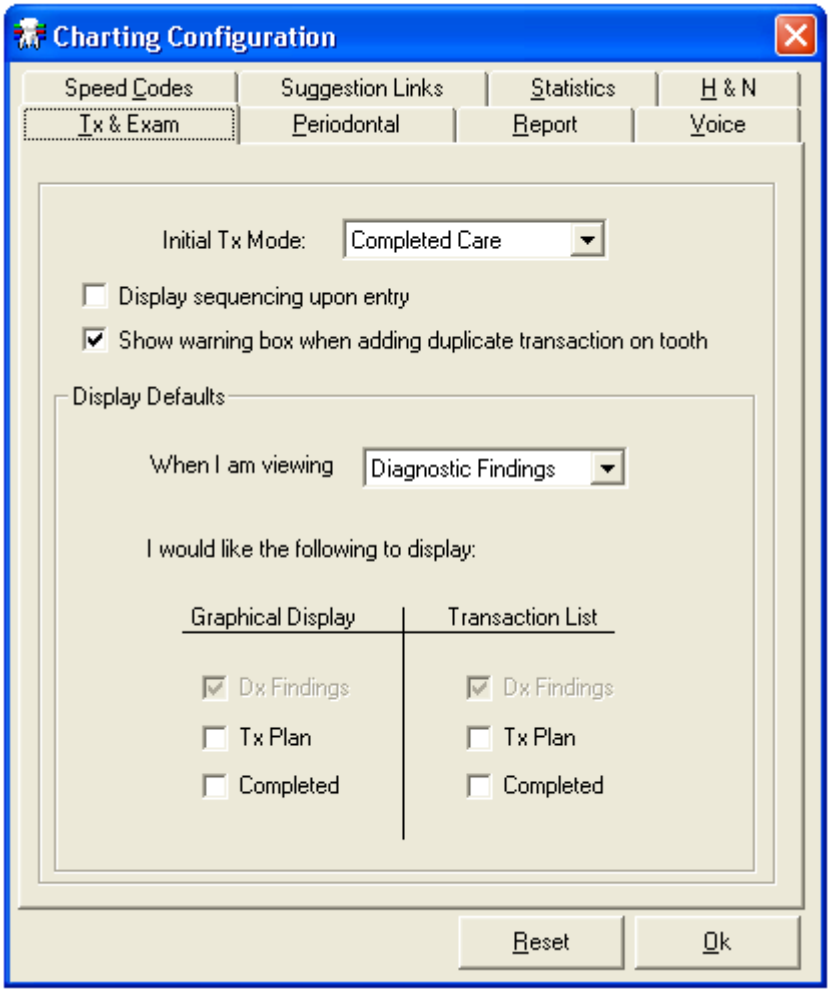
Note: Add Medical Codes to ADA Table, Edit Code Information in ADA Table, Edit Procedure Costs, Clean Slate and Undo Clean Slate are DRM Plus Administrative Functions. Please contact a DRM Plus administrator for more information about these options.



Treatment & Exam Menu

Show Configuration

Select Show Configuration to reach the Charting Configuration screen.



Charting Configuration Screen

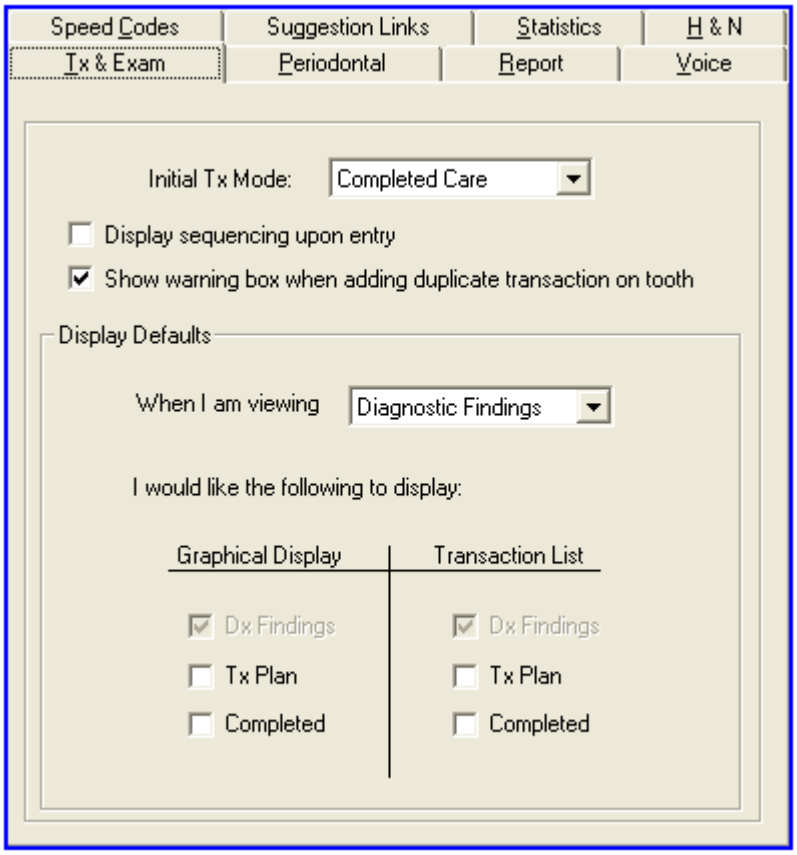
Use the various tabs to configure the chart. The tabs are: **TX & Exam, Periodontal, Report, Voice, H&N, Statistics, Suggestion Links** and **Speed Codes.** These parameters on each tab are a user specific function; changing it does not impact other users. When finished, click **OK**.

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.

Sequencing screen displayed upon entry is not selected as a default parameter; however, showing a warning box when adding duplicate transaction on a tooth for each view chart is a default parameter. Use the checkboxes to change these user specific parameter functions.

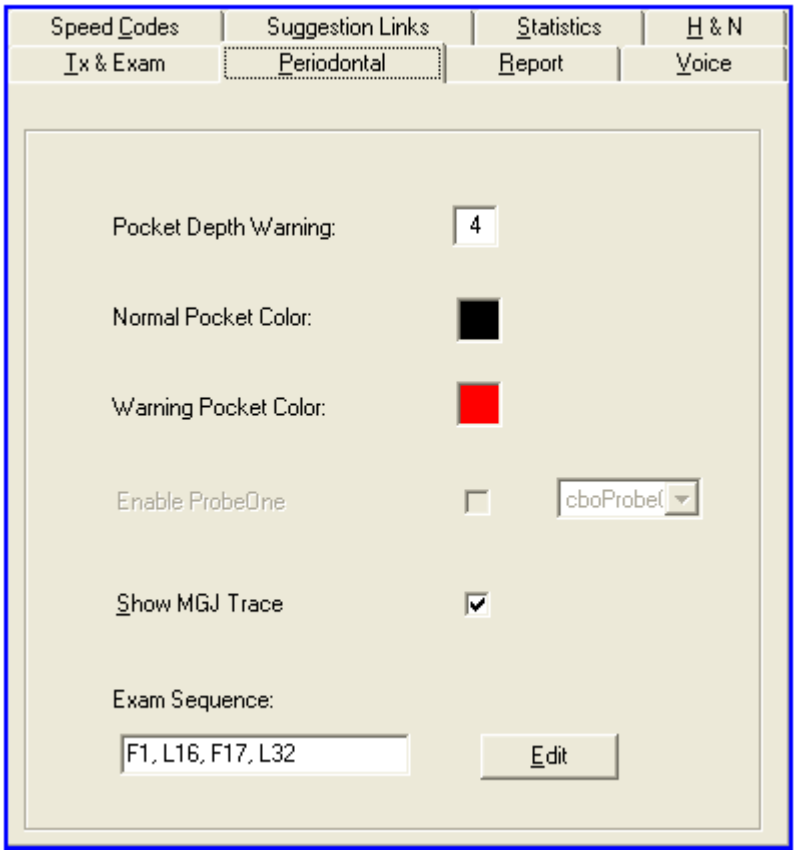
Use the functions on this tab to fine tune the Display Defaults; choose Graphical Displays or Transaction Lists to display check boxes based on the screen being viewed.



Tx & Exam Tab

Periodontal

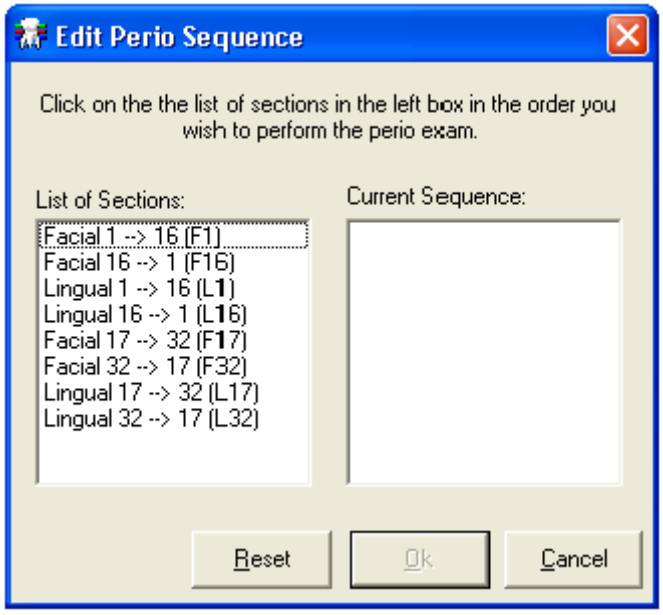
Choose the Periodontal tab to set pocket depth warning and choose the colors that appear as pocket warnings and normal pockets on the Periodontal Chart screen. Other options on this tab include MGJ Trace and Exam Sequence.



Periodontal Tab

To change the exam sequence:

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



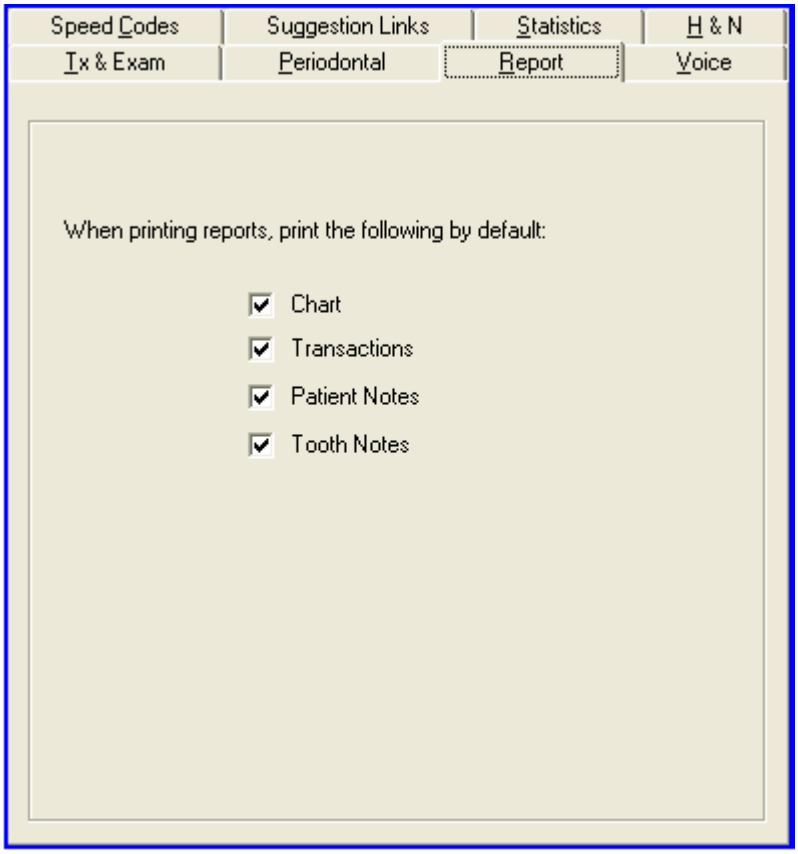
Edit Perio Sequence Screen

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

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

Report

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



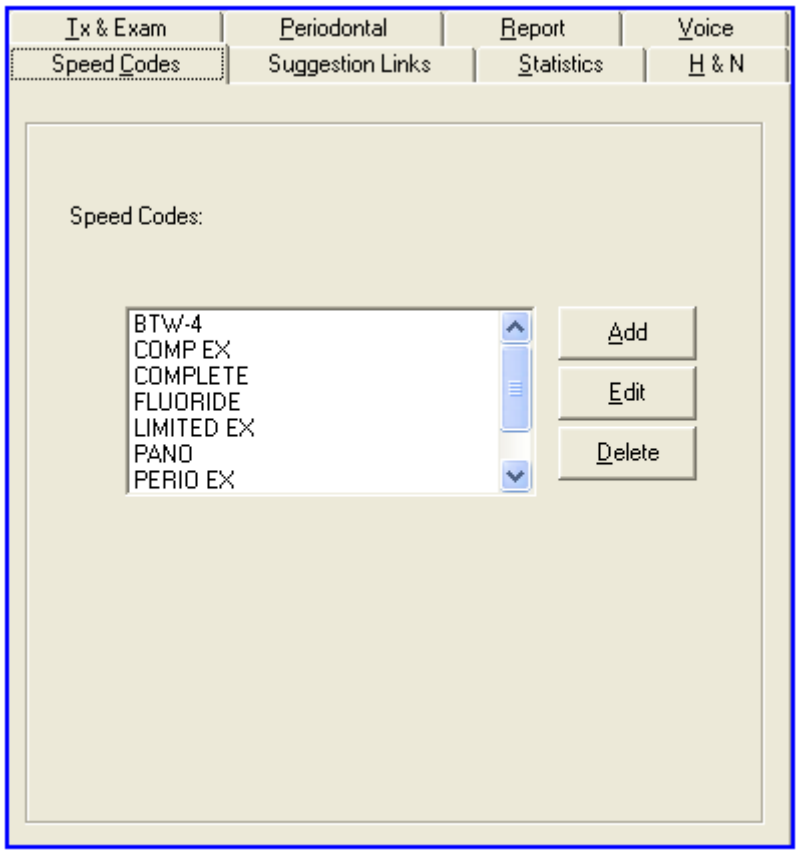
Report Tab

Voice

Voice is not enabled in DRM Plus.

Speed Codes

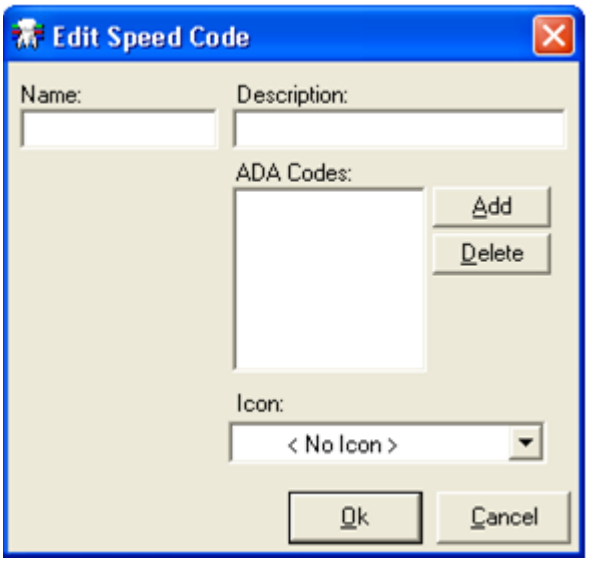
Use the Speed Codes tab to set/create individual icons in DRM Plus for frequently used procedure codes entered using the Treatment Plan or Completed Care viewing screens.



Speed Codes Tab

To add a Speed Code:

1. Click **Add**. 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 **OK** to begin finalization.

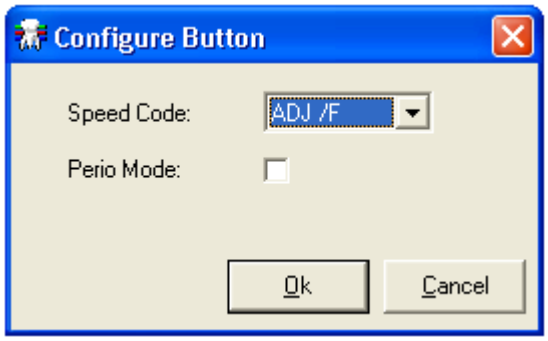


Edit Speed Code Screen

To edit or delete the speed code, highlight the desired name in the Speed Codes screen and click **Edit** or **Delete**. 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.



Configure Button Screen

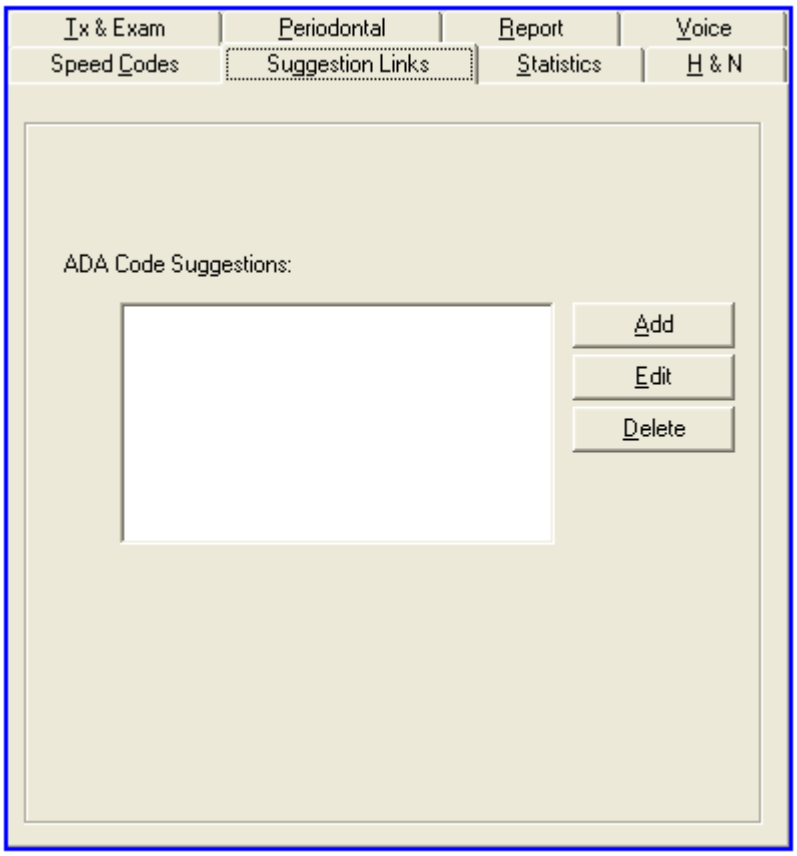
3. Click the **drop-down arrow**, highlight and click the **desired Speed Code name**.
4. Click the **OK** button and the Speed Code is linked to that icon.

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 section of this manual entitled Perio Buttons Icon under the chapter entitled Chart/Treatment -- Treatment & Exam for more information.

Suggestion Links

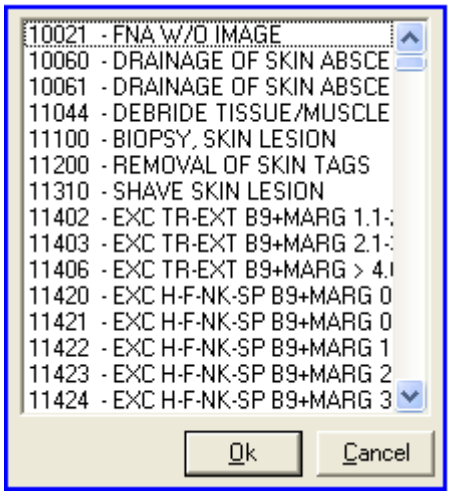
Use this tab to enter code suggestions, when entering one procedure code which is linked to another procedure code(s), without having to use an icon to find the other code. A screen displays asking if other linked codes should be added providing an opportunity to decline the entry of suggested linked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



Suggestion Links Tab

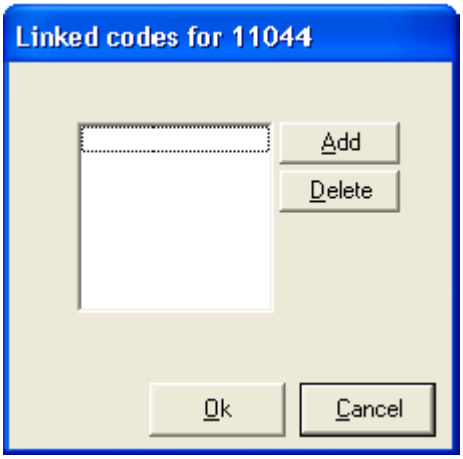
To add a suggestion link:

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 **OK**.



Suggestion Links List

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



Linked Codes Screen

4. Click the **Add** button to add the first linked code. The list of all DRM Plus procedure codes appears 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.

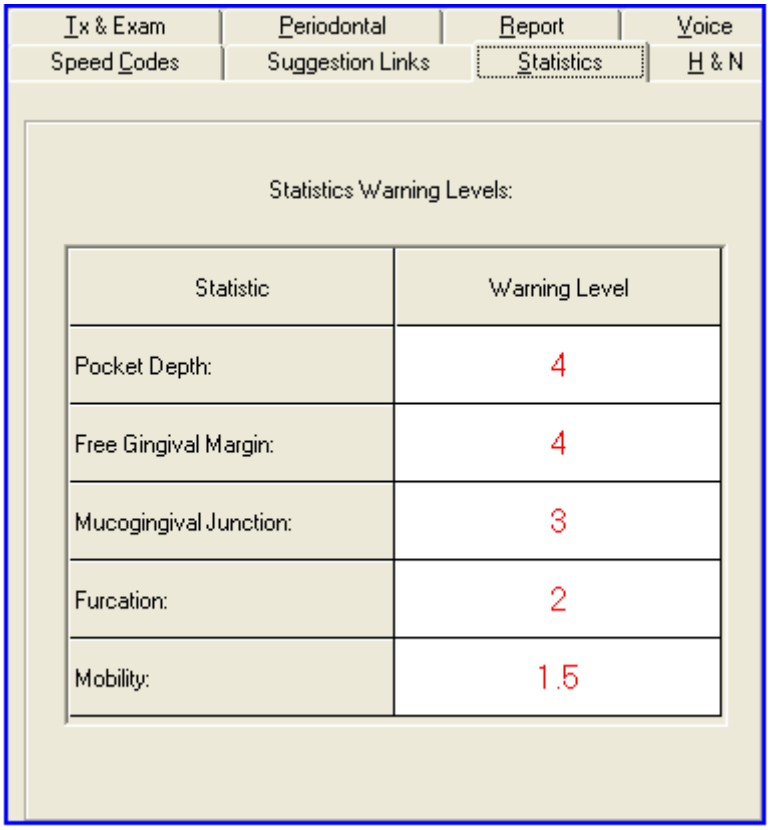
To edit the suggestion link:

1. Select a suggestion link to be edited and click the **Edit** button. The Linked Codes screen displays.
2. Click **Add** for another procedure code, and the list of procedure codes appear. 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

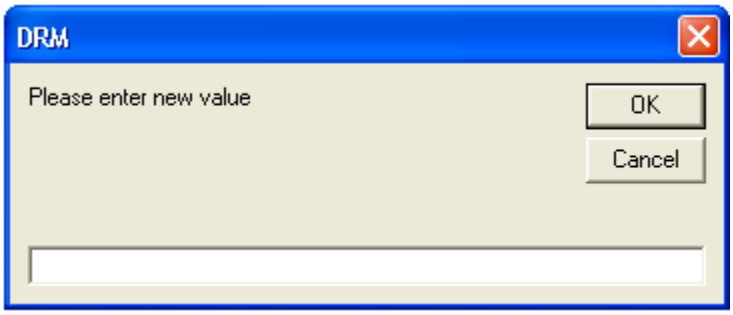
Choose the Statistics tab to set the warning level for pocket depth, free gingival margin, mucogingival junction, furcation and mobility.



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.

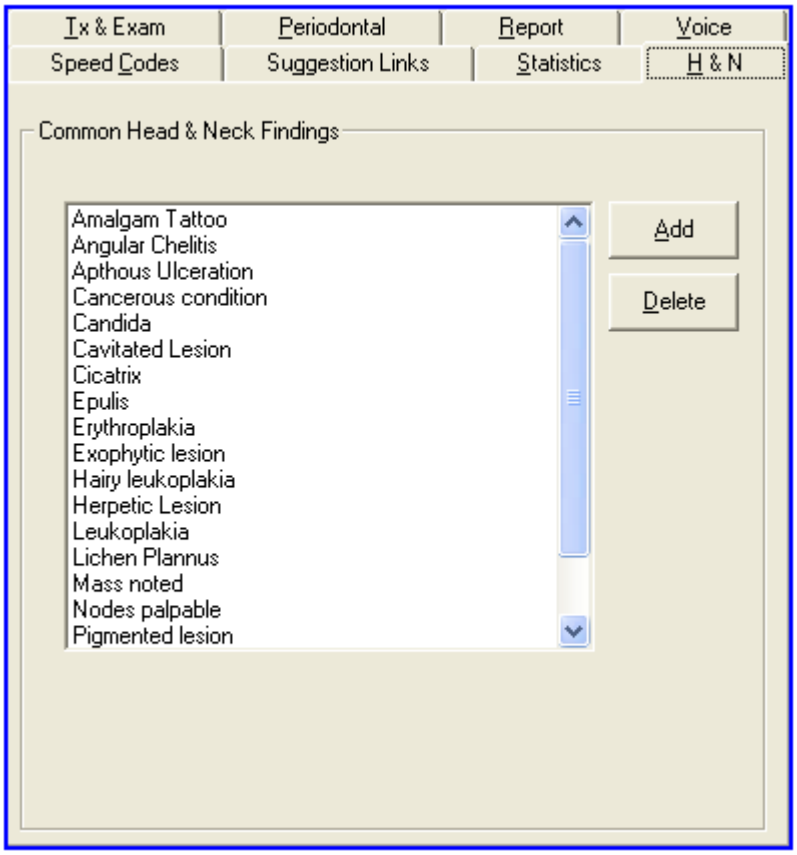


Adjust the Warning Level

3. The warning level is changed on the tab.

H&N

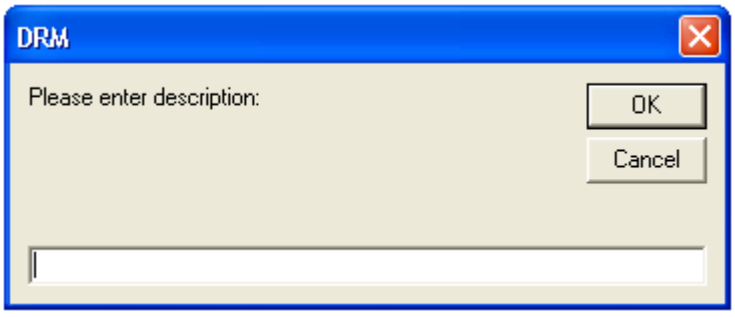
Use the **Add** and **Delete** buttons to add/delete the head and neck findings available on the H&N screen in the Treatment & Exam and Periodontal Chart screens.



H&N Tab

To add an H&N finding:

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



DRM Plus Description Screen

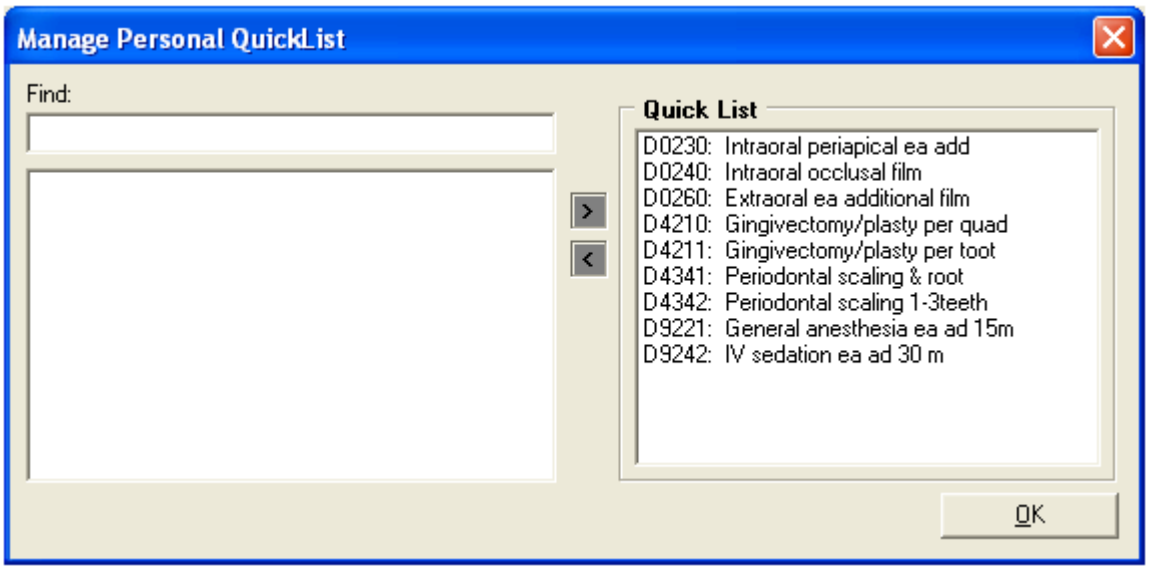
3. Click the **OK** button. The finding is added.

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

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

Add/Edit Personal QuickList

Select this option to manage a QuickList of codes for personal use. For additional convenience, enter frequently used procedure codes that have multi-add functionality associated with the code, into the QuickList. The Manage Personal QuickList screen displays.



Manage Personal QuickList Screen

To add to the QuickList:

1. Type the search criteria into the Find text box. Search by words or numbers.
2. A matching list appears 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 QuickList.
4. Click the **OK** button to end and close the screen or repeat to add another code to the QuickList.

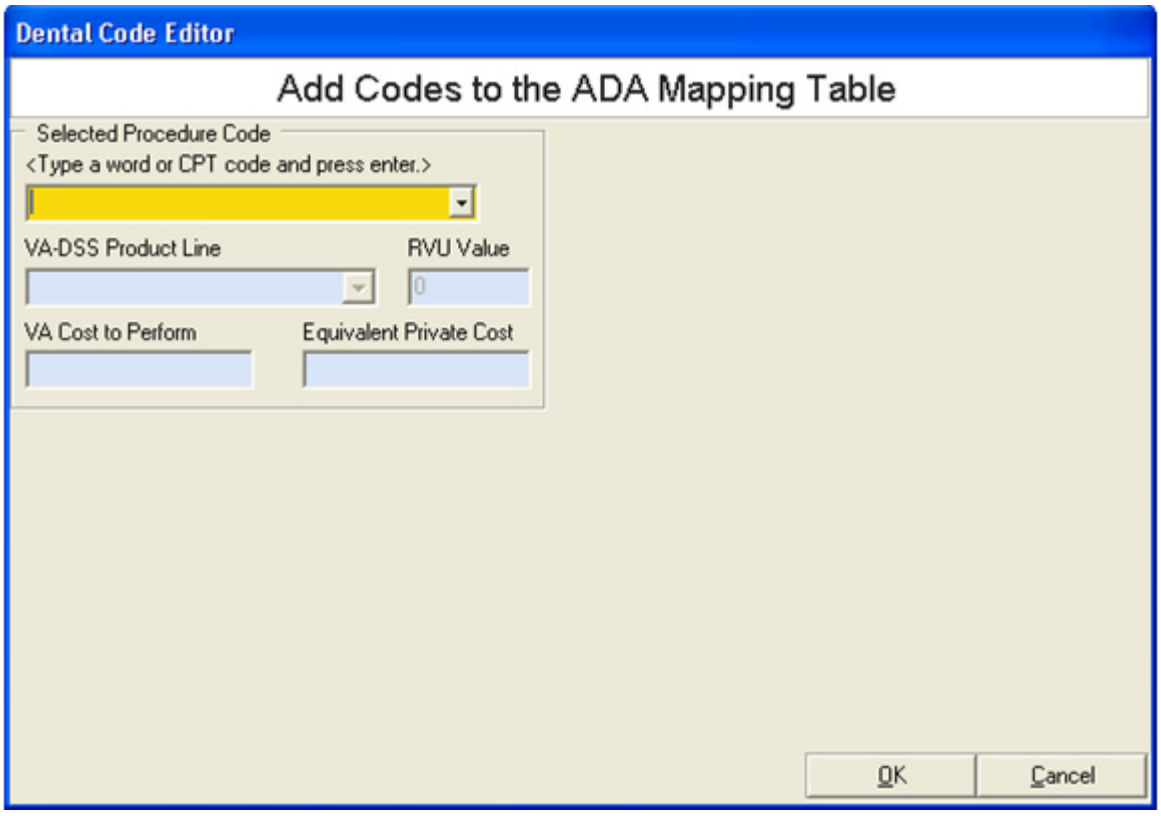
To remove from the QuickList:

1. Select an entry from the QuickList 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 QuickList are accessed through the Quick Code icon.

Add Medical Codes to ADA Table

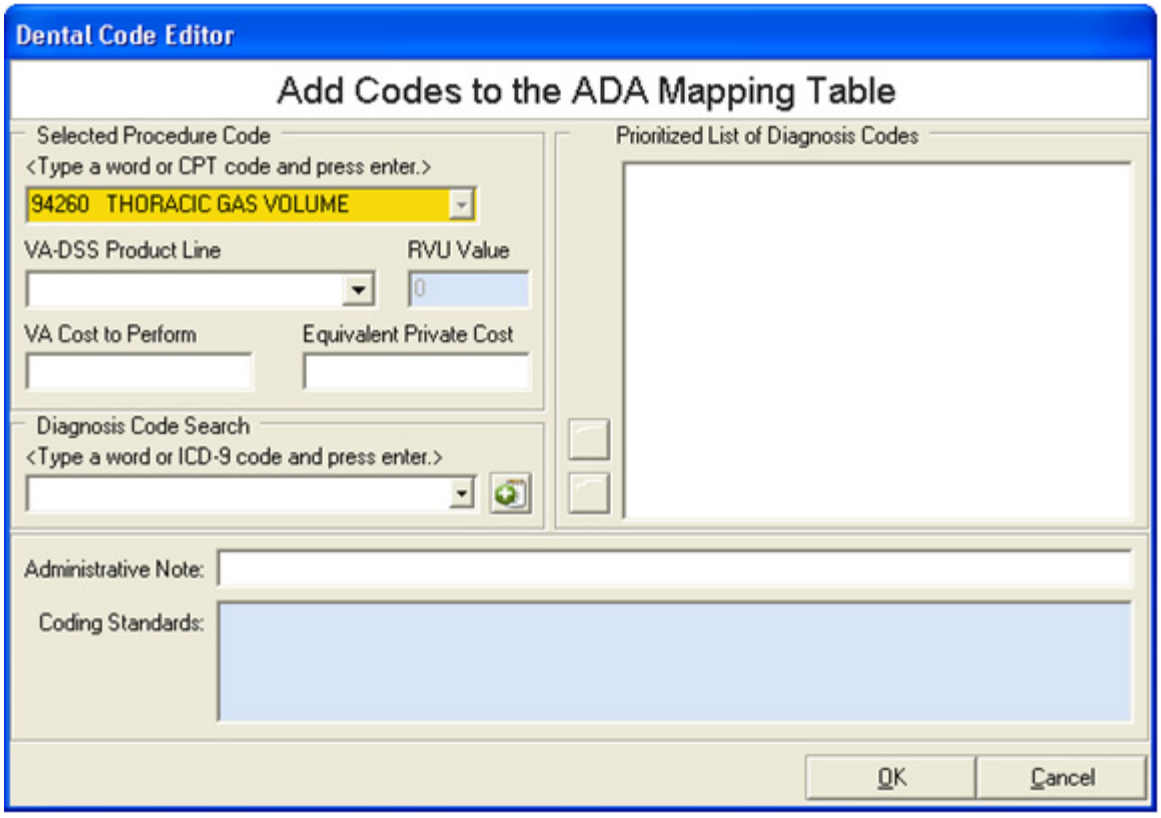
A DRM Plus administrator may select this function to add medical CPT procedure codes to the ADA Mapping Table. Each medical CPT procedure code must have at least one designated ICD-9 diagnosis code entered with it. Once an ICD-9 diagnosis code has been designated, it may be changed at any time. These changes apply only to the local VistA system for specific facilities.



Dental Code Editor Screen

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

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



Dental Code Editor Screen with Additional Fields

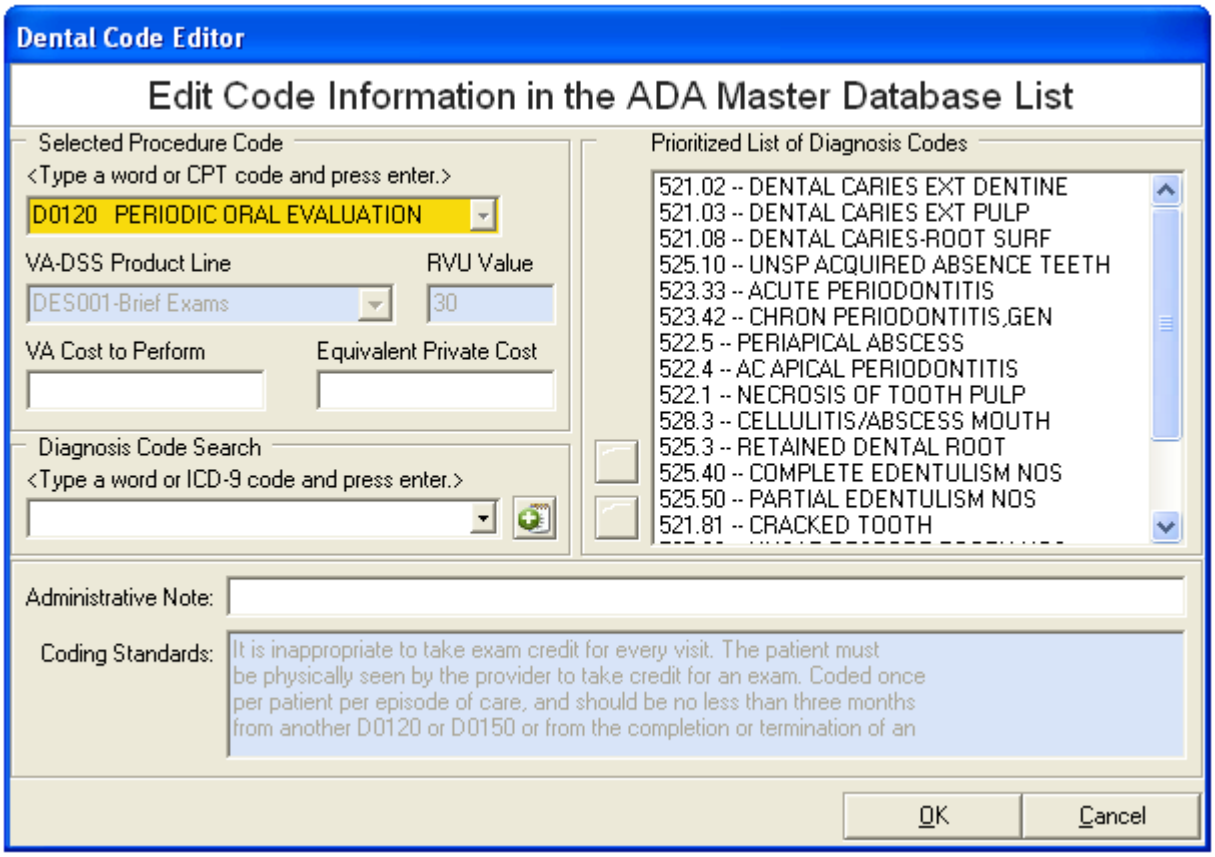
5. Choose the VistA DES code from the VA-DSS Product Line drop-down menu. Enter the VA Cost to perform and the Equivalent Private Cost information in the respective text boxes. The VA-DSS Product Line field is required; the cost fields are optional.
6. The RVU Value in the text field is always zero for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

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

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

Edit Code Information in the ADA Table

Select this function to edit all CPT dental and medical procedure codes on the ADA mapping table. ICD-9 diagnosis codes may be added to the existing national list of ICD-9 diagnosis codes; however, the existing national list of ICD-9 diagnosis codes may not be edited.



Dental Code Editor Screen

To edit a code in the ADA Master Database List:

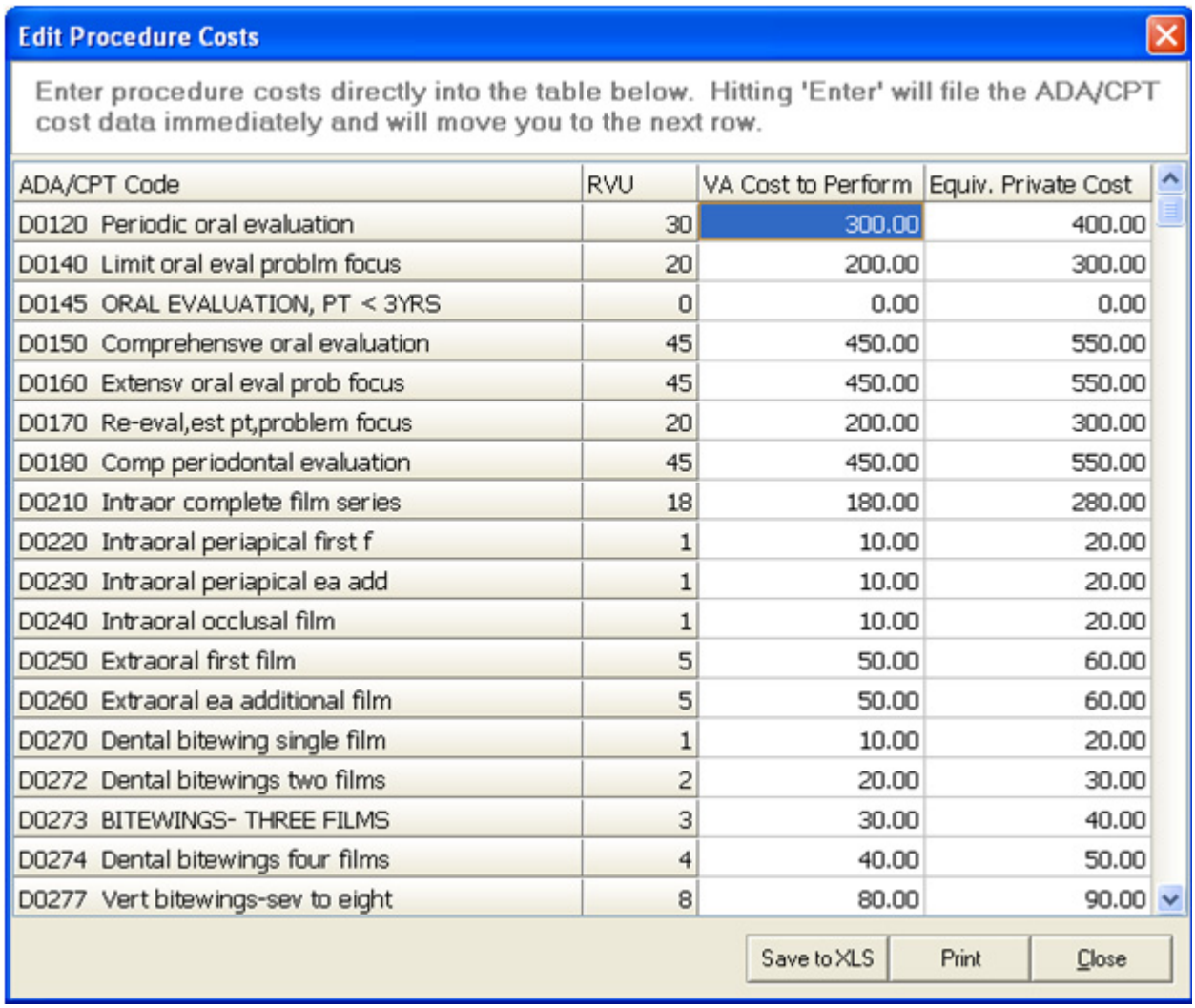
1. Type in the search term in the yellow drop-down box. Only those codes which are in the ADA master database list appear.
2. The VA-DSS Product Line, RVU Value and Coding Standards cannot be edited.
3. Type in the fields that are to be edited; the VA Cost to Perform, Equivalent Private Cost, prioritized List of Diagnosis Codes and the Administrative Note fields can be edited.
4. To add a list of local ICD-9 diagnosis codes, see the previous Add Medical Codes to ADA Table section and follow steps 7-10.
5. When finished, click the **OK** button.

Note: When any ICD-9 diagnosis codes are added to a CPT procedure code, a line appears dividing the list into the preset national list of ICD-9 diagnostic codes above the line, and the added local ICD-9 diagnostic codes below the line.

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

Edit Procedure Costs

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



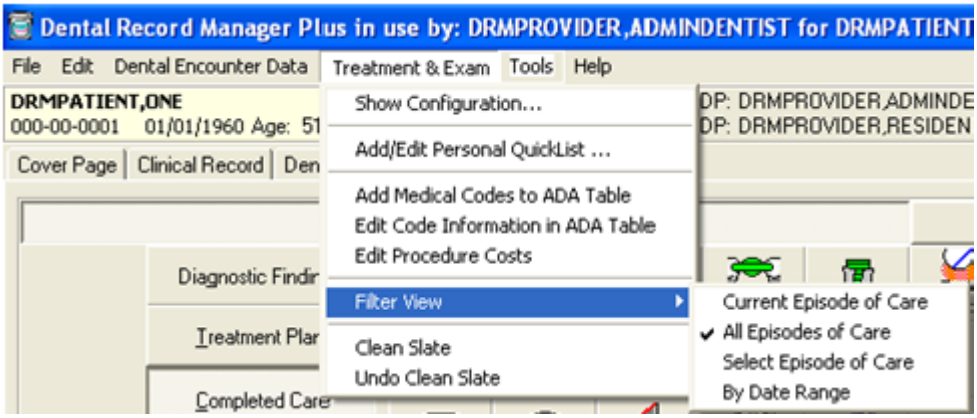
Edit Procedure Costs Screen

To add/edit a procedure code cost:

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

Filter View

Use the Filter View function to choose which encounters appear on the Chart/Treatment tab of DRM Plus.



Filter View Options

Current Episode of Care

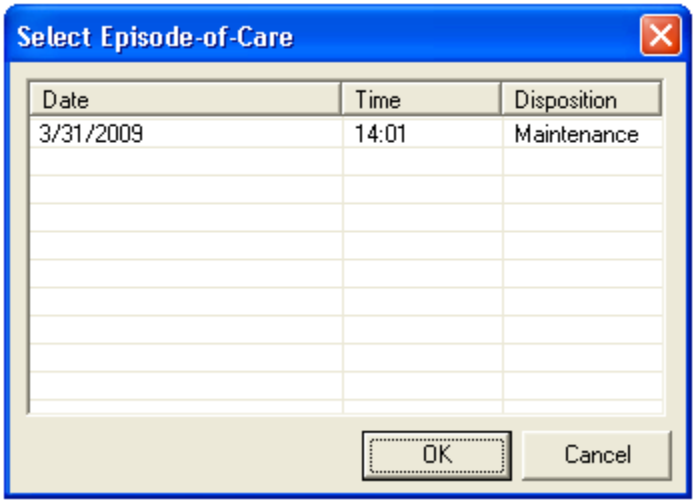
Choose this filter to show only those treatments that have been completed for all visits during the current disposition or patient status.

All Episodes of Care

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

Select Episode of Care

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

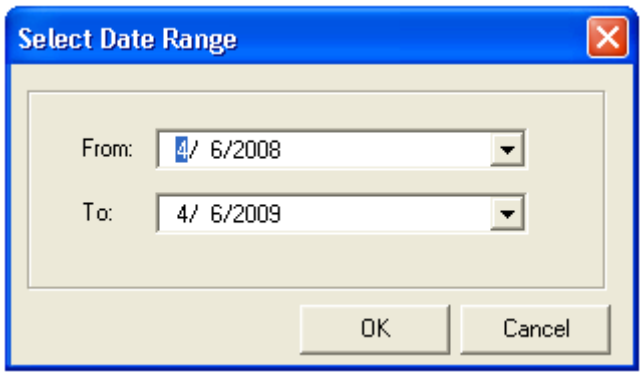


Select Episode of Care Screen

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

Date Range

Choose 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.



Select Date Range Screen

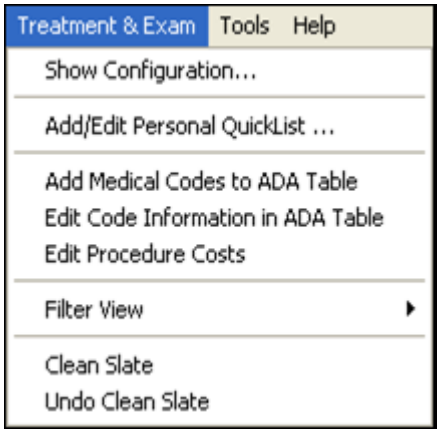
To filter by date range:

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

Clean Slate

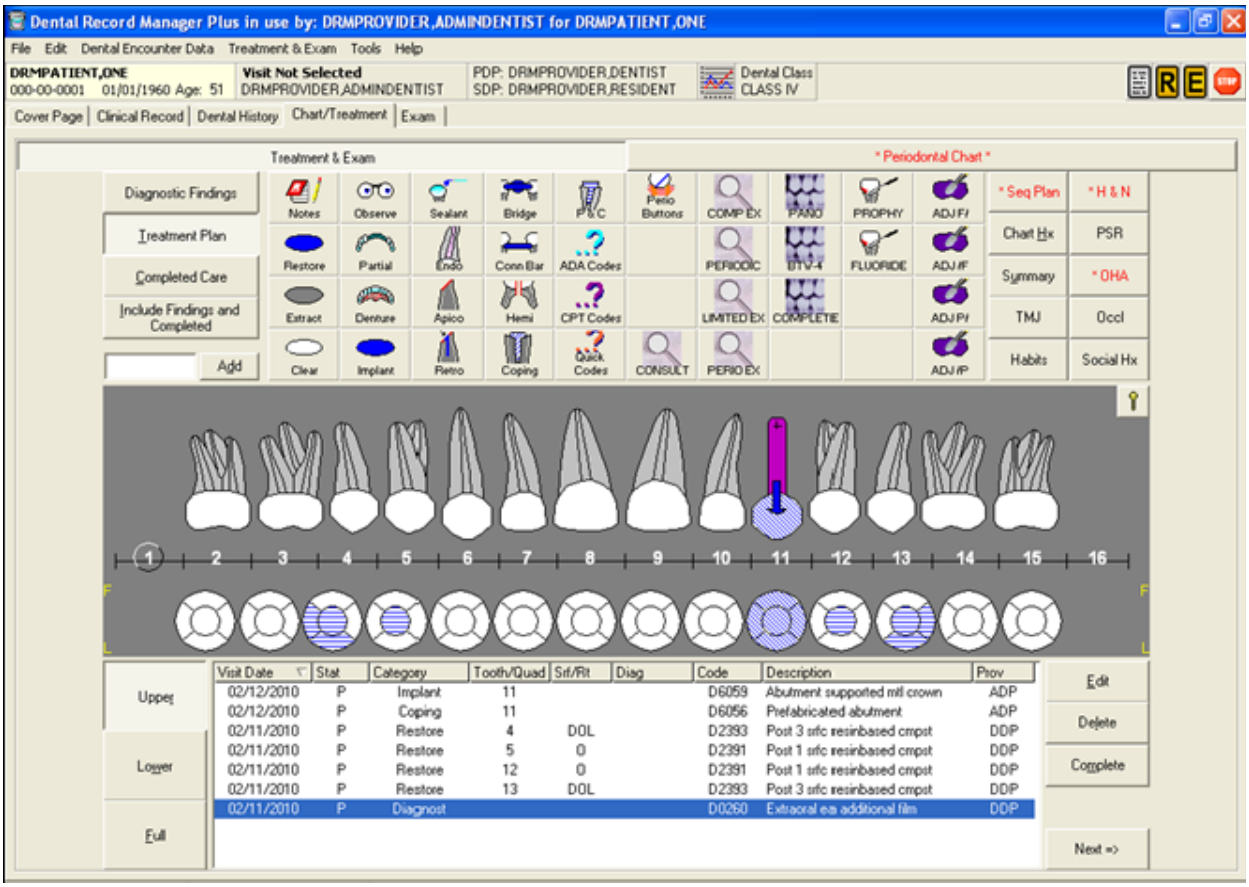
Clean Slate functionality clears the graphical portion of the Treatment & Exam screen, and deletes all planned treatment for the selected patient. The new clean slate can be restored for this patient at any time until a new encounter has been filed on this patient's chart. The deleted planned treatment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

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



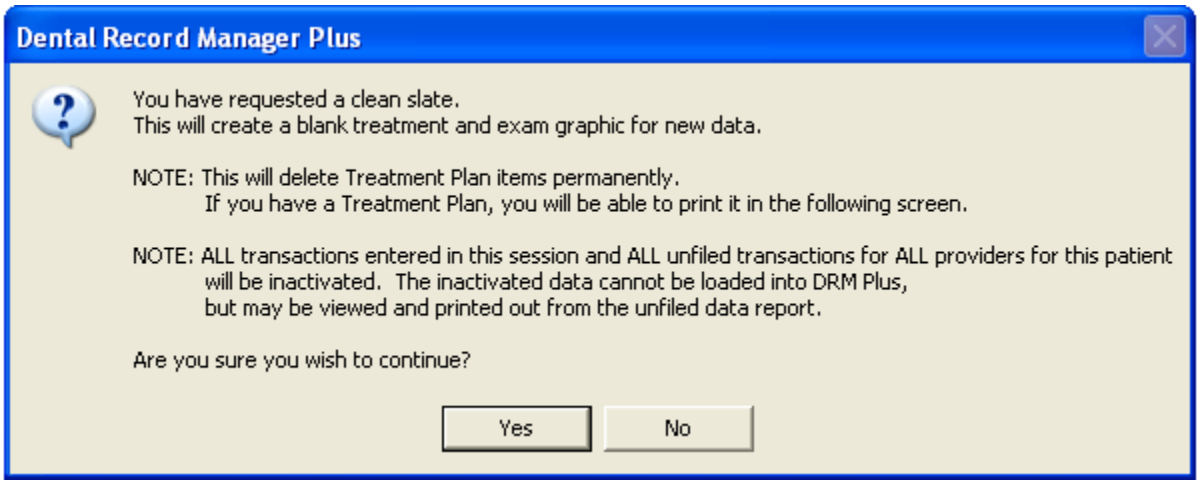
Clean Slate Option

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



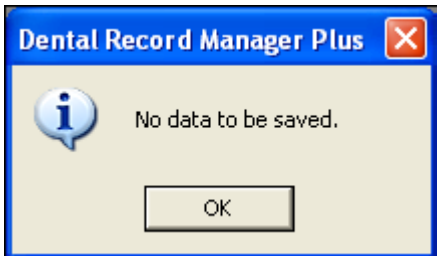
Patient Chart

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



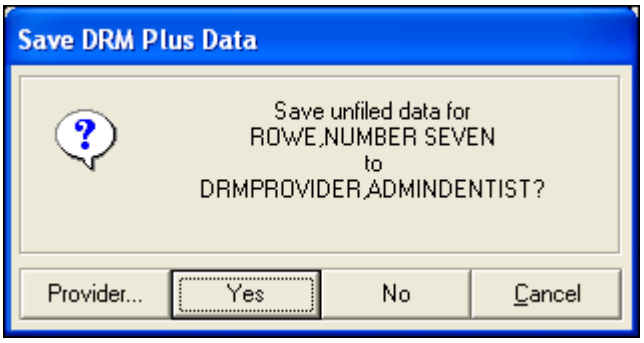
Clean Slate Screen

The next screens may or may not display to the administrator. The first screen, Dental Record Manager Plus, only displays if there was any unfiled data that was saved for this patient by any provider in the past. This unfiled data is inactivated if the administrator completes the Clean Slate.



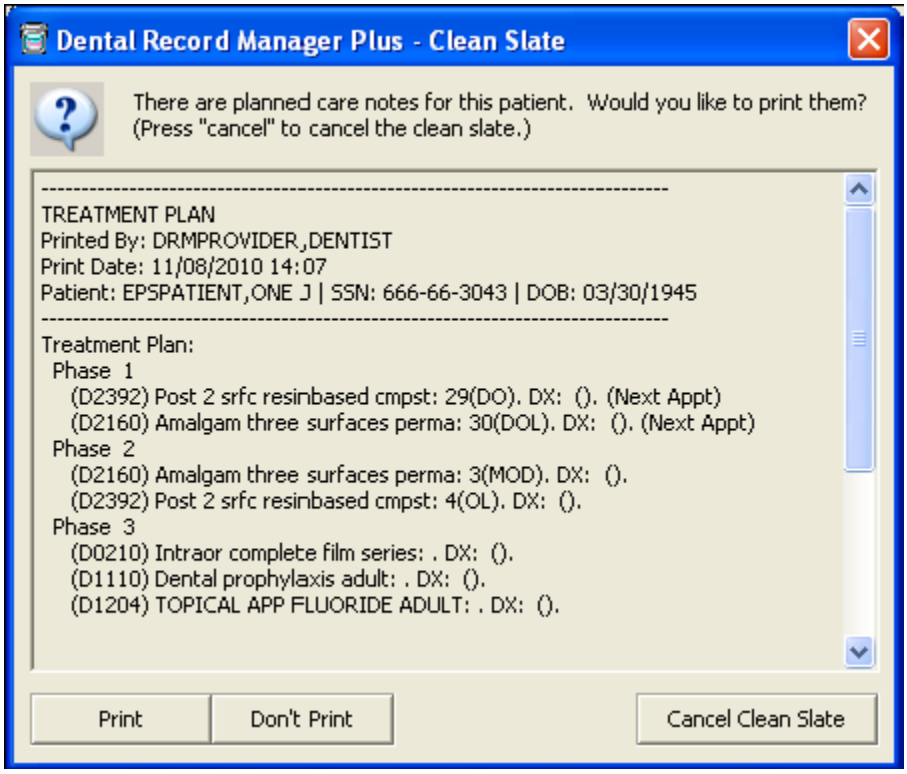
No Data Saved

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



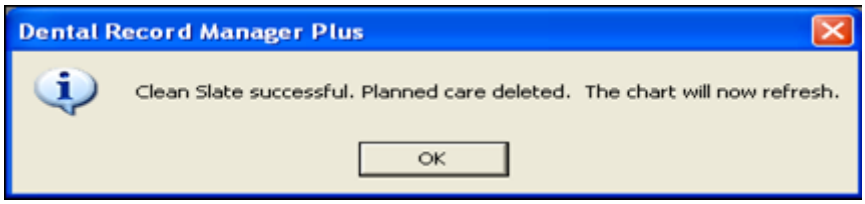
Save DRM Plus Data

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



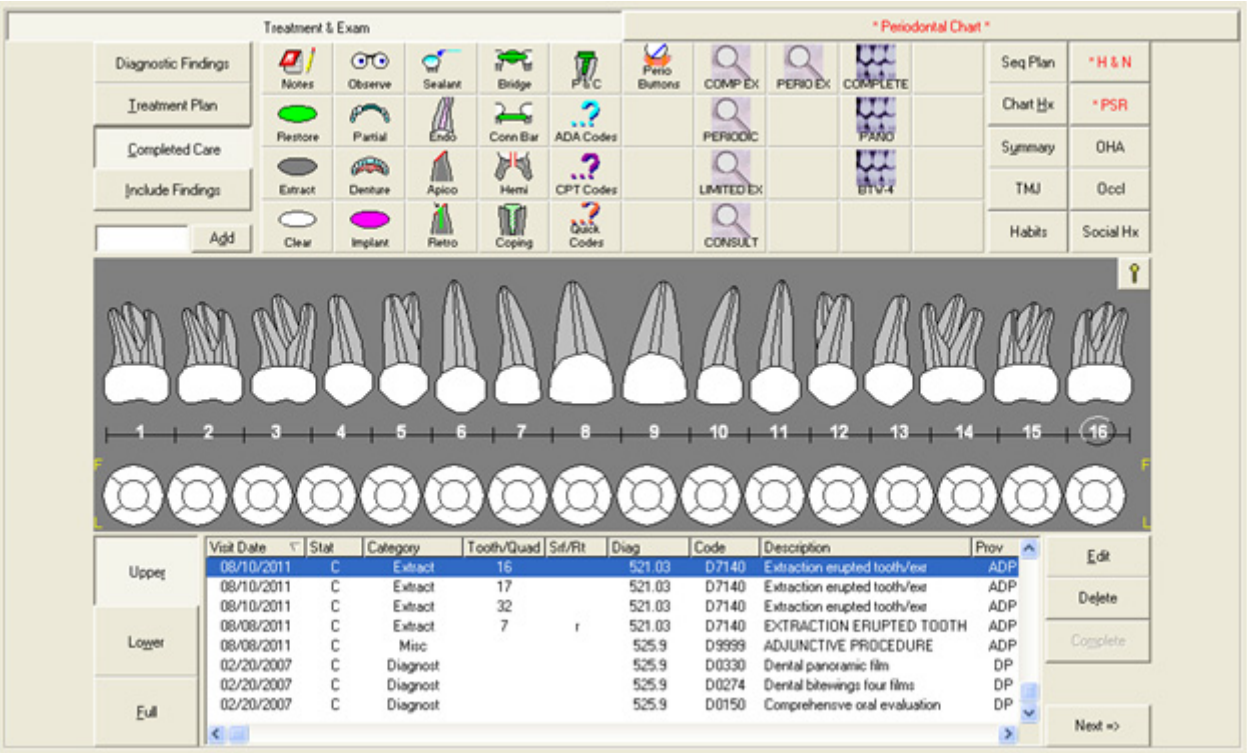
Print Planned Care Notes

The following screen displays to inform the clean slate was successful, click the **OK** button.



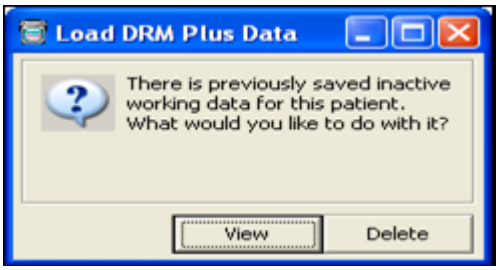
Clean Slate Successful

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



Patient Chart

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



Load DRM Plus Data Screen

The Clean Slate displays an icon in the banner showing the last clean slate date performed on this patient's chart. This icon is permanently on this patient's chart, however it is updated with a current date when another clean slate is performed on this patient's chart.

Clean Slate Banner Icon

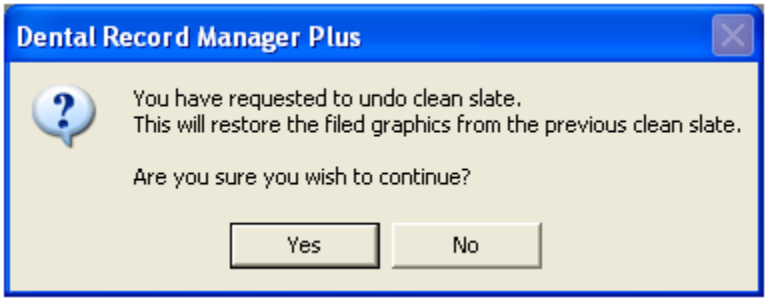
Note: The Clean Slate option may not be used for any filed completed transaction corrections or any encounters filed incorrectly on a dental patient. These still have to be deleted by the DRM Plus Administrator using the line item deletion function or the complete encounter deletion function.

Undo Clean Slate

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

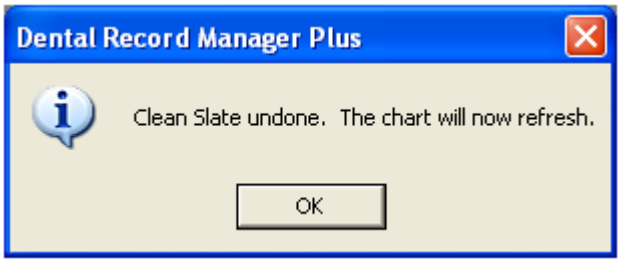
To utilize the Undo Clean Slate function:

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



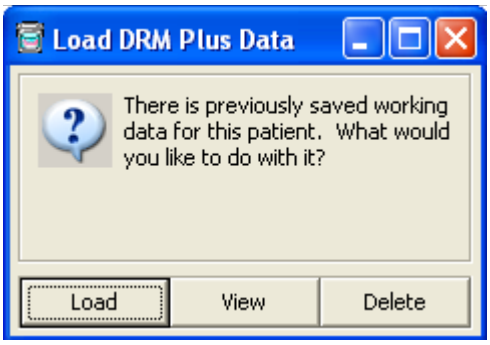
Undo Clean Slate Message Screen

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



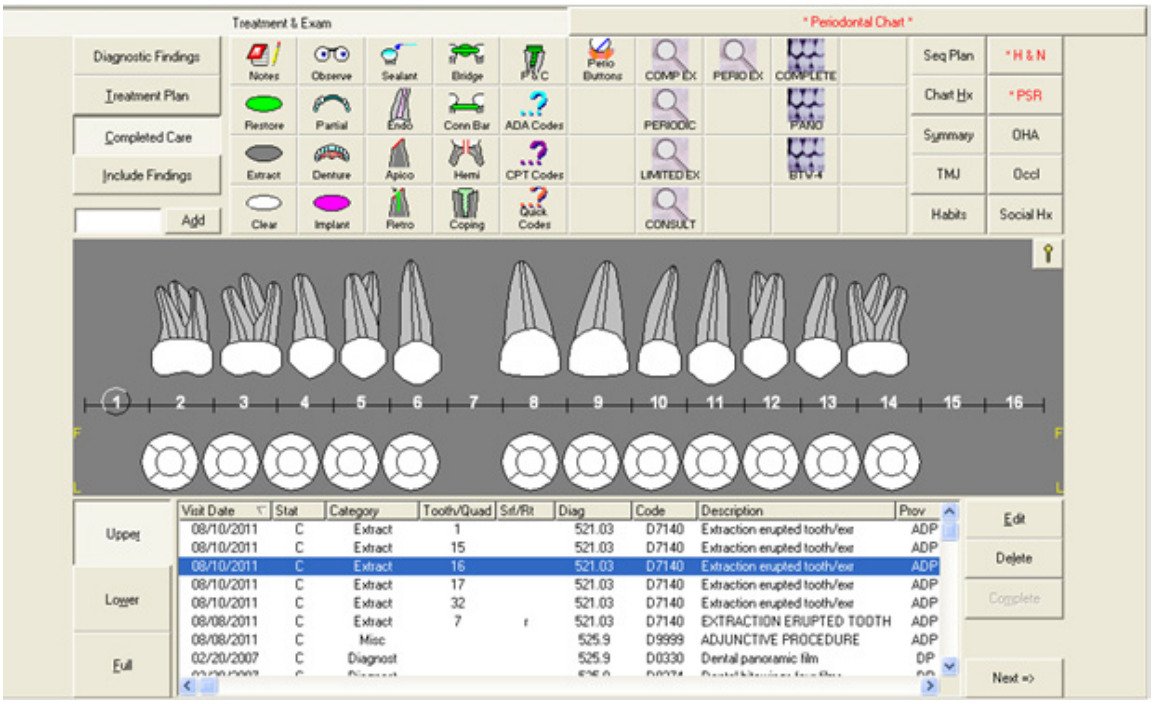
Clean Slate Undone

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



Previously Saved Working Data Message

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



Treatments and Findings Imported

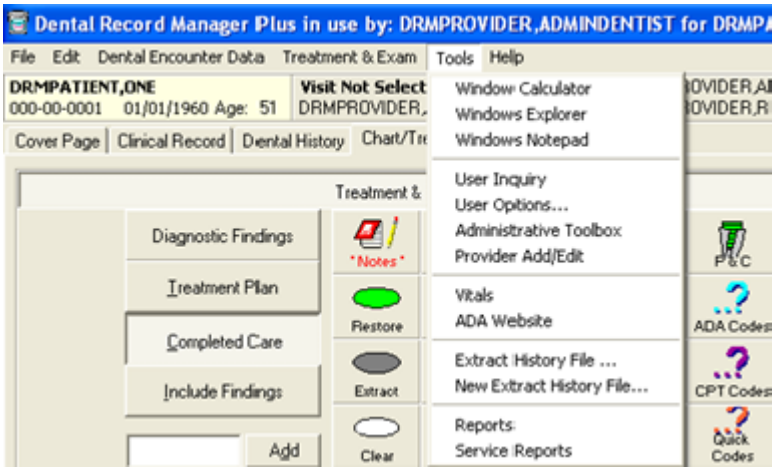
Note: Saved unfiled data for a patient may be recovered if the administrator does a Clean Slate for this patient and immediately uses the Undo Clean Slate option, before the inactive unfiled data is deleted.

Tools

The Tools menu has 12 options: Windows Calculator, Windows Explorer, Windows Notepad, User Inquiry, User Options, Administrative Toolbox, provider Add/Edit, Vitals, Extract History File, new Extract History File, Reports and Service Reports.

The ADA Website option 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, Provider Add/Edit, Extract History File and new Extract History File are DRM Plus Administrative Functions.



Tools Menu

Windows Calculator

Choosing this function opens Windows Calculator.

Windows Explorer

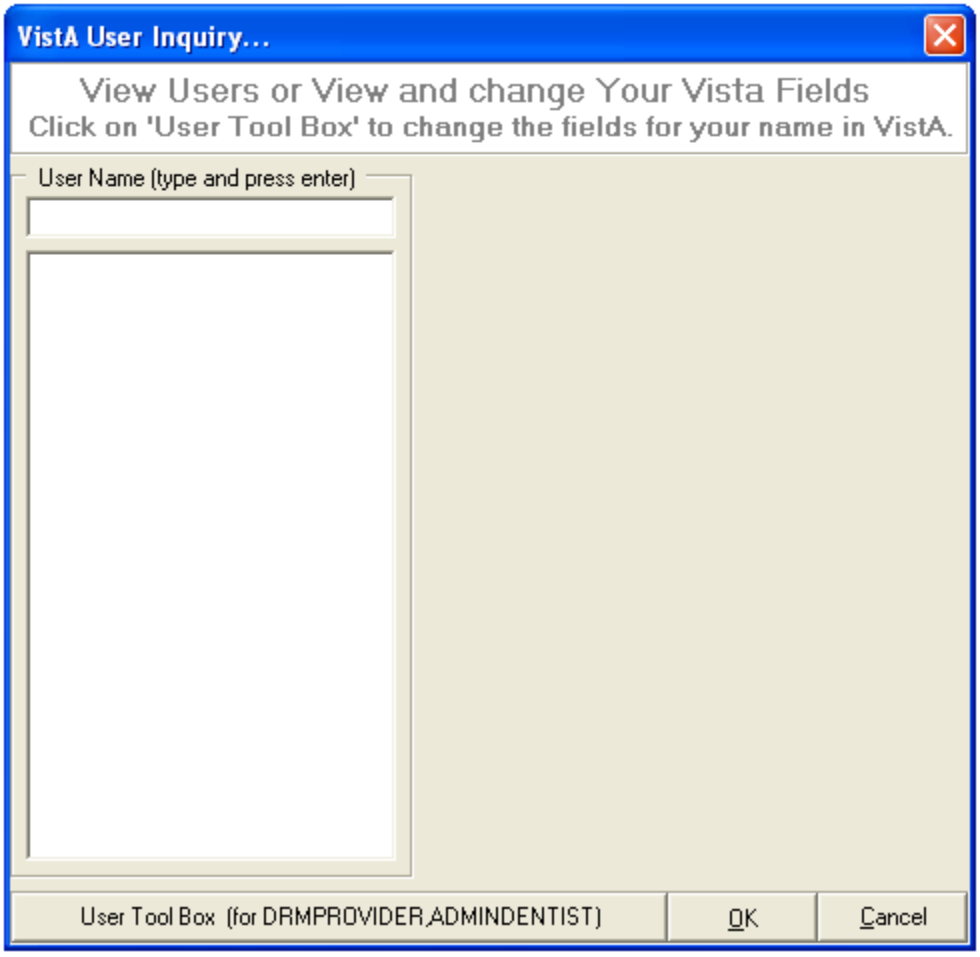
Choosing this function opens Windows Explorer.

Windows Notepad

Choosing this function opens Windows Notepad.

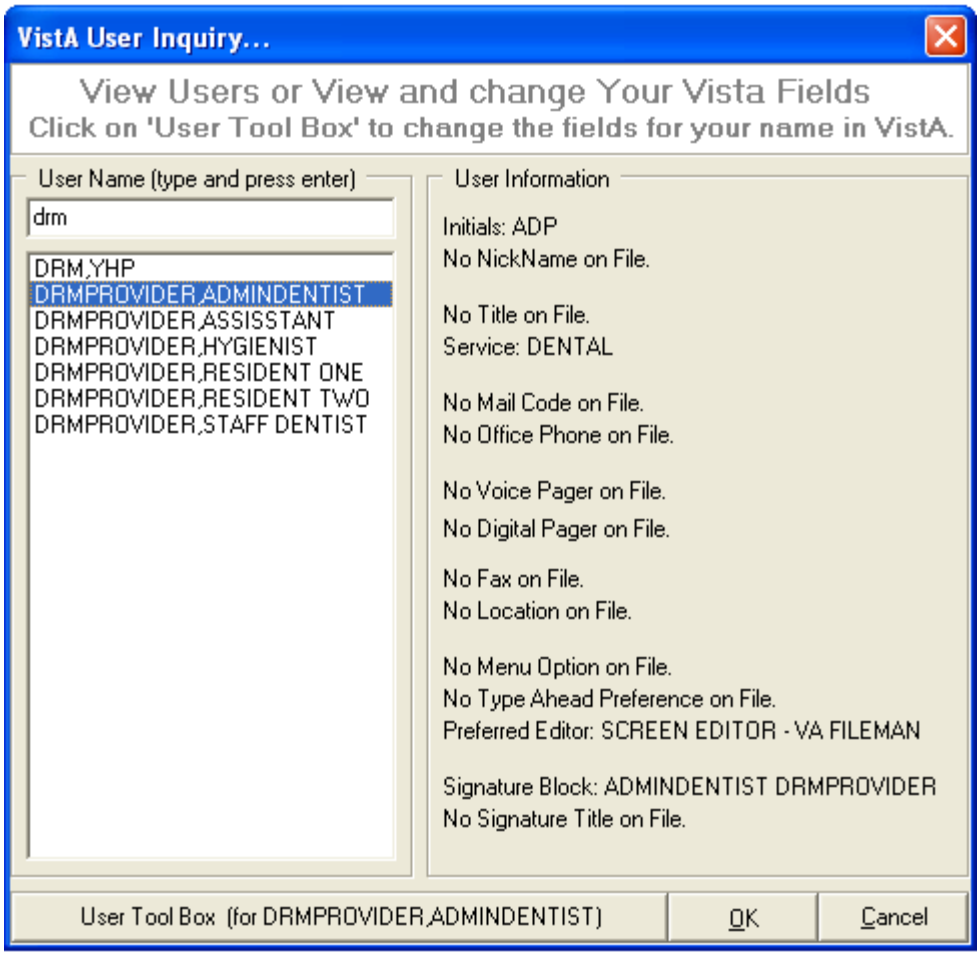
User Inquiry

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



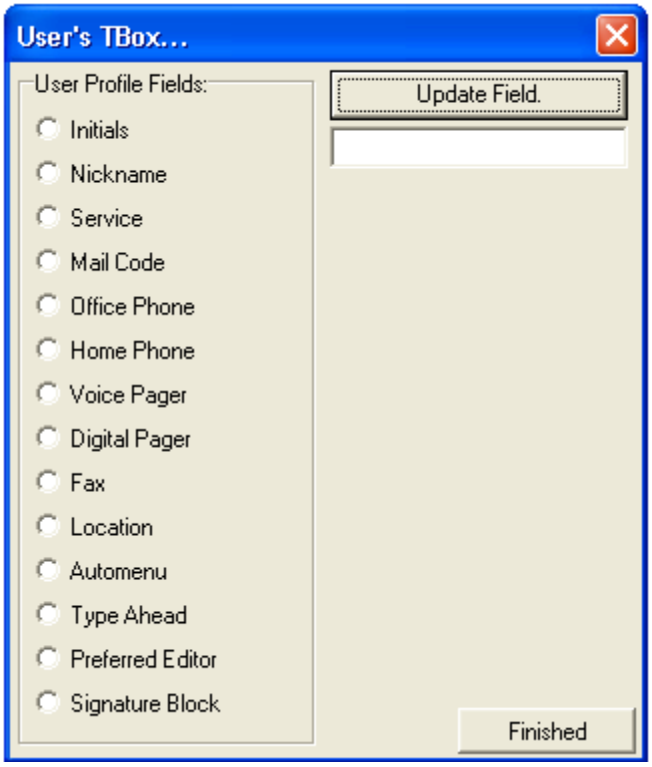
VistA User Inquiry Screen

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



VistA User Entry Screen with user Information Displayed

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

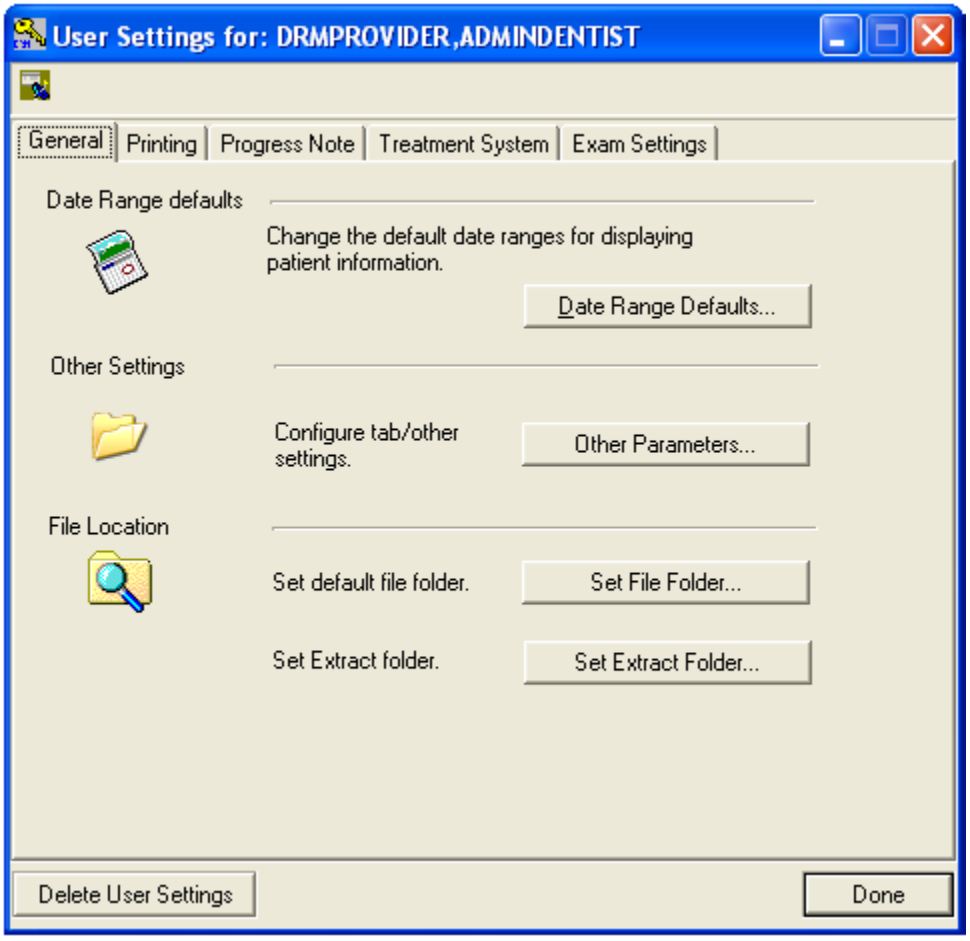


User's TBox Screen

4. Select the desired User Profile Field 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 re-displays.

User Options

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

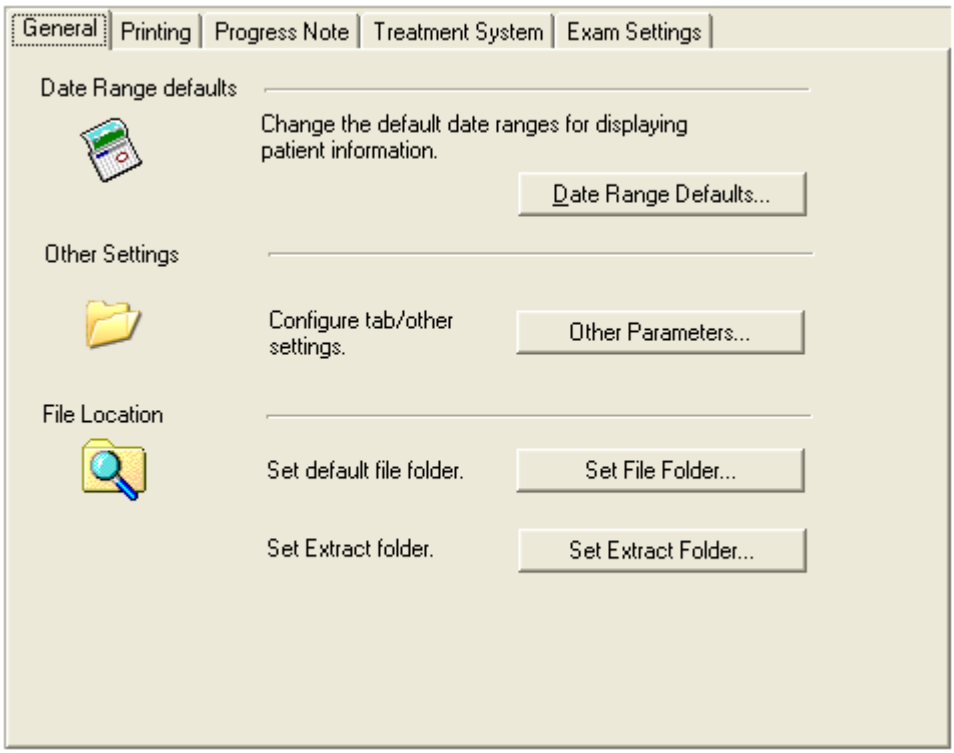


User Settings Screen

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

General

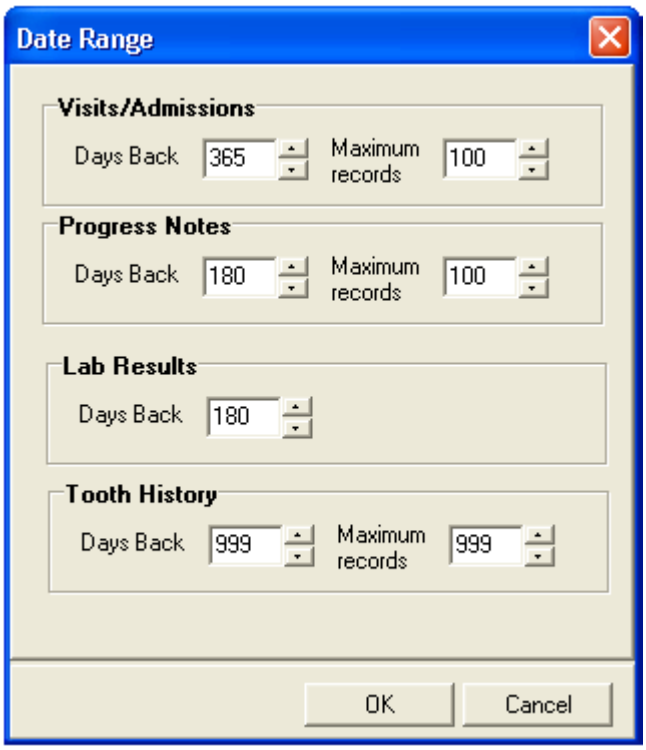
Choose this tab to change Date Range defaults, Other Settings and File Location folders.



General Tab

To change the Date Range defaults:

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

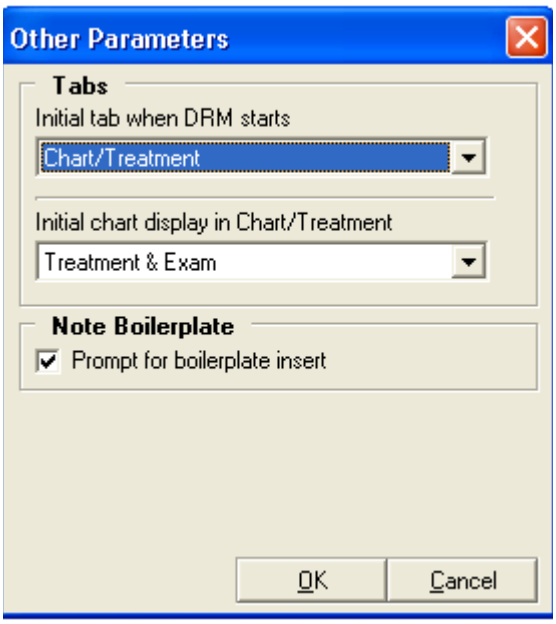


Date Range Defaults Screen

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** displays.

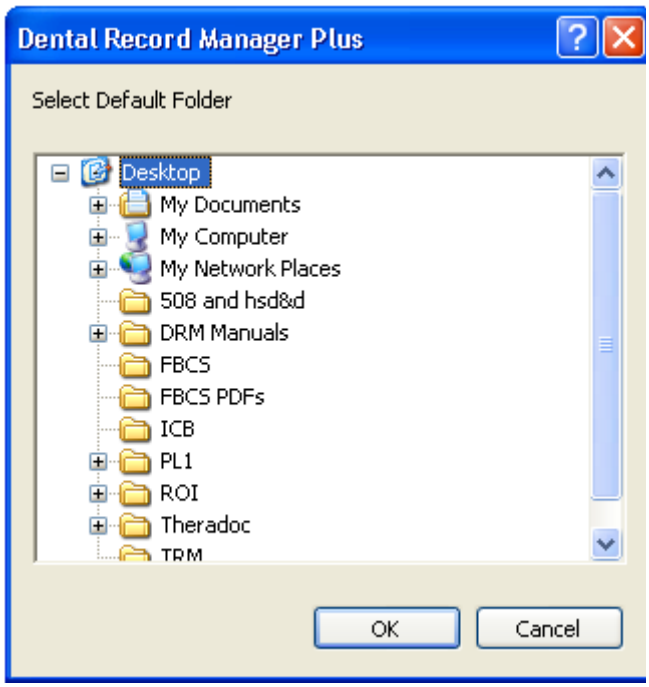


Other Parameters Screen

2. Use the **Tabs drop-down menu** to set the initial DRM Plus tab and chart display.
3. Use the **Note Boilerplate** checkbox to indicate whether the program should prompt for the boiler-plate insert associated with the VistA TIU note title selection.

To change the file location:

1. Click the **Set File Folder** button.
2. The DRM Plus Select Default Folder screen displays.



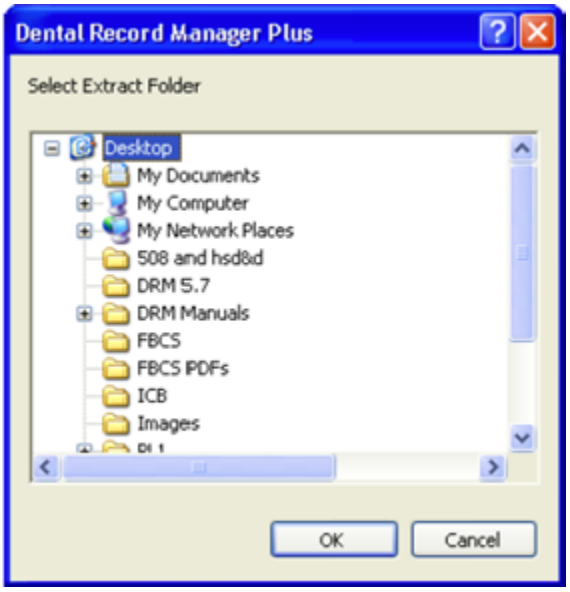
DRM Plus Select Default Folder Screen

3. Navigate to and click on **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 progress note.

To set the Extract Folder:

1. Click the **Set Extract Folder** button.
2. The DRM Plus Select Extract Folder screen displays.

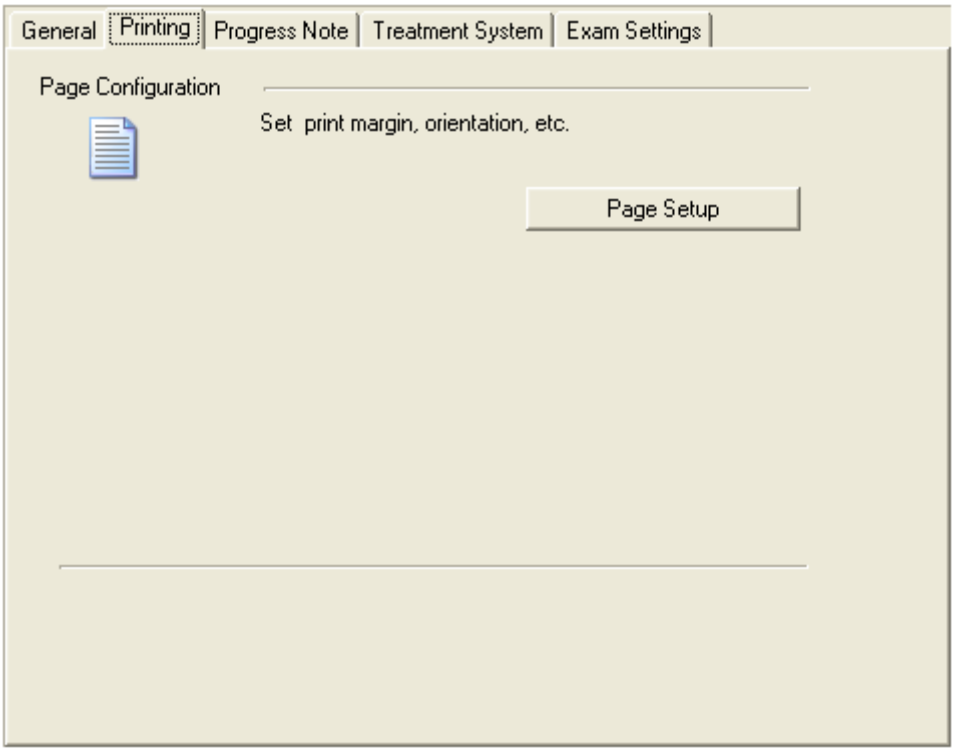


Select Extract Folder

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

Printing

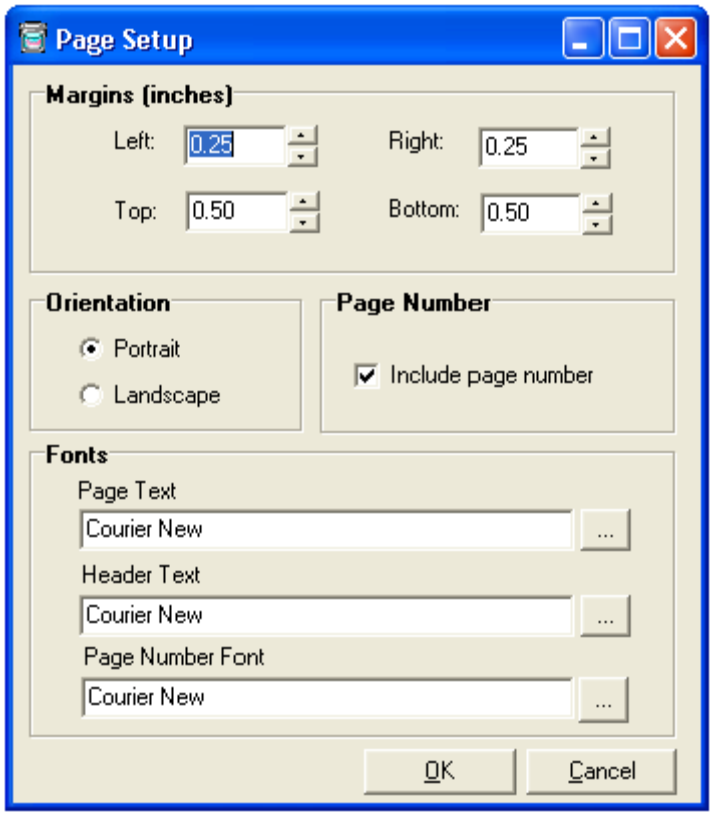
Use the Printing tab to set print margins, orientations, etc.



Printing Tab

To change the Page Configuration:

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

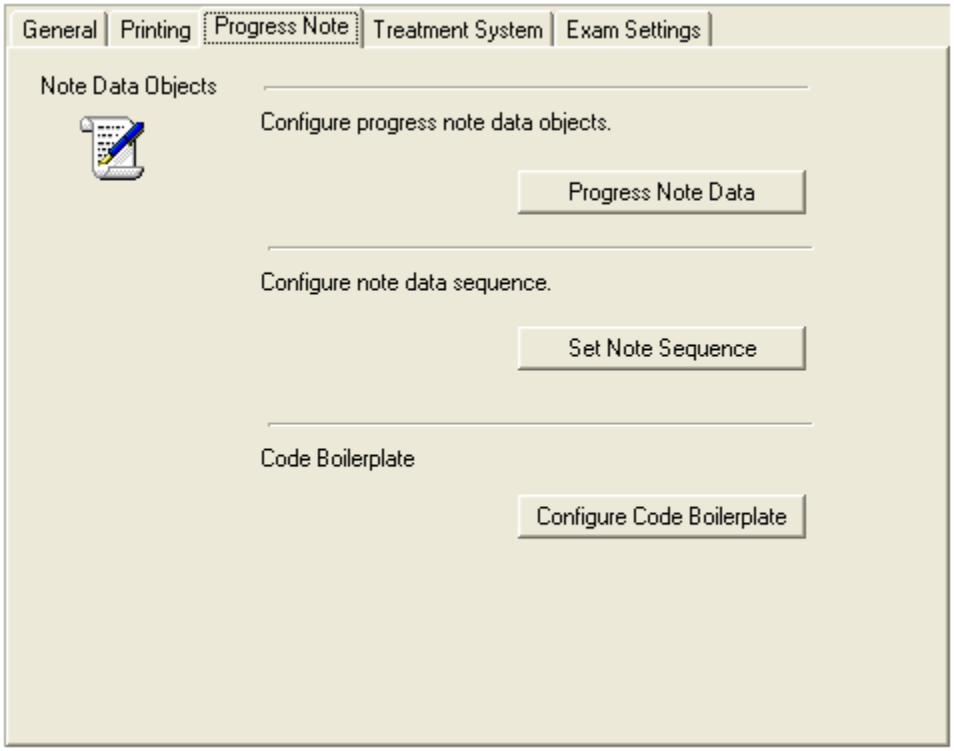


Page Setup Screen

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 checkbox** to indicate whether page numbers are to be included.
6. Use the **Ellipses 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

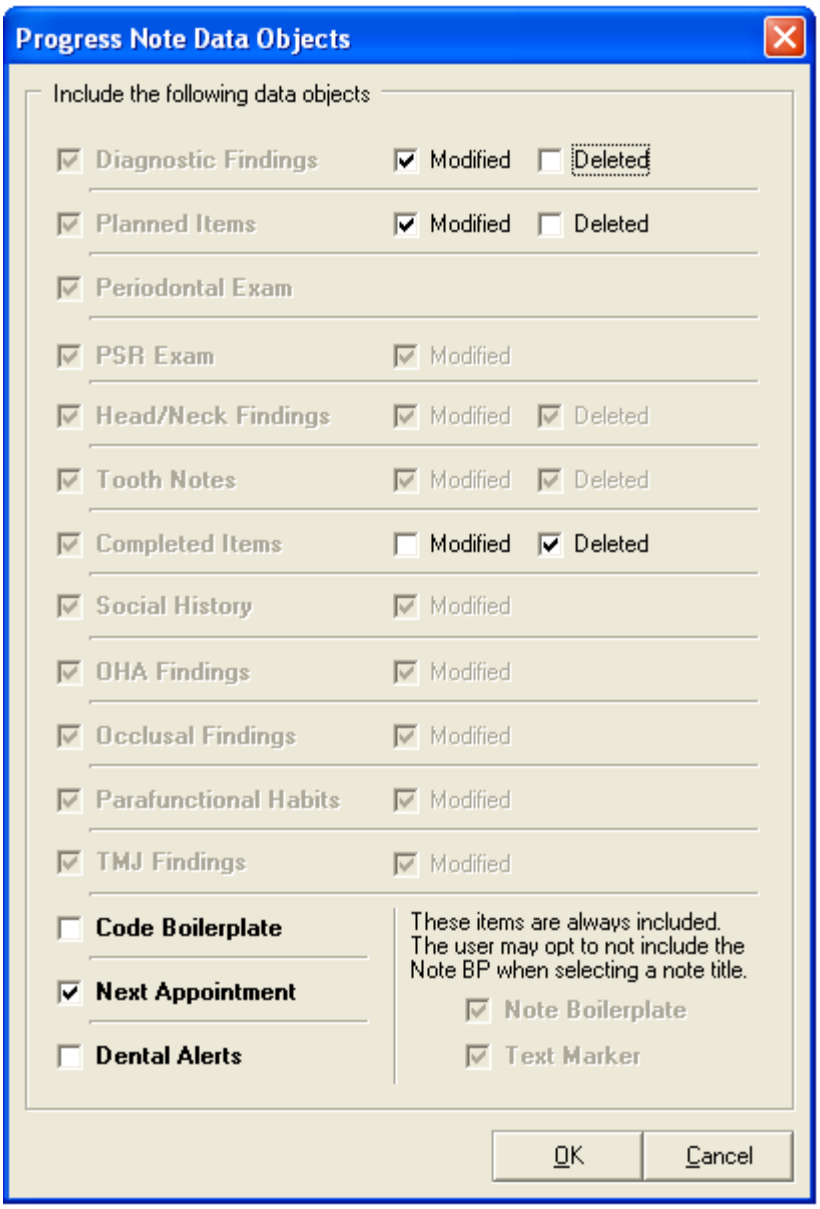
Use the functions in the Progress Note tab to configure Progress Note Data objects, configure Note Data Sequence and Configure Code Boilerplates.



Progress Note Tab

To configure progress note data objects:

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



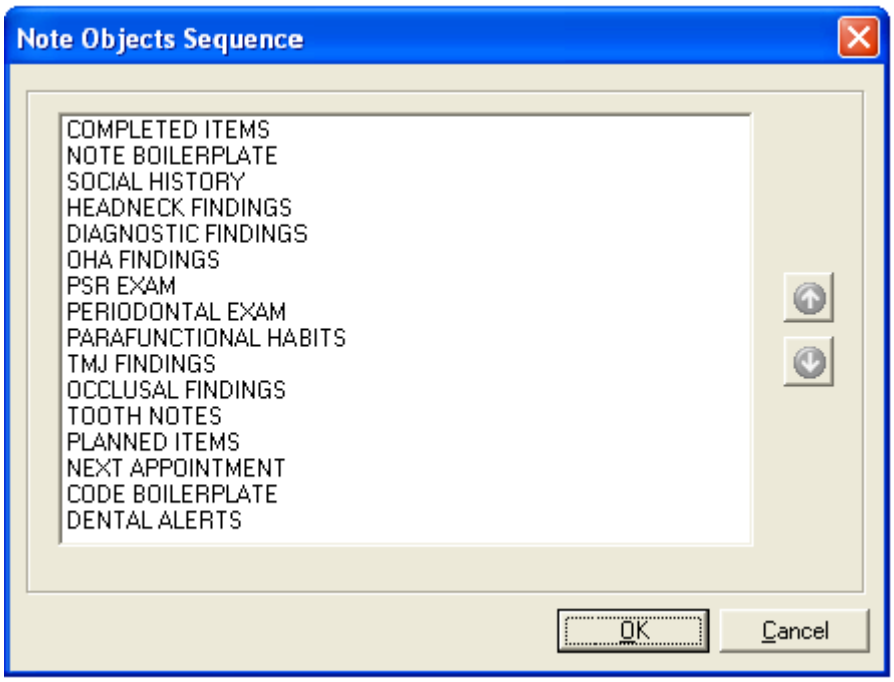
Progress Note Data Objects Screen

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

Note: This Code Boilerplate checkbox activates the automatic importing into the 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.

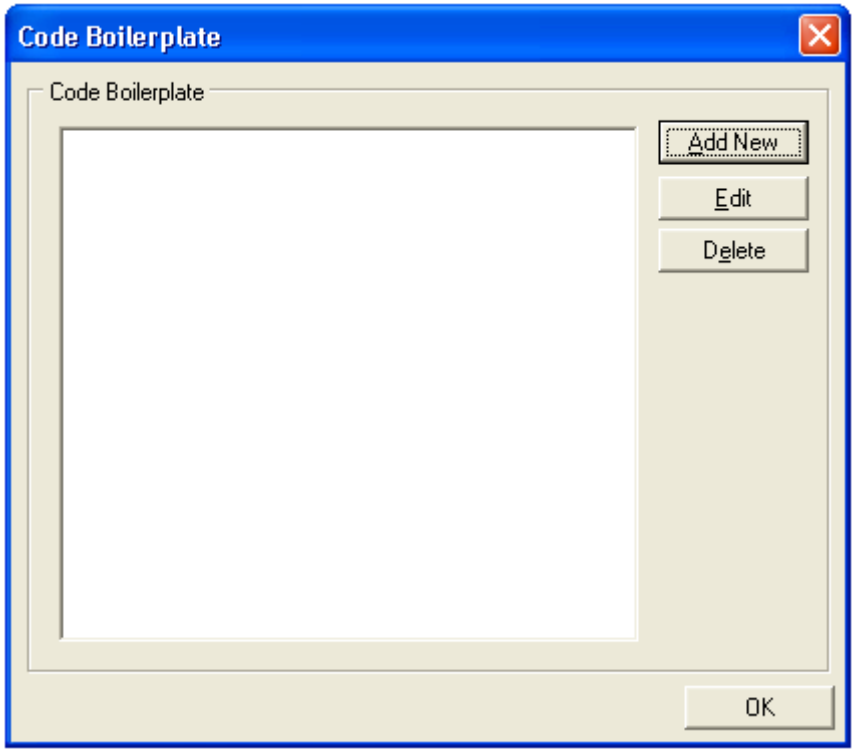


Note Object Sequence Screen

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 code boilerplate:

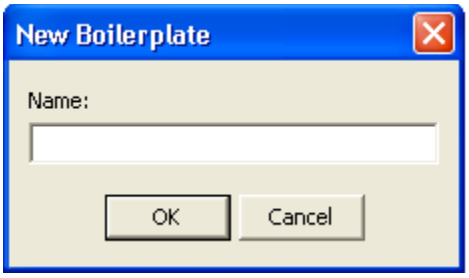
1. Click the **Configure Code Boilerplate** button.
2. The Code Boilerplate screen displays.



Code Boilerplate Screen

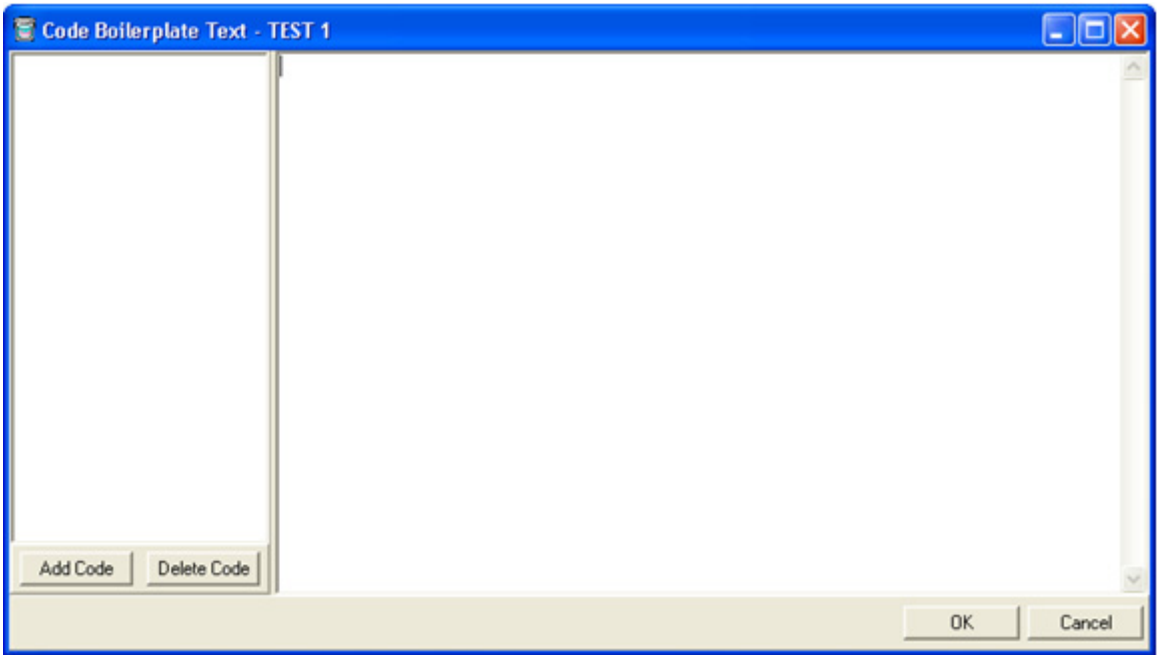
To add a new boilerplate:

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



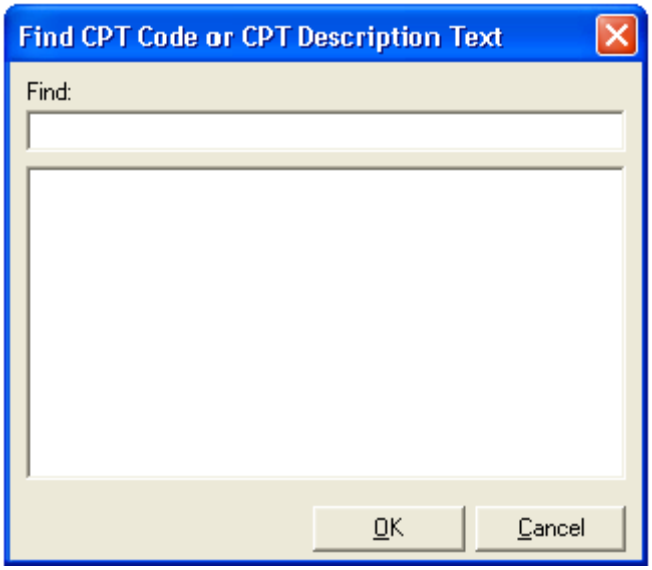
New Boilerplate Screen

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



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.



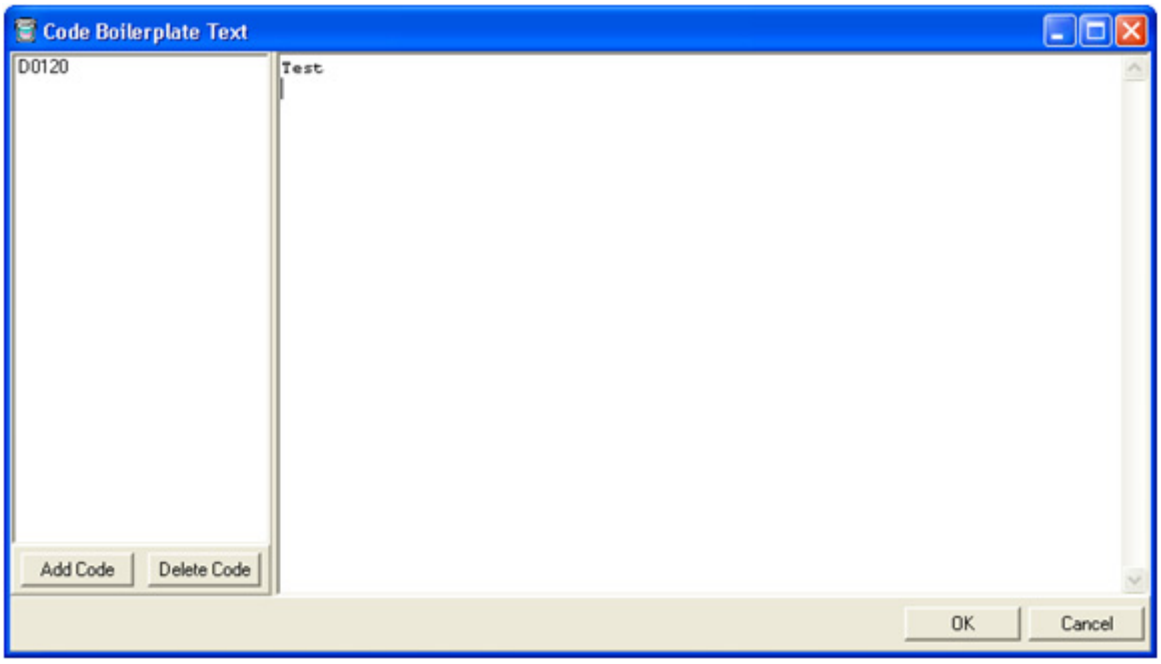
Find CPT Code or CPT Description Text Screen

7. Type in the CPT code. A partial number is acceptable. Press <**Enter**>.
8. The search results appear in the screen. Select one and click the **OK** button.
9. The selected code appears 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 the **OK** button. 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.



Code Boilerplate Text Screen

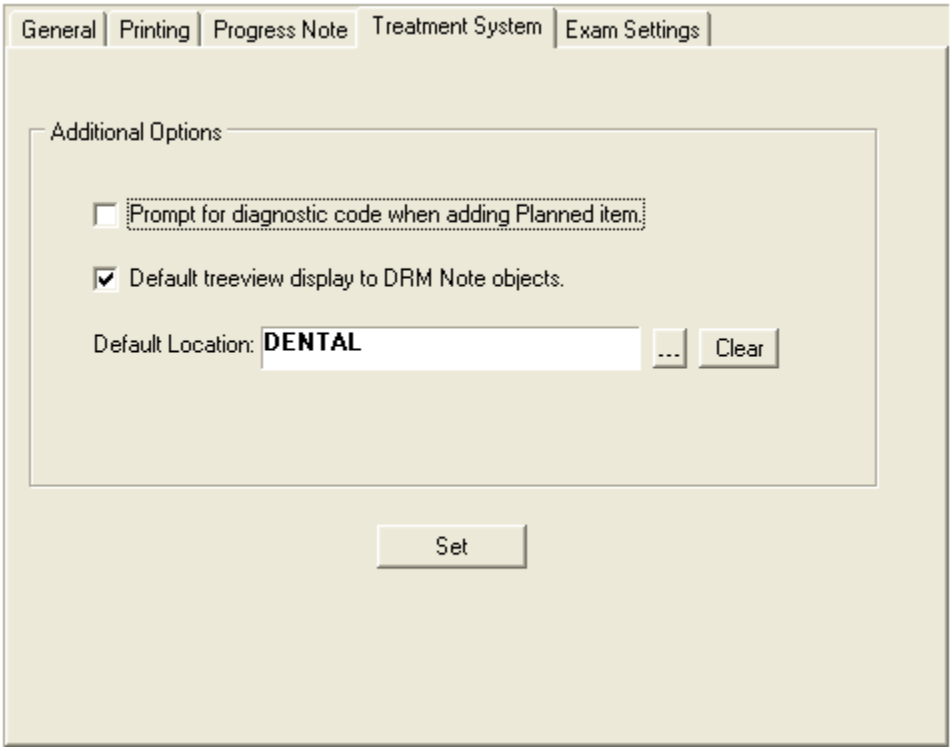
4. From here, type in the right side of the screen to add or delete text from the boilerplate. Use the **Add Code** and **Delete Code** buttons to add or delete codes form the boilerplate.
5. Click the **OK** button. An information screen displays. Click the **OK** button to return to the Code Boilerplate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



Treatment System Tab

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

To choose a default location:

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

Select Location Screen

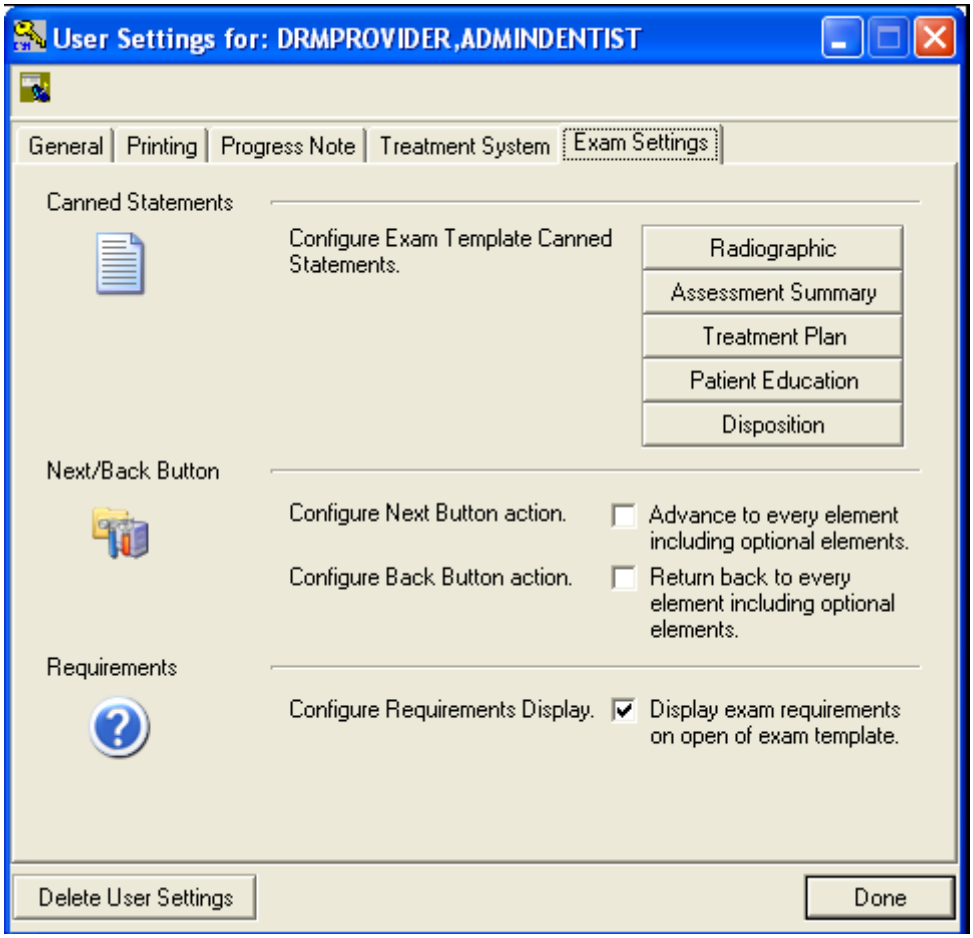
3. Type the location into the text box and press <**Enter**>.
4. Search results appear on the Select Location screen.
5. Choose the desired location and click the **OK** button.
6. Click the **Set** button to save any changes to this screen.
7. Use the **Clear** button if no location is desired, then click the **Set** button.

The **Delete User Settings** button located on the lower left corner of the screen appears in all the tabs. Use this button to delete all user settings.

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 all user settings.

Exam Settings

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



Exam Settings Tab

The Canned Statements parameter allows the addition 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, whether or not they are administrators. Any changes made from the User Settings screen effect only the individual end user.

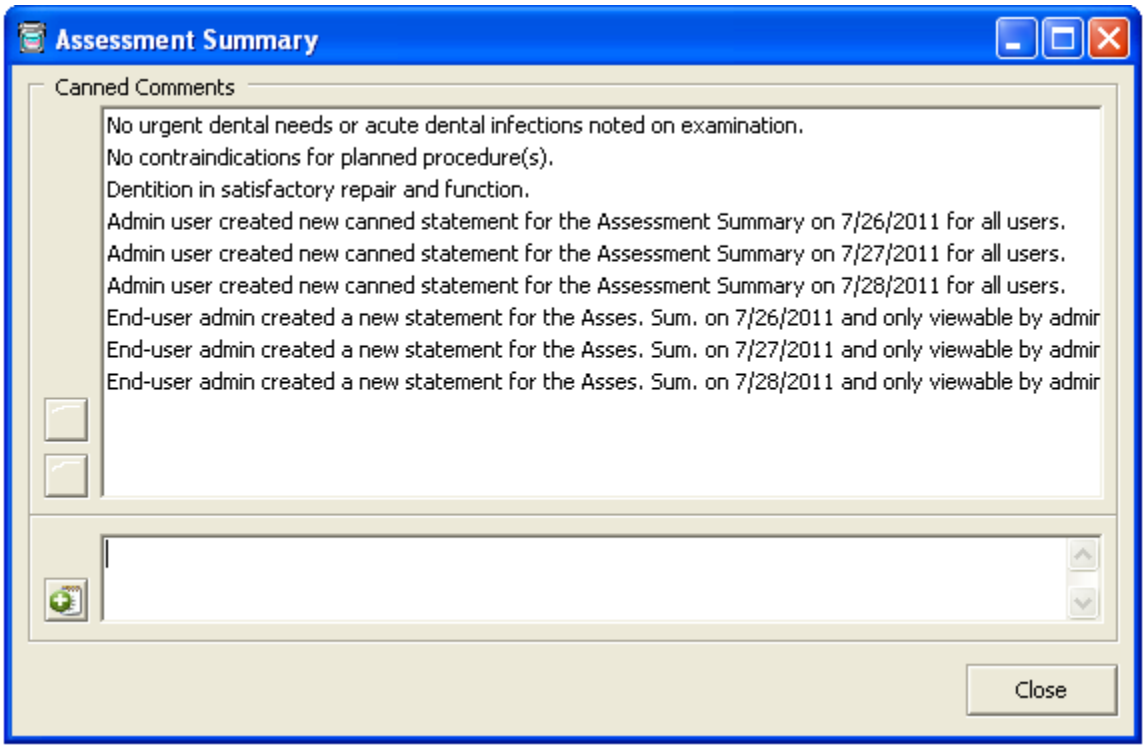
Pre-defined statements are broken into five categories: Radiographic, Assessment Summary and Treatment Plan (located in the same element), Patient Education and Disposition. There is a maximum of twelve pre-defined statements allowed pre category.

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 effect 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 Options 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.

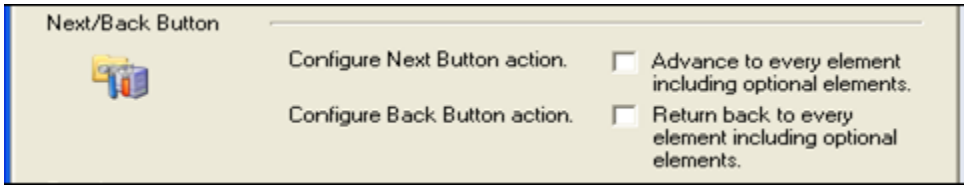


Add Pre-Defined Statement Screen

The end-user may highlight any of the pre-defined statements that were entered from their User Settings and either delete that statement or move the statement's position in the list. This deletion or rearranging 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 comments that were kept by the DRM Plus administrator; these are listed at the top.

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

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



Next/Back Button Parameters

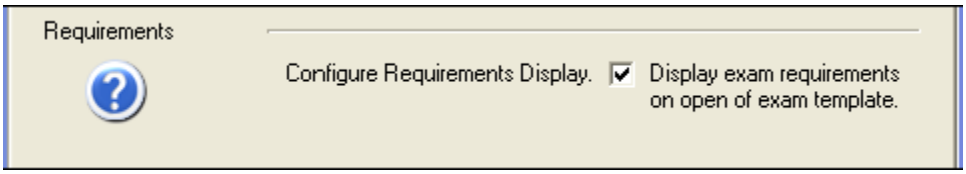
Both options are unchecked by default. When unchecked, the **Next** button skips any element that is optional or has been completed from new data entered on the Chart/Treatment tab during this session and open the next required element. When checked, the **Next** button opens the very next element no matter if 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 no matter if 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 doesn't 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 Requirements parameter allows the end-user to keep the Element Requirements Panel open when selecting any element from the Exam tab, or the definitions from the OHA or Occlusal screens.

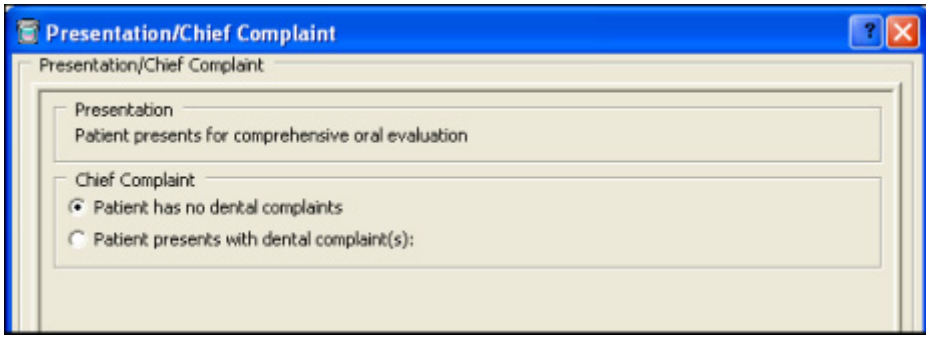


Requirements

It is checked by default, and display the Elements Requirements whenever an element is open.

When unchecked, the end-user must select the **Done** button and then close/reopen DRM Plus. The end-user must then open the Element Requirements Panel manually.

The **Requirements icon** button, located in the upper right corner of the element screen, can be clicked, and displays the Element Requirements Panel.



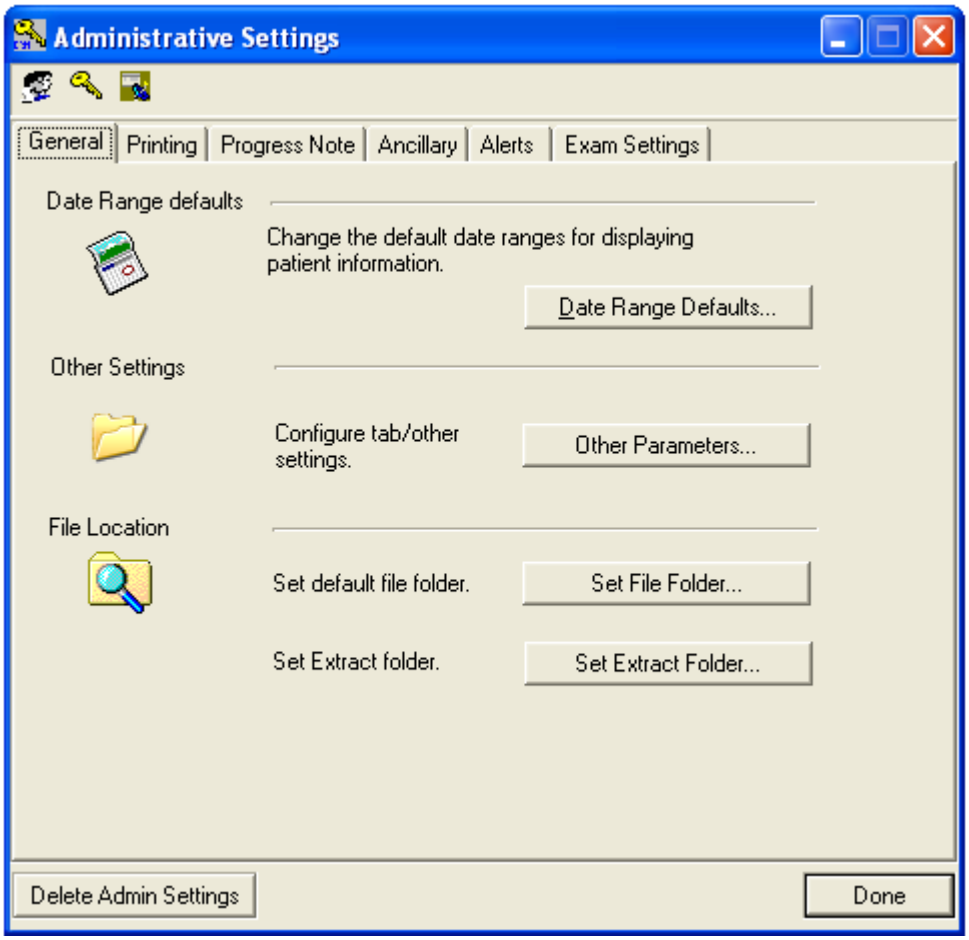
Presentation/Chief Complain Screen

Administrative Toolbox

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

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

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



Administrative Settings Screen

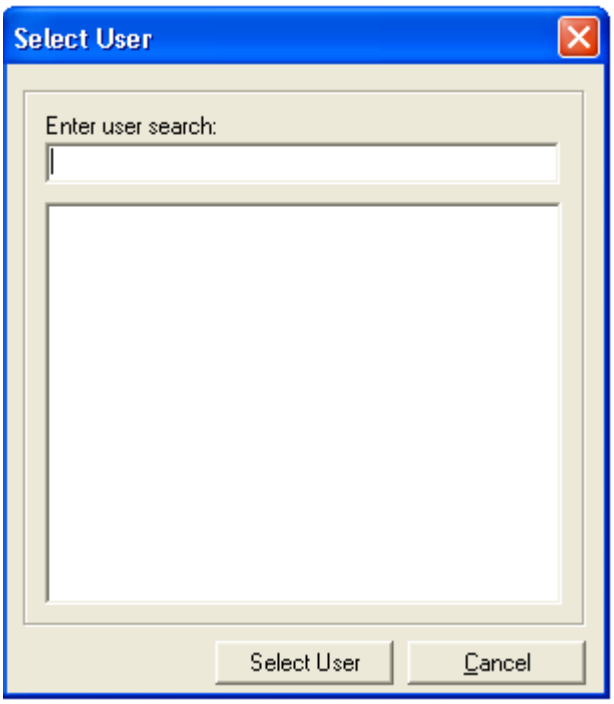
The three icons found in the upper left corner allow access to other functions.

Click the **User** icon to select another user, allowing the DRM Plus administrator to become the provider. The administrator's screen displays the five tabs normally found with the User Options of this pro-

vider, and a Security tab. The administrator may also grant full administrative privileges, or parts of this parameter, to the provider using the Security tab. The other five tabs allow the administrator to change parameters for this user, which can supersede any of their User Options parameters.

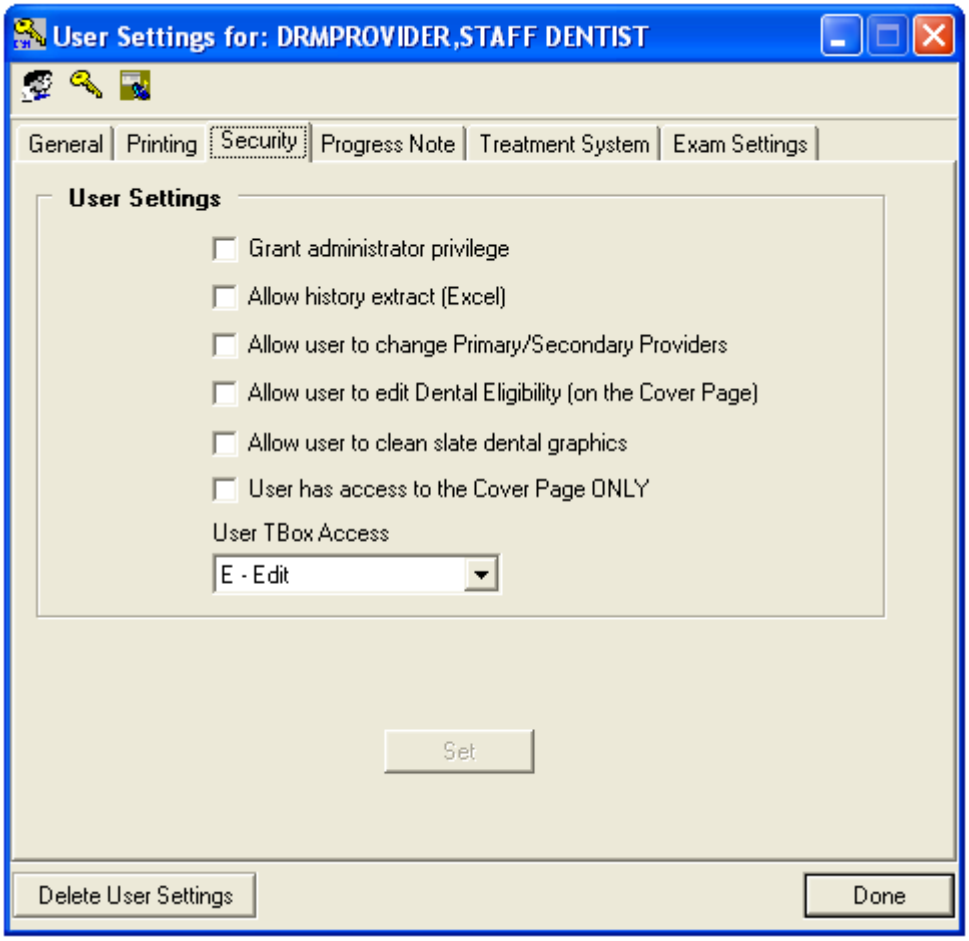
To change admin privileges or parameters for another use:

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



Select User Screen

2. Enter the search name for the provider in the text box.
3. Press the <**Enter**> key.
4. Select the desired user from the results.
5. Click the **Select User** button.
6. The tabs are changed to the User Options settings for the provider entered with an extra one.
7. Click the **Security** tab (extra tab) and grant this provider any appropriate administrative parameters.



Security Tab on the Administrator's Toolbox

8. Check the **Grant administrator privilege** checkbox to grant full administrative permission.
9. Check the **Allow history extract** checkbox to allow the designated user to save Extract History Reports to be used in Excel/Access.
10. Check the **Allow user to change Primary/Secondary Providers** checkbox to allow the user to change the patient's primary and secondary provider.
11. Check the **Allow user to edit Dental Eligibility (on the Cover Page)** checkbox to allow the designated user to edit the patient's dental eligibility information.
12. Check the **Allow user to clean slate dental graphics** checkbox to allow the designated user to clear all of the graphics in the three Treatment & Exam view screens.
13. Check the **User has access to the Cover Page Only** checkbox to allow the user to only see the Cover Page tab of DRM Plus.
14. The User TBox Access menu is provided to allow users the option to customize their profiles.

    a) The default for all users is E -- Edit. however, some facilities may prefer to deny this permission.
    b) The N -- No Access Allowed option allows no editing of the user's profile.
    c) The D-- Display Only setting allows the user to view their profile setting.
15. Check on any other tab to change this provider's User Options parameters.

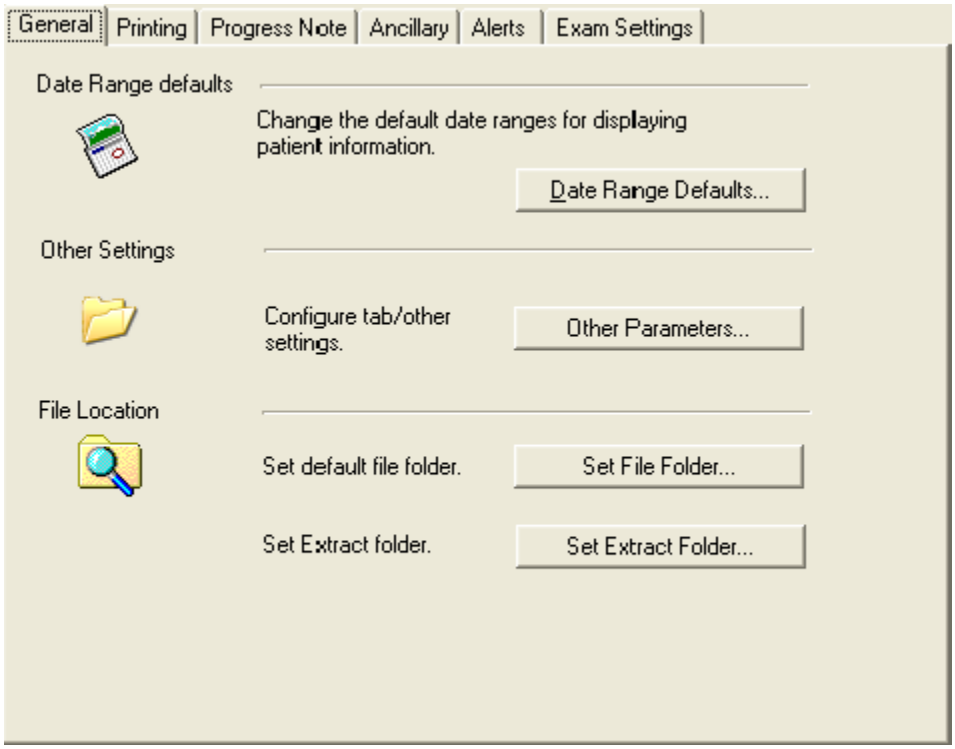
Click the Key icon to return back to the main Administrative Settings screen.

The Broker Call History icon opens the broker calls screen. See the Last Broker Call section, under the Help subtitle in this chapter, for further information.

General

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

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



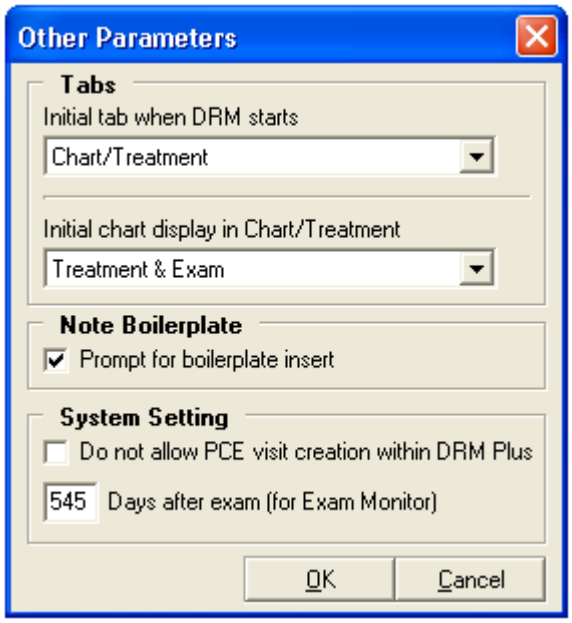
General Tab

To change the Date Range Defaults, see the User Options section of this chapter.

Note: Date Range Defaults should not be changed unless the administrator first checks with local IRM support. Increasing these values can degrade overall network/systems performance.

To change other settings:

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



Other Parameters Screen

2. Use the Tabs drop-down menus to change the tab that displays when the program first opens. Use the second drop-down menu to choose Treatment & Exam or Periodontal Chart for the default view of the Chart/Treatment tab.
3. Click the **Note Boilerplate** check box to choose whether to be prompted for a boilerplate insert. These note boilerplates reside in VistA (created with CPRS, not DRM Plus) and usually tie to a TIU Progress Note title.
4. Click the **System Setting** checkbox to determine if PCE visit creation within DRM Plus is allowed in the local dental clinic, and to set the number of days after the exam for the Exam Monitor to appear. This option is unavailable in the User Options settings.

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

The Set Extract Folder allows the DRM Plus administrator, or users with the Administrative parameter option for Extract History Reports, to set the directory/file location where the extraction of the Dental History file is stored.

To set the Extract Folder:

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

Printing

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

The Printing tab parameter settings entered by a DRM Plus administrator will be the default settings until that user resets or changes those parameter settings from User Options.

Progress Note

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

The DRM Plus administrator may configure code boilerplates from the Progress Note tab located on the Administrative Settings screen. Every user planning to access these code boilerplates must enter the exact name of the code boilerplate created using the administrative parameter. After entering the exact name of the code boilerplate in User Options and clicking the OK button the administrative code boilerplate will automatically import.

Treatment System

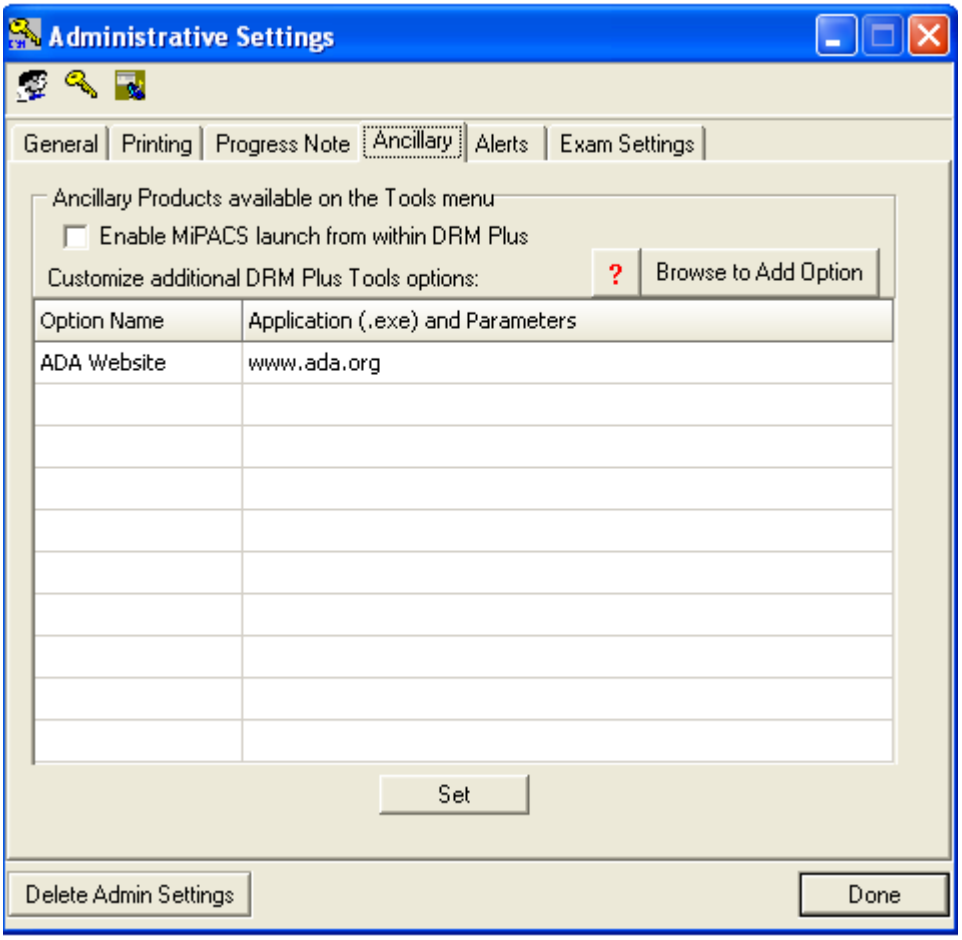
Treatment System tab parameters set by a DRM Plus administrator can only be set for one user at a time. If a DRM Plus administrator is setting Treatment System tab parameter(s) for another DRM Plus user, then the DRM Plus administrator must select the Double Heads icon on the Administrative Settings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

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

Setting the Default Location parameter from the Treatment System tab cannot be changed using the Administrators Toolbox option.

Ancillary

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

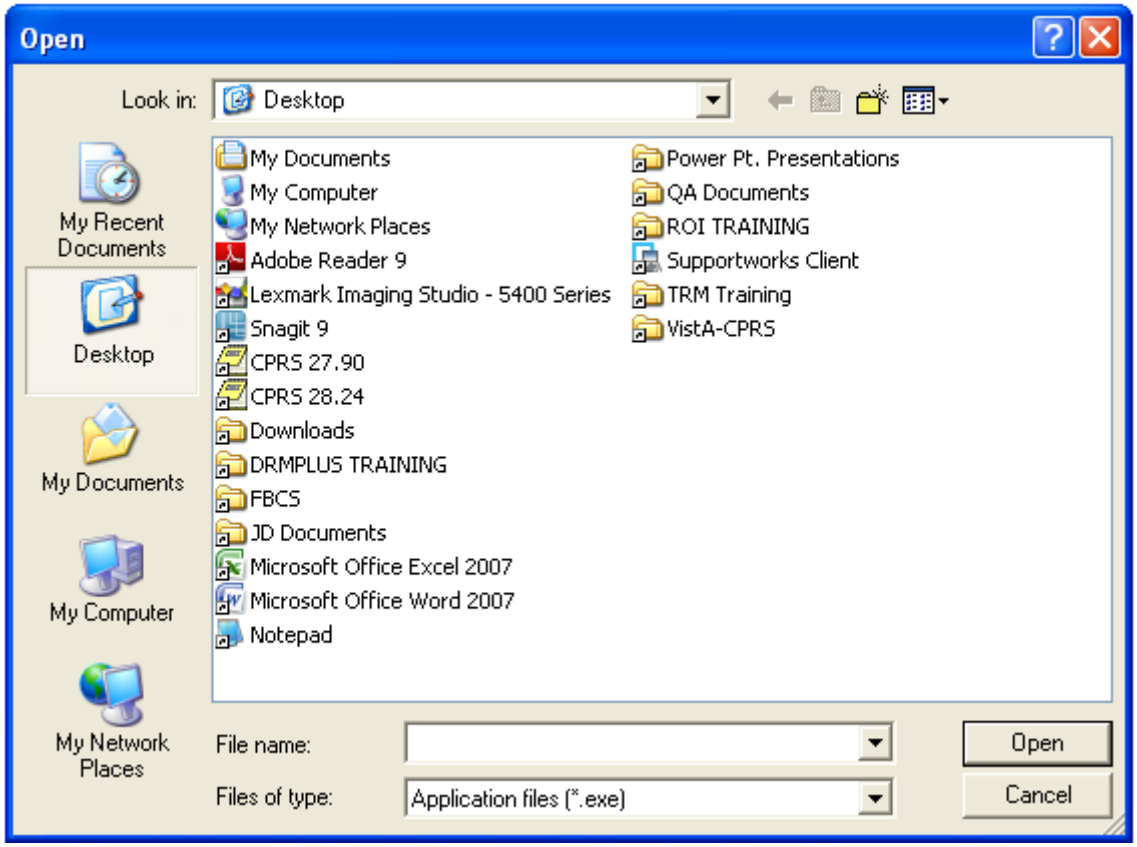


Ancillary Tab Screen

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

To add an executable:

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



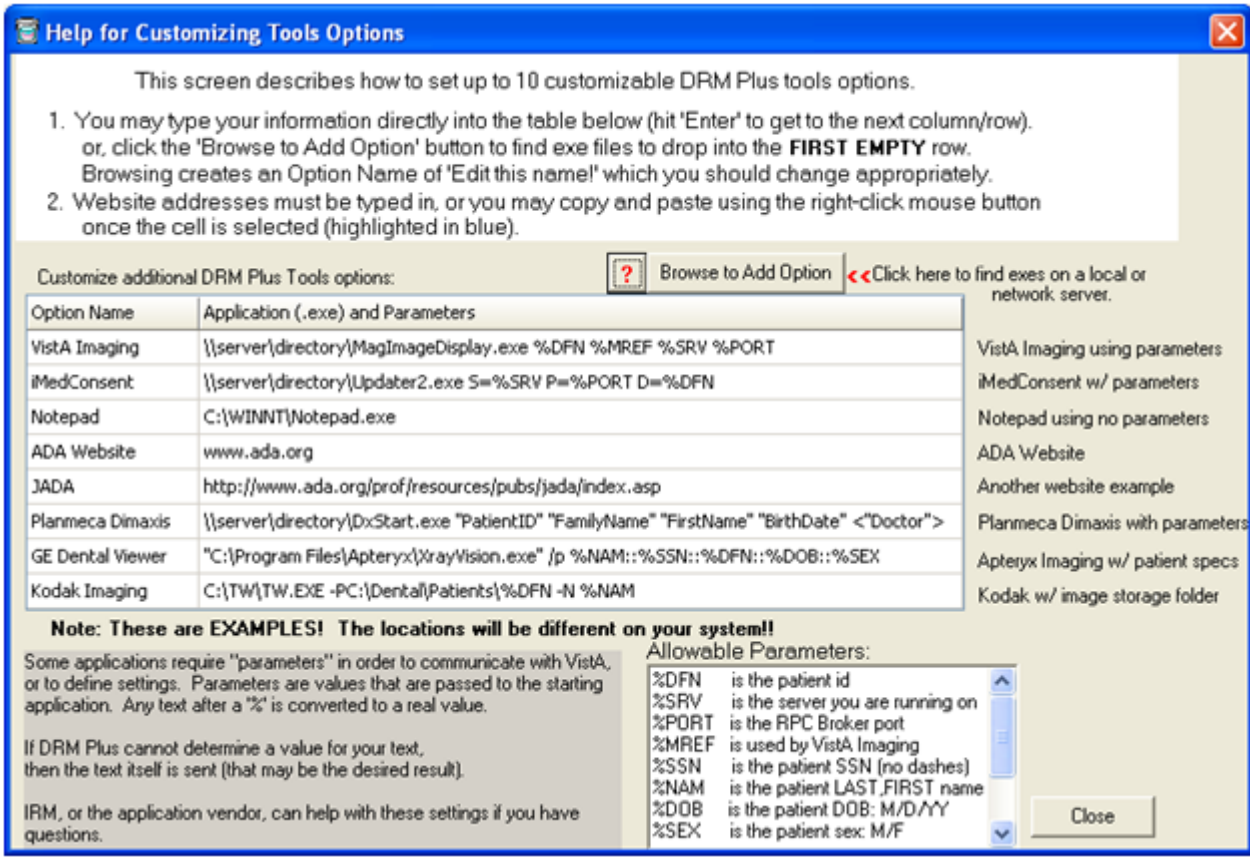
Microsoft Open Screen

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

To delete an executable:

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

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



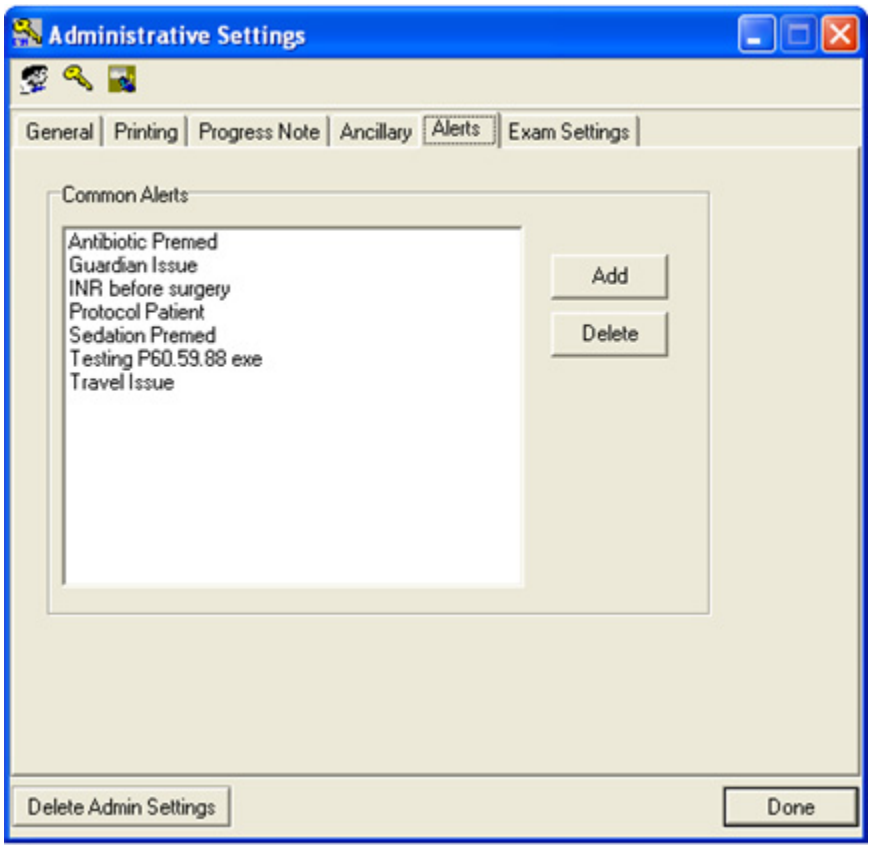
Help for Customizing Tools Options Screen

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

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

Alerts

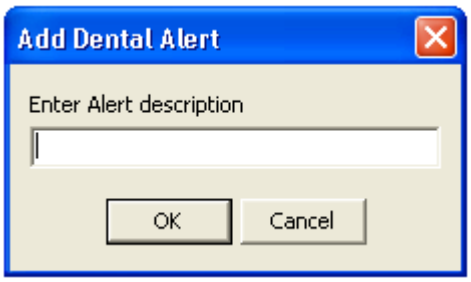
Use the functions on this tab to add or delete DRM Plus alerts. These alerts permanently saved by the DRM Plus administrator may be entered by any user with the Alert icon, located on the banner. When entered, the alerts appear on the Cover Page tab.



Alerts Tab Screen

To add an alert:

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



Add Dental Alert Screen

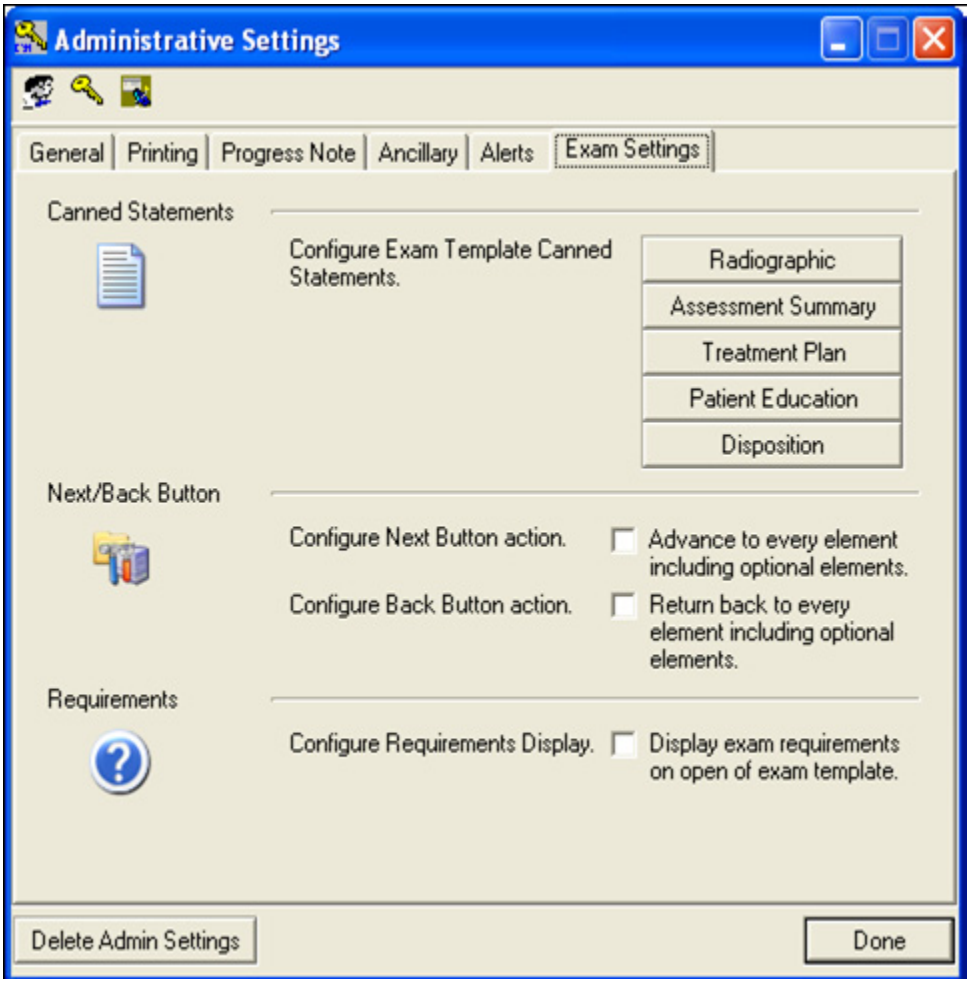
2. Type the alert name into the text box.
3. Click the **OK** button. The alert appears on the list.

To delete an alert:

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

Exam Settings

The Administrative Settings parameter allows the DRM Plus administrator to add/delete system wide all the national and local admin pre-defined comments. This parameter may be accessed from the Tools menu, Administrative Toolbox and then the Exam Settings tab by only DRM Plus administrators.



Exam Settings

These parameters allow Administrative end-users to create pre-defined statements that import to all end-users accounts using the local VistA system. The five pre-defined statement buttons are Radiographic, Assessment Summary and Treatment Plan, which are located in the same element, Patient Education and Disposition. There are two to four national pre-defined statements pre-developed for these five categories.

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

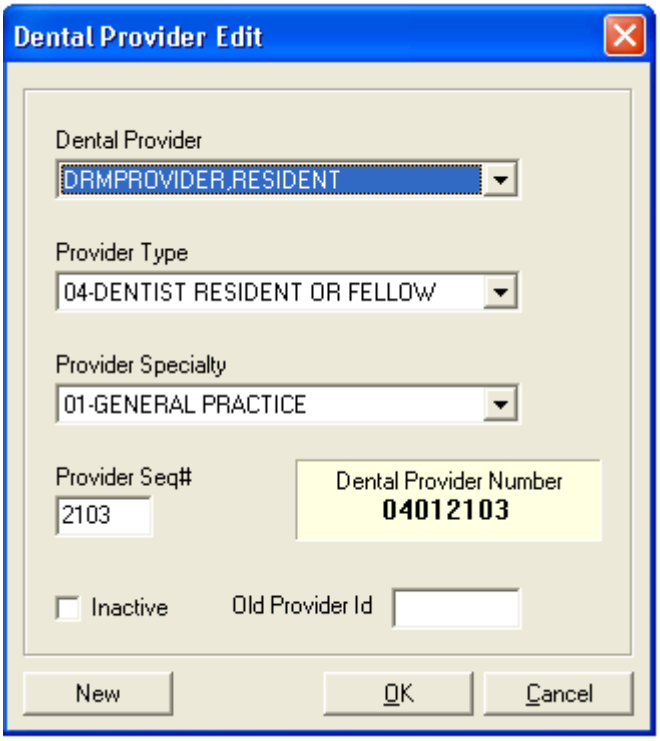
The DRM Plus administrator may delete or rearrange the sequencing of any national or administrator pre-defined statements entered by this parameter. Highlight the pre-defined statement and use one of the two buttons on the left side of the screen to delete or rearrange the sequence of this pre-defined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

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

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

Provider Add/Edit

Use this function to add a new provider, or to edit a provider's information in DRM Plus. Dental providers may also be inactivated using this function. Inactivated providers can not be selected for reports.



Dental Provider Edit Screen

Dental Provider Menu

This menu auto- on the all entries in the VistA Dental Provider file. Once a new provider is added to the Dental Provider file, they may not be deleted by the DRM Plus administrator.

Provider Type Menu

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

Provider Specialty Menu

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

Provider Seq

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

Dental Provider Number

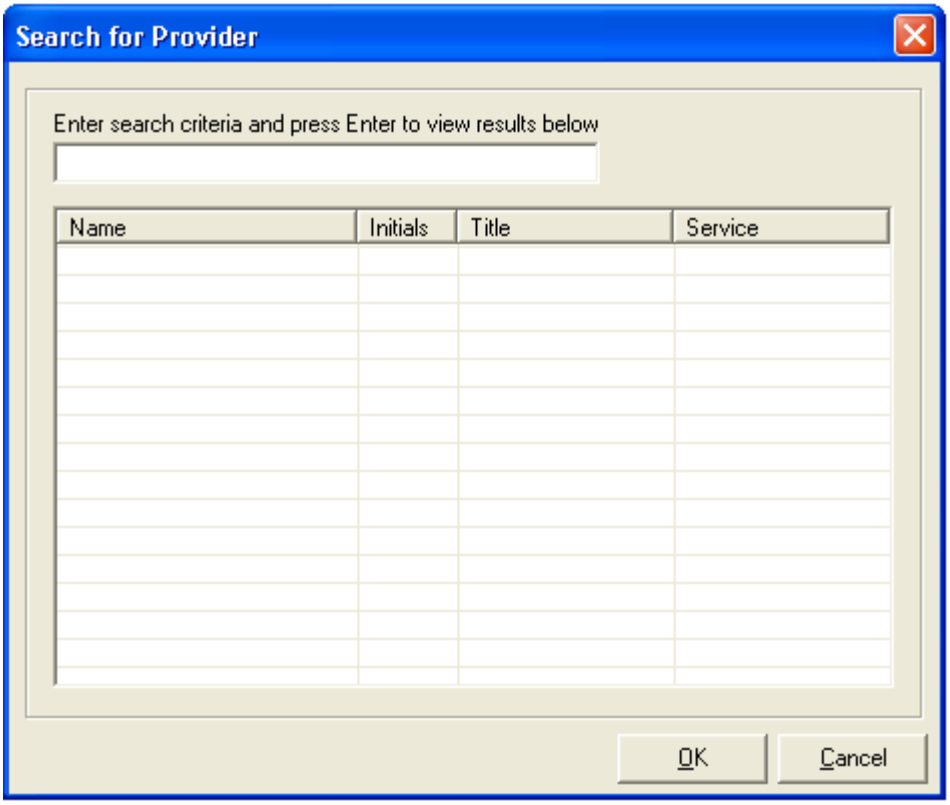
This displays the new eight digit provider ID, which is a read only field. The first two digits are the two digit code of the Provider Type. The next two digits are the two digit code of the Provider Specialty. The last four digits are the Provider Seq #.

Note: All dental providers must have an eight digit provider number to file and receive workload credit.

Checking the inactive checkbox does not allow the provider to be selected for any reports. Old Provider IDs may be filed with old four digit IDs from previous provider numbers; however, this field is not required for new DRM Plus users.

To add a new provider:

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



Search for Provider Screen

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

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

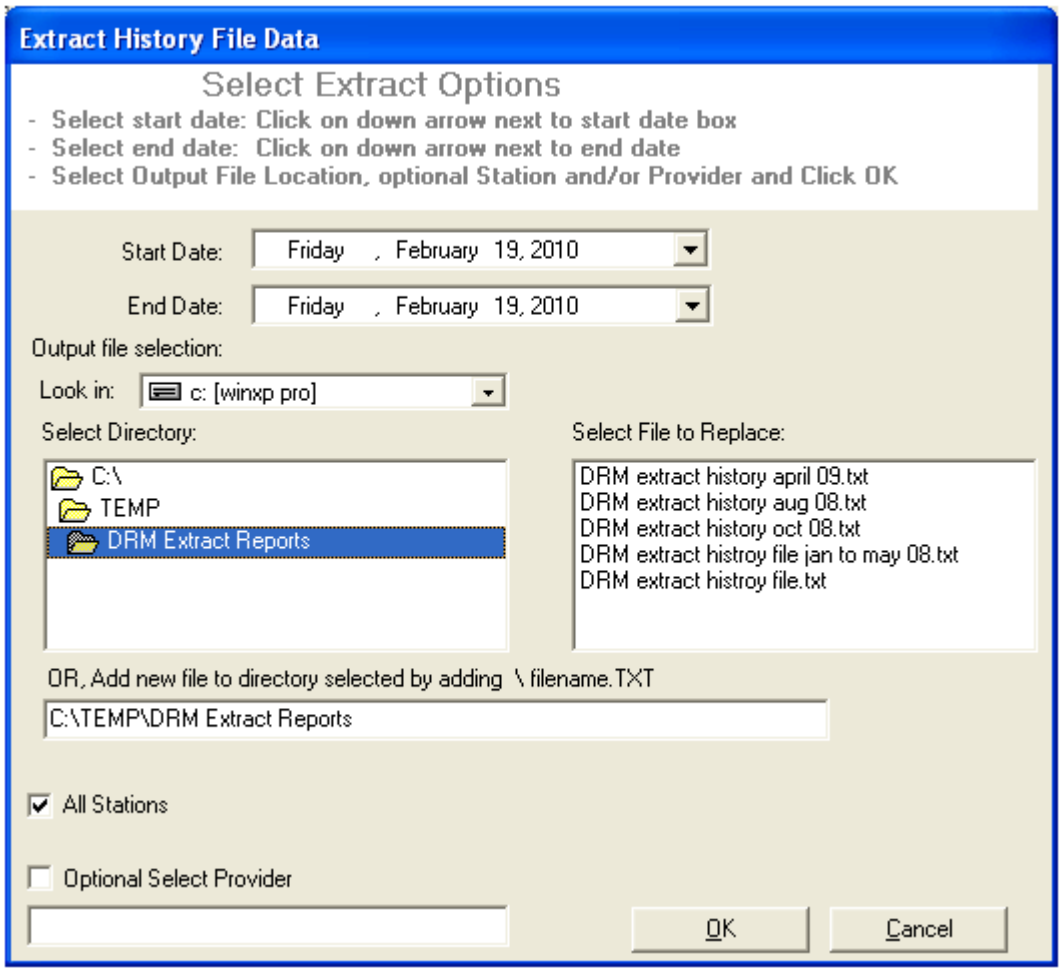
1. Select the provider from the dental provider drop-down menu.
2. Select the Provider Type from the next drop-down menu.
3. Enter the Provider Sequence number in the text box.
4. Check the Inactive box, if appropriate.
5. The Dental Provider Number is listed.
6. Click the **OK** button.
7. A confirmation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

Ancillary Tool Functions -- ADA Website

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

Extract History File

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



Extract History File Data Screen

To extract data:

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

Select Provider Screen

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

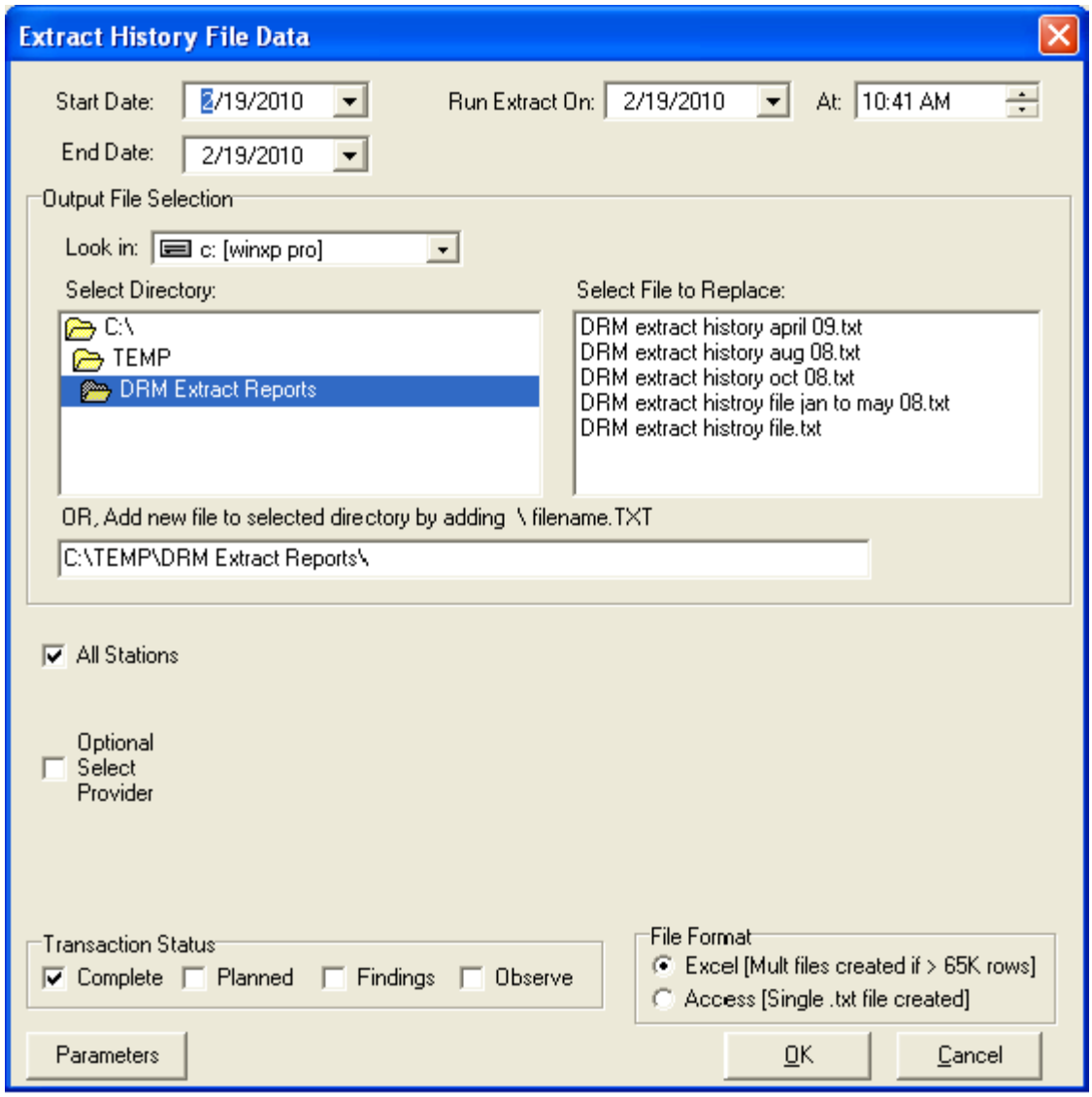
Note: Do not use this extract function for long reports. The workstation screen displays an hourglass, and no other applications can be run until the extract report finishes. When planning to run a long report, use the New Extract History File function.

New Extract History File

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

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

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

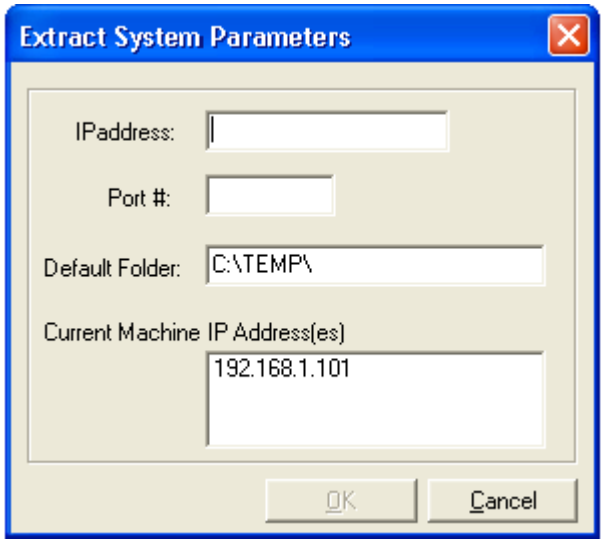


New Extract History File Data Screen

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

1. Use the drop-down menus to choose the start and end date for the date range the extract is performed in. Use the Run Extract On drop-down menus to determine the date/time to perform the extract.
2. The Output File Selection and the All Stations functions are identical to those found on the Extract History File screen. See the previous section for further information.
3. Check the **Optional Select Provider** check box to gather information from a specific provider. The Select Provider screen does not appear; instead, a scroll menu displays on screen. Select the provider by highlighting a specific name.
4. Check the desired **Transaction Status** checkbox.
5. Click the **radio** button corresponding to the desired file format.

6. Click the **Parameters** button. The Extract parameters screen displays.



Extract System Parameters

7. Enter the IP address and Port number. IRM can provide this information.
8. Once the parameter information is entered, Click the **OK** button. This extracts the data to the chosen directory folder location.

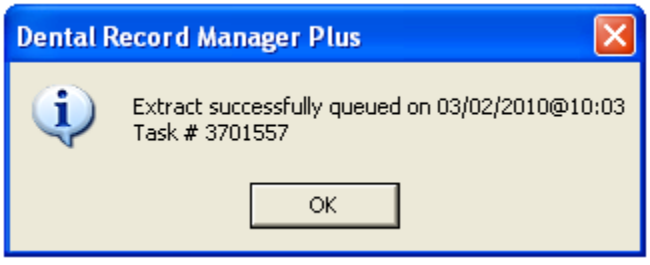
Considerations and Additional Information

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

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

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

Clicking the **OK** button displays the screen shown below:



Extract Successfully Queued Message

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

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

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

DRM Extract Already Running Message

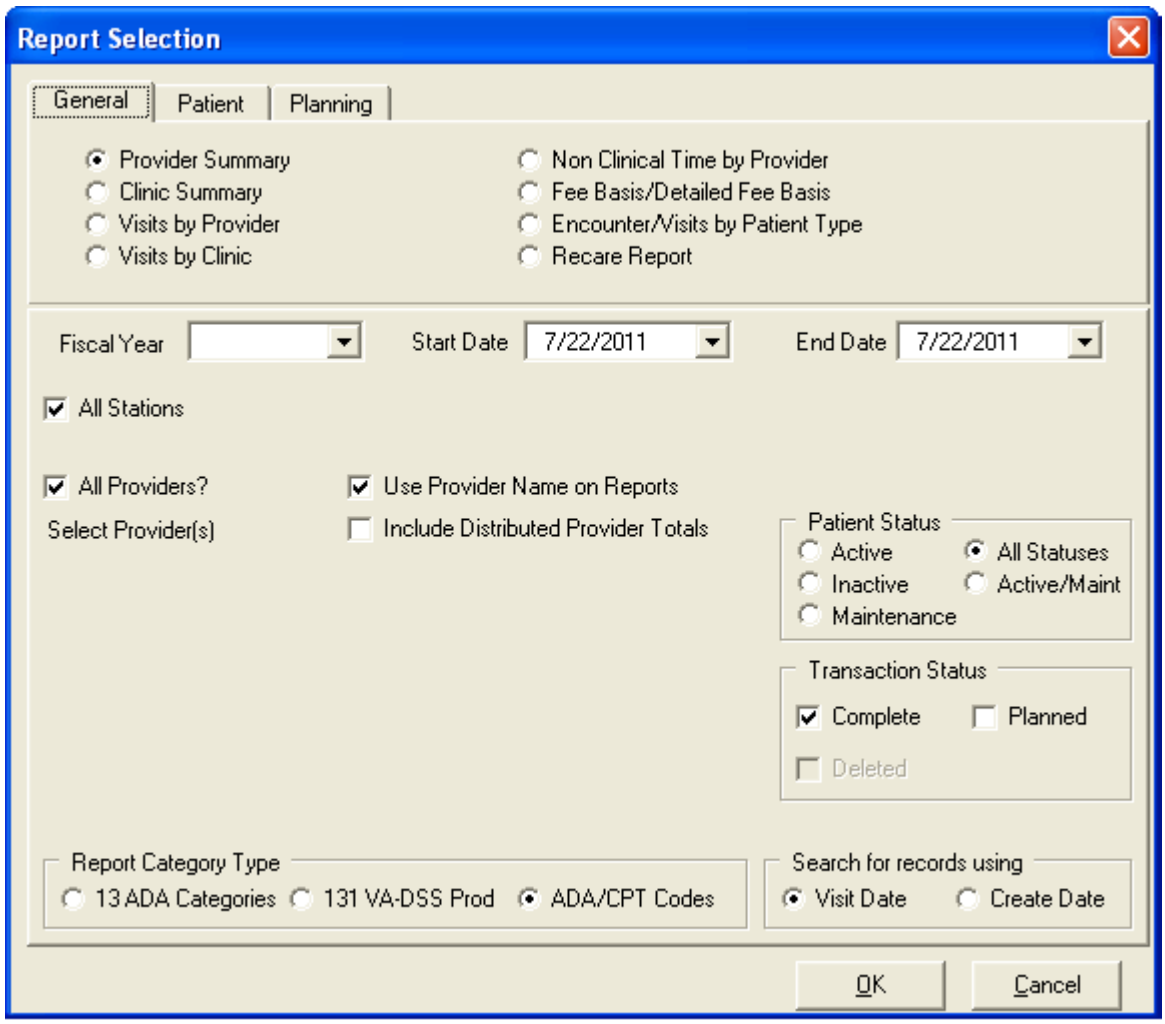
When the extract is completed, the DRMEXTSRV application closes automatically, and another extract can be queued. If multiple files are generated for the extract, they are numbered sequentially, i.e. Extract.txt is the user selected name, followed by: Extract1.txt, Extract2.txt, etc. Since the extract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

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

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

Reports

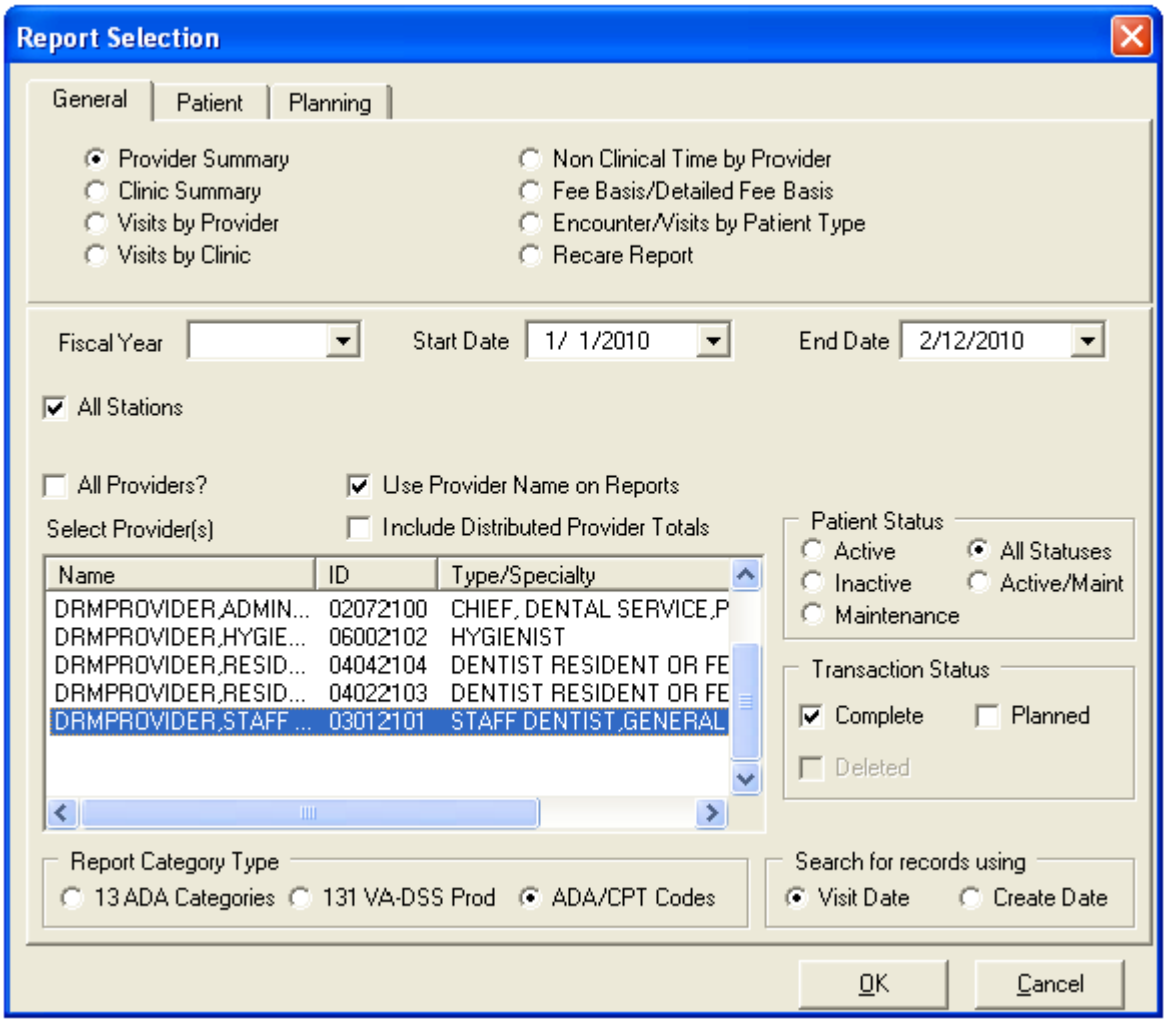
When this option is selected, the Report Selection screen displays.



Report Selection Screen

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

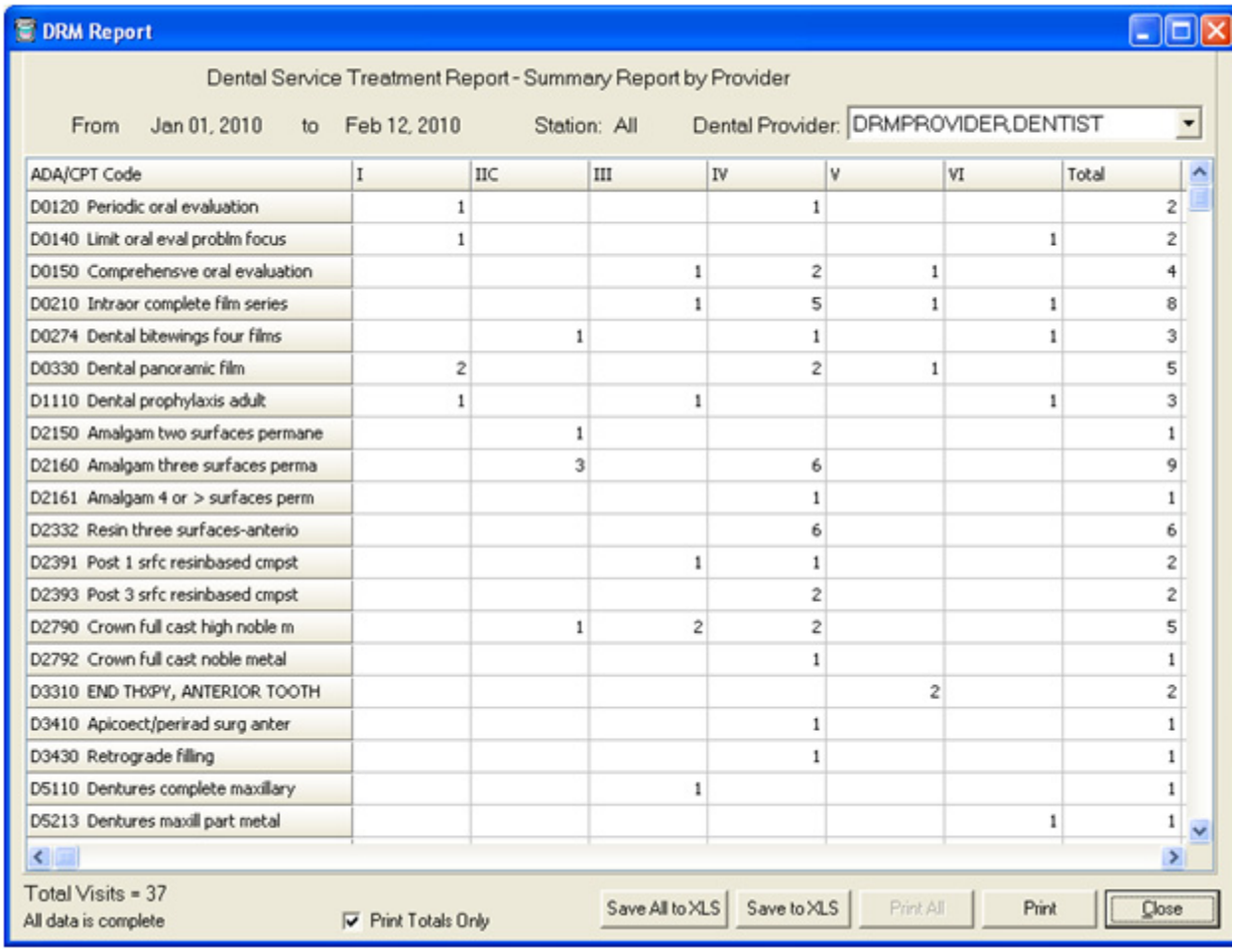
General



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 checkbox 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. Pick the report category type.
7. Choose the progress note date type that is to be represented on the report.
8. Click the **OK** button to generate the report. The report screen displays.



ADA/CPT Code	I	IIC	III	IV	V	VI	Total
D0120 Periodic oral evaluation	1			1			2
D0140 Limit oral eval problm focus	1					1	2
D0150 Comprehensve oral evaluation			1	2	1		4
D0210 Intraor complete film series			1	5	1	1	8
D0274 Dental bitewings four films		1		1		1	3
D0330 Dental panoramic film	2			2	1		5
D1110 Dental prophylaxis adult	1		1			1	3
D2150 Amalgam two surfaces permane		1					1
D2160 Amalgam three surfaces perma		3		6			9
D2161 Amalgam 4 or > surfaces perm				1			1
D2332 Resin three surfaces-anterio				6			6
D2391 Post 1 srfc resinbased cmpst			1	1			2
D2393 Post 3 srfc resinbased cmpst				2			2
D2790 Crown full cast high noble m		1	2	2			5
D2792 Crown full cast noble metal				1			1
D3310 END THXPY, ANTERIOR TOOTH					2		2
D3410 Apicoect/perirad surg anter				1			1
D3430 Retrograde filling				1			1
D5110 Dentures complete maxillary			1				1
D5213 Dentures maxill part metal						1	1

DRM Report Screen

This screen has options to save an Excel file (Save to XLS) 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.
- **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 checkboxes to customize these reports.

There are seven checkbox options:

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

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

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

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

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

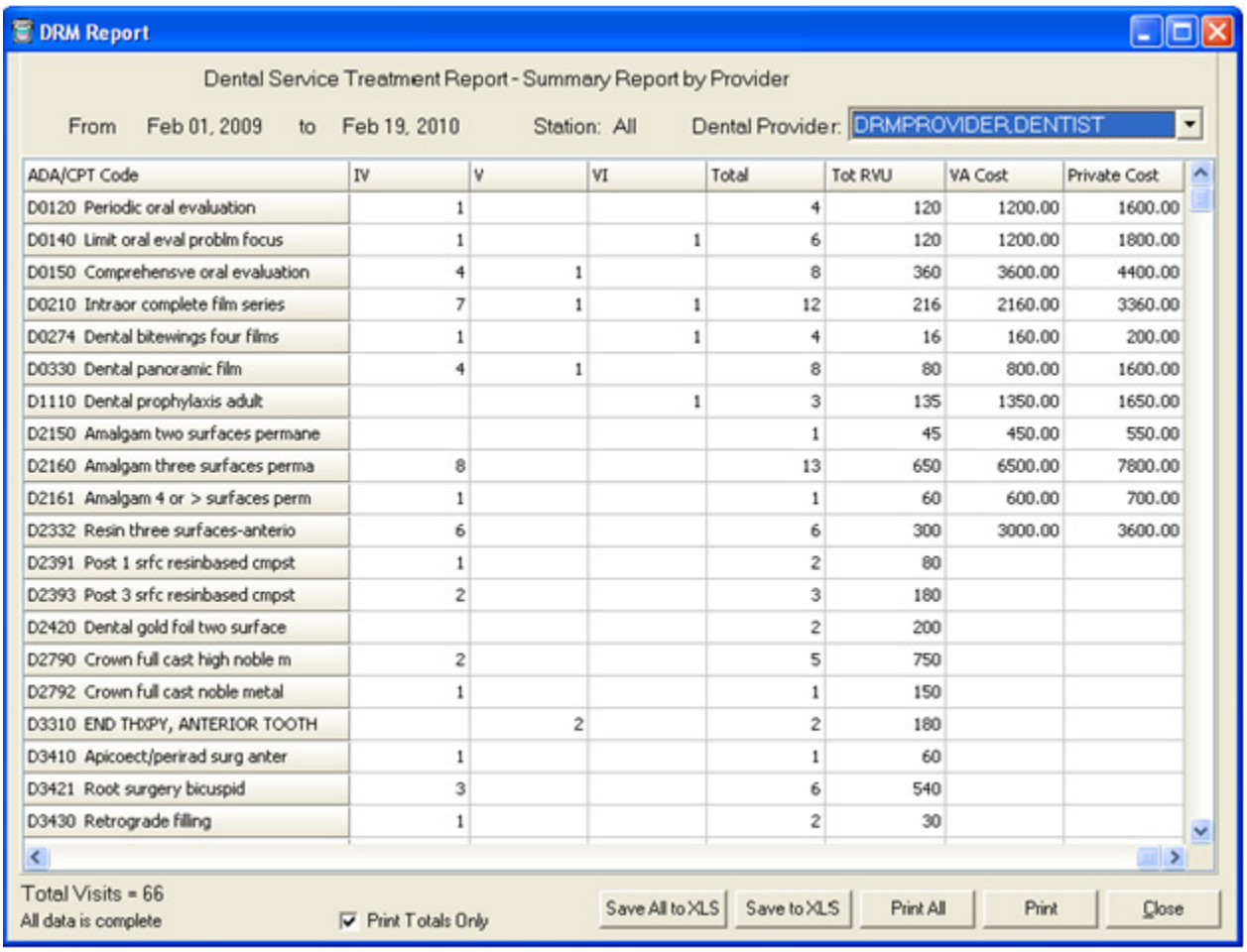
Distributed Provider workload may be viewed on the Provider Summary or Visits by provider report. When All Providers? is checked for these provider reports, and Include Distributed Provider Totals is checked, the Distributed Provider workload is included. The report may contain providers who are not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

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

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

Provider Summary

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



ADA/CPT Code	IV	V	VI	Total	Tot RVU	VA Cost	Private Cost
D0120 Periodic oral evaluation	1			4	120	1200.00	1600.00
D0140 Limit oral eval problm focus	1		1	6	120	1200.00	1800.00
D0150 Comprehensve oral evaluation	4	1		8	360	3600.00	4400.00
D0210 Intraor complete film series	7	1	1	12	216	2160.00	3360.00
D0274 Dental bitewings four films	1		1	4	16	160.00	200.00
D0330 Dental panoramic film	4	1		8	80	800.00	1600.00
D1110 Dental prophylaxis adult			1	3	135	1350.00	1650.00
D2150 Amalgam two surfaces permane				1	45	450.00	550.00
D2160 Amalgam three surfaces perma	8			13	650	6500.00	7800.00
D2161 Amalgam 4 or > surfaces perm	1			1	60	600.00	700.00
D2332 Resin three surfaces-anterio	6			6	300	3000.00	3600.00
D2391 Post 1 srfc resinbased cmpst	1			2	80		
D2393 Post 3 srfc resinbased cmpst	2			3	180		
D2420 Dental gold foil two surface				2	200		
D2790 Crown full cast high noble m	2			5	750		
D2792 Crown full cast noble metal	1			1	150		
D3310 END THXPY, ANTERIOR TOOTH		2		2	180		
D3410 Apicoect/perirad surg anter	1			1	60		
D3421 Root surgery bicuspid	3			6	540		
D3430 Retrograde filling	1			2	30		

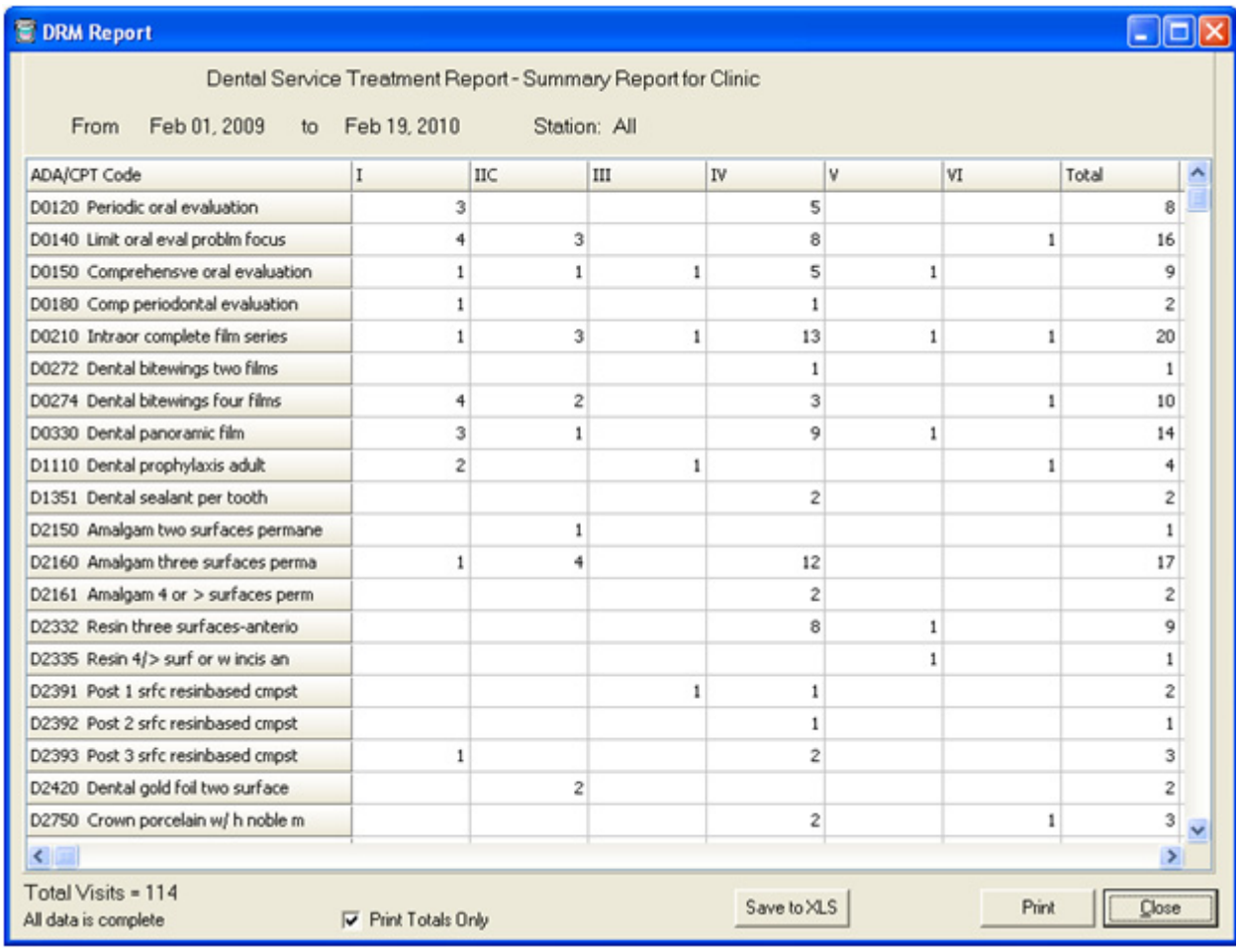
Provider Summary

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

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

Clinic Summary

The Clinic Summary report replaces the DENTREATCLINIC RPT in VistA. This report is essentially the same as the Provider Summary report, except that the entire station is displayed (all providers). ADA/CPT Codes, listed under the date range, which are included in this report, come from the selection of either the Visit Date or the Create Date designated on the General tab.

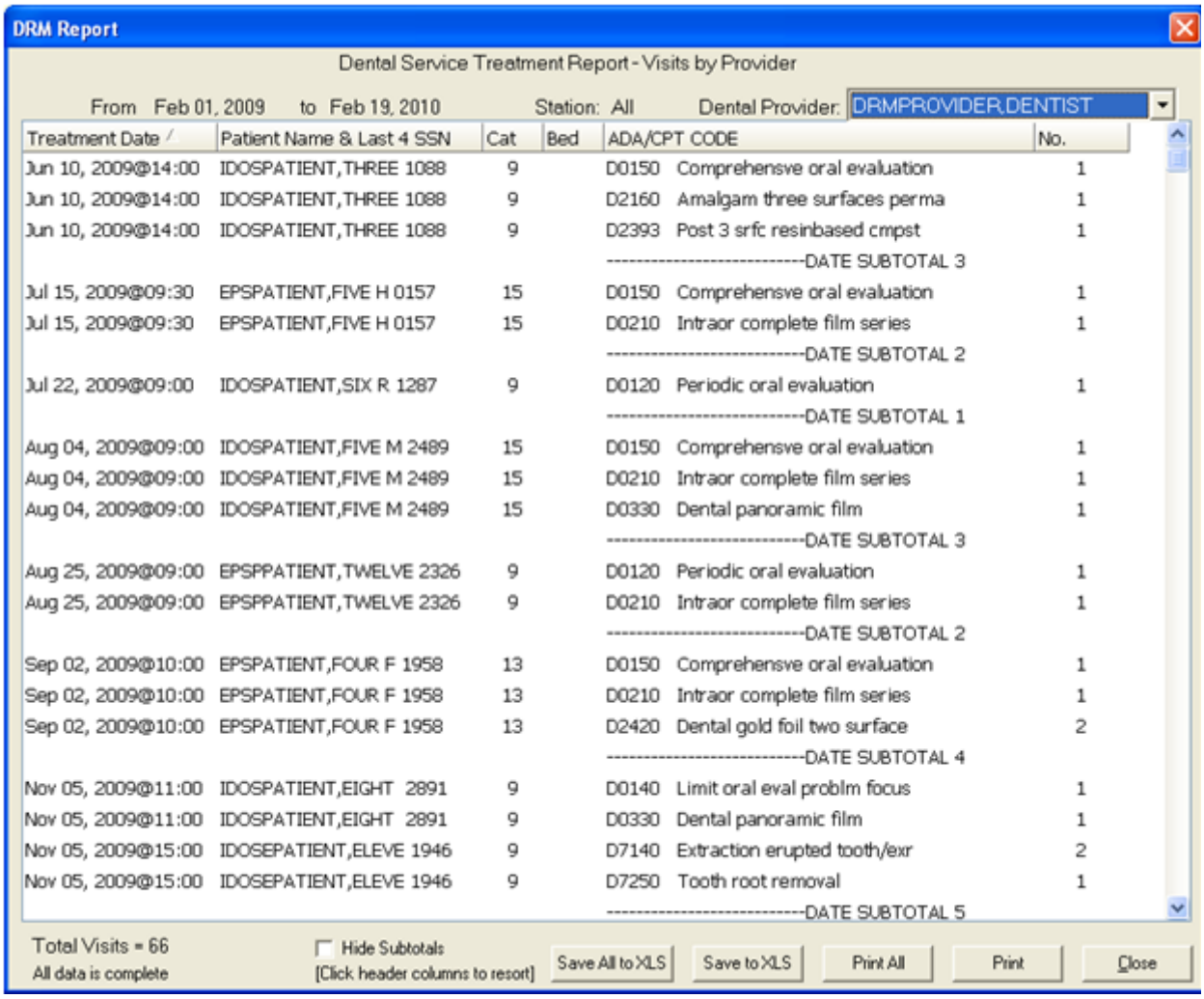


ADA/CPT Code	I	IIC	III	IV	V	VI	Total
D0120 Periodic oral evaluation	3			5			8
D0140 Limit oral eval problm focus	4	3		8		1	16
D0150 Comprehensve oral evaluation	1	1	1	5	1		9
D0180 Comp periodontal evaluation	1			1			2
D0210 Intraor complete film series	1	3	1	13	1	1	20
D0272 Dental bitewings two films				1			1
D0274 Dental bitewings four films	4	2		3		1	10
D0330 Dental panoramic film	3	1		9	1		14
D1110 Dental prophylaxis adult	2		1			1	4
D1351 Dental sealant per tooth				2			2
D2150 Amalgam two surfaces permane		1					1
D2160 Amalgam three surfaces perma	1	4		12			17
D2161 Amalgam 4 or > surfaces perm				2			2
D2332 Resin three surfaces-anterio				8	1		9
D2335 Resin 4/> surf or w incis an					1		1
D2391 Post 1 srfc resinbased cmpst			1	1			2
D2392 Post 2 srfc resinbased cmpst				1			1
D2393 Post 3 srfc resinbased cmpst	1			2			3
D2420 Dental gold foil two surface		2					2
D2750 Crown porcelain w/ h noble m				2		1	3

Clinic Summary

Visits By Provider

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



Treatment Date	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE		No.
Jun 10, 2009@14:00	IDOSPATIENT,THREE 1088	9		D0150	Comprehensve oral evaluation	1
Jun 10, 2009@14:00	IDOSPATIENT,THREE 1088	9		D2160	Amalgam three surfaces perma	1
Jun 10, 2009@14:00	IDOSPATIENT,THREE 1088	9		D2393	Post 3 srfc resinbased cmpst	1
				----------DATE SUBTOTAL 3		
Jul 15, 2009@09:30	EPSPATIENT,FIVE H 0157	15		D0150	Comprehensve oral evaluation	1
Jul 15, 2009@09:30	EPSPATIENT,FIVE H 0157	15		D0210	Intraor complete film series	1
				----------DATE SUBTOTAL 2		
Jul 22, 2009@09:00	IDOSPATIENT,SIX R 1287	9		D0120	Periodic oral evaluation	1
				----------DATE SUBTOTAL 1		
Aug 04, 2009@09:00	IDOSPATIENT,FIVE M 2489	15		D0150	Comprehensve oral evaluation	1
Aug 04, 2009@09:00	IDOSPATIENT,FIVE M 2489	15		D0210	Intraor complete film series	1
Aug 04, 2009@09:00	IDOSPATIENT,FIVE M 2489	15		D0330	Dental panoramic film	1
				----------DATE SUBTOTAL 3		
Aug 25, 2009@09:00	EPSPPATIENT,TWELVE 2326	9		D0120	Periodic oral evaluation	1
Aug 25, 2009@09:00	EPSPPATIENT,TWELVE 2326	9		D0210	Intraor complete film series	1
				----------DATE SUBTOTAL 2		
Sep 02, 2009@10:00	EPSPATIENT,FOUR F 1958	13		D0150	Comprehensve oral evaluation	1
Sep 02, 2009@10:00	EPSPATIENT,FOUR F 1958	13		D0210	Intraor complete film series	1
Sep 02, 2009@10:00	EPSPATIENT,FOUR F 1958	13		D2420	Dental gold foil two surface	2
				----------DATE SUBTOTAL 4		
Nov 05, 2009@11:00	IDOSPATIENT,EIGHT 2891	9		D0140	Limit oral eval problm focus	1
Nov 05, 2009@11:00	IDOSPATIENT,EIGHT 2891	9		D0330	Dental panoramic film	1
Nov 05, 2009@15:00	IDOSEPATIENT,ELEVE 1946	9		D7140	Extraction erupted tooth/exr	2
Nov 05, 2009@15:00	IDOSEPATIENT,ELEVE 1946	9		D7250	Tooth root removal	1
				----------DATE SUBTOTAL 5		

Visits by Provider

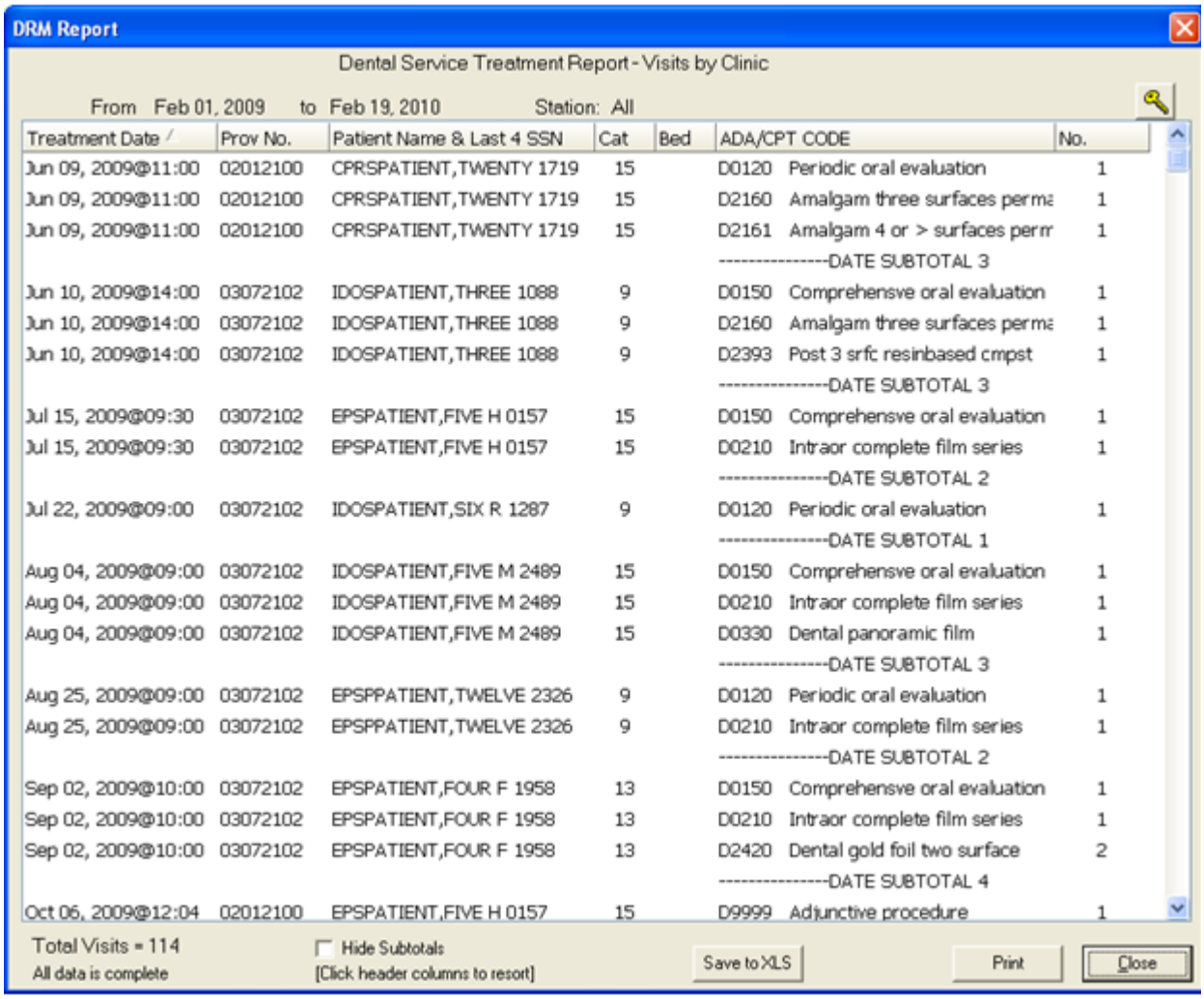
To create a Visits by Provider report, select one or more providers by pressing the <**Shift**> and <**Ctrl**> keys, or select all providers by checking the All Providers checkbox. Click the **Save All to XLS** or **Save to XLS** buttons to save the current data to an Excel spreadsheet. The print options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

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

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

Visits by Clinic

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



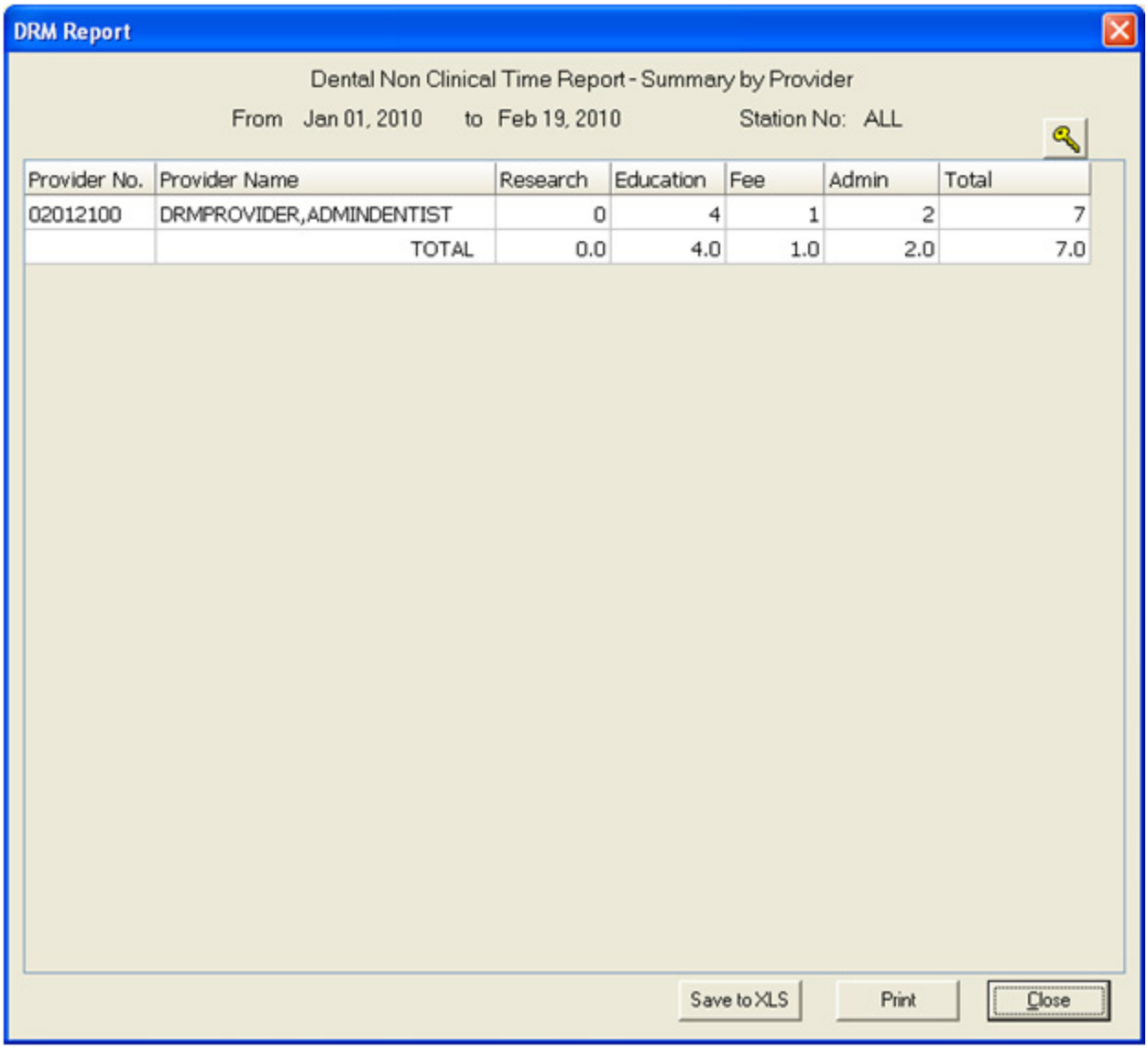
Treatment Date	Prov No.	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE	No.
Jun 09, 2009@11:00	02012100	CPRSPATIENT,TWENTY 1719	15		D0120 Periodic oral evaluation	1
Jun 09, 2009@11:00	02012100	CPRSPATIENT,TWENTY 1719	15		D2160 Amalgam three surfaces perma	1
Jun 09, 2009@11:00	02012100	CPRSPATIENT,TWENTY 1719	15		D2161 Amalgam 4 or > surfaces perm	1
					----------DATE SUBTOTAL 3	
Jun 10, 2009@14:00	03072102	IDOSPATIENT,THREE 1088	9		D0150 Comprehensve oral evaluation	1
Jun 10, 2009@14:00	03072102	IDOSPATIENT,THREE 1088	9		D2160 Amalgam three surfaces perma	1
Jun 10, 2009@14:00	03072102	IDOSPATIENT,THREE 1088	9		D2393 Post 3 srfc resinbased cmpst	1
					----------DATE SUBTOTAL 3	
Jul 15, 2009@09:30	03072102	EPSPATIENT,FIVE H 0157	15		D0150 Comprehensve oral evaluation	1
Jul 15, 2009@09:30	03072102	EPSPATIENT,FIVE H 0157	15		D0210 Intraor complete film series	1
					----------DATE SUBTOTAL 2	
Jul 22, 2009@09:00	03072102	IDOSPATIENT,SIX R 1287	9		D0120 Periodic oral evaluation	1
					----------DATE SUBTOTAL 1	
Aug 04, 2009@09:00	03072102	IDOSPATIENT,FIVE M 2489	15		D0150 Comprehensve oral evaluation	1
Aug 04, 2009@09:00	03072102	IDOSPATIENT,FIVE M 2489	15		D0210 Intraor complete film series	1
Aug 04, 2009@09:00	03072102	IDOSPATIENT,FIVE M 2489	15		D0330 Dental panoramic film	1
					----------DATE SUBTOTAL 3	
Aug 25, 2009@09:00	03072102	EPSPPATIENT,TWELVE 2326	9		D0120 Periodic oral evaluation	1
Aug 25, 2009@09:00	03072102	EPSPPATIENT,TWELVE 2326	9		D0210 Intraor complete film series	1
					----------DATE SUBTOTAL 2	
Sep 02, 2009@10:00	03072102	EPSPATIENT,FOUR F 1958	13		D0150 Comprehensve oral evaluation	1
Sep 02, 2009@10:00	03072102	EPSPATIENT,FOUR F 1958	13		D0210 Intraor complete film series	1
Sep 02, 2009@10:00	03072102	EPSPATIENT,FOUR F 1958	13		D2420 Dental gold foil two surface	2
					----------DATE SUBTOTAL 4	
Oct 06, 2009@12:04	02012100	EPSPATIENT,FIVE H 0157	15		D9999 Adjunctive procedure	1

Visits by Clinic

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

Non-Clinical Time by Provider Report

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



Non-Clinical Time Report

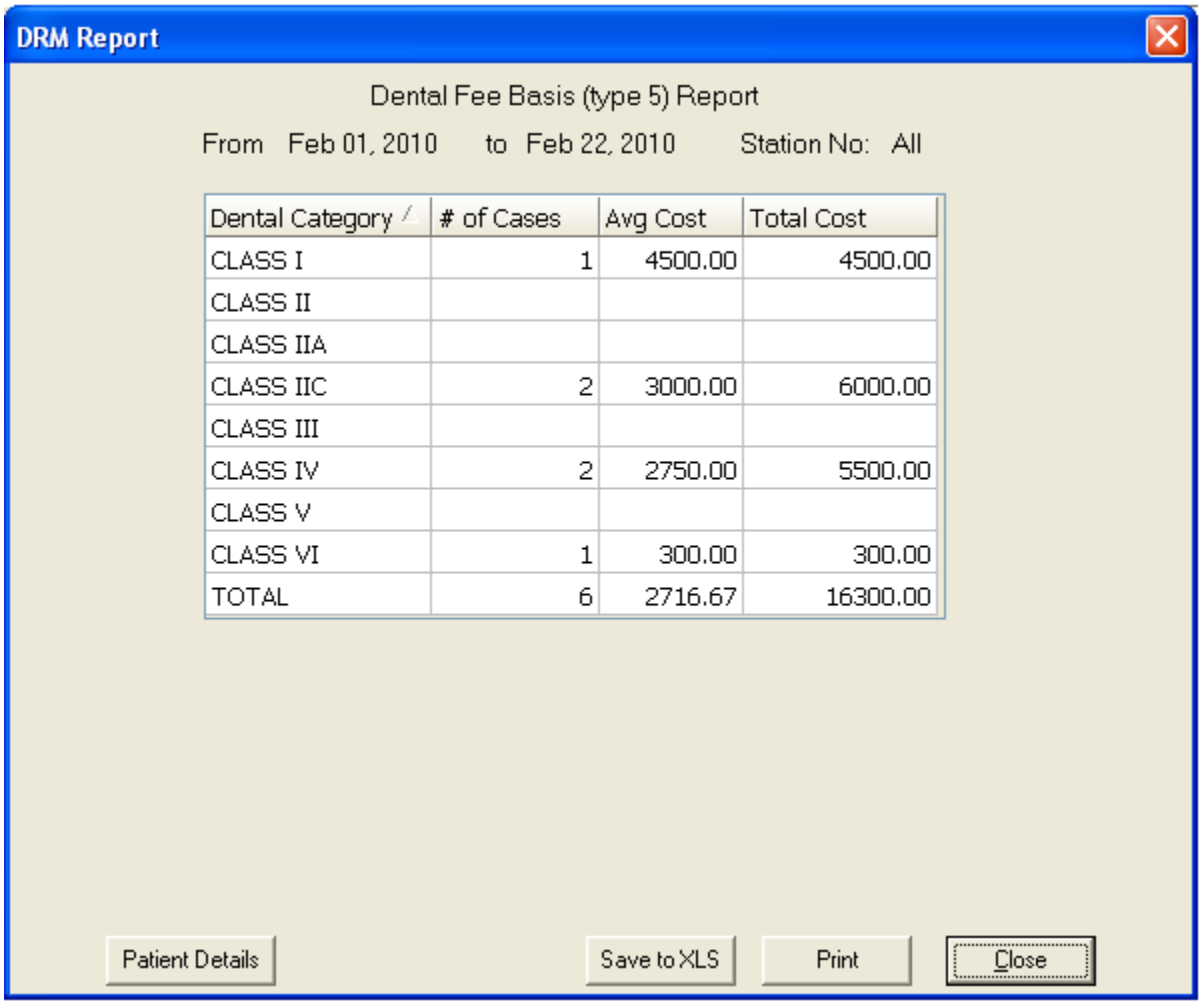
The entry option allows the user to record Administrative, Fee Basis, Education and Training, and Research time in hours and minutes (15 minute increments) for local reporting only. The Non-Clinical Time by Provider report displays an approximate numerical unit of days (1 day = 8 hours). The accumulation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

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

Fee Basis/Detailed Fee Basis Report

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

The Fee Basis report displays data from the DRM File Fee Basis option available from the File drop-down menu.

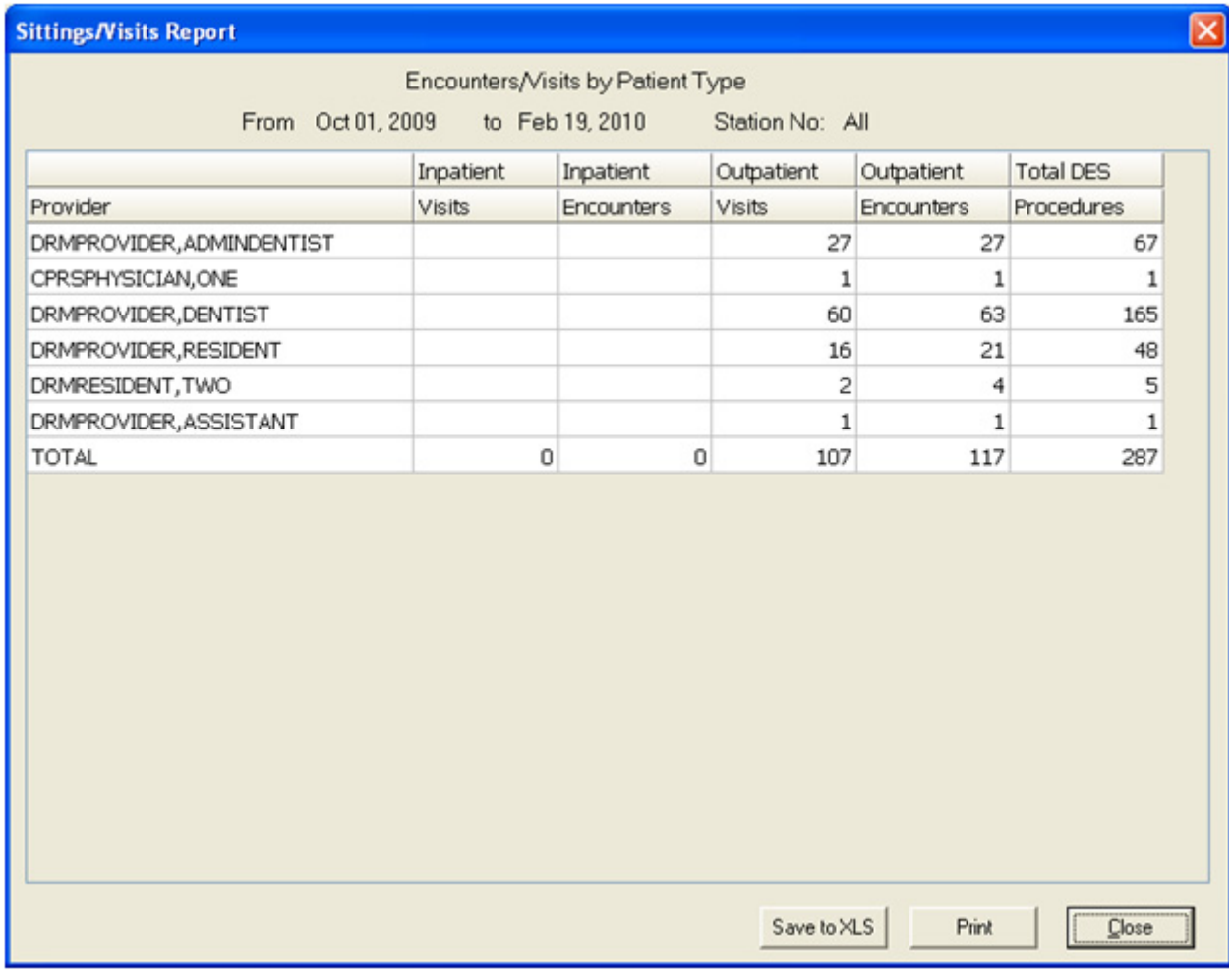


Dental Fee Basis

Note: Dental HL7 fee basis data does not transmit to the CFD; however, the data is still available in DRM Plus for any site to enter the information and run a local report.

Encounters/Visits by Patient Type Report

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



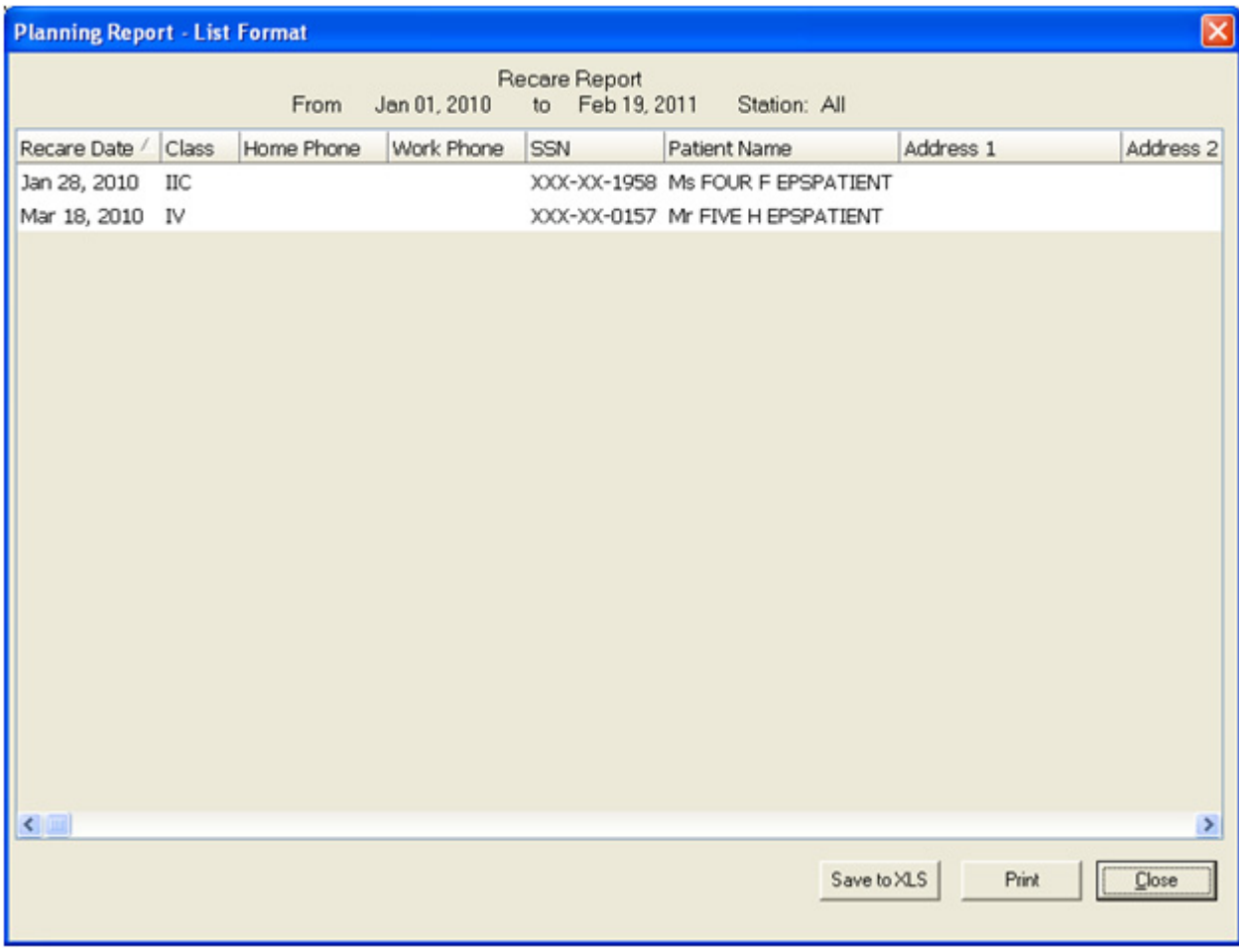
Provider	Inpatient Visits	Inpatient Encounters	Outpatient Visits	Outpatient Encounters	Total DES Procedures
DRMPROVIDER,ADMINDENTIST			27	27	67
CPRSPHYSICIAN,ONE			1	1	1
DRMPROVIDER,DENTIST			60	63	165
DRMPROVIDER,RESIDENT			16	21	48
DRMRESIDENT,TWO			2	4	5
DRMPROVIDER,ASSISTANT			1	1	1
TOTAL	0	0	107	117	287

Encounters/Visits by Patient Type

Recare Report

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

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

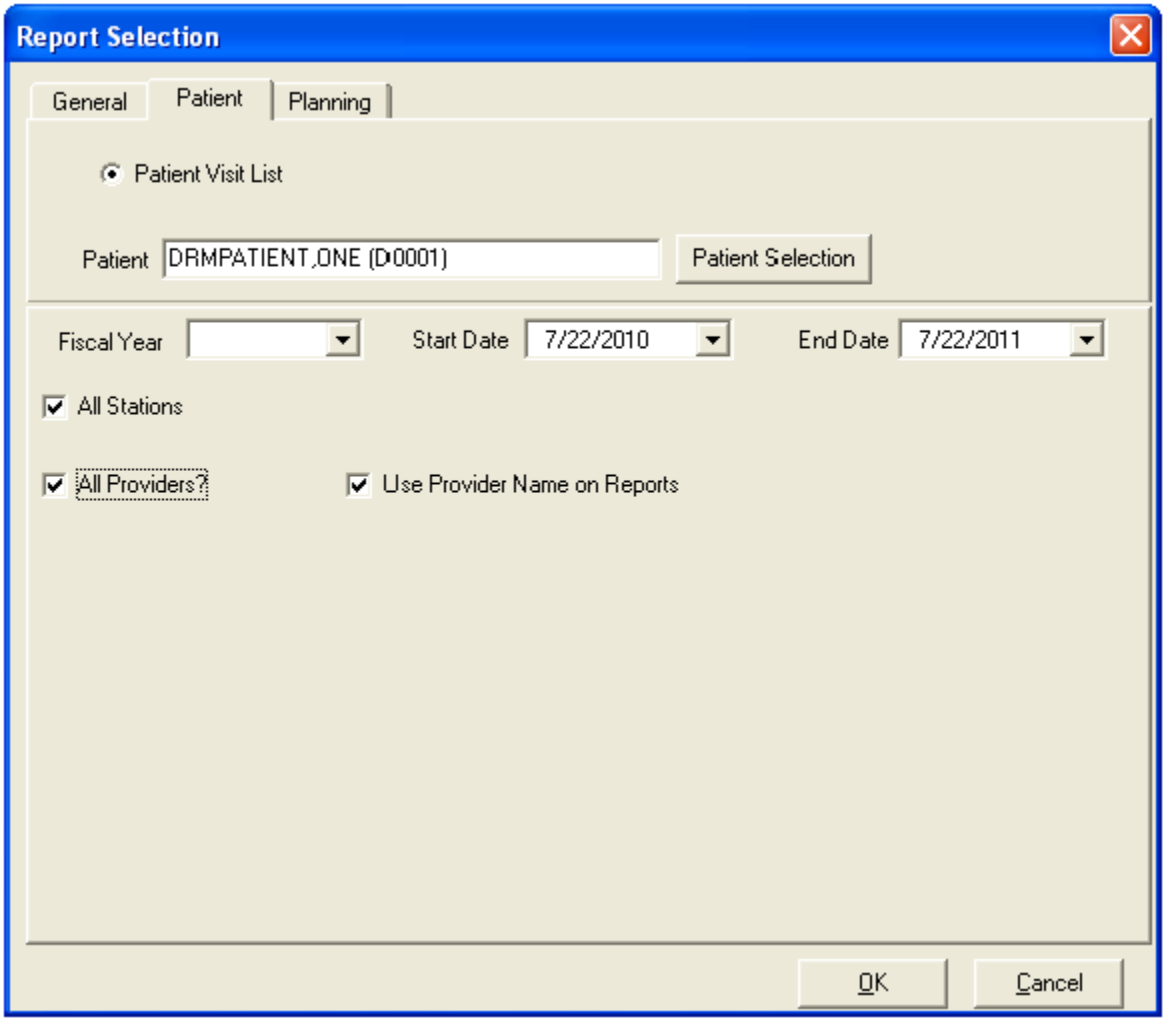


Recare Report

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

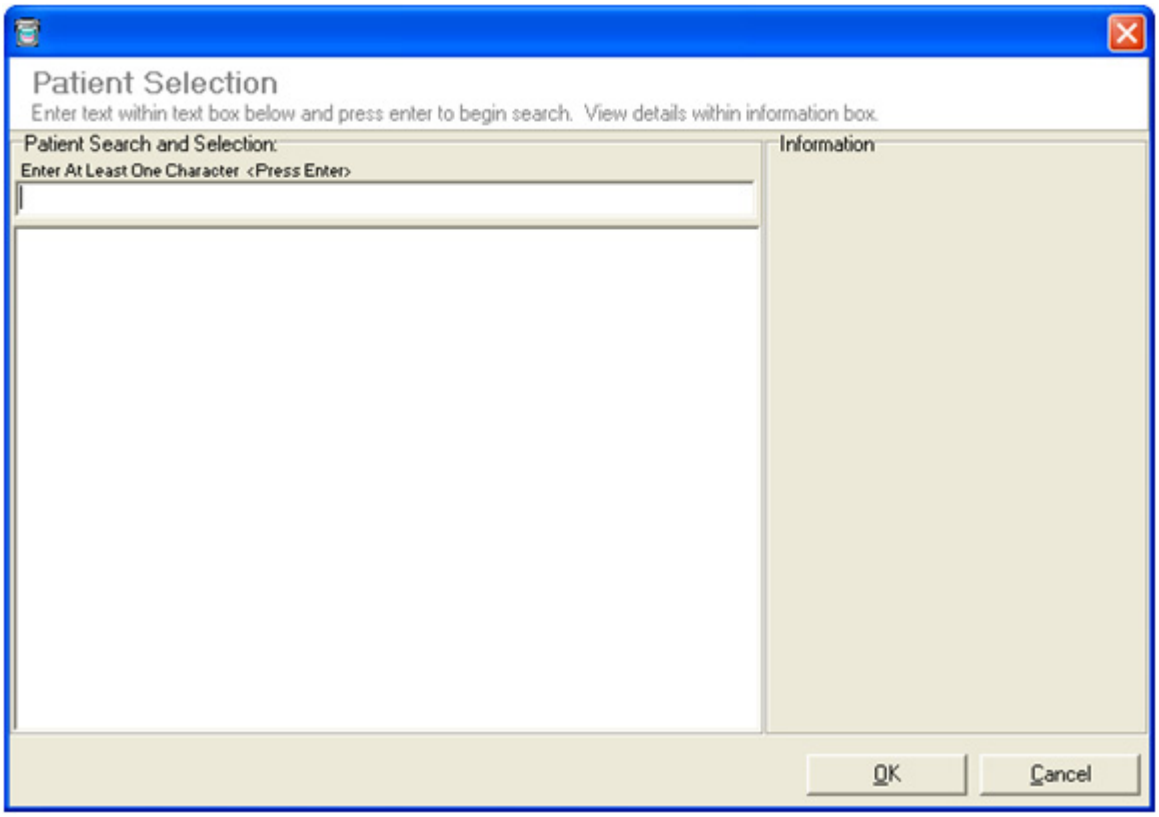
Patient

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.



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.

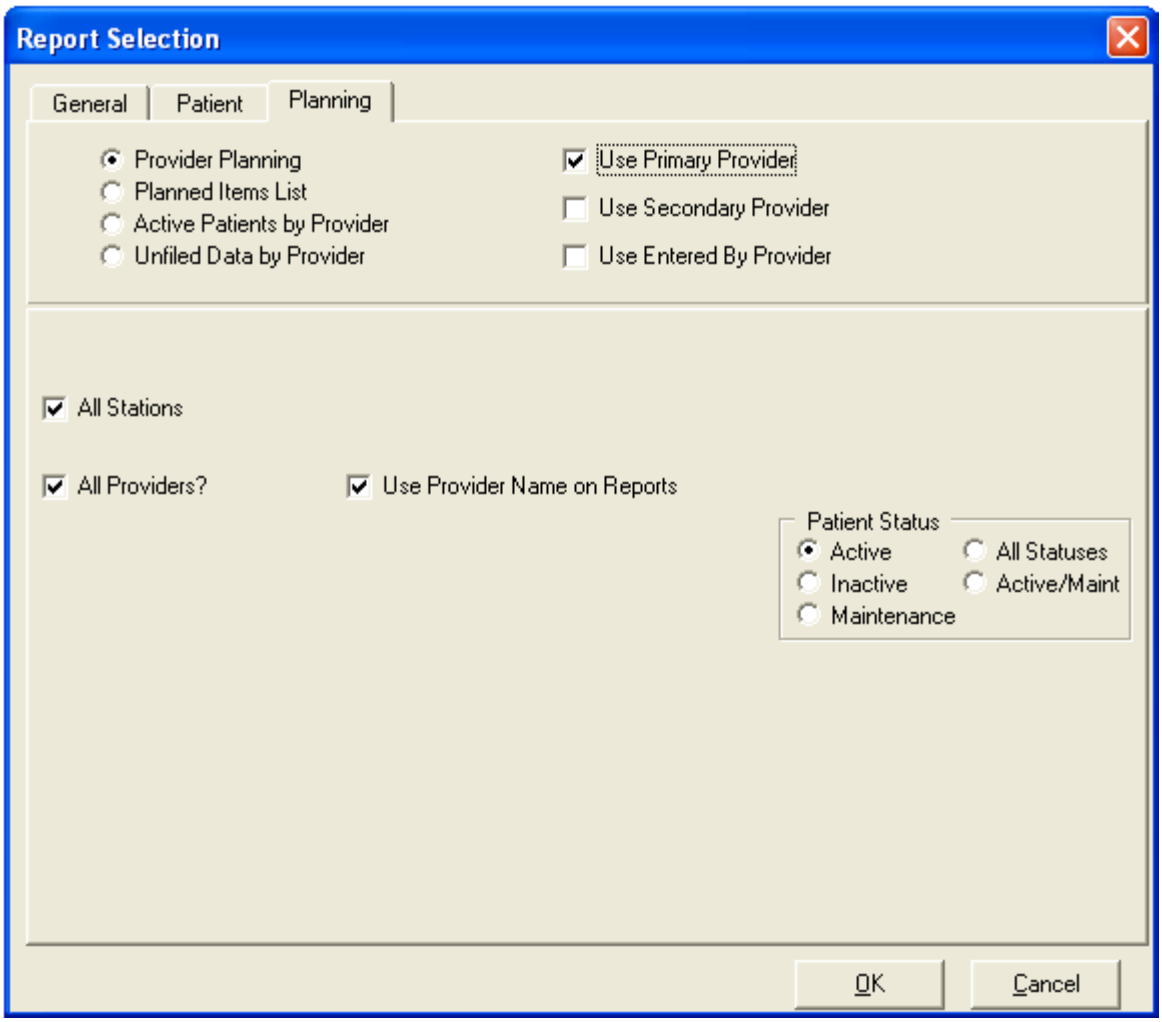


Patient Selection Screen

3. Type a patient name into the text box and press <**Enter**>. 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 appears on the Patient tab.
6. Choose the date and select other information to be included or excluded using the checkboxes on the patient tab.
7. Click the **OK** button.
8. The DRM Report Screen displays. Save to an Excel file, print or close.

Planning

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



Planning Tab

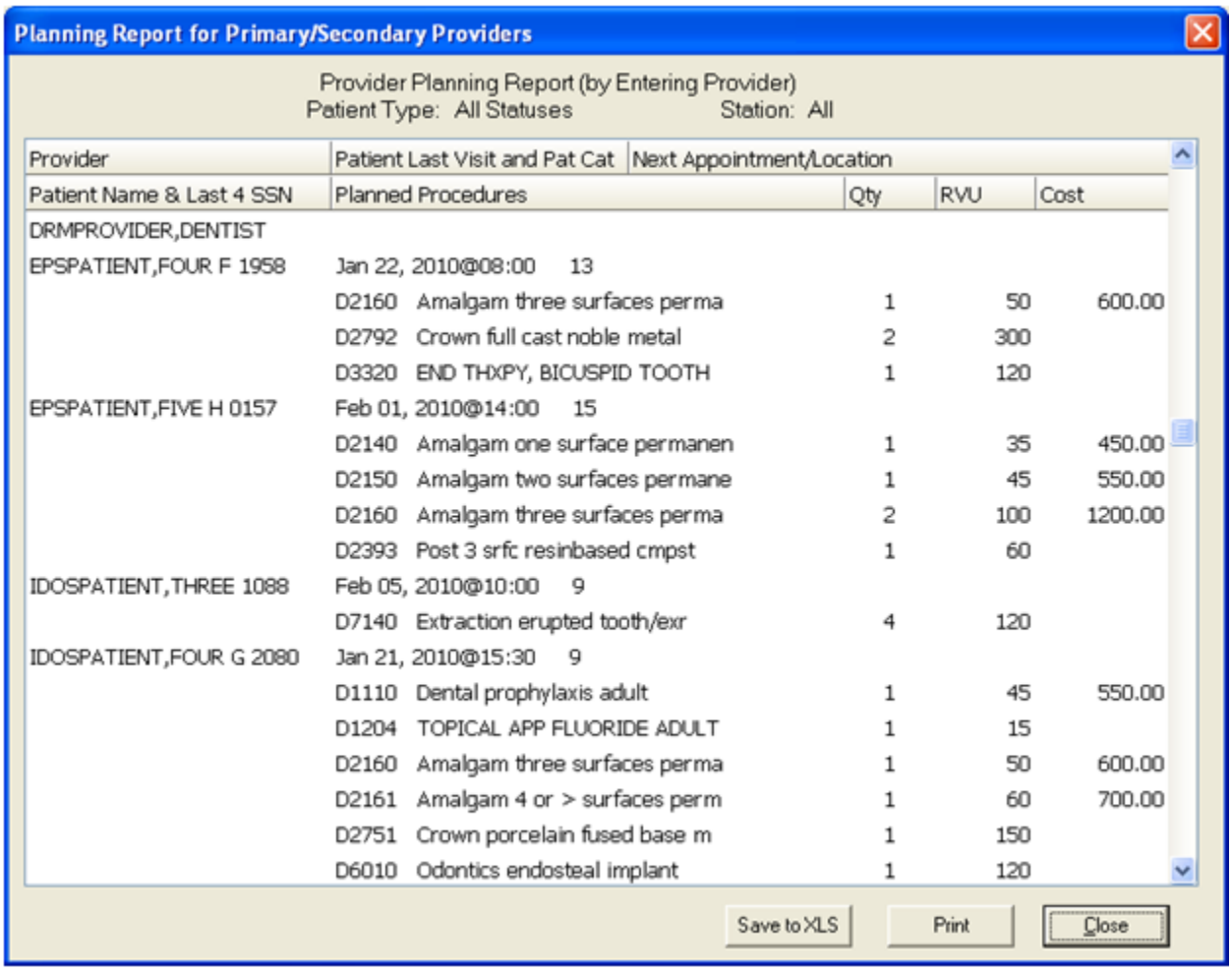
1. Select the type of report.
2. Use the check boxes to indicate provider information.
3. Choose a patient status.
4. Click the **OK** button.
5. The DRM Reports screen displays. Print or save the results to Excel.

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

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

Provider Planning

The Provider Planning Report contains the Provider, Patient Name and last four Social Security Number digits, Patient Last Visit and patient Category, Planned Procedures, Next Appointment/Location and the Qty/RVU/Cost.

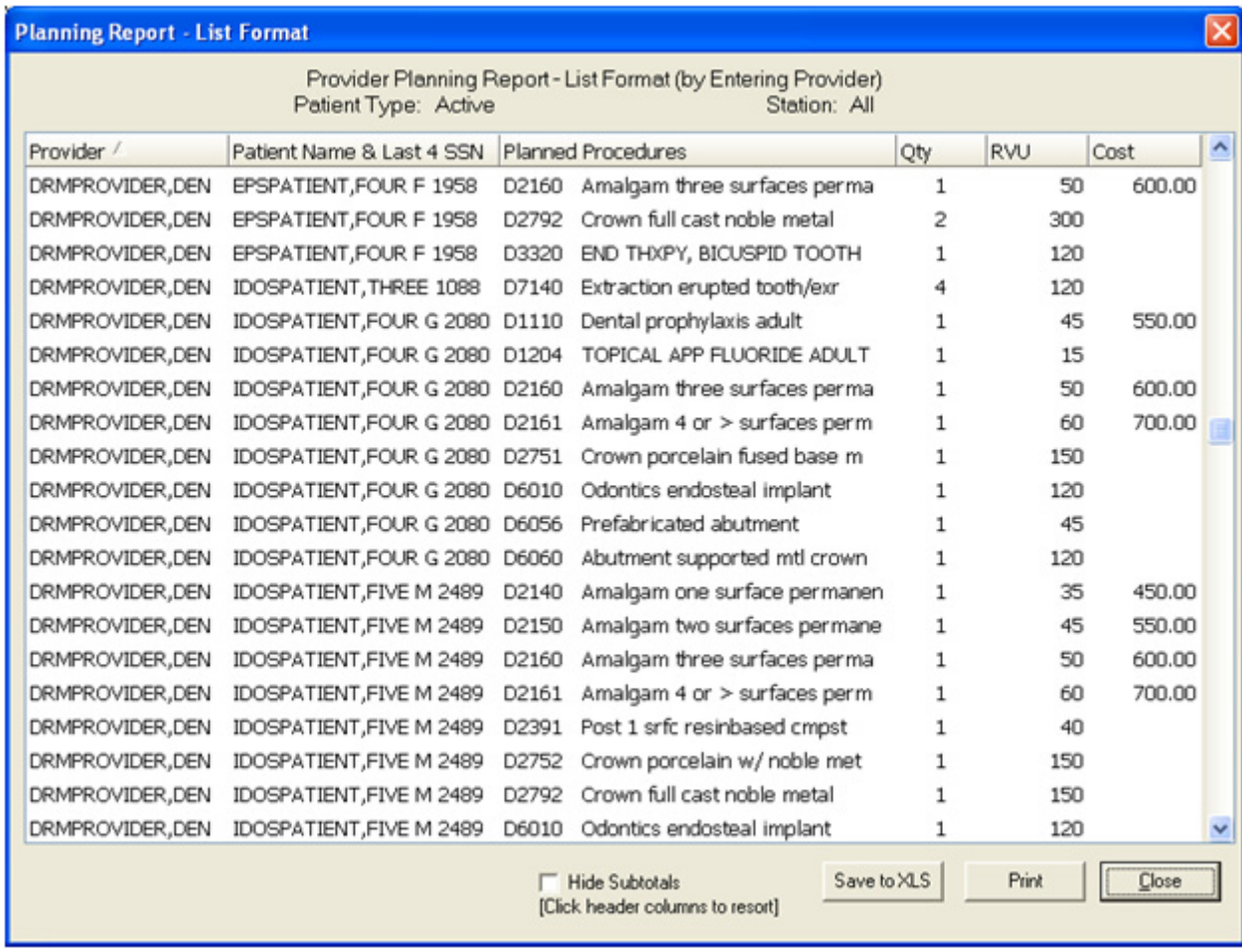


Planning Report

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

Planned Items List

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



Provider	Patient Name & Last 4 SSN	Planned Procedures		Qty	RVU	Cost
DRMPROVIDER,DEN	EPSPATIENT,FOUR F 1958	D2160	Amalgam three surfaces perma	1	50	600.00
DRMPROVIDER,DEN	EPSPATIENT,FOUR F 1958	D2792	Crown full cast noble metal	2	300	
DRMPROVIDER,DEN	EPSPATIENT,FOUR F 1958	D3320	END THXPY, BICUSPID TOOTH	1	120	
DRMPROVIDER,DEN	IDOSPATIENT,THREE 1088	D7140	Extraction erupted tooth/exr	4	120	
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D1110	Dental prophylaxis adult	1	45	550.00
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D1204	TOPICAL APP FLUORIDE ADULT	1	15	
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D2160	Amalgam three surfaces perma	1	50	600.00
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D2161	Amalgam 4 or > surfaces perm	1	60	700.00
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D2751	Crown porcelain fused base m	1	150	
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D6010	Odontics endosteal implant	1	120	
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D6056	Prefabricated abutment	1	45	
DRMPROVIDER,DEN	IDOSPATIENT,FOUR G 2080	D6060	Abutment supported mtl crown	1	120	
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2140	Amalgam one surface permanen	1	35	450.00
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2150	Amalgam two surfaces permane	1	45	550.00
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2160	Amalgam three surfaces perma	1	50	600.00
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2161	Amalgam 4 or > surfaces perm	1	60	700.00
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2391	Post 1 srfc resinbased cmpst	1	40	
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2752	Crown porcelain w/ noble met	1	150	
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D2792	Crown full cast noble metal	1	150	
DRMPROVIDER,DEN	IDOSPATIENT,FIVE M 2489	D6010	Odontics endosteal implant	1	120	

Planned Items List

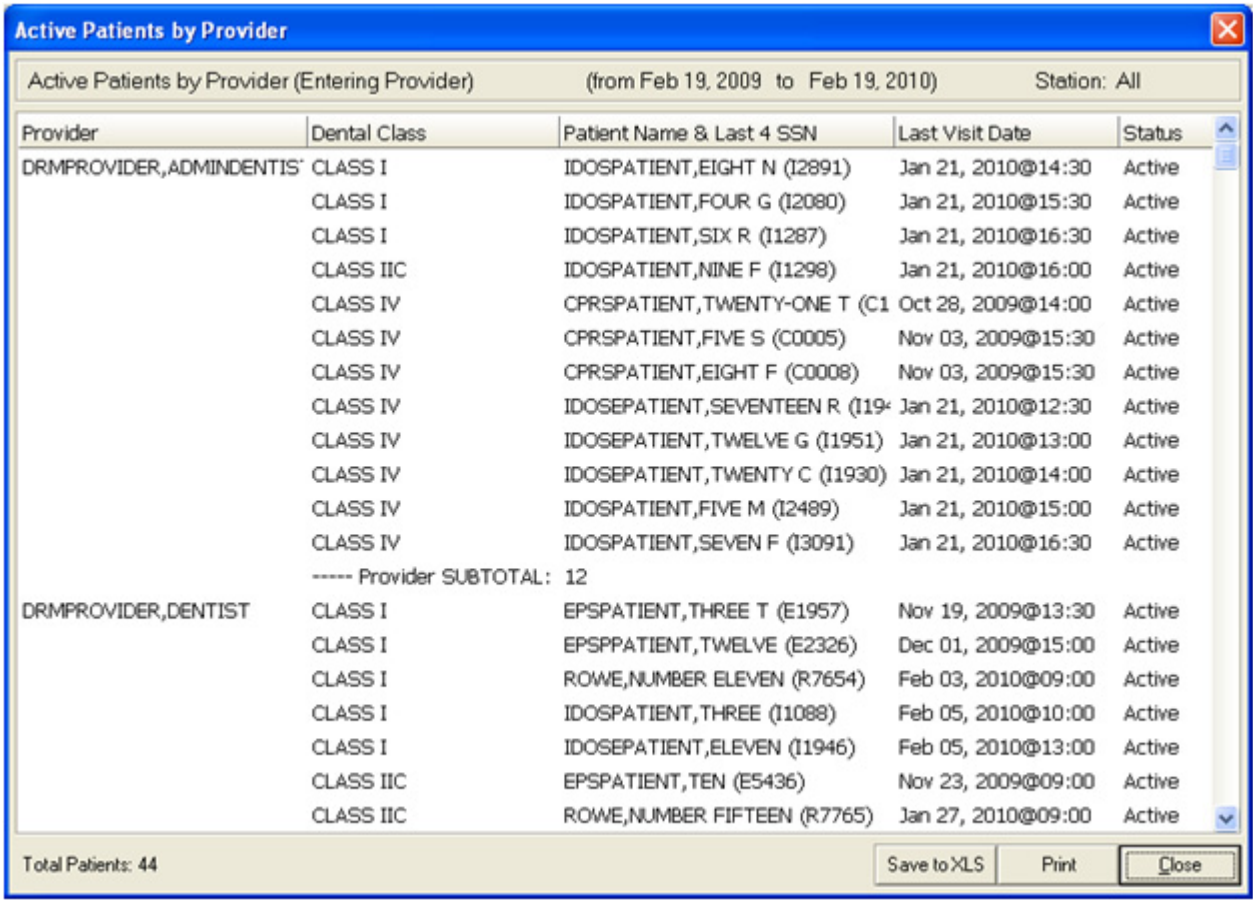
Note: The cost is included if it has previously been entered locally by a DRM Plus administrator.

Active Patients by Provider Report

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

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

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

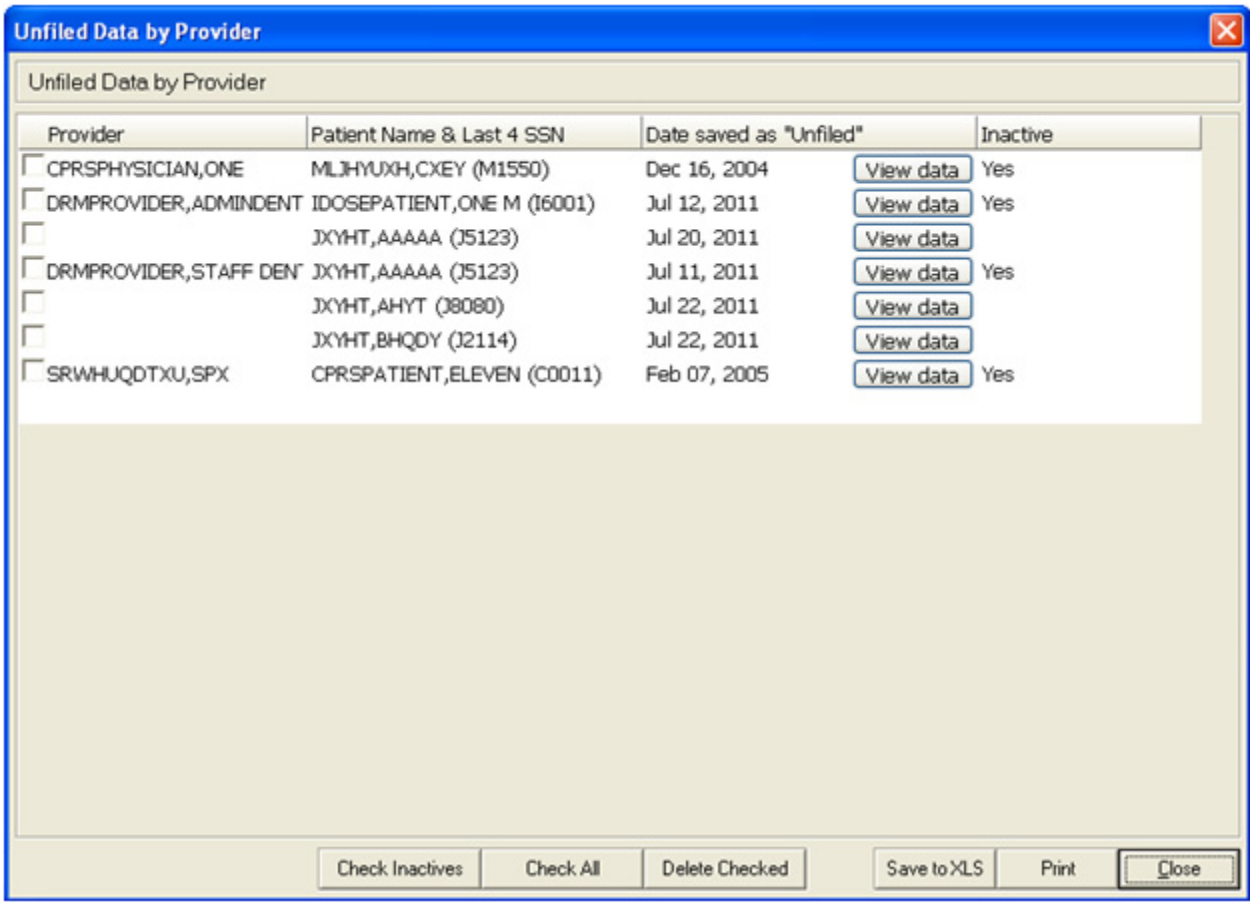


Active Patients By Provider

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 days; the saved data is viewable but no longer available to be filed.



Unfiled Data By Provider Report

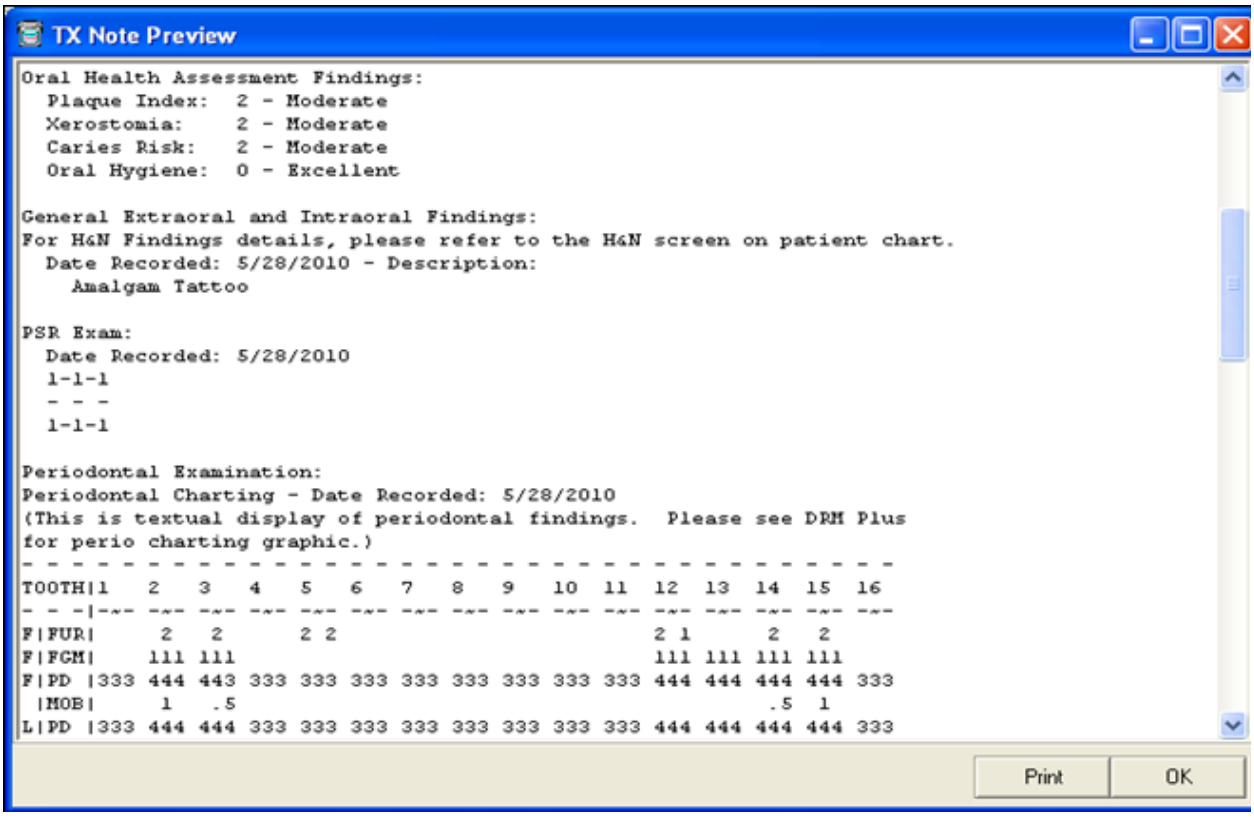
After selecting an Unfiled Data report, the provider needs to select the **View data** button which allows the user to display the data that was saved as unfiled data on that patient.

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 option on this patient's chart. An example of inactive unfiled data would have a "Yes" listed in the Inactive column. There is no way for DRM Plus to reload this inactive data back into the patient's chart, so 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 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 report.

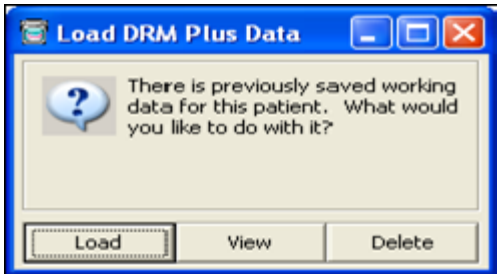
The following dialog is an example of unfiled data saved on a patient. The user may print the unfiled data by selecting the **Print** button or close the screen by clicking the **OK** button.



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 new screen that allows the provider to load, view (non-load) or delete any unfiled data when opening the DRM Plus chart for a patient. This screen now has a third button allowing 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 this **Delete** button option from this screen.

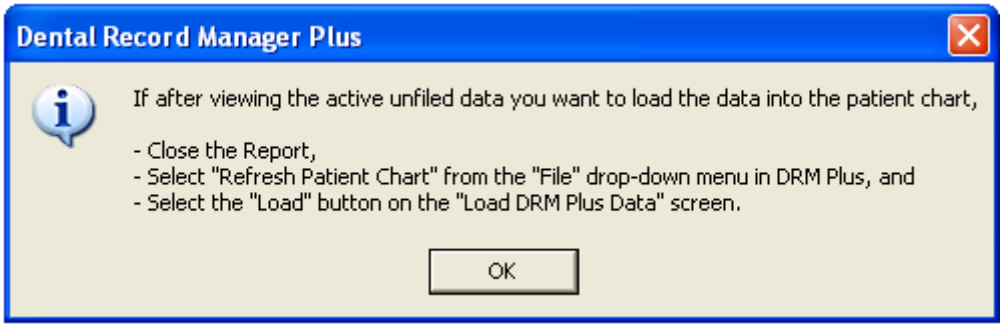


Load DRM Plus Data Screen

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 report located from the Tools menu / Reports option / Planning tab / Unfiled Data by Provider report selection.

The second way to view unfiled data when the provider can't remember exactly what was saved as unfiled data is to select the **View** button. This option directs the user directly to the Unfiled Data by Provider report however it did 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 under the File menu.

This action displays the screen again and allows the user to select the **Load** button as the patient's chart reopens. Then they are able to file the encounter. The following screen displays after selecting the **View** button stating the same steps.



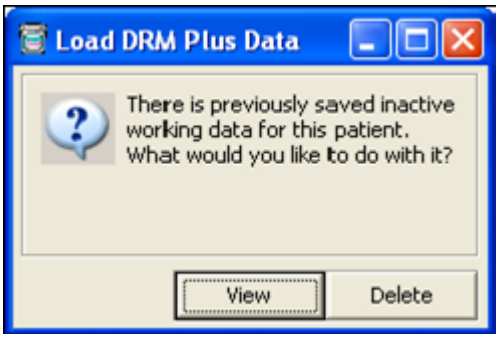
View Data Steps

If the Load or View was selected upon entry into the patient's chart and the provider wants to delete the unfiled data after viewing the data, just 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 from the File menu.

Note: VistA dental patients that are configured as test patients with the first three or five digits of the SSN begin with a zero are NOT allowed to be saved or stored as unfiled data in any DRM Plus report. Those dental patients that do not have any unfiled data displaying in the Unfiled Data by Provider report found in DRM Plus.

Unfiled Data becomes inactive after eight 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 options to either view or delete the inactive unfiled data.

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



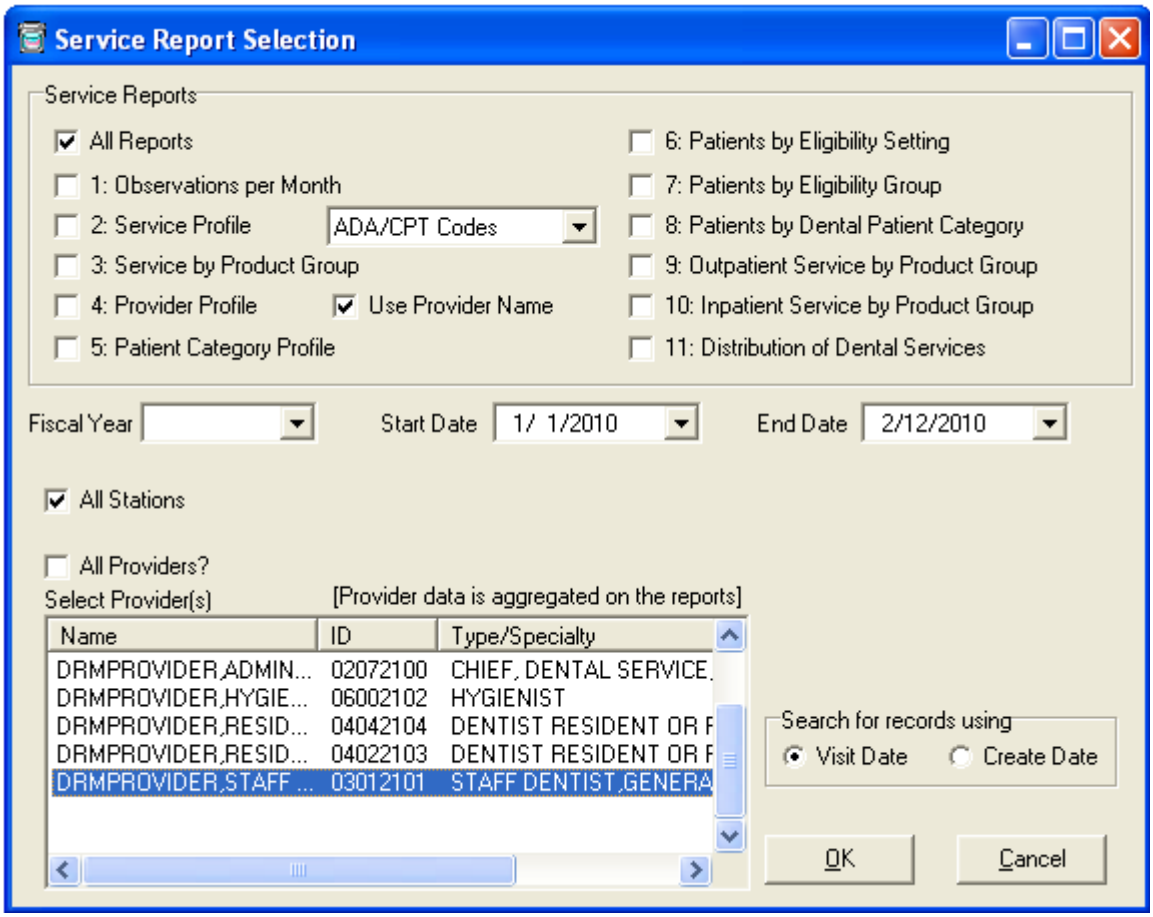
Previously Saved Inactive Data

The **View** button takes the user directly to the Unfiled Data 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.

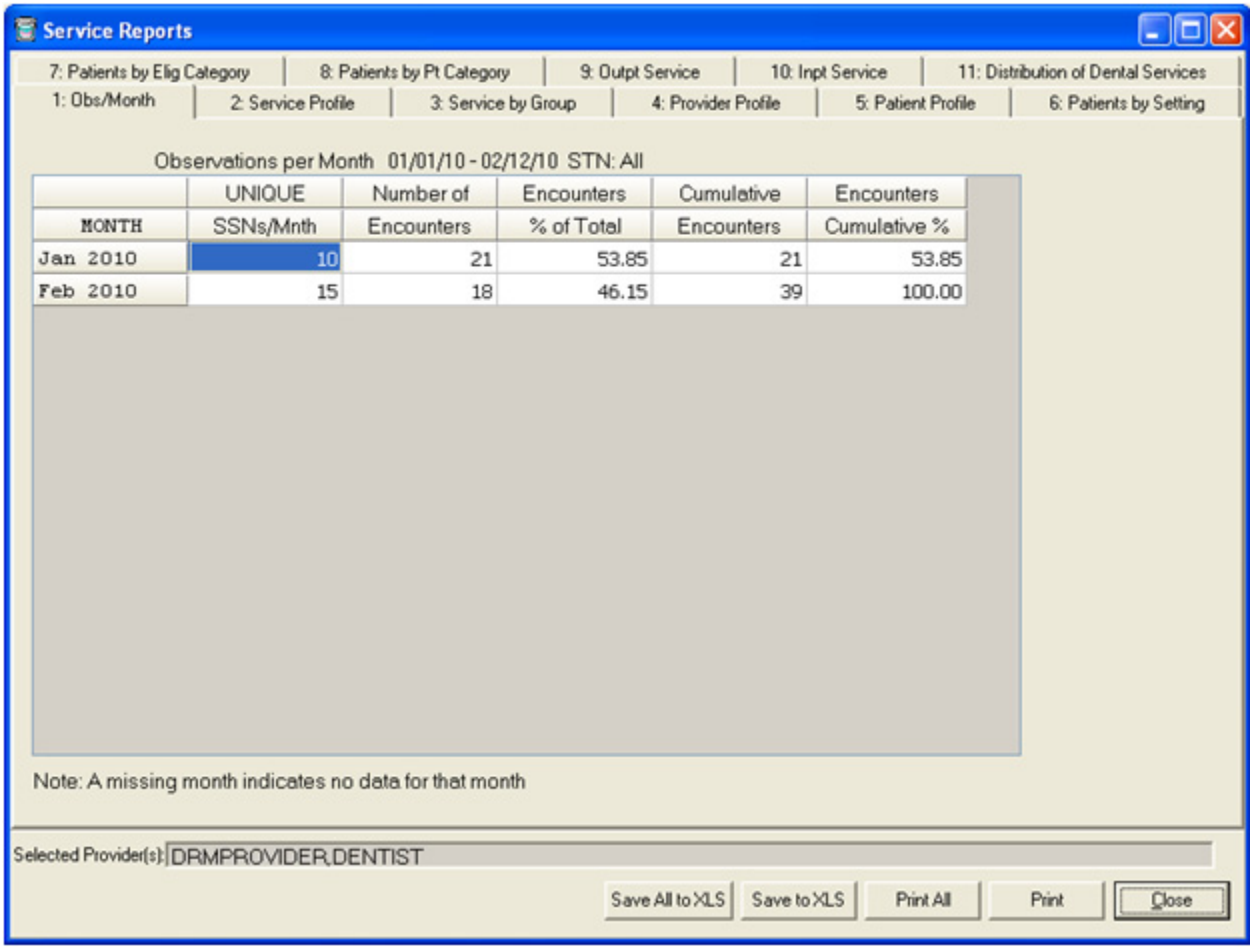
Service Reports

Use this tool option to select and create a service report.



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 progress note date type that is to be represented on the report.
4. Click the **OK** button.
5. The Service Reports screen displays with the results.

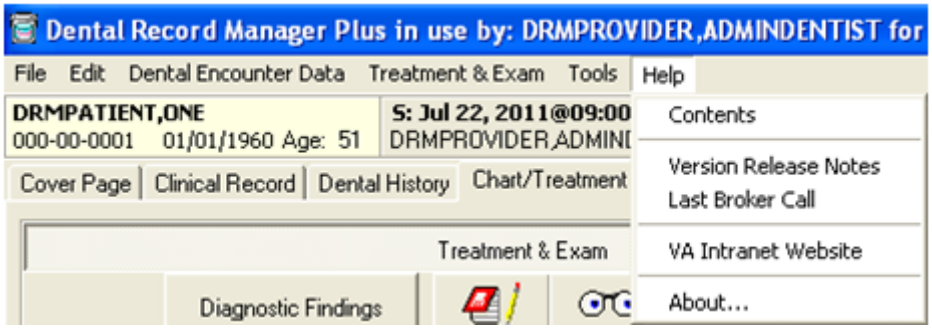


Service Reports Screen

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.

Help

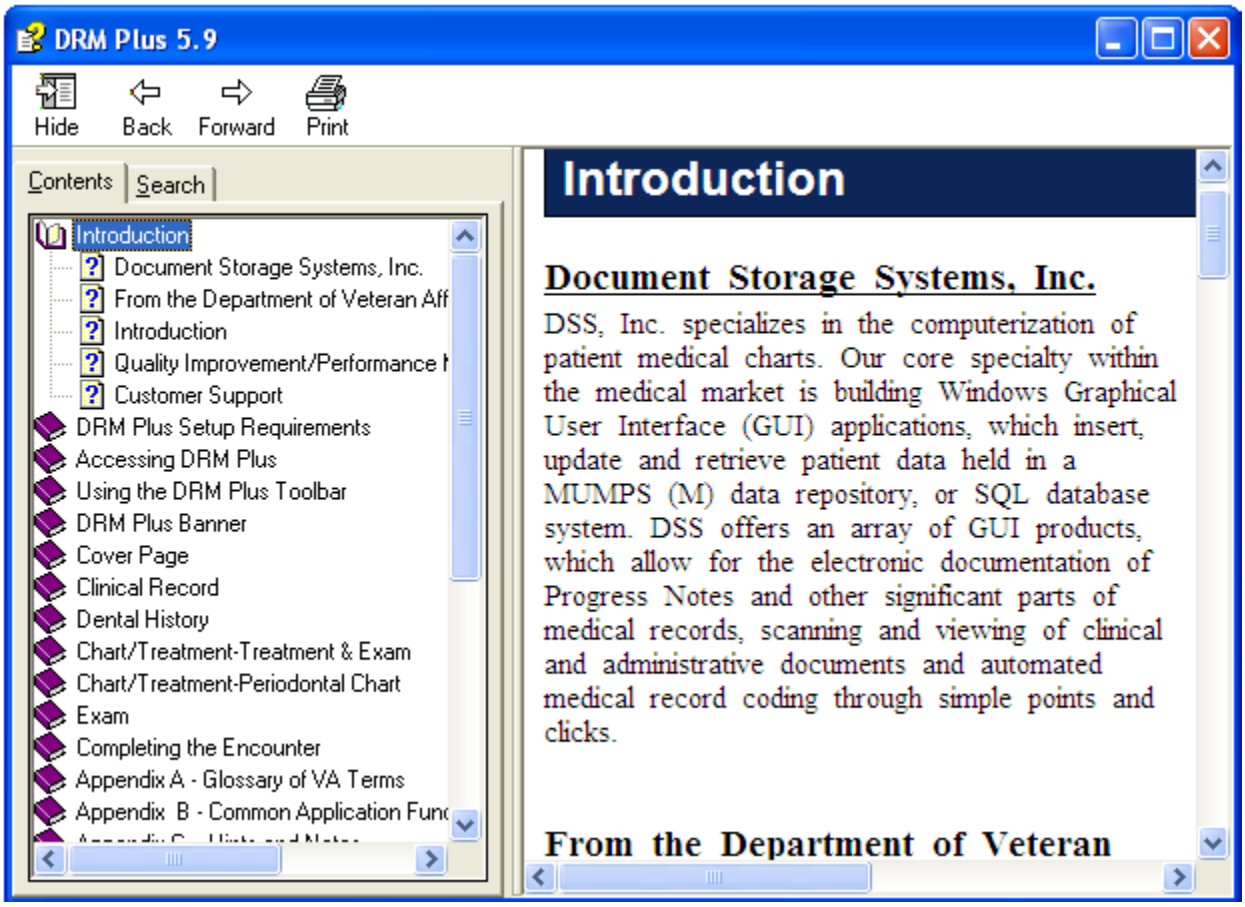
Use the Help menu to access more information on DRM Plus. There are five options: Contents, Version Release Notes, Last Broker Call, VA Intranet Website and About.



Help Menu

Contents

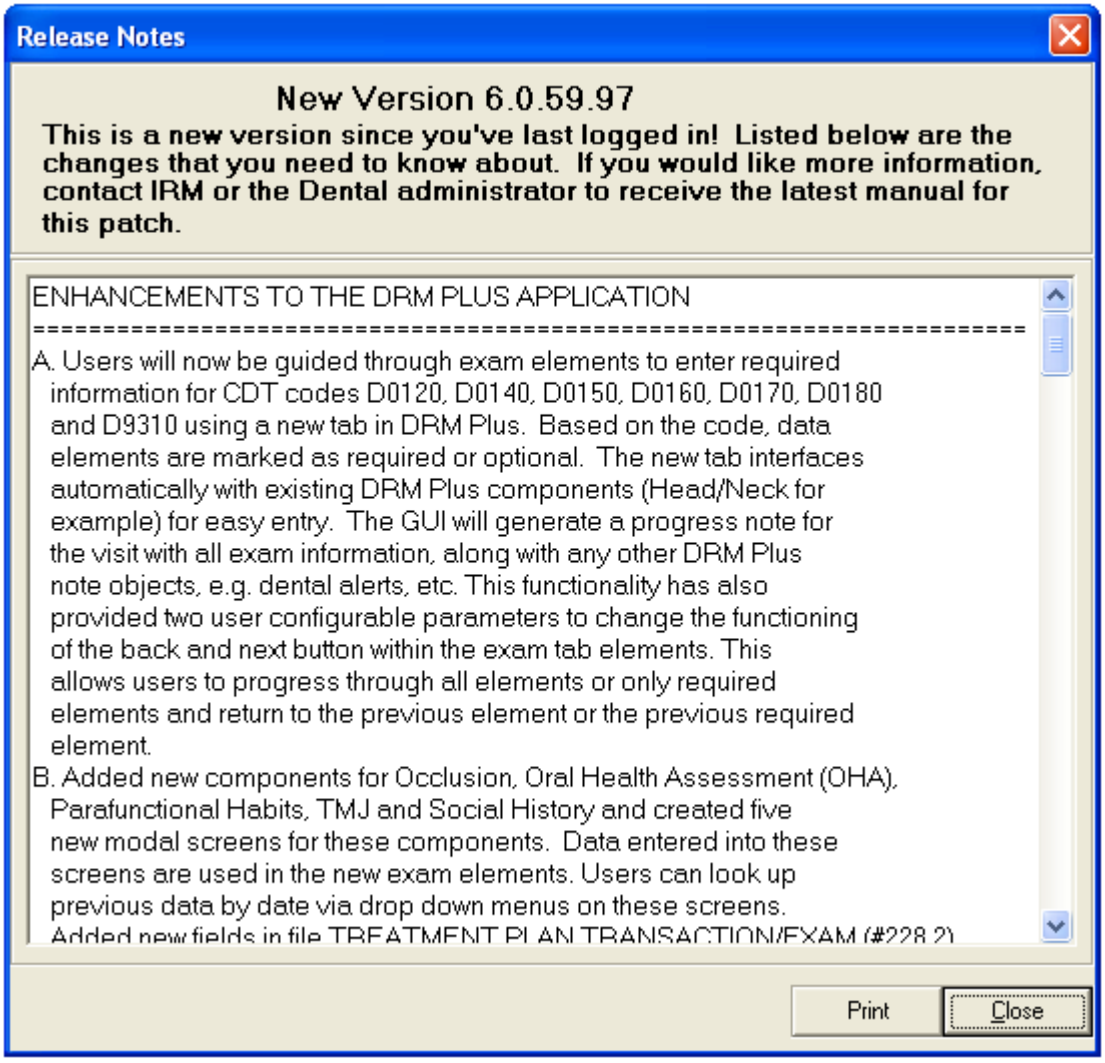
Use the contents to find information on using DRM Plus.



DRM Plus Contents

Version Release Notes

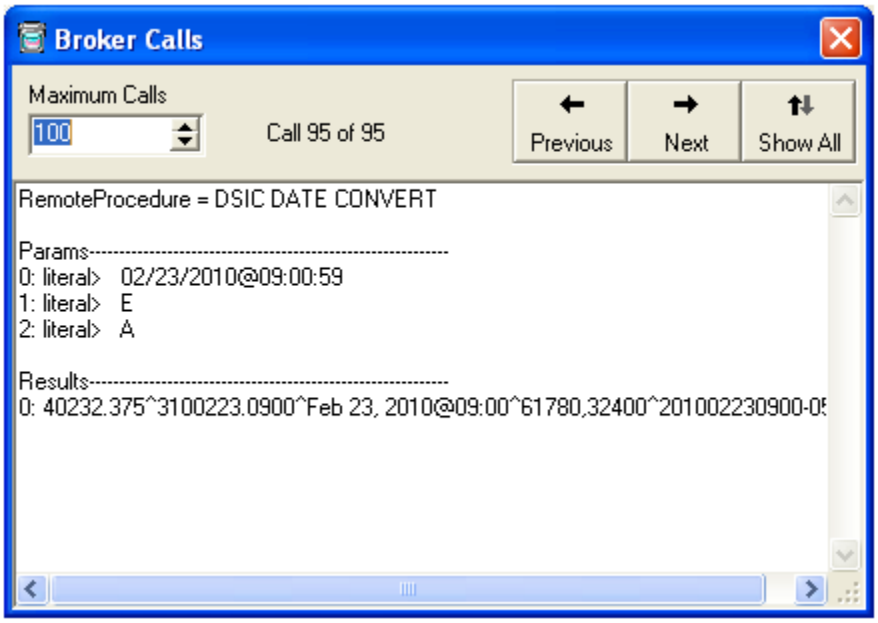
Choosing this option allows the user to see what was introduced in the current version of DRM Plus.



Release Notes

Last Broker Call

Select this option to see the last broker call.



Broker Call 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.

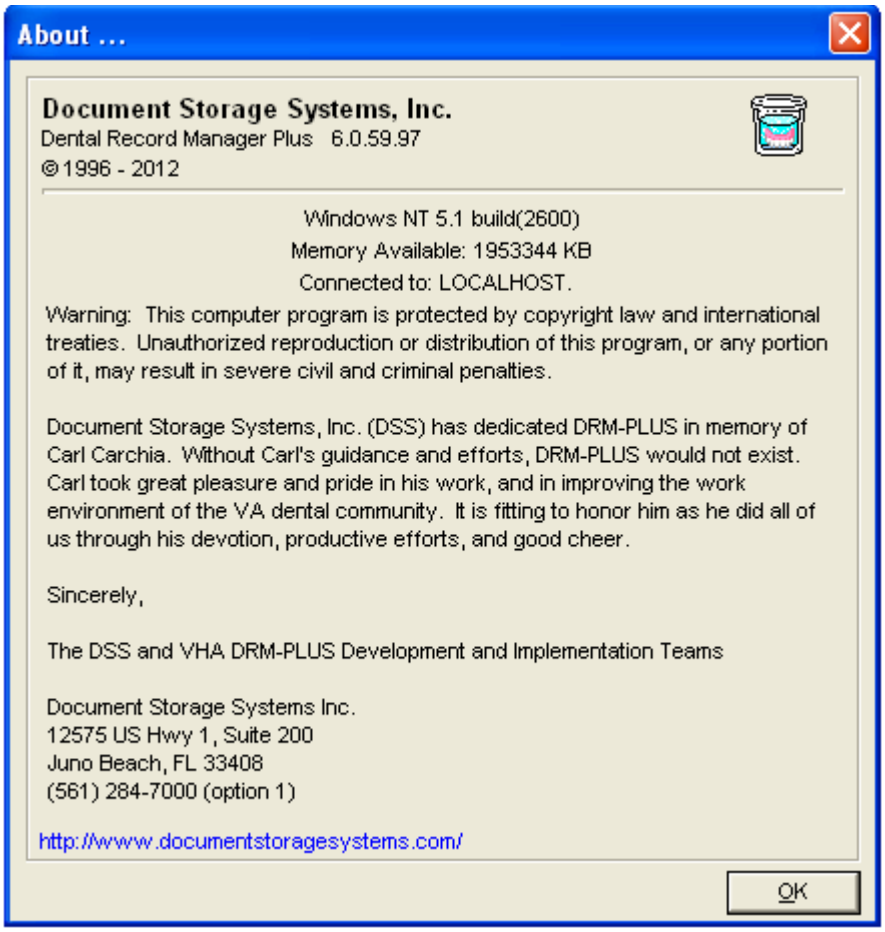
VA Intranet Website

Select this option to access the VA Intranet website.

Note: Clicking this option 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.



DRM Plus About Screen

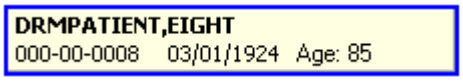
DRM Plus Banner

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

DRM Plus Banner

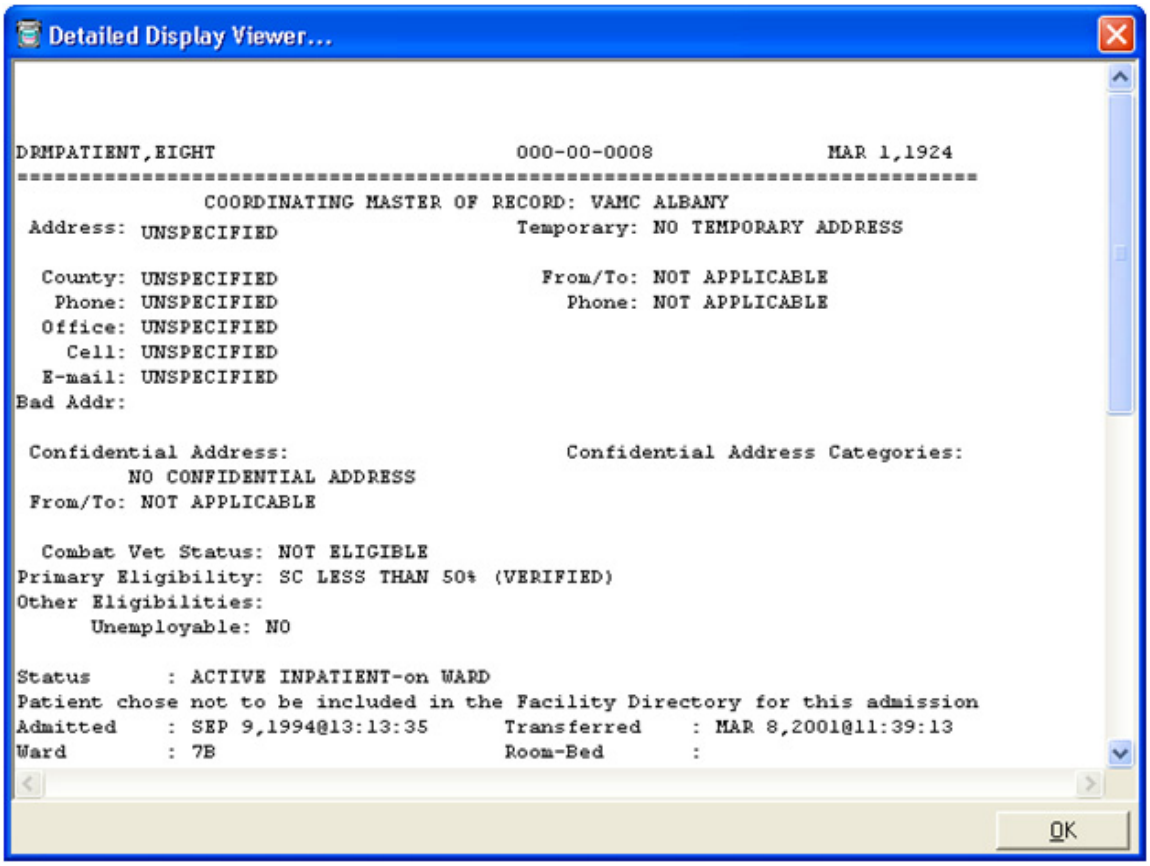
Patient Information

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



Patient Information

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



Patient Inquiry Screen

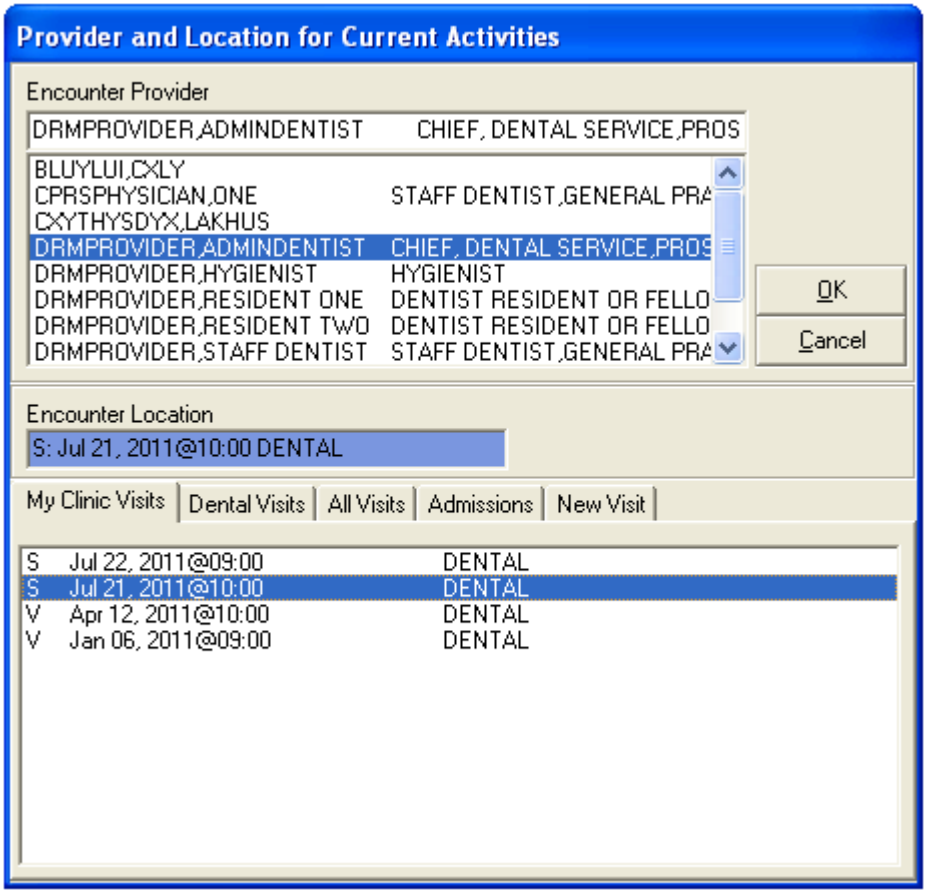
The Patient Inquiry screen contains more detailed information about the patient, including: address, phone number, means test information, status and admissions information.

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.

Visit Information

To change visit or provider information, click this area of the banner. The Provider and Location for Current Activities screen displays.



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, see the section of this manual entitled Dental Encounter Data, under the chapter entitled Using the DRM Plus Drop-Down Menus.

Dental Provider Information

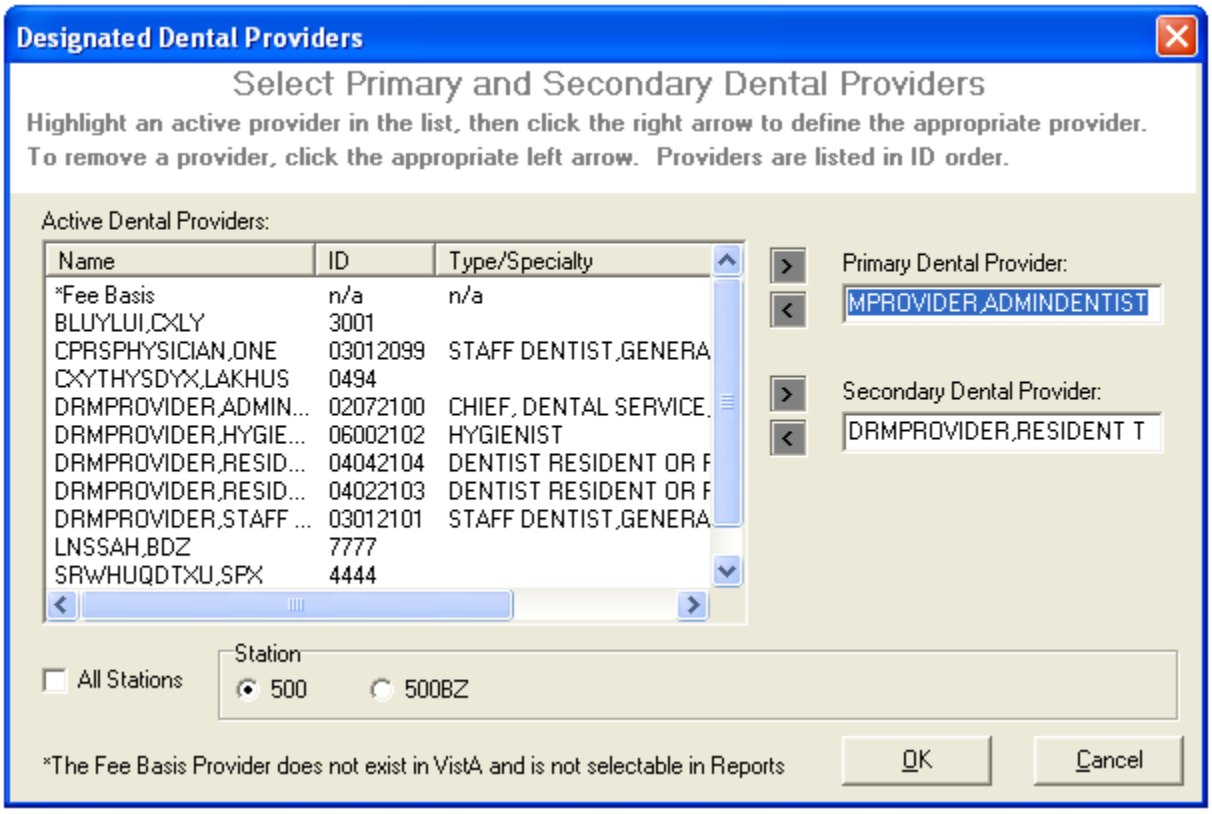
This section of the banner displays information on the primary and secondary dental providers. To assign a Primary and/or Secondary dental provider for a patient requires an Administrative parameter option, given by the DRM Plus administrator. Primary/Secondary providers are only for planned care, and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

PDP: DRMPROVIDER,ADMINDE
SDP: DRMPROVIDER,RESIDENT

Dental Provider Information

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

1. Click the dental provider area of the banner.
2. The Designated Dental Providers screen displays.



Designated Dental Providers Screen

3. Select the provider from the list of active dental providers.
4. Click the **right arrow** associated with the Primary Dental Provider and/or Secondary Dental Provider.
5. The provider's name appears in the designated provider area. To remove the provider, click the **left arrow**.
6. Select the Station or mark the checkbox for All Stations.

7. Click the **OK** button.
8. The provider information appears in the banner.

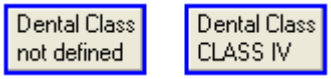
The Primary Dental Provider or Secondary Dental Provider can be set as Fee Basis in DRM Plus. The Fee Basis provider does not exist in VistA. This is a "free-text" entry and, therefore, most reports in DRM Plus do not recognize the Fee Basis provider.

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

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

Dental Class Information

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



Dental Class

Click this section of the banner to go to the DRM Plus Cover Page tab. However, only a DRM Plus administrator or a user that has this Administrative parameter option can change a patient's dental class. See the chapter of this manual entitled Cover Page for more information.

Clean Slate

This section, when present, is located between the Dental Class and 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 provider who has received the Administrative parameter option.

Clean Slate

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 new Clean Slate can be restored for this patient at any time until a new encounter has been filed.

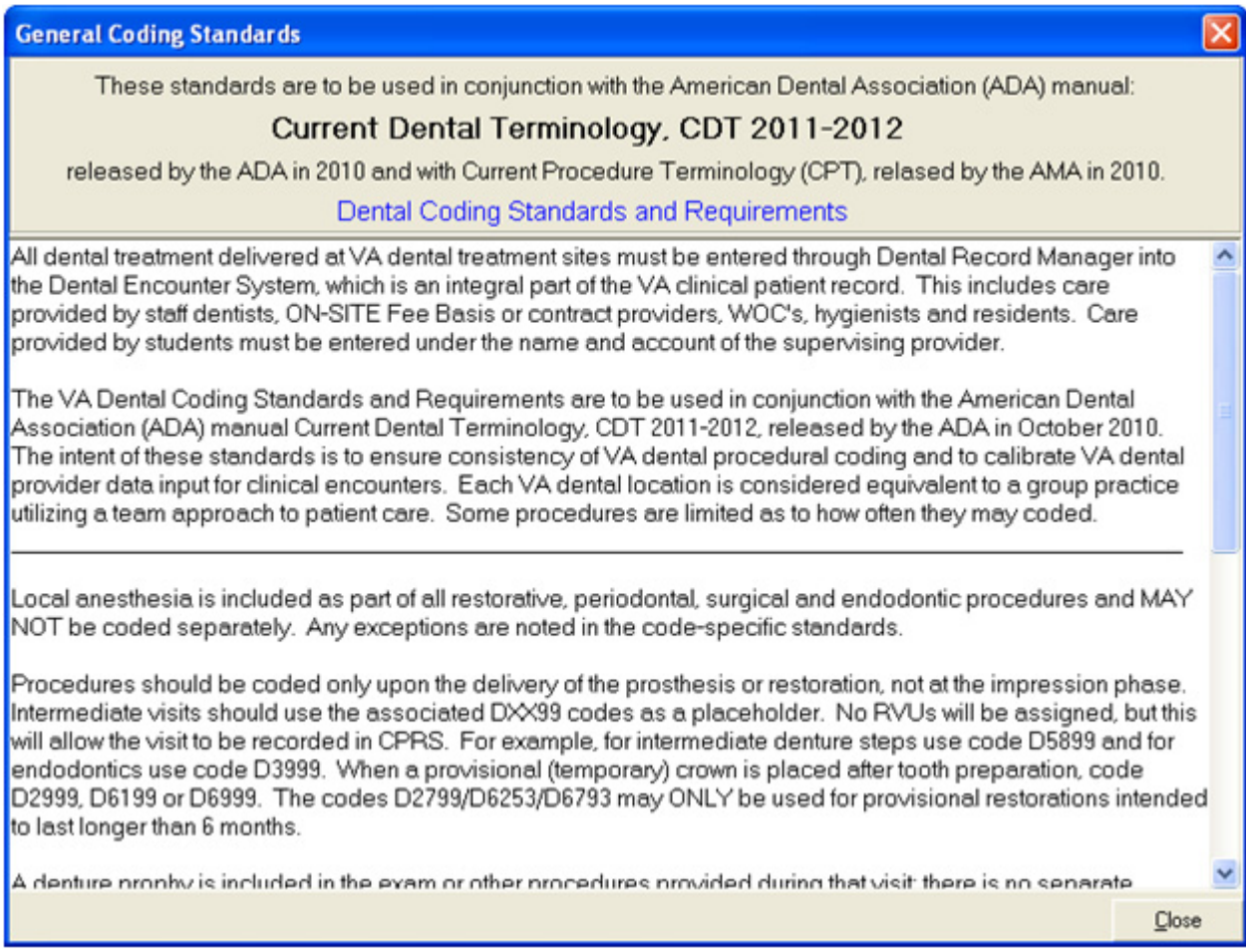
Icons

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.

DRM Plus Banner Icons

Coding Standards

The first icon is the Coding Standards icon . Clicking this icon produces the General Coding Standards screen.



General Coding Standards Screen

This screen contains dental coding standards and requirements as approved by the VA Dental Coding Committee. Go directly to the ADA Dental Coding Standards and Requirements by clicking on the hyperlink. Some sites may not allow access to the internet while others require an additional sign-in.

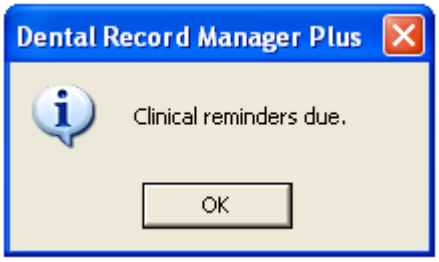
Patient Flags

There are four possible patient flags that can appear in DRM Plus, including: Clinical Reminders, Consult, Exam Monitor and Fluoride Monitor.

Clinical Reminders

The Reminders icon appears 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 on the Reminders icon displays a Dental Record Manager Plus information screen, stating that the selected patient has Clinical Reminders due.



Clinical Reminders Due

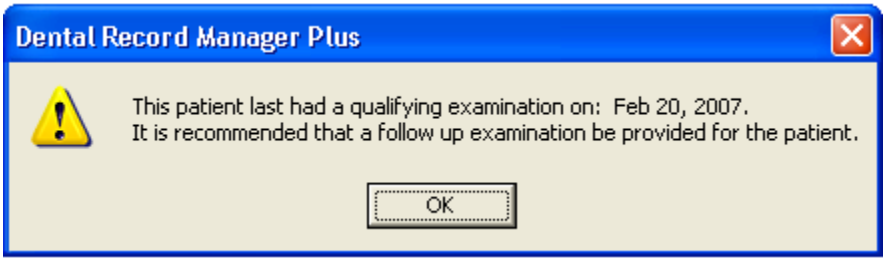
The Clinical Reminders icon should only display if the current end-user is responsible for, and may resolve the Clinical Reminder(s) listed. If Clinical Reminder(s) appearing in the list cannot be resolved by the end-user, contact local IRM for assistance.

Consult

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

Exam Monitor

The Exam Monitor icon appears when the patient is due for a monitored exam. The icon only displays if the patient meets certain class restrictions. Clicking on this icon produces a screen, which reveals when the patient last received a qualifying exam.

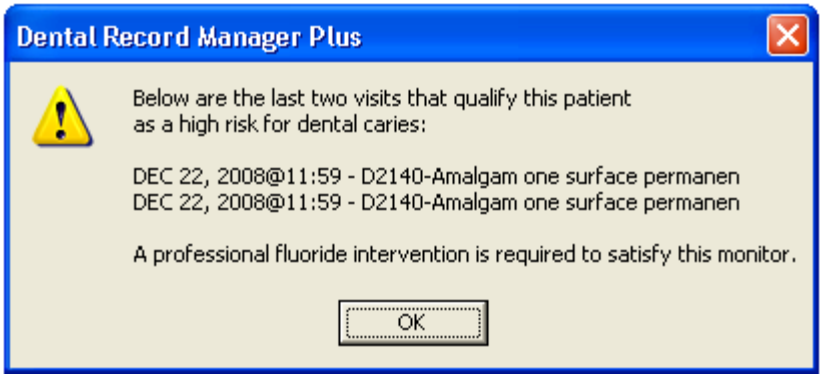


DRM Plus Exam Information Screen

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

Fluoride Monitor

The Fluoride Monitor icon appears when the patient is due for a fluoride intervention. Clicking on this icon displays and explanation of why the patient is at risk and needs intervention.



Fluoride Intervention Monitor Screen

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

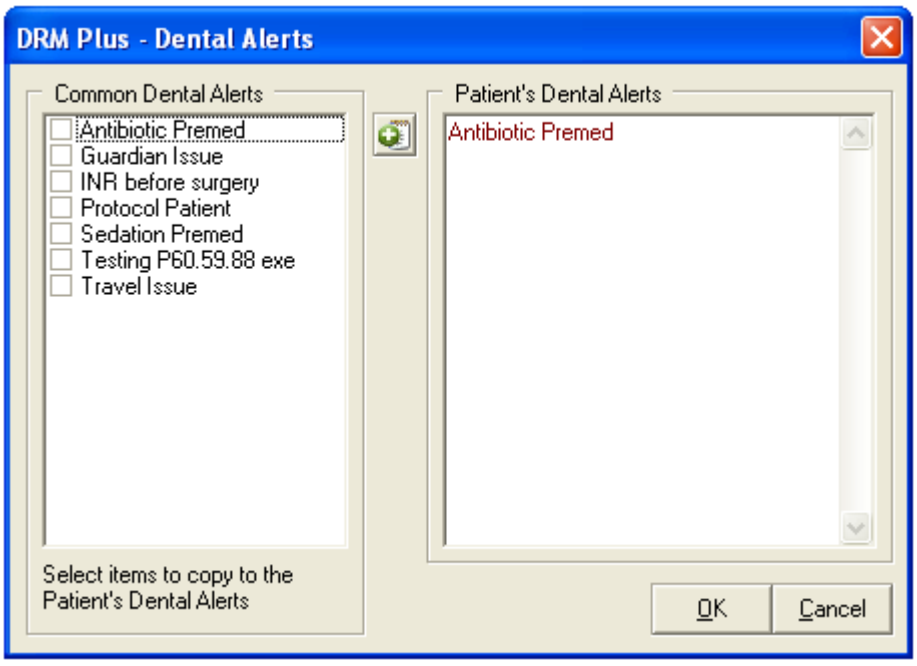
Alerts

The DRM Plus Alerts icon

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

To add an alert:

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



Dental Alerts Screen

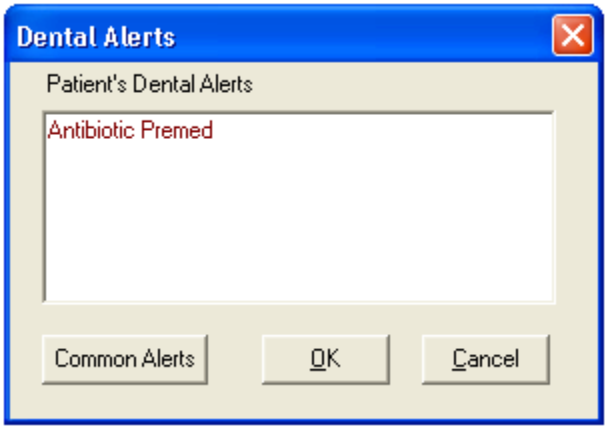
3. Click the desired **Common Dental Alerts** on the left side of the screen.
4. Click the **right arrow** button.
5. The selected alert(s) appear on the right side of the screen.
6. Alternatively, type the alert directly into the Patient's Dental Alerts area of the screen.
7. Click the **OK** button.

The alert icon changes when patient alerts are present, and appears as a stop sign

.

To view the alerts:

1. Click on the **alerts** icon.
2. The patient's Dental Alerts screen displays.

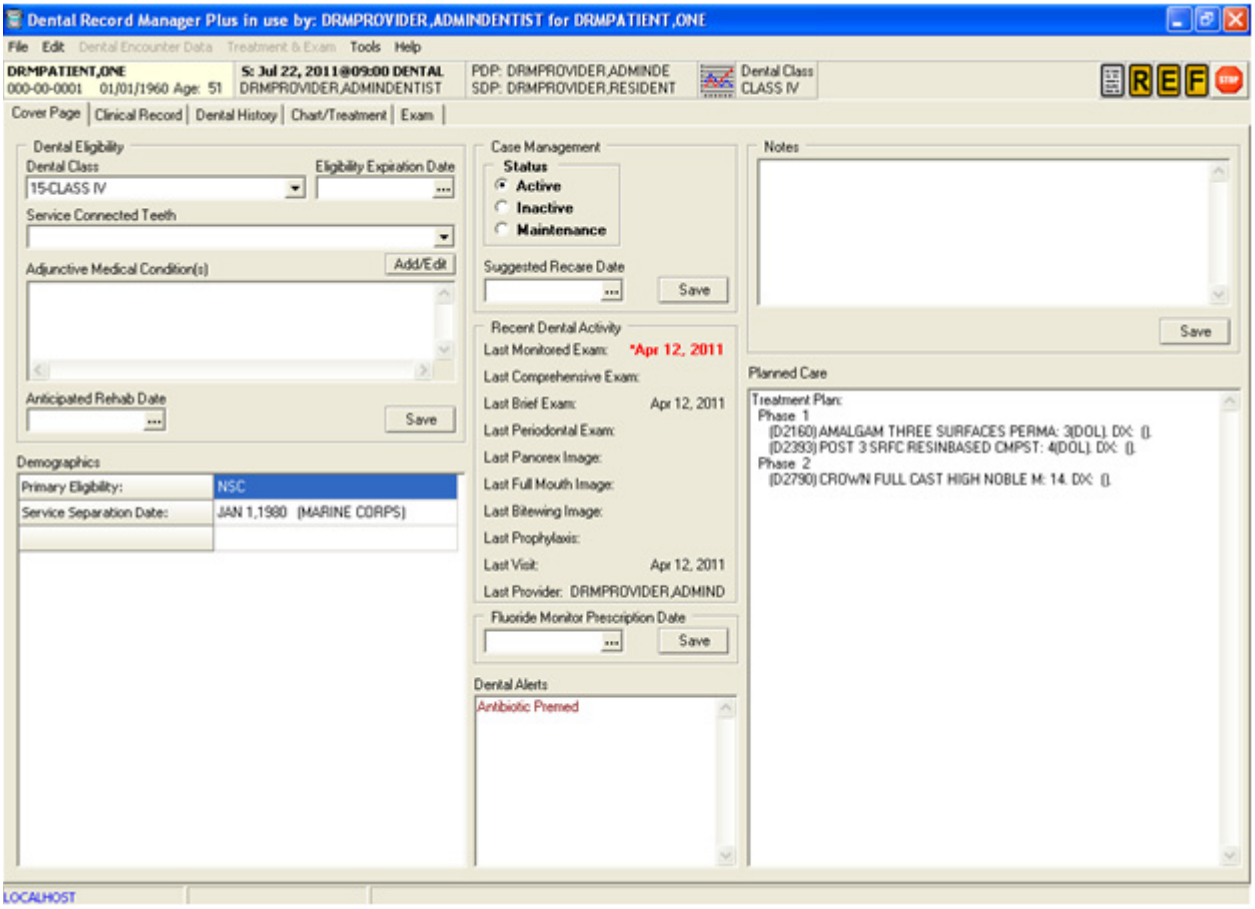


Patient's Dental Alerts Screen

3. Click the **Common Alerts** button.
4. The Dental Alerts screen displays. From here, more dental alerts can be added or the alert can be erased by putting the cursor into the Patents Dental Alerts field and deleting the text.
5. Click the **OK** button to finish.

Cover Page

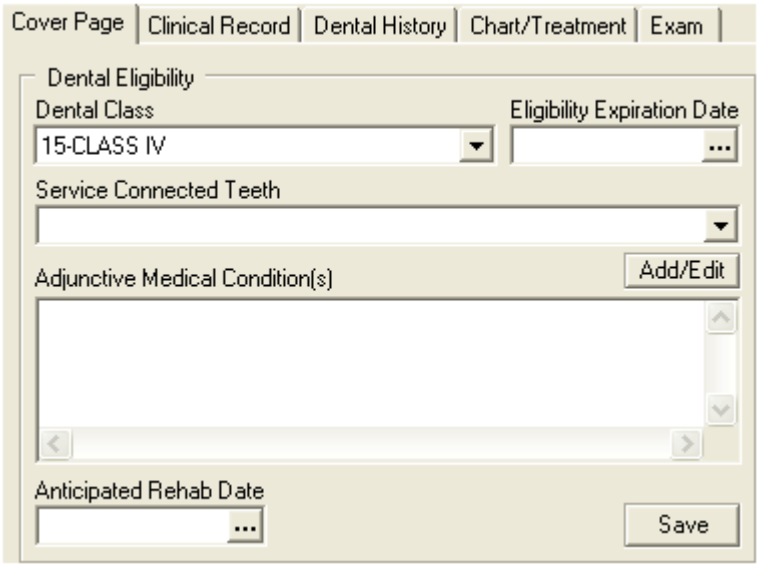
The DRM Plus Cover Page tab displays important patient information. The tab has 8 major sections: Dental Eligibility, Demographics, Case Management, Recent Dental Activity, Fluoride Monitor Prescription Date, Dental Alerts, Notes and Planned Care.



DRM Plus Cover Page Tab

Dental Eligibility

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



Dental Eligibility

Dental Class

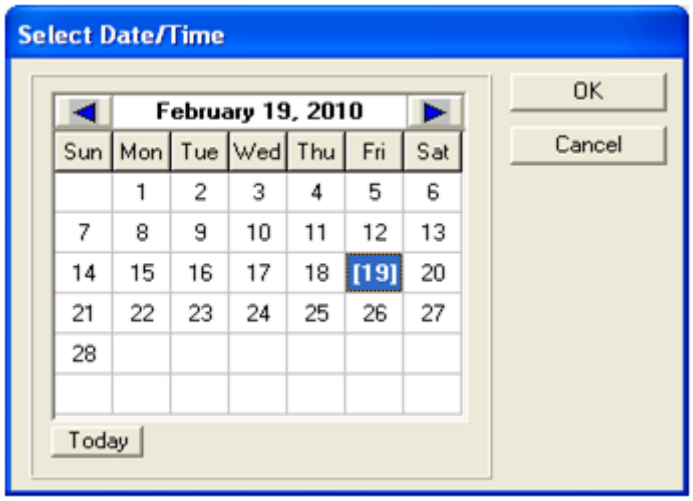
Use the drop-down menu to change the patient's Dental Class. Selecting the top, empty field on this menu allows the administrator to remove any dental classification.

Eligibility Expiration Date

Only a dental Class II or Class V patient can have an eligibility expiration date, which is not required to be entered for either class.

To change the eligibility expiration date:

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



Select Date/Time Screen

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

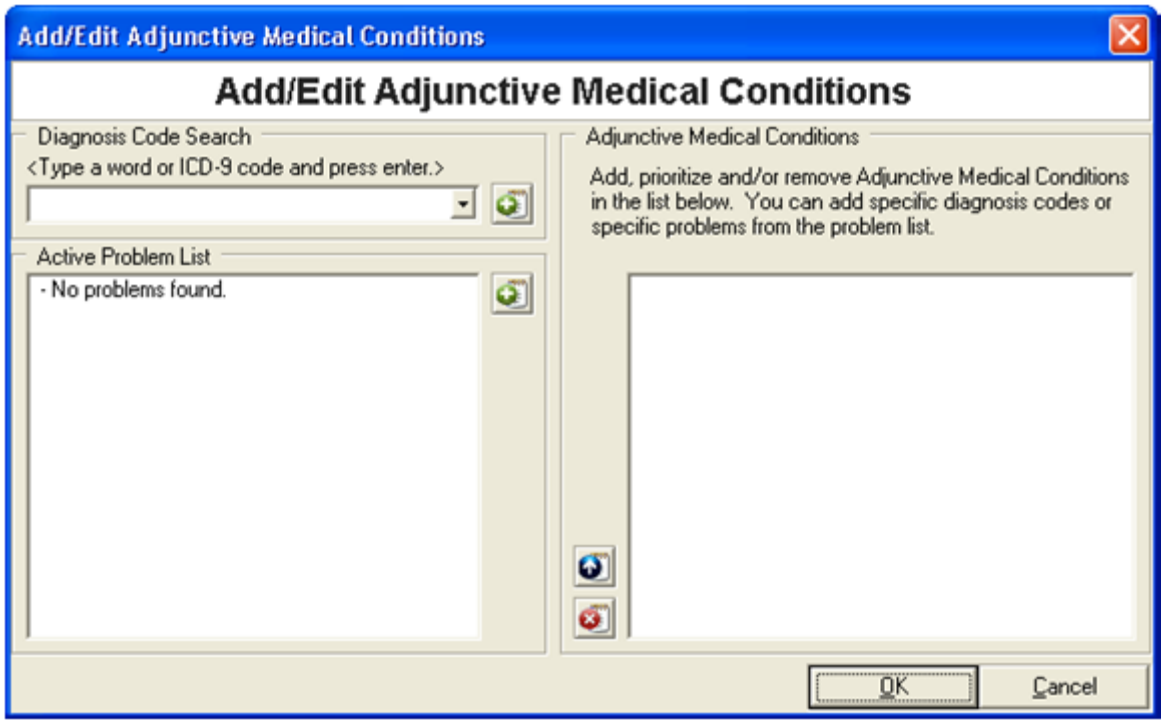
Service Connected Teeth

Choose the service connected teeth by opening the drop-down menu and marking the checkbox in each of the service connected teeth. This is required for Class IIA patients.

Adjunctive Medical Condition(s)

To add or edit the patient's adjunctive medical conditions, which is required for Class II and Class VI patients:

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



Add/Edit Adjunctive Medical Conditions Screen

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

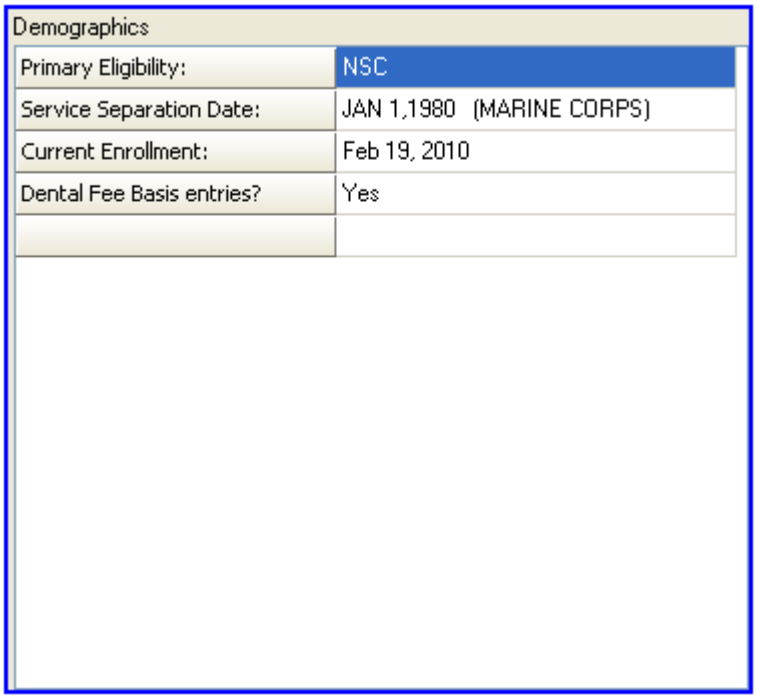
Anticipated Rehab Date

Anticipated Rehab Date can only be changed by a DRM Plus administrator or user who has received this Administrative parameter option. This is required for Class V patients only.

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

Demographics

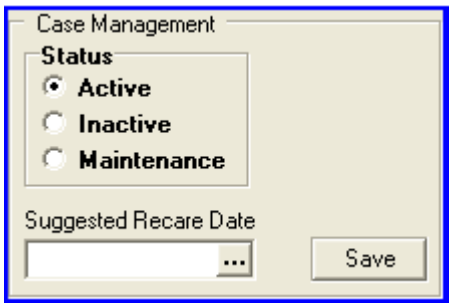
Patient demographic information is located here and is imported from VistA. The fields cannot be updated or changed in DRM Plus.



Demographics

Case Management

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



Case Management

Status

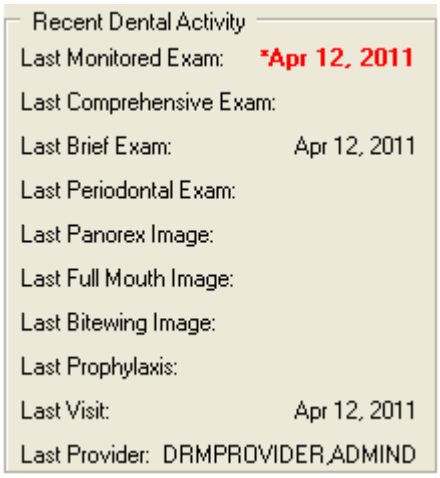
Change the status of the patient by clicking the **appropriate radio** button.

Suggested Recare Date

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

Recent Dental Activity

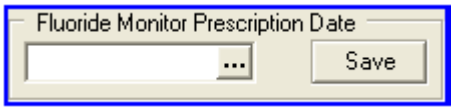
This section displays dates, if applicable, of when specific completed procedures were last performed on the patient. Procedure codes that activate the date in this section may be viewed by hovering the mouse cursor over the recent dental activity description.



Recent Dental Activity

Fluoride Monitor Prescription Date

Add a Fluoride Monitor Prescription Date here.



Fluoride Monitor Prescription Date

1. Click the **ellipses (...)** 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 on **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 Monitor.

Note: No future dates are allowed for Fluoride Monitor Prescriptions. The field is active regardless of whether or not the patient has a Fluoride Monitor.

Dental Alerts

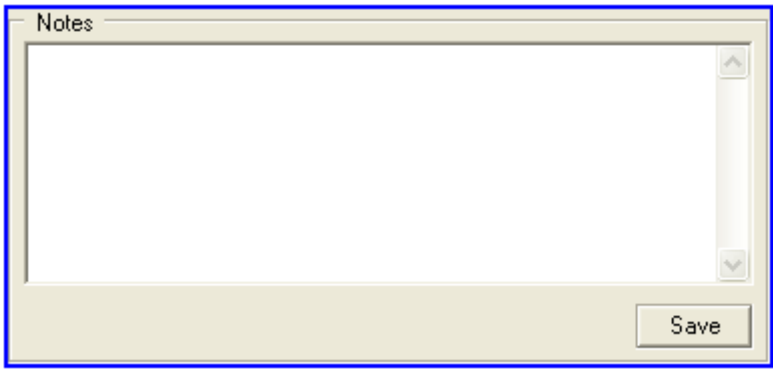
The patient's Dental Alerts, if any, are listed here.

Dental Alerts

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

Notes

Add general notes in this text box. These notes are not imported into the Progress Note.

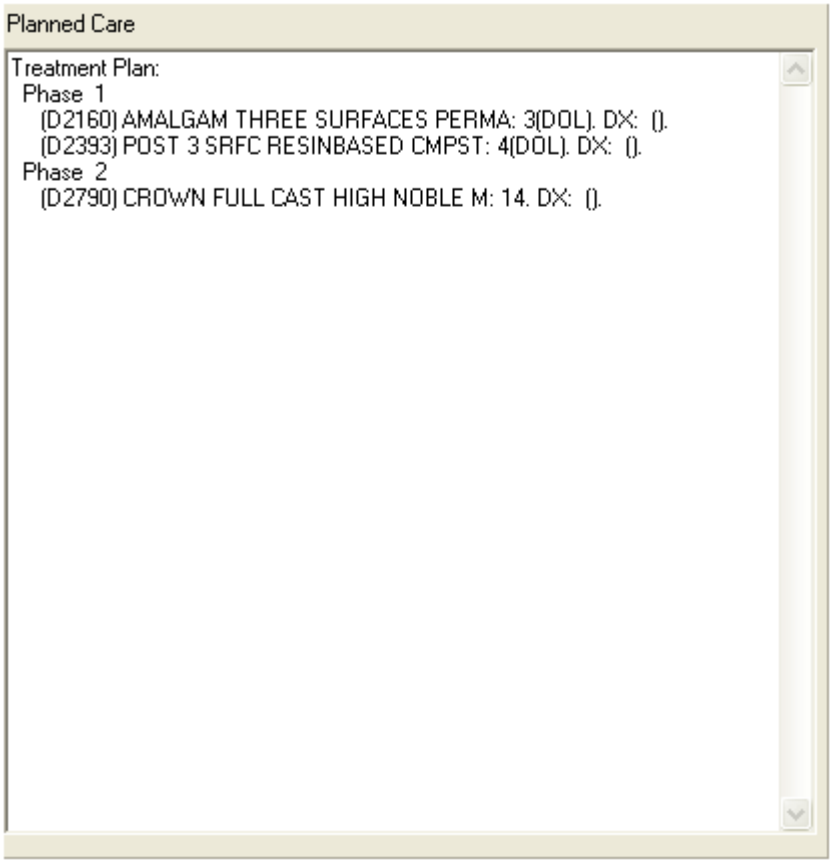


Notes

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.

Planned Care

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

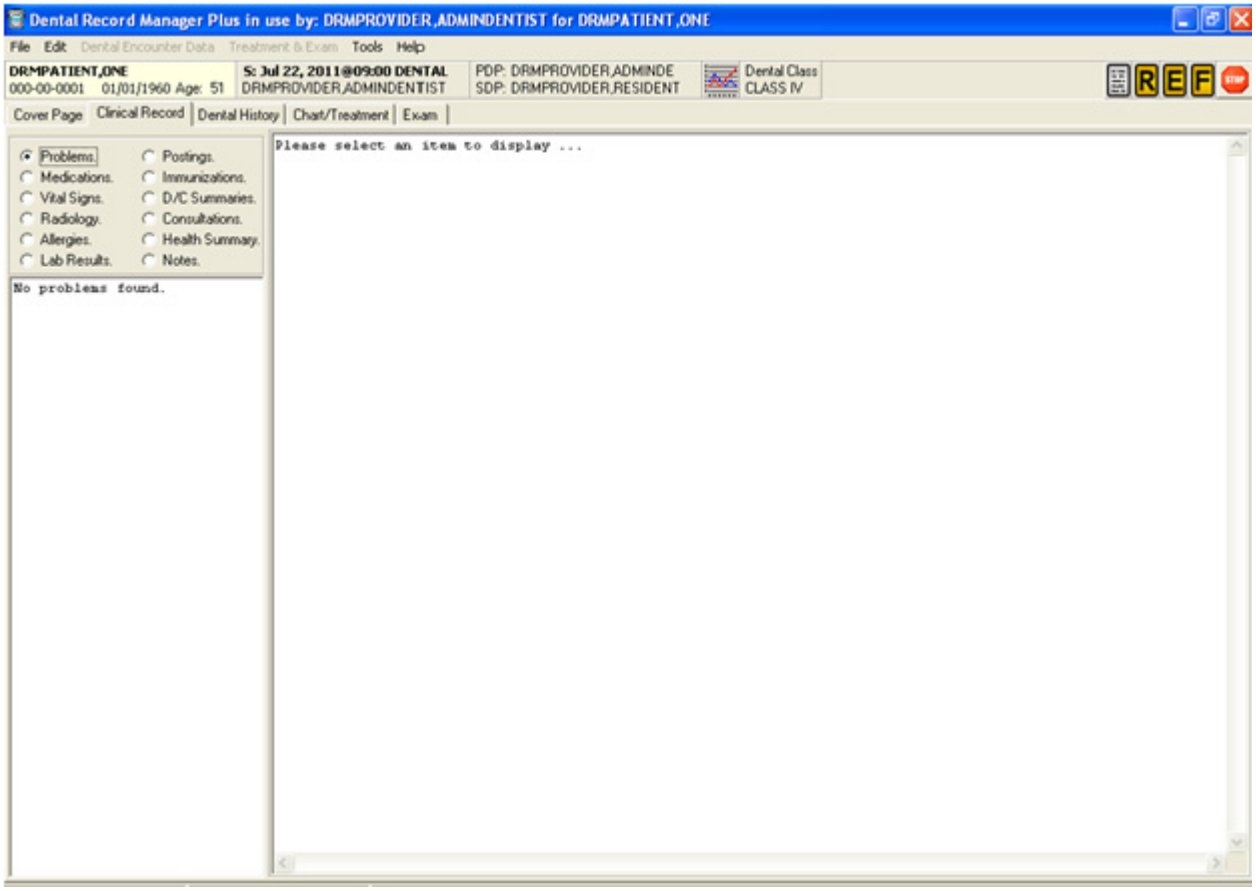


Planned Care

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

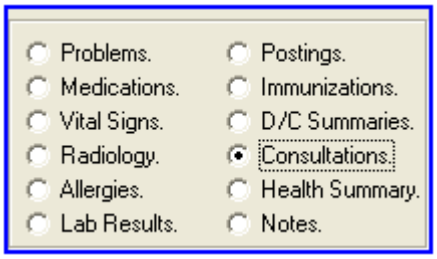
Clinical Record

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.



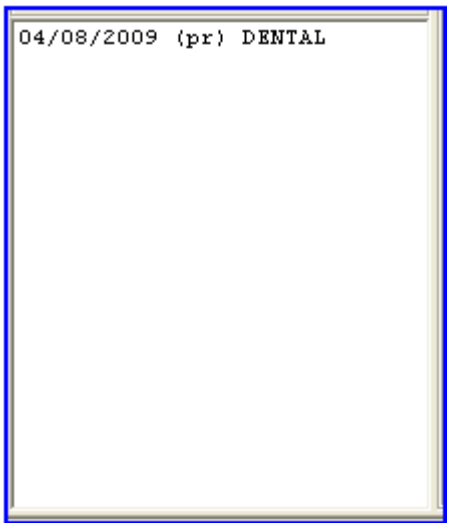
Clinical Record Tab

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



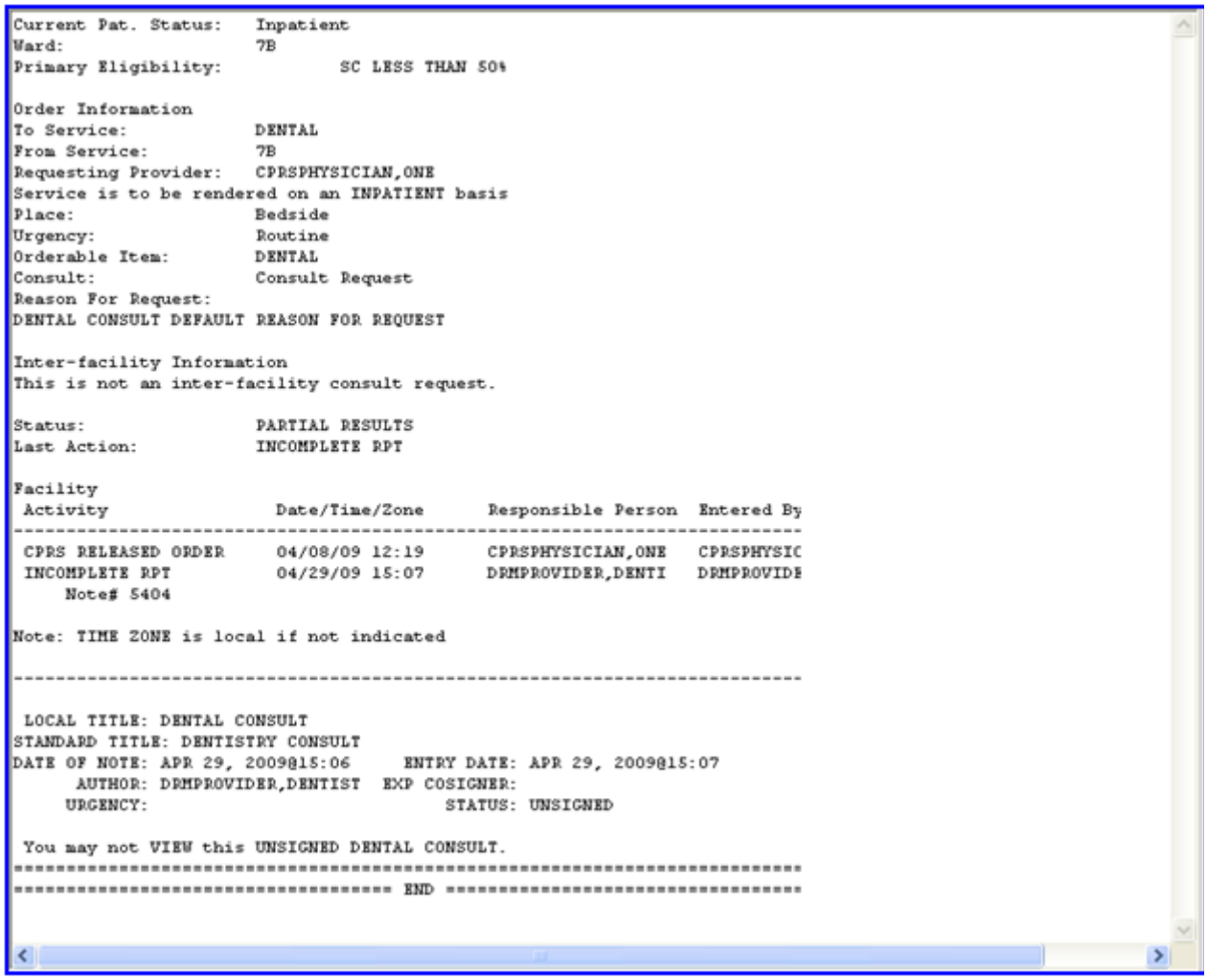
Clinical Record Types

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



Clinical Record Entries

3. Select an entry. Details for the entry appear on the right side of the screen.



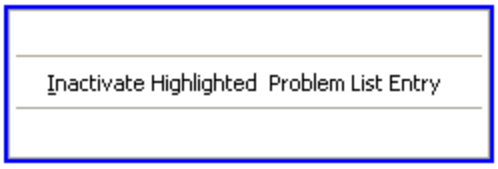
Clinical Record Entry Information

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 in the entries area directly below the list of **radio** buttons.
3. The Inactive Highlighted Problem menu displays.



Inactivate Highlight Problem Menu

4. Select the option to inactivate the problem.

5. A screen displays, confirming the inactivation. The description on the right side of the page now lists the problem as inactive.

Use CPRS or DRM Plus (see File Data Option Screen section under the chapter entitled Completing the Encounter) to reactivate the 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:

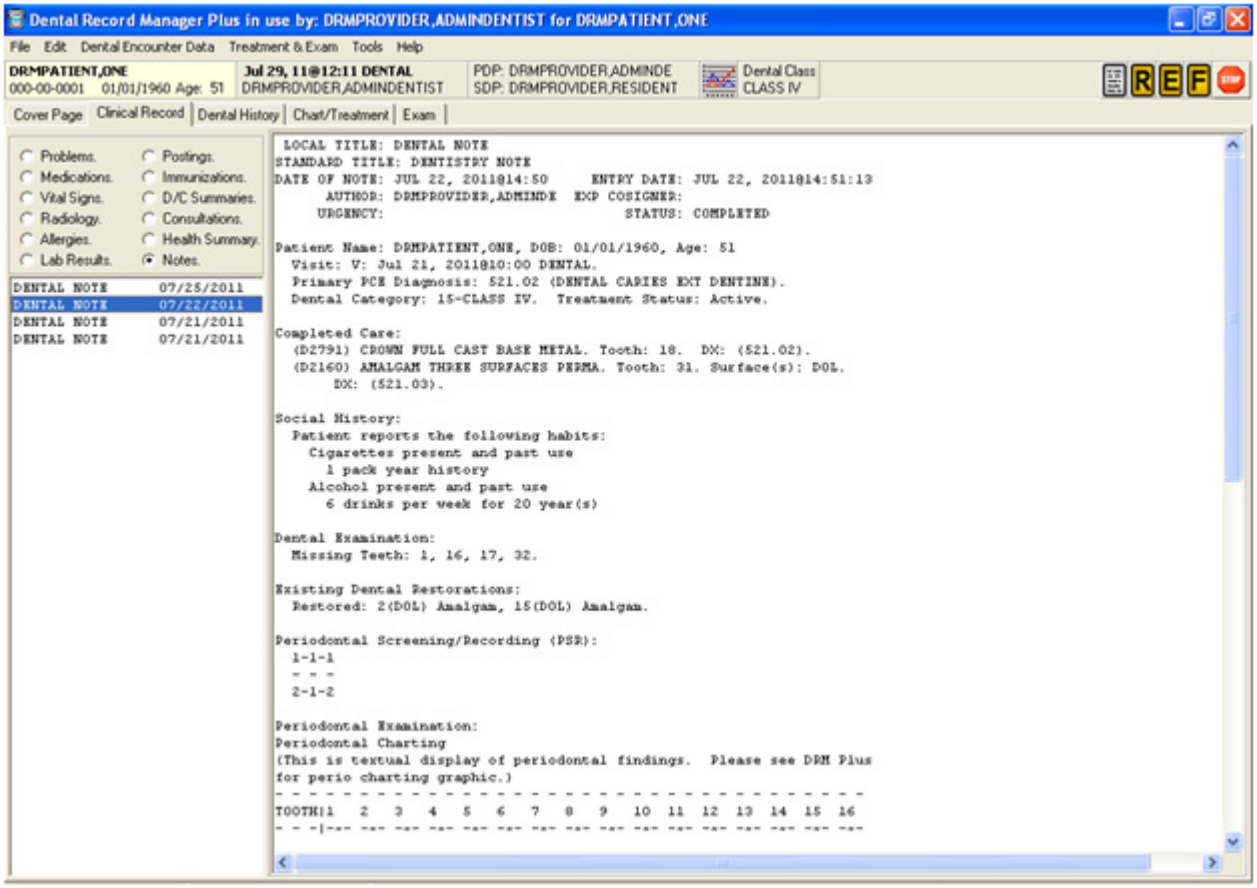
1. Click the **Consultations** radio button. Consultations, if present, appear in the entries area.
2. Right-click in the entries area. The filter menu displays.

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 appears results in this consult displaying on the right side of the Clinical Record tab screen.

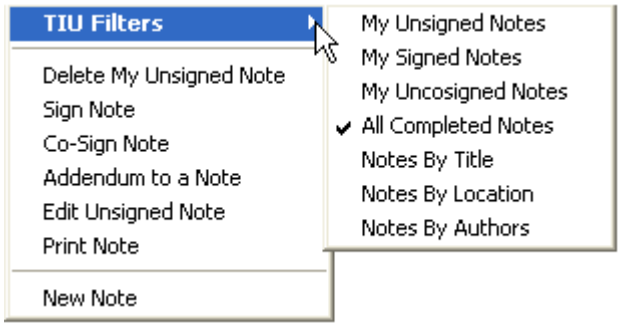
Notes

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



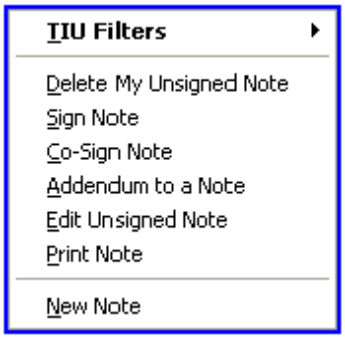
All TIU Completed Notes List

Select the TIU Filters option to filter the list of TIU notes by the listed criteria.



TIU Filters Options

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



Note Functions Menu

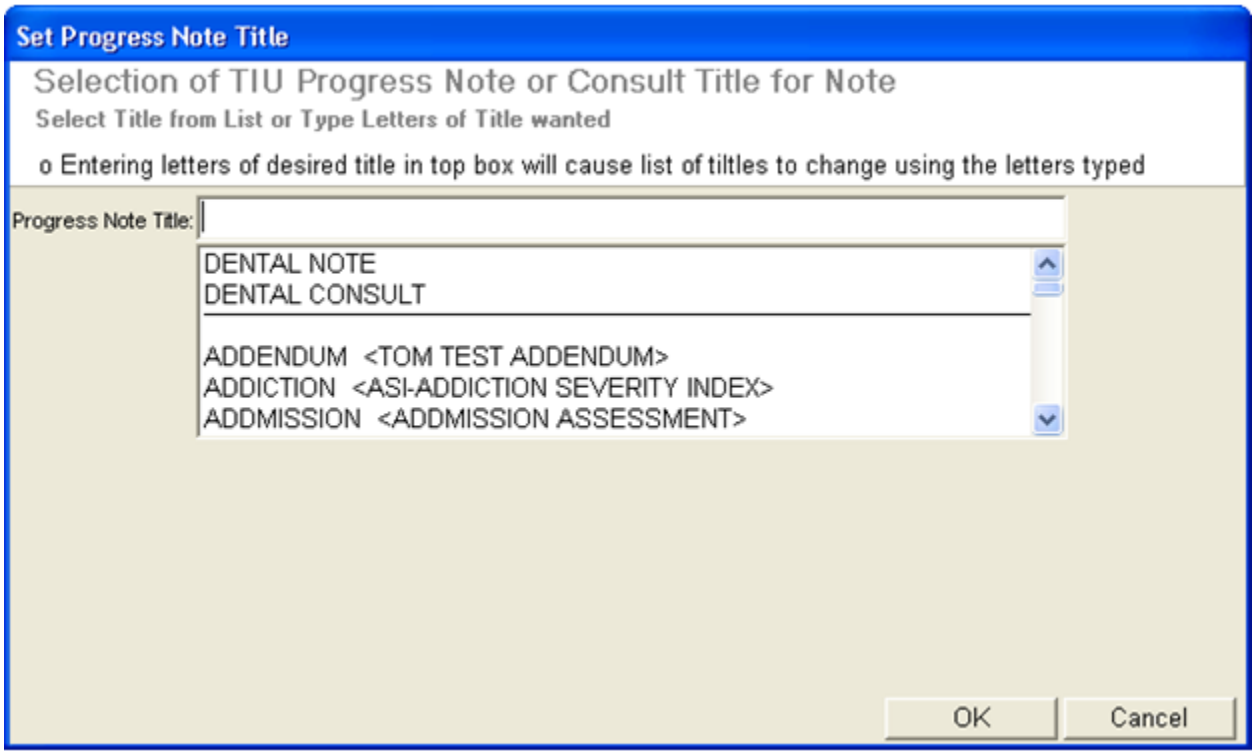
The functions available coincide with the Action menu options, as seen on the Notes tab in CPRS, and works similarly. The note functions can be selected with a left-click.

Adding a New TIU Note

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

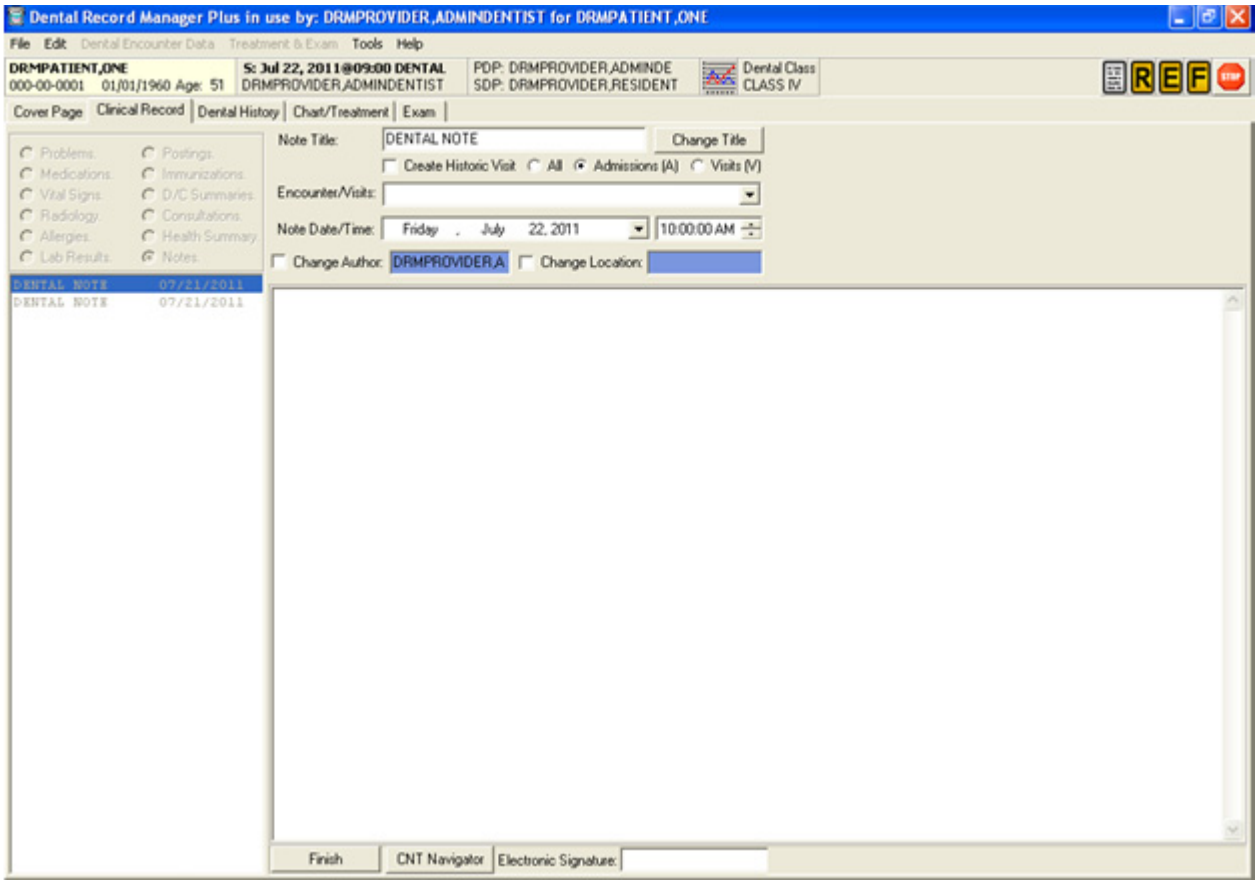
1. Select the **New Note** option from the Note Functions Menu.
2. The Set Progress Note Title screen displays.

Selecting the New Note option displays the appropriate Set Progress Note Title screen.



Set Progress Note Title Screen

3. Select the TIU Note Title from the list on the Set Progress Note Title screen. Note Information displays on the screen.



New TIU 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.

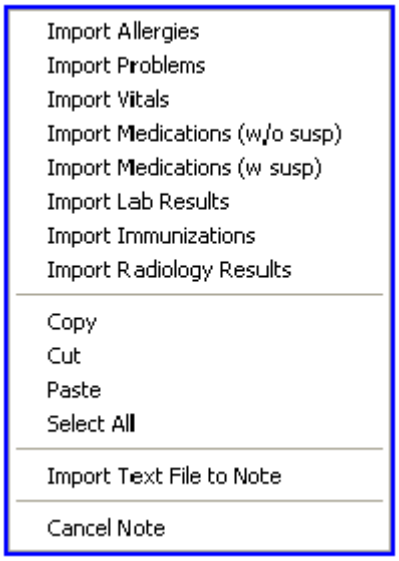
Adding a New TIU Note Addendum

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

To record a Note Addendum without an ADA procedure code:

1. Select the **note to be appended** from the list of notes.
2. The note appears 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 in the viewer to import information or cancel.



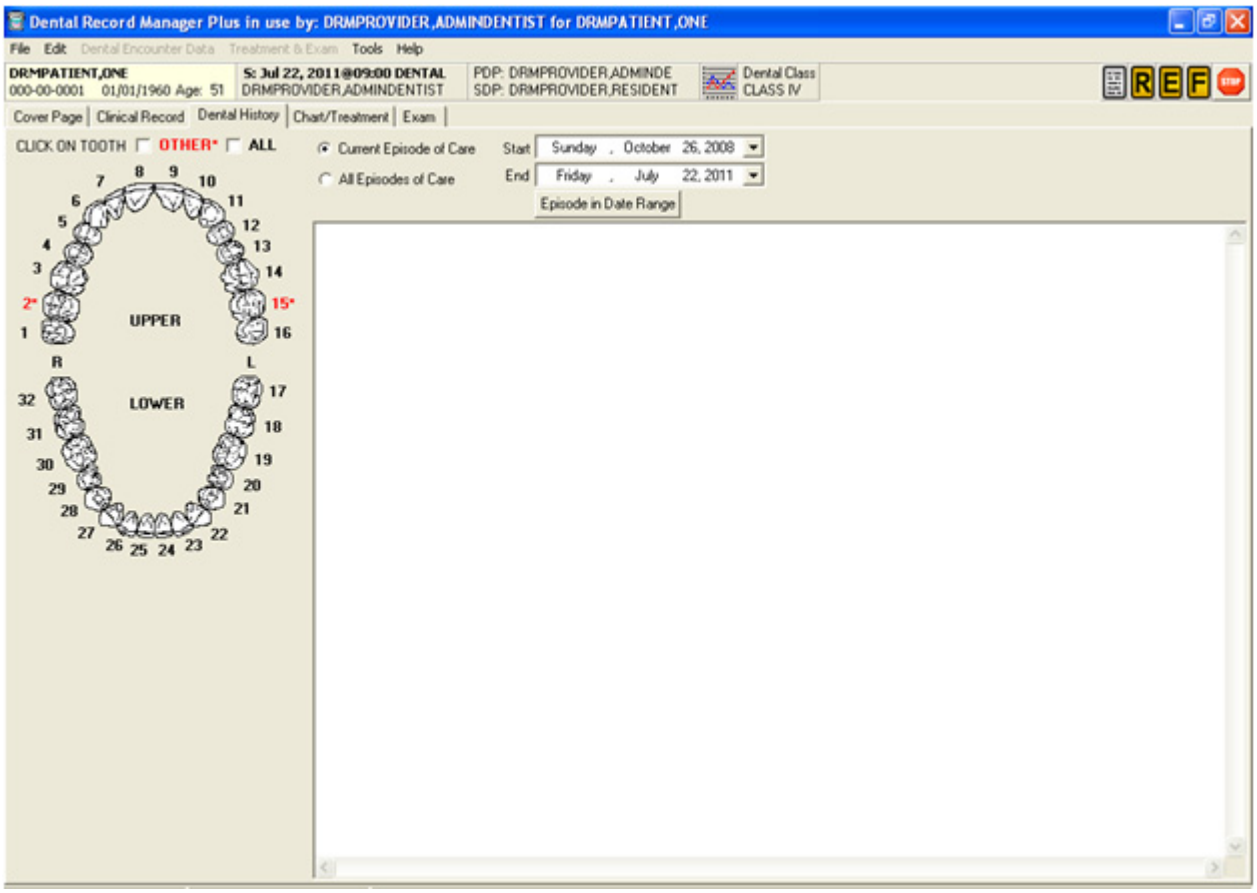
Viewer Right-Click Menu

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** option.

Dental History

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

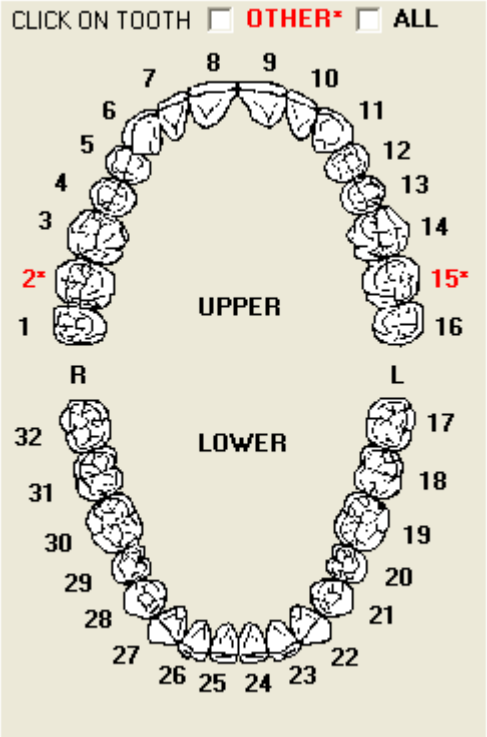


Dental History Tab

Viewing Dental Information By Tooth

To view dental information by tooth:

1. Click on 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 is colored red in the diagram.



Dental History Teeth Diagram

2. Information about the selected tooth appears 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.

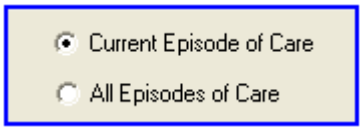
Viewing All Dental History Information

To see all dental history associated with this patient, mark 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.



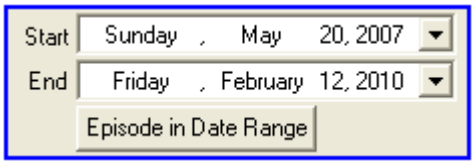
Episode of Care Radio Buttons

2. Select the tooth or teeth to be viewed, or click the **Other** or **All** check boxes.
3. The information appears 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.



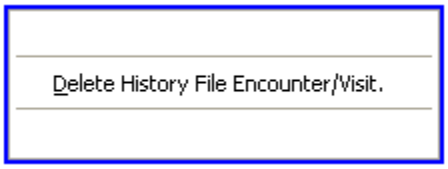
Episode in Date Range

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

Deleting an Encounter

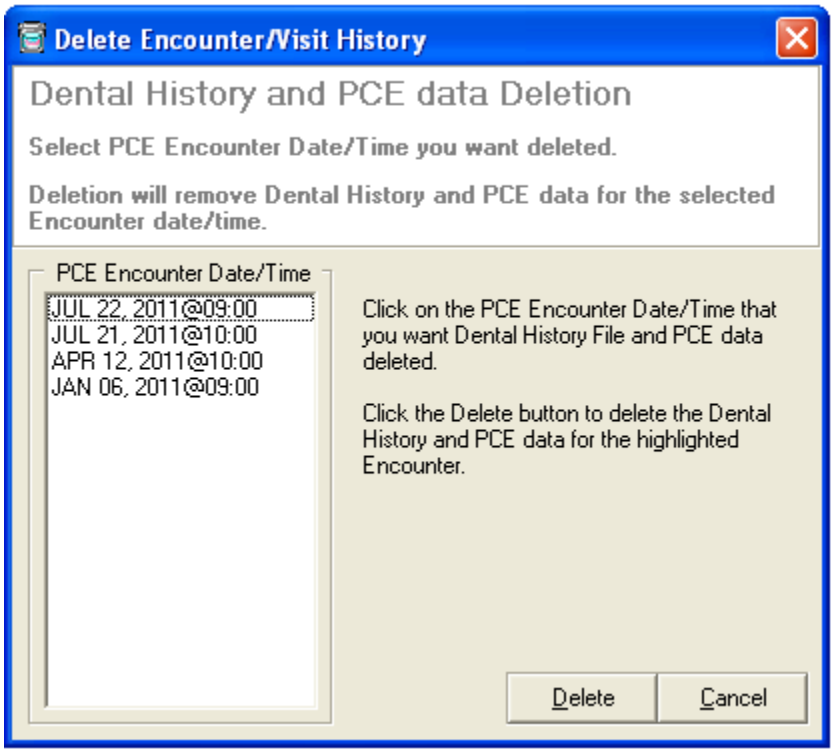
An erroneous dental history encounter may be deleted directly from DRM Plus. Only DRM Plus administrators can delete filed dental history encounter data. To delete an encounter:

1. Right-click in the large blank area on the tab. A menu displays.



Dental History Right-click Menu

2. Select **Delete History File Encounter Visit** from the menu.
3. The Delete Encounter/Visit History screen displays.



Delete Encounter/Visit History Screen

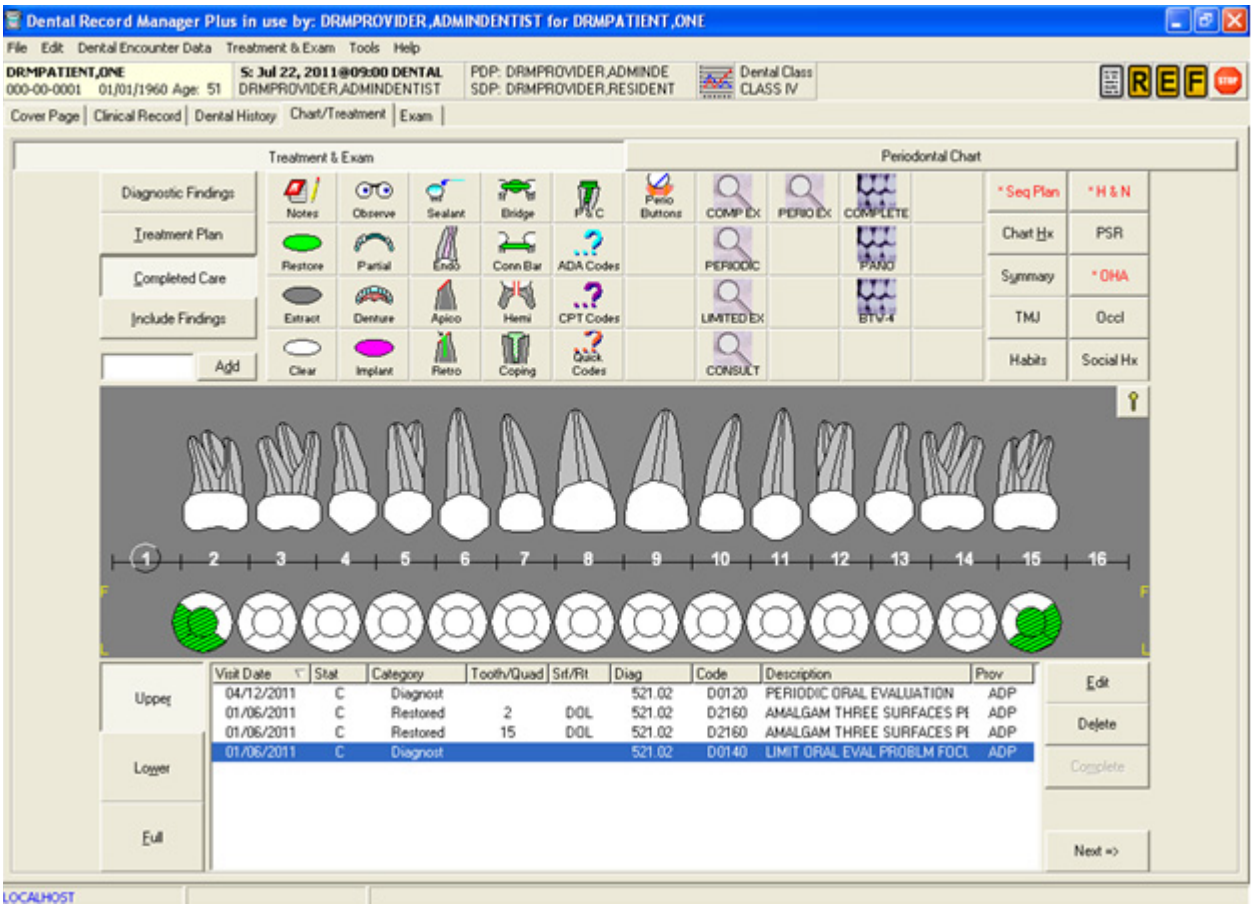
4. Select the **PCE Encounter Date/Time** from the list.
5. Click the **Delete** button. A confirmation screen displays.
6. Click the **OK** button. The PCE Encounter dental data is deleted.

Completed Care can also be deleted via the Chart/Treatment-Treatment & Exam screen. See the Deleting Completed Care Line Item(s) section in the Chart/Treatment-Treatment & Exam chapter of this manual for further information.

Note: Deleting information from the Dental history tab removes the entire encounter. Once an encounter is deleted, it cannot be recovered. DRM Plus automatically updates PCE encounter entries and deletes them from PCE. Local IRM support follows local guidelines as to whether to append or hide the associated TIU (CPRS) Note.

Chart/Treatment-Treatment & Exam

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



Chart/Treatment Tab Displaying Treatment & Exam Screen

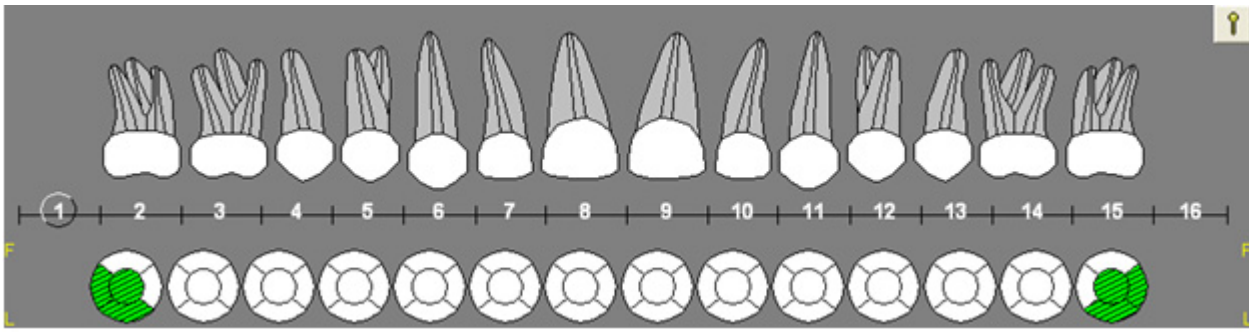
The Treatment & Exam screen has several important component views. On the upper left side of the screen are the following functions: Diagnostic Findings, Treatment Plan and Completed Care views, with corresponding buttons. These tools are used to enter information on diagnostic findings, create treatment 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.

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) and Occl (Occlusion) and Social Hx (History) buttons are on the upper right side of the screen.

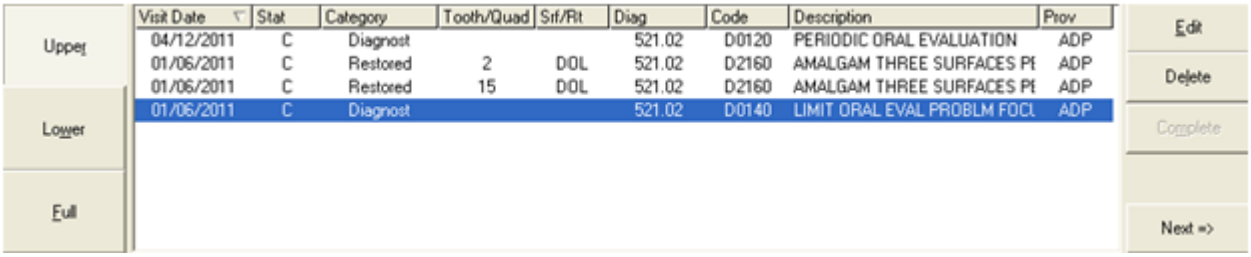
Treatment & Exam Specialty Buttons

The center of the screen displays by 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.



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 into 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**, **Complete** from the Treatment Plan or click **Next**, to move on to updating the progress note. Toggle between the teeth of the upper and lower arch by clicking on 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 only view the two arches.



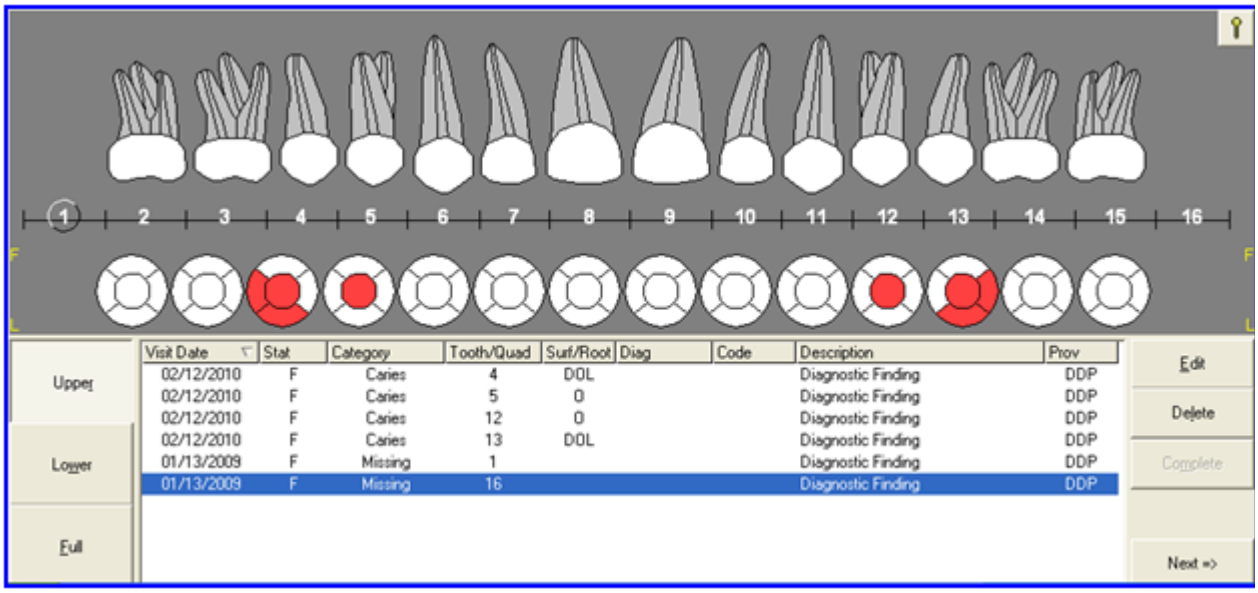
Completed Care Transaction Table

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.

Diagnostic Findings Button Active with Icons

3. Click on 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.



Diagnostic Findings Graphic and Transaction Table View Screen

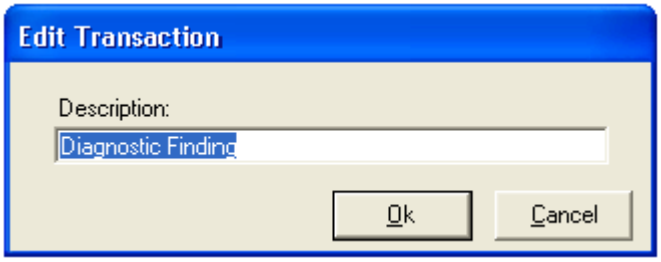
4. The finding appear in both the text and graphic display. Click the **Key** button in the upper right corner of the graphic display to see how various findings are displayed in the graphic.
5. Use the **Clear** icon to remove any finding entered during today's encounter only. Click the **Clear** icon 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 "finding".

Editing Diagnostic Findings Description

Diagnostic Findings descriptions that have been entered, but for which no 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.



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 appears in the transaction table.

Deleting a Diagnostic Finding

Diagnostic Findings that have been entered, but for which no progress note has yet been filed, can be deleted. To delete a diagnostic finding:

1. Select the diagnosis by highlighting it in the transaction table.
2. Click the **Delete** button on the right side of the transaction table.
3. The Diagnosis 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 non-DRM Plus administrator.

Note: Clicking on a transaction table column heading sorts the table. Generally in ascending order dependent 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 treatment procedure for a patient: by adding the code directly utilizing the **Add** button with text box or by selecting the icon that corresponds to the treatment and choosing the tooth from the graphic display. Use the ADA Codes, CPT Codes, Quick Codes Icon and personal Speed Code Icons as additional ways to enter treatment for the patient.

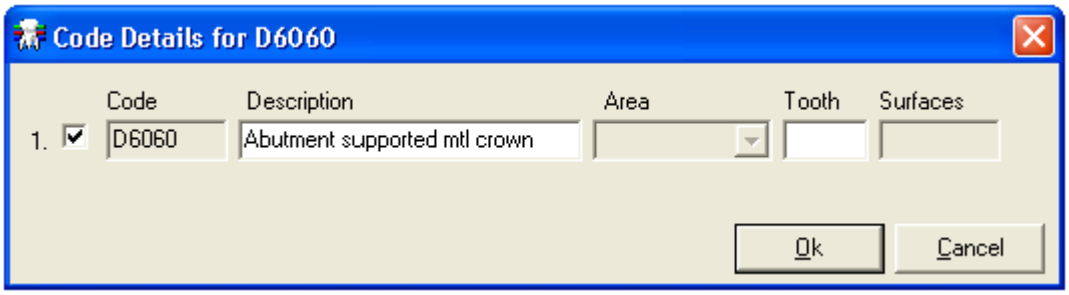
Rules for entering a procedure code for a planned item in the Treatment Plan view include:

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 they are performed on the patient.

Treatment Plan Button Active and Icons

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

1. Click the **Treatment Plan** button. Notice that the **Add** text field and button 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.



Code Details Screen

4. Enter the Tooth number and, if applicable, the area or surface modifiers and click the **OK** button. The graphic display and the text display adjusts to reflect the addition.

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

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

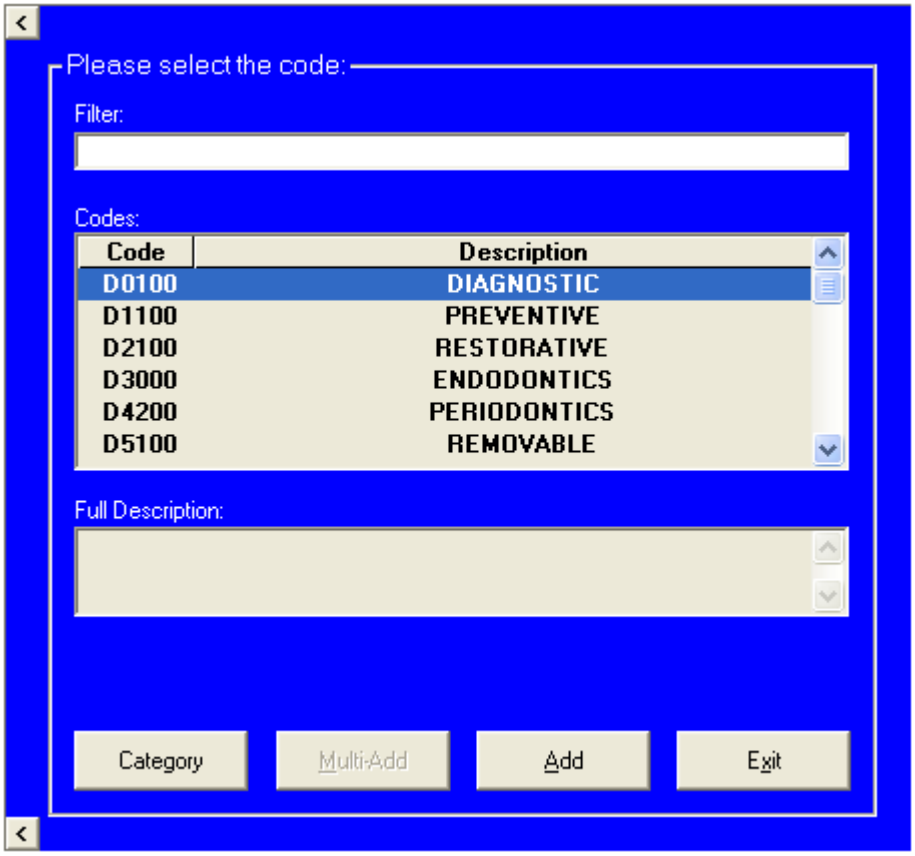
1. Click the **Treatment Plan** button.
2. Click the **icon to the right** that corresponds to the desired treatment plan.
3. Click the **appropriate tooth, area**, and/or **surface**.
4. As in Diagnostic findings, toggle between the upper and lower arch by clicking the **Upper** or **Lower** button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

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

1. Click the desired icon.

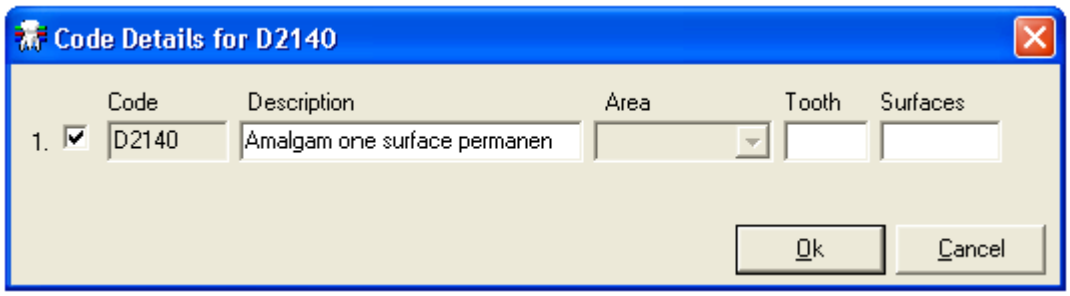
ADA, CPT and Quick Codes Icons

2. The Code Search screen displays for the ADA Codes icon selection.



CPT Procedure Code Search Screen

3. Type the code into the filter, or use the scroll bar to search for a code.
4. A description of the highlighted code appears 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 codes on the same tooth.
6. When the desired code is highlighted, click the **Add** button.
7. If the code needs to be attached to a specific tooth and surface modifier, the Code Details screen displays.



Code Details Screen

8. Fill in the fields with the requested information and click the **OK** button.
9. The Treatment Plan Code screen displays if the parameter is activated.

10. Select the treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does not appear, use the Additional Diagnosis Code Search to find a different diagnosis code.
11. Click the **OK** button. The information appears 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 section of this chapter entitled Diagnostic Findings.

To enter a treatment using the Quick Codes icon is similar when adding with the ADA Code Icon. To enter a treatment using the personal Speed Code icons, see the section later in this chapter, entitled Perio Buttons.

Editing a Treatment Plan Description

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

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.

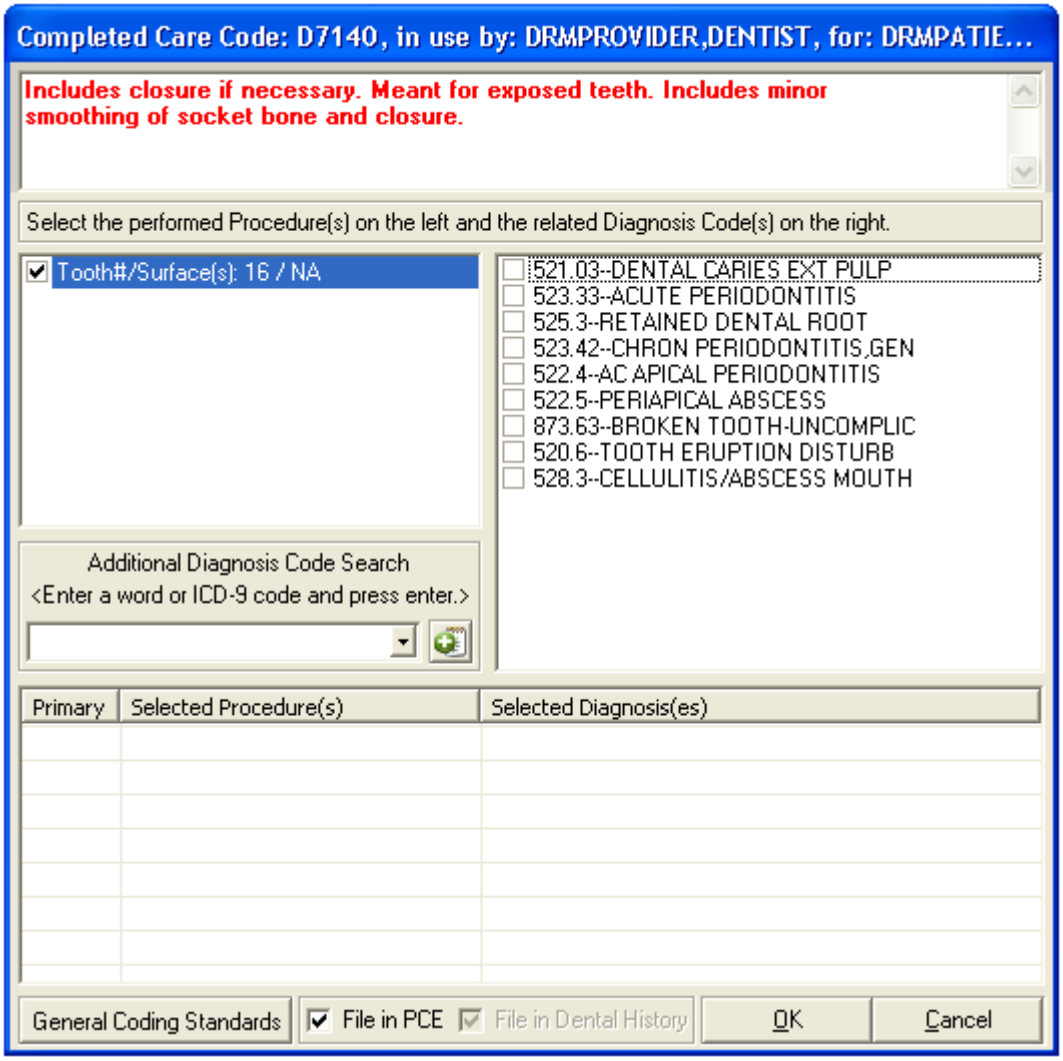
Deleting a Treatment Plan

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

Every DRM Plus user is allowed to delete any planned item, no matter 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 ICD-9 Diagnosis Code screen displays.



ICD-9 Diagnosis Code Screen

4. Select the treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side of the screen. If the correct diagnosis code is not listed, use the **Additional Diagnosis Code Search** to find a different diagnosis code.
5. Notice the **File in PCE** checkbox. If the Completed Care 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 for the patient.

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: Treatment Plan procedure codes can be designated with or without a related diagnosis. The parameter change for the end user to acquire this functionality is Tools menu/ User Options/ Treatment System tab and checking 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.

Completed Care Button Active 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 and 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 Care. Planned treatments, which are complete (see Completing a Treatment Plan), appear in the Completed Care transaction table. Completed Care can also be entered manually:

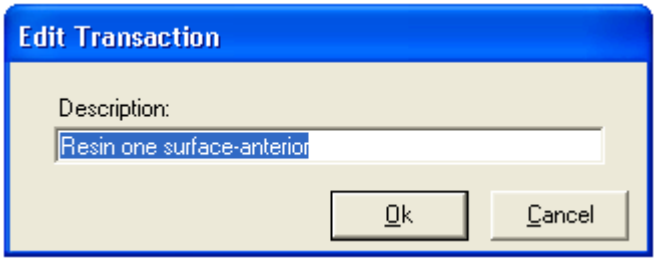
1. Click the **Completed Care** button.
2. Select the desired associated standard icon.
3. Choose the appropriate tooth/area on the graphic display.
4. Complete the ICD-9 Diagnosis Code screen.
5. The entry appears in the transaction table.
6. To undo any graphical entry on today's encounter, use the **Clear** icon as described in the Diagnostic Findings section of this manual.

Completed care can also be entered through the **Add** button and text box and the ADA, CPT and Quick Codes icons, as well as the Speed Code icons. 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 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.



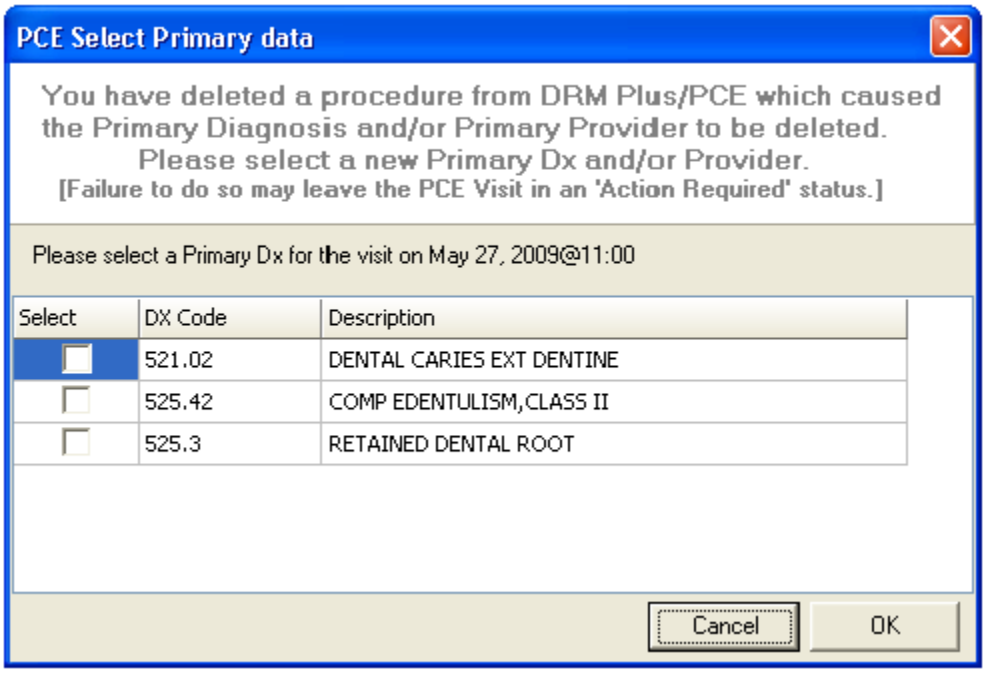
Edit Transaction Screen

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

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



PCE Select Primary Data Screen

Note: The DRM Plus administrator follows local guidelines as to whether they append the associated TIU (CPRS) progress note or have some other guideline option.

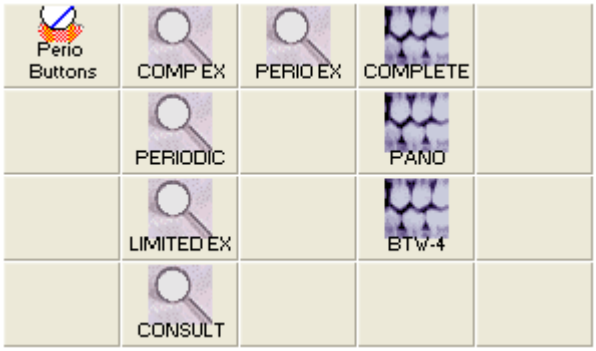
Note: To delete all entries from a Dental Encounter, never use the line item deletion in Completed Care. instead, delete the entire Dental Encounter in the Dental History tab. See the Deleting an Encounter section in the Dental History chapter of this manual for further information.

Include "Completed"/Include "Findings and Completed"/Include "Findings"

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

Perio Buttons Icon

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



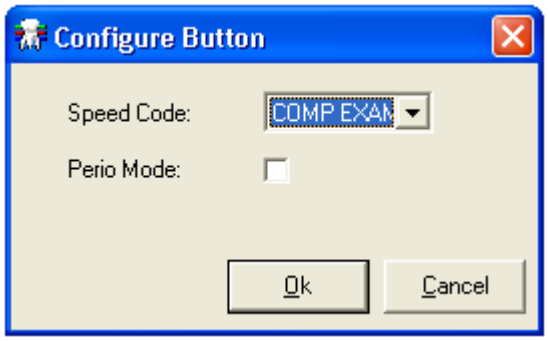
Perio Button and Icons

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 Treatment Plan. If these buttons are clicked when Completed Care is active, the ICD-9 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 on one of the blank icons where the speed code icon is to be moved.
2. The Configure Button screen displays.

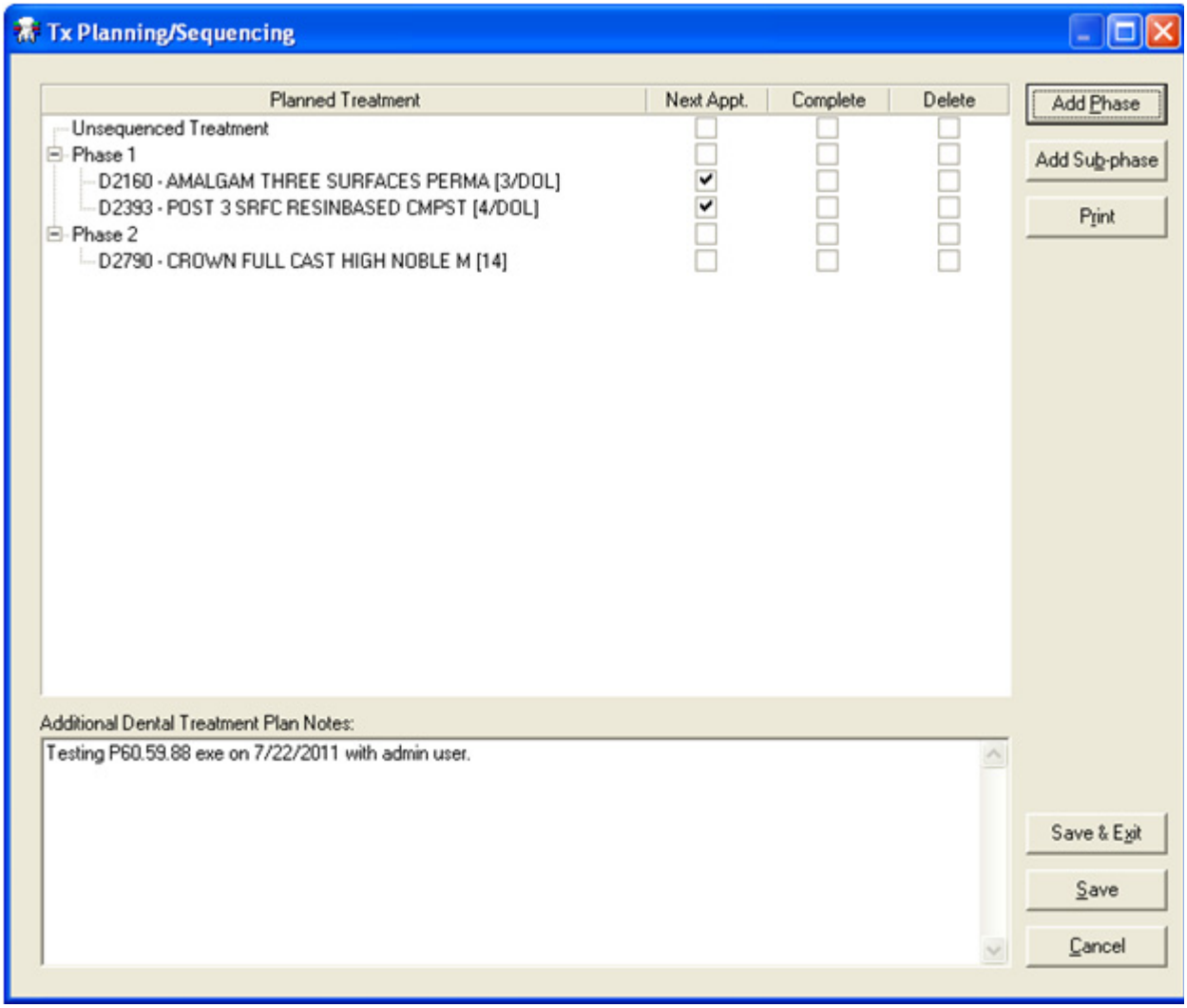


Configure Button Screen

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 function to organize when to perform specific planned treatments. Planned treatments can also be deleted or completed from this screen.



Tx Planning/Sequencing Screen

Plan a Treatment Sequence

1. Click on 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** and **Add Sub-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 desired 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.
6. Add Additional Dental Treatment Plan Notes in the text box.
7. Click the **Save and Exit** button if only planned items have been added or sequenced for this patient. This option requires that no new data may 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 and 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 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

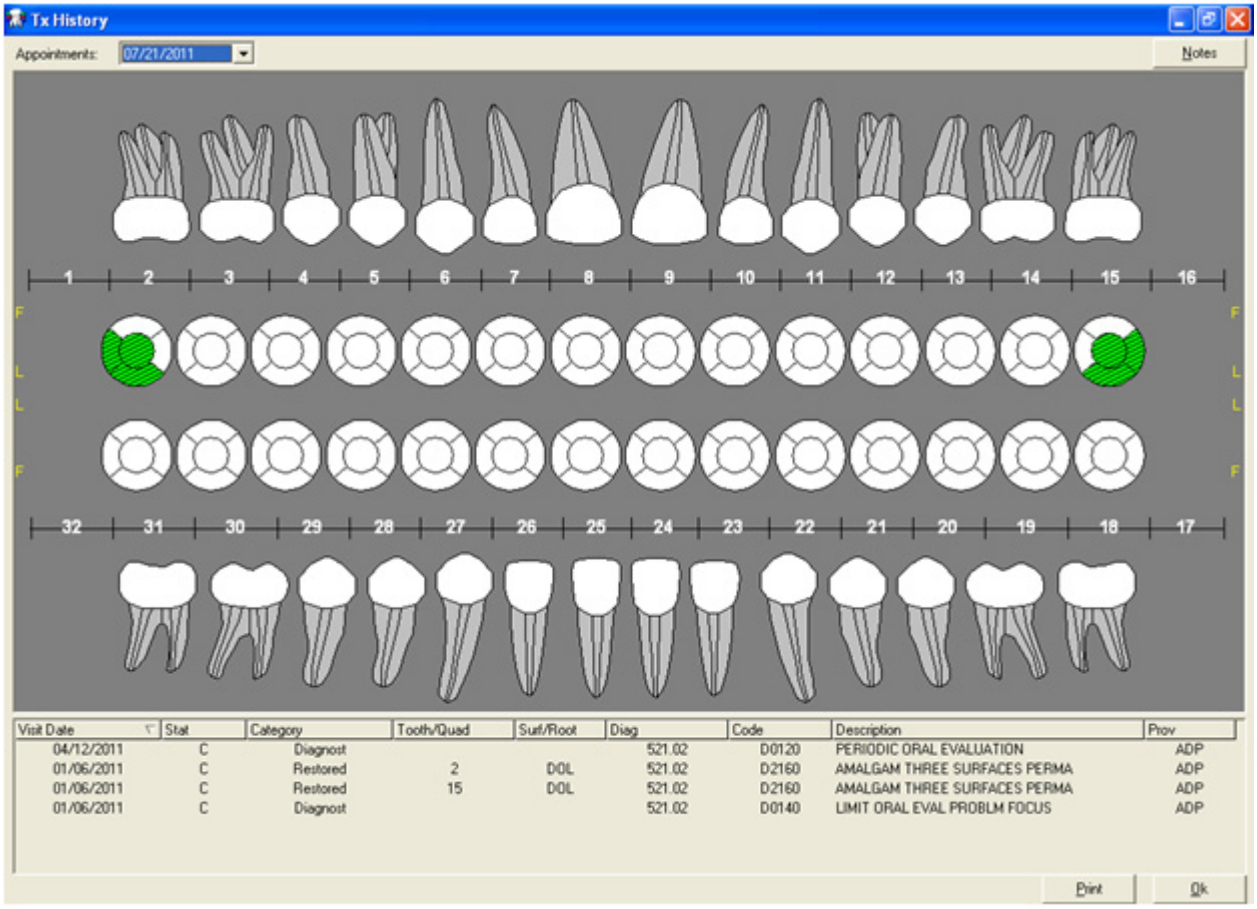
1. Click on the **Seq Plan** (Sequencing) button.
2. The Tx Planning/Sequencing screen displays.
3. Choose the planned treatment that is to be completed by checking the corresponding check box in the Complete column.
4. Click the **Save** button.
5. The Completed Code Care screen displays. See the Completing 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 on 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.
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 Providers initials.



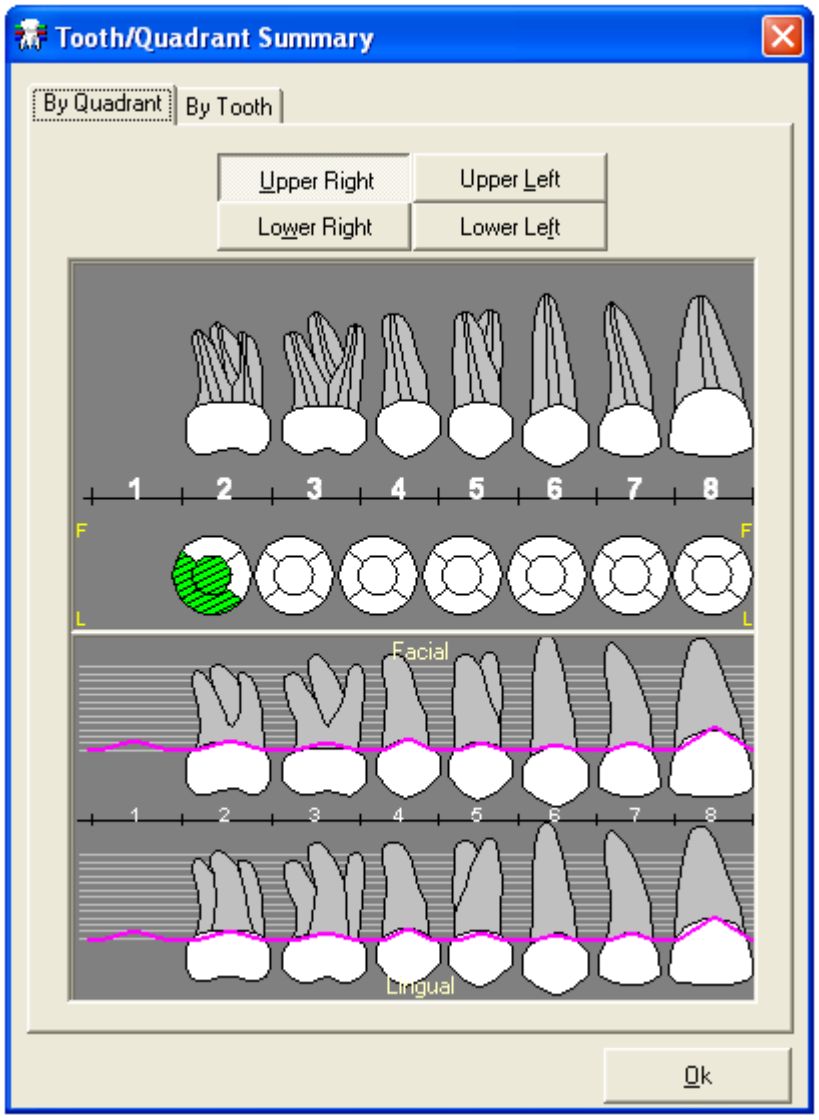
Tx History Screen

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's date.

Note: To display any past tooth-specific note, click the **History** button**.** Continue by clicking the drop-down arrow of the Appointment field, in the top left corner of the 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 appears in the summary as well.



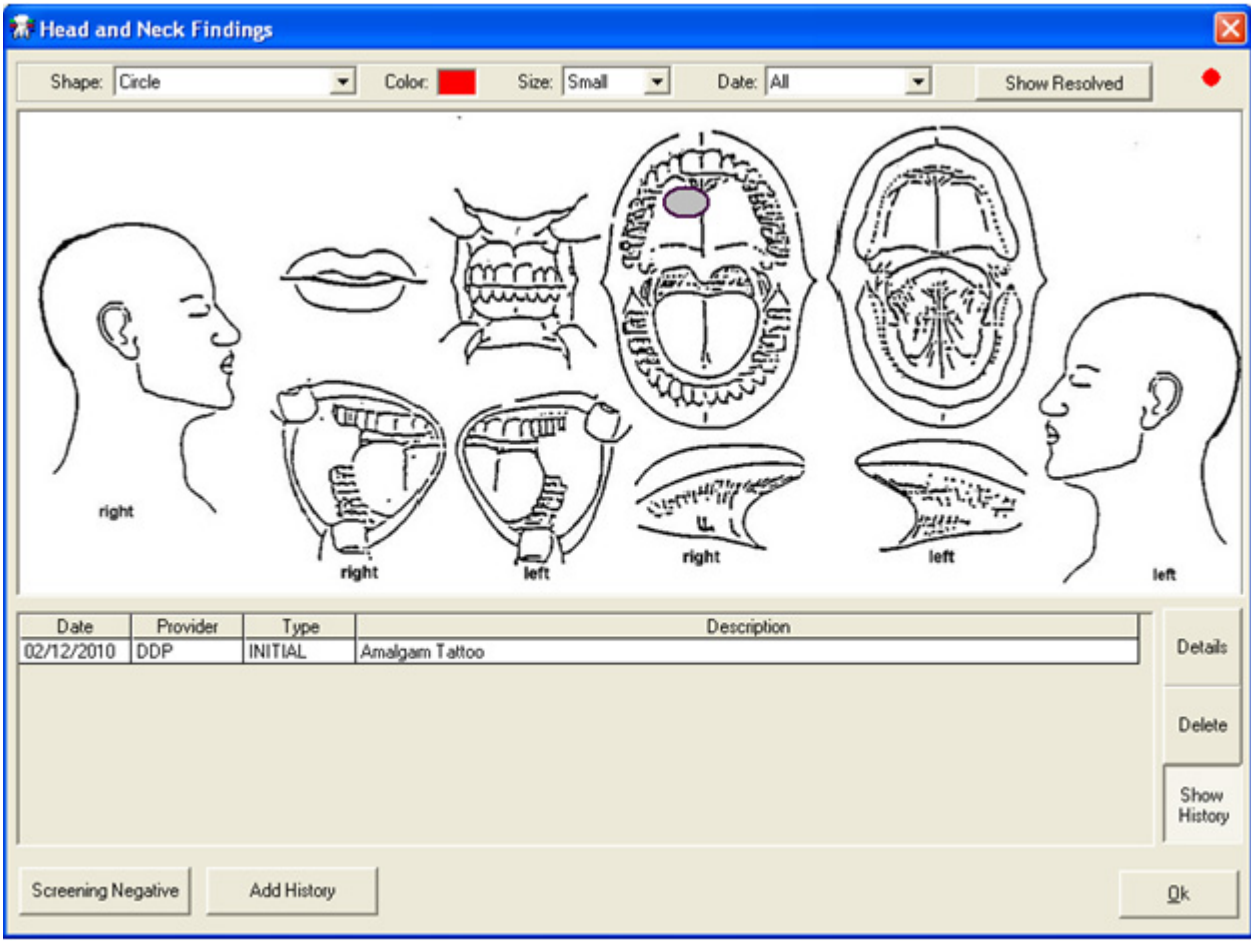
Tooth/Quadrant Summary Screen

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, is displayed in the Restorative top window. The lower half of the screen displays 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

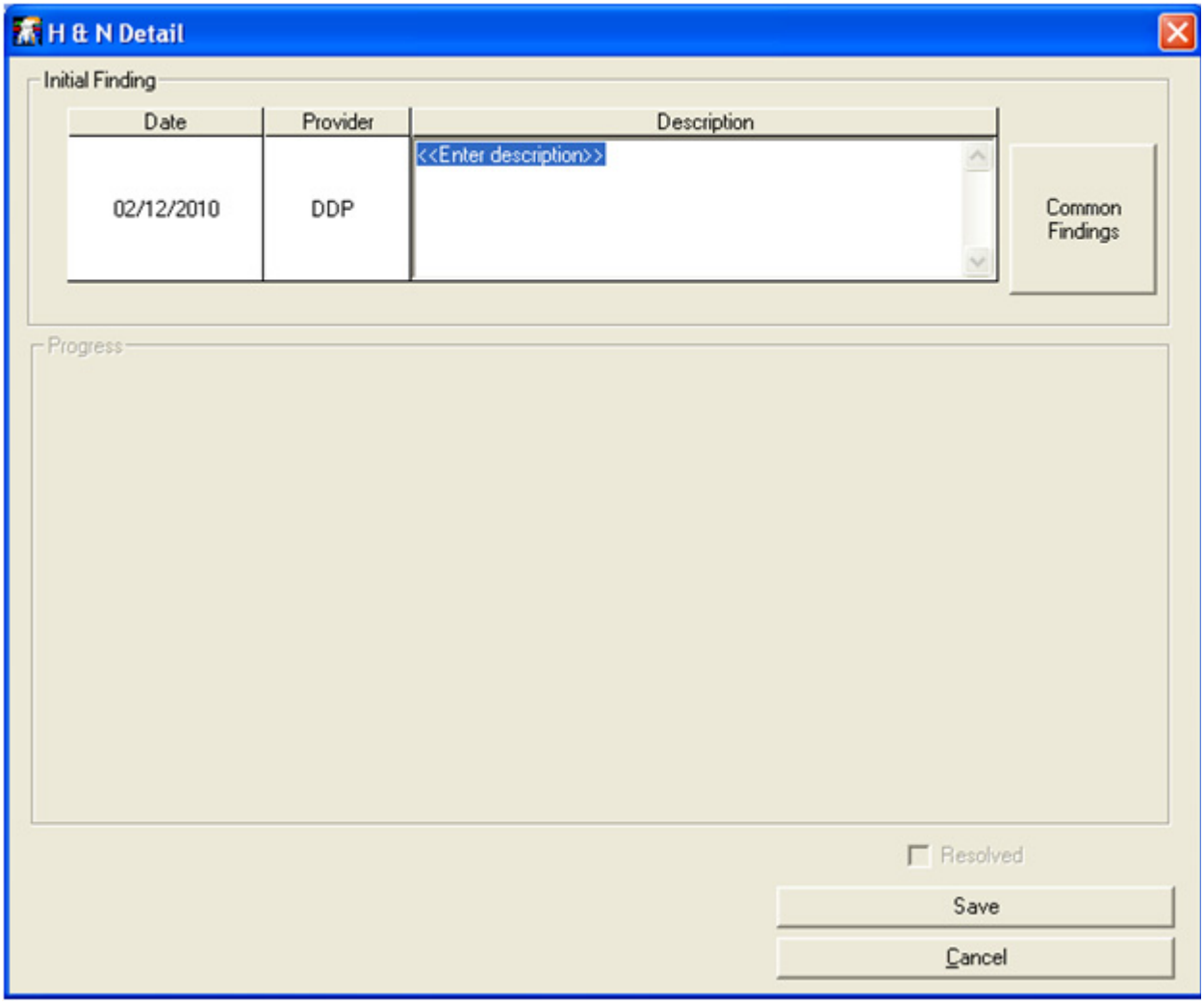
Use the functions in the **H&N (Head and Neck)** button to enter and view diagnostic information on the patient's head and neck.



Head and Neck Findings Screen

To enter a 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 appears.
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 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.

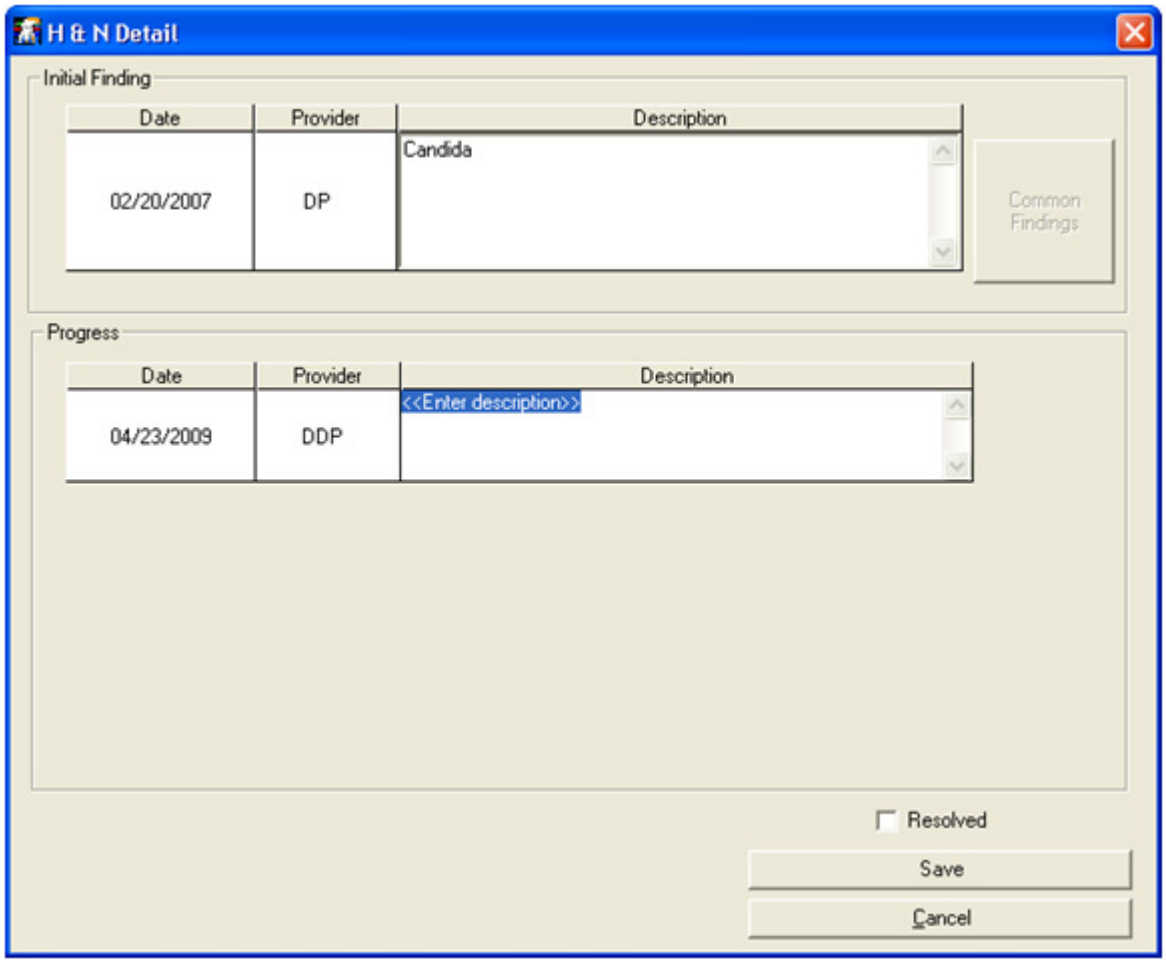


H&N Detail Screen

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 appears on the H&N transaction table.

To add new details of a finding:

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



H&N Detail Screen with Progress Description Activated

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

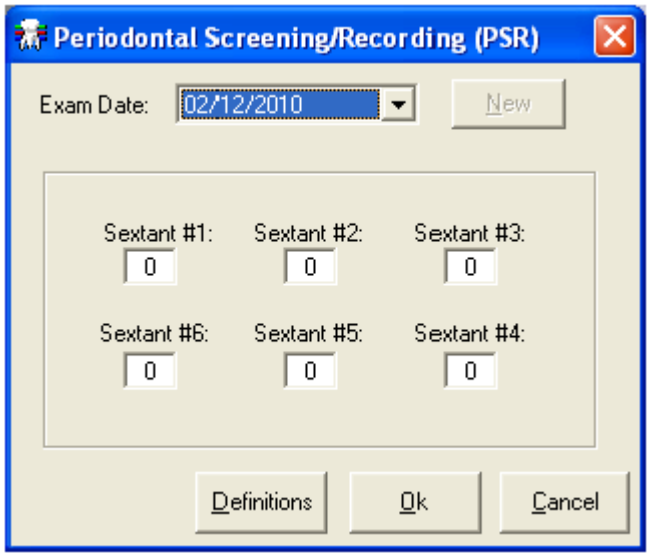
To delete a lesion:

1. Highlight the entry on the H&N 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 entry is made during this encounter.
4. The entry and the mark on the H&N graphic closes.

Note: Clicking the **Delete** button deletes the highlighted entry(s) during the same day the H&N transaction was entered. Deleting any filed H&N 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 PSR screen. Use this screen to view past PSR information if present, or to enter new PSR information.



Periodontal Screening/Recording Screen

Use the Exam Date drop-down menu to view past Periodontal Screening information.

To enter new information:

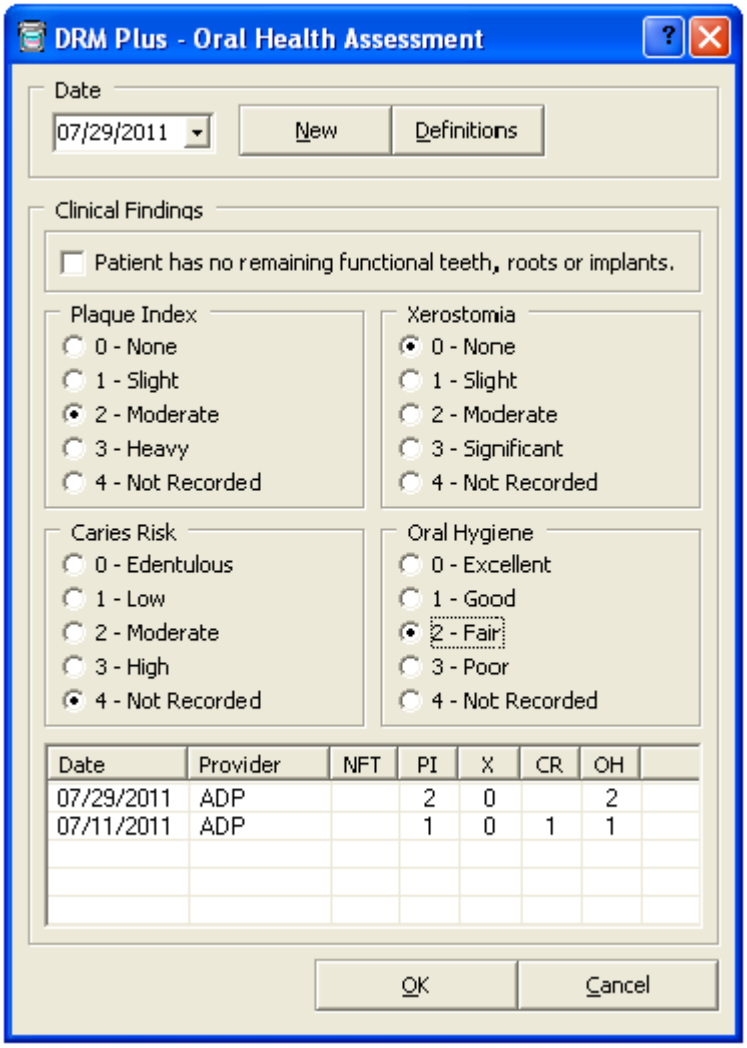
1. Click the **New** button. All the Sextant text boxes is 0, or the value from the previous exam.
2. Enter the desired national dental value in each Sextant text box. Entering a "*" requires a number added with the symbol to be saved (i.e. "3*").
3. Click the **Definitions** button to view PSR definitions 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 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 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 OHA screen, click the **New** button. Today's date is imported into the Date field on the screen. Today's date is the date of entry or the create date for this finding; when reloaded and filed as unfiled data, it retains the date from when the finding was originally entered.



Oral Health Assessment (OHA) Screen

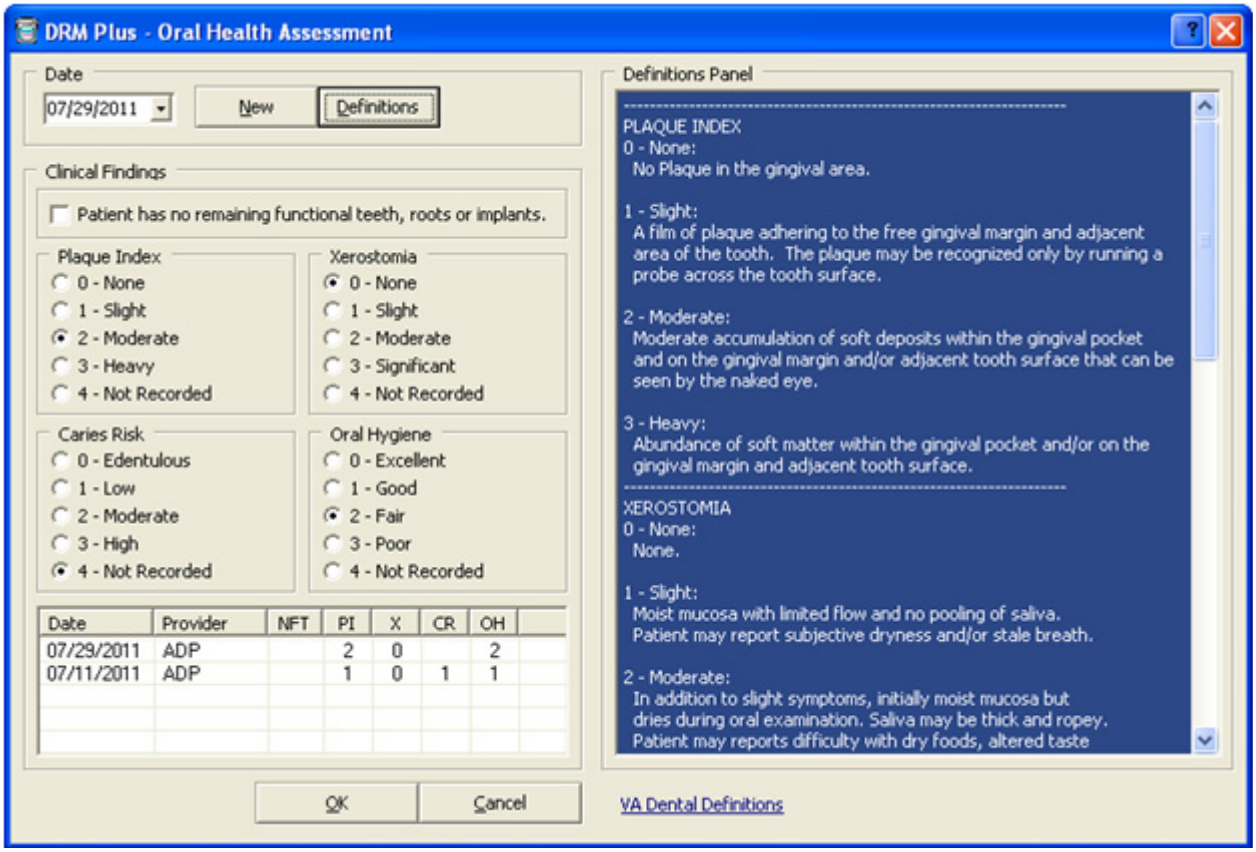
The NFT check box option, listed as "Patient has no remaining functional teeth, roots or implants" may be selected in the event the patient meets these criteria and no findings can be entered in the Diagnostic Findings chart.

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 progress note, nor 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 or create 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.



OHA Definitions Showing Plaque Index and Xerostomia Risk

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

At the bottom of the OHA Definitions panel is the internet link for possible newer ‘VA Dental Definitions' which displays any new definition updates that have been changed for these findings.

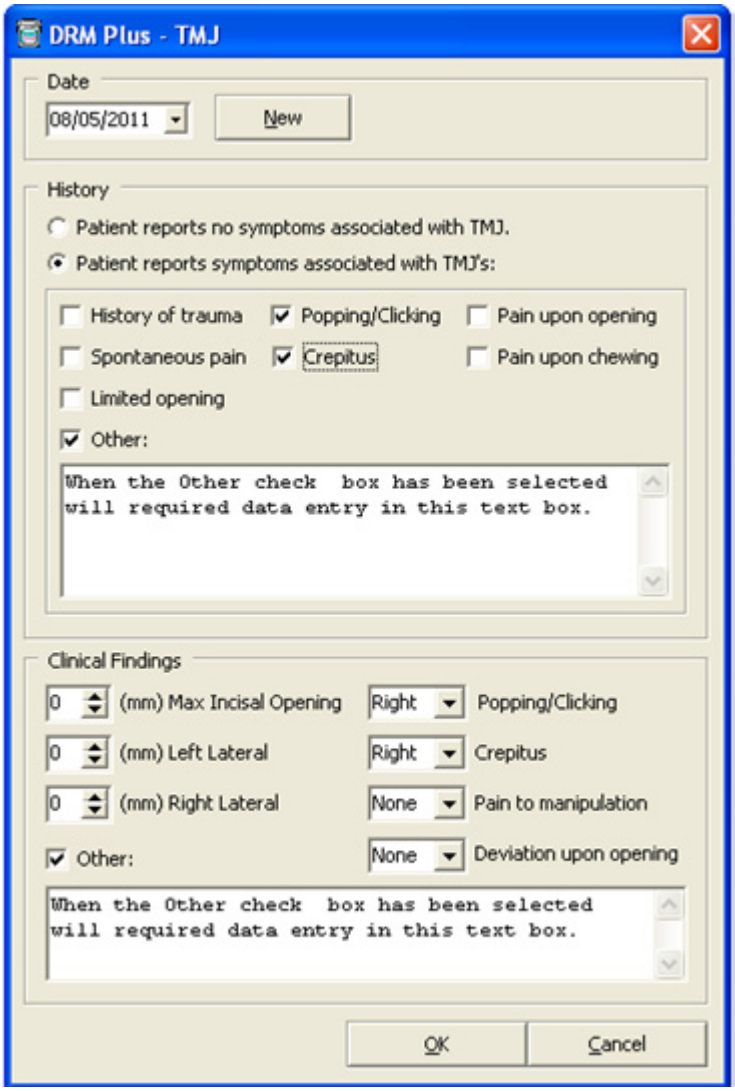
Note: The Plaque definitions have been reprogrammed and only allow whole number entries. Most Plaque values filed before the loading of the new exam template patch retain the decimal value, if entered with one, and is located in the PI column of the new OHA transaction table.

TMJ Button

The new specialty button **TMJ** functions similar to the **OHA** button when entering a new exam. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

At least one entry in either the History or Clinical sections from this TMJ screen requires data to be selected in order to save. When 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 found 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.



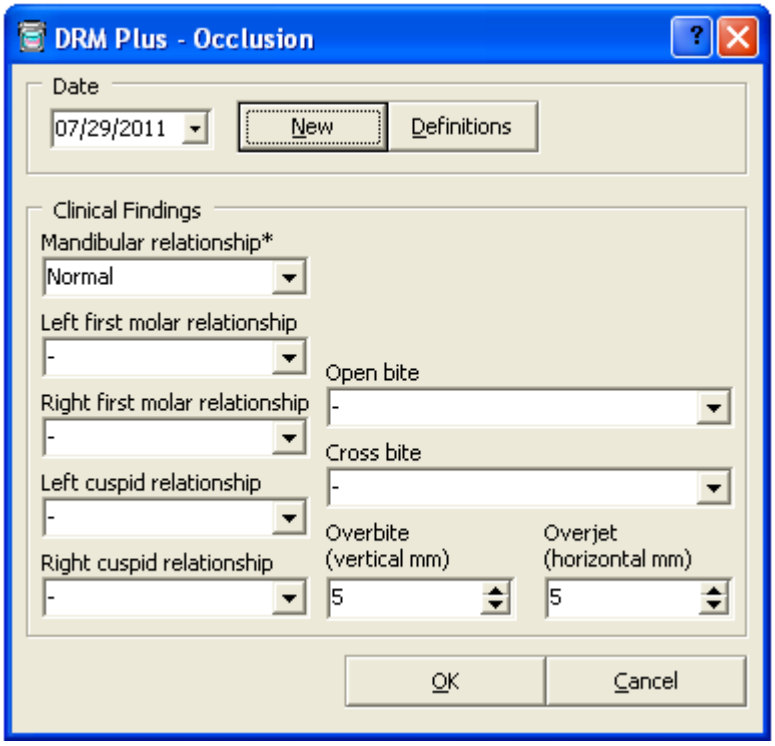
TMJ Screen

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

Occl (Occlusion) Button

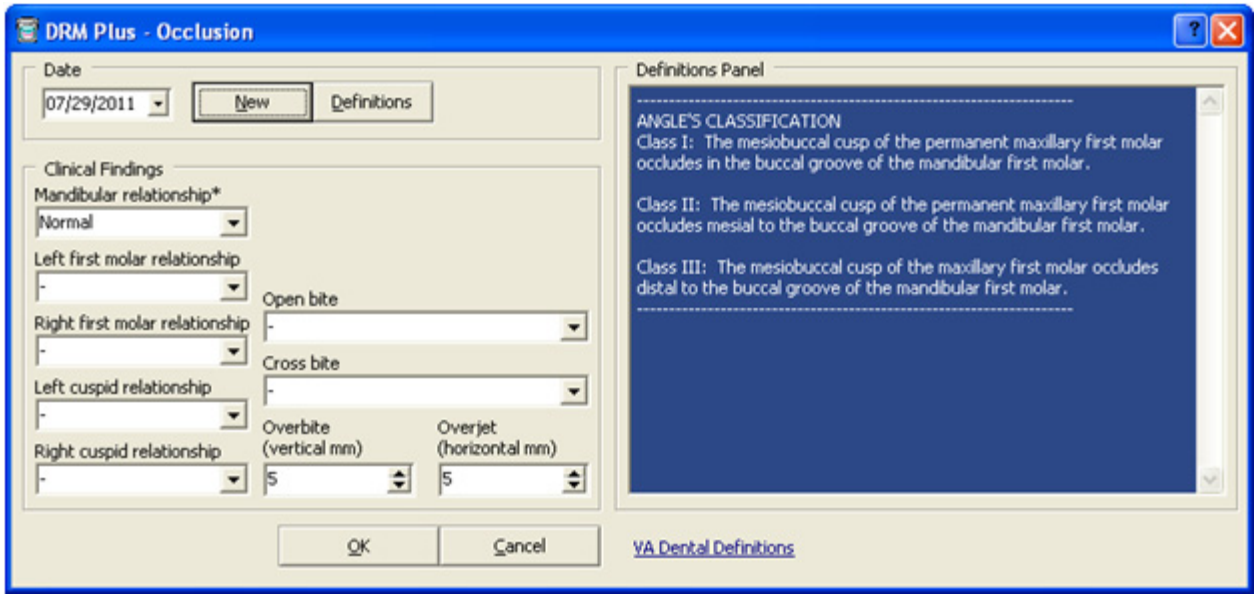
The new specialty button **Occl (Occlusion)** functions different than the other new specialty screens when entering a new occlusion finding. Click the **New** button and today's date imports into the Date field. When there is previous filed data present then all that filed data imports into the new exam. The user needs to add/delete any new occlusion findings and click the **OK** button to save. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.



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 OHA screen by selecting the **Definitions** button.



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, clicking **User Options**, then **Exam Settings** and finally un-checking the Requirements.

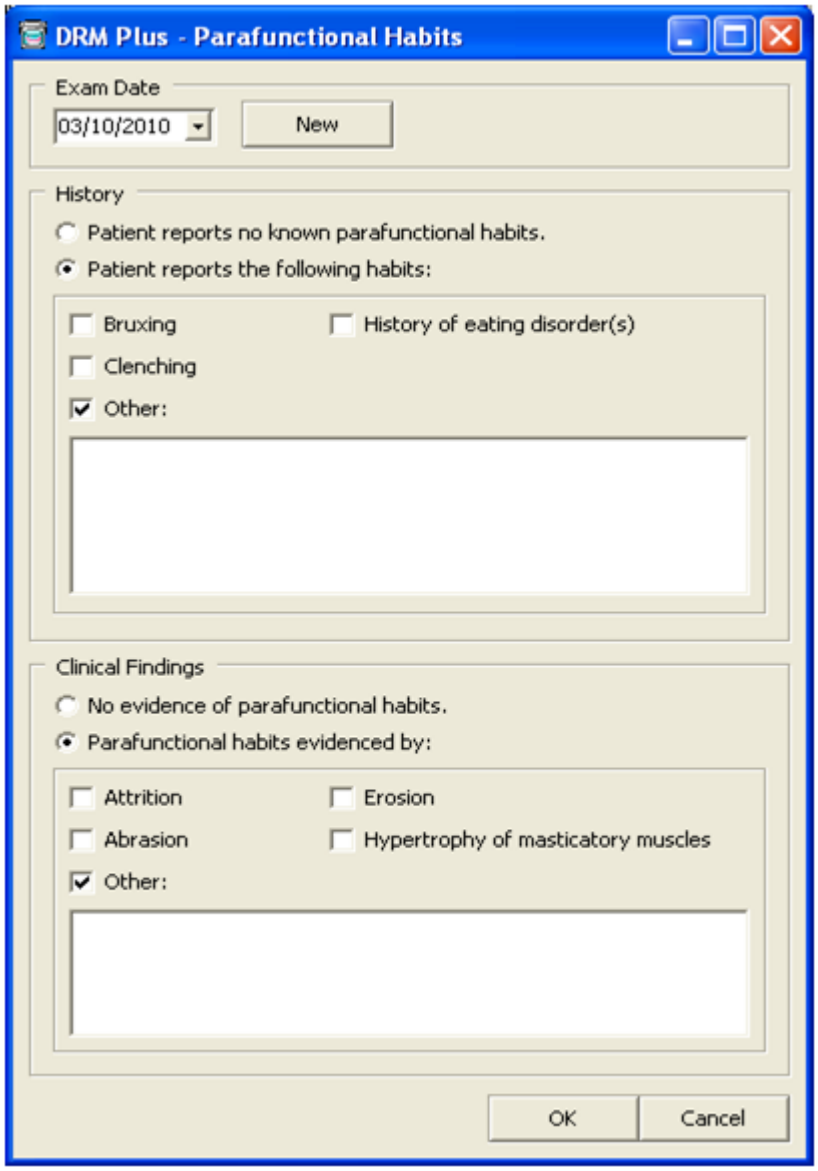
At the bottom of the Occlusion Definitions panel is the internet link for possible newer 'VA Dental Definitions', which displays any new definition updates that have been changed for these findings.

Habits (Parafunctional) Button

The new specialty button, **Parafunctional Habits,** functions similar to the **OHA** button when entering new data. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

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



Parafunctional Habits Screen

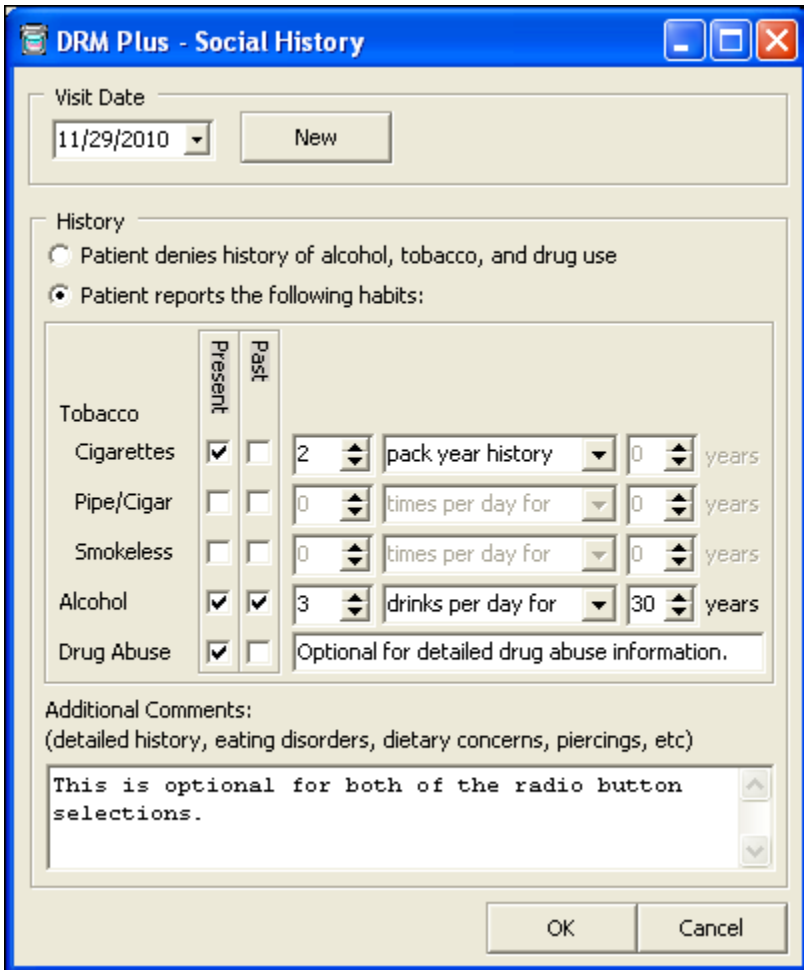
Social Hx (Social History) Button

The new specialty button, **Social History**, functions similar to the **OHA** button when entering new data. Click the **New** button and today's date imports into the Date field. Today's date is the date of entry or the create date for this finding; and when filed as unfiled data retains the same date when the finding was originally entered.

The minimal 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 the cigarettes. The 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.



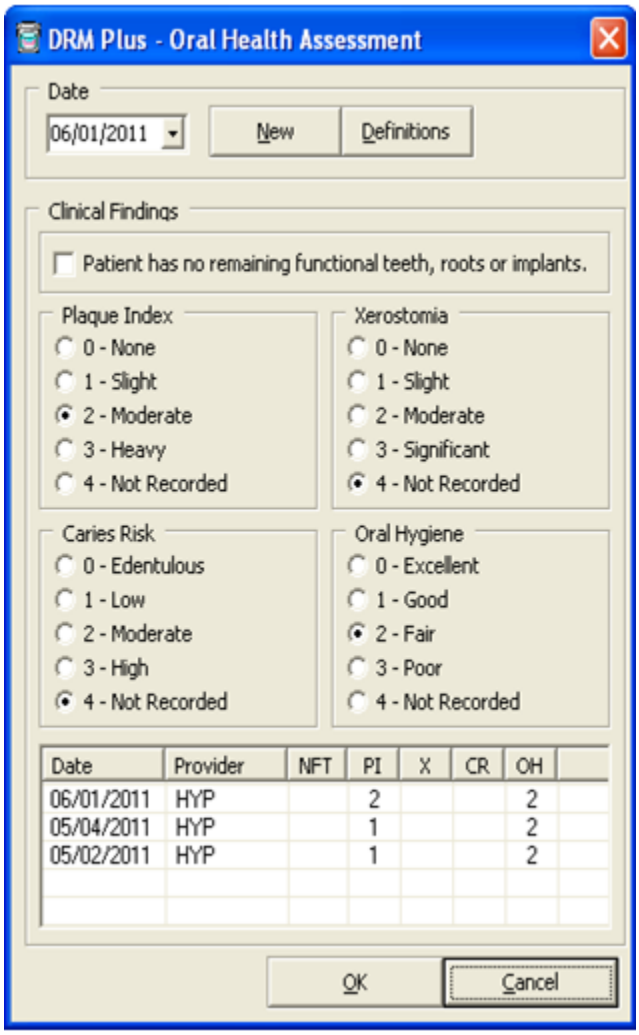
Social Hx (History) Screen

Note: All five of the new modals work like the PSR screen except for one major difference. The major difference in functionality of the new modals is that they allow the provider to clear the exam selection findings during the present session for any of the five new modals by opening that screen and selecting the **Cancel** button.

Filing Multiple Exams to Same Modal Same Day

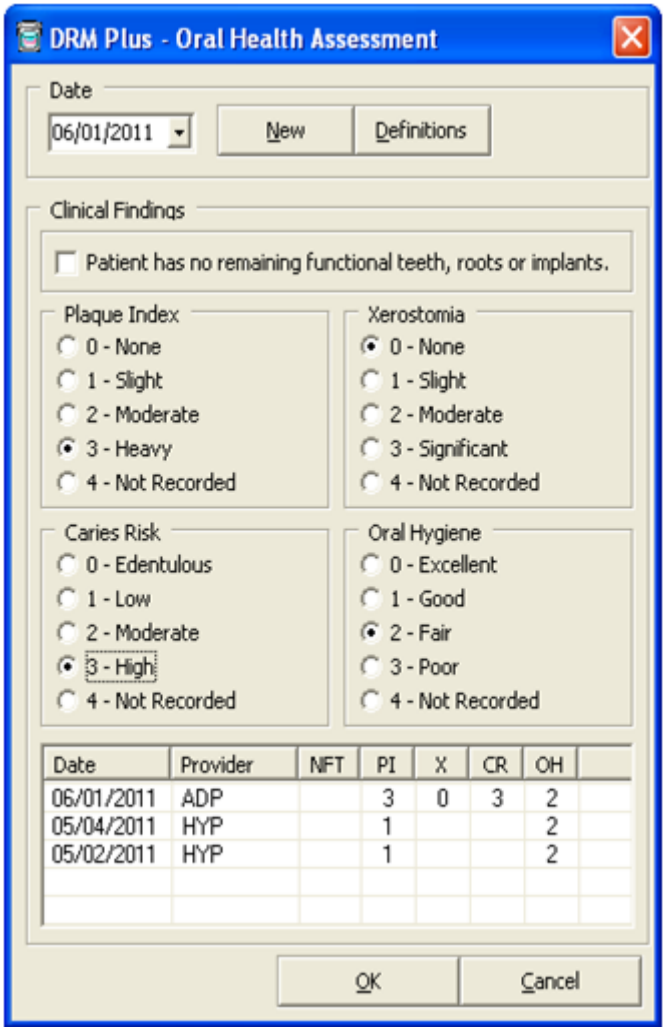
The following functionality occurs with the new modals when two providers or the same provider files two TIU notes during the same day. The second filing allows the provider to enter new data or edit the previously filed data. This is the functionality for all five new modals that work and display the same as the PSR and Periodontal Chart exams. This functionality only allows the last exam filed during one calendar day to remain in the historical date drop-down field of that screen.

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



Provider HYP Filed OHA Data First

When the second provider (ADP) filed an edited OHA exam data during the same calendar day; the second provider had to modify the first provider's filed OHA exam. This edited or modified exam after it has been filed is the only one present for the local clinical providers when they open this DRM Plus patient's chart.



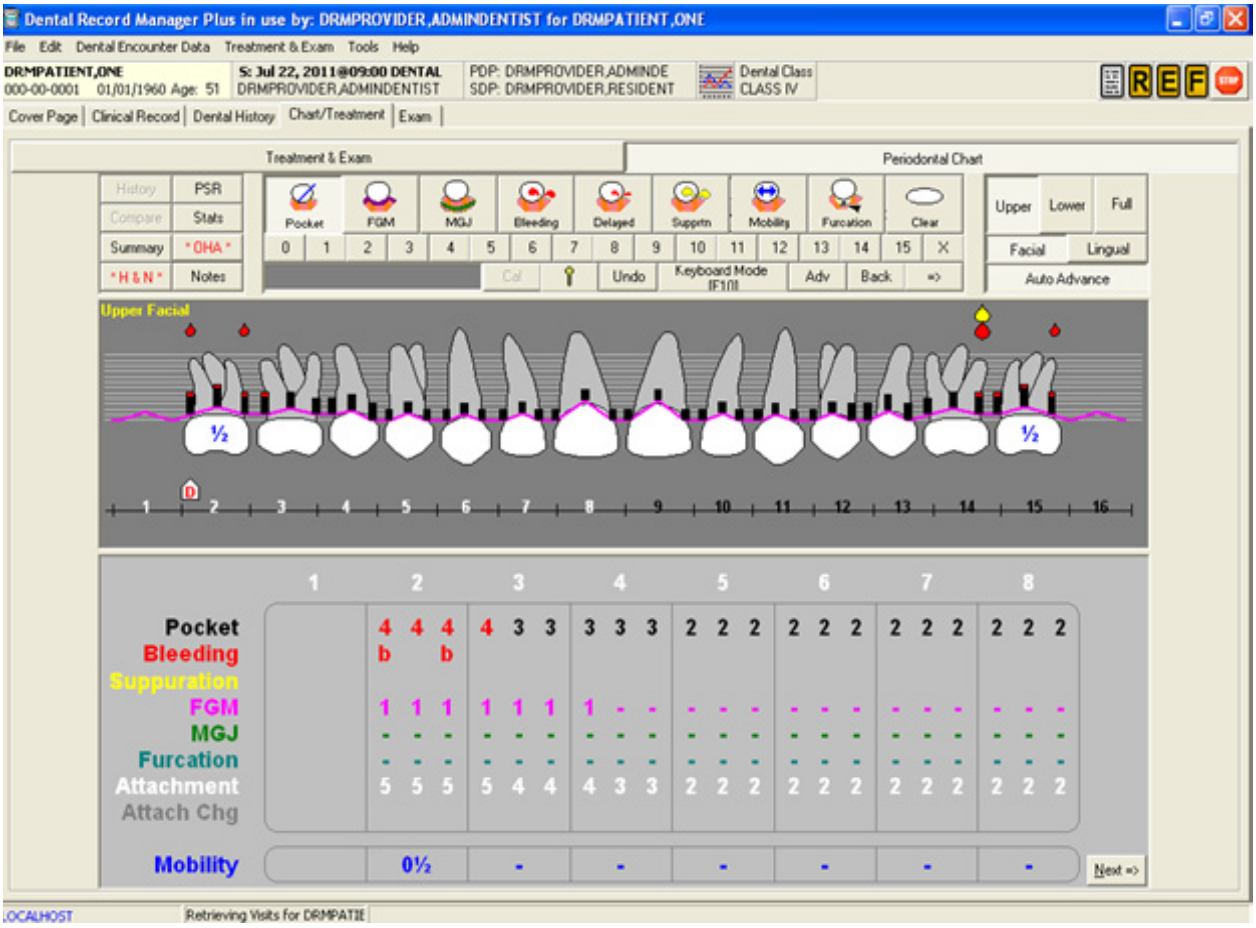
Provider ADP Edited and Filed OHA Data Second

Note: The first provider's exam is only present in their filed TIU note.

Note: The OHA is the only new modal that displays the date and the provider's initials filed with the exam data.

Chart/Treatment-Periodontal Chart

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



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.

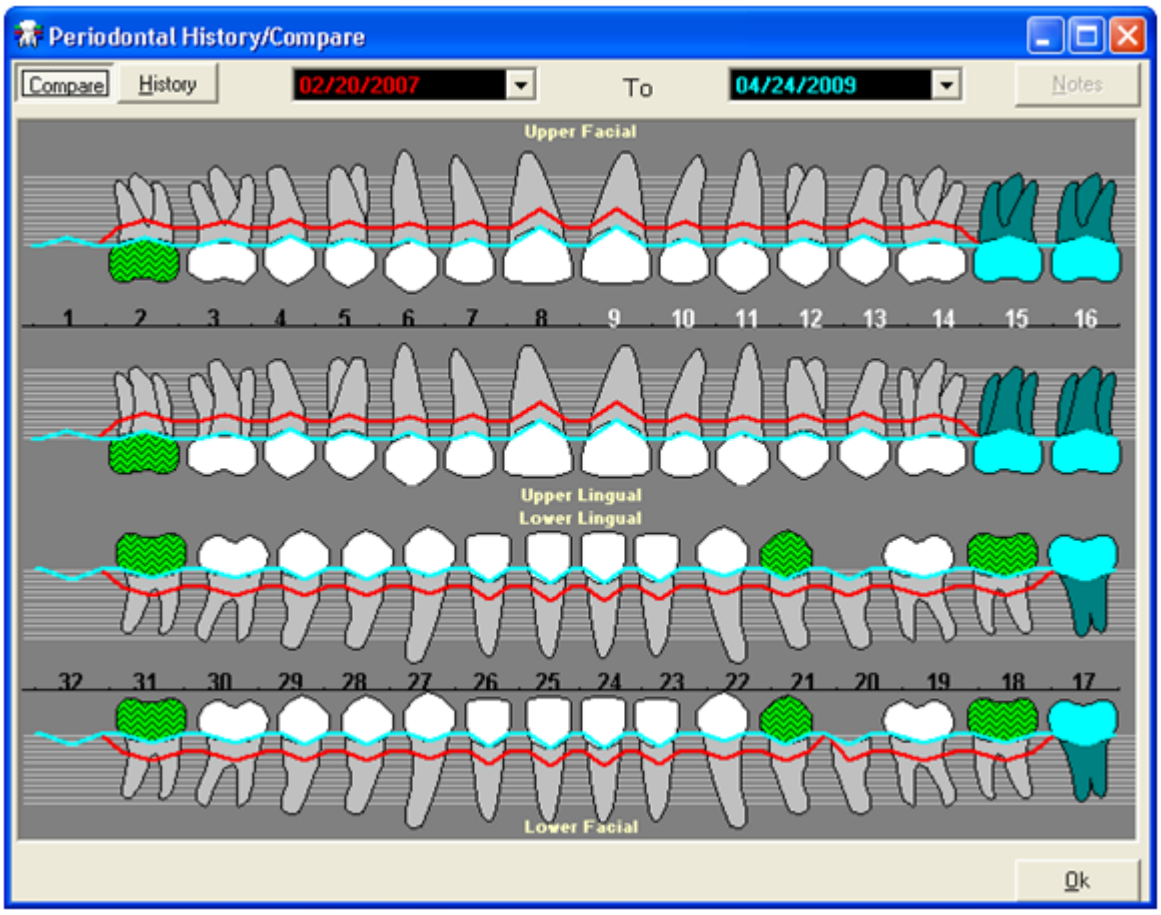
The bottom of the screen shows text (only a quadrant is viewable depending where the cursor shield is located) of the periodontal information entered using the graphic and the condition-specific icons in the top center of the screen.

Note: The Perio 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 progress note of the provider that filed the first encounter.

History and Compare Buttons

Clicking the **History** or the **Compare** button displays similar screens.

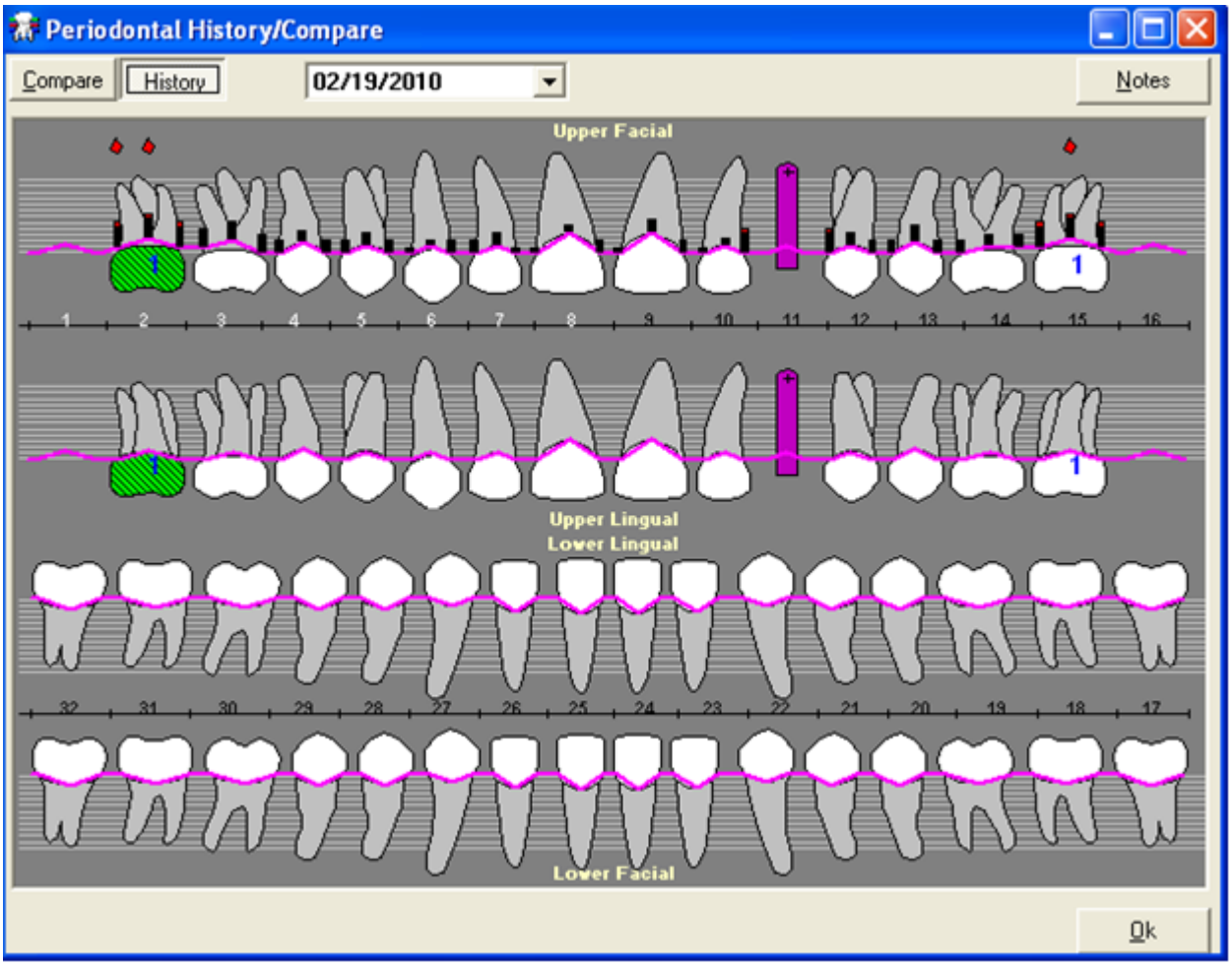
Use the **Compare** function to see two periodontal chart's for a patient.



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.



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

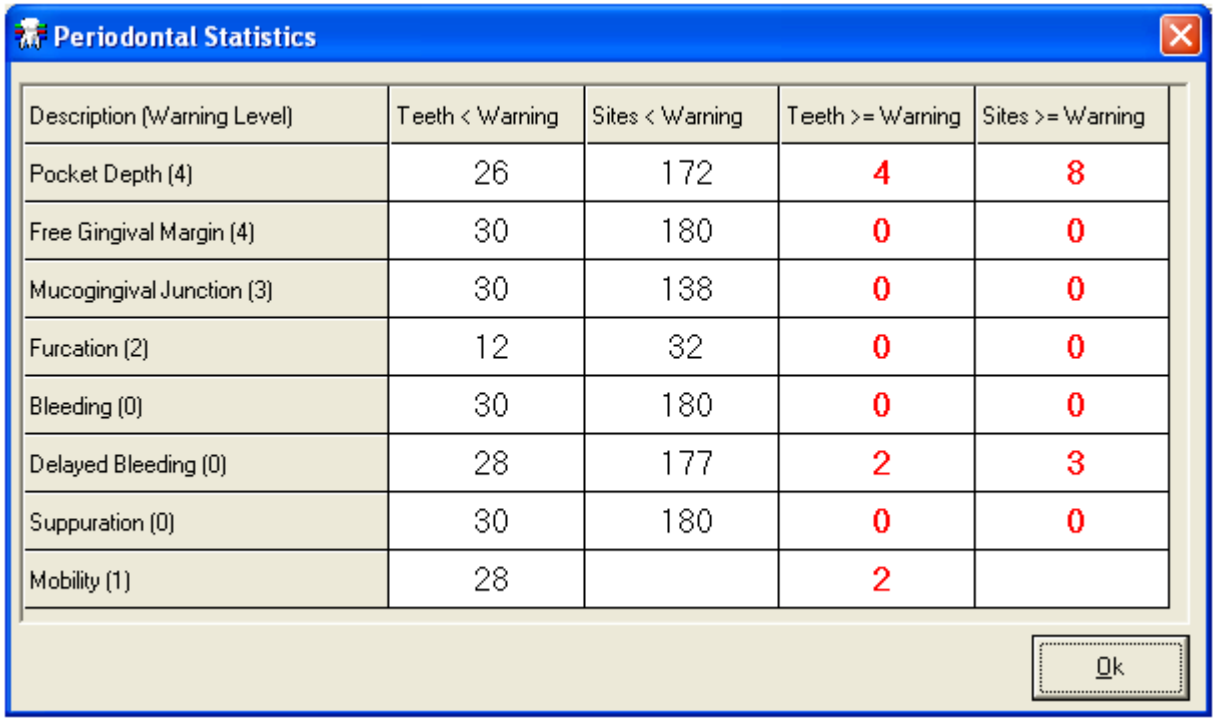
See the H&N Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

PSR Button

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

Status Button

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



Periodontal Statistics Screen

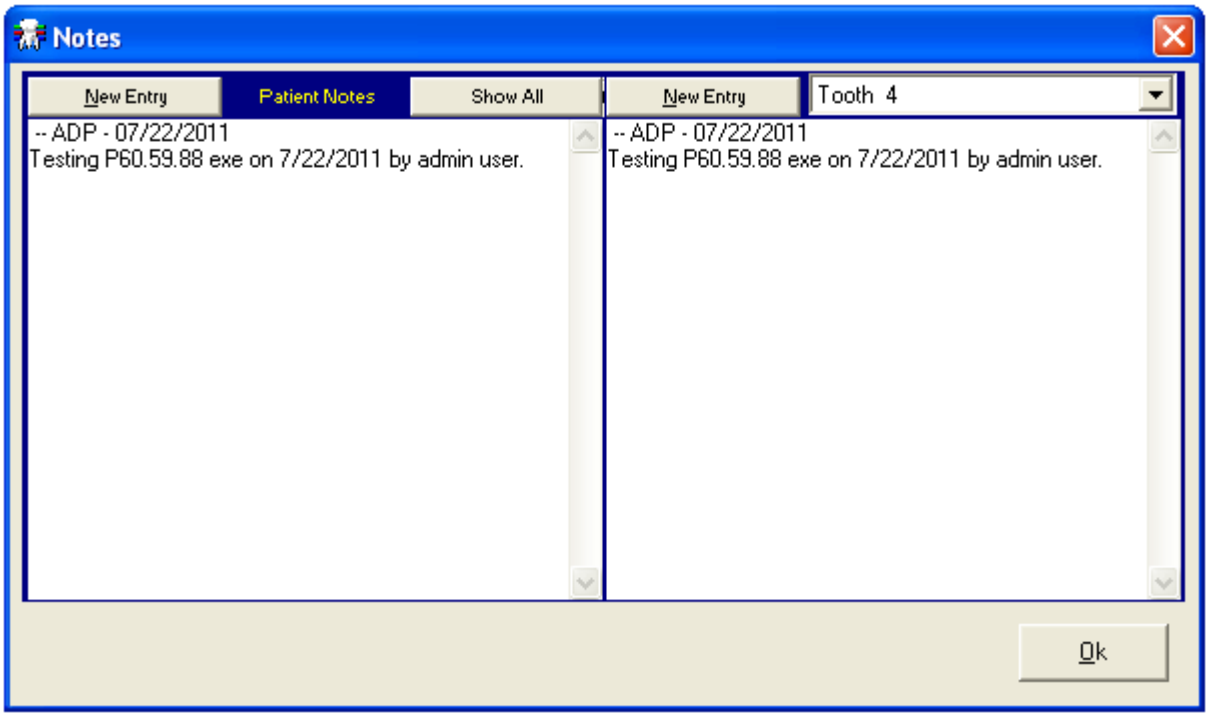
OHA (Oral Health Assessment) Button

Please see the OHA Button section in the Chart/Treatment-Treatment & Exam chapter of this manual.

Notes Button

Use the **Notes** icon button

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



Notes Screen

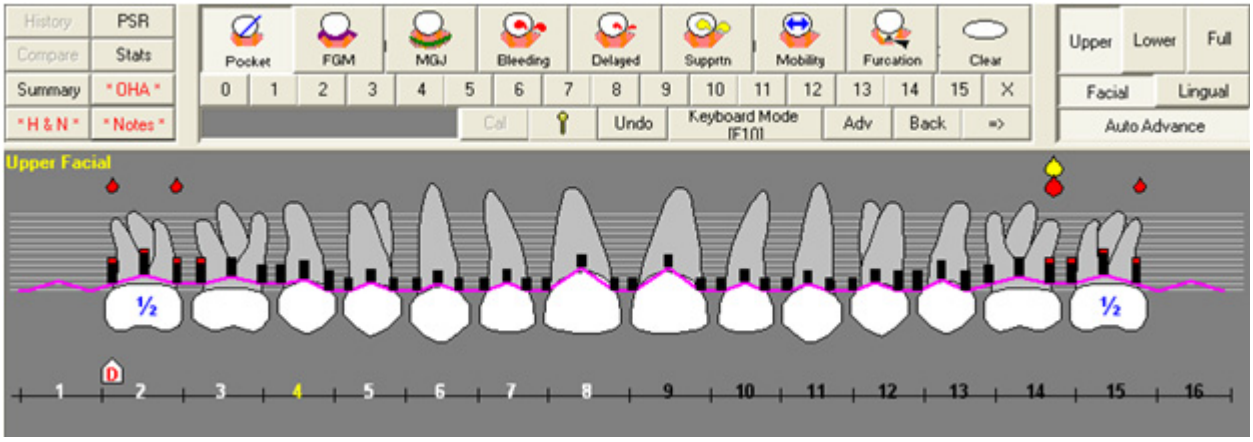
Choose between creating a more general note on the patient by using the tools on the left side of the screen, or a note about a specific tooth on the right side of the screen.

- 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 work in combination with the tooth/arch graphic.



Periodontal Icons and Periodontal Graphical Chart

To enter periodontal information:

1. Click on 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 appears 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 is allowed to be completed in a Progress Note per day, per patient. When a second exam is completed during the same day, the Periodontal Chart history only saves the second exam. Progress Notes in VistA TIU still have all the data entered.

Other Tools

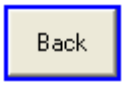
The last line of buttons in the top center of the screen features several tools.

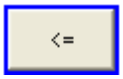
Displays keyboard shortcuts.

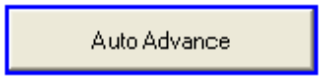
Undoes the last action performed on the screen. This action is limited to the last nine actions performed.

Switches the program to Keyboard mode.

Moves the cursor shield on the graphic forward due to the direction of the arrow.

 Moves the cursor shield on the graphic back due to the direction of the arrow.

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

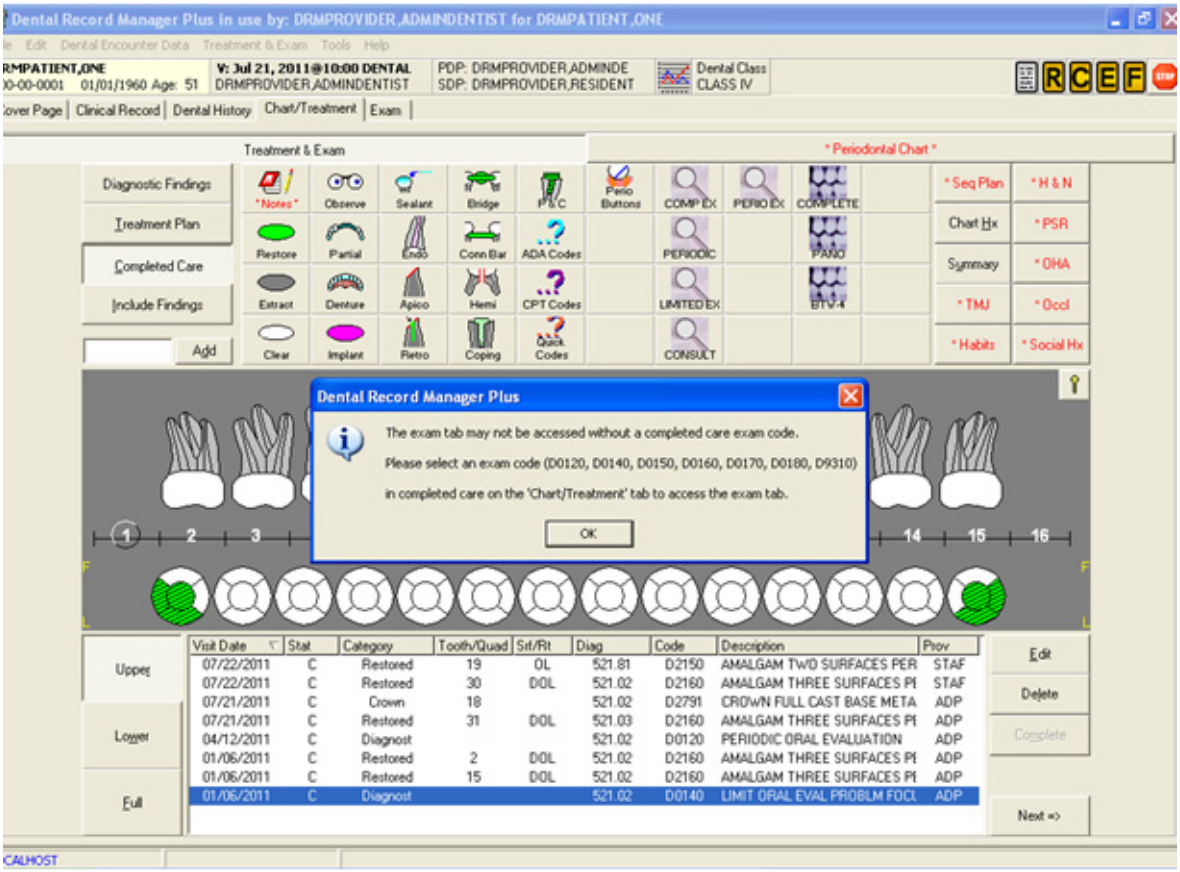
 When this button is active, the cursor shield automatically moves in the way designated for the perio exam entry of the condition-specific icons. It does not allow Bleeding, Delayed Bleeding, or Suppuration, to automatically move.

The auto exam sequence is a parameter adjustment that may be redesigned by each provider. For more information, 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 using the new 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 new Exam tab interfaces automatically with existing DRM Plus components (i.e. Head & Neck) for easy data entry. The Exam tab, when activated, generates a 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 into the Exam tab, the user is prompted select one of the six exam or consult procedure codes from the Chart/Treatment tab's Completed Care screen.



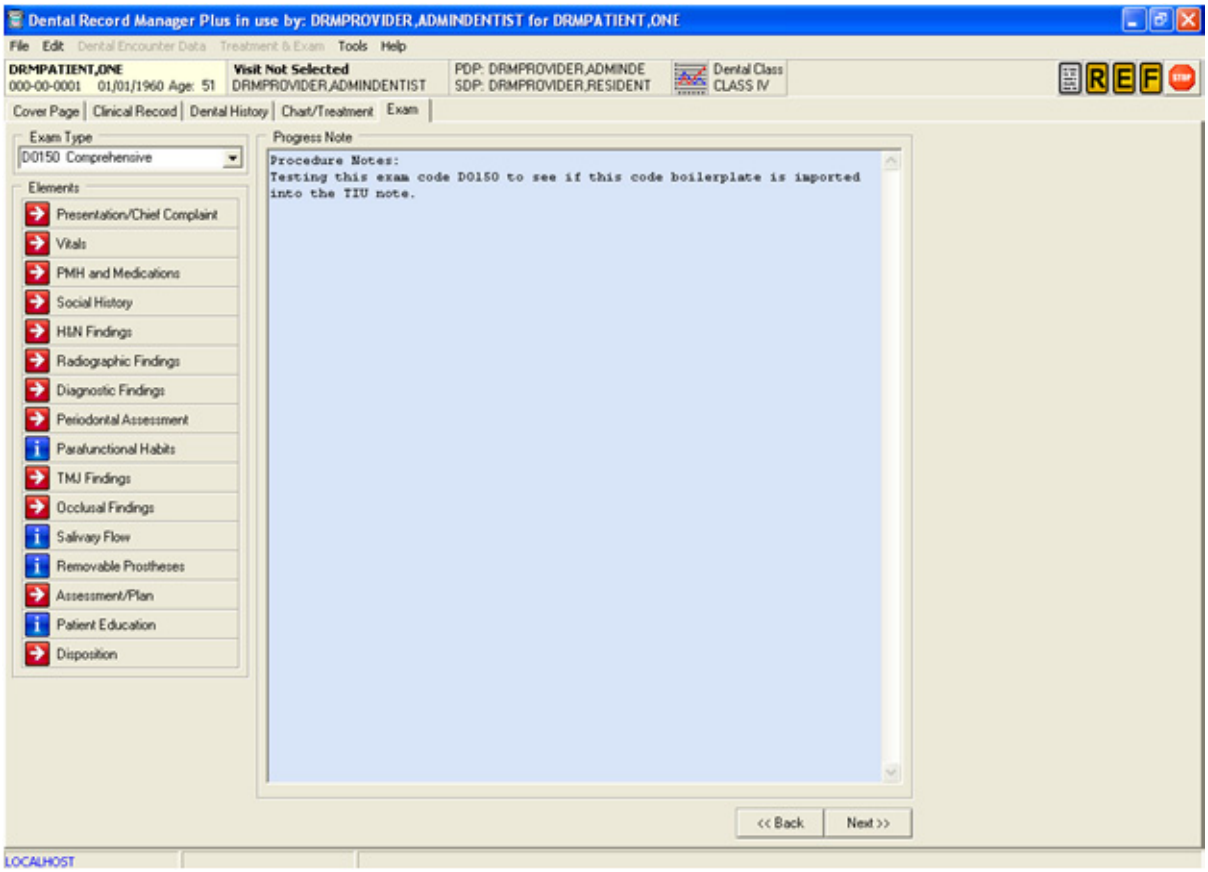
Exam Message

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 deleting the procedure from the Completed Care view screen and entering a new one.

Selecting the exam/consult code from the Completed Care view 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 view 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.



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.

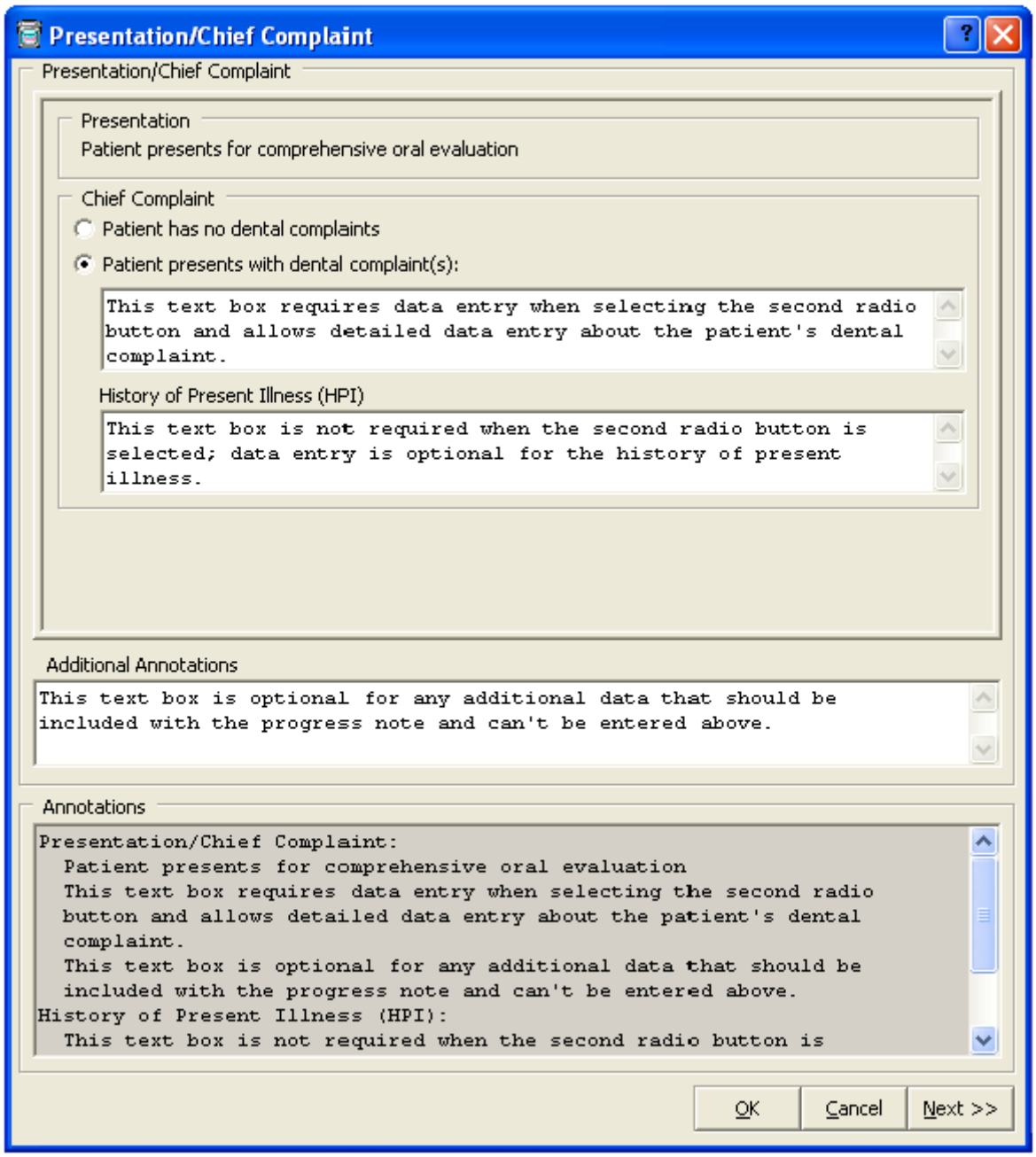
The **Next** button located on the Exam tab allows the end-user to proceed to the Filing Options screen, which is the next screen when completing the encounter. This **Next** button also opens any required element if that element hasn't been completed.

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 end-user has 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 automatically opens 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 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 patient's present illness.



Chief Complaint

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

The 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 of import .txt files if desired.

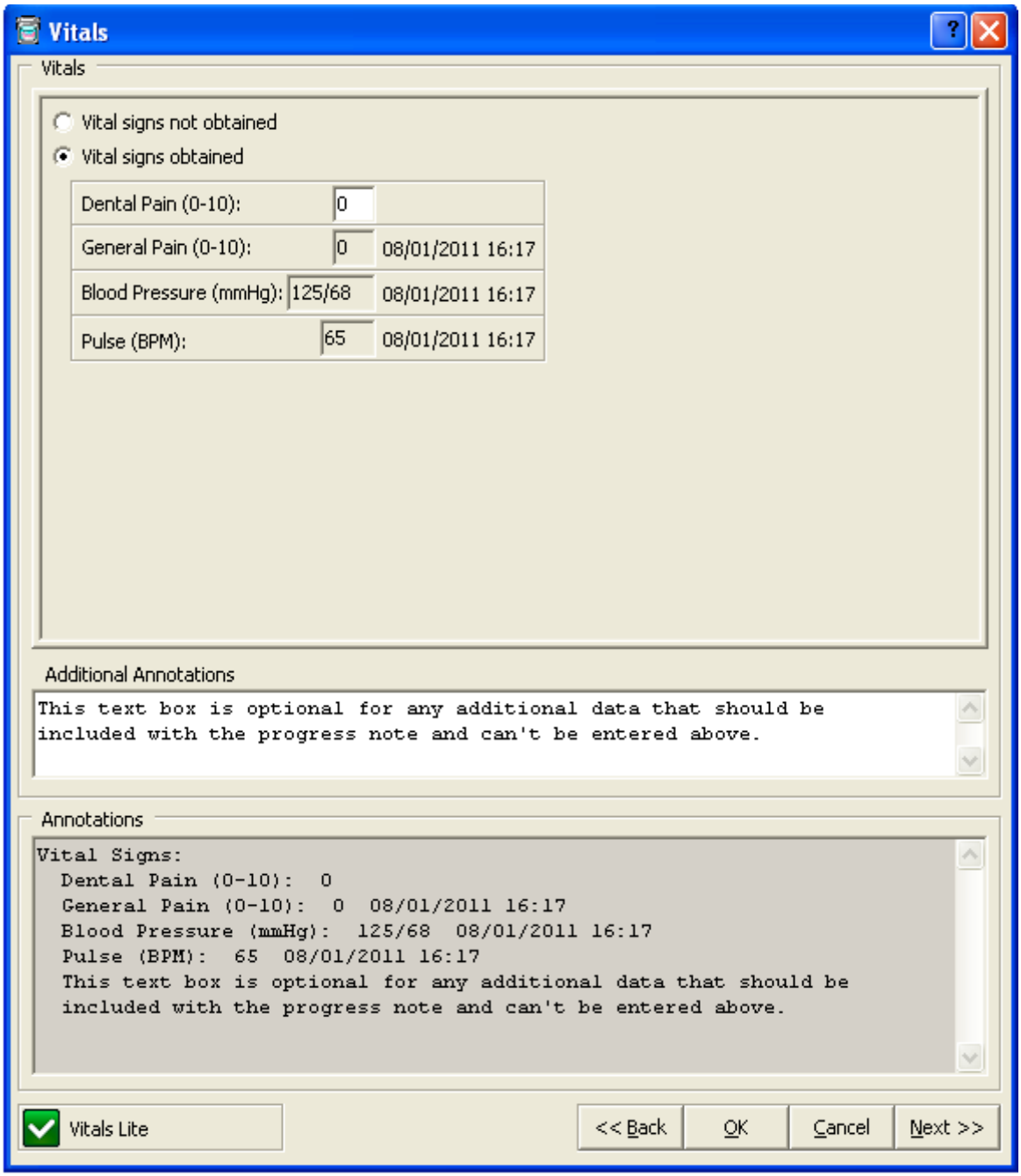
The Annotations is view-only, and captures everything entered into this element.

Select the **OK** button to save all required information entered and close the element or to move to the next required element, depending on the selected parameter, click the **Next** button.

The **Back** button moves to the previous required element, depending on the selected parameter, and is not dependent on the element's completion.

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** 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.



Vitals Element

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 today's vitals, click the Vitals Lite button, found on the DRM Plus banner. The user can also click the **Vitals Lite** button in the lower left portion of the Vitals element screen.

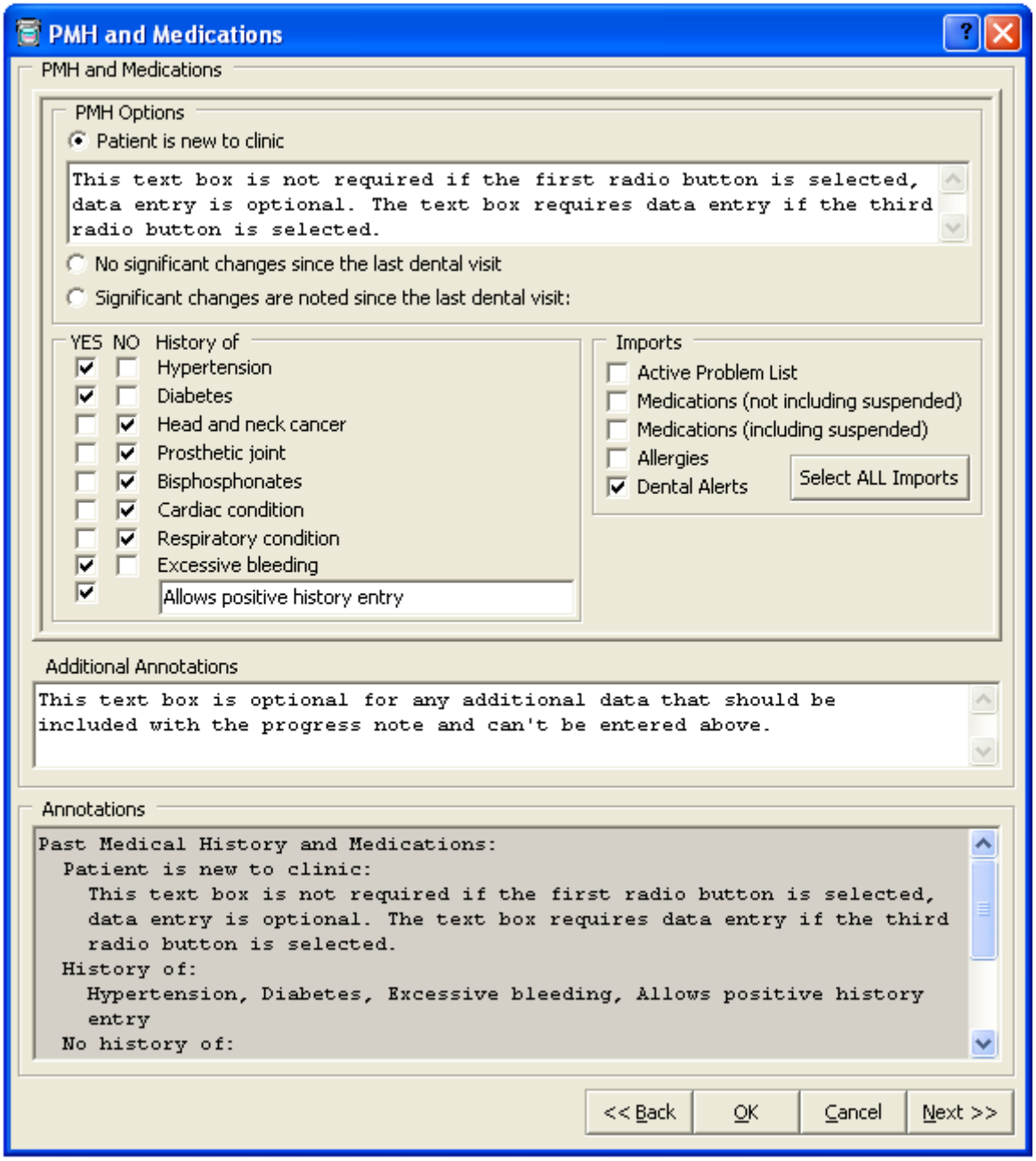
Specific vitals information can be entered into the Additional Annotations free text window. Right-click in this window to import text files, if desired. All information entered into the Vitals element appear in the read-only Annotations window. Once the element is complete, click the **Next** button 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 is being stored in a VistA Fileman database.



PMH Element

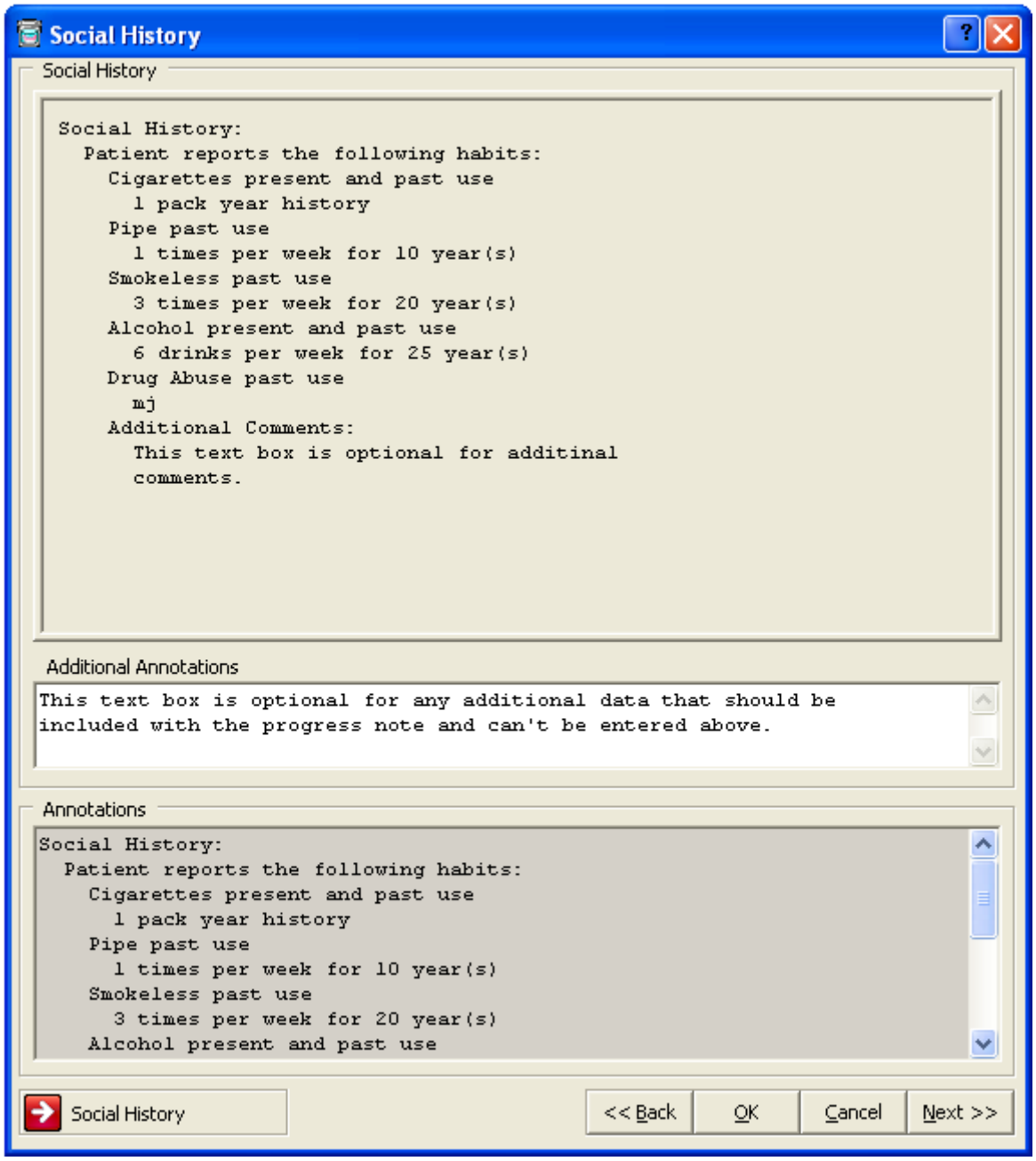
The Additional Annotations is a free text window, which allows the provider to enter additional information about the patient's chief complaint. It offers right-click functionality of import .txt files if desired. The Annotations is a view-only, and captures everything entered into this element.

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 maybe 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 minimal requirement to enter a new Social History entry is to select at least one historical finding from the Social History screen.

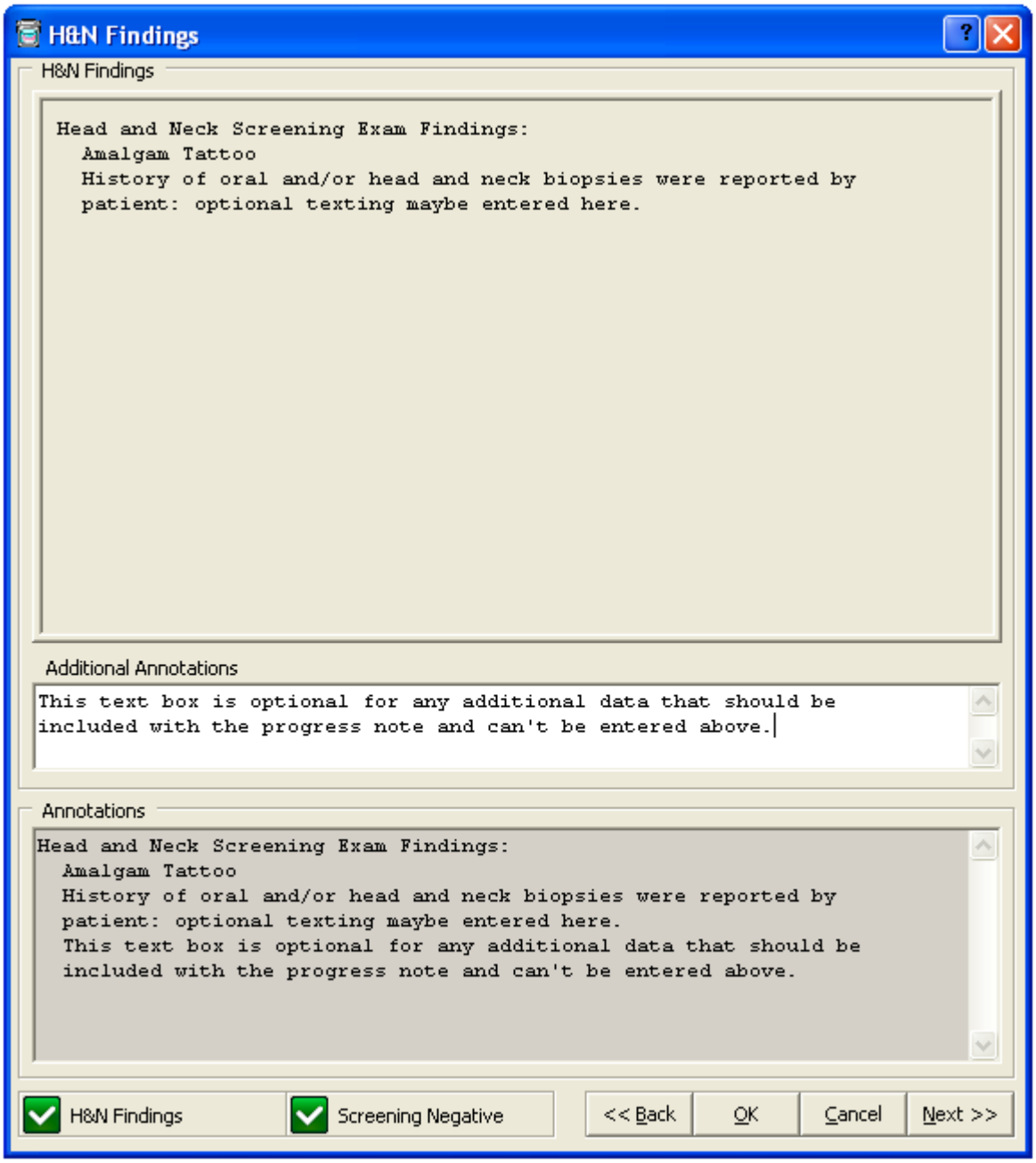


Social History Element

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 appears 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.



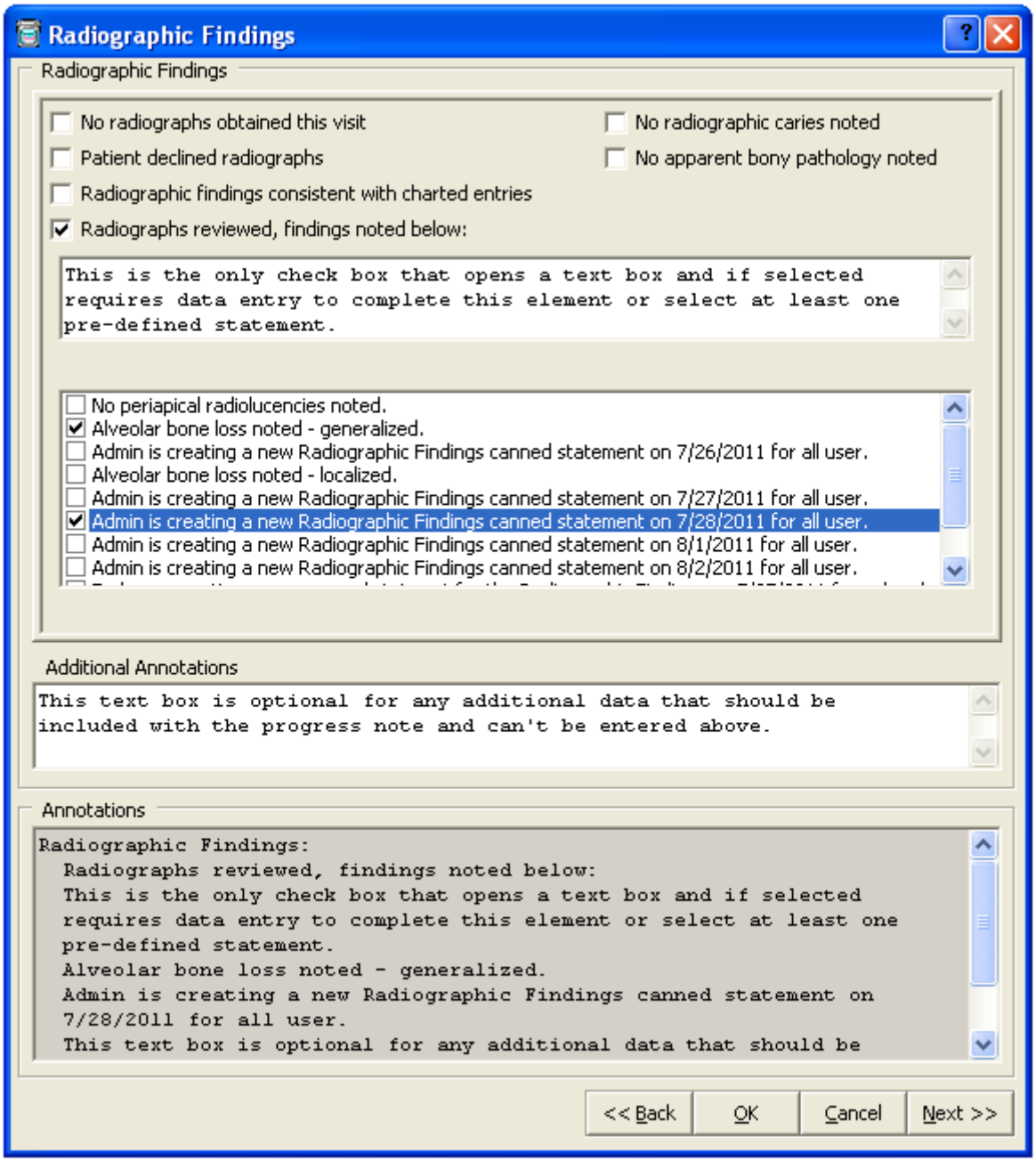
H&N Findings Element

The H&N Findings screen can be accessed either by clicking the specialty button from the Chart/Treatment tab, or simply 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 in this window to import text files, if desired. All information entered into this element appears in 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 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.



Radiographic Findings Element

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.

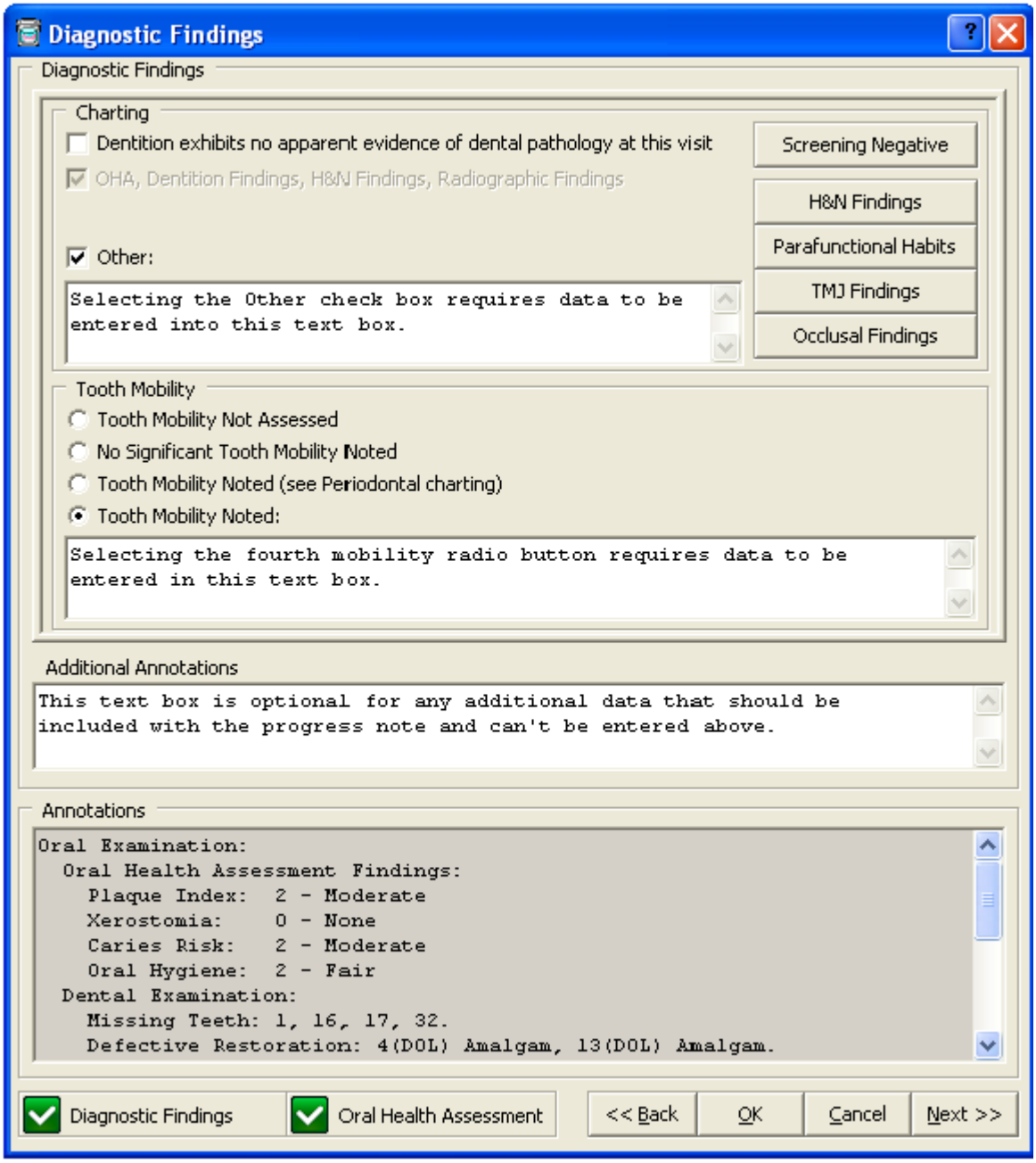
Additional information regarding the patient can be added in the Additional Annotations free text window. The user can right-click to import a text file, if desired. All information entered into this element appears in the Annotations read-only window. Once the element is complete, click the **Next** 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 another Chart/Treatment findings screen that satisfies this option. Informational screens inform 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 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.



Diagnostic Findings Element

The user can enter any additional information regarding the patient into the Additional Annotations free text window. 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 the element is complete, click the **Next** button to move on to the next element.

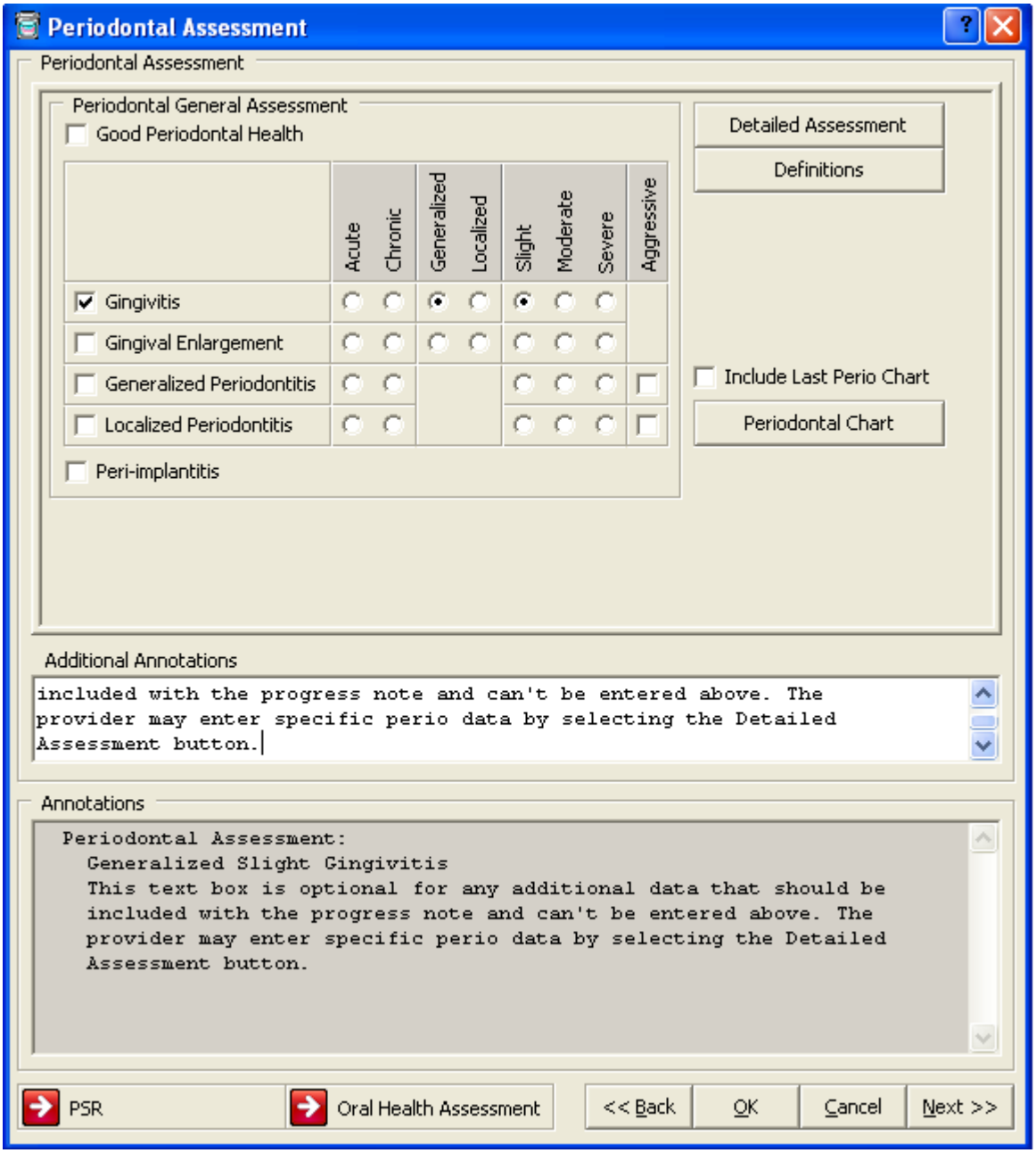
Periodontal Assessment Element

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 check box **Include Last Perio Chart** defaults as unchecked if the provider would like to import the last filed Periodontal Chart into this element. The check box **Include Last Perio Chart** 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 this session that data imports into this element and satisfies the same four exam/consult procedures as stated in the previous paragraph.

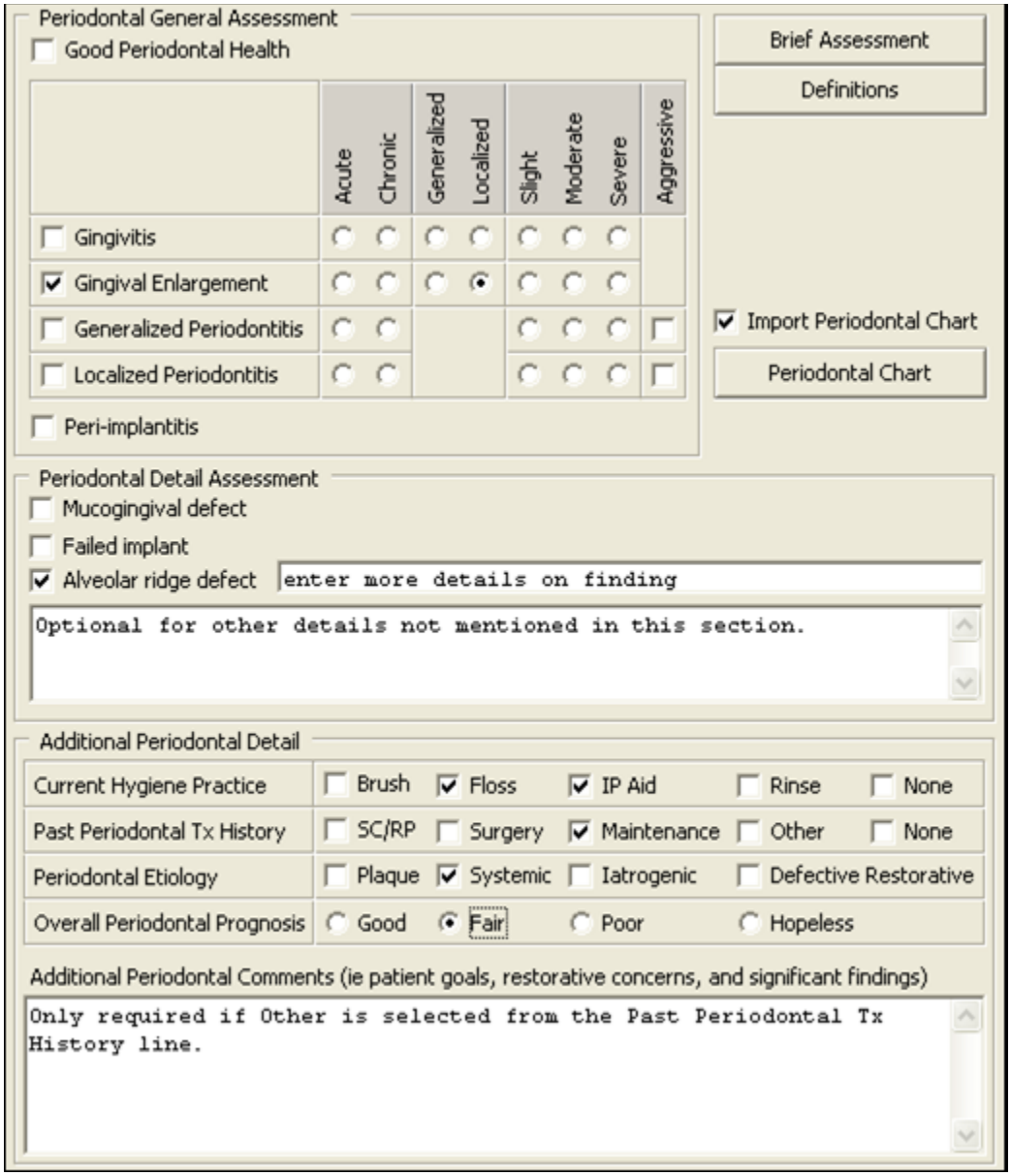
The NFT, no functional teeth, check box when selected in the OHA screen bypasses all requirements for the D0120, D0150 or D0180 exams in the periodontal element. The user may access the Periodontal Chart screen, OHA screen or PSR screen using the buttons found on this Periodontal Assessment element screen.



Periodontal Findings Element

The D0180 exam requires one selection from the Periodontal General Assessment section as well. The Periodontal Detail 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 Details to have at least one selection. The last Additional Periodontal Comments text box is optional in this section. When the Other check box is selected from the Past Periodontal Tx History row requires data entry in the Additional Periodontal Comments text box.



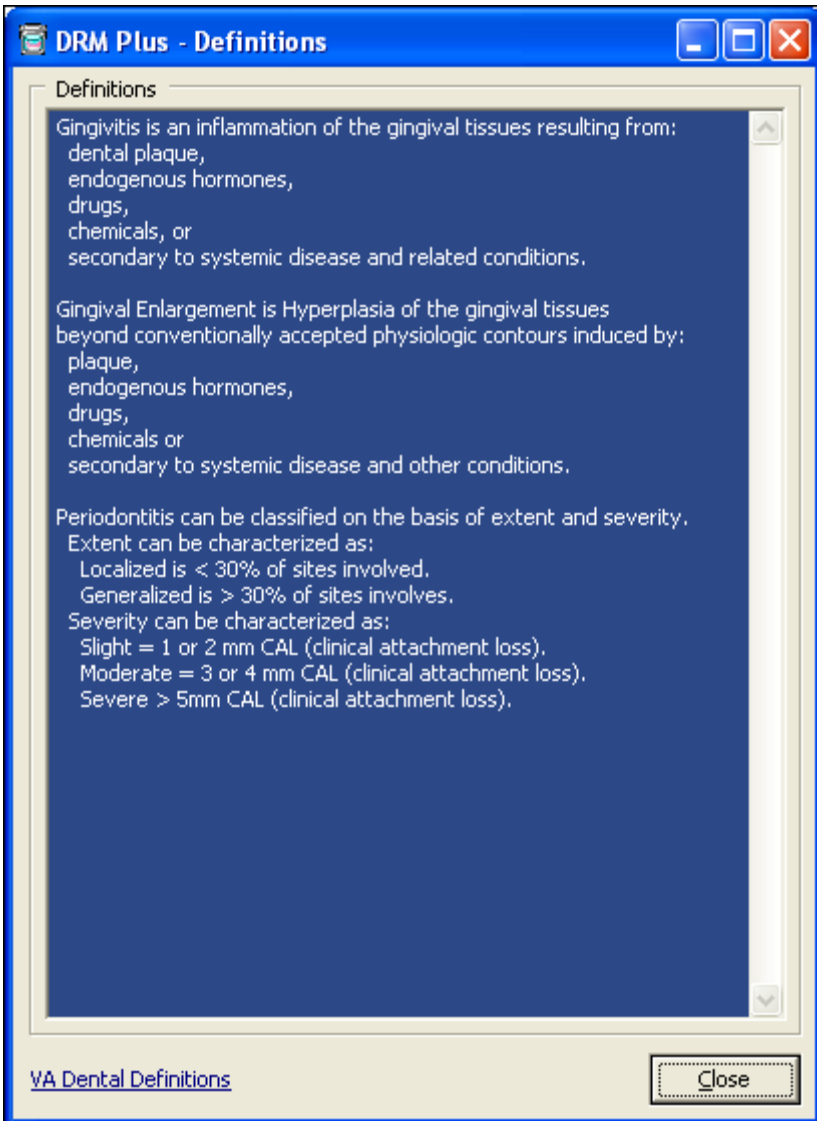
Periodontal General Assessment

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 this session.

The following dialog displays the VA Office of Dentistry perio definitions.

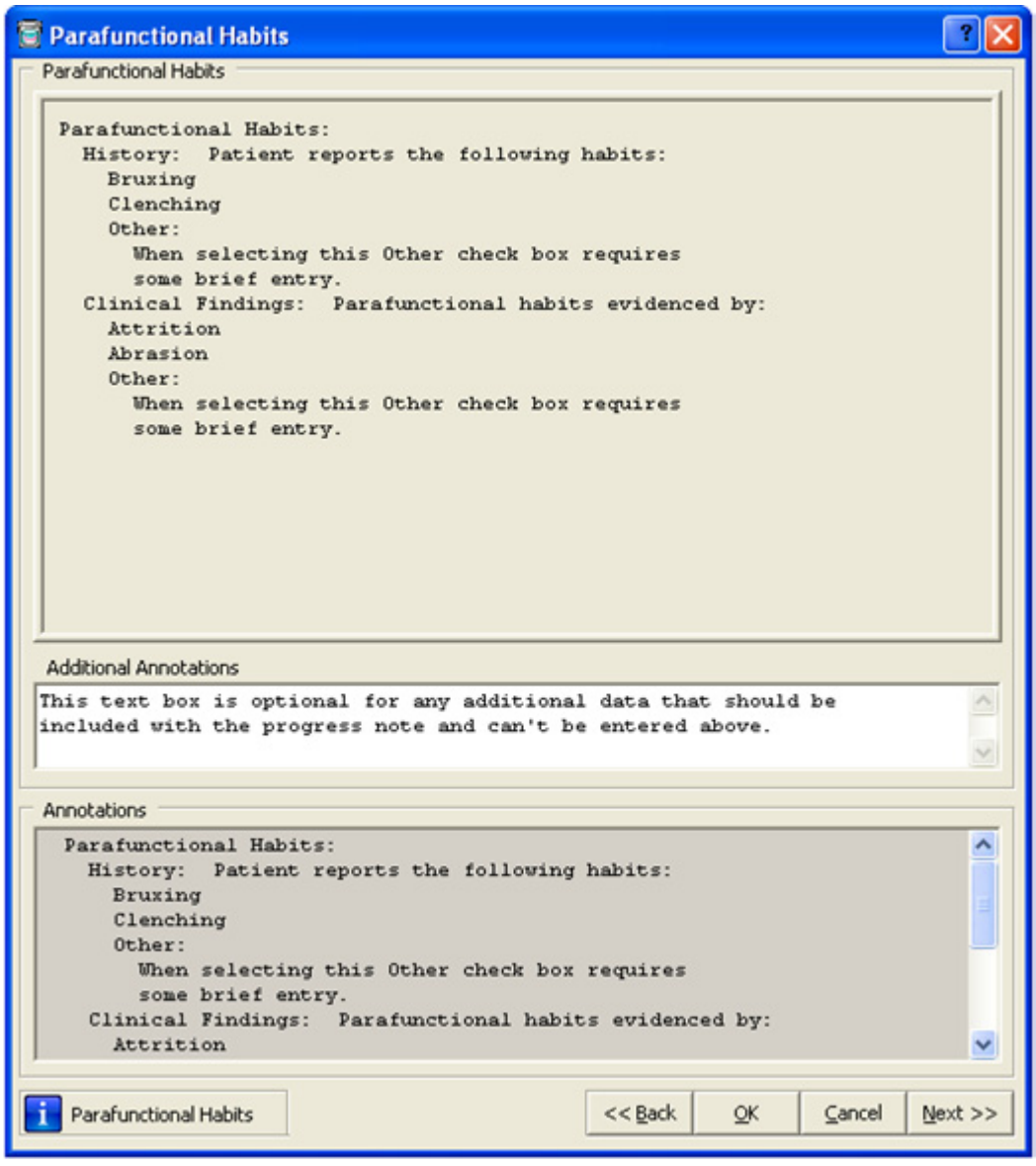


VA Dentistry Definitions

Parafunctional Habits Element

This element is optional for all seven exam/consult types. It imports all data entered this session from the Parafunctional Habits screen, or simply is left blank. The Parafunctional Habits screen can be opened by clicking the specialty button from the Chart/Treatment tab, or by clicking the **Parafunctional Habits** button in the bottom left portion of this element.

The minimal requirement to enter a new Parafunctional Habit finding is to select at least one history or one clinical finding from the Parafunctional Habits screen.



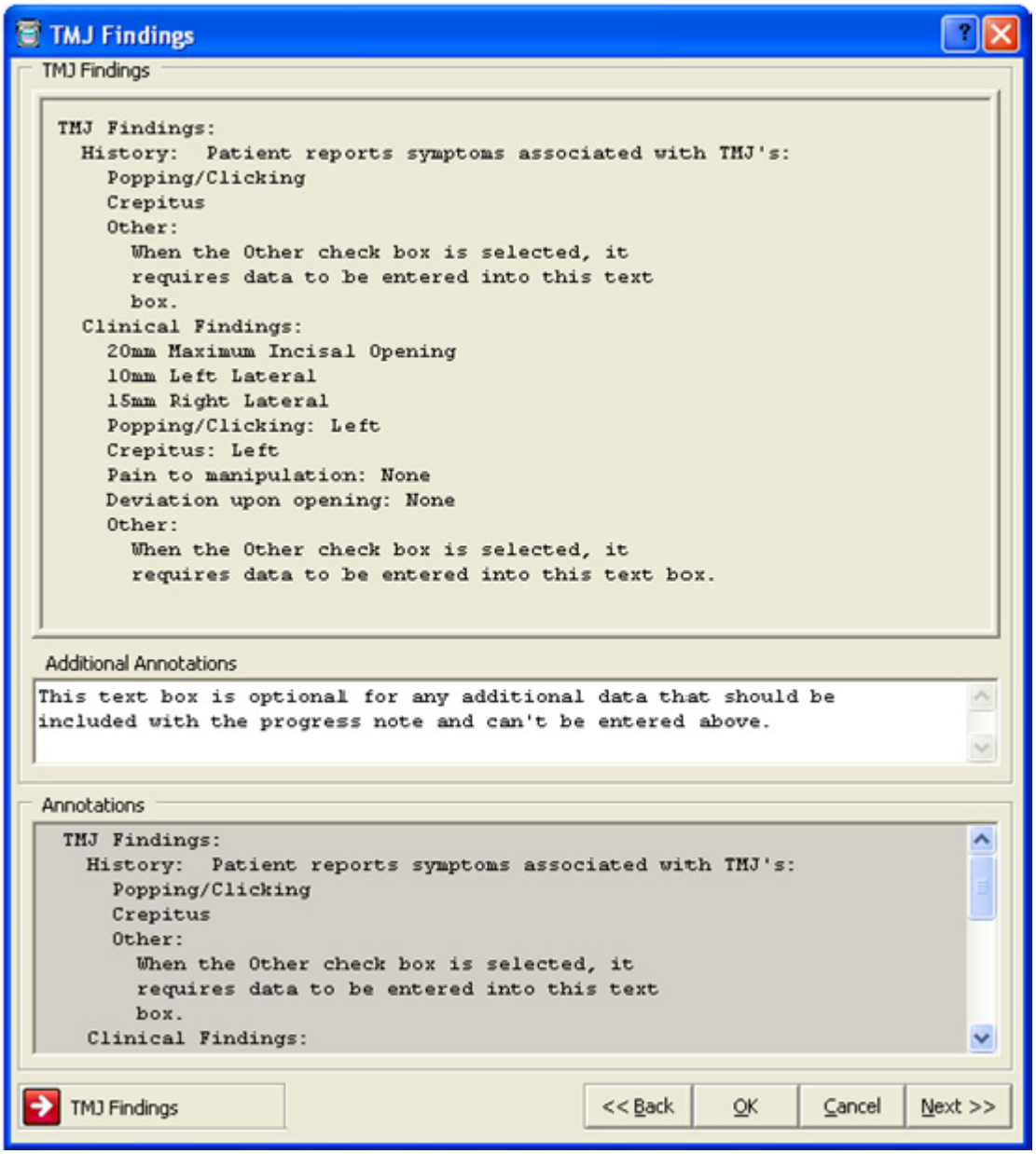
Parafunctional Habits Element

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 appears 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 specialty** 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.



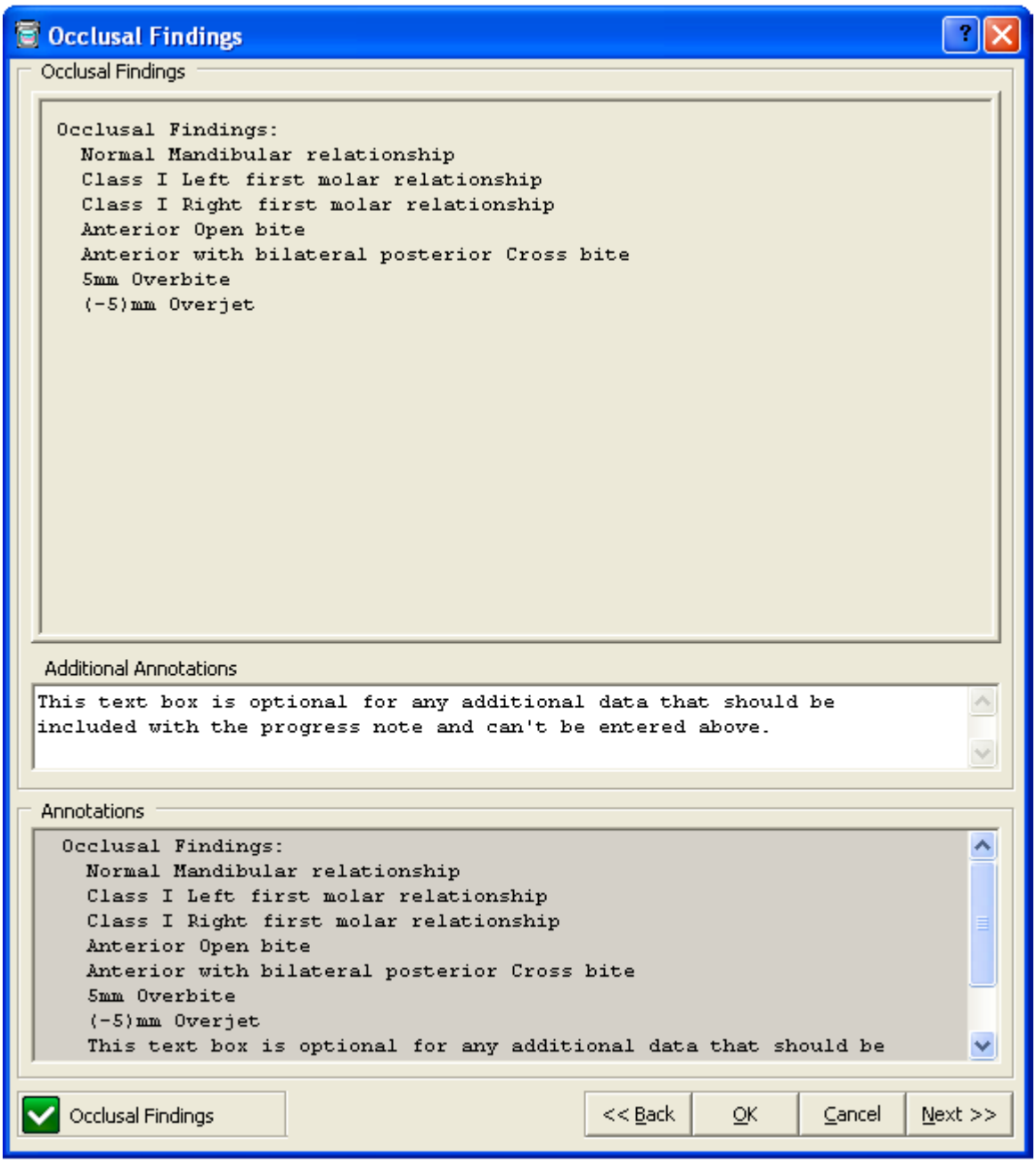
TMJ Findings Element

All information entered into this element appears in the read-only Annotation window. Once the element is complete, click the **Next** button to move on to the next element.

Occlusal Findings Element

This element is required for every D0150 and D0180 exam. 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** specialty 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 drop-down menu, click **Mandibular relationship**. This is the only required field. All data from the last filed Occlusion exam imports into the screen when a new exam is selected, which requires the provider to remove and/or add correct data.



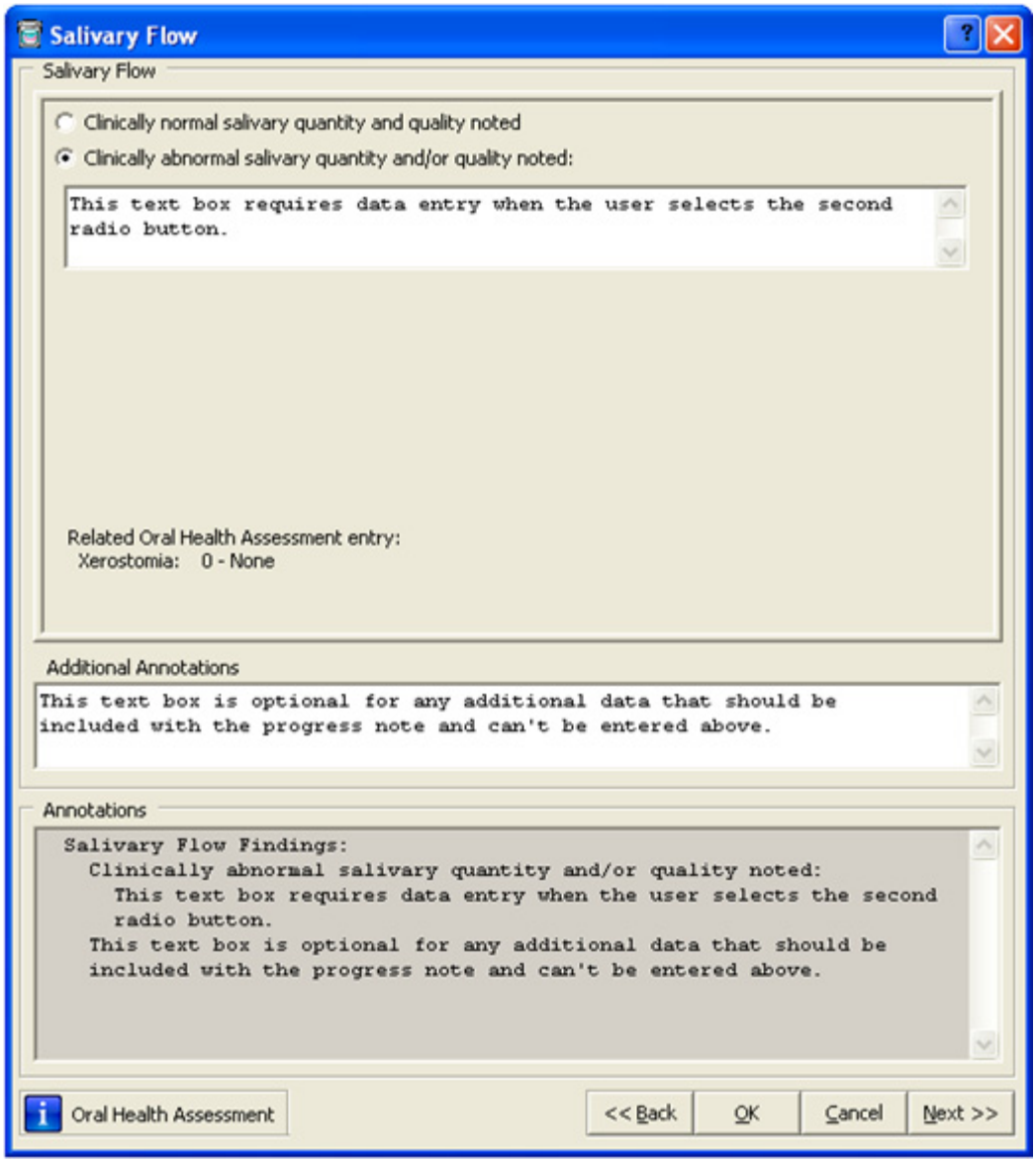
Occlusal Findings

The user can enter additional information regarding the patient into the Additional Annotations free-text window. This window appears 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 option requires a statement 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.



Salivary Flow

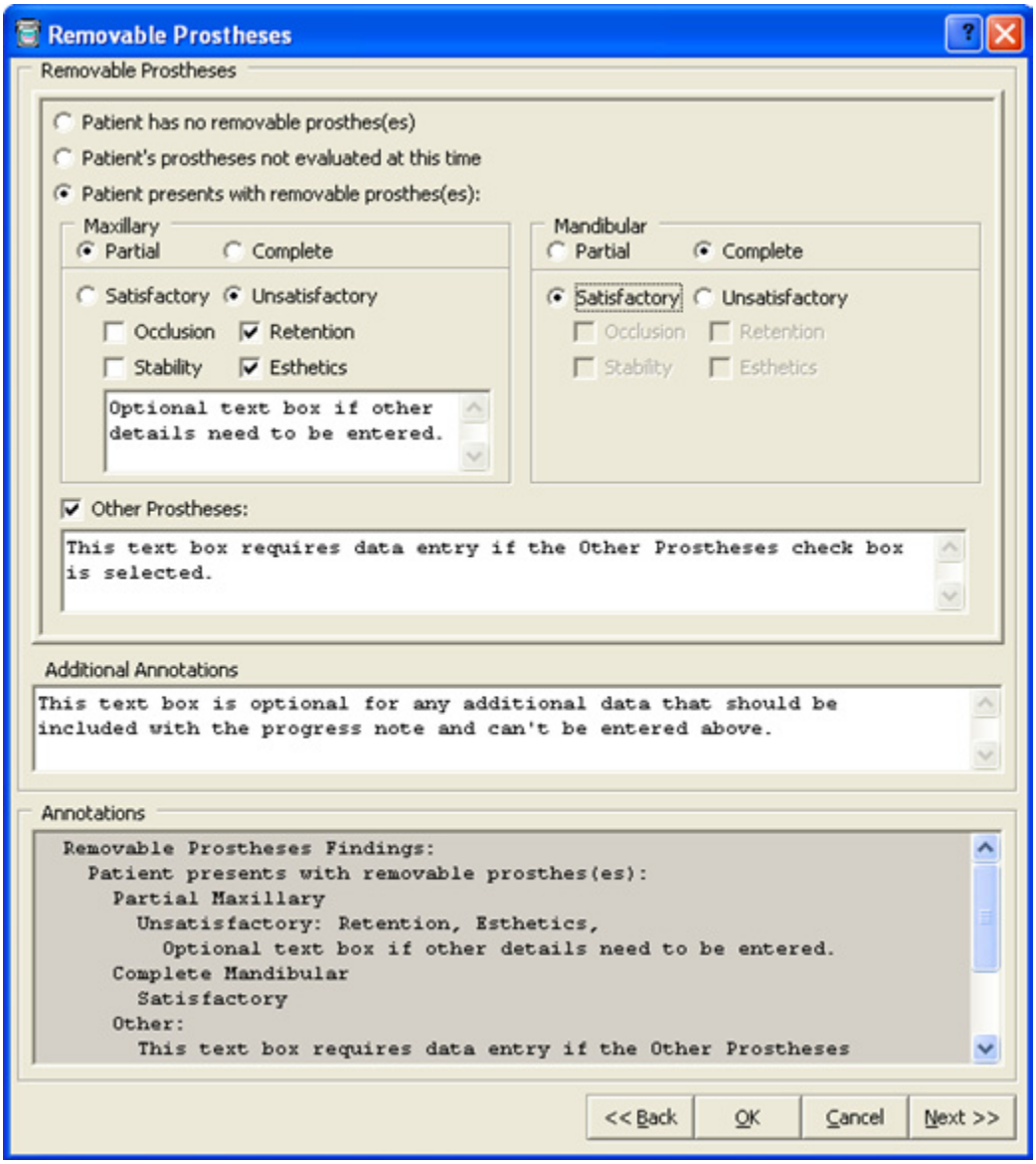
The user can enter additional information regarding the patient into the Additional Annotations free text window. This window offers right-click functionality to import text files, if desired. All information entered into the element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Removable Prostheses Element

This 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, **Patient presents with removable prosthes(es):** button, the user must then select must select one of either the Maxillary or Mandibular radio buttons: **Partial** and **Complete**. Only one is required and, once selected, opens two more radio buttons: **Satisfactory** and **Unsatisfactory**.

If the user selects **Unsatisfactory**, four checkboxes (Occlusion, Retention, Stability, Esthetics) and a text box become active. The user should check any box pertaining to the patient, and note any additional prostheses in the text box.

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



Removable Prostheses

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 appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

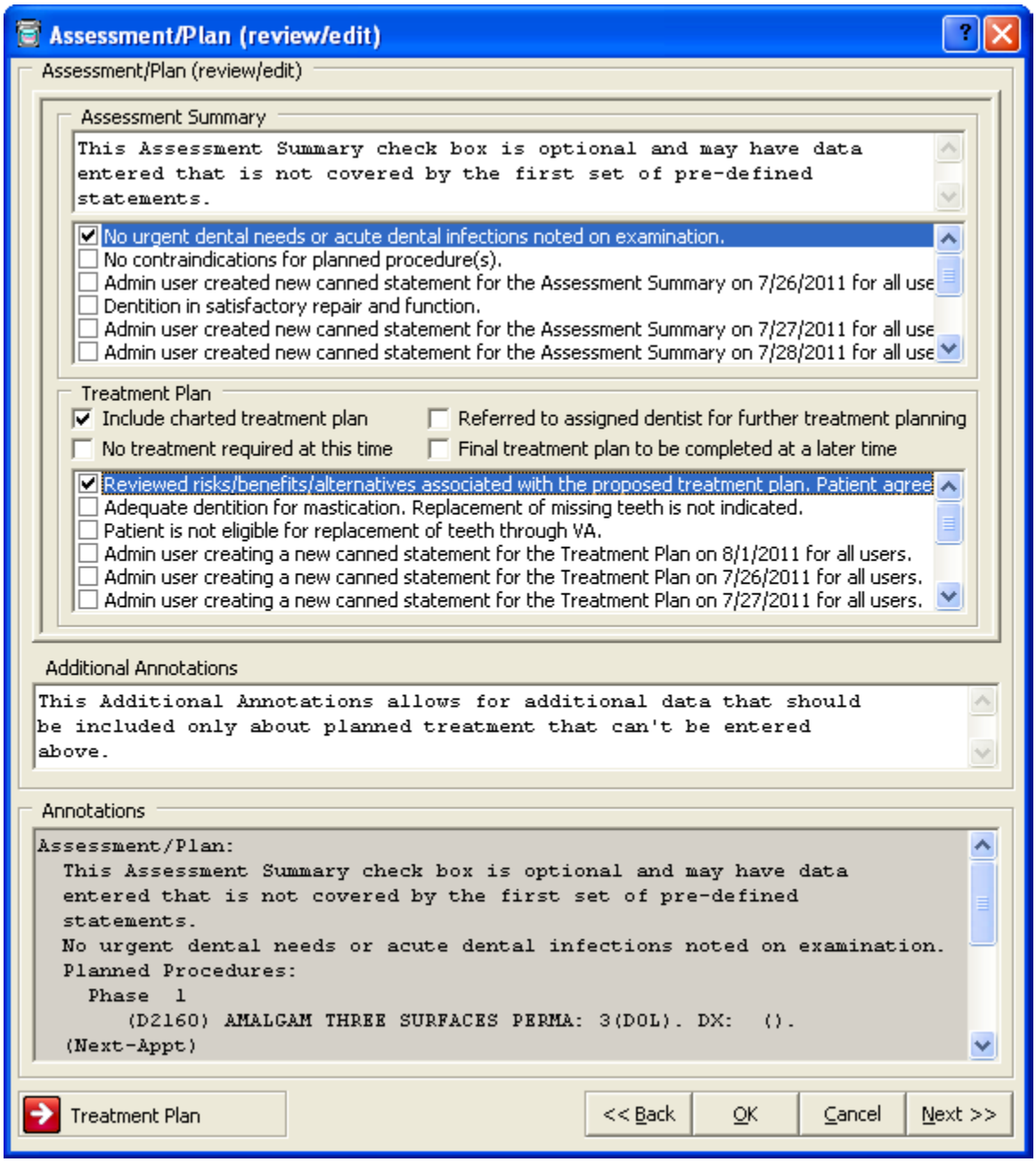
Assessment/Plan Element

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 checkboxes 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.



Assessment Summary Element

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.

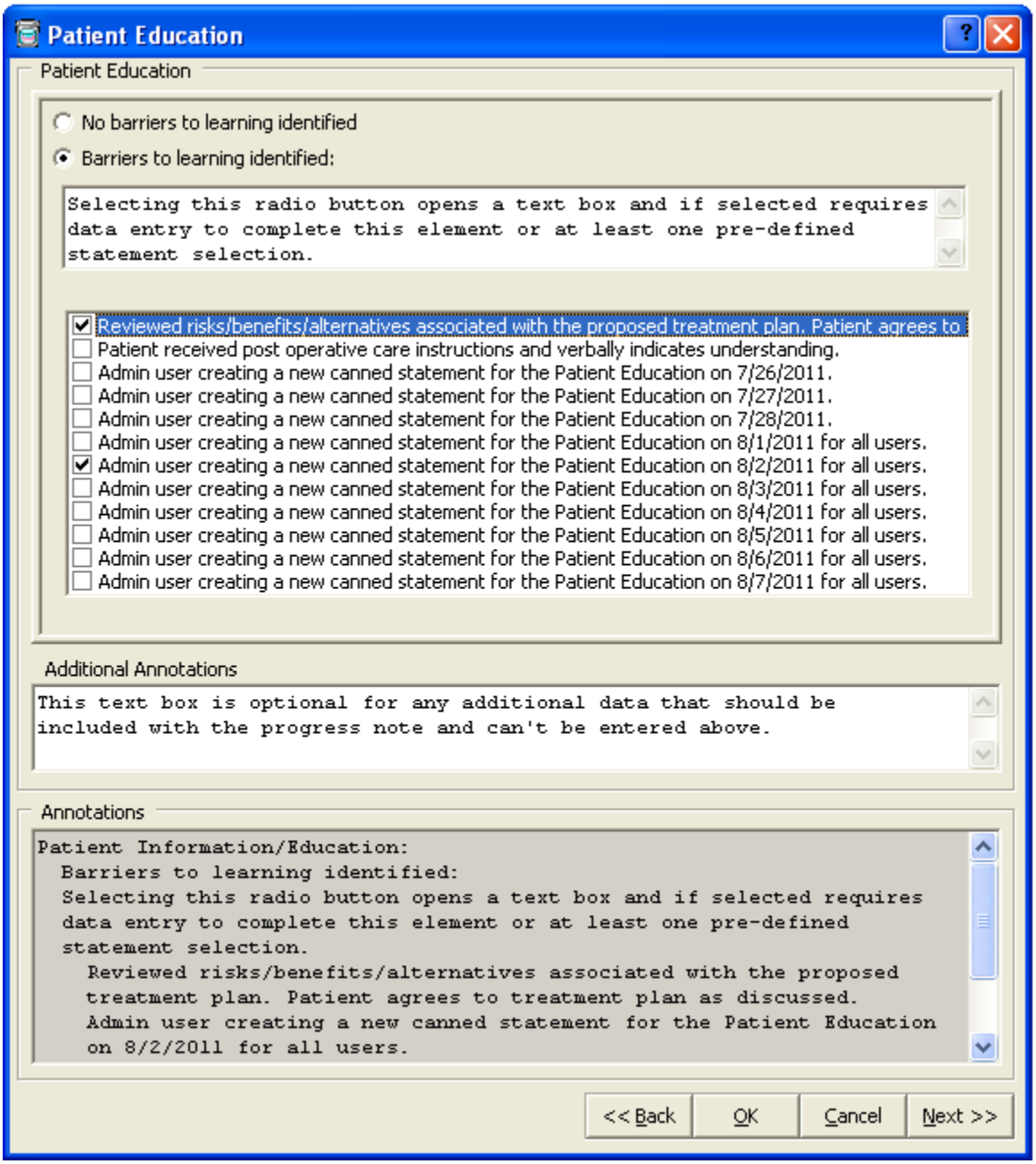
The element imports incomplete when saved as unfiled data and then reloads. The provider is required to review/edit this element again at this time.

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 checkboxes 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.



Patient Education

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.

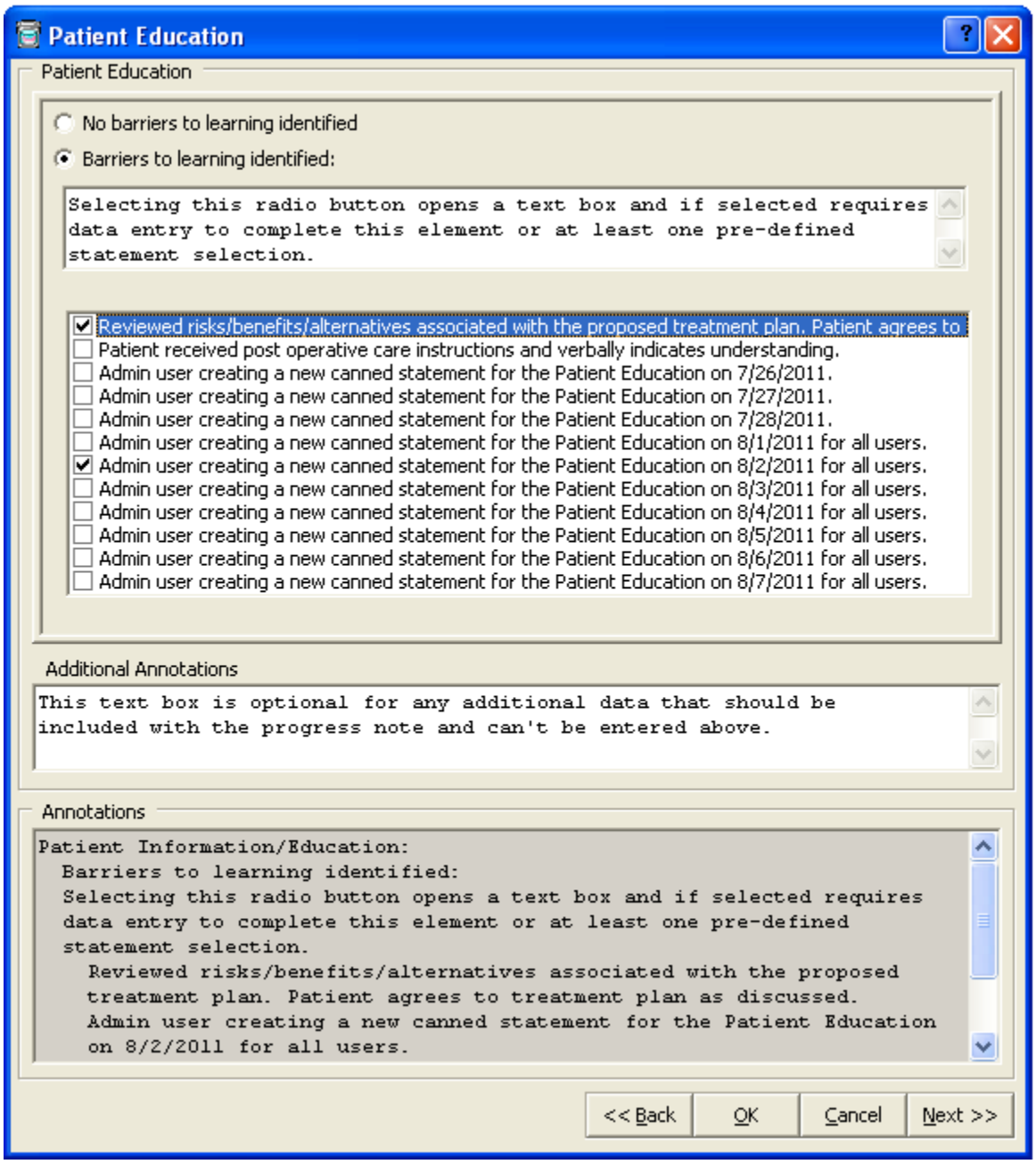
Disposition Element

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 requires at least one of the following: one selection of the eight data 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 box, if selected in the Sequencing screen, imports automatically into the Annotations view window of this element.

Up to twelve pre-defined statements on disposition can be selected from this screen. The checkboxes 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.



Disposition

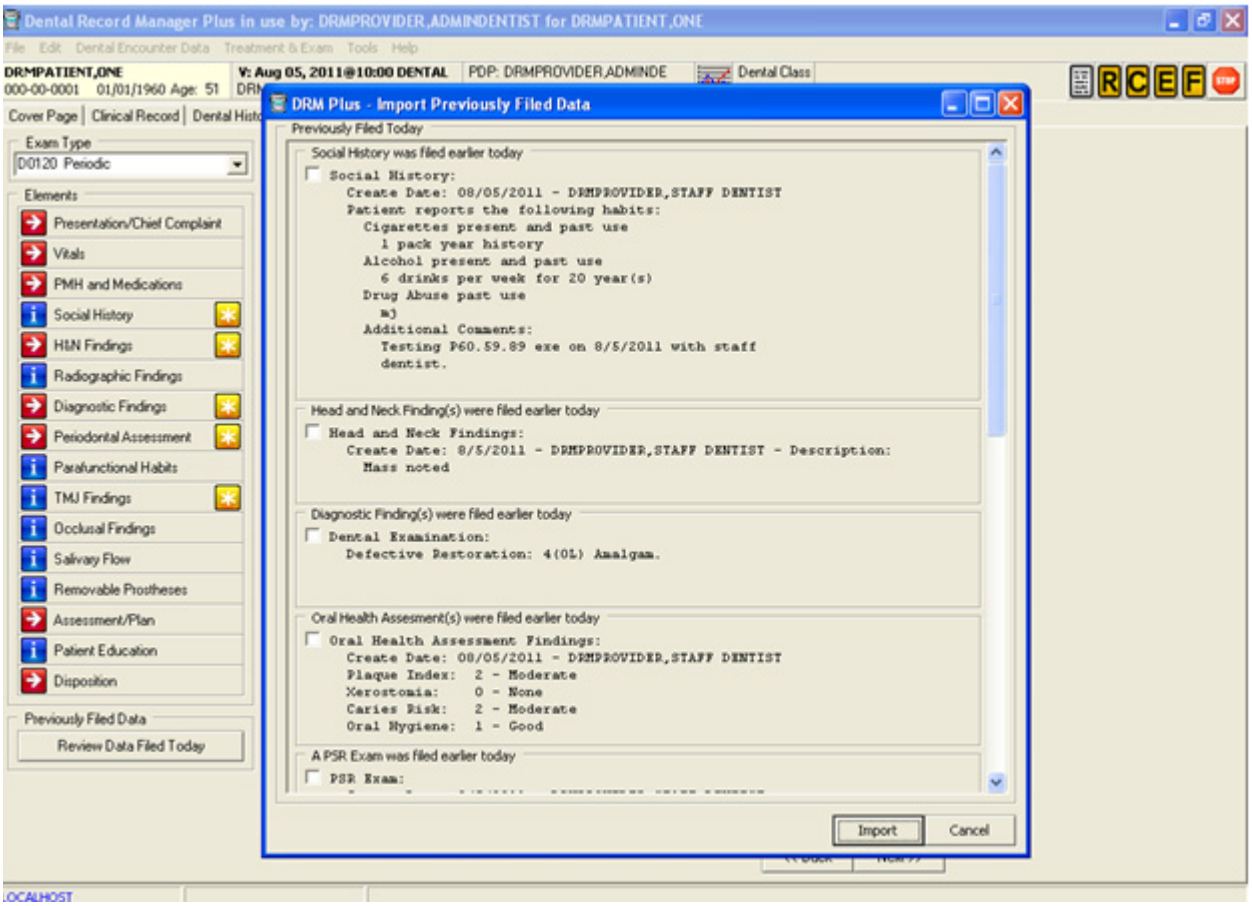
The user may enter additional information regarding the patient into the Additional Annotations free text window. This window offers right-click functionality to import text files, if desired. All information entered into this element appears in the read-only Annotations window. Once the element is complete, click the **Next** button to move on to the next element.

Usage of the **Back** button is not dependent on the element's completion.

New Import Previously Filed Data Screen

When any provider has filed patient dental data previously today in any of the following screens: Social History, OHA, TMJ, Parafunctional Habits, Occlusion, Diagnostic Findings, Head and Neck Findings, PSR Exam or Periodontal Chart, then that data may be imported by a second provider entering an exam today as well. 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 this 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 today 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 today's filed data to be imported into this new TIU note. After selecting the desired check boxes the provider selects the **Import** button to incorporate this data into the current exam template. When none of the data should be imported into the current exam template, then select the **Cancel** button.



Import Previously Filed Data

The icon on the right of the element button displays when there was previously filed data today and that data is associated with the element. The Diagnostic Findings element informs the provider when the icon is displayed and there may have been one or any combination of diagnostic findings, OHA or PSR filed earlier today by another provider.

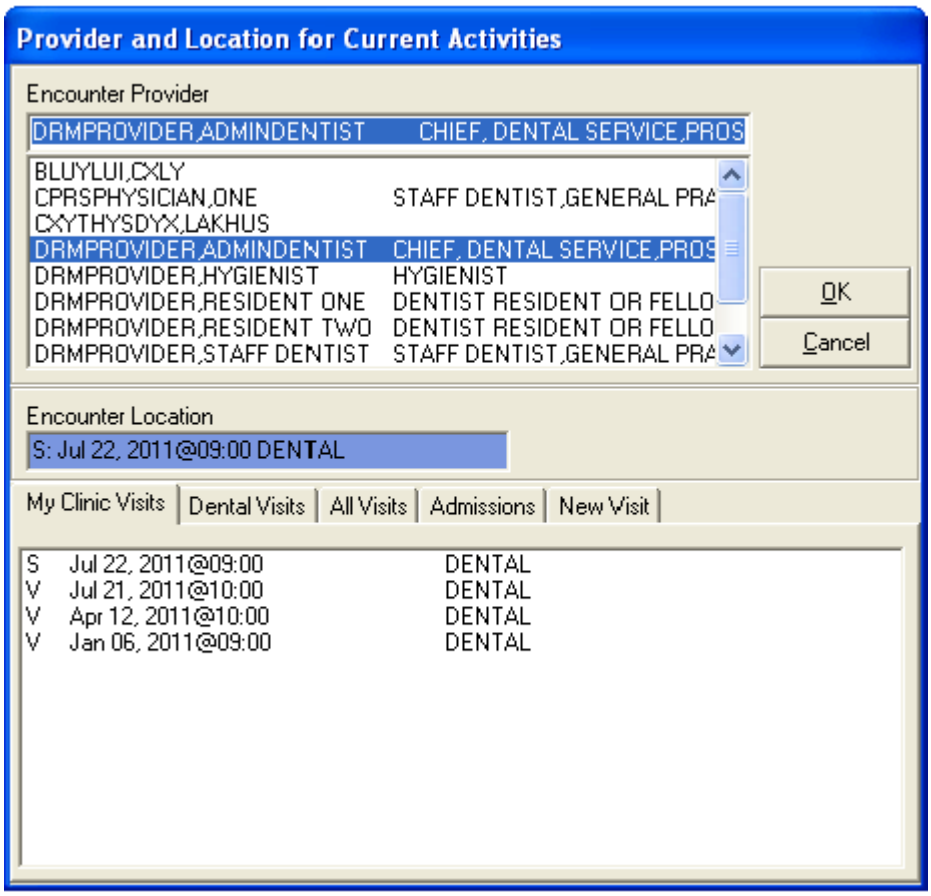
Below the element icons located on the left side of the Exam tab is a new Review Data Filed Today button. This button only displays when data was filed to TIU earlier today by any provider for this patient. This button allows the provider to open the Import Previously Filed Data screen to make edits or corrections after the provider has reevaluated what was filed previously today.

Completing the Encounter

To begin completing the encounter with the patient, click the **Next** button, located in the bottom right corner of both the Periodontal Chart and Treatment & Exam screens. If the provider/visit/date was not selected from the banner when the patient's chart was opened, then after clicking the **Next** button produces the Provider and Location for Current Activities screen. However, if no procedure code has been entered in completed care for the patient, the File Data Options screen displays, which is explained later in this chapter. In addition, if the system sees possible duplicate procedure codes, the Potential Duplicate Transaction screen displays.

To complete the patient encounter:

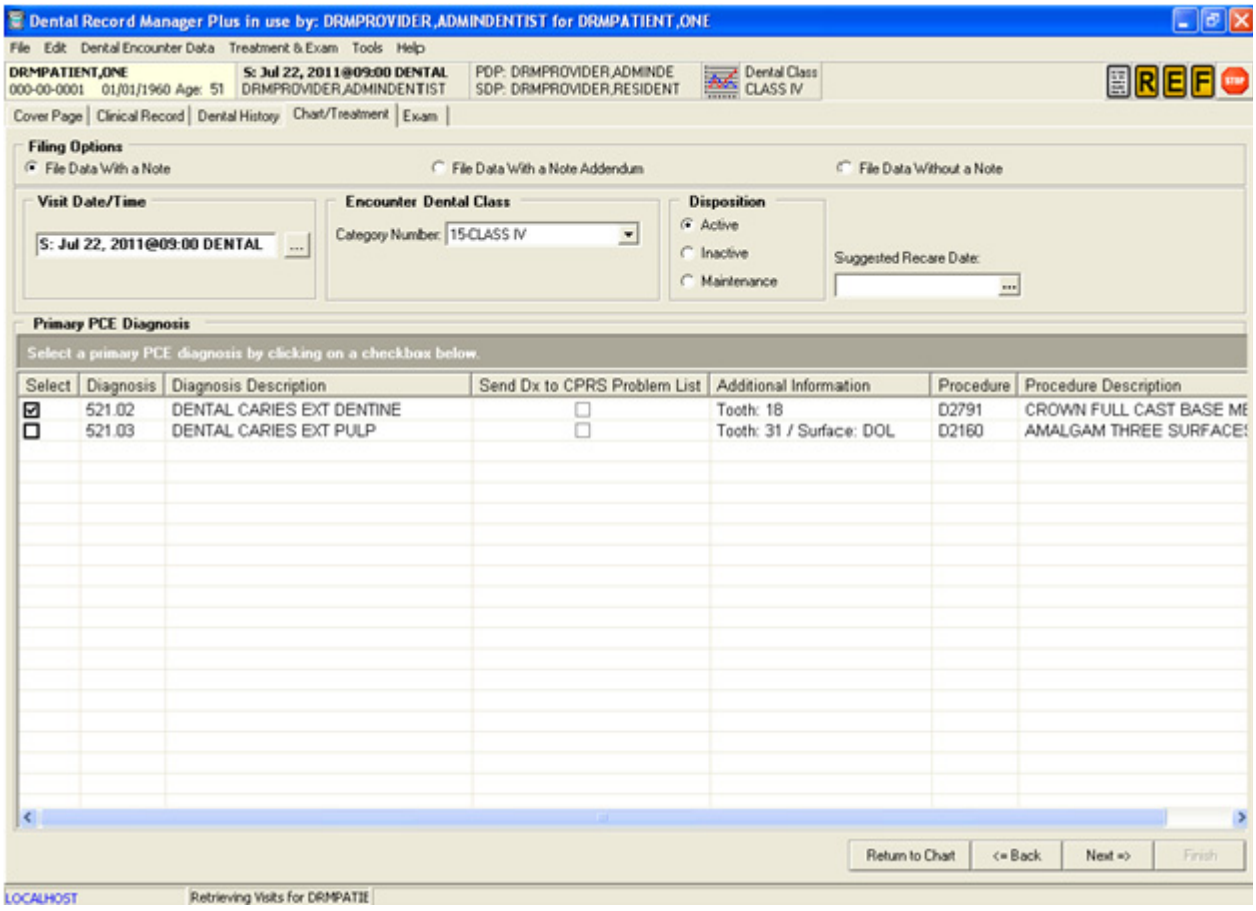
1. Click the **Next** button on the bottom right corner of either the Treatment & Exam or Periodontal Chart screens.
2. The Provider and Location for Current Activities screen displays. For further information, see the Dental Encounter Data section in the Using the DRM Plus Drop-Down Menus chapter of this manual.



Provider and Location for Current Activities Screen

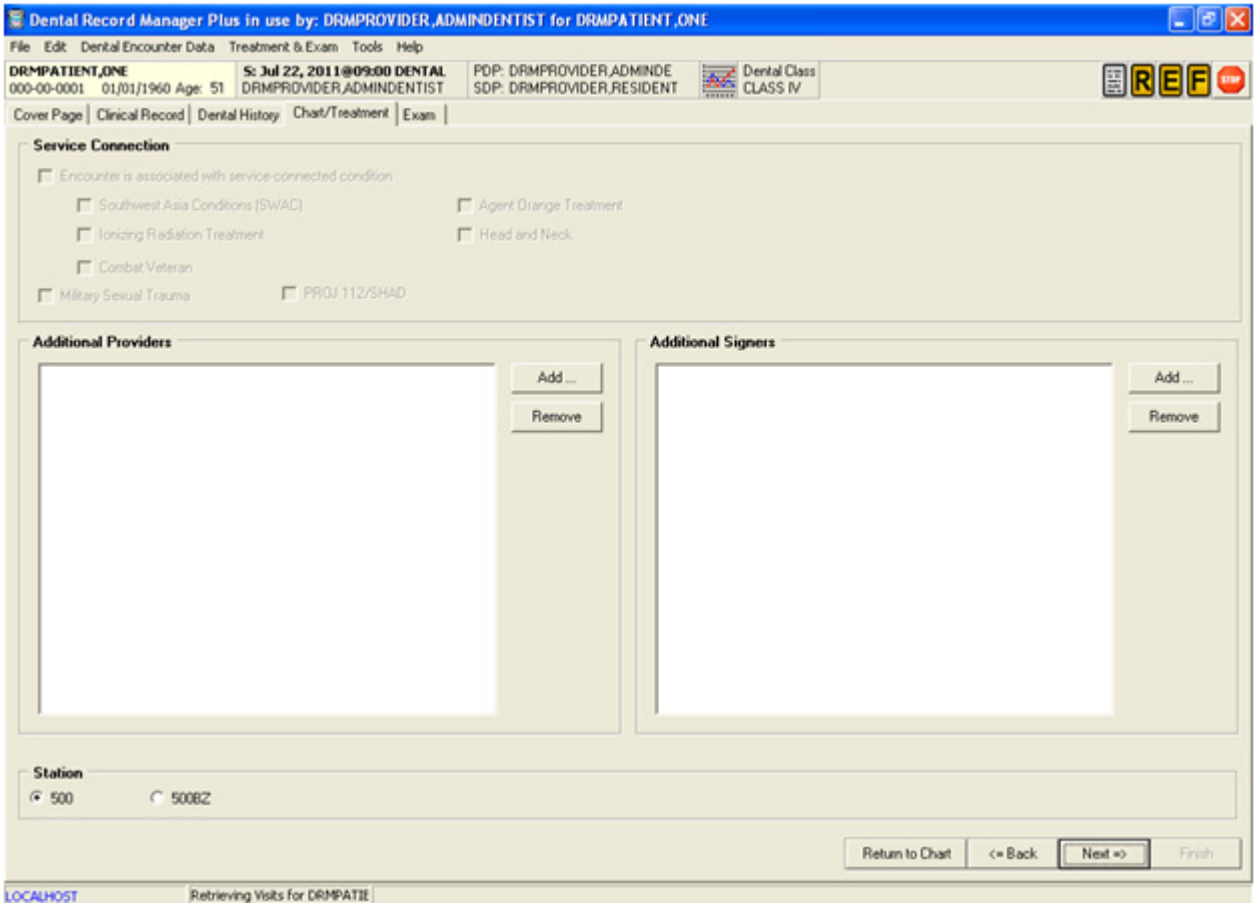
3. Select the provider from the Encounter Provider list. The program automatically defaults to the provider currently logged-in.
4. Select the desired visit from any of the tabs on the bottom of the screen.

5. Click the **OK** button.
6. The Filing Options screen displays.



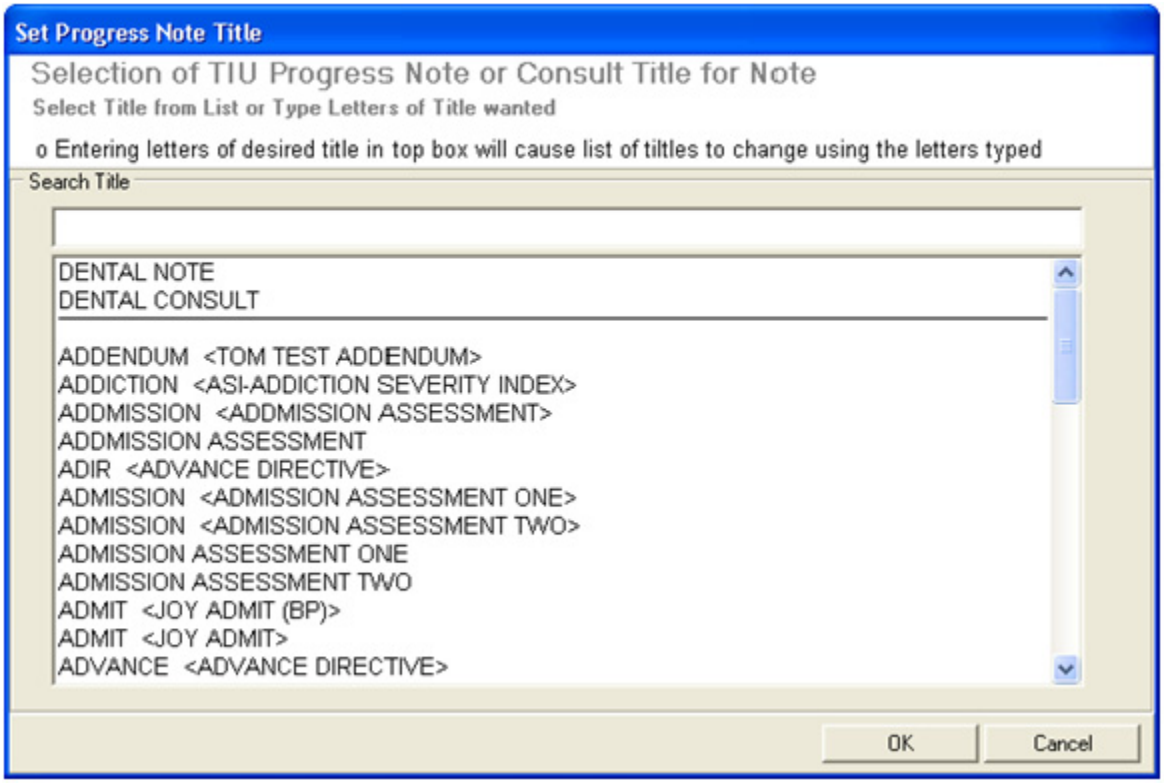
Filing Options Screen

7. Select the correct Filing Option. The information displayed in the Visit Date/Time, Encounter Dental Class, and the Disposition is defaulted but can be changed. Select the Suggested Recare Date if applicable to the patient.
8. Select the Primary PCE Diagnosis for the encounter, unless there is only one, which is defaulted.
9. Provider may select the diagnosis to be sent to the patient's problem list.
10. Click the **Next** button.
11. The Dental Class Discrepancy screen may appear, if the Encounter Dental Class and Cover page Dental Class don't match. This does not stop the user from completing the encounter.
12. The Service Connection screen displays.



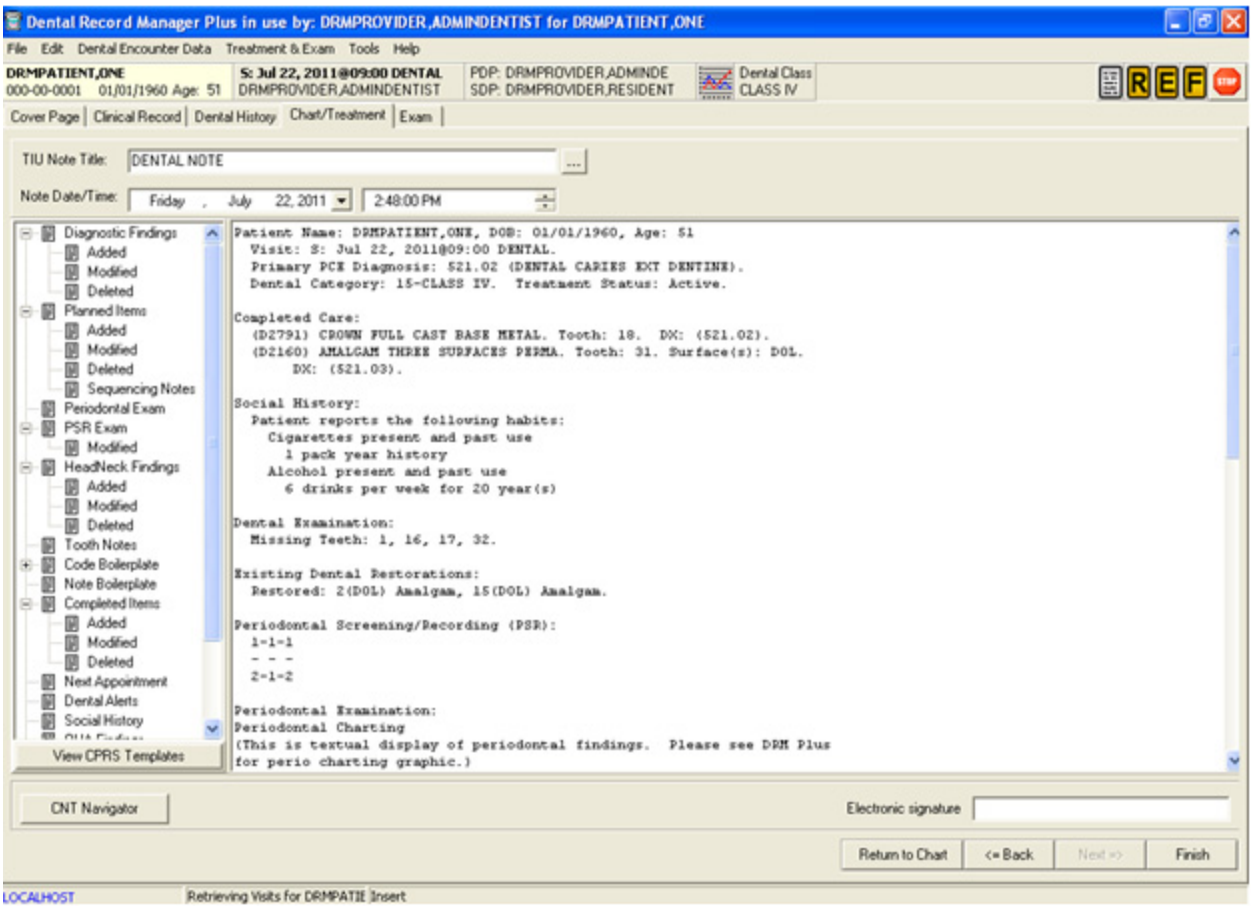
Service Connection Screen

13. Enter the locally required information on this screen. Please see the section of this manual entitled Service Connection Screen for more information.
14. Enter the optional information of Additional Providers or Additional Signers on this screen. Please see this section of this manual entitled Additional Providers/Additional Signers, found later in this chapter, for additional information.
15. Select the appropriate facility (station) by clicking the appropriate radio button.
16. Click the **Next** button.
17. The Set Progress Note Title screen displays. Note that this screen does not appear if the File Data with Note Addendum or File Data Without Note options were selected from the Filing Options screen.



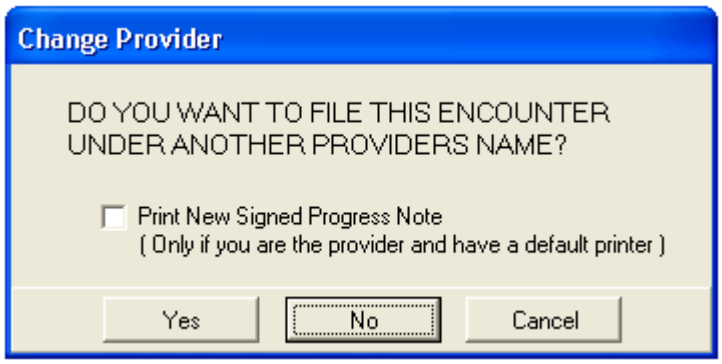
Set Progress Note Title

18. Search for the Title using the Search box, or use the scroll bar to select the desired title from the list. Default TIU note titles at the top of the list are set in the CPRS Tools menu/Options/Notes tab/ Document Titles button.
19. Click the **OK** button.
20. The Progress Note screen displays.



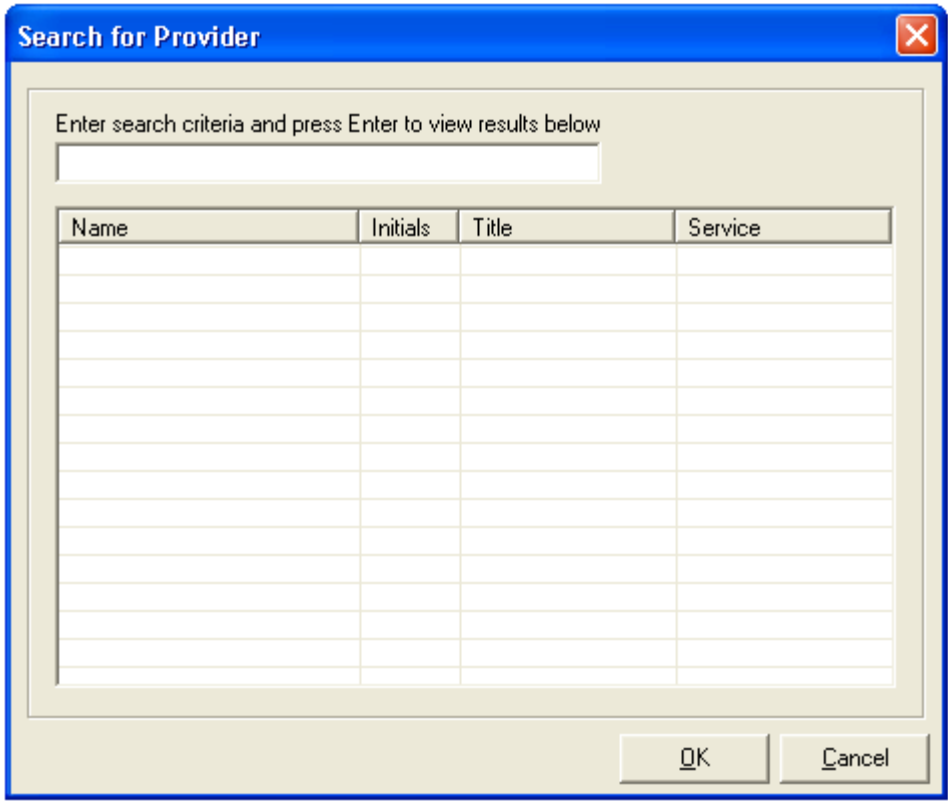
Progress Note Screen

21. 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. See the Electronic Signature section later in this chapter for more information.
22. The Change Provider screen displays.



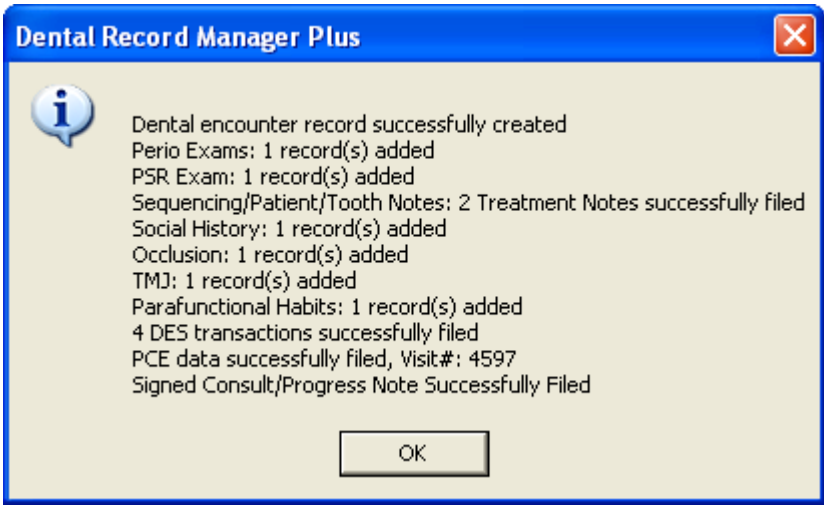
Change Provider Screen

23. Click the **Yes** button to change the provider. The Search for Provider screen displays. If **No** is selected, a screen displays. See step 25.



Search for Provider Screen

24. Enter the search information and press <**Enter**>. Select the provider from the list and click the **OK** button.
25. A screen displays stating that the encounter record has been created.

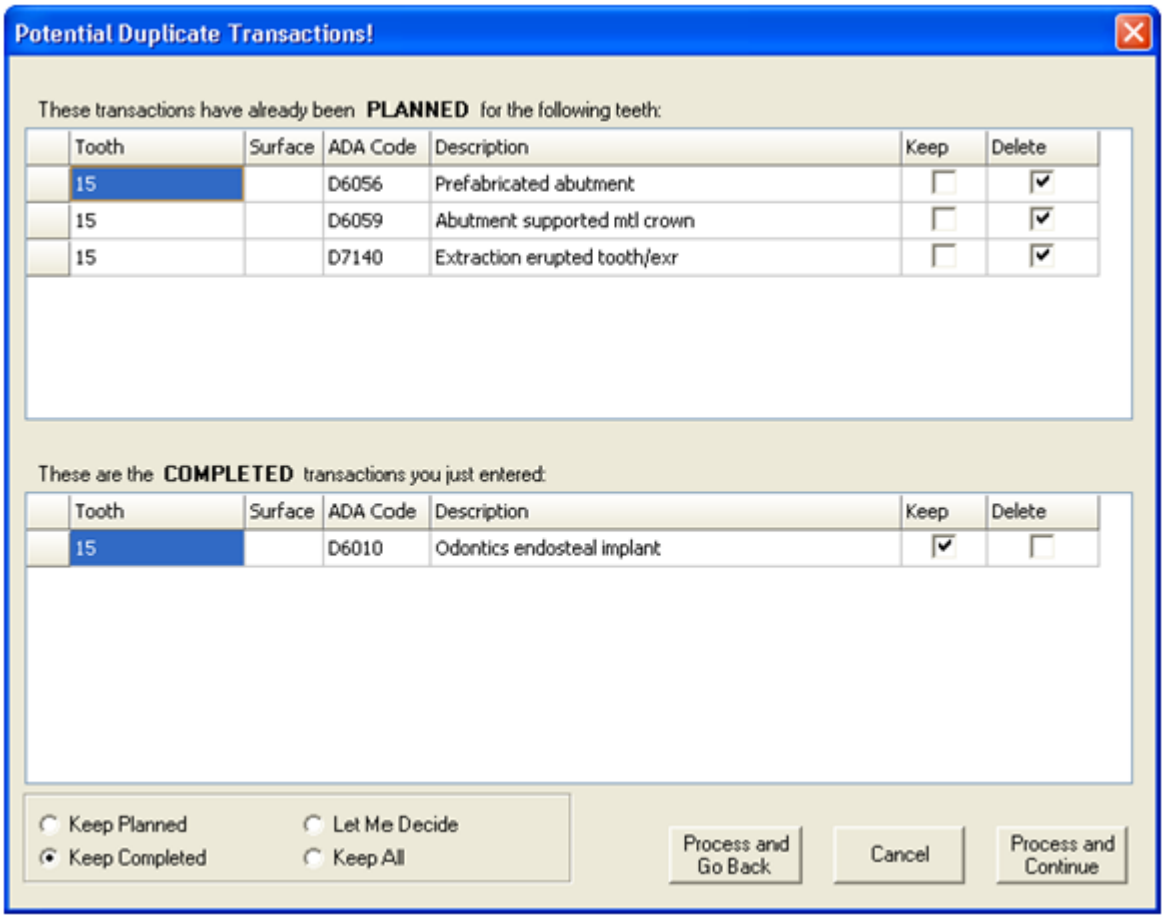


Dental Encounter Records Created

26. Click the **OK** button. 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 screens is clicked.



Potential Duplicate Transaction 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 to be 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 checkboxes 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.

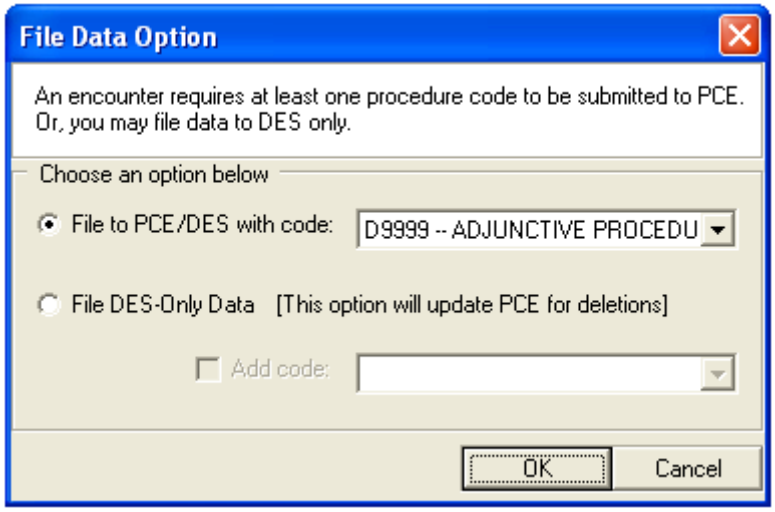
After clicking the desired radio button and selecting, if necessary, which transactions are kept and/or discarded, click either the **Process and Go Back**, **Cancel** or **Process and Continue** button to continue completing the encounter. **Process and Go Back** processes the procedure codes and returns to the Treatment & Exam or Periodontal Chart screen, depending. **Cancel** displays the Periodontal Chart or Treatment & Exam screen without processing any information. **Process and Continue** processes the procedure codes

and continues updating the progress note. The Filing Options screen displays. Continue closing the encounter from this point, as outlined in the previous 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 complemented treatment on the Completed Care screen and the user clicks the **Next** button, the File Data Options screen displays.



File Data Option Screen

Click on 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 procedure code:

1. Click the corresponding radio button on the File Data Options screen.
2. The program defaults to D4999 if entering this screen from the Periodontal Chart and D9999 if entering from Treatment & Exam.
3. If the default procedure codes are incorrect, click the code drop-down menu and select the desired procedure code.
4. Click the **OK** button.
5. The ICD-9 Diagnosis Code screen displays.
6. Fill in the information on the ICD-9 Diagnosis Code screen. See the Completing a Treatment Plan section of this manual, in the Chart/Treatment-Treatment & Exam chapter of this manual, for further information.
7. The Provider and Location screen displays. See the Dental Encounter Data section, in the DRM Plus Drop-Down Menus chapter of this manual, for further information.

File to DES-Only Data

To file to DES-Only Data:

1. Click the **File to DES-Only Data** radio button.
2. 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.
3. The ICD-9 Diagnosis Code screen displays. See the Completing a Treatment Plan section, in the Chart/Treatment-Treatment & Exam chapter of this manual, for further information.
4. The Provider and Location screen displays. Please see the Dental Encounter Data section, in the Using the DRM Plus Drop-Down Menus chapter of this manual, for further information.

Filing Options Screen

The filing options screen is divided into 6 main sections: Filing Options, Visit Date/Time, Encounter Dental Class, Disposition, Suggested Recare Date and Primary PCE Diagnosis & Send DX to CPRS Problem List.

Filing Options

Use the Filing Options radio buttons to choose how the encounter is to be filed.

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.

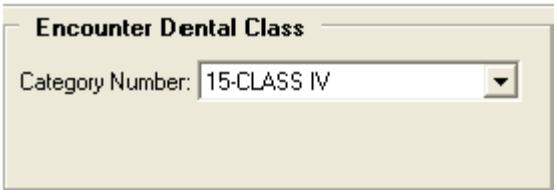
Visit Date/Time

To change the visit date and time:

1. Click the **ellipses (...)** 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. See the Dental Encounter Data section, in the Using DRM Plus Drop-Down Menus chapter of this manual, for further information on the functions of this screen.

Encounter Dental Class

Use the drop-down menu to change the Category Number/Encounter Dental Class for this encounter.



Encounter Dental Class

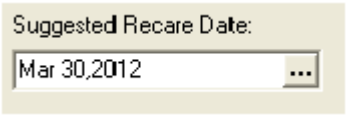
Disposition

Use the radio buttons to change the patient's Disposition or Case Management status.

Disposition

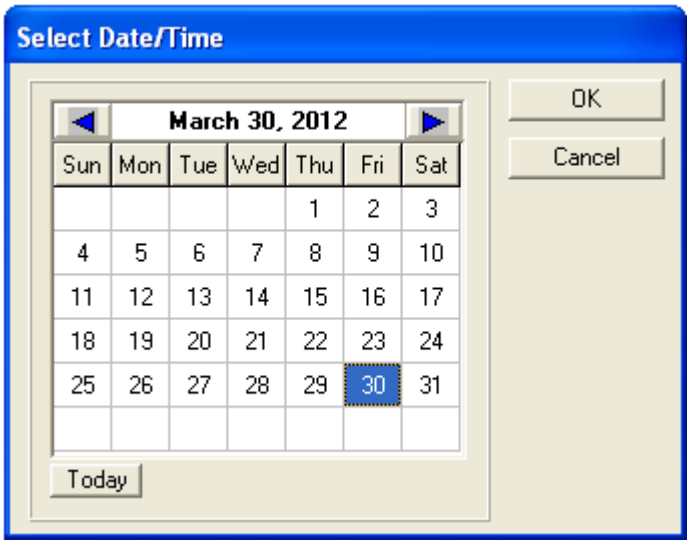
Suggested Recare Date

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



Suggested Recare Date

Clicking the **ellipses (...)** button opens the Select Date/Time screen.



Select Date/Time Screen

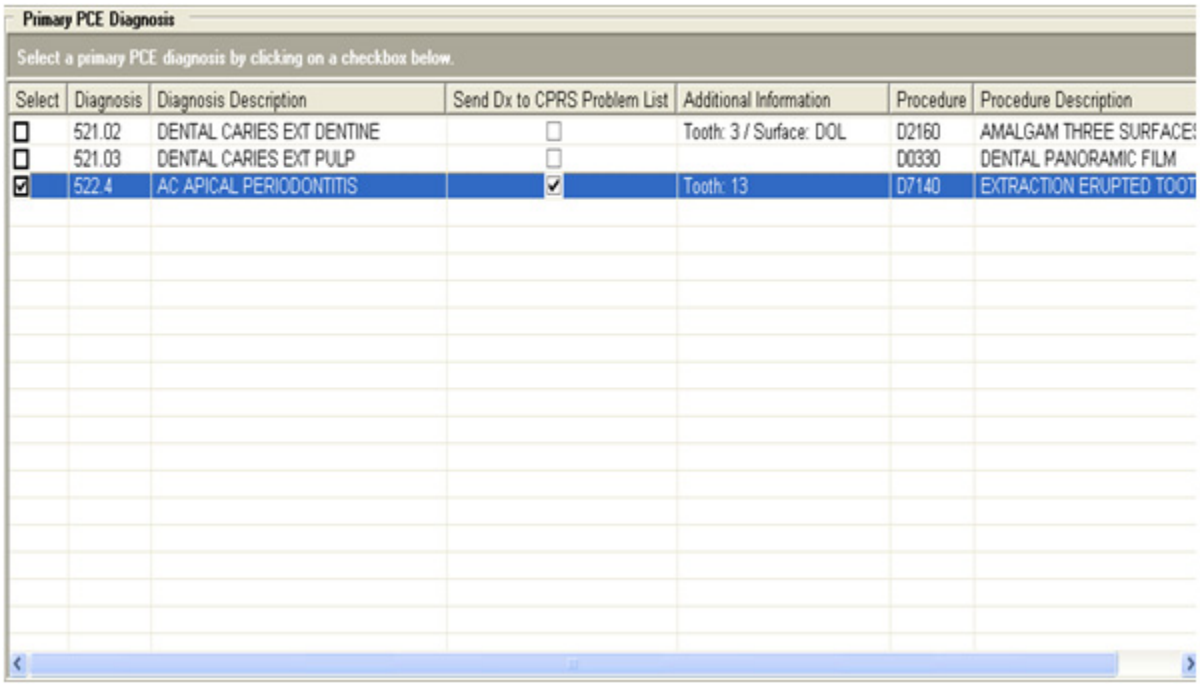
Select the date from the calendar and click the **OK** button.

Primary PCE Diagnosis & Send Dx to CPRS Problem List

This area 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 many 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.



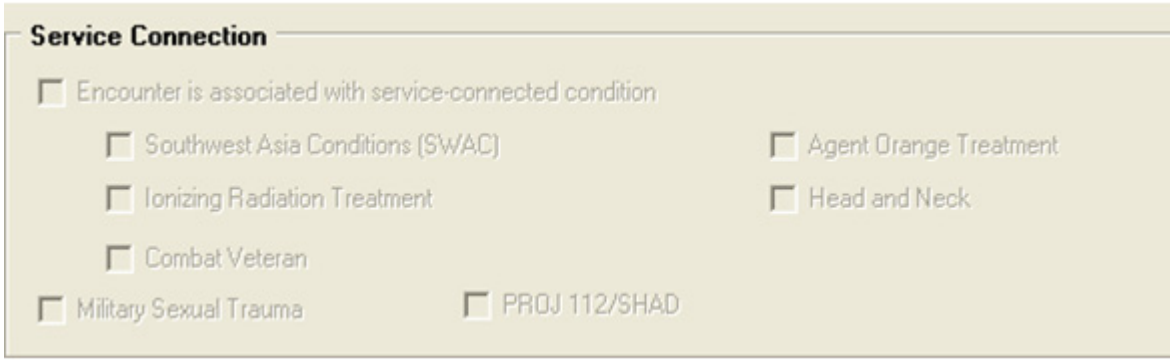
Primary PCE Diagnosis Window

Service Connection Screen

The Service Connection screen has four main areas: Service Connection, Additional Providers, Additional Signers and Station.

Service Connection

Use the check boxes to denote service connection, if applicable.



Service Connection

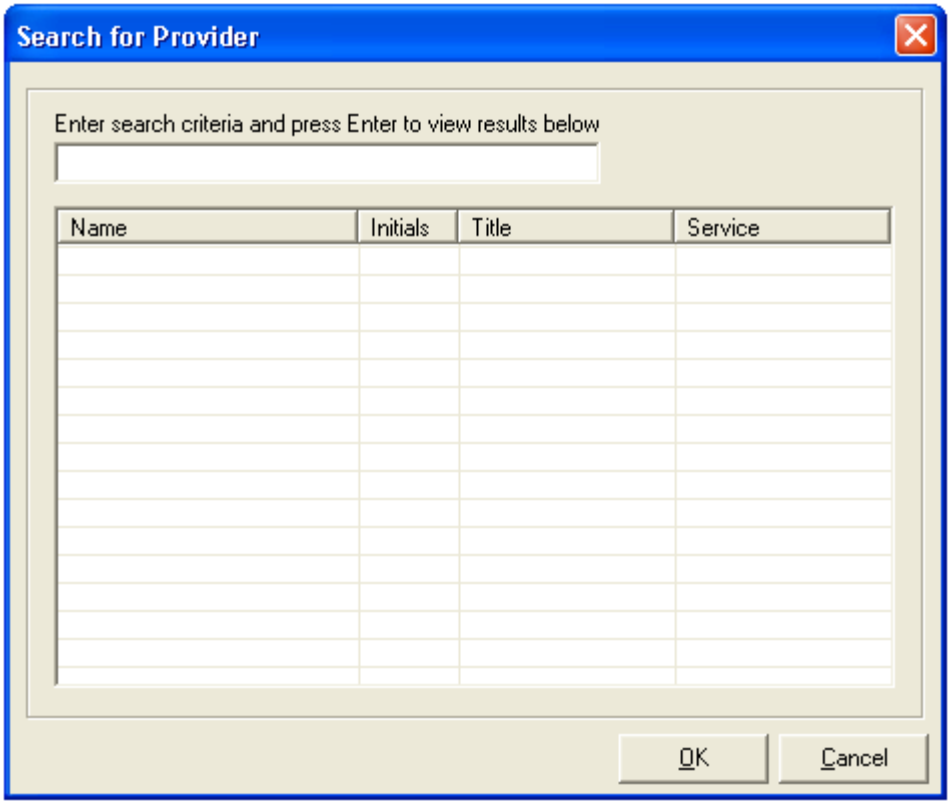
Additional Providers/Additional Signers

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

Additional Providers/Additional Signers

To add a provider or signer:

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



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 appears on the main screen. Repeat as necessary.

To remove a Provider/Signer:

1. Highlight the provider or signer name.
2. Click the **Remove** button.
3. A confirmation screen displays. Click the **Yes** button.
4. The name is removed from the Additional Provider list.

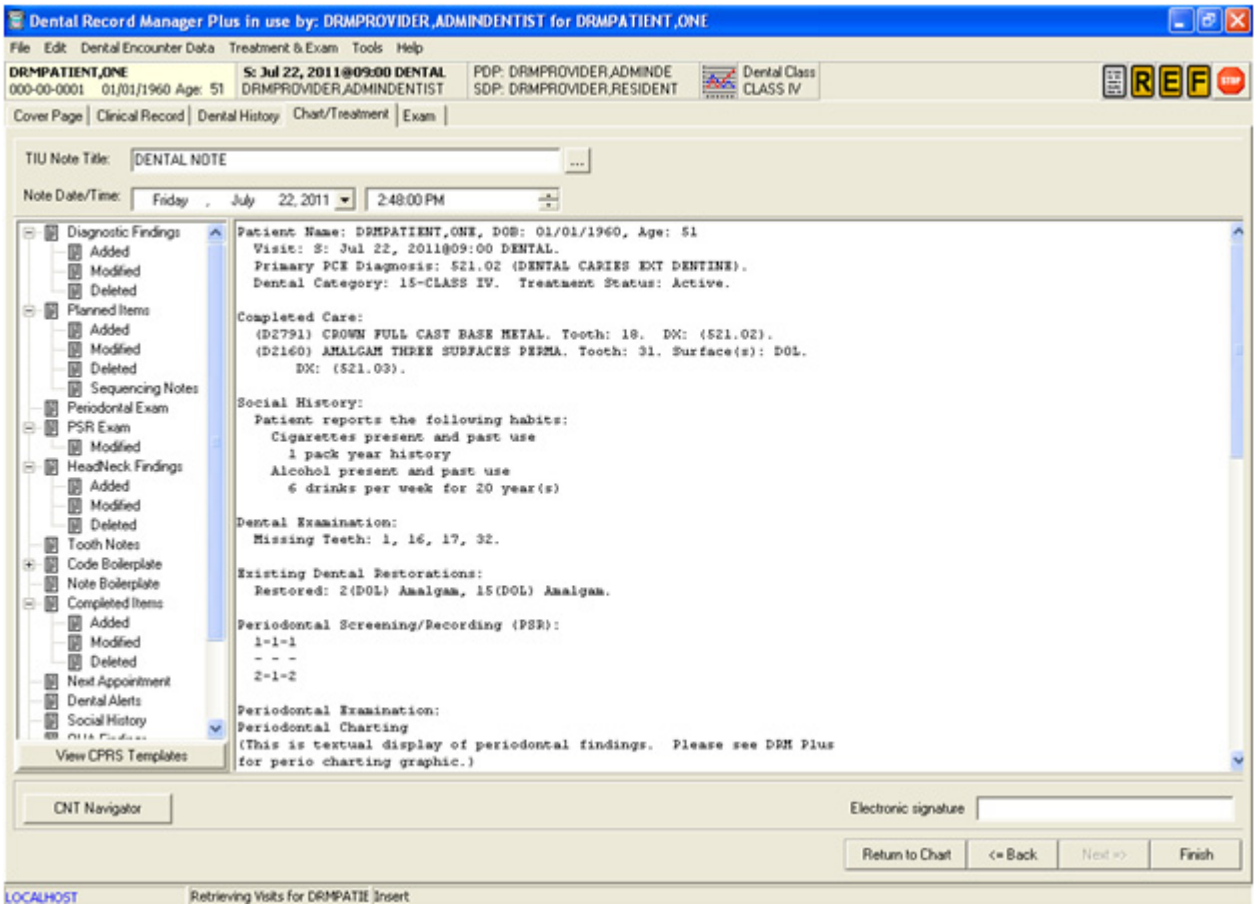
Station

Select the appropriate facility (station) by clicking the appropriate radio button, if applicable.

Station

Progress Note Screen

The Progress Note screen has several major areas and functions. This is the final major screen in completing an encounter with the patient, and has different incarnations depending on how the transaction is to be filed: With a Note, With a Note Addendum, or Without a Note. The following screen displays when the transaction is filed using the With a Note option.



Progress Note Screen

Use the ellipses **(...)** button to change the TIU 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 CNT Navigator (DSS product clinical note templates), view the patient's progress note, import VistA medical information and add an electronic signature.

Viewing/Importing DRM Object/Progress Note

To view/import DRM objects:

1. View the DRM object in the tree on the left side of the screen.
2. Double-click the DRM object and it appears 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

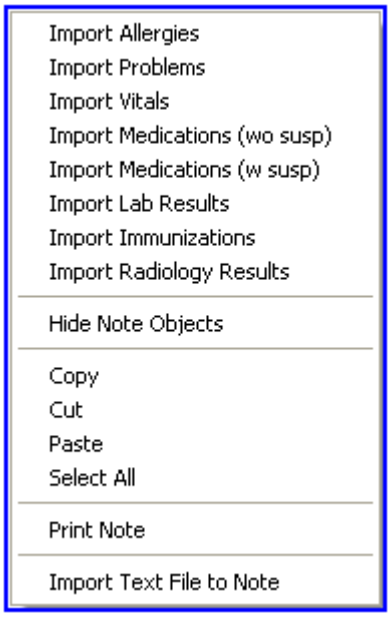
To view/import CPRS templates:

1. Click the **View CPRS Template** button**.**
2. The shared/personal templates tree, if expanded, appears on the left side of the screen. Functionality of CPRS templates in DRM Plus is the same as in CPRS.
3. Click the **View DRM Plus Object** button to return to the DRM Plus Objects tree.

Importing VistA Medical Information

To import VistA medical information into the patient's progress note:

1. Right-click in the progress note area.
2. The Import Menu displays.



Import Menu

3. Choose the information that is to be imported from the top half of the menu.
4. The information appears 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 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: Navigate 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

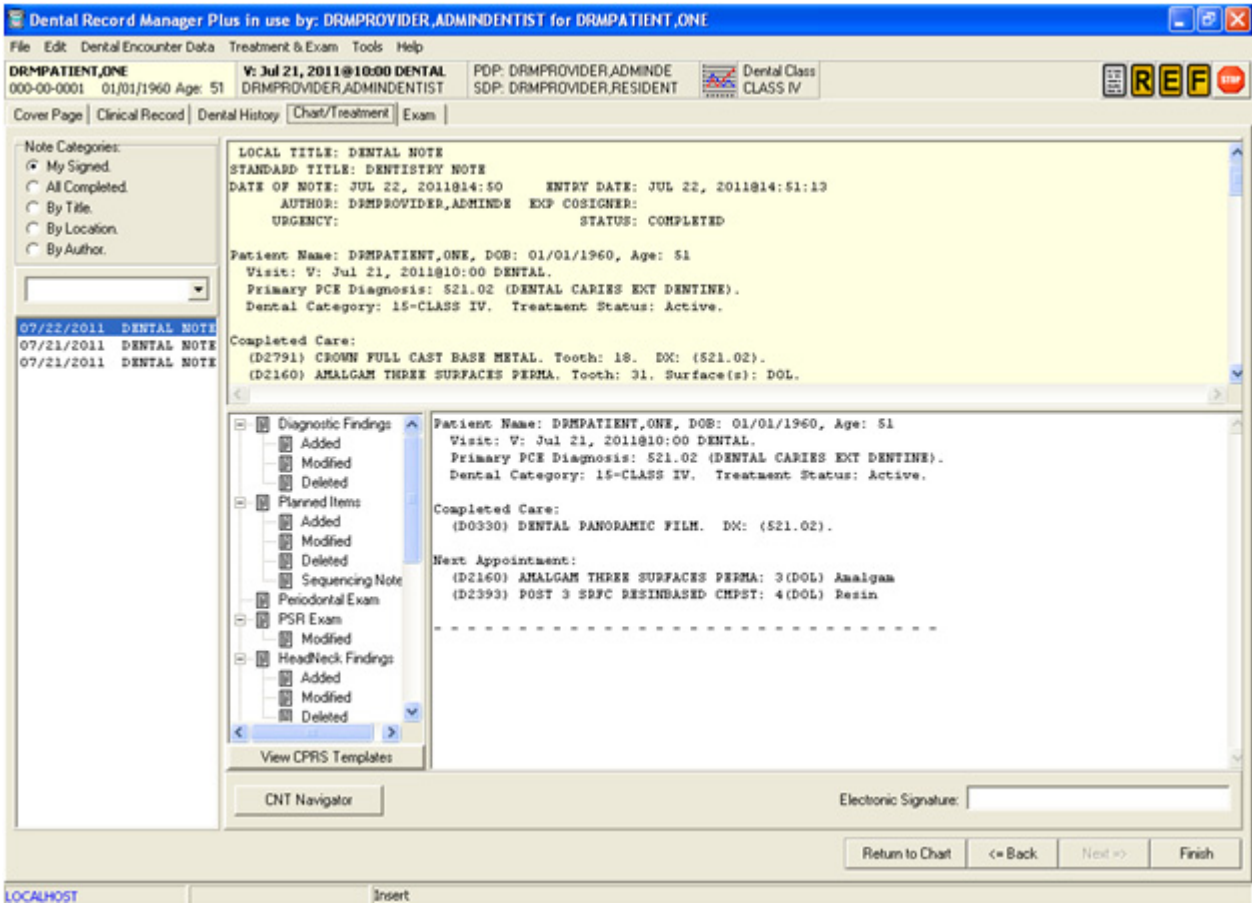
Click the **CNT Navigator** button to access Dental CNTs. These are DSS product clinical note templates. The Dental CNTs may not be mapped for DRM Plus at the user's site, which would require IRM assistance. Please see the CNT Navigator section, further in this chapter.

Electronic Signature

Enter the Electronic Signature and click the **Finish** button to complete the progress note. Clicking the **Finish** button without entering an electronic signature leaves the patient progress note status: 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, and the Note Display.



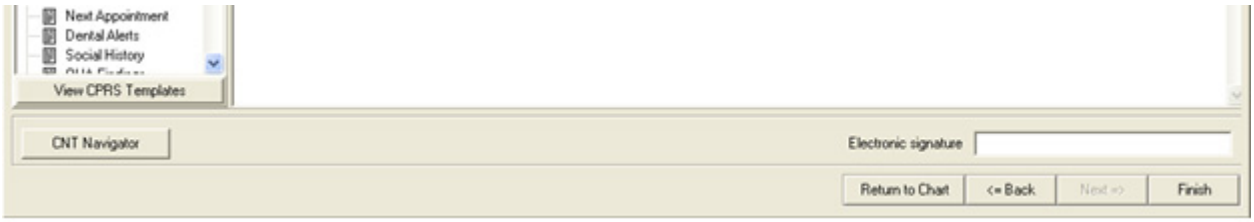
Progress Note Addendum Screen

The notes associated with the selected note categories appear in the white space below the note categories area. Use the drop-down menu below the note categories screen to filter the results. Click a primary note to view details in the upper right area of the screen.

Select a category/note to finish the process of filing the encounter with a note addendum, which is displayed in the lower right area of the screen.

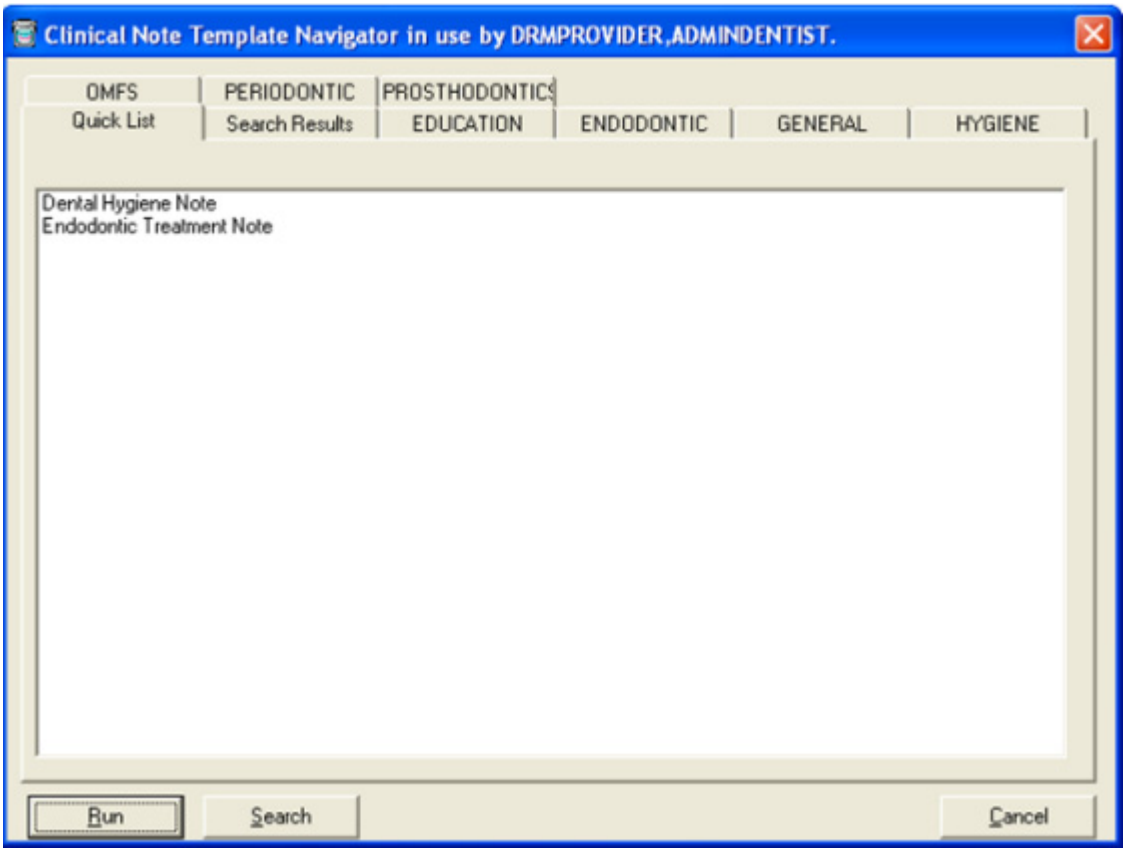
CNT Navigator

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 adding 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 IRM assistance.



CNT Navigator button

Using the mouse, point and click to select pre-determined text in the development of a note. Free text type within the CNT, if the pre-determined text or statement does not contain the necessary verbiage.

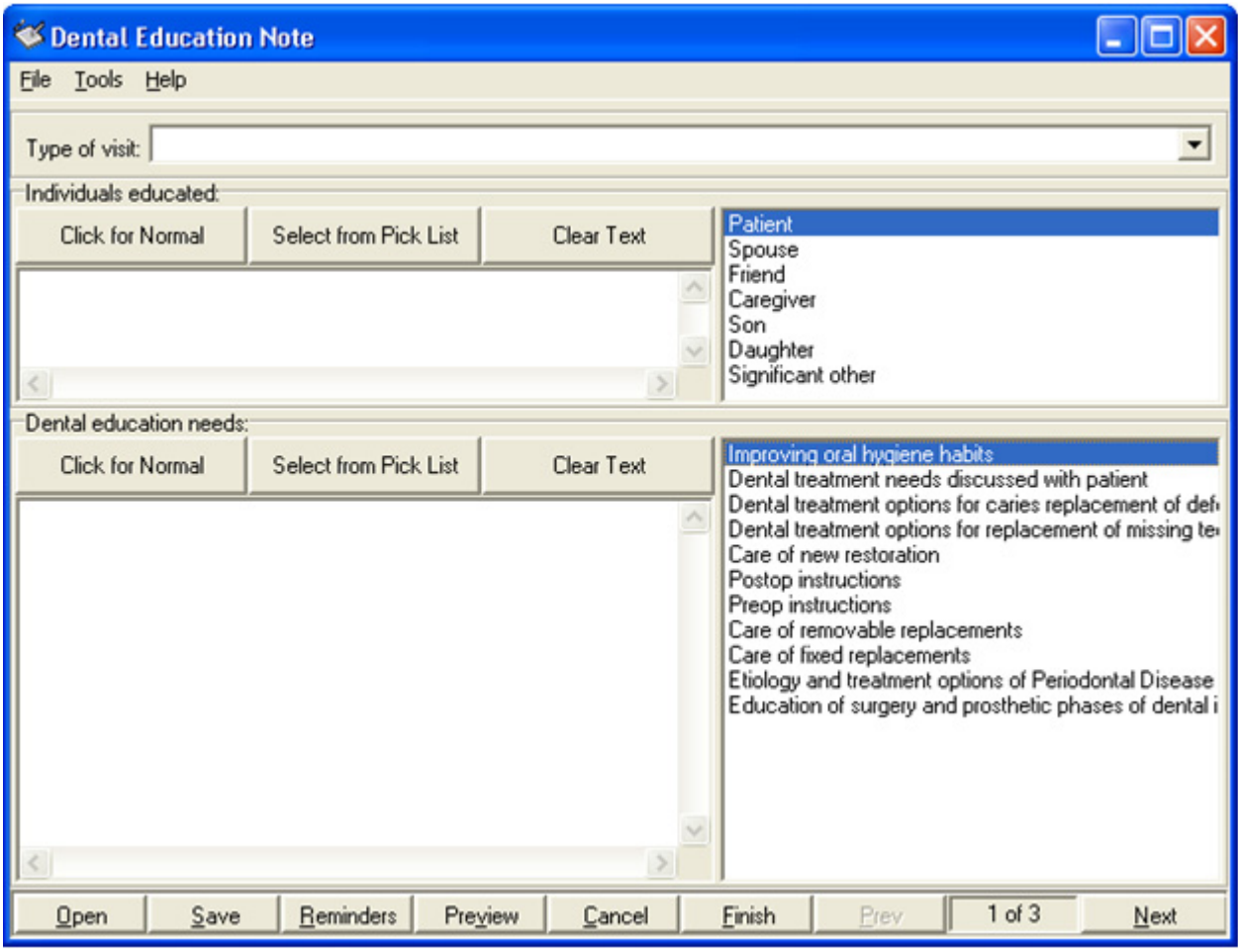


Using the CNT Navigator

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.

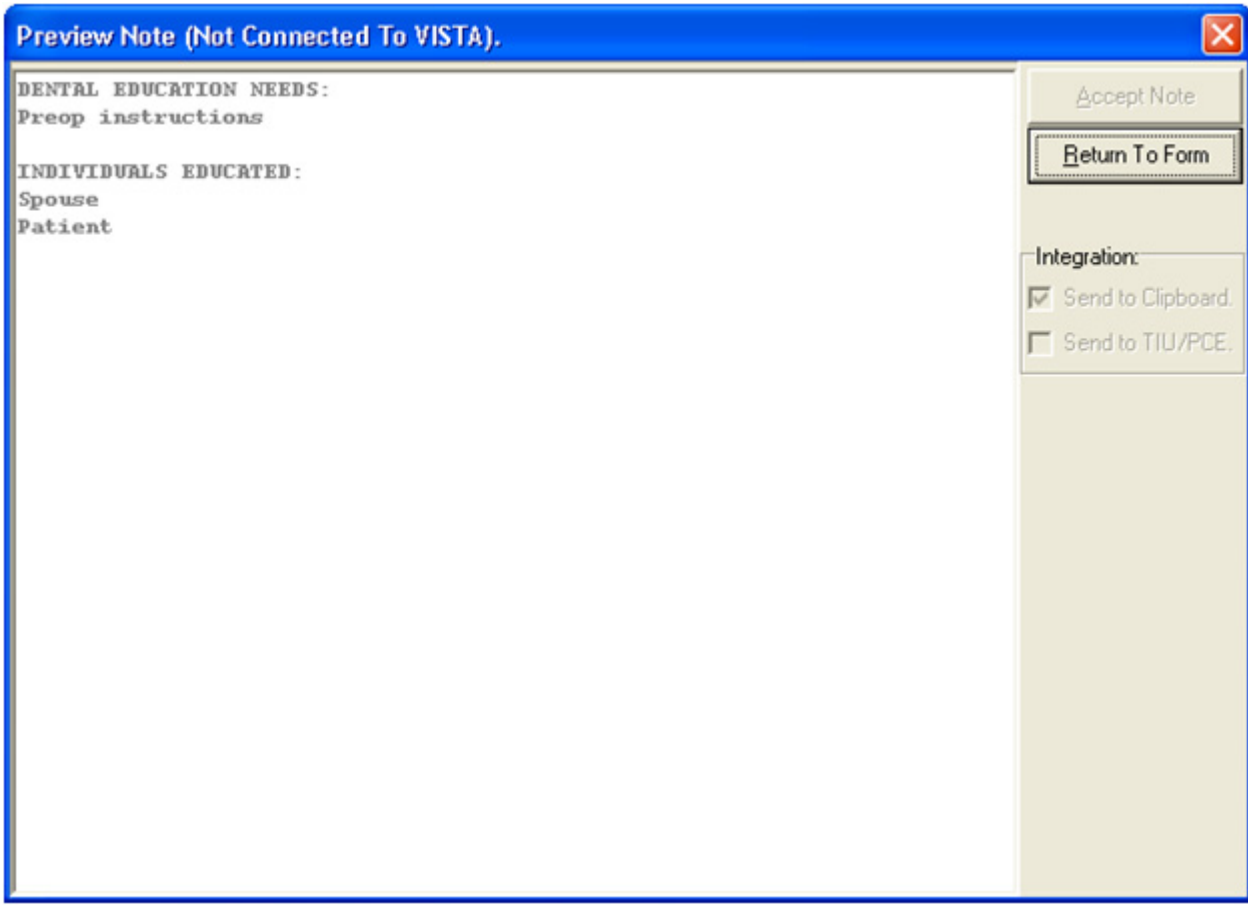
Navigating Within CNTs



Navigating Within CNT

To navigate within a CNT:

1. Point and click within the windows, tabs, drop-down arrows, check boxes and radio buttons. Each navigational method provides the user with a different method of entering or selecting information.
2. Preview the note by clicking the **Preview** button.
3. Click the **Return** button to continue writing the note.

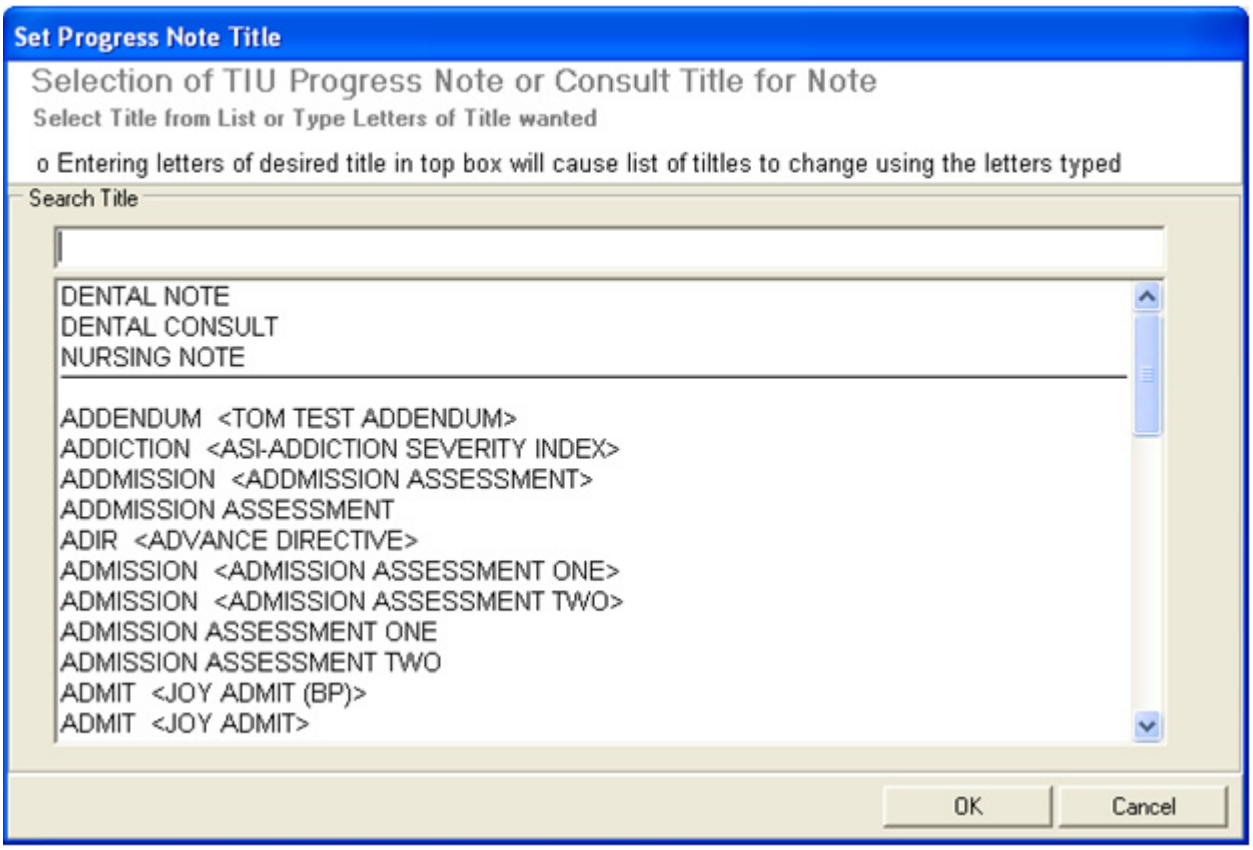


Preview Note

When the note is complete, click the **Finish** button. Then click the **Accept Note** button.

Consult Notes

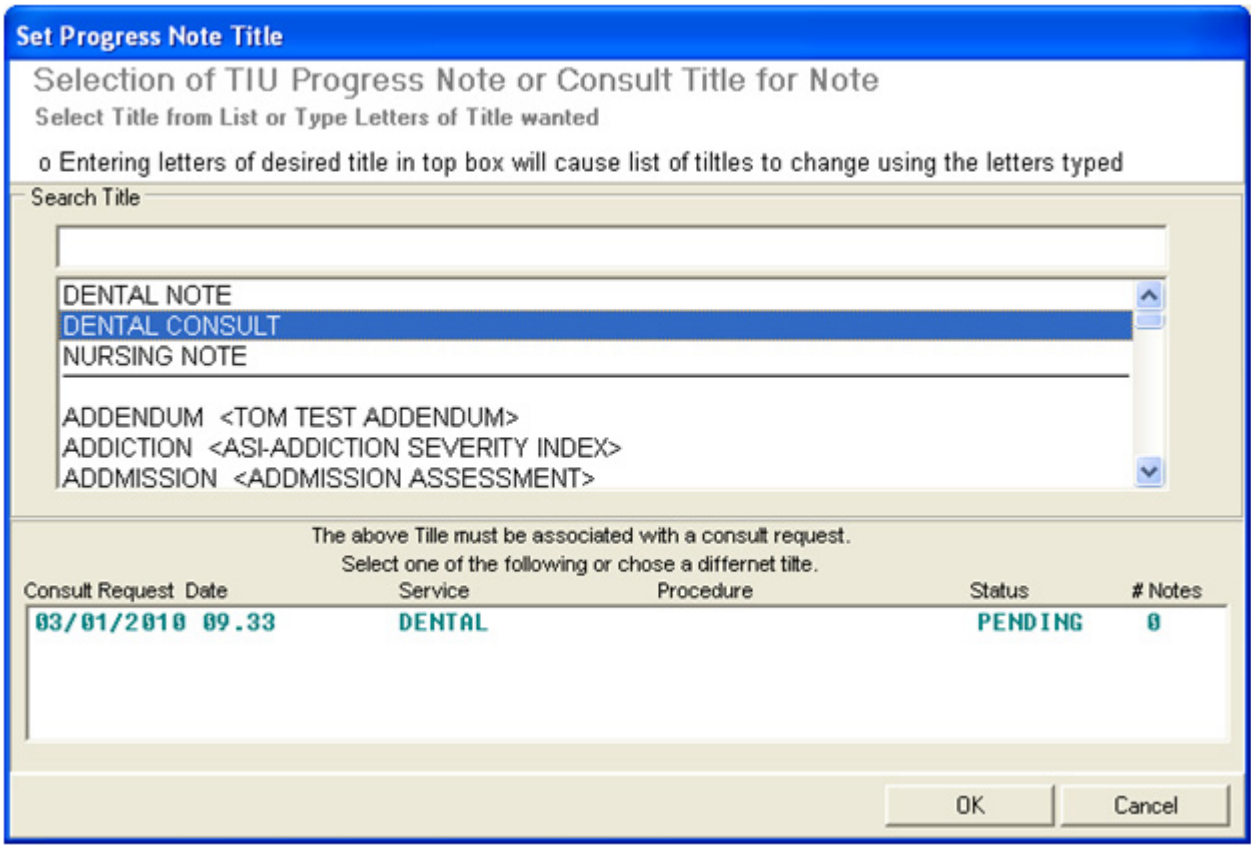
The option to complete a consult follows the service connection screen, during the process of completing a patient encounter, when the Set Progress Note Title screen displays.



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 appear on the screen.



Set Progress Note Title with Consult Requests

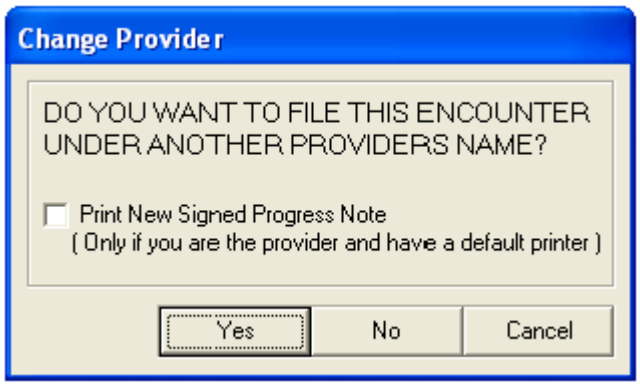
3. Select the consult from the list.
4. The consult is added to the progress note on the Progress Note screen. Once the electronic signature is entered on the Progress Note screen, the consult is complete.

Resident Filing as Cosigners or Distributed Providers

A 2006 VA Directive stated that residents are users with a Person Class of V030300, or V11550 or V115600. 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.

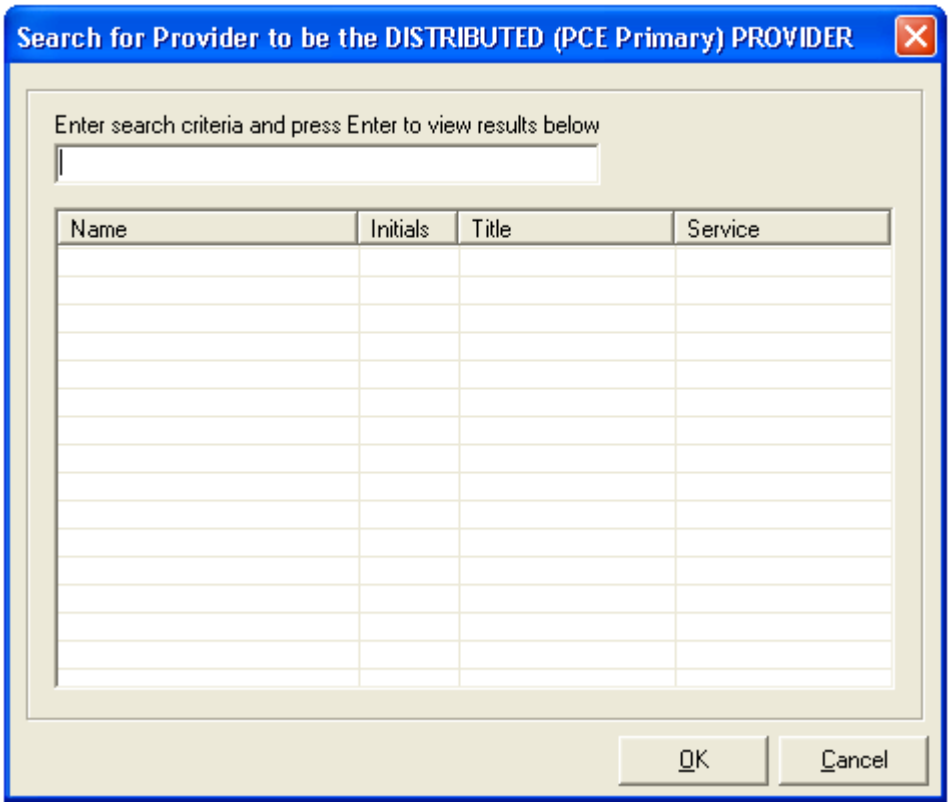
To add a distributed provider:

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



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.

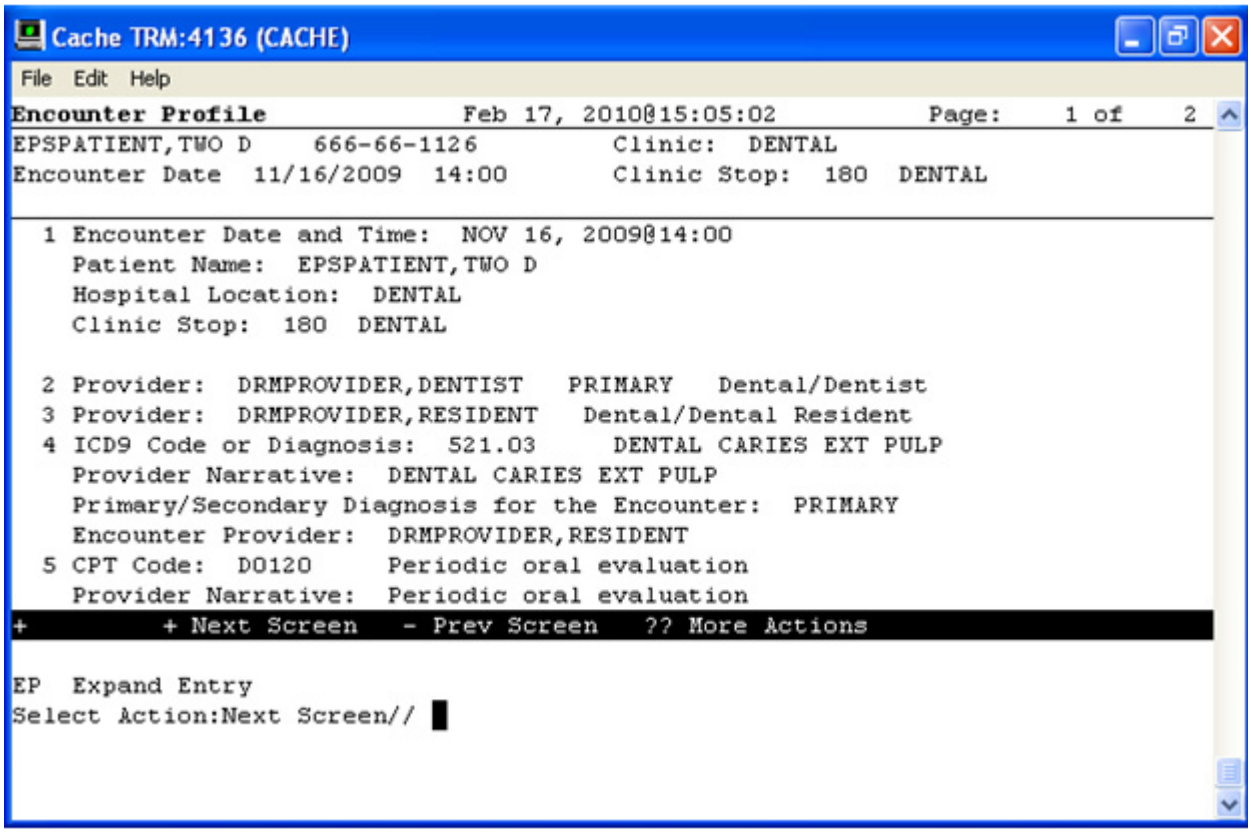


Search for Distributed Provider Screen

5. Enter the search terms in the text box and press <**Enter**>.
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 residents actually performing the procedures, all of which is filed to DES; to meet the VA requirement that the attending (distributed) gains credit for, requires this to be filed in PCE.

When the visit is filed to PCE, the resident becomes the secondary provider, and the distributed provider becomes the primary provider for the visit. All procedures and diagnoses are assigned to the resident.



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 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 Veteran 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

M V V	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
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.

Finish: Same as the **OK** button.

Browse Buttons: Clicking the **browse** buttons 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.

Checkboxes: Clicking a checkbox works the same as a radio button, however multiple selections may be added from one group.

Text Boxes: Clicking in a textbox 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 on 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 on 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 only two options to eliminate this saved, unfiled data. The first is to select the **Delete** button when opening the patient, and the dialogue screen asks the user if they want to load 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 appears 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 appears 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

The 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 endentulous 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 any end user. If this happens after the encounter has been filed, the findings deleted are removed from the graphic; however, the text entry remains in the transaction table with a line through it. An administrator of DRM Plus has the ability to completely remove any Diagnostic Finding entry from the transaction table, unless the entry was already deleted by an end user.

Treatment Plan

For implant procedures entered in the Treatment Plan screen, and if a related Diagnostic 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 treatment plan with the Diagnostic Findings and not use the automatic Include option in DRM Plus. The automatic Include option is the original default in DRM Plus when the end user is viewing a Treatment Plan, and the screen of Diagnostic Findings is included. End users may edit this parameter by accessing the Treatment & Exam menu/ Show Configuration option / Tx & Exam tab / Display Defaults drop-down menu and removing the check marks in the check boxes.

Multi-Add Screen

Small buttons [<] and [>] have been added to the CPT Procedure Codes screen and multi-add 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 view screens. When other options are utilized for selecting these CPT procedure codes, when using the ADA codes icon or Add box, the ranged codes are grayed out and cannot be selected.

Speed Codes

Speed Codes do not have Multi-Add or Suggestion Links functionality. Multi-Add and Suggestion Links functionality 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.

Sequencing Screen

There is a maximum of nine phases which may be added to the Planned Treatment for one patient. There are an unlimited number of sub-phases possible in each phase.

Ranged codes, mostly prosthetics, move as a block when one code is highlighted, by left-clicking on the item, holding, and dragging to the proper phase.

End users are able to re-size and move the Sequencing screen in all directions. DRM Plus allows the 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 Sequencing screen and file the changes without having to click the **Next** button and create a 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** and **Exit** button from the Sequencing screen files any changes made, and minimizes DRM Plus. Any new planned entries added have the same visit date as the latest progress note filed for the patient.

If the completed care screen is set as the display default in DRM Plus, completed care transactions completed from the sequencing screen may require a refresh for those transactions to appear 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 as signed Progress Notes can only be deleted by a DRM Plus administrator. If end users don't have this Administrative parameter option and highlight an entry in the transaction table of Completed Care, then click the **Delete** button. A screen displays, stating that the transaction cannot be deleted. When a DRM Plus administrator deletes any entry from DRM Plus, appropriate procedures must be followed to correct any associated entry filed in VistA TIU.

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 ICD-9 diagnosis code, de-select the procedure code by clicking the procedure code located on the upper left side of the ICD-9 Diagnosis Code Dialog screen. The de-selected procedure code no longer appears highlighted, and is also removed from the table at the bottom of the screen, indicating that it does not file with the selected ICD-9 diagnosis code. Click the **OK** button at the bottom of the screen, and the remaining procedure code(s) recycle and appear highlighted in the ICD-9 Diagnosis Code Dialog screen for the user to assign an ICD-9 diagnosis code. This process of recycling continues until all procedure codes added with the multi-add functionality have an ICD-9 diagnosis code assigned by the user.

Periodontal Chart

The **History** button maintains all 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 the Pocket, FGM, MGJ, Mobility and Furcation icons. 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 no entry in the 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 Progress Note, because 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 the transaction table entry.

When perio data is imported into the 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 progress note explains certain symbols. There may be a statement at the bottom of the perio data, which informs other providers that this 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 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 Configuration option from the Treatment & Exam menu.

Completing the Encounter

Entering data in the Encounter Dental Class drop-down menu has category numbers 1-8 displayed for inpatients, and numbers 9-22 for outpatients.

Selecting any Service Connection check box sends the 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 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 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 progress note. If the Note Boilerplate parameter is set with a check mark, an informational screen displays when selecting a TIU 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 progress note without an opportunity to decline this action. This parameter is located under the Tools menu/User Options/General tab/Other **Parameters** button.

CPRS templates will automatically import into a patient 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 appears or opens, complete or fill-in the appropriate information on the template and close or finish it. The information entered on the template will import into the patient progress note. Please note: DRM Plus does not support Reminder Dialog or COM Object CPRS templates.

There are generally two types of progress notes created using DRM Plus: 1. using the Exam tab or 2. not using the Exam tab. A 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. Progress notes created without using the Exam tab will 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/User Options/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 window of the Progress Note screen may be imported into the note automatically. This depends on whether the parameter is 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. This parameter is located by selecting File menu, User Options, Progress Note tab and then clicking the **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 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 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** to navigate to and open the saved file. The file is then placed in the 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/ click the **Set File Folder** option and navigate to the folder created in step 1. Set the folder by double-clicking on it.
3. Create a text file from the Tools menu/ Windows Notepad option 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 Progress Note is filed in VistA (PCE, DES and TIU) as an unsigned note, and may be viewed with CPRS. If the electronic signature is entered before clicking the **Finish** button, the Progress Note is filed as a signed note in VistA (PCE, DES and TIU).

When the user clicks the Finish button, a prompt may appear if there are no planned items, and if the patient status is Active. Correctly identifying the patient's status is important for reporting. The end 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 rounds up to the nearest whole number day.

Code Boilerplates

Multiple boilerplates may be added for a single code, or multiple codes may be associated to the same boilerplate. The user may establish as many boilerplates and related codes as necessary.

If an administrator of DRM Plus creates a code boilerplate in their Administrative Toolbox option, 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 Options. This action imports the administrative code boiler plate to the end user code boilerplates.

Last Broker Call

The Last Broker Call option 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 Monitored 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, D0274 or D0277
- Last Prophylaxis = D1110, D1205, D4341, D4342 or D4910
- Last Visit = the last dental visit date
- Last Provider = the provider for the last visit

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

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Conn Bar					See Special Instructions
Hemi	No	No	As many as required	Selected roots	Graphic in dark grey
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

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
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
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, appear 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
Hemi	No	No	As many as required	Code Selection Box	Graphic in grey
Coping	Yes	No	No	Code Selection Box	Graphic in blue

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
P&C	No	No	As many as required	Code Selection Box	Graphic in blue
Perio Buttons	No	No	No	None	No Graphic. See Speed Code instructions.

(1) Certain codes associated with these icons are defined as Ranged codes. Ranged codes can only be entered by clicking the **Icon** button. The ADA Codes table, QuickLists or Speed Code entries are prohibited to enter these codes.

(2) 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
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 green
P&C	No	No	As many as required	Code Selection Box	Graphic in green
Perio Buttons	No	No	No	None	No Graphic. See Speed Code instructions.

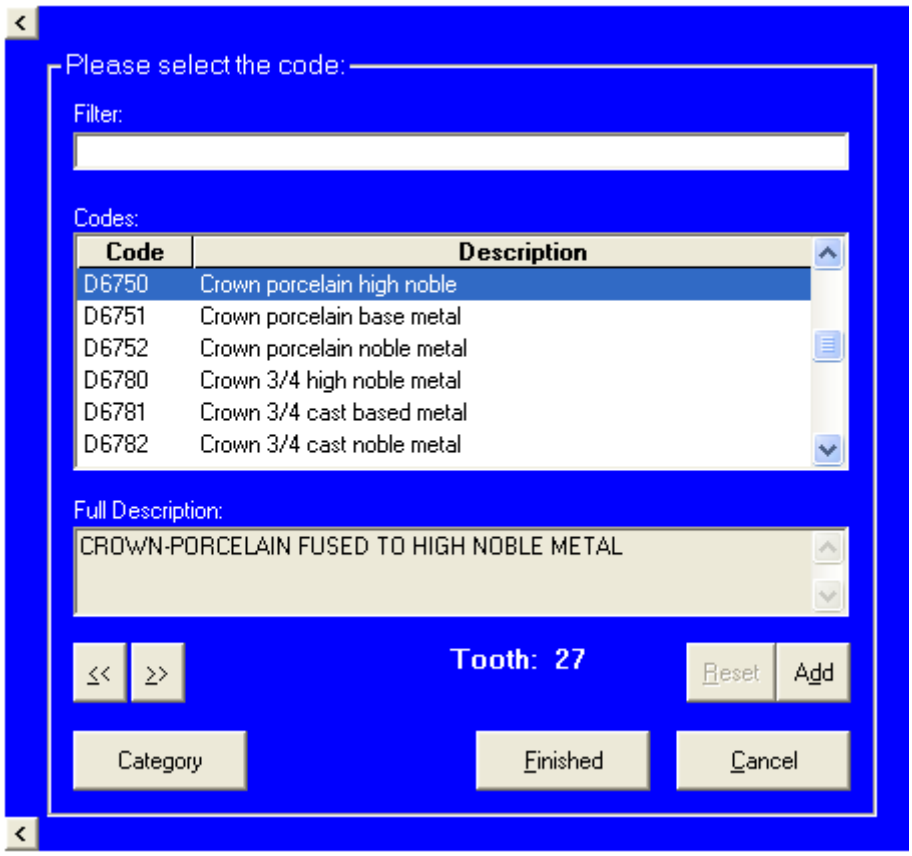
(1) Certain codes associated with these icons are defined as Ranged codes. Ranged codes can only be entered by clicking the **Icon** button. The ADA Codes table, QuickLists or Speed Code entries are prohibited for entering Ranged codes.

(2) To designate a root restoration, click the **Restore** icon. Click the tooth surface that corresponds to the root surface. Using a tooth note, and 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. 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, these items 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 Code Selection screen displays, with the lowest number tooth selected, as shown below.



Special Descriptions -- Bridge Code

Select the appropriate code and click the **Add** button. The 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 CPT 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 not with 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 grayed out. The note appears grayed out if it was saved as unfiled data and DRM Plus is closed and reopened. It also grays out when an assistant saves unfiled data to a provider. When the provider re-opens DRM Plus to complete the Progress Note, they may edit-delete the Note (tooth/patient note) by clicking the **New Entry** button. This activates the grayed out entry so the provider is able to modify or delete the note before the Progress Note is finished.

Appendix E -- Create Reports in MS Excel and Access

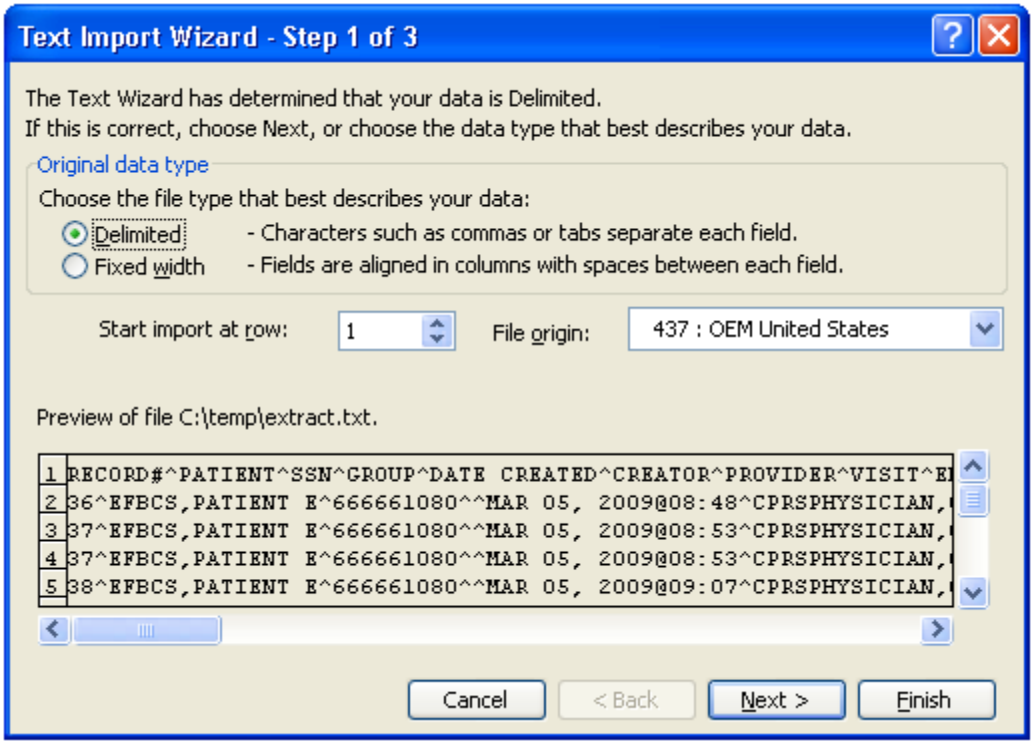
Developing Excel Reports

To open Excel:

1. Click the **Excel** shortcut (if available) If unavailable;
2. Click the **Start** button.
3. Click the **Programs** button.
4. Click **Microsoft Office**.
5. Click **Microsoft Excel**. A blank Excel workbook opens.

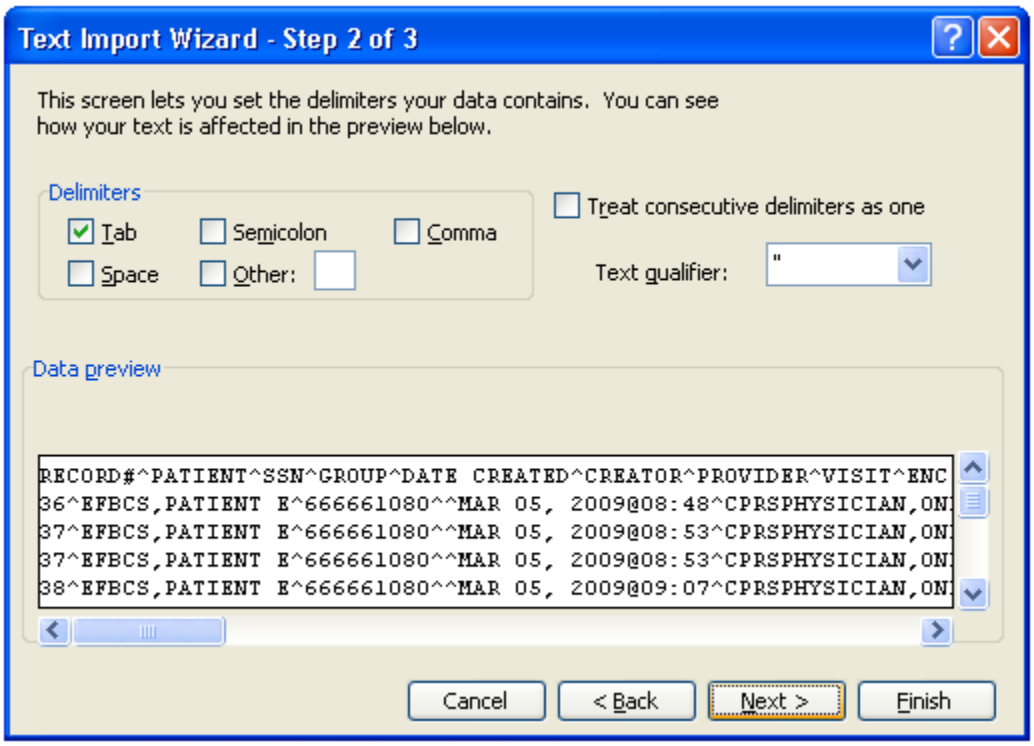
To open a saved file:

1. Select the File menu from the top menu bar.
2. Click the **Open** option.
3. Navigate to the directory/network where the extract file is saved.
4. Navigate to the saved .txt file and click **Open** or double-click the file name.
5. A screen similar to the one below is displayed.



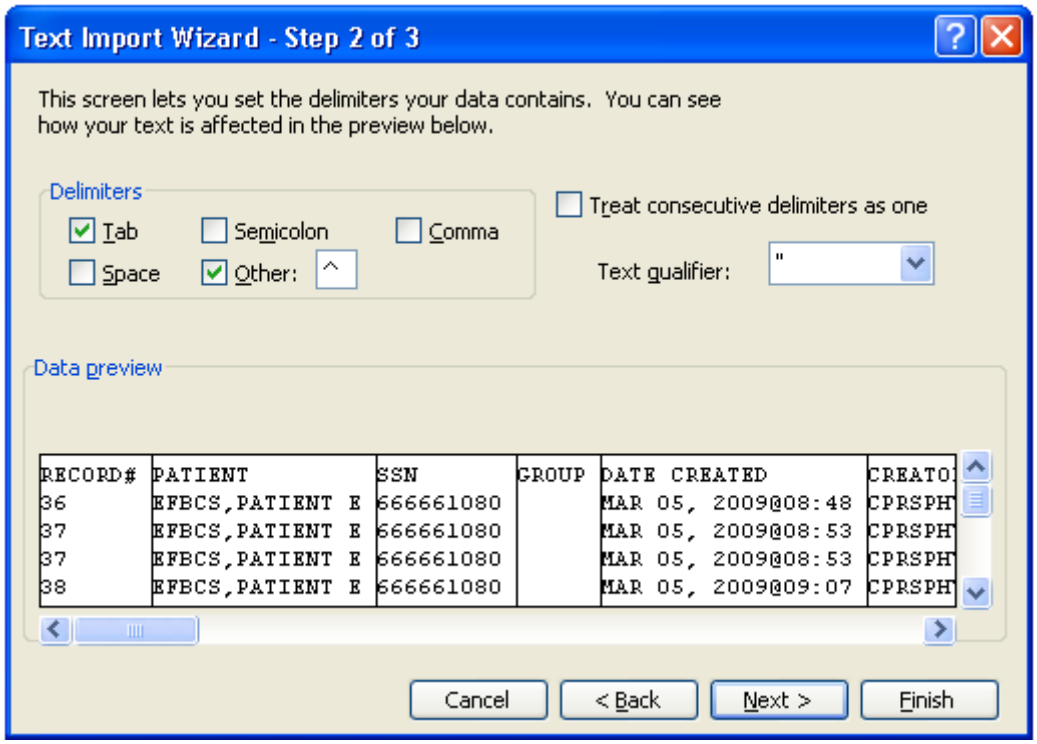
Developing Excel Spreadsheet Reports

6. Click the **Delimited** radio button.
7. Click the **Next** button. Another screen displays.



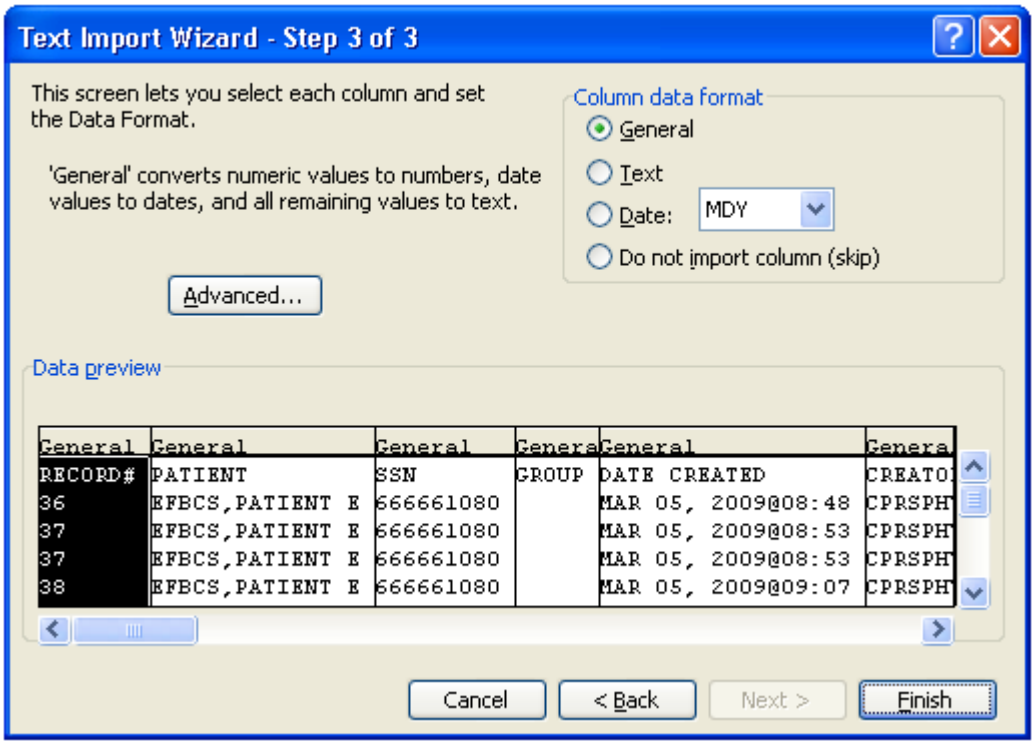
Delimiters Options

8. The checkbox beside Tab is checked by default.
9. Click the checkbox next to **Other**.
10. Type a ^ (<**Shift**> + <**F6**>) within the window beside Other. Then click the **Next** button.



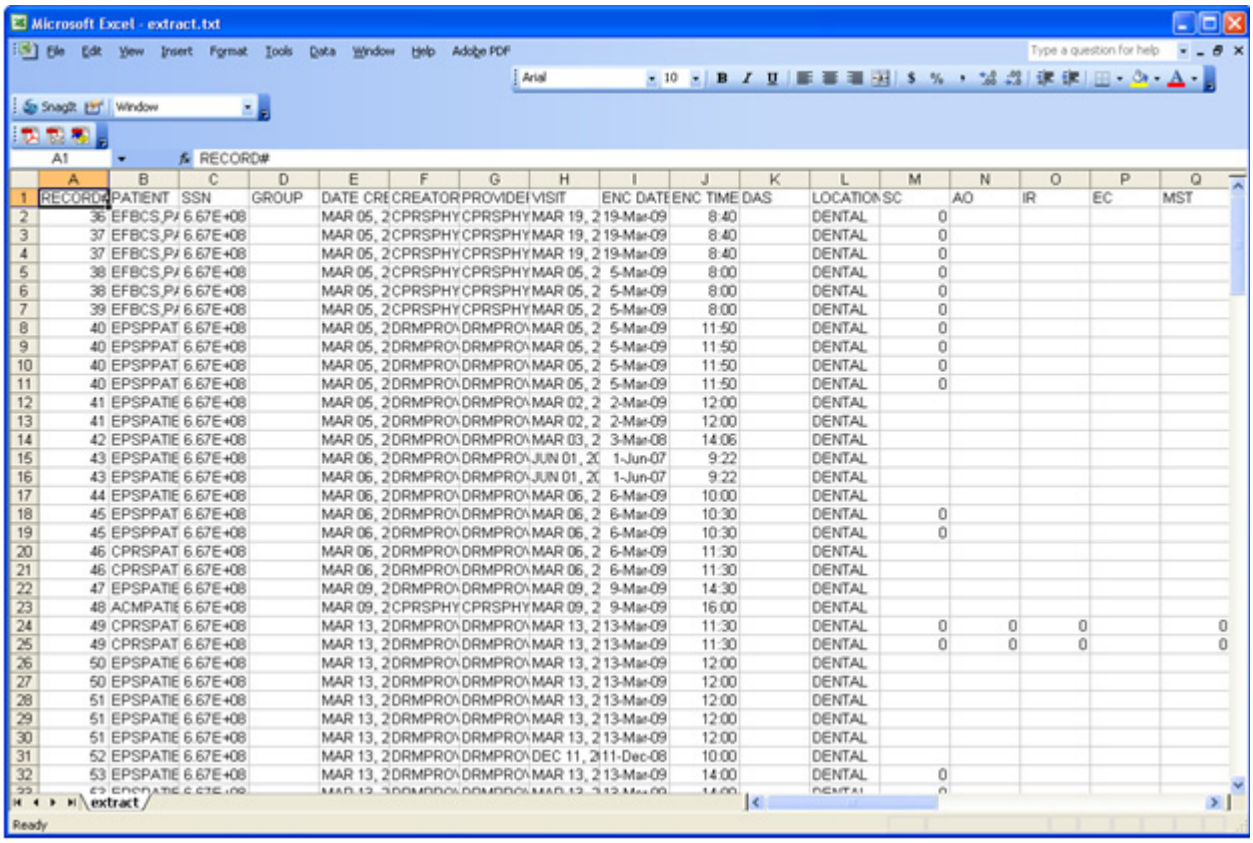
Preview Text

11. Click the **Next** button. A similar screen displays.



Text Import Wizard Final Screen

12. Click the **Finish** button. The extracted data displays in Excel.



RECORD#	PATIENT	SSN	GROUP	DATE CRE	CREATOR	PROVIDEI	VISIT	ENC DATE	ENC TIME	DAS	LOCATION	SC	AO	IR	EC	MST
36	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 19, 2	19-Mar-09	8:40		DENTAL	0				
37	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 19, 2	19-Mar-09	8:40		DENTAL	0				
37	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 19, 2	19-Mar-09	8:40		DENTAL	0				
38	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 05, 2	5-Mar-09	8:00		DENTAL	0				
38	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 05, 2	5-Mar-09	8:00		DENTAL	0				
39	EFBCS,P/	6.67E+08		MAR 05, 2	CPRSPHY	CPRSPHY	MAR 05, 2	5-Mar-09	8:00		DENTAL	0				
40	EPSPPAT	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 05, 2	5-Mar-09	11:50		DENTAL	0				
40	EPSPPAT	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 05, 2	5-Mar-09	11:50		DENTAL	0				
40	EPSPPAT	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 05, 2	5-Mar-09	11:50		DENTAL	0				
40	EPSPPAT	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 05, 2	5-Mar-09	11:50		DENTAL	0				
41	EPSPATIE	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 02, 2	2-Mar-09	12:00		DENTAL					
41	EPSPATIE	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 02, 2	2-Mar-09	12:00		DENTAL					
42	EPSPATIE	6.67E+08		MAR 05, 2	DRMPRO\	DRMPRO\	MAR 03, 2	3-Mar-08	14:06		DENTAL					
43	EPSPATIE	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	JUN 01, 2(	1-Jun-07	9:22		DENTAL					
43	EPSPATIE	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	JUN 01, 2(	1-Jun-07	9:22		DENTAL					
44	EPSPATIE	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	MAR 06, 2	6-Mar-09	10:00		DENTAL					
45	EPSPPAT	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	MAR 06, 2	6-Mar-09	10:30		DENTAL	0				
45	EPSPPAT	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	MAR 06, 2	6-Mar-09	10:30		DENTAL	0				
46	CPRSPAT	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	MAR 06, 2	6-Mar-09	11:30		DENTAL					
46	CPRSPAT	6.67E+08		MAR 06, 2	DRMPRO\	DRMPRO\	MAR 06, 2	6-Mar-09	11:30		DENTAL					
47	EPSPATIE	6.67E+08		MAR 09, 2	DRMPRO\	DRMPRO\	MAR 09, 2	9-Mar-09	14:30		DENTAL					
48	ACMPATIE	6.67E+08		MAR 09, 2	CPRSPHY	CPRSPHY	MAR 09, 2	9-Mar-09	16:00		DENTAL					
49	CPRSPAT	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	11:30		DENTAL	0	0	0		0
49	CPRSPAT	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	11:30		DENTAL	0	0	0		0
50	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	12:00		DENTAL					
50	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	12:00		DENTAL					
51	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	12:00		DENTAL					
51	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	12:00		DENTAL					
51	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	12:00		DENTAL					
52	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	DEC 11, 2	11-Dec-08	10:00		DENTAL					
53	EPSPATIE	6.67E+08		MAR 13, 2	DRMPRO\	DRMPRO\	MAR 13, 2	13-Mar-09	14:00		DENTAL	0				

Report Preview

13. The text file can now be saved in an Excel format (.xls file). Select **File** from the top menu bar, then choose the **Save As** option. Rename the file and save with the .xls suffix.
14. The Excel worksheet can now be modified to create any number of custom reports to meet specific needs. The Excel tools are powerful, and numerous report types can be created depending on the user's level of Excel proficiency.

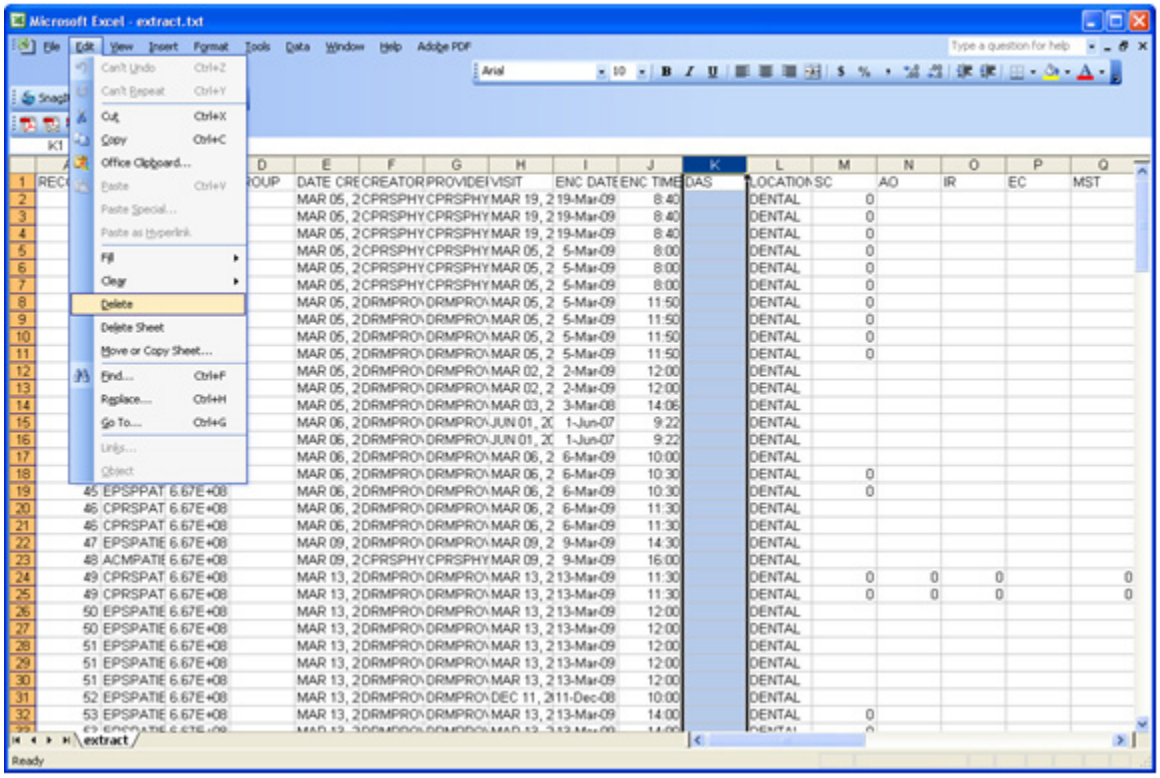
Examples of possible reports include:

- All Procedures by Provider
- All Procedures by Patient
- All Procedures by Clinic
- Reports by ADA Code
- Specific ADA Codes by Provider
- Reports by Diagnosis

Creating Custom Reports Using Excel

Reports can be customized using a variety of Excel functions including: deleting, expanding, formatting, sorting and subtotaling fields. Data may also be copied to other Excel worksheets to create numerous separate reports.

Deleting Columns or Rows



Creating Custom Reports in Excel -- Deleting Columns or Rows

To delete a column or row:

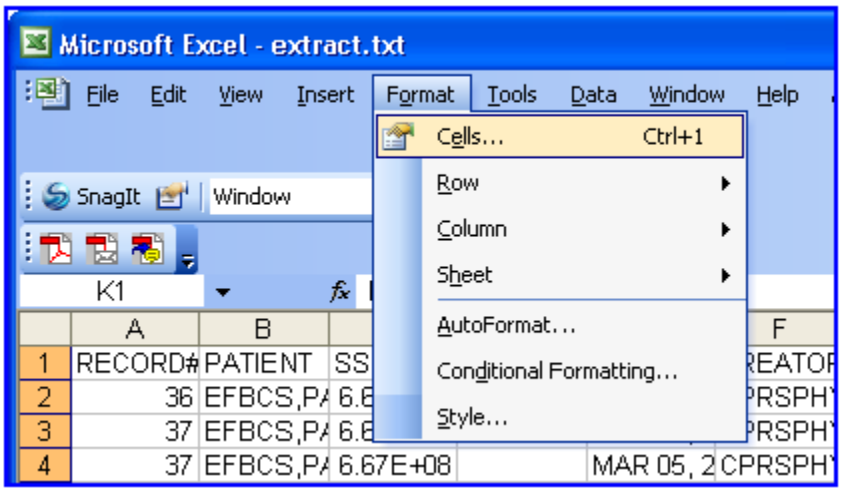
1. Click the column or row header. This highlights the column or row for deletion.
2. Click the **Edit** button.
3. Click the **Delete** button. This function can be initiated by right-clicking with the cursor in the highlighted area.

Expanding Columns or Rows

Put the cursor on the line between the column heading letters. The cursor turns into a cross with two arrows. Holding the left mouse button down and dragging right or left expands or contracts the column or row. Double-clicking automatically expands or contracts the column or row to fit the contents.

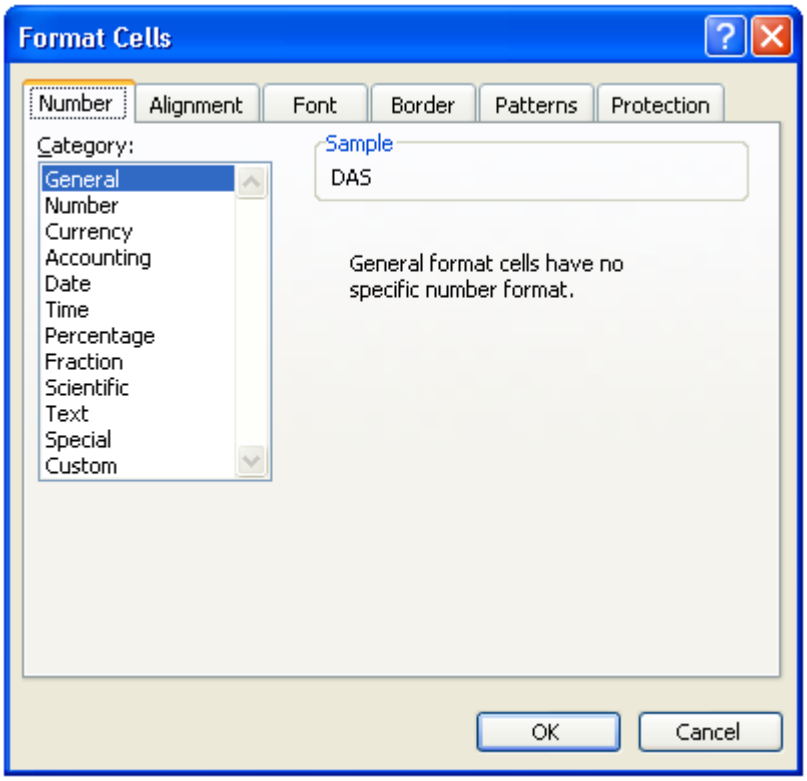
Field Formatting Options

Click the **Format** menu. The following is displayed.



Field Formatting Options

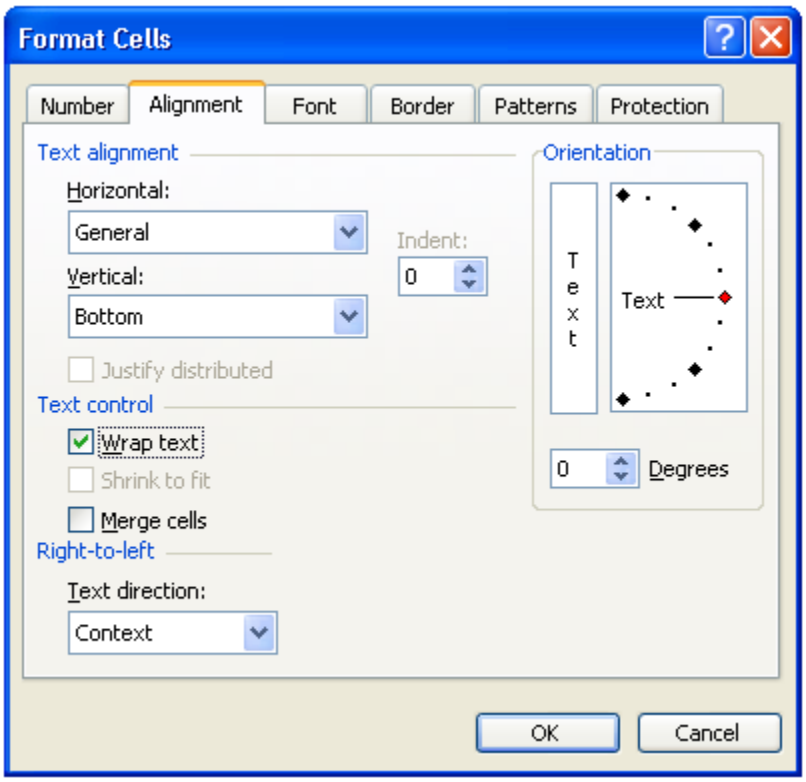
Click on **Cells**. The following screen displays.



Format Cells

Select the desired option, then enter the desired changes.

Set Horizontal/Vertical settings to make the report easier to read. Setting the text control to wrap text automatically wraps the text within the space allotted for the cell. The height of the cells in a row or column changes. Click the **Alignment** tab to display the following screen.



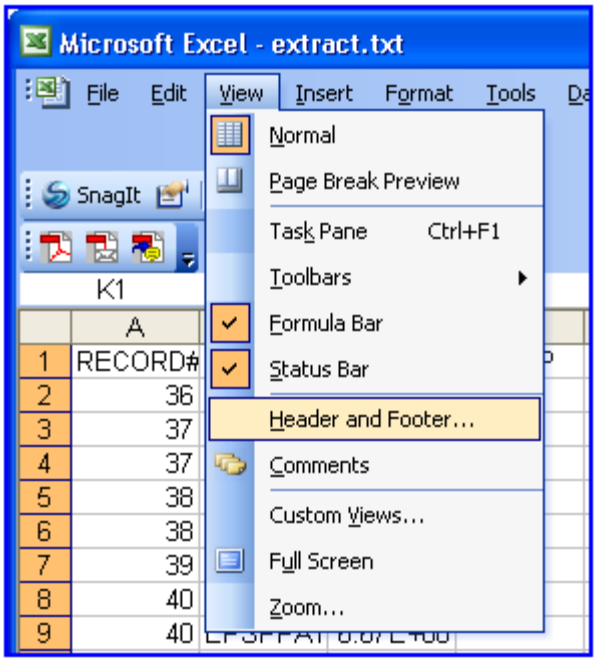
Text Alignment Options

Click the **Wrap text** checkbox. Click the **OK** button to complete the process.

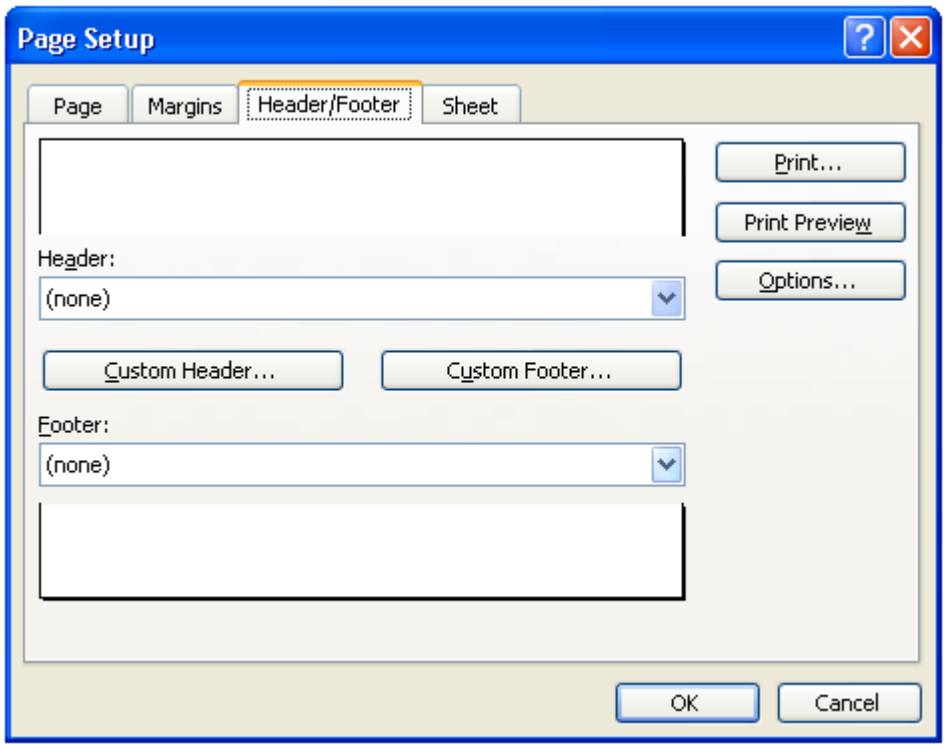
Creating a Header For a Report

1. Click the drop-down **View** menu.
2. Click on **Header and Footer**.
3. Click **Custom Header** or **Custom Footer.**

Place the cursor within the appropriate section and either type the Header or click on one of the icons to bring in the date, time or to format the entered text (select the text to be formatted before selecting the icon to format the text).

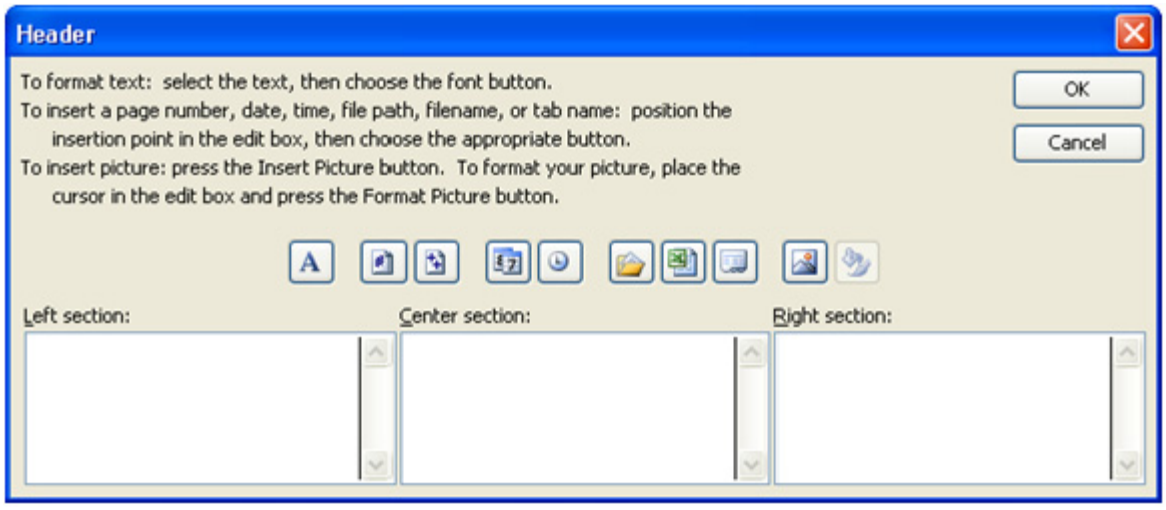


Header and Footer Option



Page Setup Screen

The screen below displays.

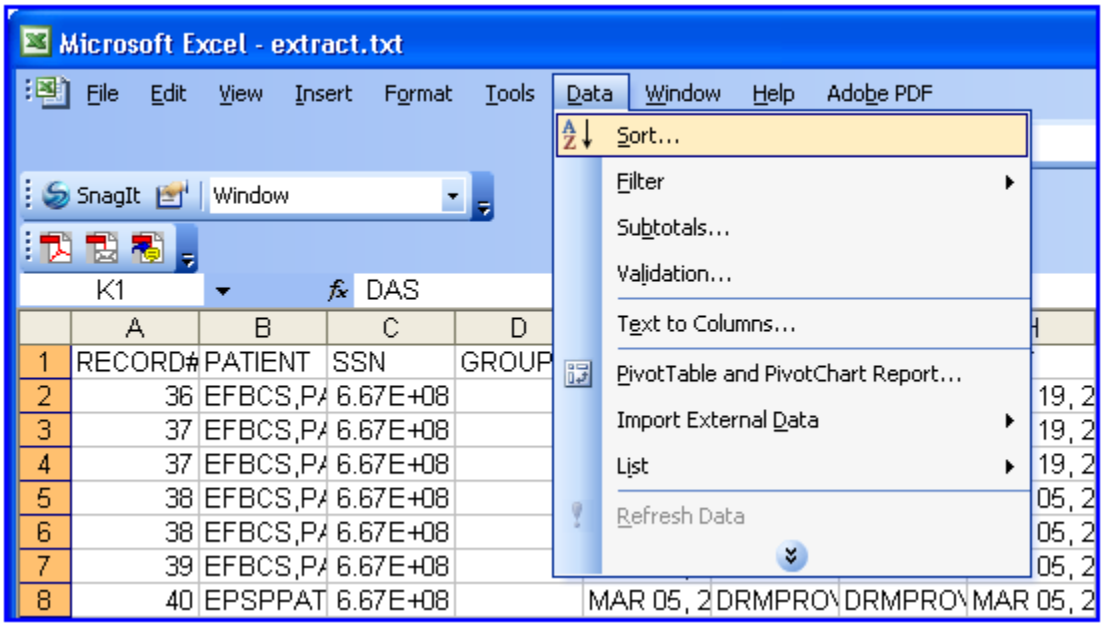


Header Formatting Screen

Sorting Data

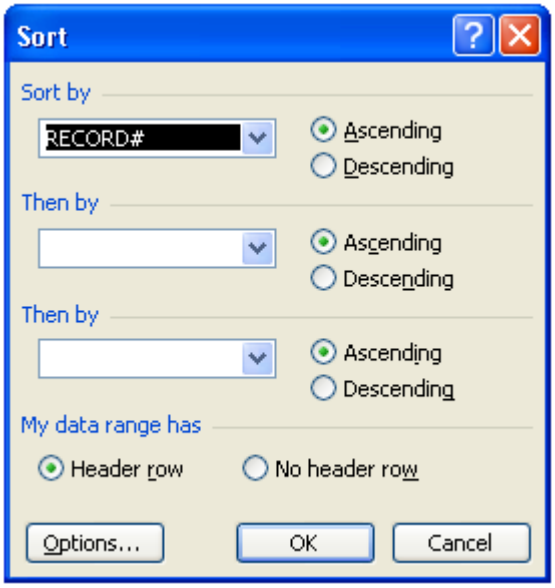
To sort data:

1. Highlight the fields to include in the sort.
2. Click the **Data** button.
3. Click the **Sort** button.



Sorting Data

The Sort screen displays.



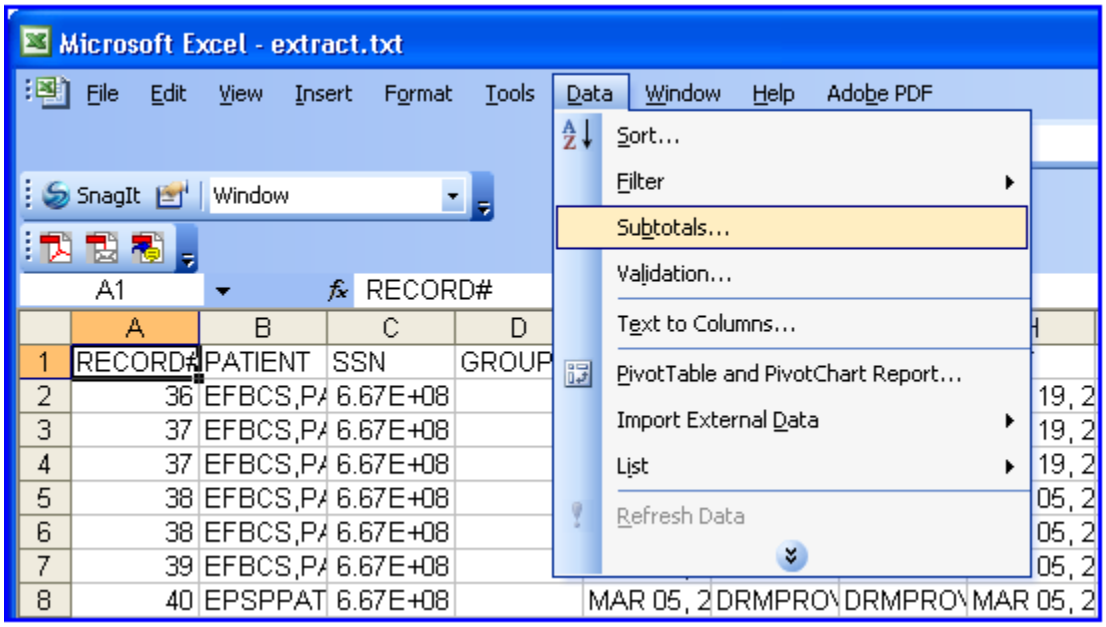
Data Sort Options

Choose the sorting options by clicking the drop-down menus and selecting the desired options.

Subtotaling Data

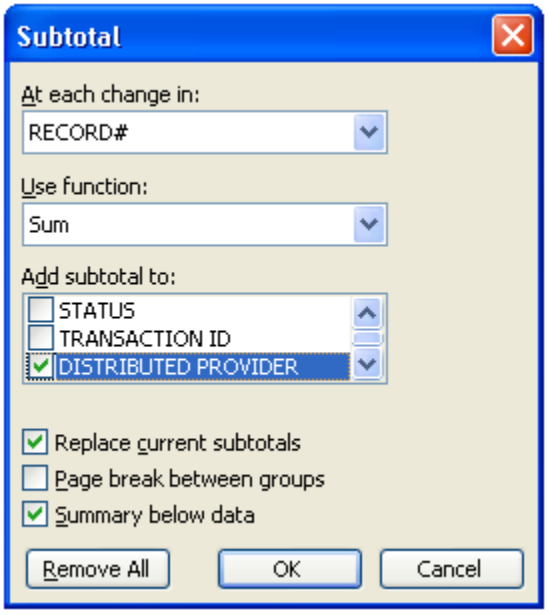
To subtotal data:

1. Highlight the fields to be included in the sub-total. Then click **Data** menu from the menu bar.



Subtotaling Data

2. Click **Subtotals**... The following screen displays.

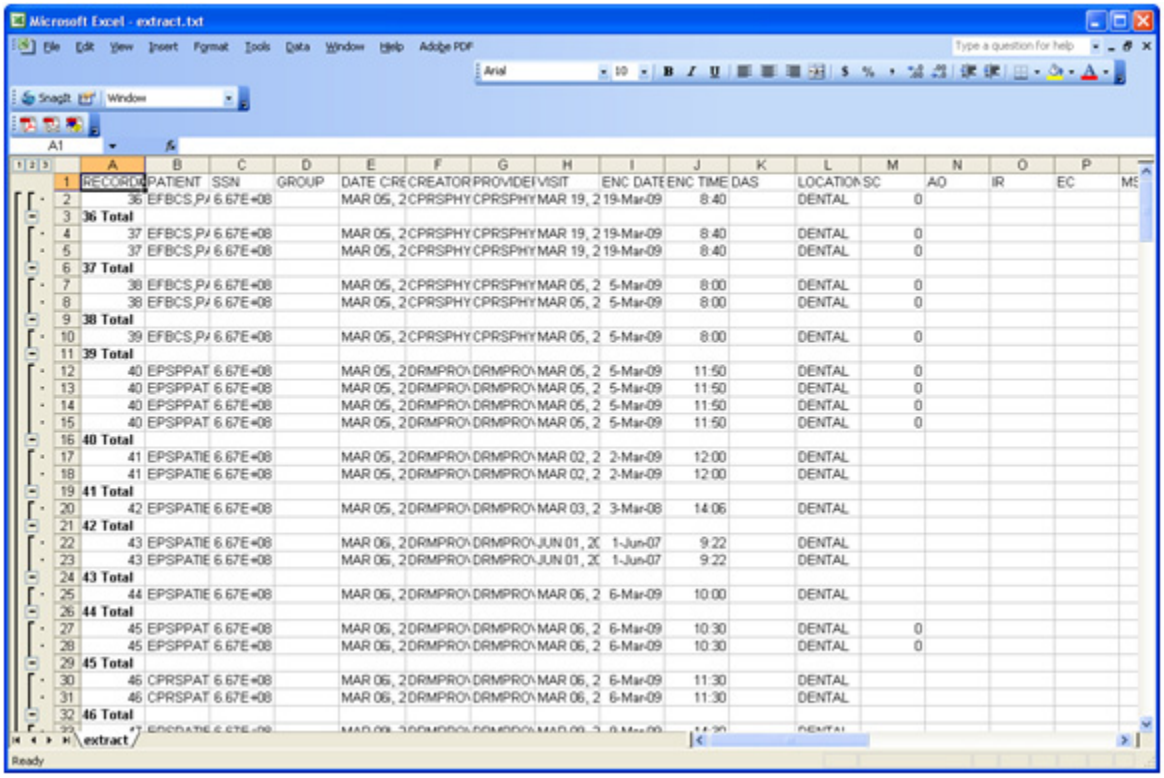


Subtotal Options

Pull Down Options

At Each Change In: Select an item to perform subtotals when a change occurs. The example uses CPT code.
Use Function: This example counts the number of times a provider performs a CPT Procedure in a given time frame.
Add Subtotal To: Location subtotals appear.

Below is a sample report:



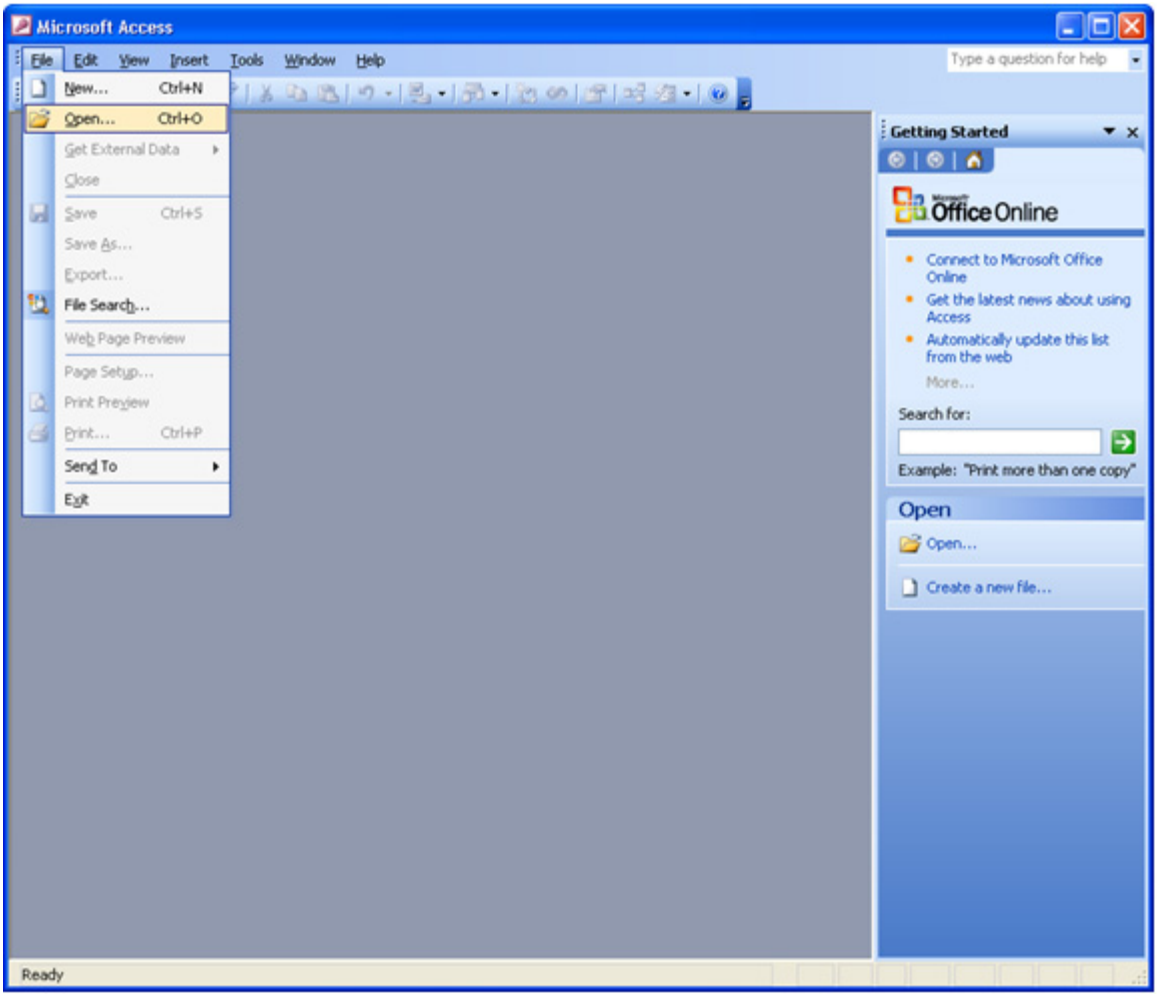
Sample of History File

Importing the DRM Plus Extract Text File into an Access Report

After creating a .txt file through the extract function, and saving this information in a preset folder, this information can be placed in Microsoft Access for reporting purposes.

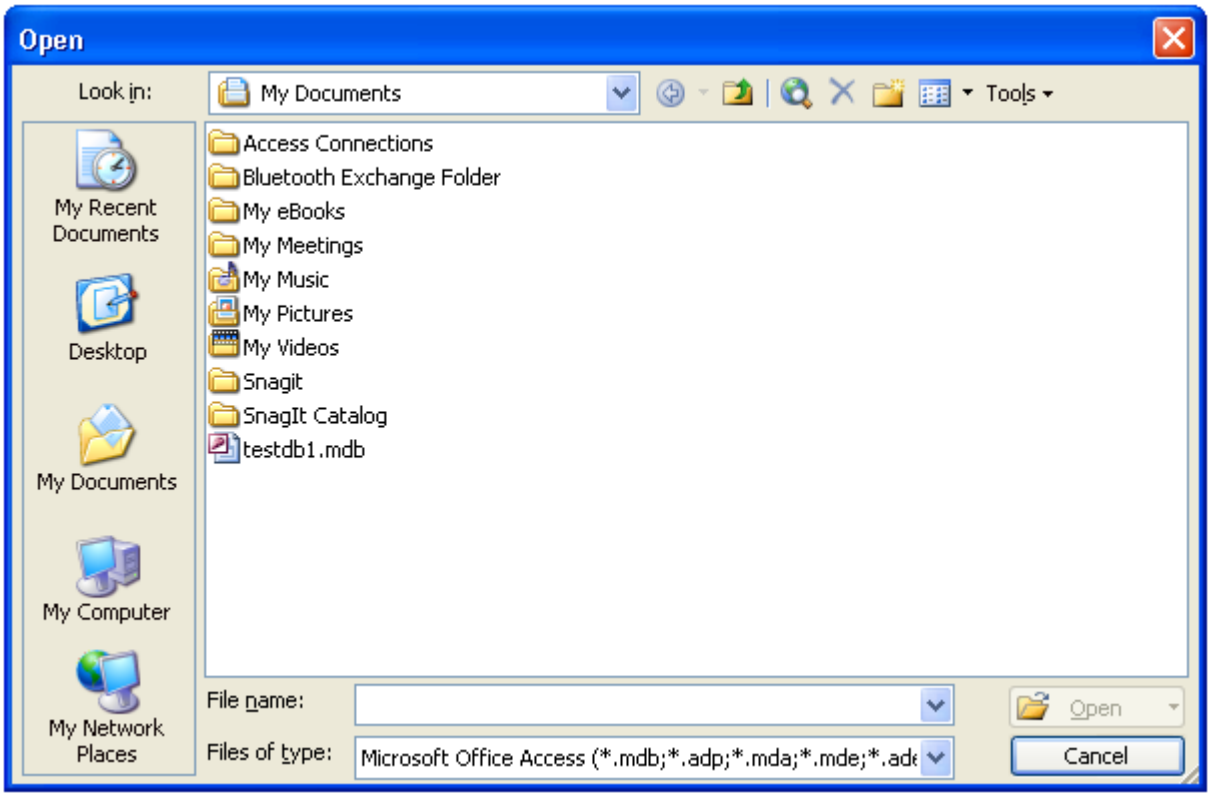
To import a DRM Plus extract file into Microsoft Access:

1. Open Microsoft Access. Click the **File** drop-down menu and choose the **Open** option.



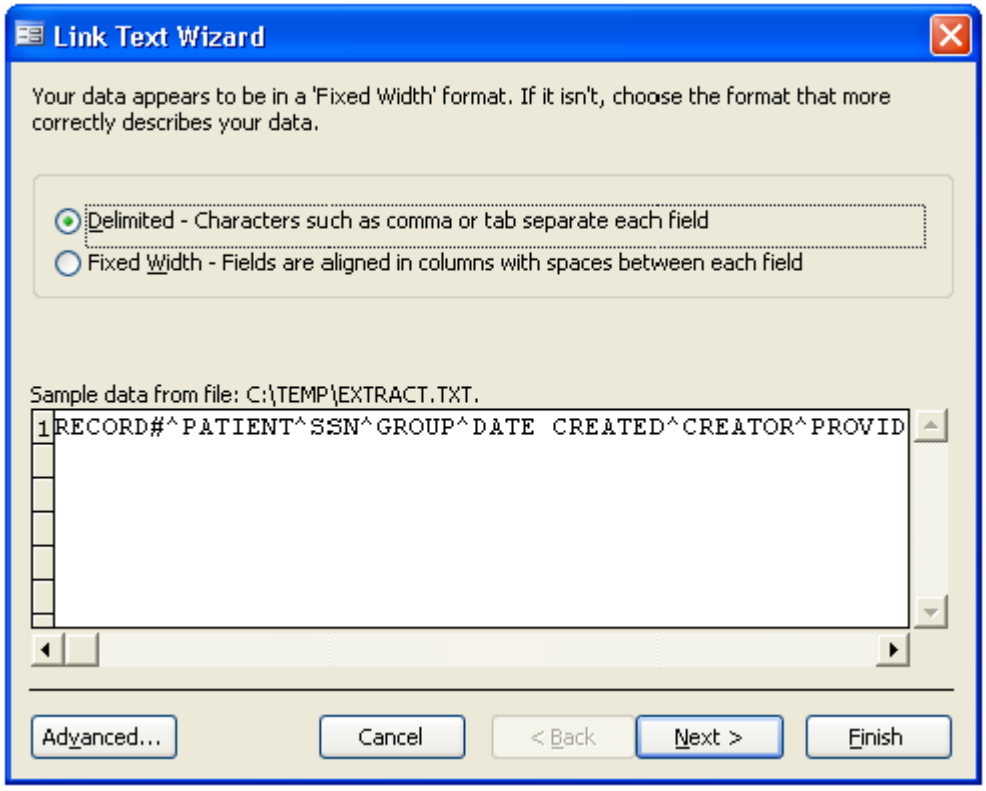
Import Extract File into Microsoft Access

2. The Open window displays. Using the drop-down menu, search and highlight the area where the preset extract folder is located. The preset extract folder contains the information previously extracted from DRM Plus.



Open File

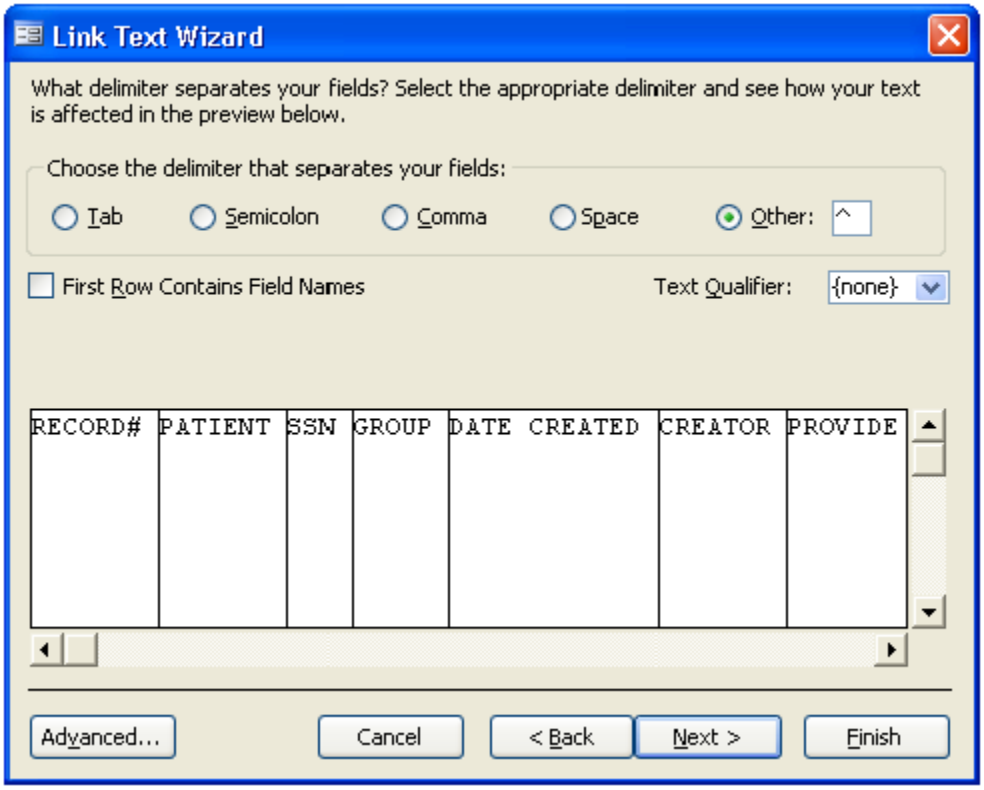
3. Once the folder is located in the Open screen, click and highlight it.
4. Click the **Files of type:** drop-down menu and choose All Files (*.*) as the extension.
5. Click and highlight the .txt file extraction. To access the file, choose one of the following options: double-click the .txt file; or, with the .txt file highlighted, click the **Open** button.
6. The following wizard screen displays, and the radio button preceding **Delimited...** must be selected. Select the **Next** button to continue the process.



Link Text Wizard

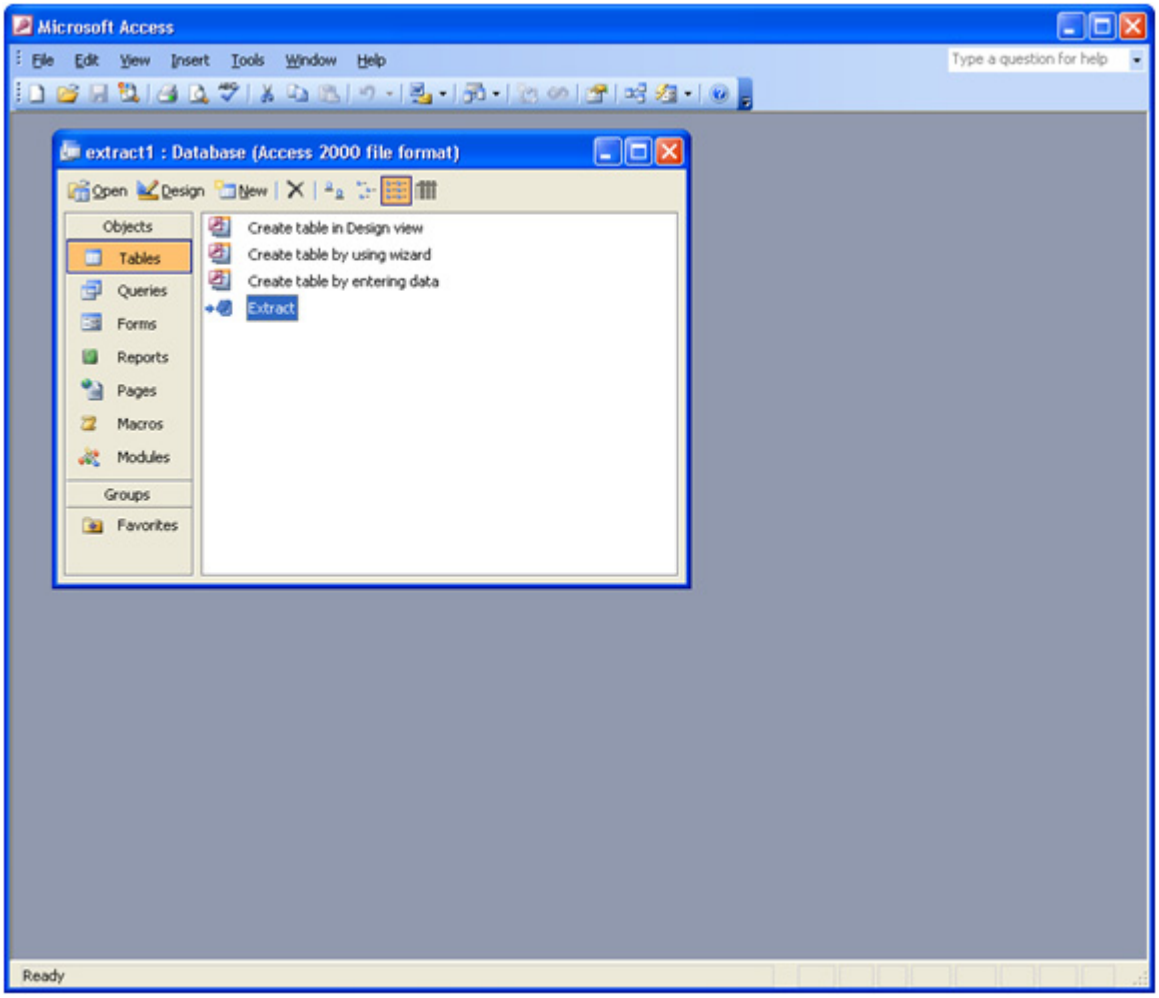
7. Click the **Next** button to continue the process.

8. Within the Link Text Wizard screen, select the radio button preceding **Other** and in the text area beside it, type a ^ (<**Shift**> + <**F6**>).



Link Text Wizard

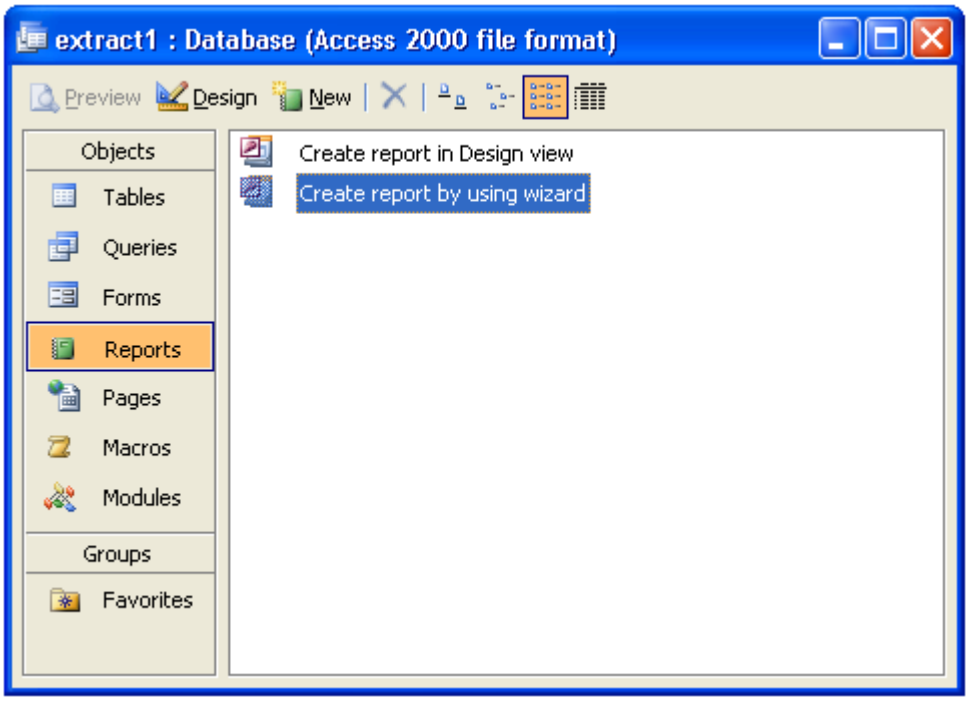
9. To continue, click the **Finish** button.
10. When the Finished linking table... screen displays, click the **OK** button.
11. The file appears in the Access Database screen.



File in Access Database Screen

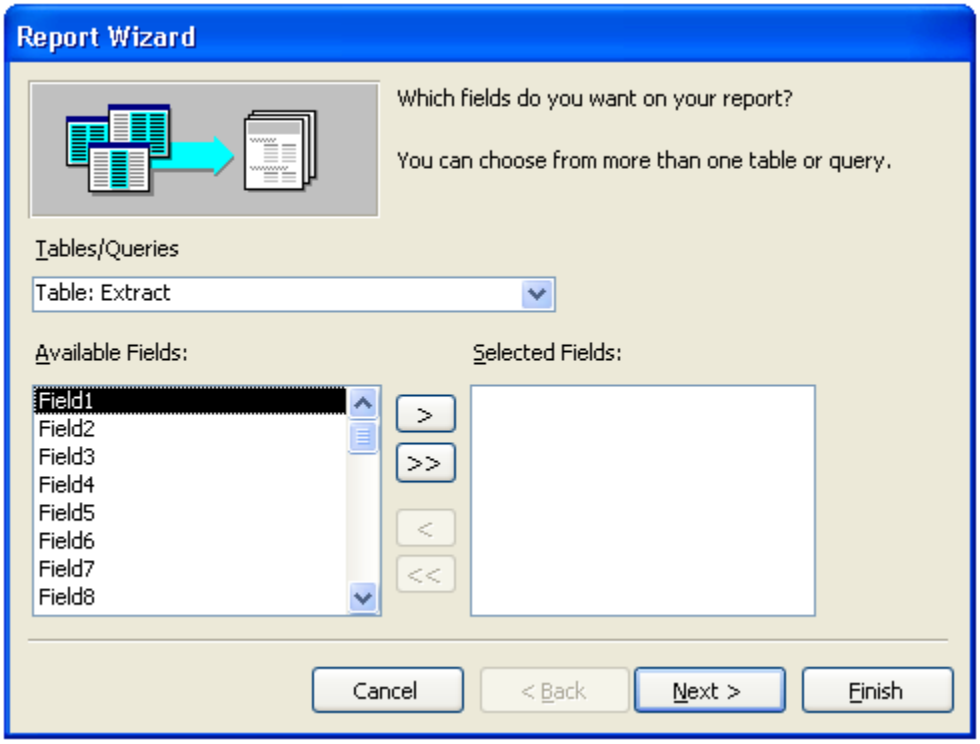
12. Click the **Reports** option, which displays on the remaining screen.

13. Highlight and double-click the **Create report by using wizard** feature.



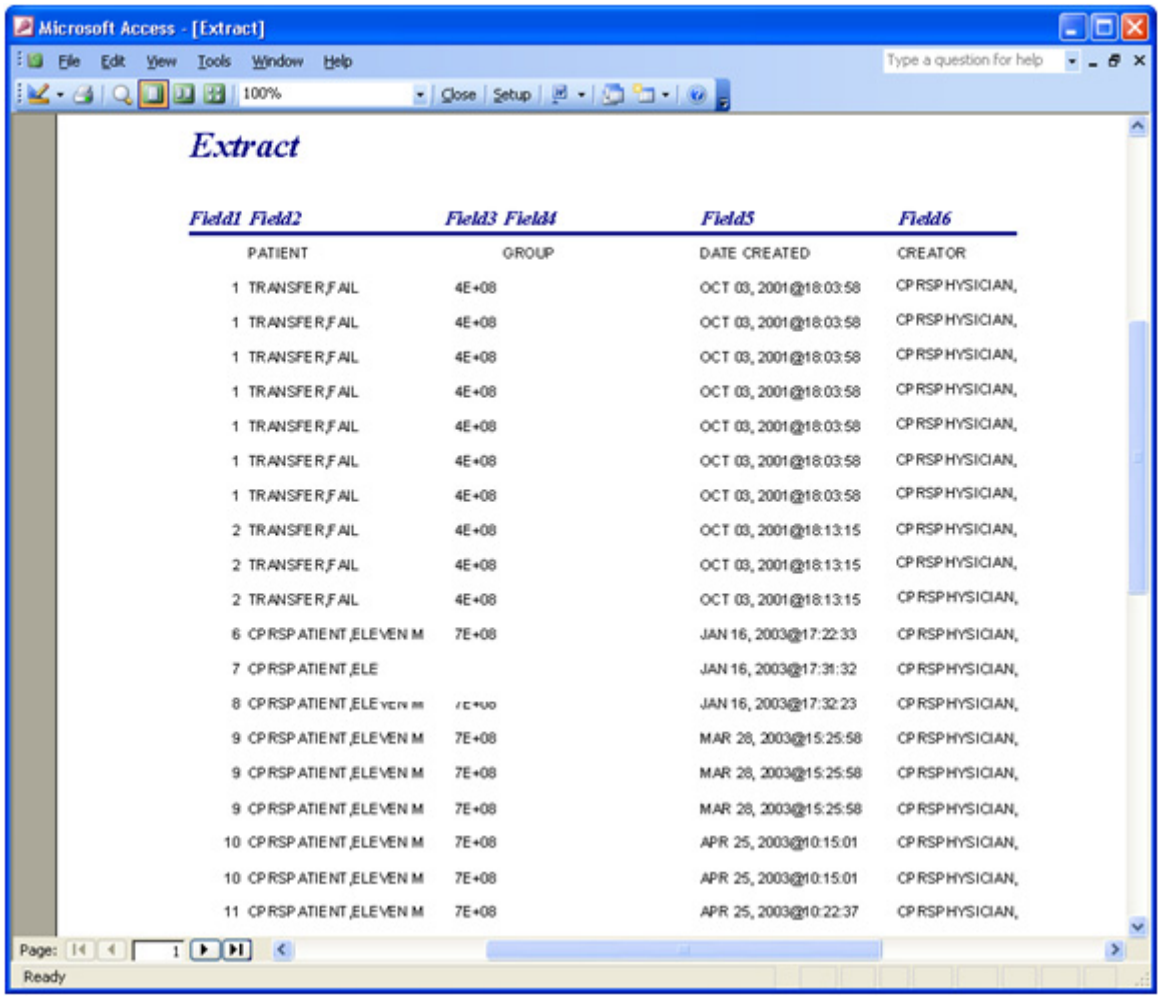
Create Report By Using Wizard

14. The Report Wizard window displays. Indicate the desired fields in the report by choosing by highlighting the field and moving it to the selected fields area using the double arrow (>>) buttons located in the center of the screen. Once all desired fields are selected, click the **Next** or **Finish** button to continue (or finish).



Choose Desired Fields For Report

15. Customized Microsoft Access reports appear with the selected field information.



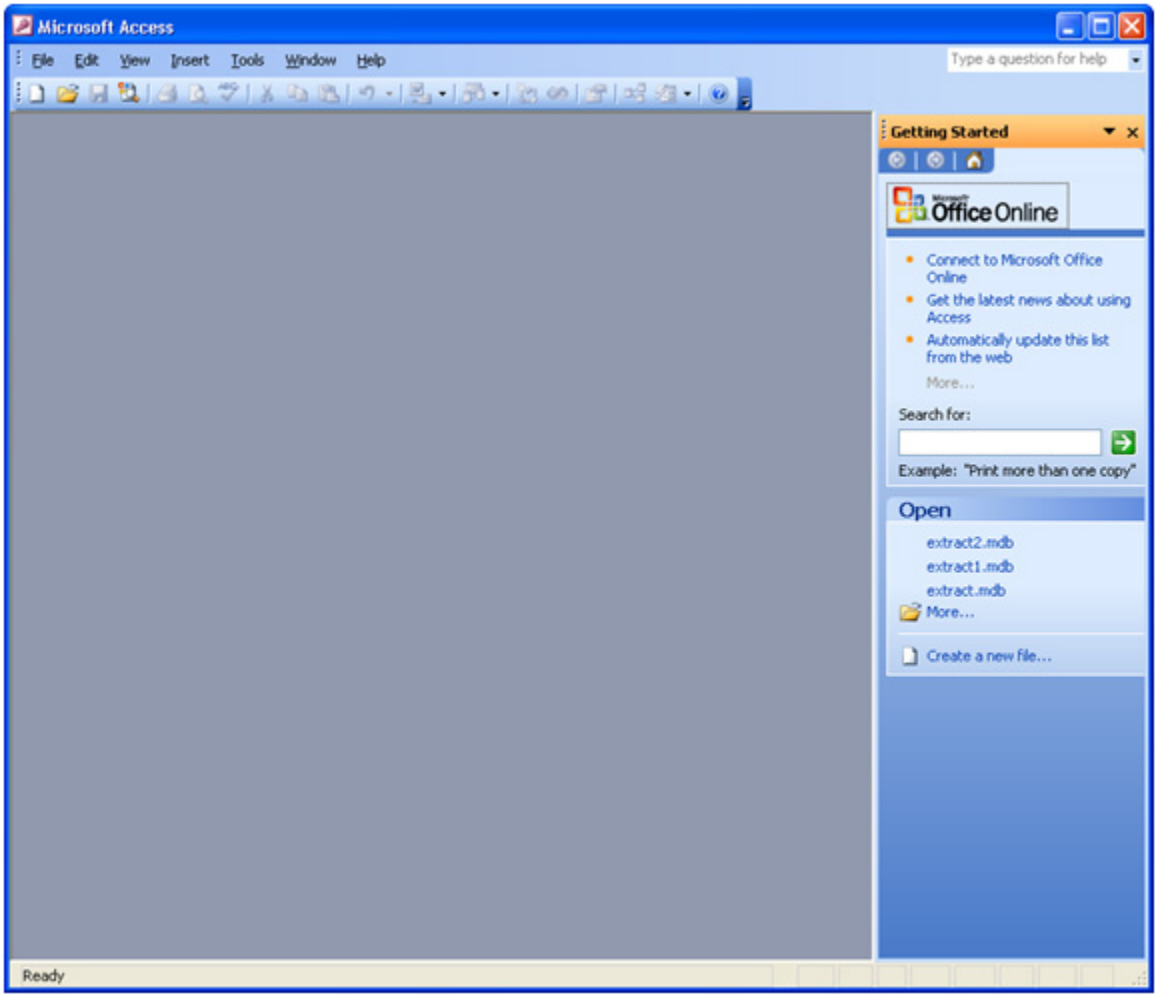
Customized Microsoft Access Report

The number of pages for any report depends on the number of fields selected. Total viewing of the Access report may require use of the Page arrow buttons, which appear on the bottom left of the screen.

Importing the DRM Plus Extract Excel File into Access Database

To import the DRM Plus extract file (Excel spreadsheet) into a new Microsoft Access database:

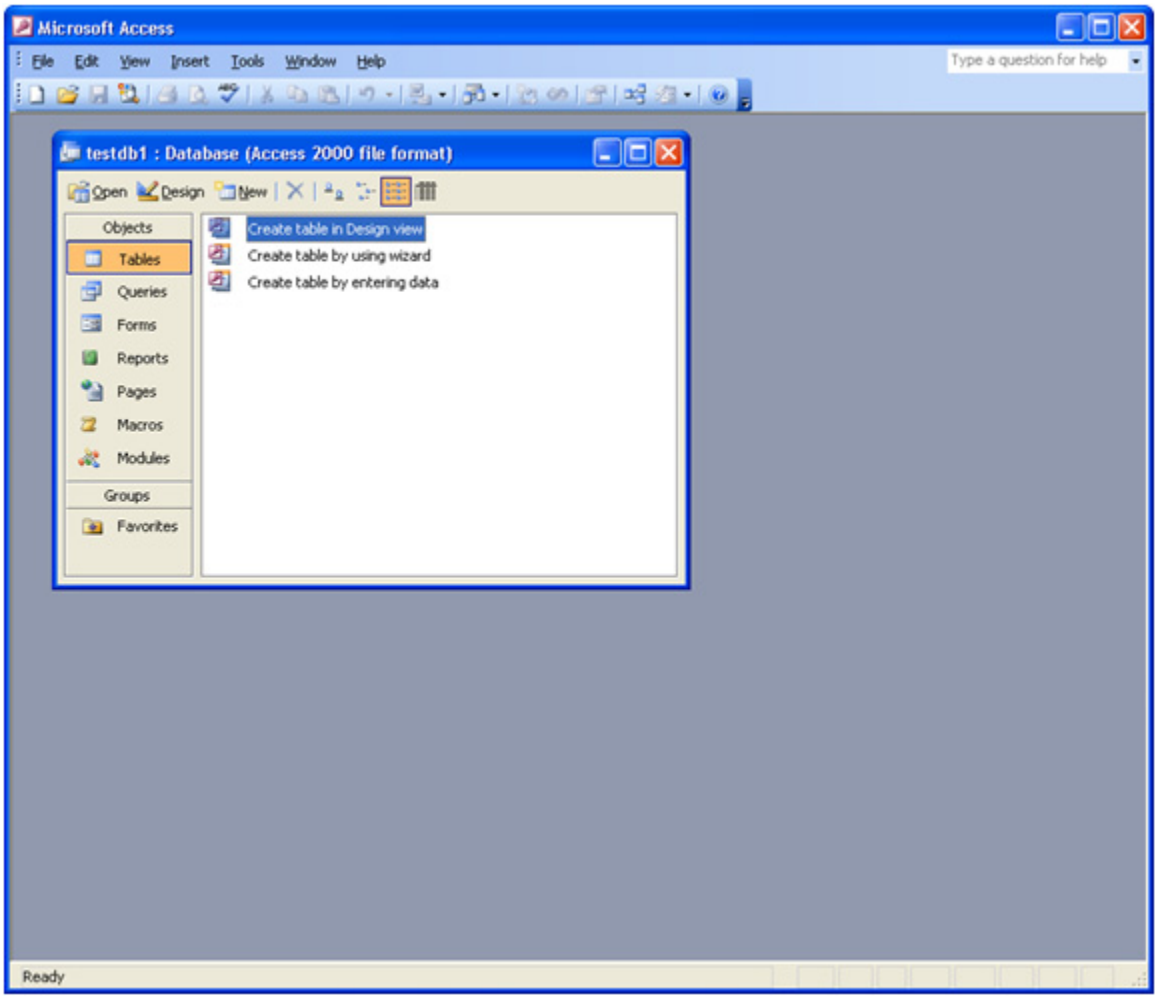
1. Open **Microsoft Access**.
2. Create a new database.



Import Excel File In Microsoft Access

3. Select **Create a blank database**.
4. **Save** the new database.

Upon saving the database, the following screen displays.

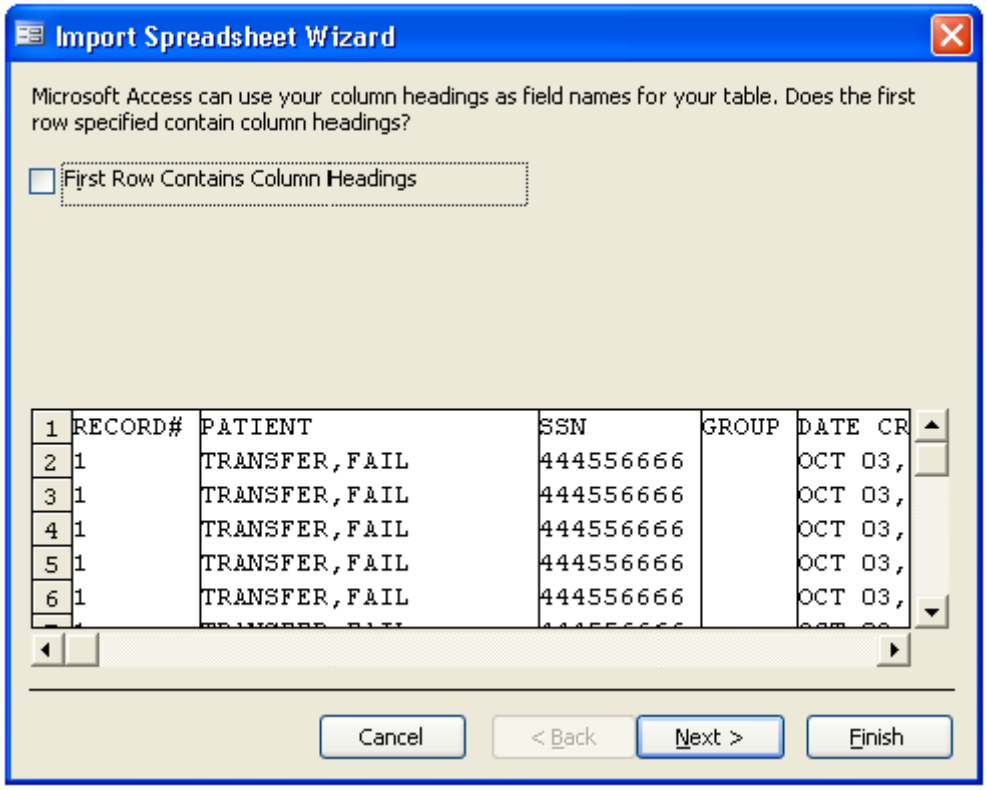


Microsoft Access Tables Window

To import an extract Excel file:

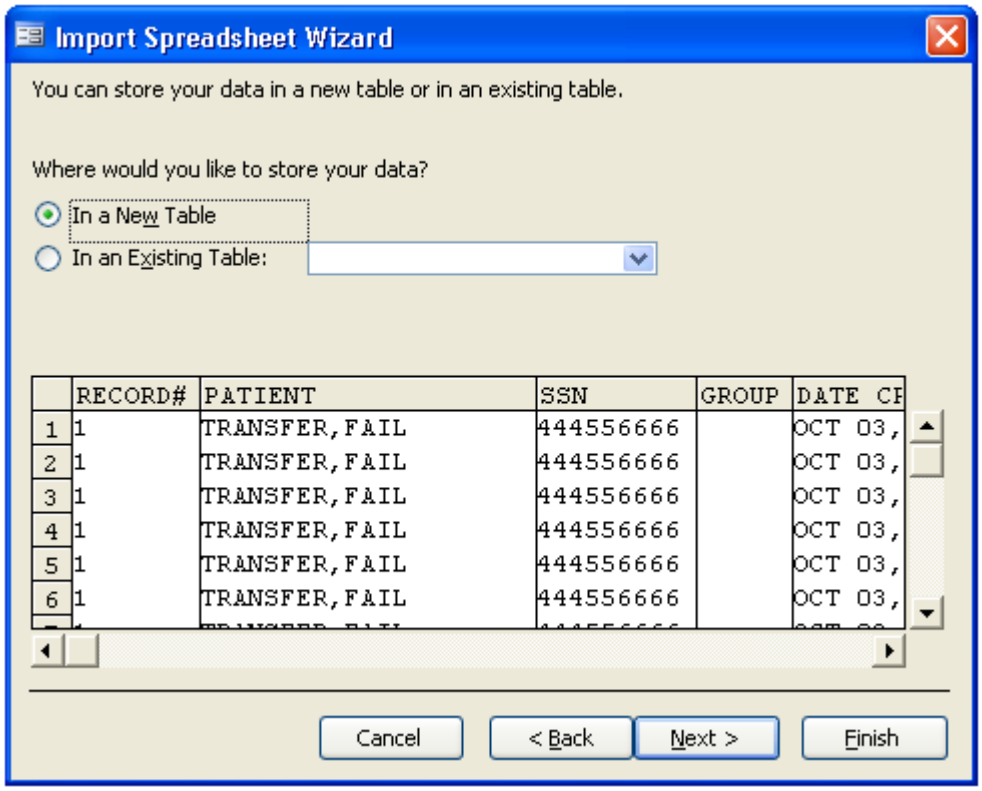
1. Click the **File** drop-down menu.
2. Click the **Get External Data** option.
3. Click the **Import** option.
4. Select the desired Excel file to import.

5. Click the **Import** button, and the Import Spreadsheet wizard displays. In the event that this wizard is not installed, contact local IRM for additional support.



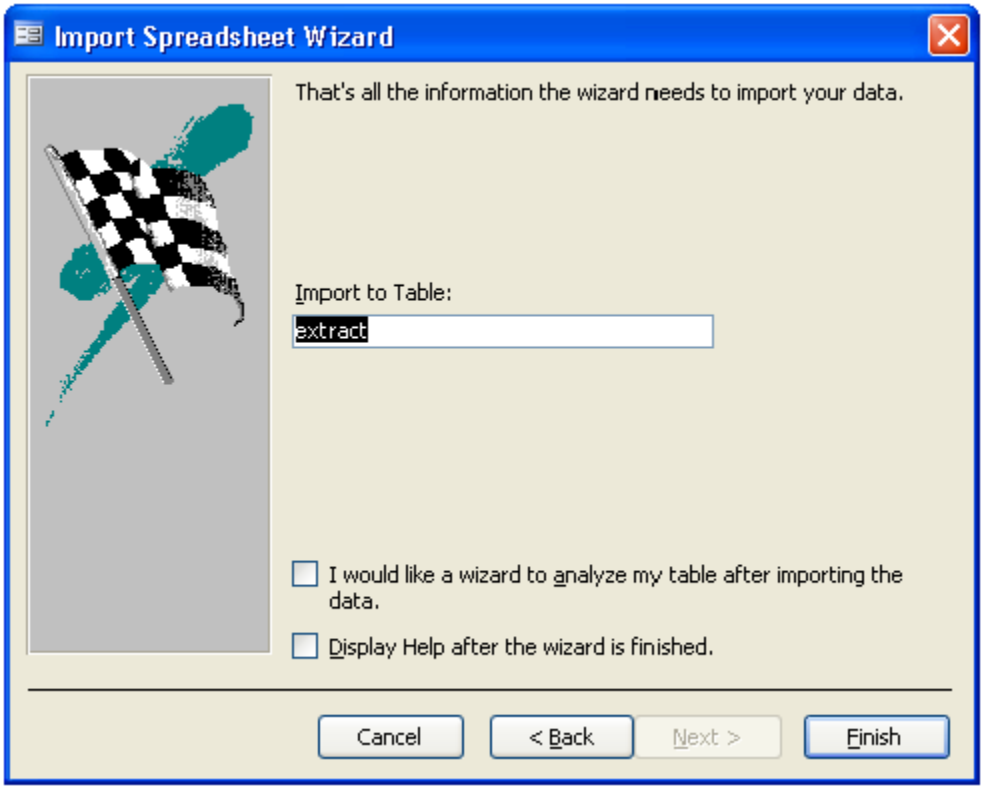
Import Spreadsheet Wizard

6. Select the defaults, then click the **Next** button to continue.



Select Defaults For Storing Data

7. Continue to select defaults until the following screen displays.



Import To Table

8. The extract spreadsheet is now in a Microsoft Access database.

Note: Microsoft Access training may be available. Contact local IRM for further information.

Appendix F -- Transmission & Correction of Processed DES Data

Sending DES data to the Austin Corporate Franchise Datacenter (CFD) is a weekly process. The CFD receives this transmission of DES records in the form of standard HL7 messages from the site, through the VistA Interface Engine (VIE).

Errors should not be anticipated during this process; however, in the event that the data is corrupted, the software warns users that the data cannot be sent. Also, the software informs users if sent data was not received accurately.

There are two types of errors that may occur during transmission:

- The first is generated by the dental application on VistA when the DES data is being validated, prior to being sent to the CFD.
- The second is generated by the CFD when attempting to validate the data within the HL7 message.

Note: Both error types are rare, particularly those generated by the CFD.

The dental application on VistA attempts to verify DES data before sending it to the CFD. A new mail group has been added called DENTV HL7 MESSAGES. When missing or invalid data is found, a Mailman message generates and is sent to members of the DENTV HL7 MESSAGES mail group. Members of this group should include a DRM Plus administrator, and someone from IRM, in order to research the cause of the error.

The following is an example of a transaction with an invalid RVU value:

```
Subj: Dental Transaction Error [#844] 10/18/04@13:16 2 lines
From: POSTMASTER (Sender:            ) In 'IN' basket.  Page 1 *New*
---------------------------------------------------------------------
An error was reported for a dental transaction HL7 message.
Invalid data for PATIENT,TEST transaction 42220, file TREATMENT PLAN
TRANSACTION/EXAM field RVU.

Enter message action (in IN basket): Delete//
```

Transaction With Invalid RVU Value

IRM may be asked to use FileMan to view the record 42220 in file Treatment Plan Transaction/Exam (file 228.2) to see what the field RVU contains. The RVU should be a numeric value between 0-9999 (based on the data dictionary definition).

To repair the data, the DRM Plus administrator should delete the transaction from the patient's transaction list, and re-enter it with the correct information. In order to find the correct transaction to delete, the DRM Plus administrator may need additional information from the transaction, such as date entered, ADA code, etc., which can be retrieved via the FileMan Inquire option. Again, receiving these messages and having to

repair data should be an exceedingly rare occurrence. These messages were designed to ensure that all workload data is transmitted to the CFD, and to alert all users in the event this does not occur.

Hl7 messages sent to the CFD may also be rejected due to missing or invalid data. This is also a rare occurrence, due to system checks previously performed by VistA. These checks are performed on the CFD side as a safety measure, in the event that a problem occurs with the transmission batch, or the transmission process itself.

Due to the nature of the HL7 message, along with the rejection received from the CFD, this type of message is more difficult to decipher. In order to successfully decipher HL7 messages, some knowledge of HL7 segments and fields is required.

The following is an example of a transaction with a required field missing.

```
Subj: Dental Transaction Error [#721] 08/23/04@12:14 5 lines
From: POSTMASTER (Sender:          ) In 'HL7' basket.  Page 1
---------------------------------------------------------------------
Application error or reject for HL7 message 4638449599-3
received from Austin Automation Center.
Error code:  , Error text:
SEG: PID SEQ: 03
FLD: 01 Code: 101&REQUIRED FIELD MISSING

Enter message action (in HL7 basket): Ignore//
```

Transaction With Required Field Missing

The HL7 message ID is contained in the dental DES/HL7 TRANSMISSION (#228.25) file. This ID can be used to look up the HL7 transmission entry. At that point, it can be used to find the transaction ID for the Dental Encounter (file 228.2) rejected message.

In addition to adding members to the VistA mail group, an Exchange Group (Distribution Group) must also be created on the exchange server (should have been created when Patch 40 was installed) so that it appears in the Outlook Global Address List (GAL) as follows: VHAUserSiteVIEMessages, i.e. VHABHHCS VIE MESSAGES (Black Hills Health Care).

This group provides the Vista Interface Engine (VIE) Team with an address to send error messages to. Since all HL7 messaging eventually are directed through local VIEs, it is vital that this group includes persons on site with knowledge of HL7 functionality.

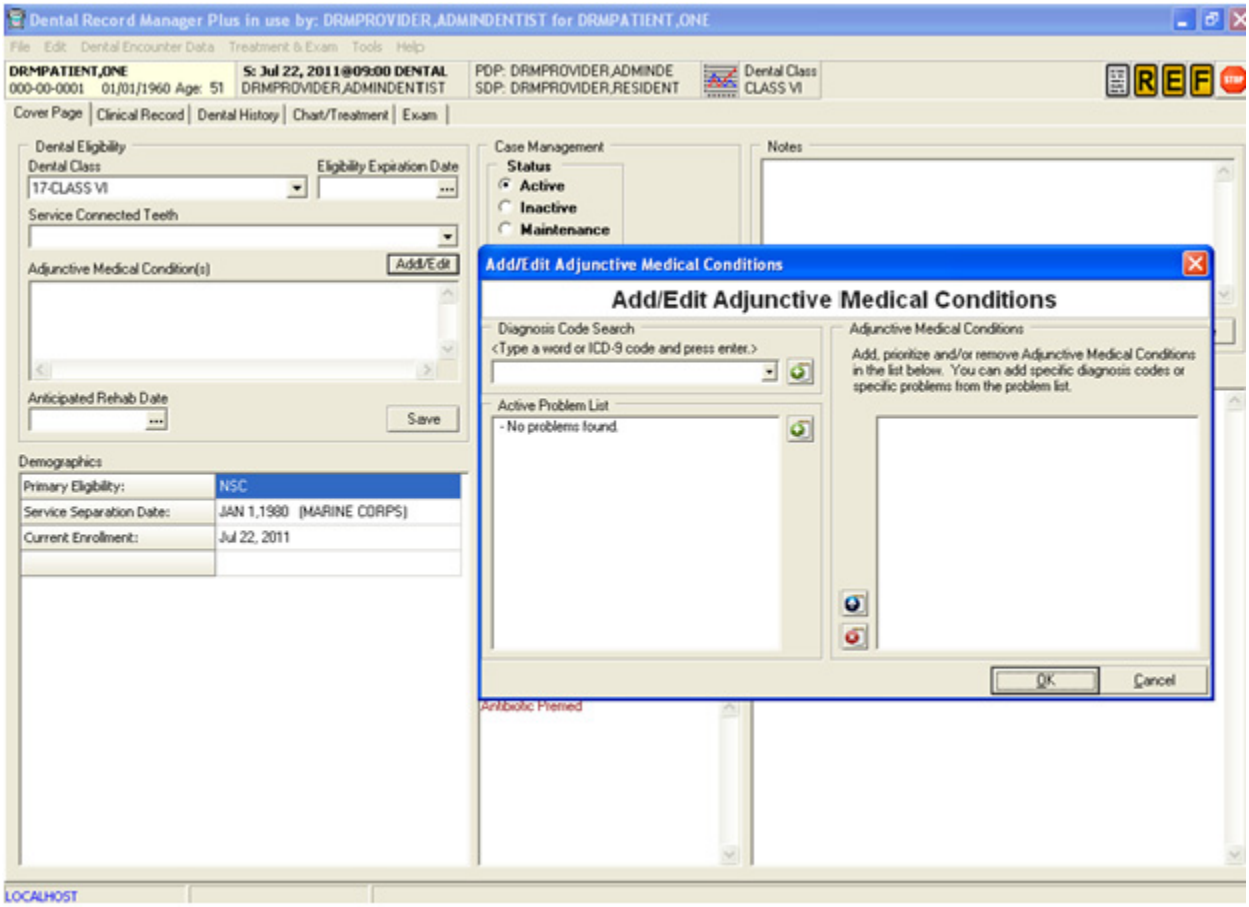
The SEGment, SEQuence, FieLD and Error Code values are used to show which piece of data was missing or invalid. Repairing the data follows the same procedures as those performed by VistA.

HL7 Transaction Data from Dental will be Automatically Resent

During the weekly transmission of dental encounter/transaction data, a process checks whether the CFD has received and acknowledged the transactions. If there are no acknowledgements for two weeks, the data is resent during the next week's transmission. This should prevent the manual re-transmissions that IRM performs when data does not reach the national database.

Additional Reporting Data will be Sent to CFD

Additional reporting data has been added to the HL7 message sent to the CFD for national reporting. This data includes the Primary and Secondary Provider designations for the patient, the patient's Dental Class and Recare Date from the DRM Plus Cover Page, and up to five Adjunctive Medical Conditions (AMC). The AMC data now includes the diagnosis code, in addition to the text, so that the code data may be sent to the CFD.



Adjunctive Medical Condition Entries

For further information, see the Adjunctive Medical Conditions section in the Cover Page chapter of this manual.

Appendix G -- Using the Keyboard to Enter Periodontal Data

Overview

The Periodontal screen is designed for data entry using the mouse. Data entry using the keyboard is also an option. Clicking the **Keyboard Mode** key, <**F10**>, initiates keyboard navigation and data entry on this screen.

Keyboard Mode Button on the Periodontal Chart Screen

When this button is clicked, all of the icons are grayed out 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 form 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, 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 "+" 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: With the cursor in the correct position, press the <**B**> key.

D = Delayed Bleeding: With the cursor in the correct position, press the <**D**> key.

S = Supporation: 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 and with the cursor in the correct position 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
X = Lock

For convenience, a tear-out of the following Periodontal Keyboard shortcut chart is available on the last page of this manual.

Appendix H -- Ranged Codes

Using the graphic icon on the Treatment Plan and Completed Care screens is not only straightforward, it minimizes the potential for errors. Certain codes, designated as Ranged Codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted to icon use only for procedure entry. These codes are listed below.

Removable 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
5860	6077	6252
5861	6078	6253
	6079	6545
	6194	6448
		6600
		6601
		6602
		6603
		6604
		6605
		6606
		6607
		6608
		6609
		6610
		6611
		6612
		6613
		6614
		6615
		6624
		6634
		6710
		6720
		6721
		6722
		6740
		6750
		6751
		6752
		6780

Maxillofacial Prosthetics	Fixed Prosthodontics
5934	6781
5935	6782
	6783
	6790
	6791
	6792
	6793
	6794
	6920

Appendix I -- Active-Inactive Maintenance Control

With the introduction of DRM Plus, the direct entry of **[Completed]** or **[Terminated]** cases was removed from the program. Instead, the concept of Patient Disposition was introduced. The provider can choose between an **[Active]** or **[Inactive]** status, and if no planned items remain, the case records as **[Completed]**. If the provider changed the patient from **[Active]** to **[Inactive]** status, and planned items remained, the case records as **[Terminated]**. The Current Episode of Care is defined as that interval from when the patient was last updated from **[Inactive]** to **[Active]**, then back to **[Inactive]**.

A need has been recognized to account for patients who may not be active under care (i.e. have currently planned dental procedures) but may be in a maintenance status, pending future diagnostic or preventive dental care. Effective with Patch 47, DRM Plus now allow providers to choose the status of **[Active]**, **[Inactive]** or **[Maintenance]** for their patient.

Case Management Status

By design, whenever a new dental patient is created in the Dental Patient file that patient's status is set to **[Active]**. As before, if the provider changes the patient from an **[Active]** to **[Inactive]** status, and there are no planned items remaining, the case is recorded as [Completed]. If the provider changes the patient from an **[Active]** to **[Inactive]** status, and there were planned items remaining, the case is recorded as **[Terminated]**. Now additionally, if the provider changes the patient's status from **[Active]** to **[Maintenance]**, and there are no planned items remaining, the case is recorded as **[Completed]** and the episode of care ends. If the provider changes the patient's status from **[Active]** to **[Maintenance]**, and there are planned items remaining, the case remains ongoing with no changes to the episode of care. No matter what the patient's previous status, a patient's status is set to **[Active]** if an entry is made for additional planned care.

The provider also now has the option of entering a Recommended Recare Date for the patient, which provides a date flag for reporting and re-evaluation purposes. (As CPRS re-engineering continues, this flag eventually is used for setting a clinical reminder in CPRS).

Effective with Patch 47, the install routine traverses the Dental Patient file and cross reference the most recent dental care for each patient. If there are no transactions on file for the patient in the last 24 months, the patient's status is set to **[Inactive]**. Then, on a monthly basis, a maintenance routine is set **[Inactive]** those patients that have an **[Active]** status that have no transactions on file in the last 24 months and no Recommended Recare Date set, or those patients with an **[Active]** or **[Maintenance]** status where 24 months have elapsed past their Recommended Recare Date.

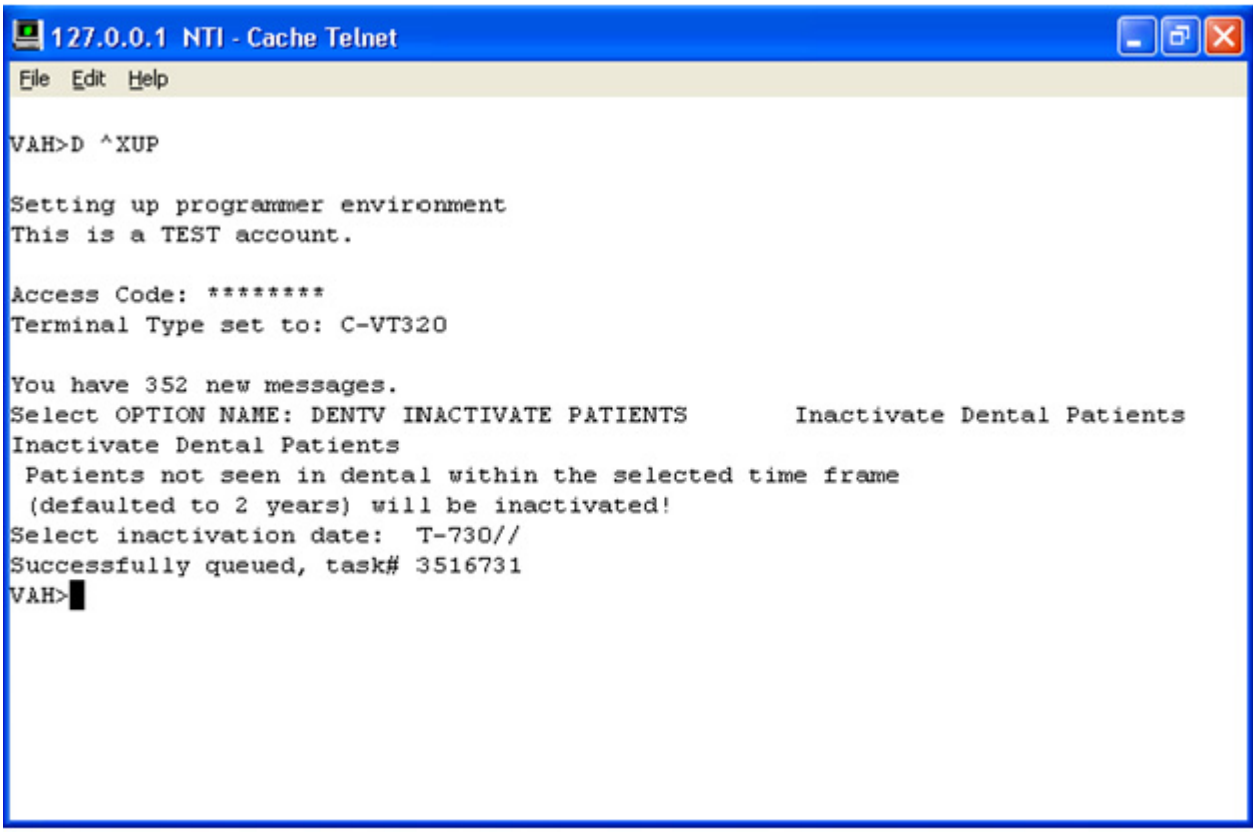
Here are some likely scenarios and the recommended use of this control:

- A newly enrolled Veteran is eligible for dental care and the patient is new to the Dental Clinic. Their case is automatically set to **[Active]** without user intervention upon the first time opening the patient in DRM Plus.
- A Class II patient has had their post-discharge dental care episode finished. Upon completion of care, their status is changed to **[Inactive]**.
- A Class I/IIC/IV patient has had all of their restorative and periodontal care complete. They should be seen in four months for a periodontal checkup. Upon completion of the restorative and periodontal care, their status is changed to **[Maintenance]** with the Recommended Recare Date set four months from today. There is no statutory requirement for the VA to meet that recommendation, but if the patient calls in for an appointment and an appointment cannot be scheduled within the later of 30 days of that recommended date or the patient's call, they should be placed on the EWL.
- A Class III/VI patient has had their adjunctive care completed. Upon completion of the adjunctive care, their status is changed to **[Inactive**]. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation.
- A Class V patient has had their necessary dental care completed. Upon completion of care, their status is changed to **[Inactive]**. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation.
- A newly enrolled Veteran is eligible for dental care. Limited capacity requires they be placed on the EWL. Their dental eligibility information should be entered in DRM Plus and thus by opening the patient in DRM Plus as a new patient their status is set to **[Active]**. Patients on the EWL should always be recorded as **[Active]** until their care is complete. If it is likely the patient may have a significant wait for care, it is suggested the Recommended Recare Date be set to the approximate date the patient's dental care is initiated to avoid automatic inactivation of the patient after 24 months.
- A Class I/IIC/IV patient has failed to keep appointments and not followed through with their care. The provider makes a progress note of the patient's failure to adhere to medical recommendations and change the patient's status to **[Inactive]**. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation. The patient's status is changed to **[Active]** upon a new application for care.
- Necessary emergent care has been provided a patient with no other dental eligibility. Once all clinically proper follow-up care is complete, the patient's status is changed to **[Inactive]**.

Appendix J -- Option to Set Dental Patients to “Inactive” Status

A new option that IRM may run (or may give as a secondary VistA option to a DRM Plus user) 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).



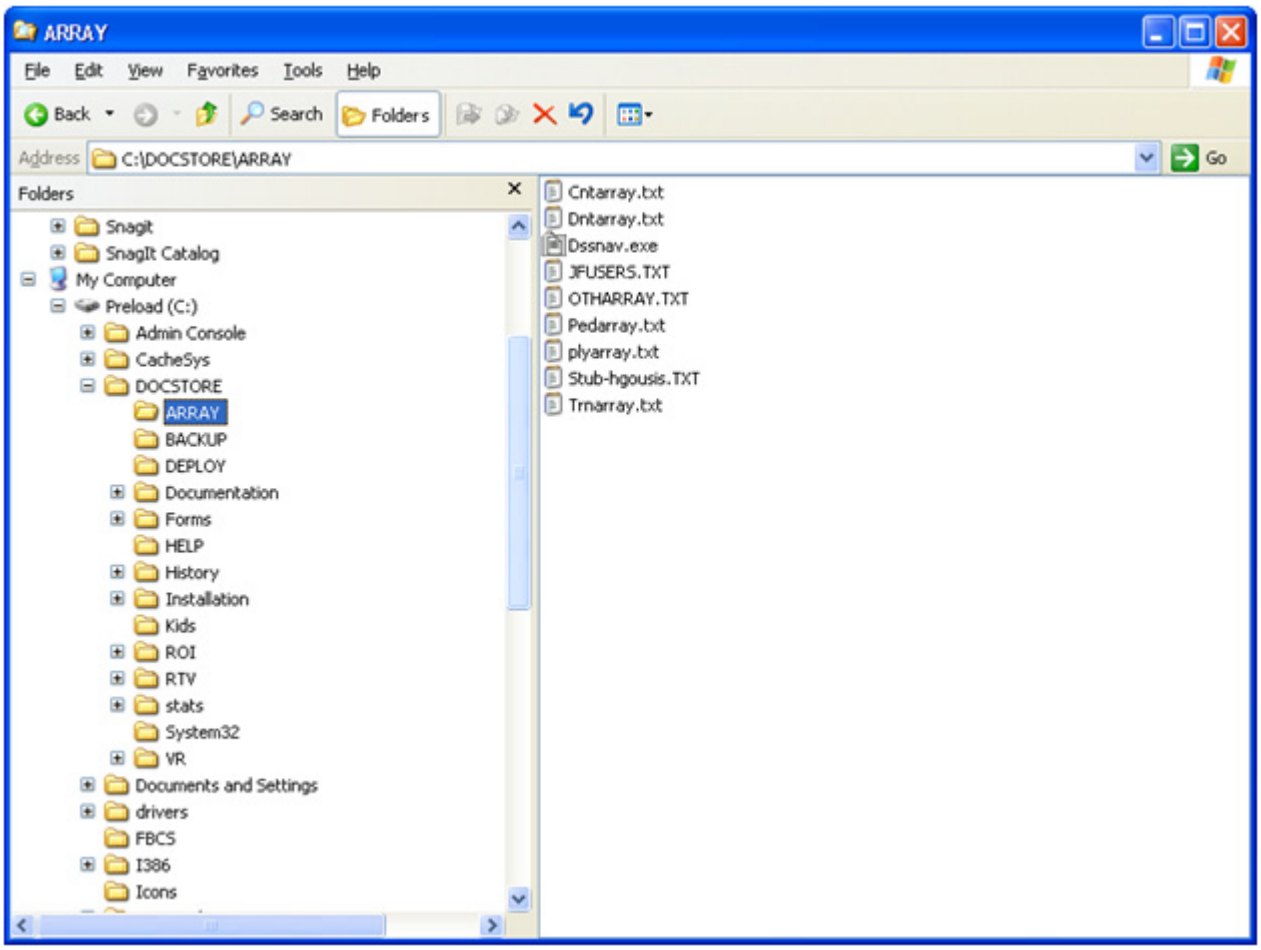
VistA Option to Set an Inactivation Date

Appendix K -- How to Map Dental CNTs

Note: These procedures require IRM Assistance. The dental staff should provide these instructions to IRM.

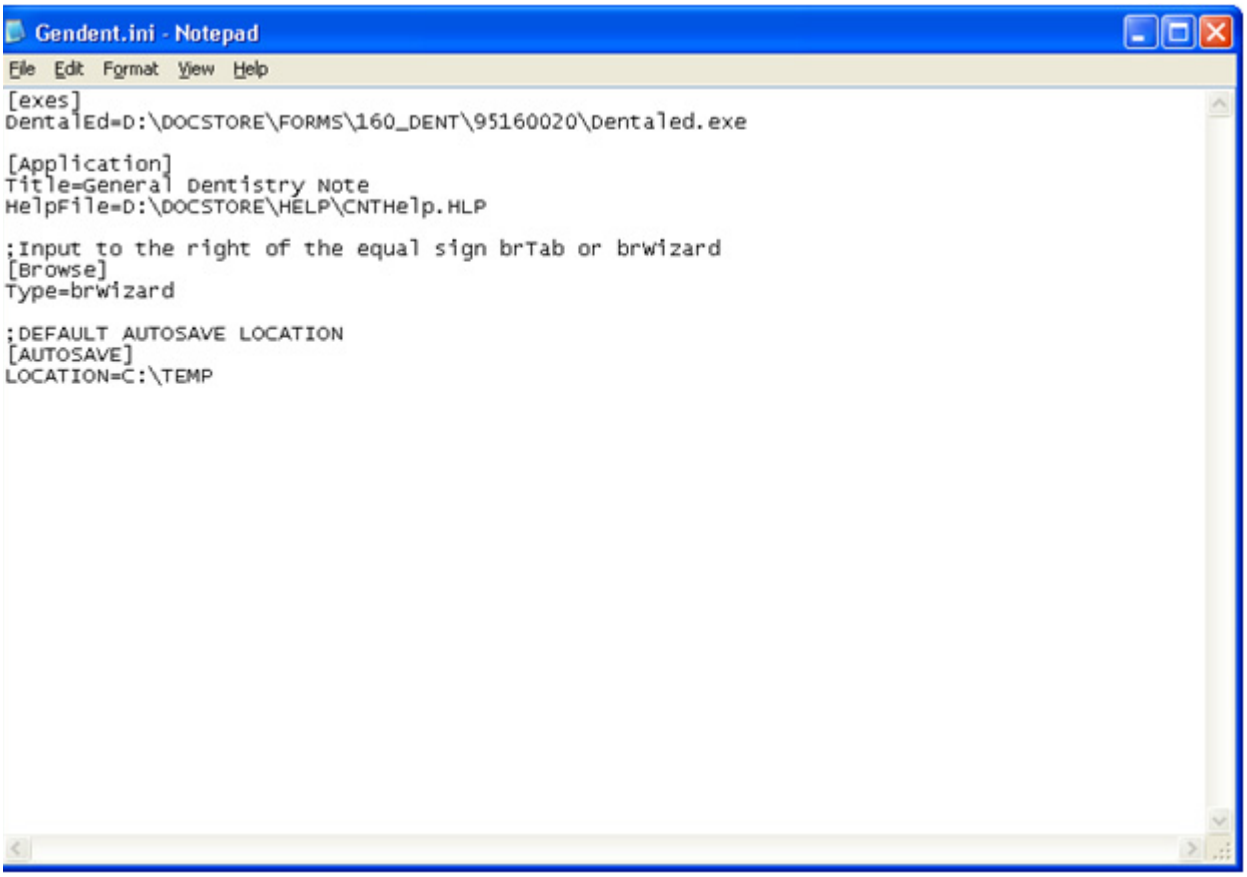
In order to confirm that the CNTs are mapped correctly:

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:



How to Map Dental CNTs

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



CNT .ini File

3. Confirm that the VHAservername path matches what was in the \Array\dntarray.txt file and is correct.
4. If the VHAservername within any of the \FORMS\160_DENT\########\ini_files does not match the directory shown above (in the ARRAY folder) then each .ini file within the FORMS directory need to be opened and edited to reflect the correct path.

Appendix L -- Recommendations for Coding of Prosthetic Appliance

Coding for prosthetic appliances is to be done at the time when the prostheses are delivered to the patient and/or home care instructions are provided and documented.

Taking workload credit for the undeliverable prosthetic appliances should occur:

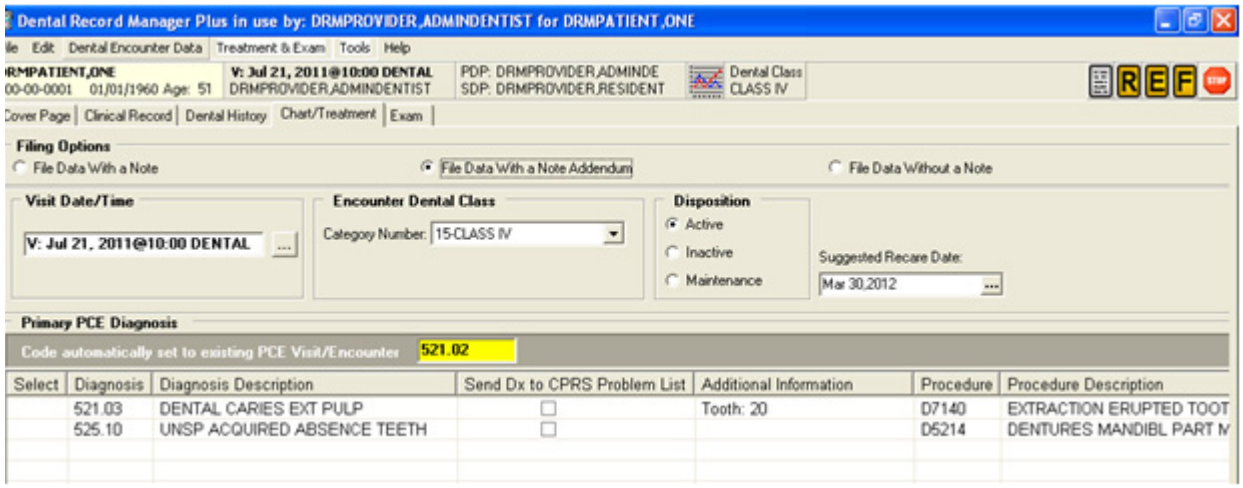
1. After death.
2. After 6 months and 3 attempted telephonic contacts. Attempts to reach patient should occur at a timely interval (i.e. at least one week apart).
3. No response to a final letter to patient's last known address.
4. CPRS documentation to insure no citation for patient abandonment.

To take workload credit with no associated patient visit (i.e. phone contact):

1. Follow local policies for documentation of telephonic contact. Codes for phone contacts in DRM Plus are listed under the CPT codes (99441, 99442 and 99443).

To file workload credit:

1. Enter codes in Completed Care and then click **Complete the Encounter**.
2. Select a Visit Date/Time, creating an addendum. Then select a date form the note to append.
3. Select the radio button labeled **File Data With a Note Addendum**.



Filing Setting and Visit Selection

4. Complete the Encounter as a Note Addendum.

Appendix M -- Business Use of DRM Plus

As important as it is to know how to use DRM Plus, it is equally important to be aware of how to enter codes, fees and similar DRM Plus business considerations.

Entering DRM Plus business information may be viewed in three different components:

- Local policy and practice
- National policy and practice
- National business practice

Adhering to the following guidelines for each is essential and critical to the success of treating our Veterans. Entering valid data can provide important information on the allocation of VA resources on a local and national level, clarify current and future funding issues and determine how to provide even better care to patients.

Review this information carefully. If the user has any questions about this software or the accompanying business policies, contact the local DRM Plus Subject Matter Expert on site. If this person cannot answer the question, s/he knows who to contact to find the correct solution.

Local Policy and Practice

This includes the workflow process addressing the provider's data entries for the following:

- Diagnostic Findings
- Observations
- Approval for proposed Patient Treatment Plans are to be established by the local dental manager.

National Policy and Practice Coding Standards

All completed procedures on site must be entered into the DES through DRM. This includes the following:

- Procedures by staff
- Fee-basis on site
- Sharing on site
- Contract on site
- Residents
- Without compensation
- Students
- Hygienists

For example, if a surgeon goes to the OR and enters the procedure into PCE through the surgery package, or through an encounter, that procedure must be entered into DES through DRM.

Coding standards should be followed in an attempt to calibrate providers, in the event that the same encounters are observed at two separate clinics. This ensures that the encounters are coded the same.

Appendix N -- Data Security

As a VA computer user, one of the best and most important ways to contribute to good computer security is to know all data, its level of sensitivity, that it is virus-free, what would happen if it were unavailable, how long it could be done-without, and the effect of another user changing it without approval.

Classifying data involves determining how sensitive and valuable it is, and what protection it needs. Information is classified according to sensitivity, which is based on its need for:

Confidentiality: the information must be kept private as its owner instructs.
Integrity: the information must not be inappropriately changed or destroyed.
Availability: the information must be ready for use, as needed.

The amount of information and the context in which it is found can effect 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 form hard disks sent out for maintenance. Do not send sensitive information over the internet unless it has been encrypted.

- Learning as much as possible about information security to assist the user's ISO. Numbers alone make users the most important security asset. Compared to one ISO for a system, users offer a chance for numerous eyes and ears to remain alert to potential threats to information systems.

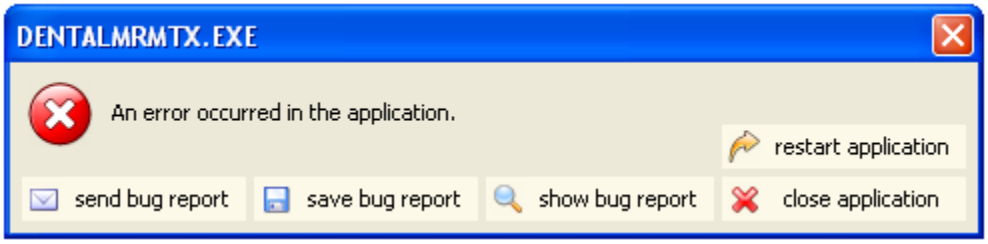
Appendix O -- MADEXCEPT

MADEXCEPT is a new 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:

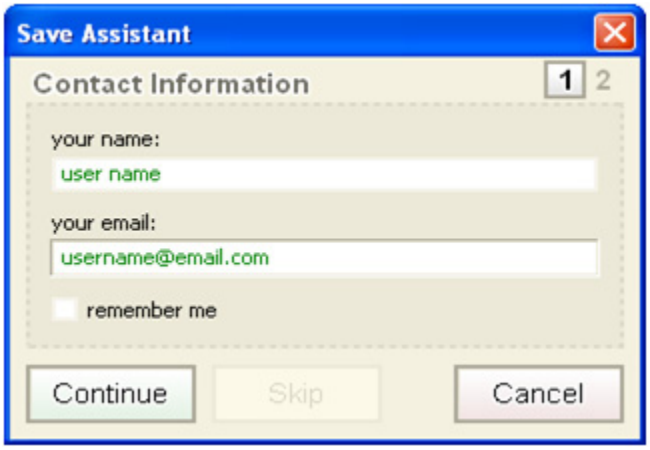
Select all the **OK** buttons from any traditional error screen that may display in DRM Plus. There may be more than one traditional error screen, but no matter how many, select the **OK** button on all. If any informational screen displays asking if the user would like to view the last broker call, 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:



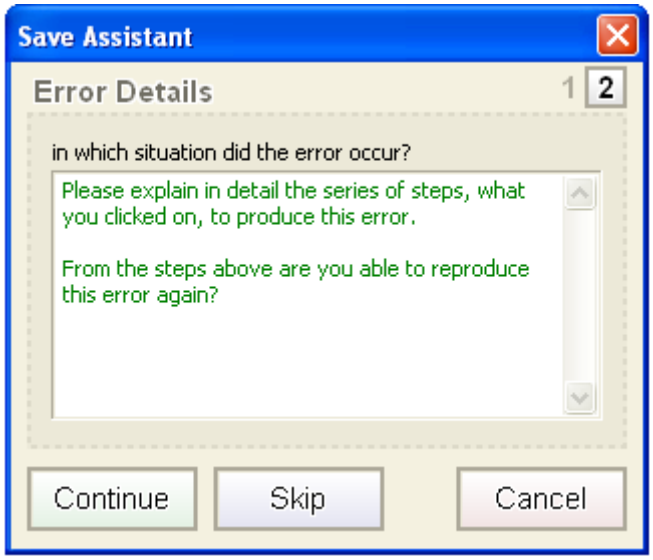
DENTALMRMTX.EXE

After selecting the **'send bug report'** button, the Save Assistant screen will appear. Enter a user name and VA email address and select the **Continue** button on the Save Assistant screen:



Save Assistant

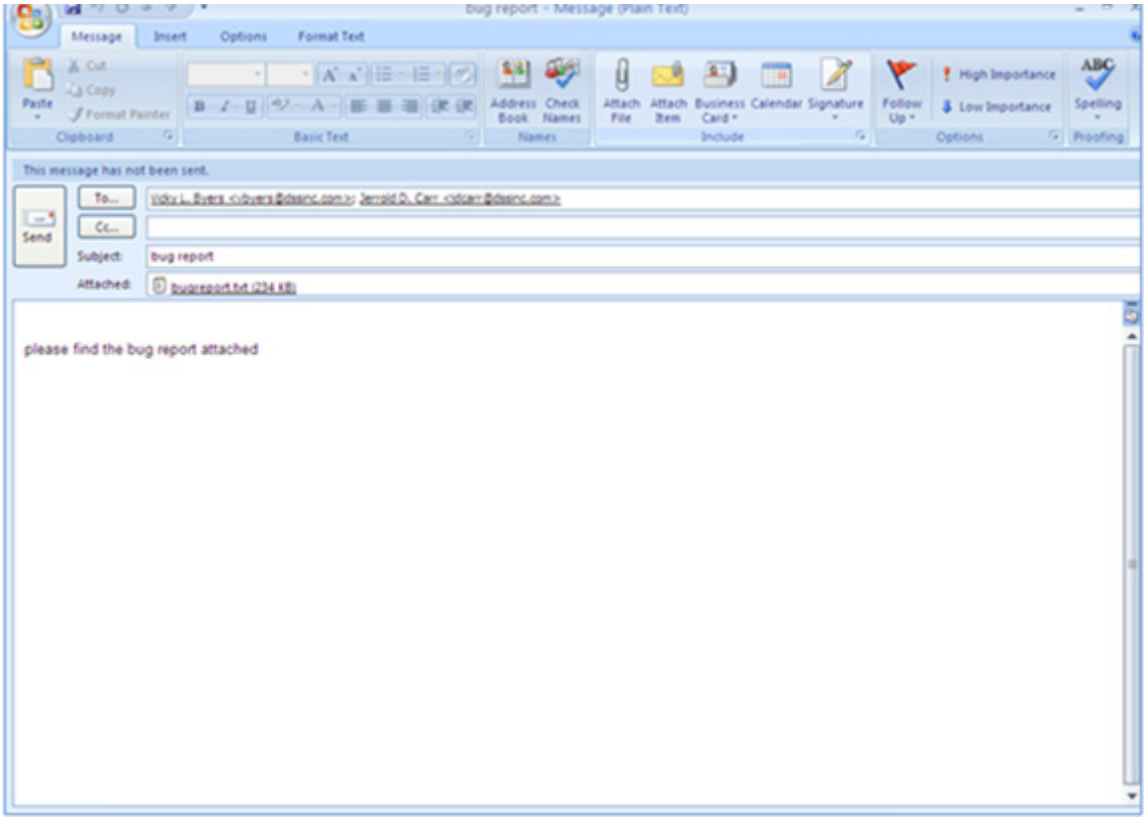
The Save Assistant Error Details screen will immediately appear. Add information in the in the Error Details screen providing as much information as possible. If known, list every click that occurred prior to the error message. The more details listed; the easier it will be to reproduce the error and fix it.



Error Details

Select the **Continue** button from the Save Assistant 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:



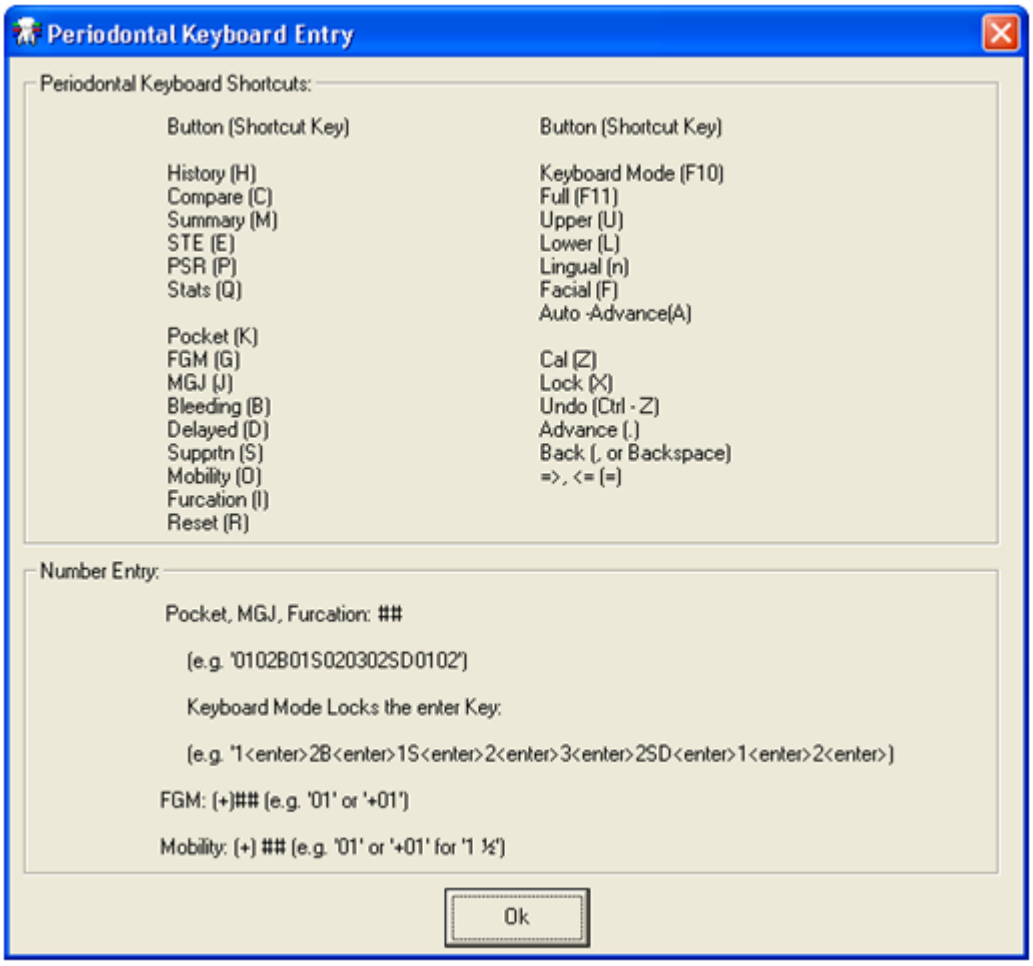
Outlook Window

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 **'close application'** button (bottom button on the right) from the DENTALMRMTX.EXE screen. This will close the MADEXCEPT tool and DRM Plus.

Note: After an error occurs while using DRM Plus, please reboot the computer before continuing.

Periodontal Keyboard Shortcuts Tear-Out