



# Dental Record Manager Plus (DRM Plus)

## Administrator Manual

---

Version 6.9

May 2018



© 2018 Document Storage Systems, Inc. All rights reserved.

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

*World Wide Web: [www.dssinc.com](http://www.dssinc.com)*

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

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

# Table of Contents

<b>Introduction.....</b>	<b>9</b>
Document Storage Systems, Inc. ....	9
From the Department of Veterans Affairs.....	9
Introduction .....	9
Quality Improvement/Performance Measures and Benefits.....	10
Customer Support.....	10
<b>Dental Record Manager Plus User and Administrator Requirements .....</b>	<b>11</b>
DRM Plus User Requirements .....	11
Administrator Option .....	12
<b>Accessing DRM Plus.....</b>	<b>13</b>
Access .....	13
<b>Using the DRM Plus Drop-Down Menus.....</b>	<b>17</b>
File .....	17
<i>Refresh Patient Chart.....</i>	<i>17</i>
<i>File Administrative Time .....</i>	<i>17</i>
<i>File Fee Basis .....</i>	<i>18</i>
<i>Print.....</i>	<i>19</i>
<i>Spell Check .....</i>	<i>20</i>
<i>Save Unfiled Data .....</i>	<i>21</i>
<i>Exit .....</i>	<i>22</i>
Edit.....	23
Copy .....	23
Cut.....	23
Paste .....	23
Select All.....	23
Dental Encounter Data.....	24
Create New PCE Visit .....	24
View Scheduled Appointments and Historical Visits.....	25
Treatment & Exam.....	28
Show Configuration.....	29
Add/Edit Personal QuickList .....	40
Add Medical Codes to ADA Table .....	41
Edit Code Information in the ADA Table .....	43
Edit Procedure Costs.....	44
Filter View .....	45
Clean Slate.....	46
Undo Clean Slate .....	51
All Planned Care to Clipboard.....	52
Tools .....	53
Windows Calculator.....	53
Windows Explorer.....	53
Windows Notepad.....	53
User Inquiry.....	54
User Options.....	56
Administrative Toolbox.....	73
Panel Add/Edit.....	87
Provider Add/Edit .....	89
Ancillary Tool Functions – ADA Website.....	91
Reports .....	92

<i>Reports</i> .....	92
<i>Service Reports</i> .....	115
<i>Data Warehouse Reports</i> .....	117
<i>Adverse Events Report</i> .....	119
<i>Device Tracking Report</i> .....	122
<i>Extract History File</i> .....	125
<i>Queued Extract History File</i> .....	127
Help.....	130
<i>Contents</i> .....	130
<i>Version Release Notes</i> .....	131
<i>Last Broker Call</i> .....	132
<i>VA Intranet Website</i> .....	132
<i>Find your DRM Plus Administrators</i> .....	132
<i>Have a Question, Comment or Suggestion about DRM?</i> .....	132
<i>About</i> .....	133
<b>DRM Plus Banner</b> .....	<b>135</b>
Patient Information .....	135
Visit Information .....	136
Dental Provider Information.....	137
Vitals Button.....	138
Adverse Events Button.....	138
<i>To add an adverse event:</i> .....	139
<i>To edit a filed Active adverse event:</i> .....	140
<i>To delete a filed adverse event:</i> .....	140
Device Tracking Button .....	142
<i>To add completed procedure device identifiers:</i> .....	144
<i>To add non-transaction device identifiers:</i> .....	145
<i>To remove filed device identifiers for a transaction or non-transaction:</i> .....	147
<i>To delete the filed device identifiers for a transaction or non-transaction:</i> .....	148
Dental Class Information .....	149
Clean Slate.....	150
Icons .....	150
<i>General Coding Standards</i> .....	150
Patient Flags .....	150
<i>Clinical Reminders</i> .....	150
<i>Consult</i> .....	151
<i>Exam Quality Indicator</i> .....	151
<i>Fluoride Quality Indicator</i> .....	152
<i>Alerts</i> .....	153
<b>Cover Page</b> .....	<b>155</b>
Dental Eligibility .....	156
<i>Dental Class</i> .....	156
<i>Service Connected Teeth/Service Trauma</i> .....	156
<i>Adjunctive Medical Condition(s)</i> .....	157
<i>Eligibility Expiration Date</i> .....	158
<i>Anticipated Rehab Date</i> .....	158
Demographics.....	159
Case Management.....	159
<i>Status</i> .....	159
<i>Suggested Recare Date</i> .....	159
Recent Dental Activity .....	160



Fluoride Indicator Prescription Date.....	160
Dental Alerts.....	161
Notes .....	161
Filed Planned Care.....	162
<b>Clinical Record .....</b>	<b>163</b>
Problems.....	165
Consultations .....	165
Notes .....	166
<i>Adding a New TIU Progress Note.....</i>	<i>167</i>
<i>Adding a New TIU Progress Note Addendum.....</i>	<i>169</i>
<b>Dental History .....</b>	<b>170</b>
Viewing Dental Information by Tooth.....	171
Viewing Other Dental History Information.....	171
Viewing All Dental History Information .....	171
Viewing Dental History Information by Episode of Care.....	172
Episode in Date Range.....	172
Deleting an Encounter.....	172
<b>Chart/Treatment – Treatment &amp; Exam .....</b>	<b>174</b>
Diagnostic Findings .....	176
<i>Editing Diagnostic Finding Descriptions .....</i>	<i>177</i>
<i>Deleting a Diagnostic Finding.....</i>	<i>177</i>
Treatment Plan.....	178
<i>Entering a Treatment Plan .....</i>	<i>178</i>
<i>Editing a Treatment Plan Description.....</i>	<i>180</i>
<i>Deleting a Treatment Plan.....</i>	<i>181</i>
<i>Completing a Treatment Plan.....</i>	<i>181</i>
Completed Care .....	182
<i>Entering Completed Care .....</i>	<i>182</i>
<i>Editing Completed Care Description .....</i>	<i>183</i>
<i>Deleting a Completed Care .....</i>	<i>183</i>
Include “Completed”/Include “Findings and Completed”/Include “Findings” .....	184
Perio Buttons Icon .....	185
Seq Plan/Sequencing Button .....	186
<i>Plan a Treatment Sequence .....</i>	<i>187</i>
<i>Complete a Planned Treatment in the Sequencing Screen .....</i>	<i>187</i>
<i>Deleting a Planned Treatment in the Sequencing Screen.....</i>	<i>188</i>
Chart Hx (History) Button.....	188
Summary Button.....	189
H&N Button .....	190
PSR Button.....	193
OHA (Oral Health Assessment) Button .....	194
TMJ Button .....	196
Occl (Occlusion) Button .....	197
Habits (Parafunctional) Button.....	199
Social Hx (Social History) Button .....	200
<i>Multiple Filings to Same Modal on Same Day .....</i>	<i>201</i>
<b>Chart/Treatment – Periodontal Chart .....</b>	<b>203</b>
History and Compare Buttons .....	204
Summary Button.....	205
H&N Button .....	205
PSR Button.....	205

Stats Button .....	206
OHA (Oral Health Assessment) Button .....	206
Notes Button .....	207
Entering Periodontal Information .....	208
Other Tools .....	209
<b>Exam .....</b>	<b>210</b>
Exam Elements .....	212
<i>Presentation/Chief Complaint Element</i> .....	212
<i>Vitals Elements</i> .....	213
<i>PMH (Past Medical History) and Medications Element</i> .....	214
<i>Social History Element</i> .....	215
<i>H&amp;N (Head and Neck) Findings Element</i> .....	216
<i>Radiographic Findings Element</i> .....	217
<i>Diagnostic Findings Element</i> .....	218
<i>Periodontal Assessment Element</i> .....	219
<i>Parafunctional Habits Element</i> .....	222
<i>TMJ Findings Element</i> .....	223
<i>Occlusal Findings Element</i> .....	224
<i>Salivary Flow Element</i> .....	225
<i>Removable Prostheses Element</i> .....	226
<i>Assessment/Plan Element</i> .....	227
<i>Patient Education Element</i> .....	228
<i>Disposition Element</i> .....	229
<i>Import Previously Filed Data Screen</i> .....	230
<b>Completing the Encounter .....</b>	<b>232</b>
Potential Duplicate Transactions Screen .....	236
File Data Option Screen .....	237
<i>File to PCE/DES with Code</i> .....	237
<i>File to DES-Only Data</i> .....	238
Filing Options Screen .....	238
<i>Filing Options</i> .....	238
<i>Visit Date/Time</i> .....	238
<i>Encounter Dental Class</i> .....	239
<i>Disposition</i> .....	239
<i>Suggested Recare Date</i> .....	239
<i>Primary PCE Diagnosis &amp; Send Dx to CPRS Problem List</i> .....	240
<i>Service Connection</i> .....	240
<i>Additional Providers/Additional Signers</i> .....	241
<i>Station</i> .....	242
Progress Note Screen .....	242
<i>Viewing/Importing DRM Object/Progress Note</i> .....	243
<i>Viewing/Importing CPRS Templates</i> .....	243
<i>Importing VistA Medical Information</i> .....	243
<i>Other Options in the Import Menu</i> .....	244
<i>Accessing Dental CNTs</i> .....	244
<i>Electronic Signature</i> .....	244
<i>Progress Note Addendum</i> .....	245
CNT Navigator .....	246
<i>Navigating Within CNTs</i> .....	247
Consult Notes .....	249
Resident Filing as Cosigners or Distributed Providers .....	251

<b>Appendix A – Glossary of VA Terms .....</b>	<b>253</b>
<b>Appendix B – Common Application Functions .....</b>	<b>257</b>
<b>Appendix C – Hints and Notes.....</b>	<b>259</b>
Save Unfiled Data.....	259
Dental Class Displayed on Banner .....	259
Diagnostic Findings .....	259
Treatment Plan.....	259
Multi-Add Screen .....	260
Ranged Codes .....	260
Speed Codes .....	260
Tx Planning/Sequencing Screen .....	260
Completed Care .....	261
Periodontal Chart.....	261
Completing the Encounter.....	262
Reports – Non-Clinical Time by Provider.....	264
Code Boilerplates.....	264
Last Broker Call.....	264
Recent Dental Activity .....	264
<b>Appendix D – Icon Definitions.....</b>	<b>265</b>
Diagnostic Findings .....	265
Treatment Plan.....	268
Completed Care .....	270
Special Descriptions – Bridge Icon.....	272
Special Descriptions – Conn Bar Icon .....	273
Special Descriptions – Notes Icon .....	273
<b>Appendix E – Create Reports in MS Excel and Access .....</b>	<b>274</b>
Developing Excel Reports.....	274
Creating Custom Reports Using Excel .....	277
<i>Deleting Columns or Rows .....</i>	<i>278</i>
<i>Expanding Columns or Rows.....</i>	<i>278</i>
<i>Field Formatting Options.....</i>	<i>278</i>
<i>Creating a Header for a Report.....</i>	<i>281</i>
<i>Sorting Data.....</i>	<i>283</i>
<i>Subtotaling Data .....</i>	<i>284</i>
<i>Pull Down Options .....</i>	<i>286</i>
Importing the DRM Plus Extract Text File into an Access Report.....	287
Importing the DRM Plus Extract Excel File into Access Database.....	294
<b>Appendix F – Using the Keyboard to Enter Periodontal Data .....</b>	<b>299</b>
Overview .....	299
<i>Navigating the Periodontal Screen .....</i>	<i>299</i>
<i>Arch Views .....</i>	<i>299</i>
<i>Cursor Movement.....</i>	<i>299</i>
<i>Entering Data.....</i>	<i>300</i>
<i>Special Buttons.....</i>	<i>300</i>
<i>Other Functions .....</i>	<i>300</i>
<b>Appendix G – Ranged Codes.....</b>	<b>301</b>
<b>Appendix H – Active-Inactive Maintenance Control.....</b>	<b>302</b>
<b>Appendix I – Option to Set Dental Patients to Inactive Status .....</b>	<b>304</b>
<b>Appendix J – How to Map Dental CNTs.....</b>	<b>305</b>
<b>Appendix K – Recommendations for Coding of Prosthetic Appliance .....</b>	<b>307</b>
<b>Appendix L – Business Use of DRM Plus.....</b>	<b>309</b>

Local Policy and Practice .....	309
National Policy and Practice Coding Standards .....	309
<b>Appendix M – Data Security .....</b>	<b>310</b>
<b>Appendix N – madExcept Application.....</b>	<b>312</b>
<b>Periodontal Keyboard Shortcuts Tear-Out.....</b>	<b>315</b>

# Introduction

## **Document Storage Systems, Inc.**

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

## **From the Department of Veterans Affairs**

Dental Record Manager Plus (DRM Plus) captures specific dentally-related information elements NOT readily available in CPRS. These elements include: oral cavity/tooth related diagnostic findings, dental-specific care plans and a superset of completed care information. DRM Plus aids the provider in the entry of dental diagnostic information, coding and crediting dental procedures, completing TIU progress notes, and planning and tracking dental patient care. DRM Plus is adjunctive to CPRS and is NOT designed to replace CPRS for dental users. While some information from CPRS is available, and can be accessed in DRM plus, providers should use all the available tools in the VistA suite of applications. These tools include: VistA Imaging, I-Med Consent, and any clinical system applications specific to the local sites.

DRM Plus is a Dental Graphical User Interface front end for data input into the VistA Dental files, as well as the Patient Care Encounter (PCE), Text Integration Utility (TIU) and CPRS Problem List packages.

## **Introduction**

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

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

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

Some features of DRM Plus are summarized in the following:

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

### **Quality Improvement/Performance Measures and Benefits**

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

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

### **Customer Support**

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

# Dental Record Manager Plus User and Administrator Requirements

## DRM Plus User Requirements

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

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

## **Administrator Option**

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

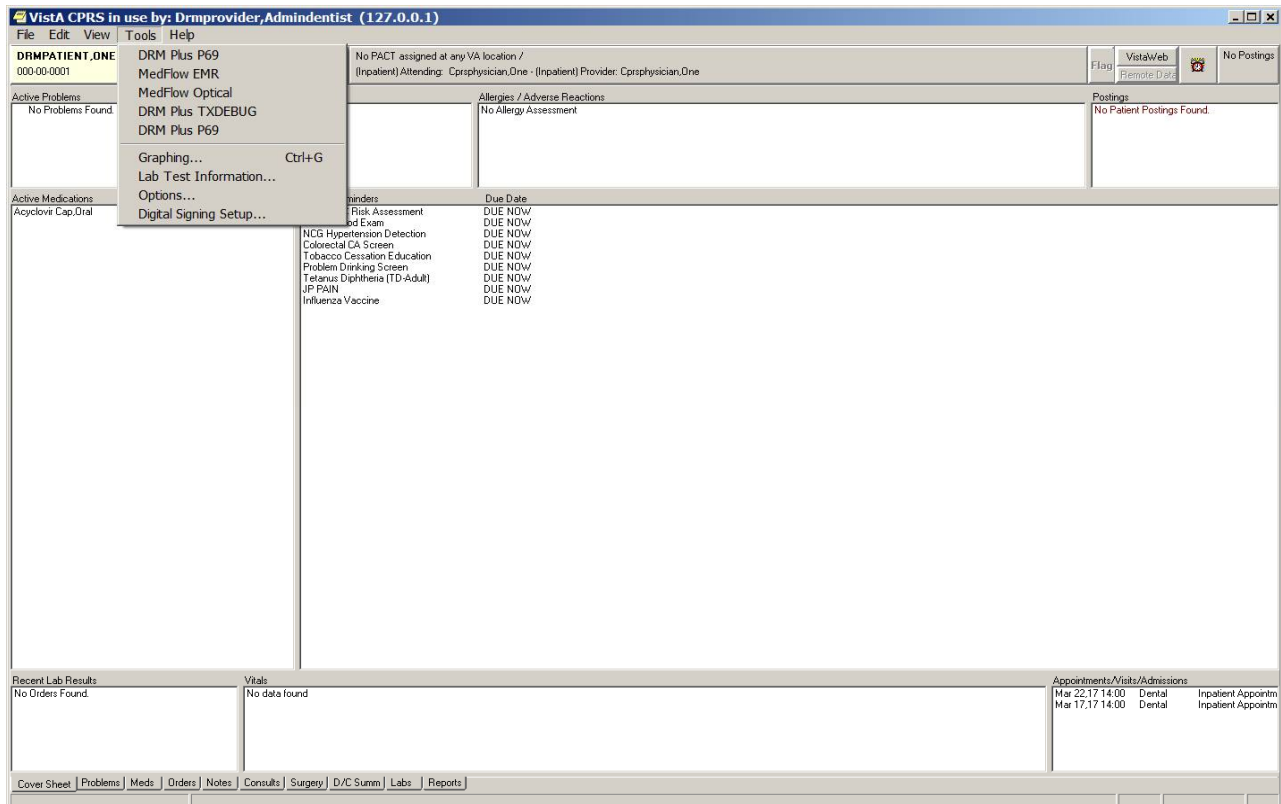
1. At Select Option Name, type: **DENTV XPAR EDIT PARAMS**.
2. At the Select PARAMETER DEFINITION NAME, type: **DENTV DRM ADMINISTRATOR**.
3. At the Select NEW PERSON NAME, type in the name of the person to be made a dental administrator.
4. Set the value to **YES**.



# Accessing DRM Plus

## Access

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



**Figure 1: Access DRM Plus through CPRS**

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

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

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

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

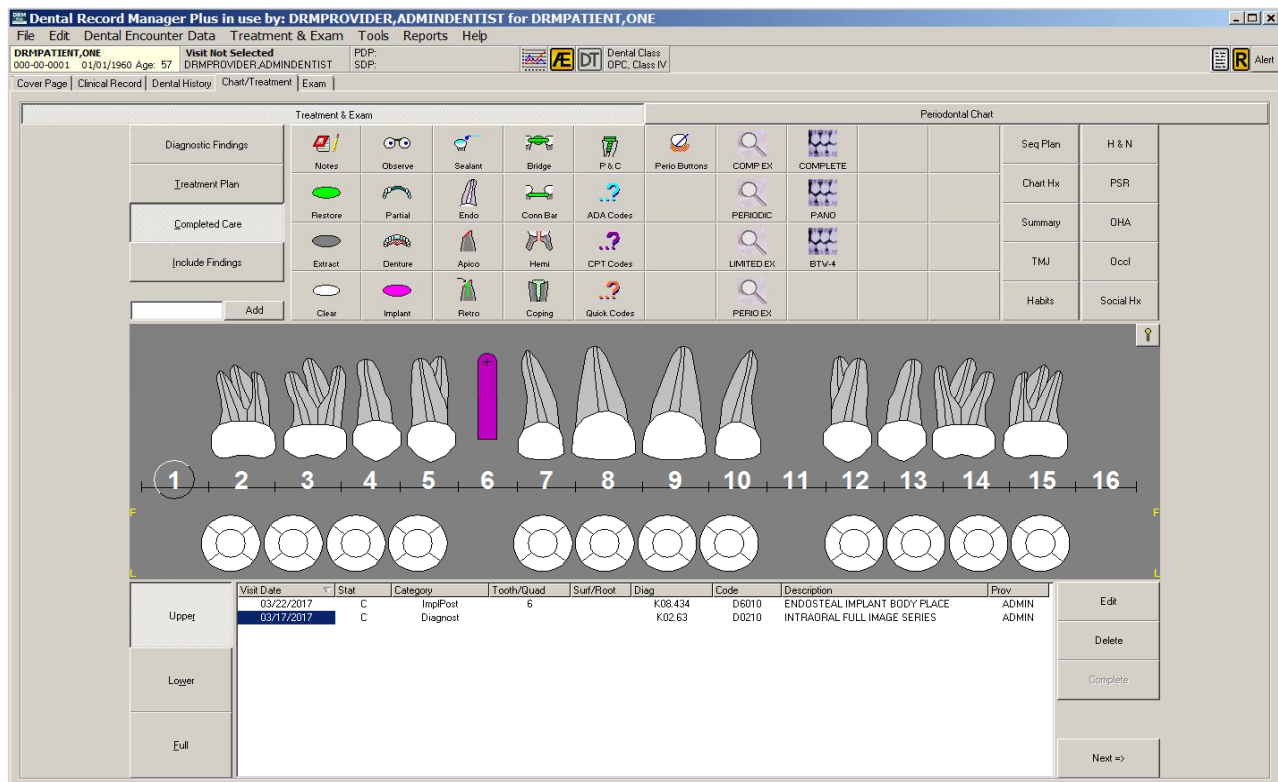


Figure 2: DRM Plus Chart/Treatment Tab

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

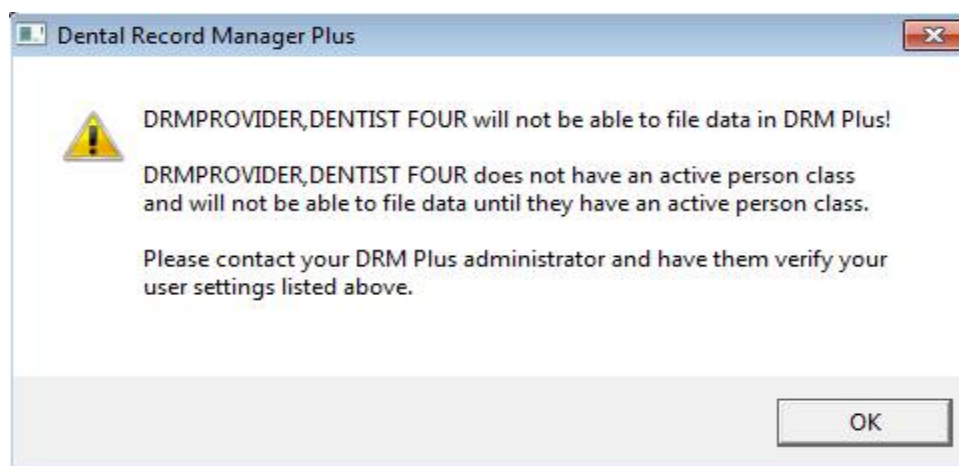


Figure 3: “!”-screen (Informational)

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

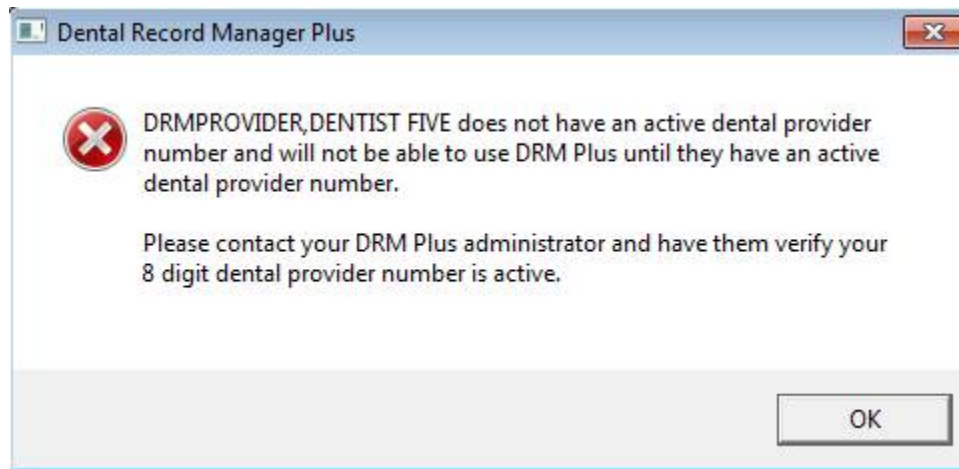


Figure 4: “Red X” –screen (Stop)

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

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

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

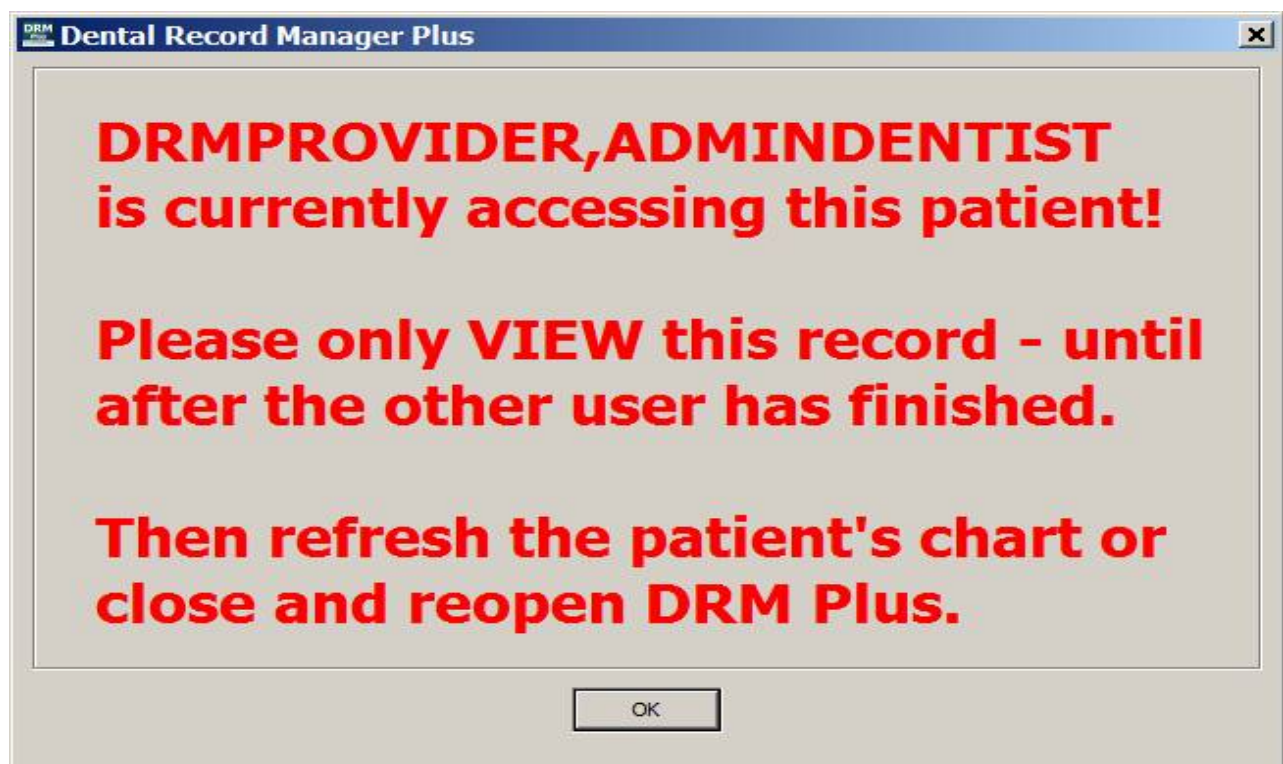


Figure 5: Warning Informational Screen

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



**Figure 6: DRM Plus Drop-Down Menus**

The banner contains patient, visit/location, provider/patient information and limited vitals entry. There are also the adverse events button, device tracking button, dental class button, coding standards and alerts icons on the banner.



**Figure 7: DRM Plus Banner**

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



**Figure 8: DRM Plus Tabs**

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

# Using the DRM Plus Drop-Down Menus

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



Figure 9: DRM Plus Drop-Down Menus

## File

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

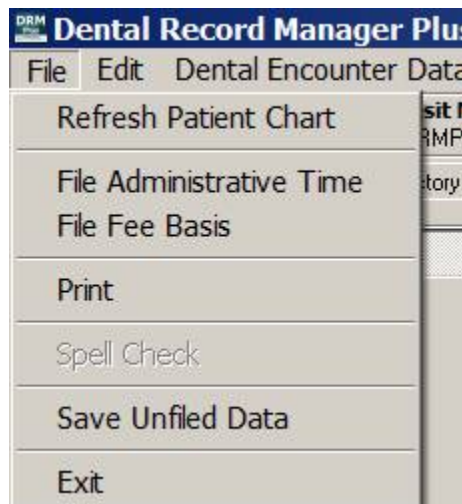


Figure 10: DRM Plus File Menu

## Refresh Patient Chart

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

## File Administrative Time

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



**Figure 11: File Administrative Time Screen**

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

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

## File Fee Basis

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

**Figure 12: Dental Record Manager Fee Basis Screen**

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

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

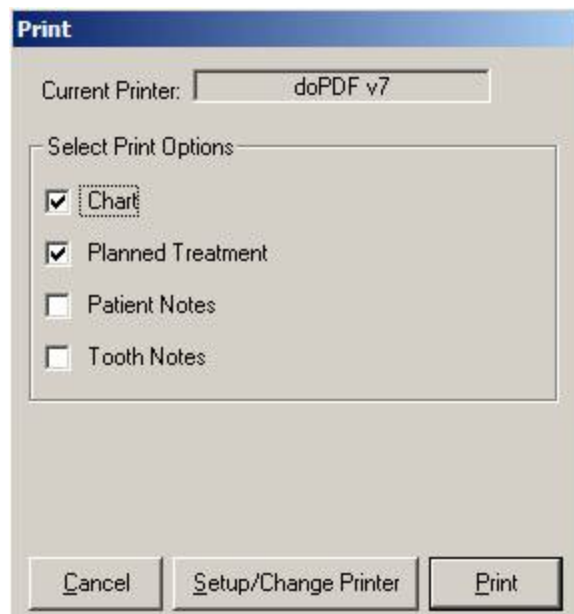
- Does need to be in the **Dental Provider file** (8-digit provider ID).
- Does NOT need a **Person Class** in VistA.
- Does need access to **CPRS**.
- Does need access to DRM Plus (**DENTV DSS DRM GUI** secondary menu option).
- Does NOT need DRM Plus **administrative access**.

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

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

## Print

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



**Figure 13: Print Screen**

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

## Spell Check

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

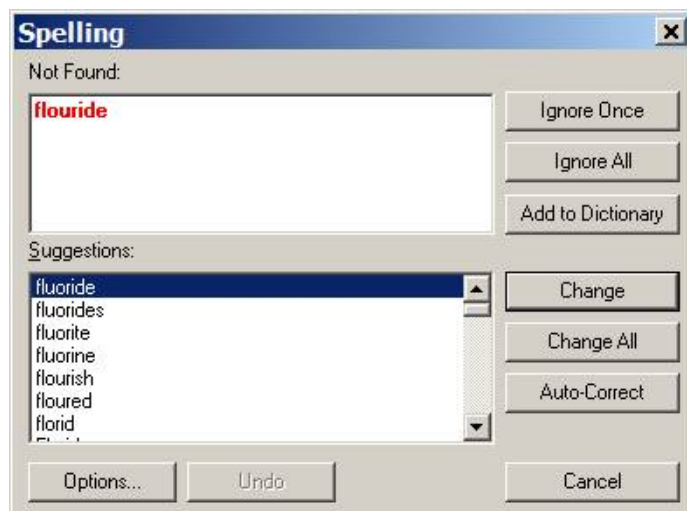


Figure 14: Spelling Screen

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

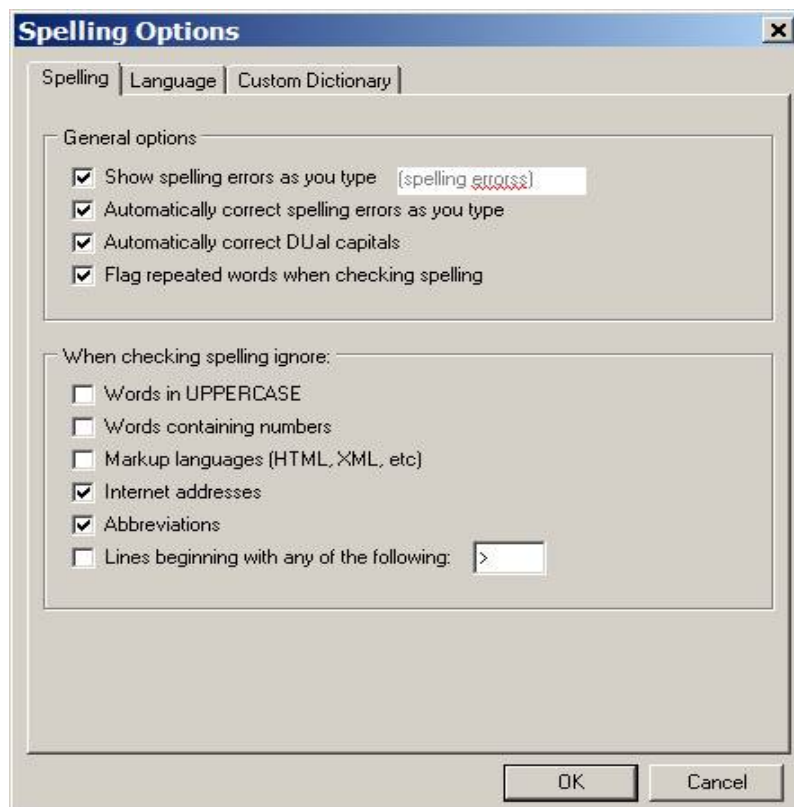


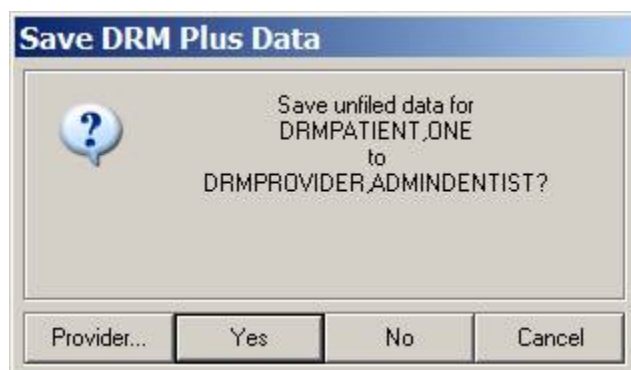
Figure 15: Spelling Options Screen



Click the check boxes beside the desired options located on the **Spelling** tab. Select the language and dictionaries from the **Language** tab and click the **OK** button. The **Spelling Options** screen closes.

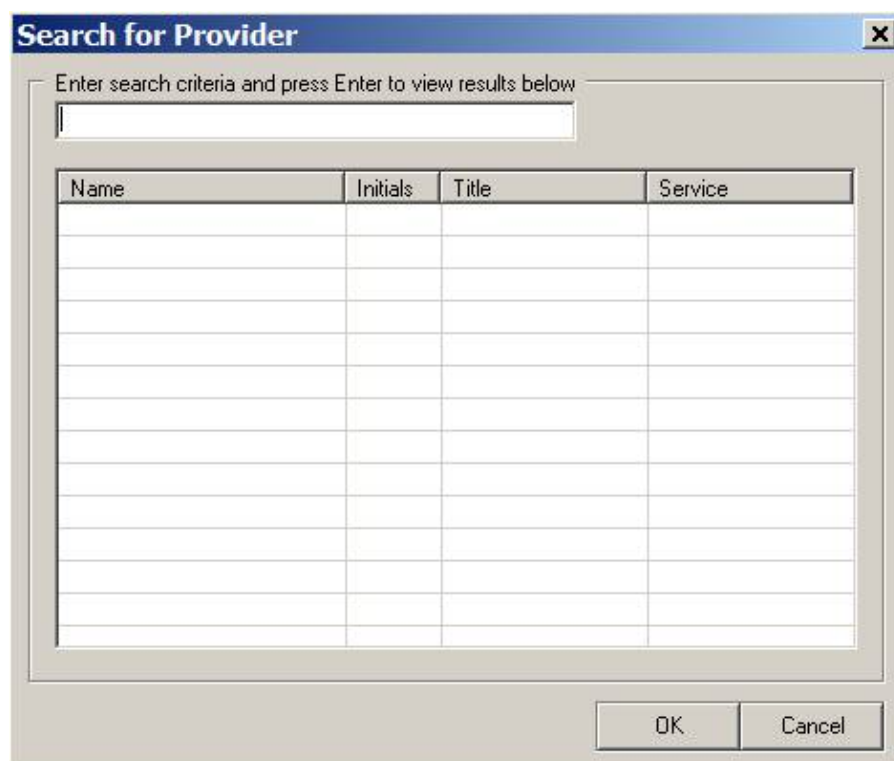
## Save Unfiled Data

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



**Figure 16: Save DRM Plus Data Screen**

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

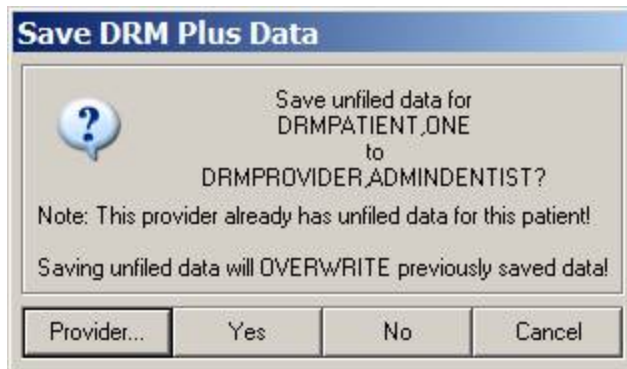


### Figure 17: Search for Provider Screen

1. Enter the name or partial name of the desired provider in the **search criteria** text box.
2. Press the <Enter> key.
3. Click the needed provider from the list of results.

4. Click the **OK** button to change the provider. The **Save DRM Plus Data** screen displays.
5. Click the **Yes** button to save the unfiled data to the new provider.

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



**Figure 18: Provider Already Has Unfiled Data**

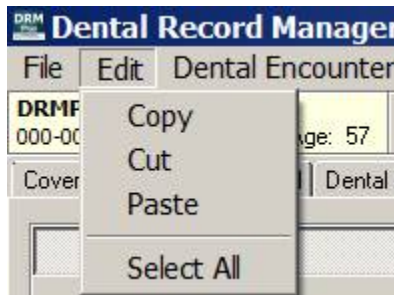
If the user clicks the **Yes** button, previously saved unfiled data originally saved by another dental provider, or this provider, is overwritten. Only one unfiled data entry may be maintained by a single provider, per patient.

## **Exit**

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

## **Edit**

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



**Figure 19: Edit Menu**

## **Copy**

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

## **Cut**

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

## **Paste**

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

## **Select All**

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

## Dental Encounter Data

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



Figure 20: Dental Encounter Data Menu

### Create New PCE Visit

Select the **Create New PCE Visit** submenu to display the **Provider and Location for Current Activities** screen.

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

The screenshot shows the 'Provider and Location for Current Activities' dialog box. It has two main sections. The top section, 'Encounter Provider', contains a list box with several entries, including 'DRMPROVIDER,ADMINIST' and 'CHIEF, DENTAL SERVICE, ORAL'. To the right of this list are 'OK' and 'Cancel' buttons. The bottom section, 'Encounter Location', contains a text field with the value 'Apr 28, 17@11:55 DENTAL'. Below this is a tabbed interface with tabs for 'My Clinic Visits', 'Dental Visits', 'All Visits', 'Admissions', and 'New Visit'. The 'Dental Visits' tab is active, showing a list box with various location names like 'DENTAL', 'CLINIC PATTERN THREE', and 'COLLATERAL'. To the right of the list box are fields for 'Visit Date' (set to 'Apr 28, 2017') and 'Visit Time' (set to '11:55'). Below these fields is a checkbox labeled 'Historical Visit' which is currently unchecked.

Figure 21: Provider and Location for Current Activities Screen

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

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

**Figure 22: New Visit Tab**

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

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

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

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

## View Scheduled Appointments and Historical Visits

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

To record the scheduled appointment for the patient:

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

**Provider and Location for Current Activities**

Encounter Provider

DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE,ORAL
BLUYLUI,CXLY	
CPRSPHYSICIAN,ONE	STAFF DENTIST,GENERAL PRA
CXYTHYSDYX,LAKHUS	
DRMPROVIDER,ADMINDENTIST	CHIEF, DENTAL SERVICE,ORAL
DRMPROVIDER,ASSISTANT	DENTAL ASSISTANT
DRMPROVIDER,DENTIST TWO	STAFF DENTIST,ENDODONTICS
DRMPROVIDER,DENTIST	STAFF DENTIST,PROSTHODON
DRMPROVIDER,HYGIENIST	HYGIENIST

OK  
Cancel

Encounter Location

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

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

V	Mar 22, 2017@14:00	DENTAL
V	Mar 17, 2017@14:00	DENTAL

**Figure 23: My Clinic Visits Tab**

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

Encounter Location

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

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

V	Mar 22, 2017@14:00	DENTAL
V	Mar 17, 2017@14:00	DENTAL

**Figure 24: Dental Visits Tab**

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

Encounter Location		
< Select a visit from the tabs below...>		
My Clinic Visits   Dental Visits   All Visits   Admissions   New Visit		
A	OCT 18,2005@13:46	7B
V	Mar 22, 2017@14:00	DENTAL
V	Mar 17, 2017@14:00	DENTAL

**Figure 25: All Visits Tab**

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

Encounter Location		
< Select a visit from the tabs below...>		
My Clinic Visits   Dental Visits   All Visits   Admissions   New Visit		
A	OCT 18,2005@13:46	7B

**Figure 26: Admissions Tab**

## Treatment & Exam

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

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

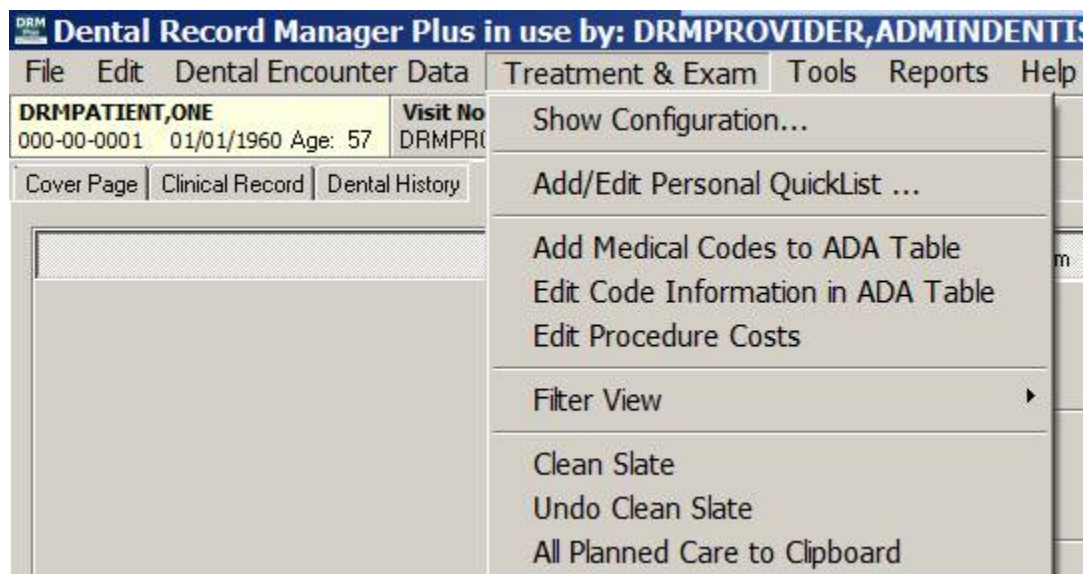


Figure 27: Treatment & Exam Menu



## Show Configuration

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

**Charting Configuration**

Speed Codes   Suggestion Links   Statistics   H & N  
Tx & Exam   Periodontal   Report   Voice

Initial Tx Mode: Treatment Plan

☐ Display sequencing upon entry  
☒ Show warning box when adding duplicate transaction on tooth

Display Defaults

When I am viewing: Diagnostic Findings

I would like the following to display:

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

Reset   Ok

**Figure 28: 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**. The parameters on each tab are a user specific function; changing it does NOT impact other users. When finished, click the **OK** button.

## ***Tx & Exam***

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

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

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

The screenshot shows the 'Tx & Exam' tab selected in a software interface. The tab bar at the top includes 'Speed Codes', 'Suggestion Links', 'Statistics', 'H & N', 'Tx & Exam' (active), 'Periodontal', 'Report', and 'Voice'. The main content area of the 'Tx & Exam' tab contains the following settings:

- Initial Tx Mode:** A dropdown menu set to 'Treatment Plan'.
- ☐ Display sequencing upon entry
- ☒ Show warning box when adding duplicate transaction on tooth
- Display Defaults:** A section with a dropdown menu set to 'Diagnostic Findings' and the text 'I would like the following to display:'.
- Below the 'Display Defaults' section, there are two columns of checkboxes:
  - Graphical Display:**
    - ☒ Dx Findings
    - ☐ Tx Plan
    - ☐ Completed
  - Transaction List:**
    - ☒ Dx Findings
    - ☐ Tx Plan
    - ☐ Completed
- At the bottom right, there are 'Reset' and 'Ok' buttons.

**Figure 29: Tx & Exam Tab**

## *Periodontal*

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

The screenshot shows a software window with a tabbed interface. The tabs are: Speed Codes, Suggestion Links, Statistics, H & N, Ix & Exam, Periodontal (selected), Report, and Voice. The Periodontal tab is active, displaying the following settings:

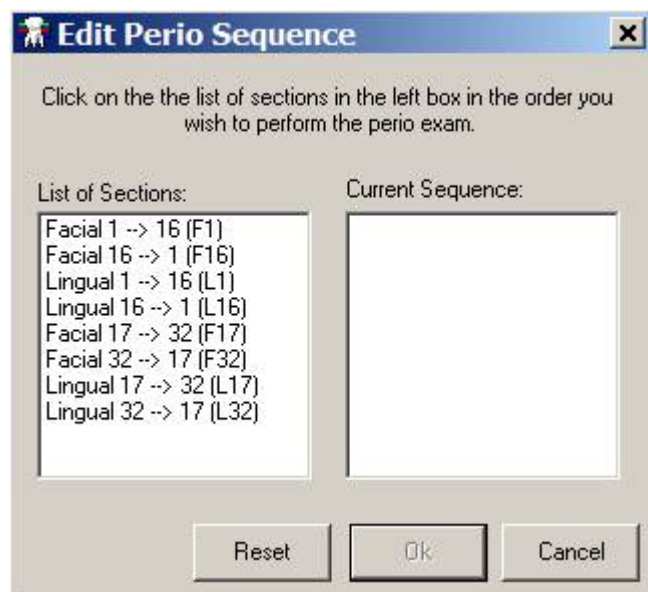
- Pocket Depth Warning: 4
- Normal Pocket Color: Black
- Warning Pocket Color: Red
- Enable ProbeOne: ☐ (disabled), cboProbet (dropdown menu)
- Show MGJ Trace: ☒
- Exam Sequence: F1, L16, F17, L32 (text box), Edit (button)

At the bottom of the window are two buttons: Reset and Ok.

**Figure 30: Periodontal Tab**

To change the exam sequence:

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



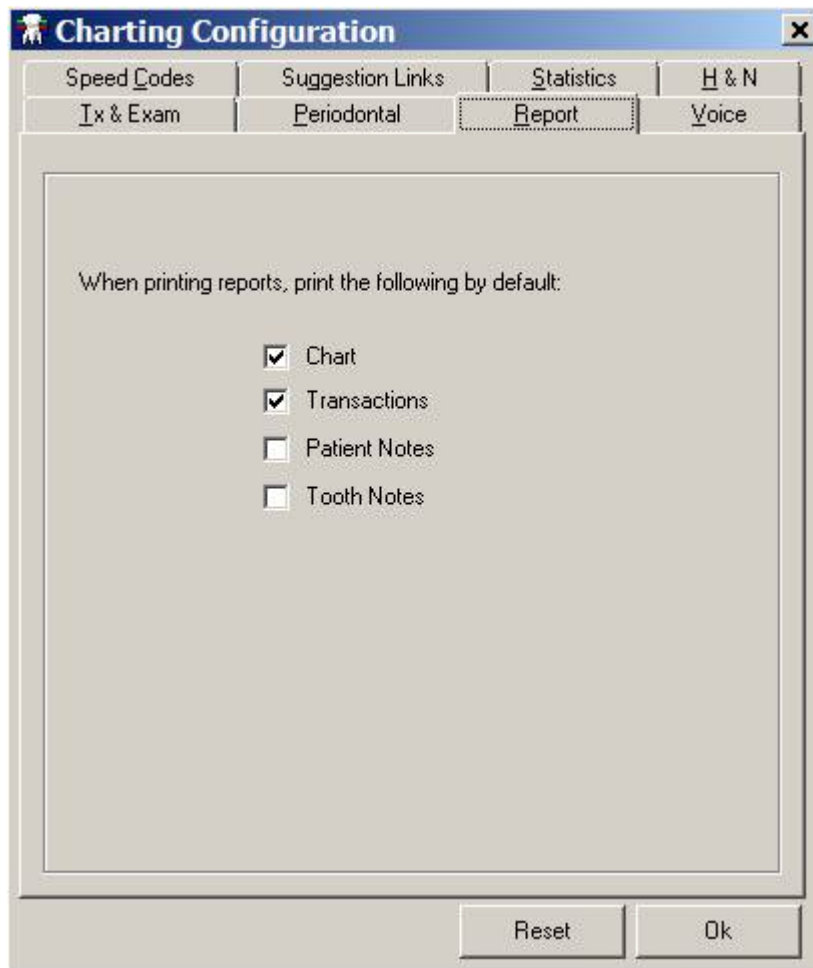
**Figure 31: Edit Perio Sequence Screen**

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

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

## ***Report***

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



**Figure 32: Report Tab**

## ***Voice***

Voice is NOT enabled in DRM Plus.

## Speed Codes

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

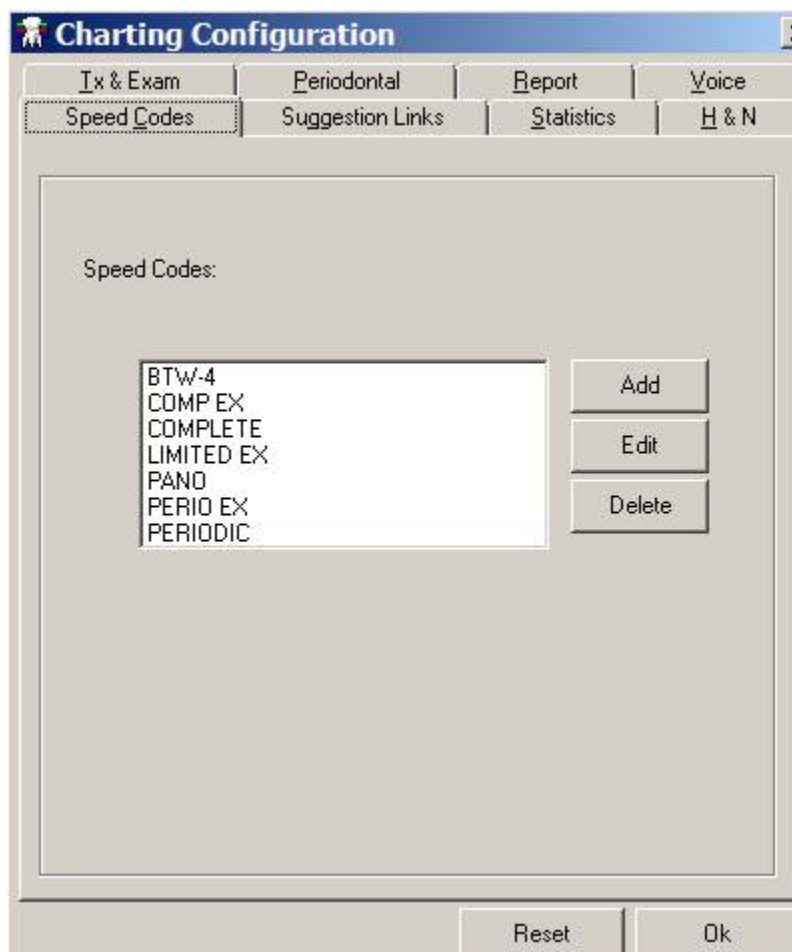
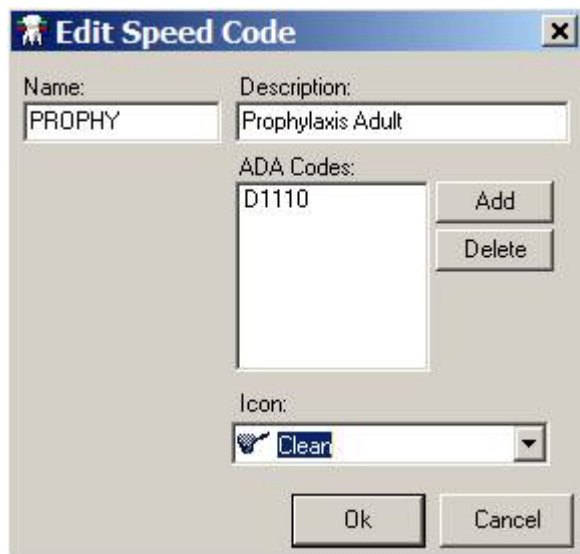


Figure 33: Speed Codes Tab

To add a Speed Code:

1. Click the **Add** button. The **Edit Speed Code** screen displays.
2. Add a new **Name**, which cannot exceed 10 characters.
3. Entering a description is optional. Two symbols; semicolon (;) and up-carrot (^) may NOT be added or used in the description text.
4. Use the search function, **ADA Codes**, to look up a procedure code(s) and add it to the new speed code.
5. Entering an icon is optional.
6. Click the **OK** button to begin finalization.



The 'Edit Speed Code' dialog box contains the following fields and controls:

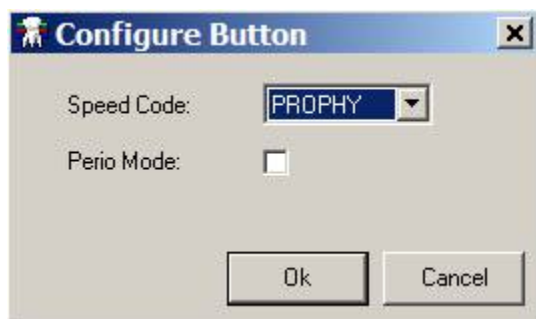
- Name:** A text box containing 'PROPHY'.
- Description:** A text box containing 'Prophylaxis Adult'.
- ADA Codes:** A list box containing 'D1110'. To its right are 'Add' and 'Delete' buttons.
- Icon:** A dropdown menu showing a small icon and the word 'Clean'.
- Buttons:** 'Ok' and 'Cancel' buttons at the bottom.

**Figure 34: Edit Speed Code Screen**

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

To complete the speed code process:

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



The 'Configure Button' dialog box contains the following fields and controls:

- Speed Code:** A dropdown menu showing 'PROPHY'.
- Perio Mode:** An unchecked checkbox.
- Buttons:** 'Ok' and 'Cancel' buttons at the bottom.

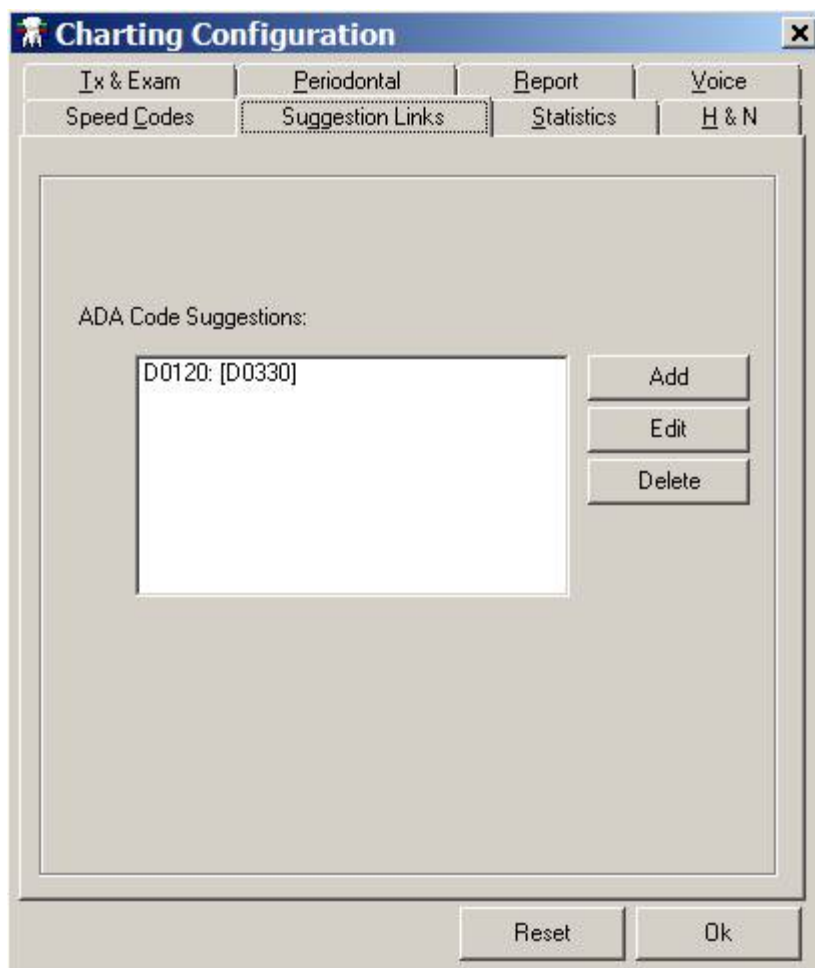
**Figure 35: Configure Button Screen**

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

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

## *Suggestion Links*

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

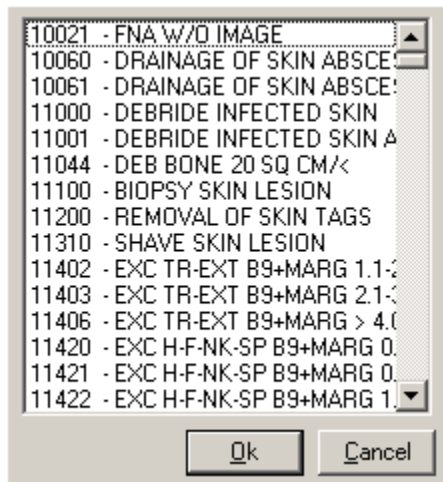


**Figure 36: Suggestion Links Tab**

To add a suggestion link:

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





**Figure 37: Suggestion Links Code List**

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



**Figure 38: Linked Codes Screen**

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

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

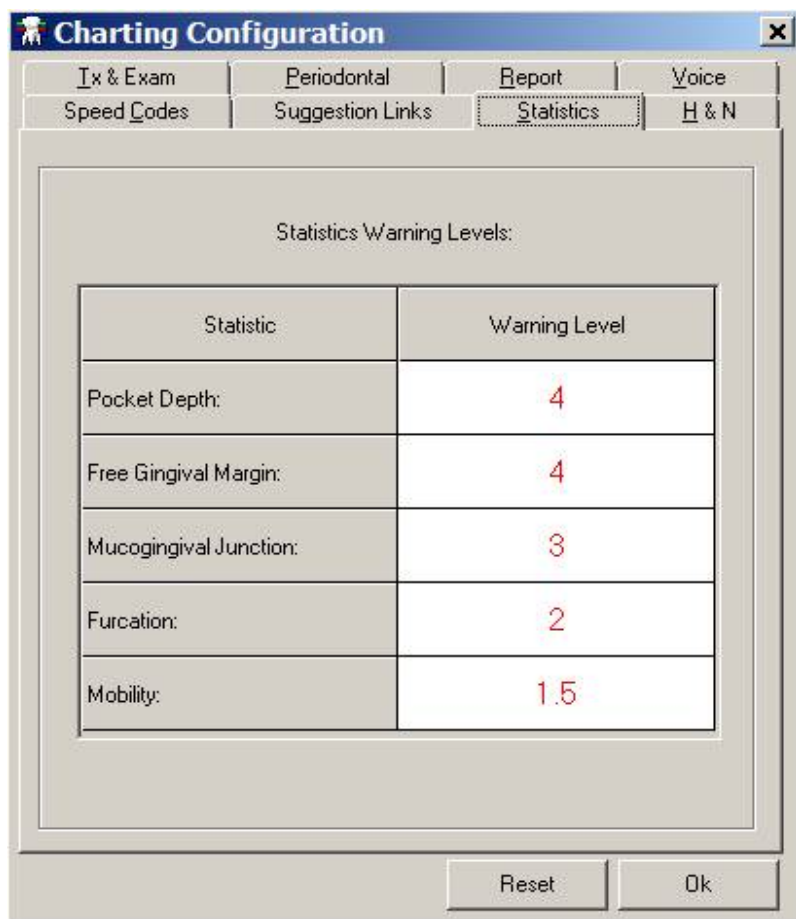
To edit the suggestion link:

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

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

## Statistics

Choose the **Statistics** tab to set the warning level for pocket depth, free gingival margin, mucogingival junction, furcation and mobility found in the **Stats** screen on the **Periodontal Chart**.



The image shows a 'Charting Configuration' dialog box with the 'Statistics' tab selected. The tab is highlighted with a dotted border. The dialog box contains a table titled 'Statistics Warning Levels:' with two columns: 'Statistic' and 'Warning Level'. The table lists five statistics with their respective warning levels: Pocket Depth (4), Free Gingival Margin (4), Mucogingival Junction (3), Furcation (2), and Mobility (1.5). At the bottom of the dialog box are 'Reset' and 'Ok' buttons.

Statistic	Warning Level
Pocket Depth:	4
Free Gingival Margin:	4
Mucogingival Junction:	3
Furcation:	2
Mobility:	1.5

Figure 39: 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.



The image shows a 'DRM' dialog box with the title 'Please enter new value'. It contains a text input field at the bottom and two buttons, 'OK' and 'Cancel', on the right side.

Figure 40: Adjust the Warning Level

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

## H&N

The **H&N** tab allows the provider to use the **Add** and **Delete** buttons to add/delete head and neck findings listed on the **H&N** screen located on both the **Treatment & Exam** and **Periodontal Chart** screens.

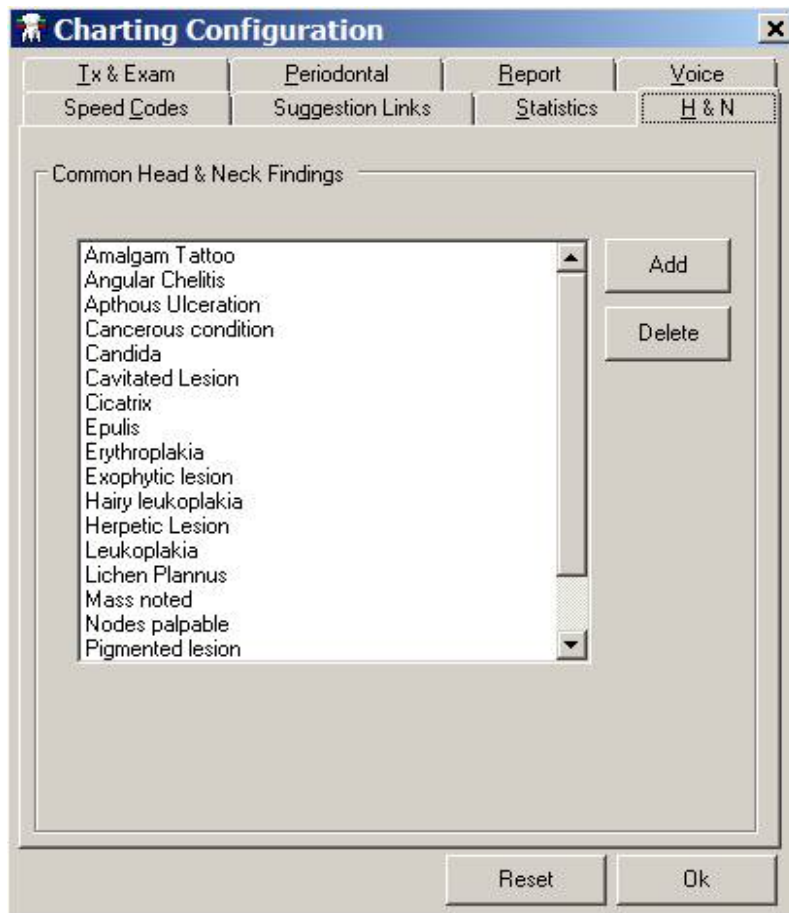


Figure 41: H&N Tab

To add an **H&N** finding:

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

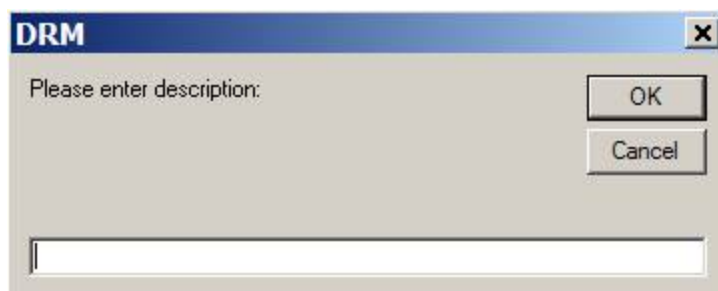


Figure 42: DRM Description Screen

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

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

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

## Add/Edit Personal QuickList

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

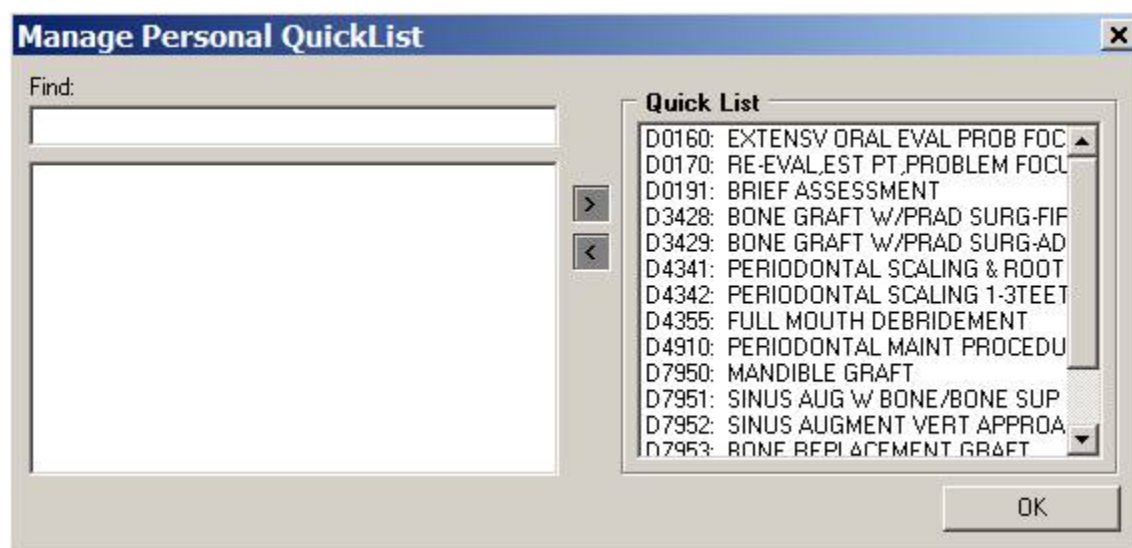


Figure 43: Manage Personal QuickList Screen

To add to the **Quick List**:

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

To remove from the **Quick List**:

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

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

## Add Medical Codes to ADA Table

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

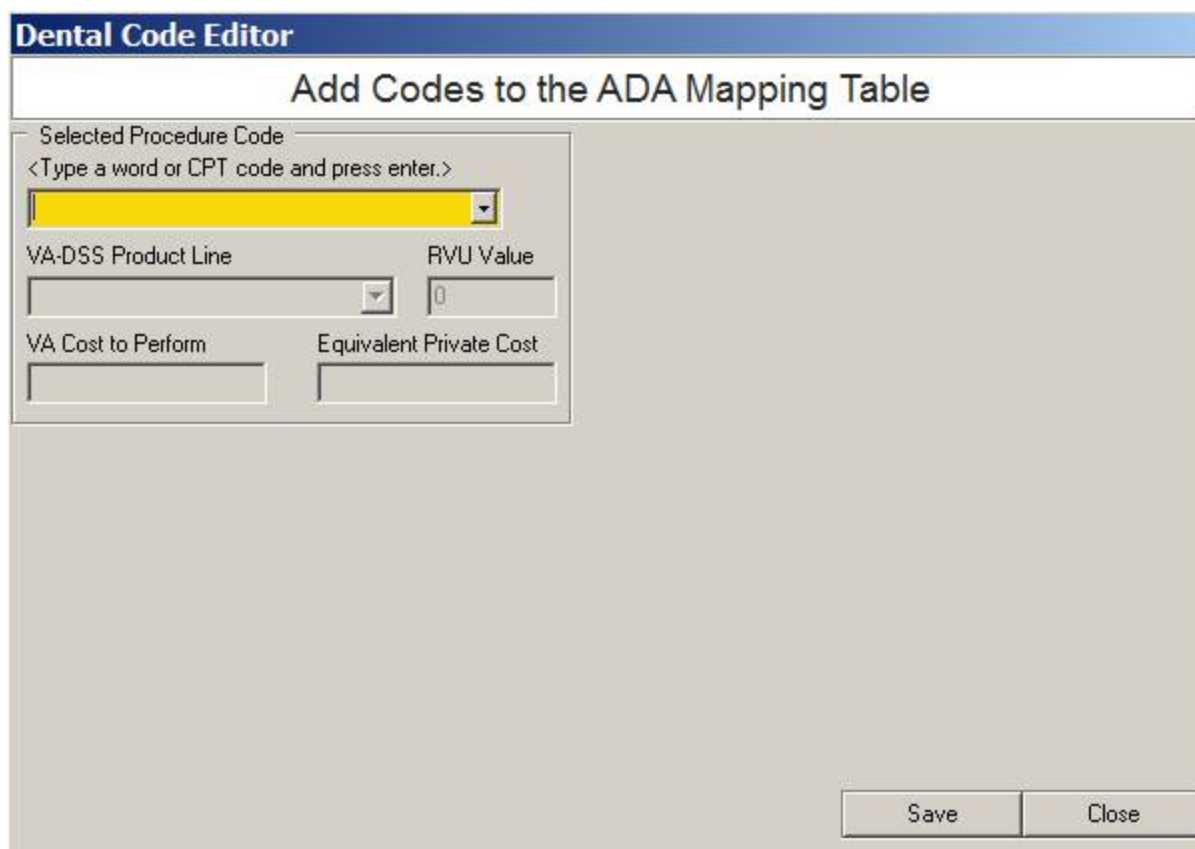


Figure 44: Dental Code Editor Screen

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

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

**Figure 45: Dental Code Editor Screen when Adding Procedure Code**

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

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

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

## Edit Code Information in the ADA Table

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

**Figure 46: Dental Code Editor Screen when Editing Procedure Code**

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

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

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

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



## Edit Procedure Costs

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

**Edit Procedure Costs**

Enter procedure costs directly into the table below. Selecting 'Enter' will file the ADA/CPT cost data immediately and then advance the user to the next VA Cost to Perform or Equivalent Private Cost.

ADA/CPT Code	RVU	VA Cost to Perform	Equiv. Private Cost
D0120 PERIODIC ORAL EVALUATION	30		
D0140 LIMIT ORAL EVAL PROBLM FOCUS	20		
D0145 ORAL EVALUATION CHILD <3 YRS	0		
D0150 COMPREHENSVE ORAL EVALUATION	50		
D0160 EXTENSV ORAL EVAL PROB FOCUS	45		
D0170 RE-EVAL,EST PT,PROBLEM FOCUS	20		
D0171 RE-EVAL,EST PT,POSTOP VISIT	0		
D0180 COMP PERIODONTAL EVALUATION	60		
D0190 ORAL SCREENING	10		
D0191 BRIEF ASSESSMENT	10		
D0210 INTRAORAL FULL IMAGE SERIES	18		
D0220 INTRAORAL PERIAPICAL FIRST	1		
D0230 INTRAORAL PERIAPICAL EA ADD	1		
D0240 INTRAORAL OCCLUSAL IMAGE	1		
D0250 EXTRAORAL 2D IMAGE	5		
D0251 EXTRAORAL POSTERIOR IMAGE	5		
D0270 DENTAL BITEWING SINGLE IMAGE	1		
D0272 DENTAL BITEWING TWO IMAGES	2		

Save to Excel
Print
Close

**Figure 47: 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 Excel**, to view in Microsoft Excel, **Print** or **Close**.



## Filter View

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

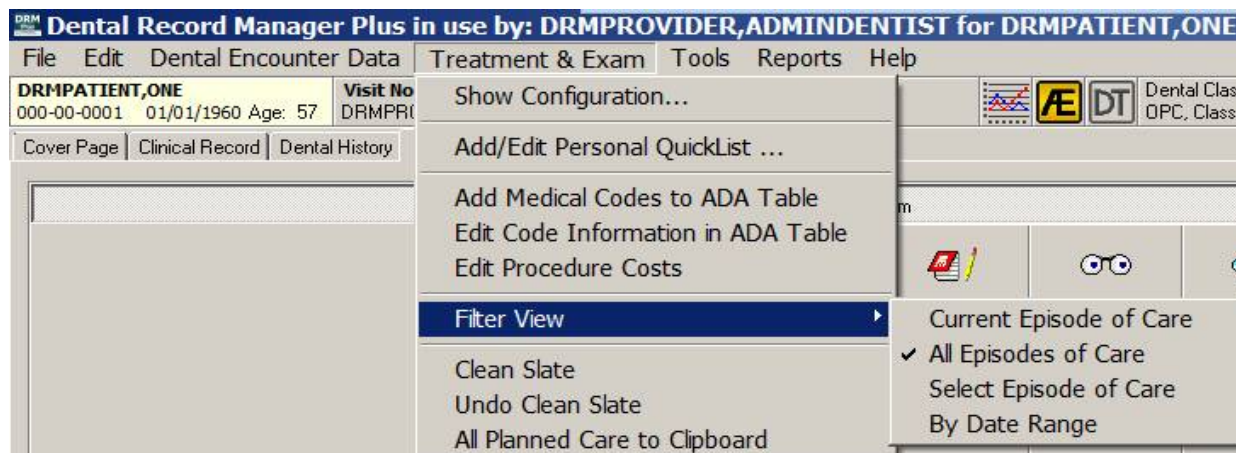


Figure 48: Filter View Submenus

### *Current Episode of Care*

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

### *All Episodes of Care*

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

### *Select Episode of Care*

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

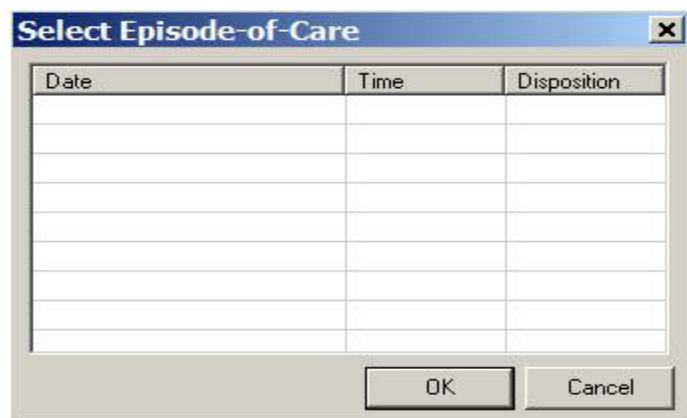


Figure 49: Select Episode of Care Screen

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

## Date Range

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

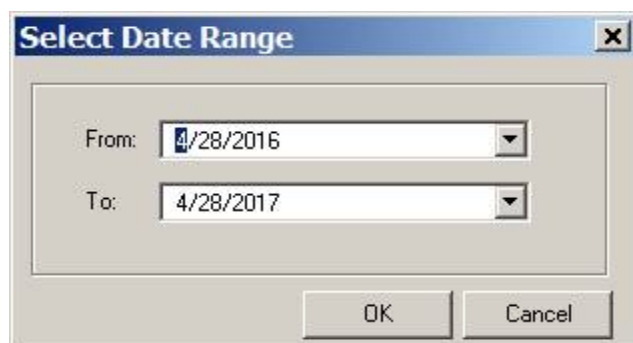
A screenshot of a 'Select Date Range' dialog box. It has a title bar with the text 'Select Date Range' and a close button (X). Inside the dialog, there are two date selection fields. The first field is labeled 'From:' and contains the date '4/28/2016'. The second field is labeled 'To:' and contains the date '4/28/2017'. Both fields have a small downward arrow on the right side, indicating they are drop-down menus. At the bottom of the dialog, there are two buttons: 'OK' and 'Cancel'.

Figure 50: Select Date Range Screen

To filter by date range:

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

## Clean Slate

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

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

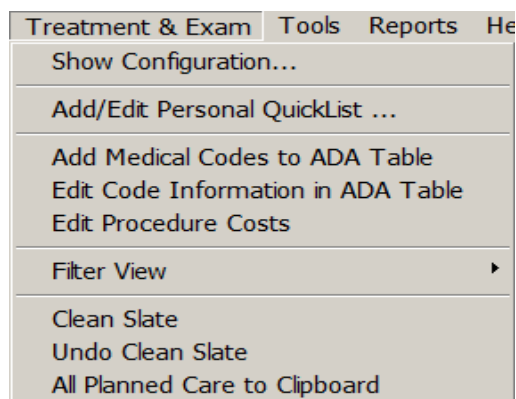


Figure 51: Clean Slate Submenu

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

**Dental Record Manager Plus in use by: DRMPROVIDER,ADMIDENTIST for DRMPATIENT,ONE**

File Edit Dental Encounter Data Treatment & Exam Tools Reports Help

DRMPATIENT, ONE V: Apr 28, 2017 @ 15:00 DENTAL FOP: DRMPROVIDER,ADMIDENTIST SGP: Dental Class OPC, Class IV

Cover Page Clinical Record Dental History Chart/Treatment Exam

**Treatment & Exam**

Diagnostic Findings: Notes, Observe, Sealant, Bridge, P & C, Perio Buttons, COMP EX, COMPLETE, \* Seq Plan, \* H & N

Treatment Plan: Restore, Partial, Endo, Conn Bar, ADA Codes, PERIODIC, PANIO, Chart Hx, \* PSR

Completed Care: Extract, Denture, Apico, Hemi, CPT Codes, LIMITED EX, BTM-4, Summary, \* OHA

Include Findings and Completed: Clear, Implant, Retro, Coping, Quick Codes, PERIODIC, Habits, Social Hx

**Periodontal Chart**

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Upper

Visit Date	Stat	Category	Tooth/Quad	Surf/Root	Diag	Code	Description	Prov
04/28/2017	P	Restore	2	DOL		D2160	AMALGAM THREE SURFACES PERMA	ADMIN
04/28/2017	P	Restore	3	OL		D2150	AMALGAM TWO SURFACES PERMANE	ADMIN
04/28/2017	P	Restore	14	OL		D2150	AMALGAM TWO SURFACES PERMANE	ADMIN
04/28/2017	P	Restore	15	DOL		D2160	AMALGAM THREE SURFACES PERMA	ADMIN

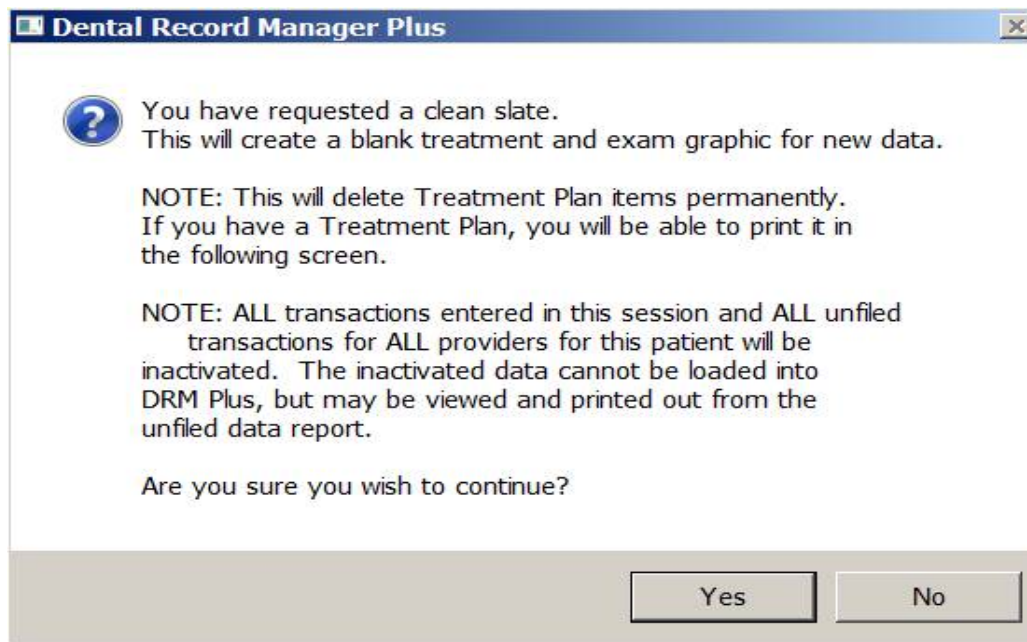
Lower

Full

Edit, Delete, Complete, Next =>

**Figure 52: Patient Chart before Clean Slate**

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



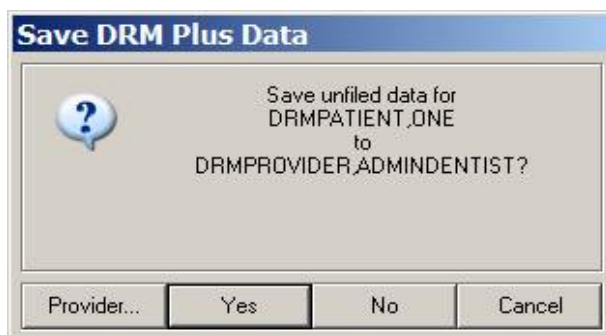
**Figure 53: Clean Slate Information Screen**

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



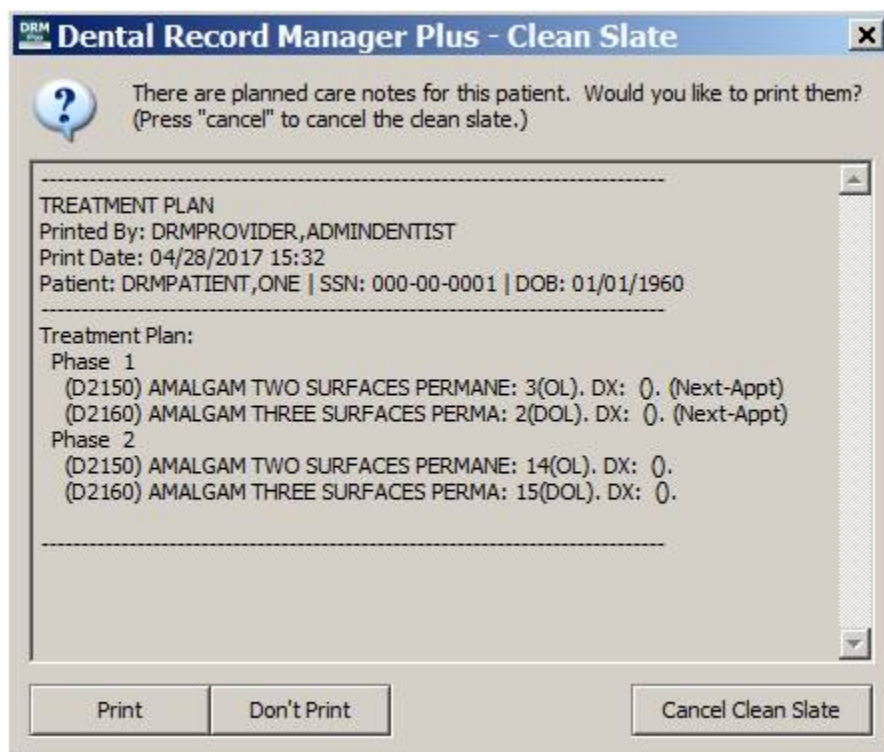
**Figure 54: No Data Saved**

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



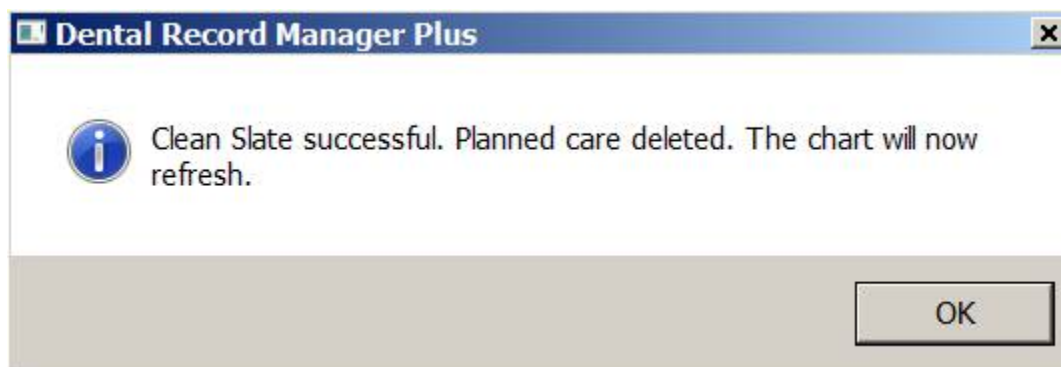
**Figure 55: Save DRM Plus Data**

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



**Figure 56: Print Planned Care Notes**

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



**Figure 57: Clean Slate Successful**

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



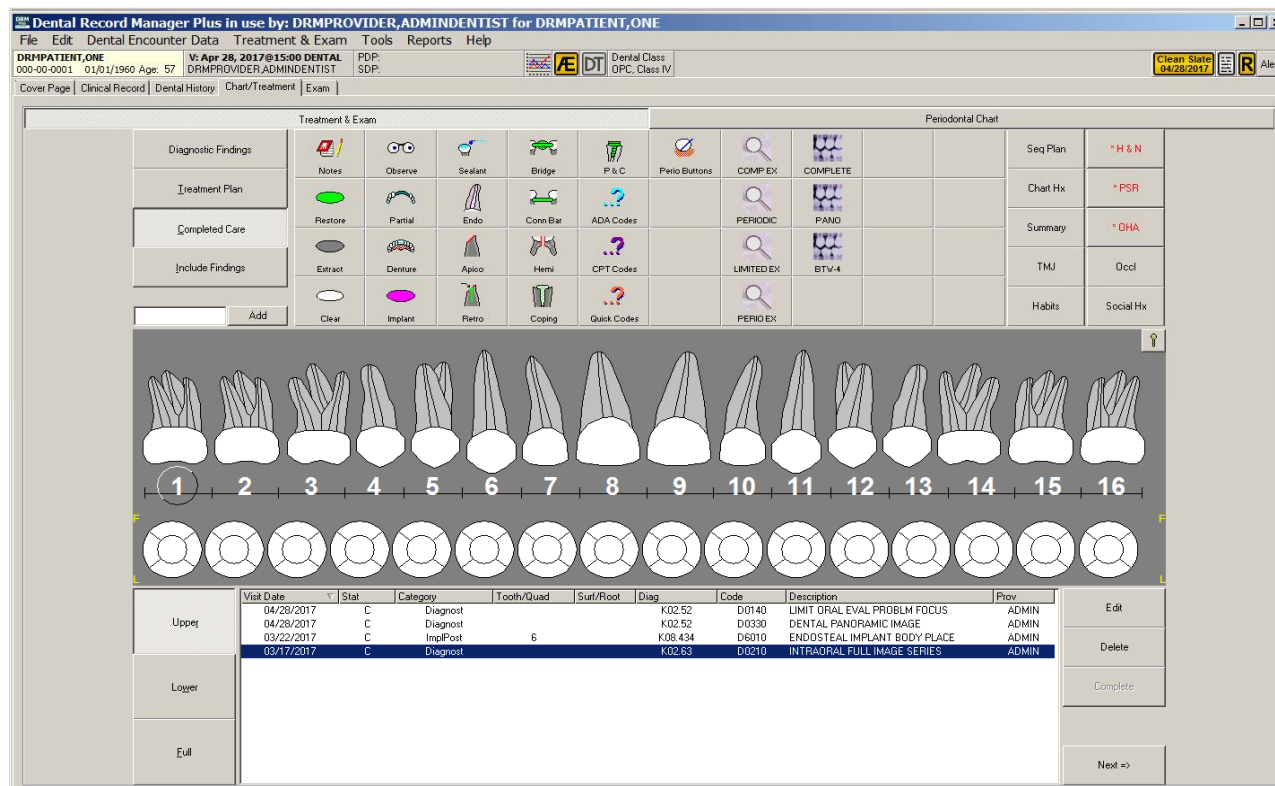


Figure 58: Patient Chart after Clean Slate

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

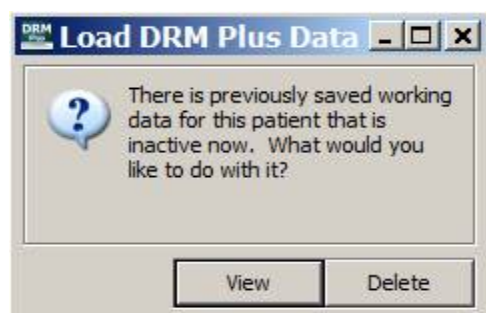


Figure 59: Load DRM Plus Data Screen

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

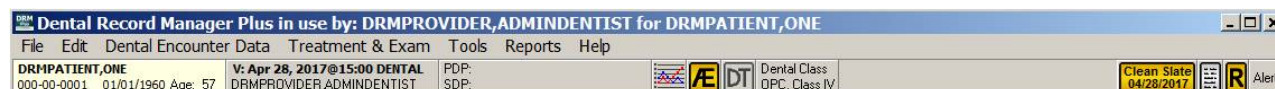


Figure 60: Clean Slate Banner Icon

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

## Undo Clean Slate

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

To utilize the undo clean slate function:

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



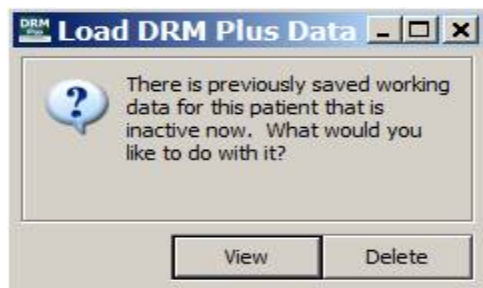
Figure 61: Undo Clean Slate Message Screen

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



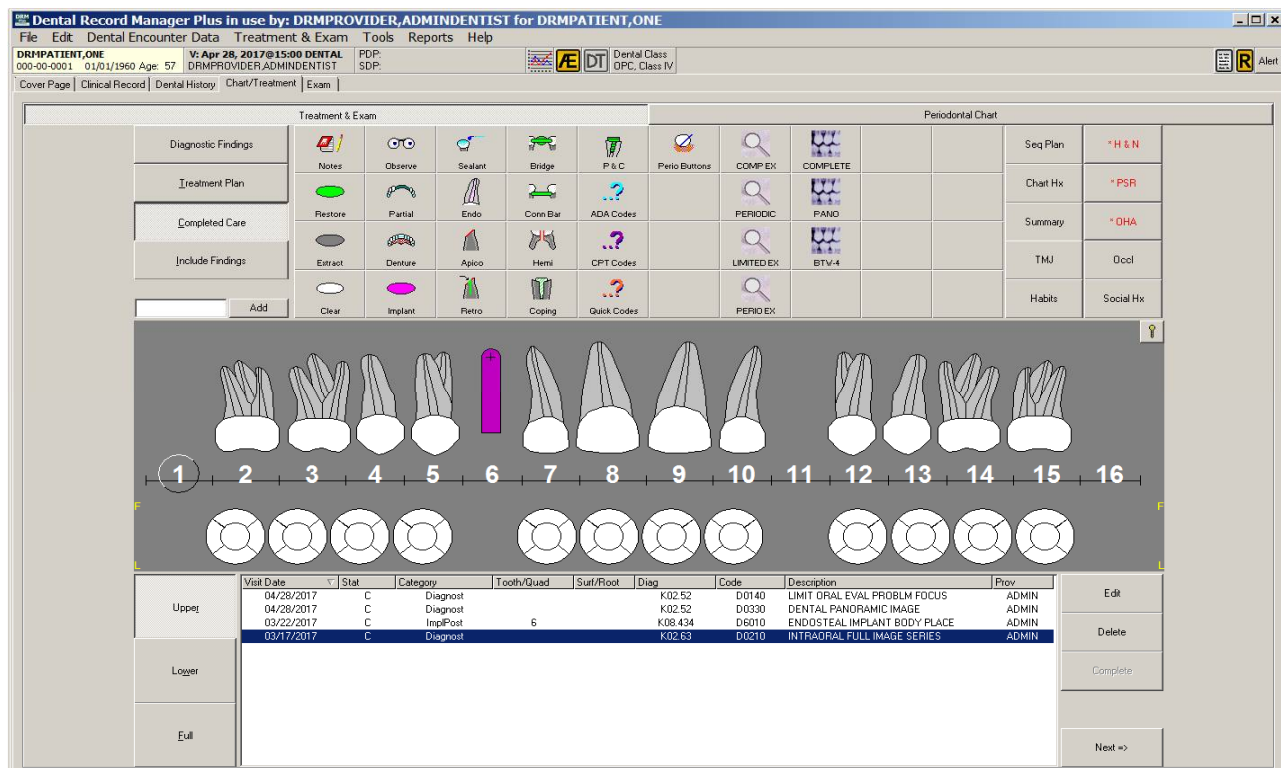
Figure 62: Clean Slate Undone

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



**Figure 63: Previously Saved Inactive Data Message**

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



**Figure 64: Completed Treatment Graphics Recovered**

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

## All Planned Care to Clipboard

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

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



## Tools

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

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

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

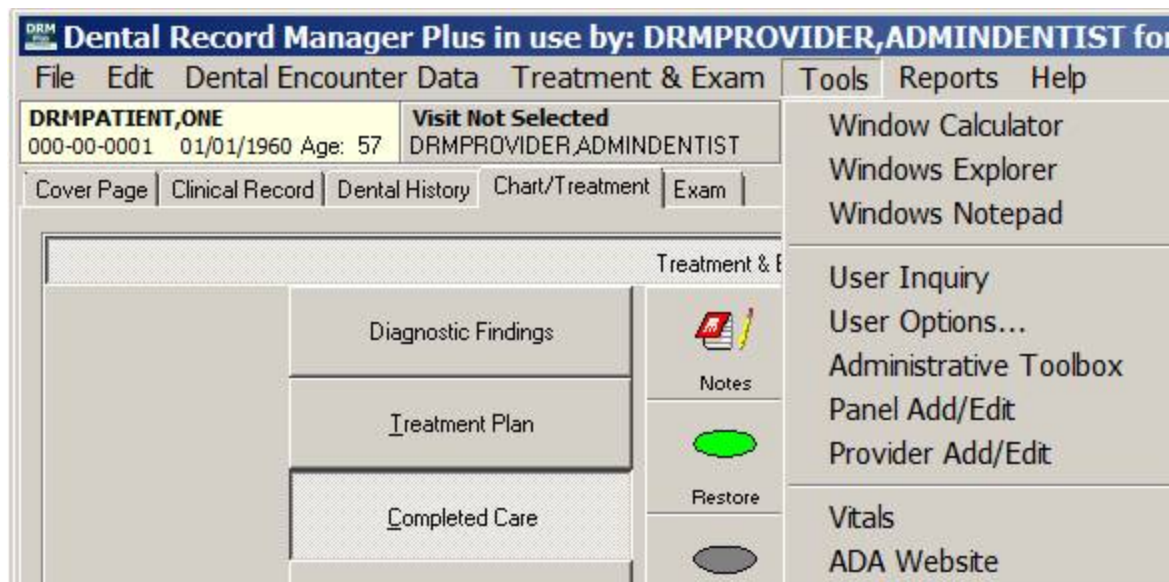


Figure 65: Tools Menu

### **Windows Calculator**

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

### **Windows Explorer**

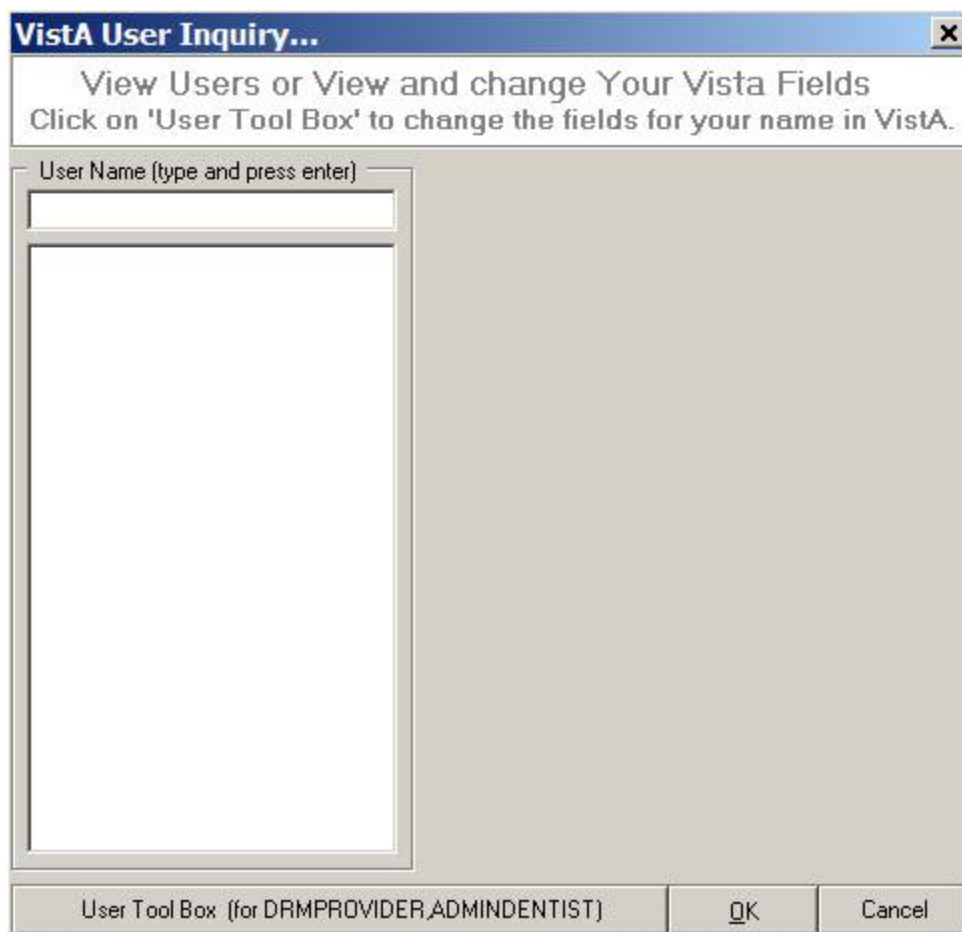
Select this submenu to open **Windows Explorer**.

### **Windows Notepad**

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

## User Inquiry

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



**Figure 66: VistA User Inquiry Screen**

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

**VistA User Inquiry...**

View Users or View and change Your Vista Fields  
Click on 'User Tool Box' to change the fields for your name in VistA.

User Name (type and press enter)  
drm

DRM,KDF  
DRM,YHP  
**DRMPROVIDER,ADMINDENTIST**  
DRMPROVIDER,ASSISTANT  
DRMPROVIDER,DENTIST  
DRMPROVIDER,DENTIST TWO  
DRMPROVIDER,HYGIENIST  
DRMPROVIDER,RESIDENT

User Information

Initials: ADMIN  
No NickName on File.  
No Title on File.  
Service: DENTAL  
No Mail Code on File.  
No Office Phone on File.  
No Voice Pager on File.  
No Digital Pager on File.  
No Fax on File.  
No Location on File.  
Menu Option: YES, MENUS GENERATED  
Type Ahead Allowed: ALLOWED  
Preferred Editor: SCREEN EDITOR - VA FILEMAN  
Signature Block: ADMINDENTIST DRMPROVIDER  
No Signature Title on File.

User Tool Box (for DRMPROVIDER,ADMINDENTIST)    **OK**    Cancel

**Figure 67: VistA User Inquiry Screen with User Information Displayed**

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

**User's TBox...**

User Profile Fields:

- ☒ Initials
- ☐ Nickname
- ☐ Service
- ☐ Mail Code
- ☐ Office Phone
- ☐ Home Phone
- ☐ Voice Pager
- ☐ Digital Pager
- ☐ Fax
- ☐ Location
- ☐ Automenu
- ☐ Type Ahead
- ☐ Preferred Editor
- ☐ Signature Block

Update Initials field.

ADMIN

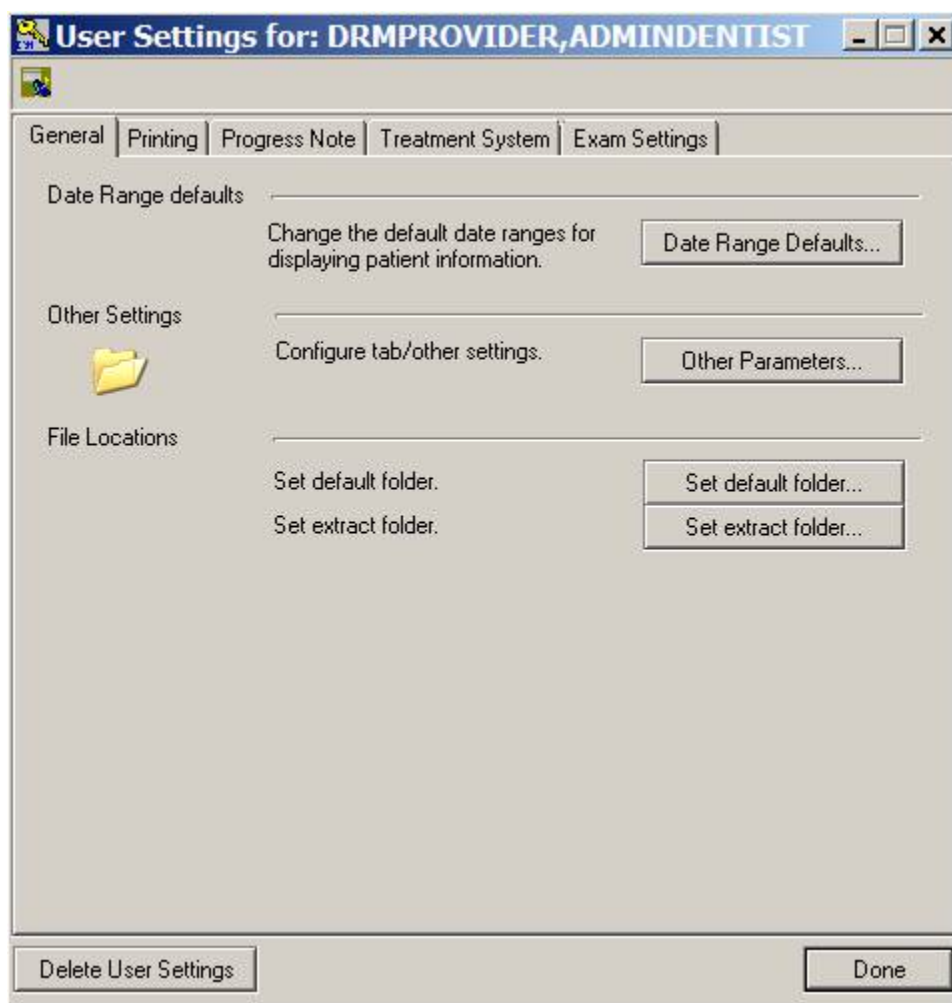
**Finished**

**Figure 68: User's TBox Screen**


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

## User Options

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



**Figure 69: User Settings Screen**

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

## General

The default **General** tab allows the provider to change **Date Range defaults**, **Other Settings** and **File Location** folders.

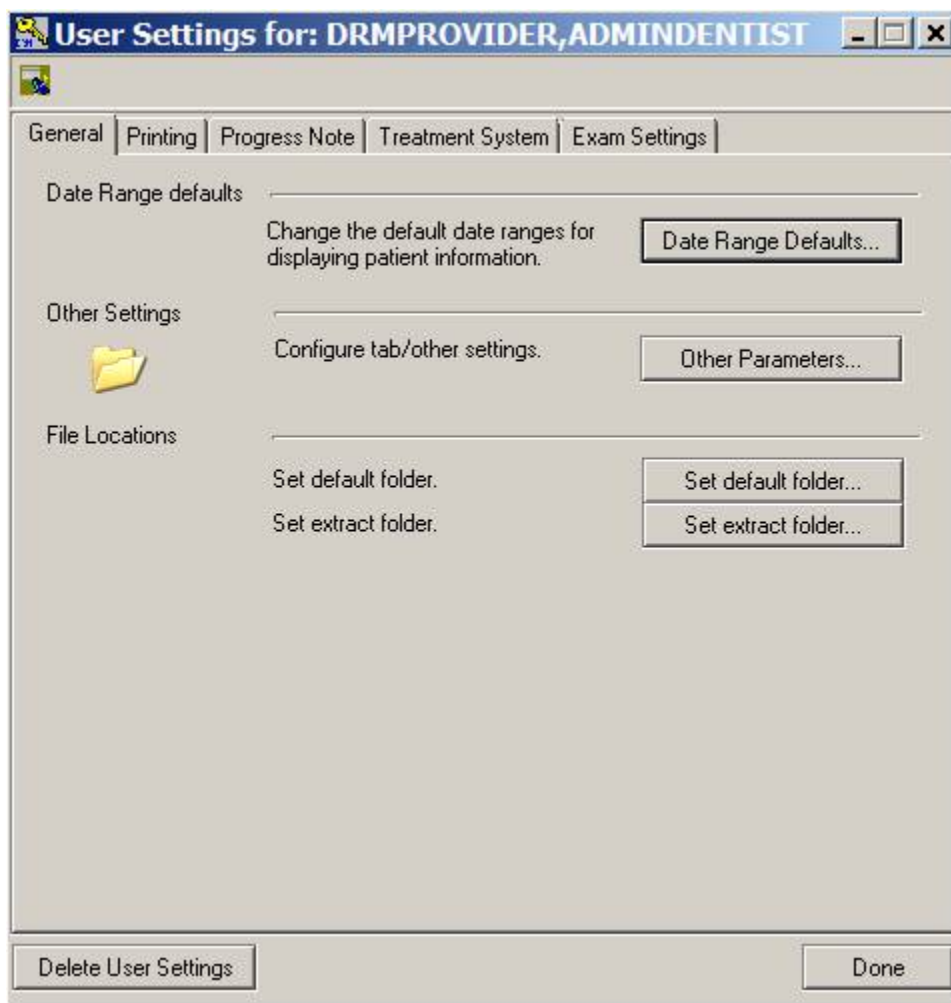


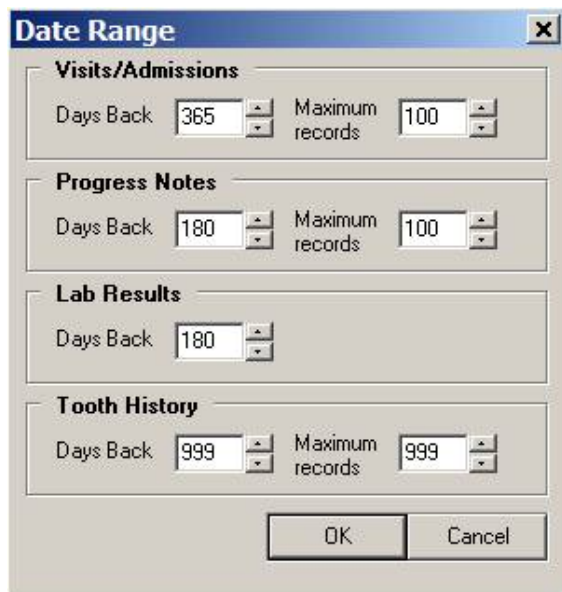
Figure 70: General Tab

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

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

To change the default date ranges:

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



**Date Range** [X]

**Visits/Admissions**

Days Back: 365 [up/down arrows] Maximum records: 100 [up/down arrows]

**Progress Notes**

Days Back: 180 [up/down arrows] Maximum records: 100 [up/down arrows]

**Lab Results**

Days Back: 180 [up/down arrows]

**Tooth History**

Days Back: 999 [up/down arrows] Maximum records: 999 [up/down arrows]

OK Cancel

**Figure 71: Date Range Screen**

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

To change other parameter settings:

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



**Other Parameters** [X]

**Tabs**

Initial tab when DRM starts: Chart/Treatment [dropdown arrow]

Initial chart display in Chart/Treatment: Treatment & Exam [dropdown arrow]

**Note Boilerplate**

☒ Prompt for Note Boilerplate insert

OK Cancel

**Figure 72: Other Parameters Screen**

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

To change the file folder location:

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



**Figure 73: Select Default Folder Screen**

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

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

To set the extract folder location:

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



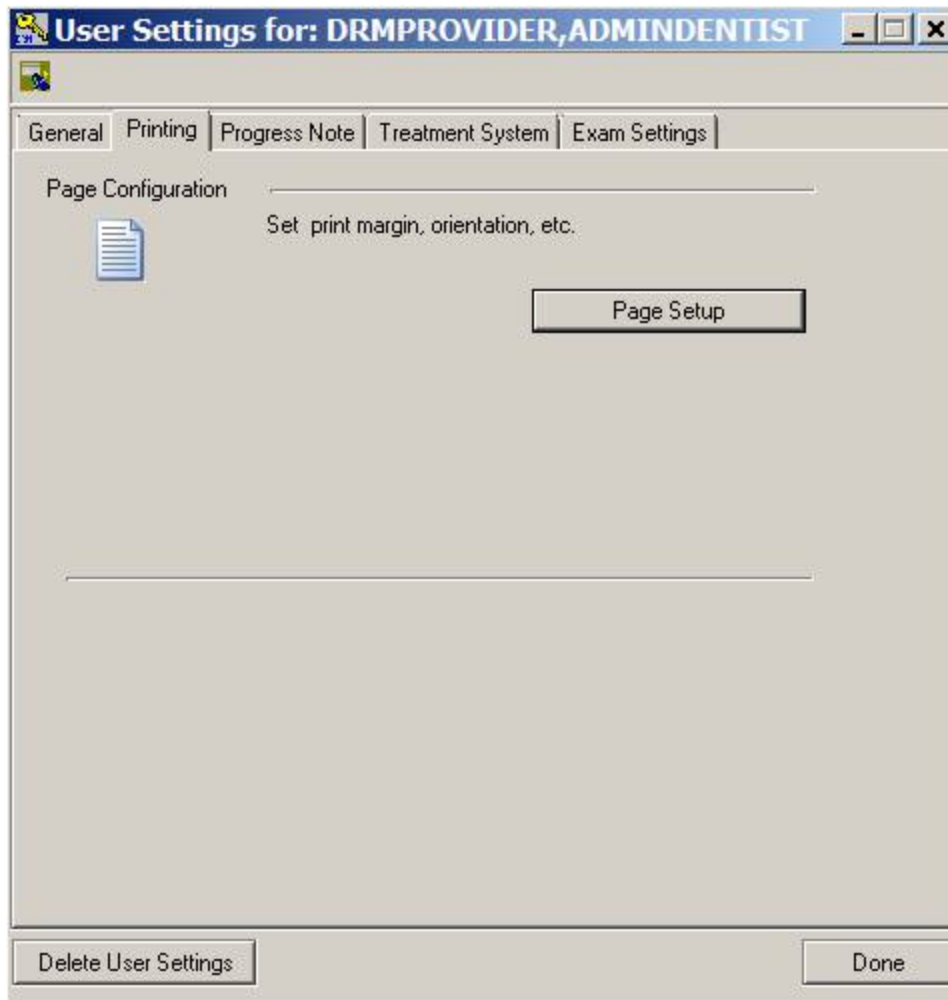
**Figure 74: Select Extract Folder Screen**

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



## *Printing*

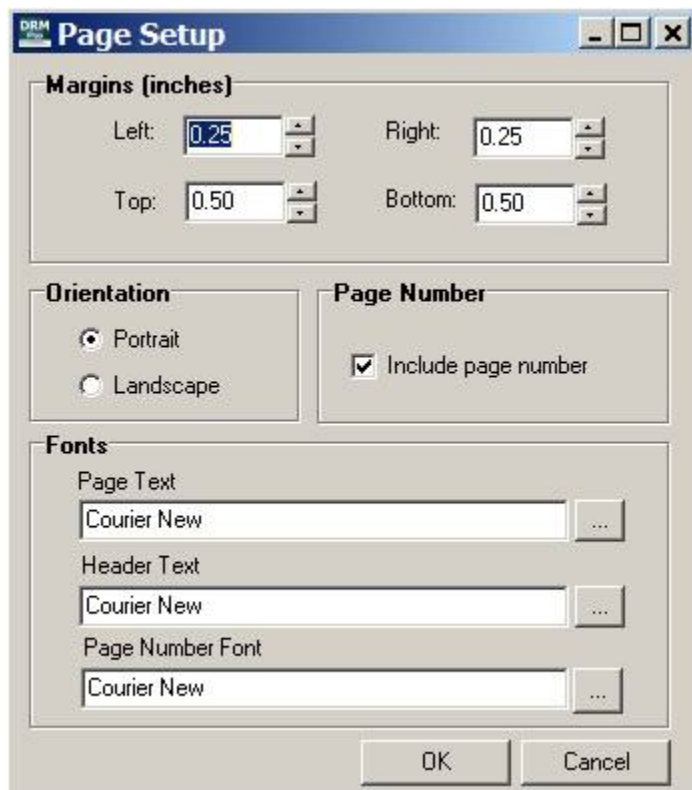
Use the **Printing** tab to set print margins, orientations, etc.



**Figure 75: Printing Tab**

To change the page configuration:

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

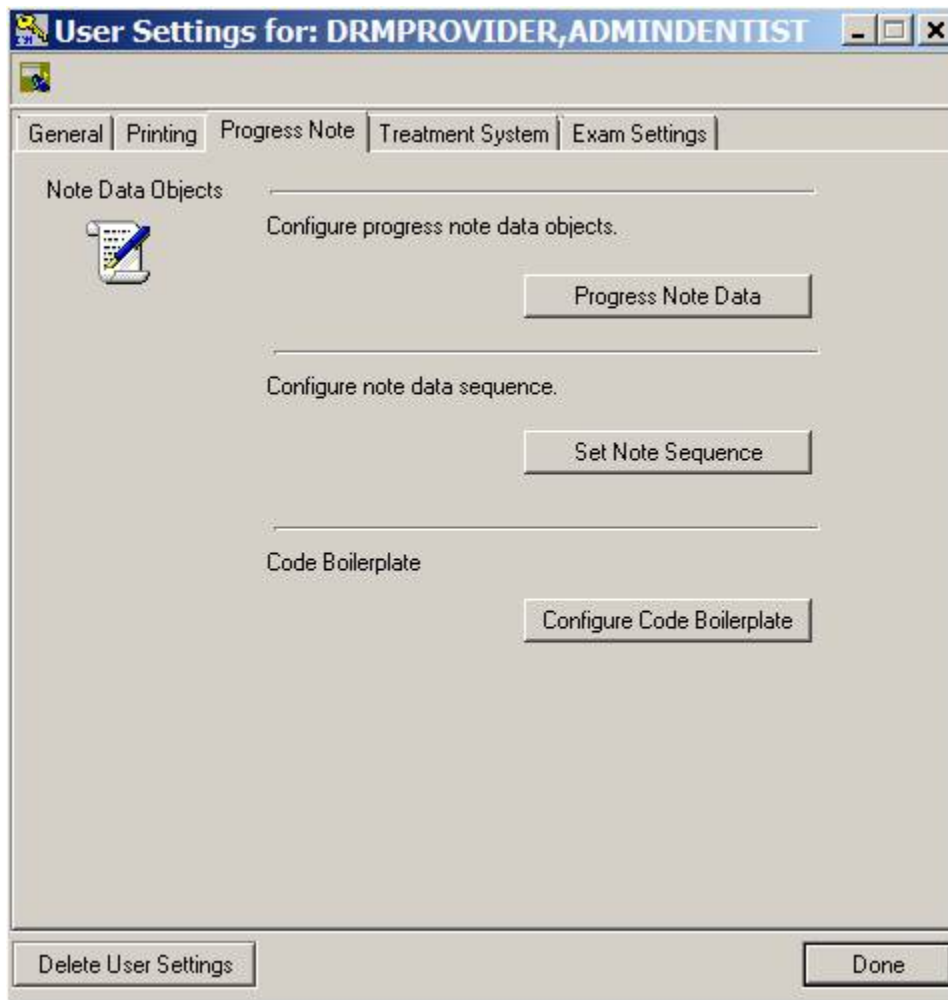


**Figure 76: Page Setup Screen**

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

## *Progress Note*

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



**Figure 77: 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** [X]

Include the following data objects:

<input checked="" type="checkbox"/> Diagnostic Findings	<input checked="" type="checkbox"/> Modified	<input type="checkbox"/> Deleted
<input checked="" type="checkbox"/> Adverse Events	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> Planned Items	<input checked="" type="checkbox"/> Modified	<input type="checkbox"/> Deleted
<input checked="" type="checkbox"/> Periodontal Exam		
<input checked="" type="checkbox"/> PSR Exam	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> Head/Neck Findings	<input checked="" type="checkbox"/> Modified	<input checked="" type="checkbox"/> Deleted
<input checked="" type="checkbox"/> Tooth Notes	<input checked="" type="checkbox"/> Modified	<input checked="" type="checkbox"/> Deleted
<input checked="" type="checkbox"/> Completed Items	<input type="checkbox"/> Modified	<input checked="" type="checkbox"/> Deleted
<input checked="" type="checkbox"/> Device Tracking	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> Social History	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> OHA Findings	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> Occlusal Findings	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> Parafunctional Habits	<input checked="" type="checkbox"/> Modified	
<input checked="" type="checkbox"/> TMJ Findings	<input checked="" type="checkbox"/> Modified	
<input type="checkbox"/> Code Boilerplate	These items are always included. The user may opt to not include the Note BP when selecting a note title.	
<input checked="" type="checkbox"/> Next Appointment	<input checked="" type="checkbox"/> Note Boilerplate	
<input type="checkbox"/> Dental Alerts	<input checked="" type="checkbox"/> Text Marker	

OK Cancel

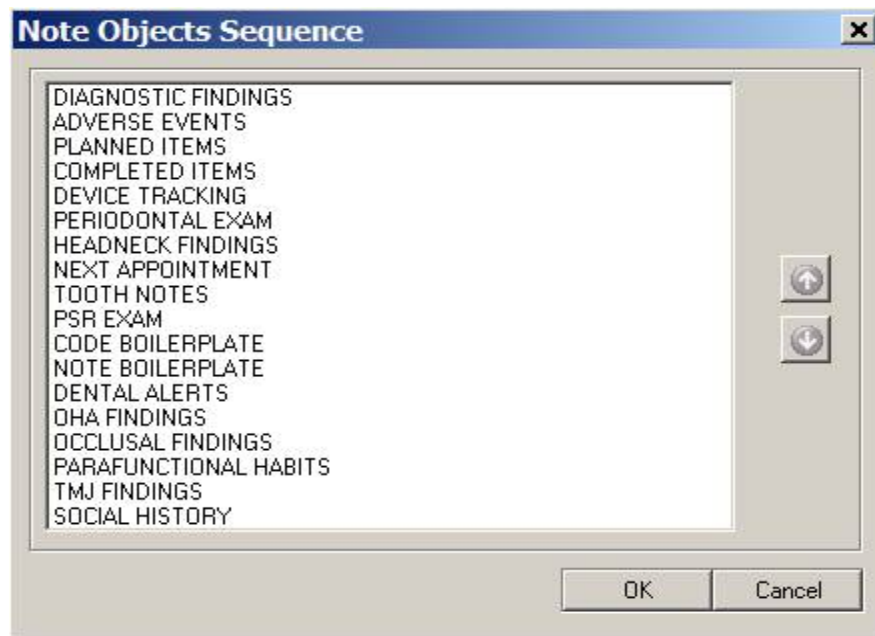
**Figure 78: Progress Note Data Objects Screen**

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

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

To configure the note data sequence:

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

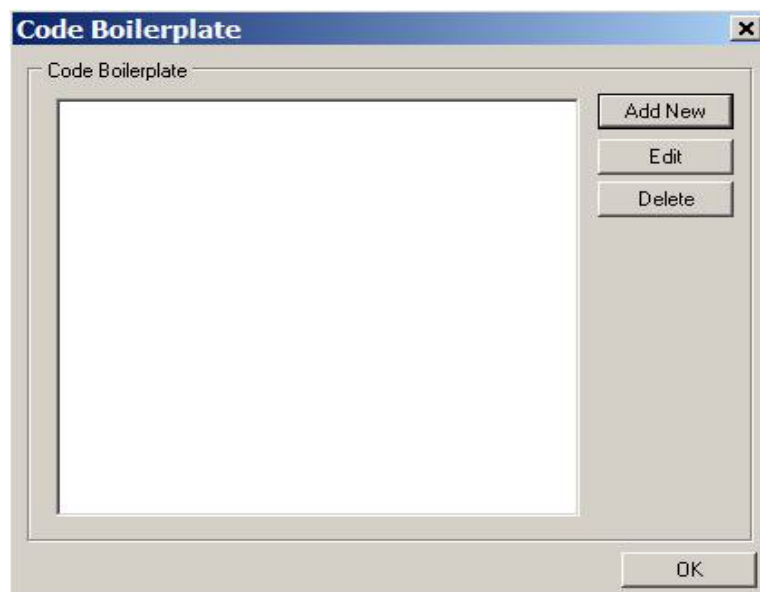


**Figure 79: Note Object Sequence Screen**

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

To configure the code boilerplate:

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



**Figure 80: Code Boilerplate Screen**

To add a new code boilerplate:

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



Figure 81: New Boilerplate Screen

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

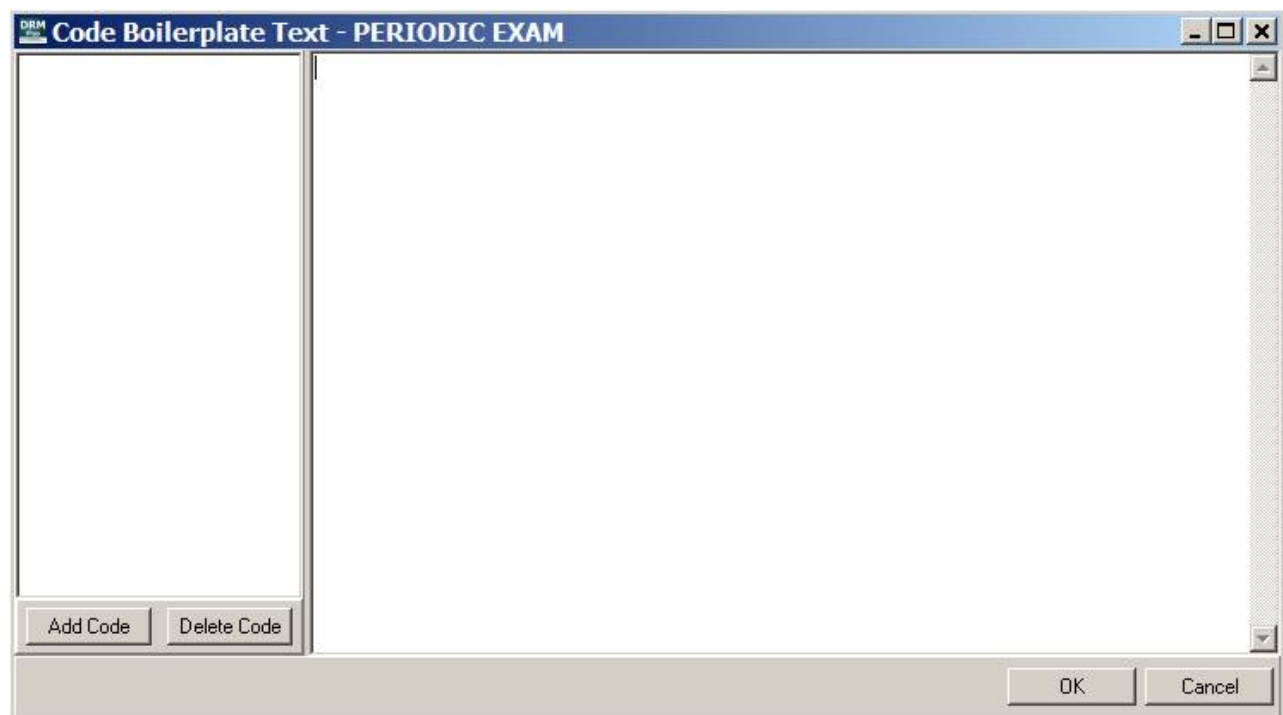
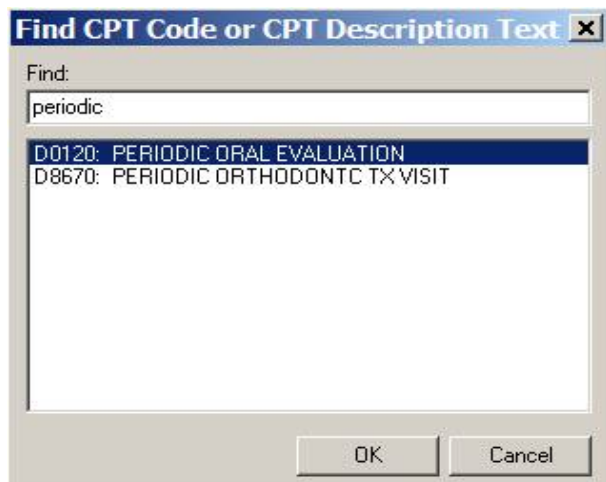


Figure 82: Code Boilerplate Text Screen

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

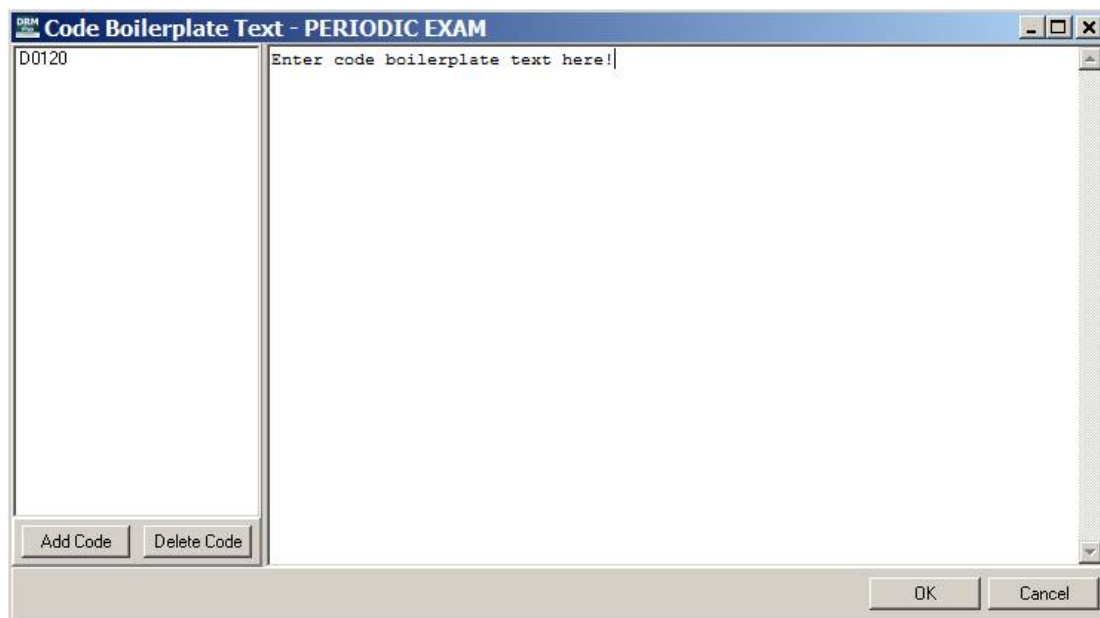


**Figure 83: Find CPT Code Screen**

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

To edit a code boilerplate:

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



**Figure 84: Code Boilerplate Text Screen**

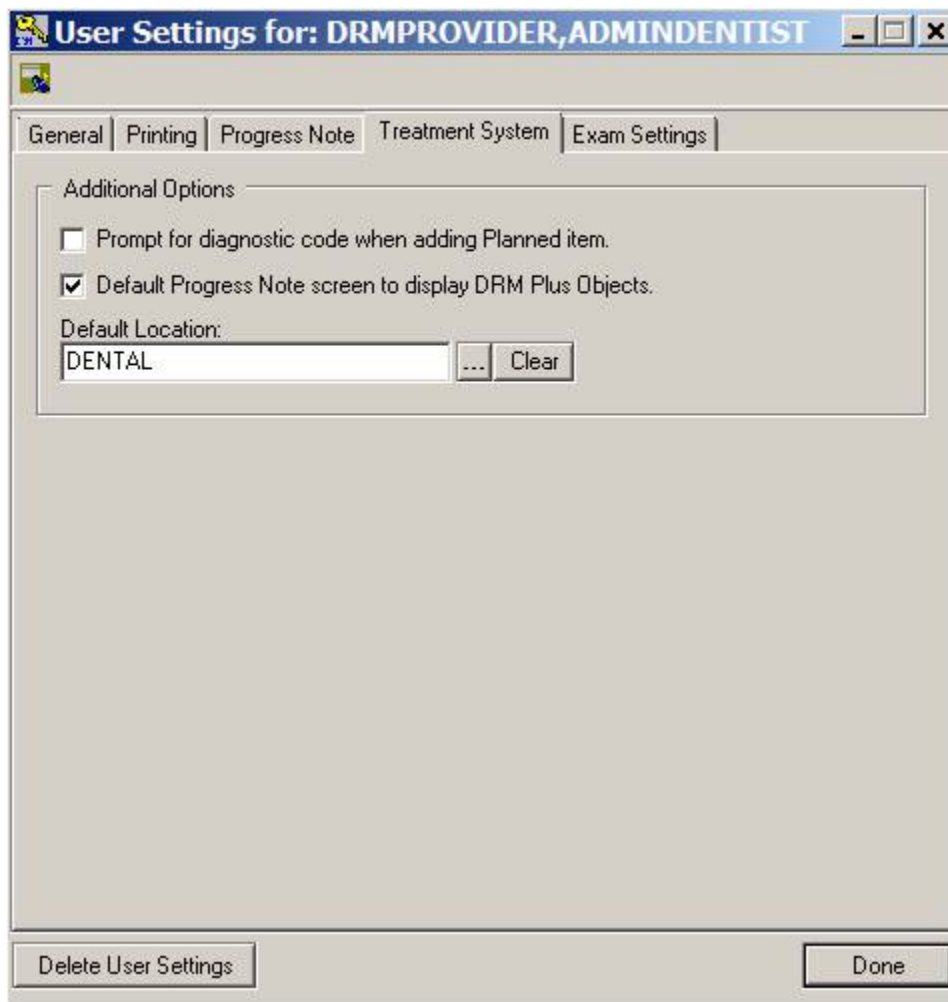
4. From here, type in the right side of the screen to add or delete text from the boilerplate. Use the **Add Code** and **Delete Code** buttons to add or delete codes from the boilerplate.
5. Click the **OK** button. An information screen displays. Click the **OK** button to return to the **Code Boilerplate**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

To delete a code boilerplate:

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

### *Treatment System*

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



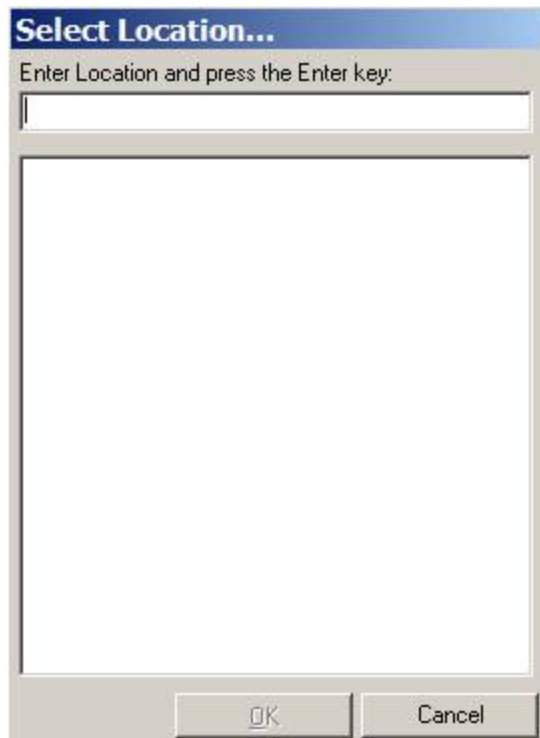
**Figure 85: Treatment System Tab**

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



To choose a default location:

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

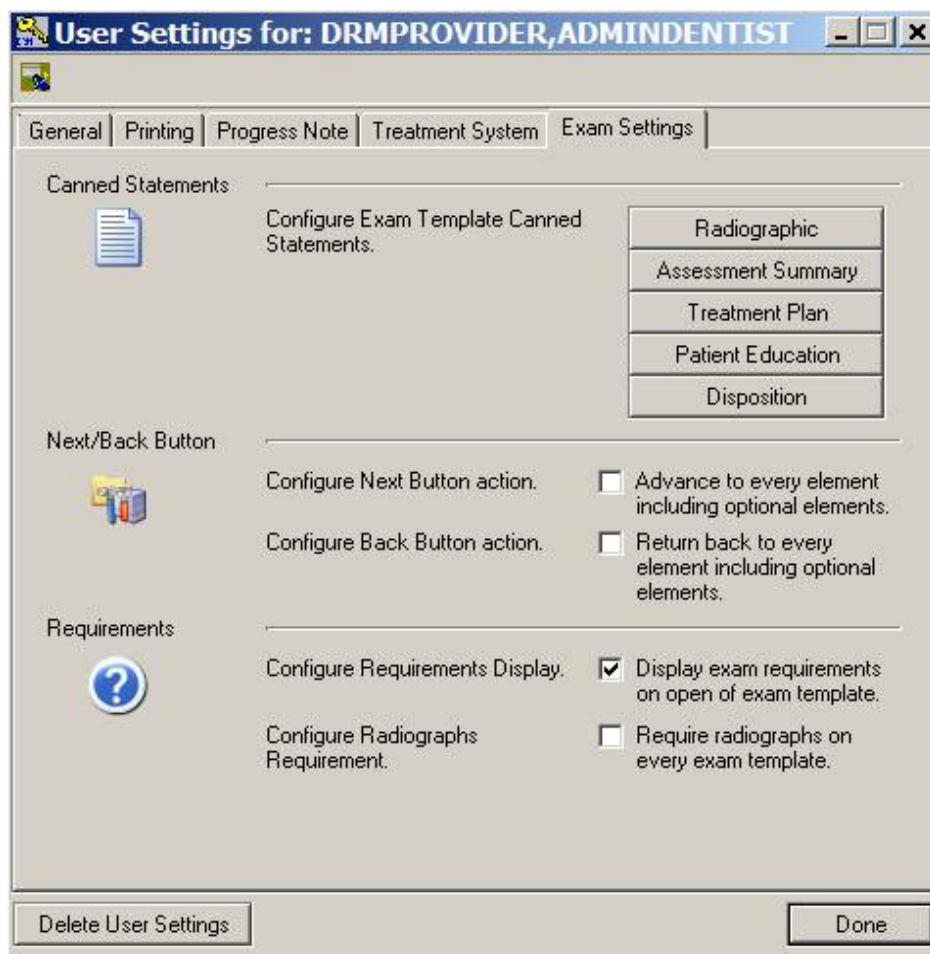


**Figure 86: Select Location Screen**

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

## Exam Settings

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



**Figure 87: Exam Settings Tab**

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

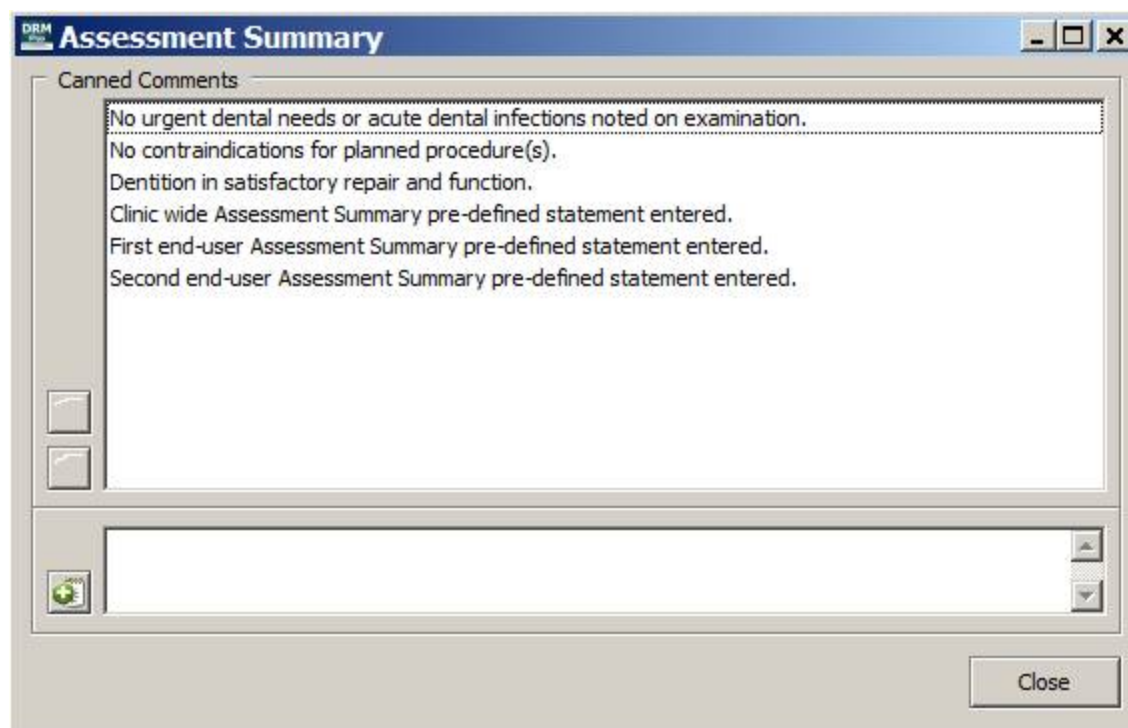
Pre-defined statements are broken into five categories: **Radiographic**, **Assessment Summary** and **Treatment Plan** (located in the same element), **Patient Education** and **Disposition**. There is a maximum of twelve pre-defined statements allowed per category.

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

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

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

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

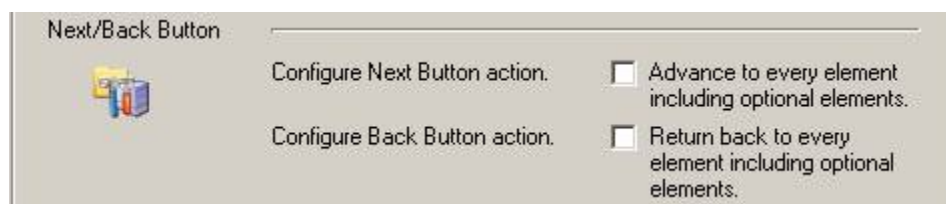


**Figure 88: Assessment Summary Screen**

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

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

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



**Figure 89: Next/Back Button Parameters**

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

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

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

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

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

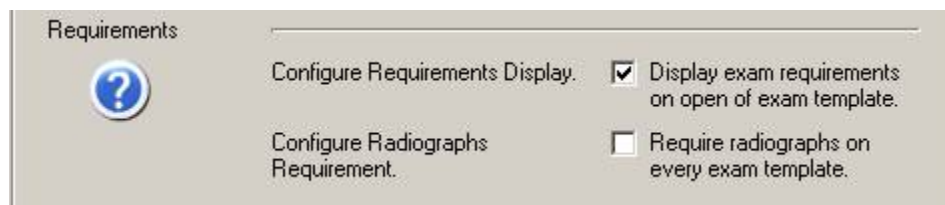


Figure 90: Requirements Parameters

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


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



Figure 91: Presentation/Chief Complaint Element Screen

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

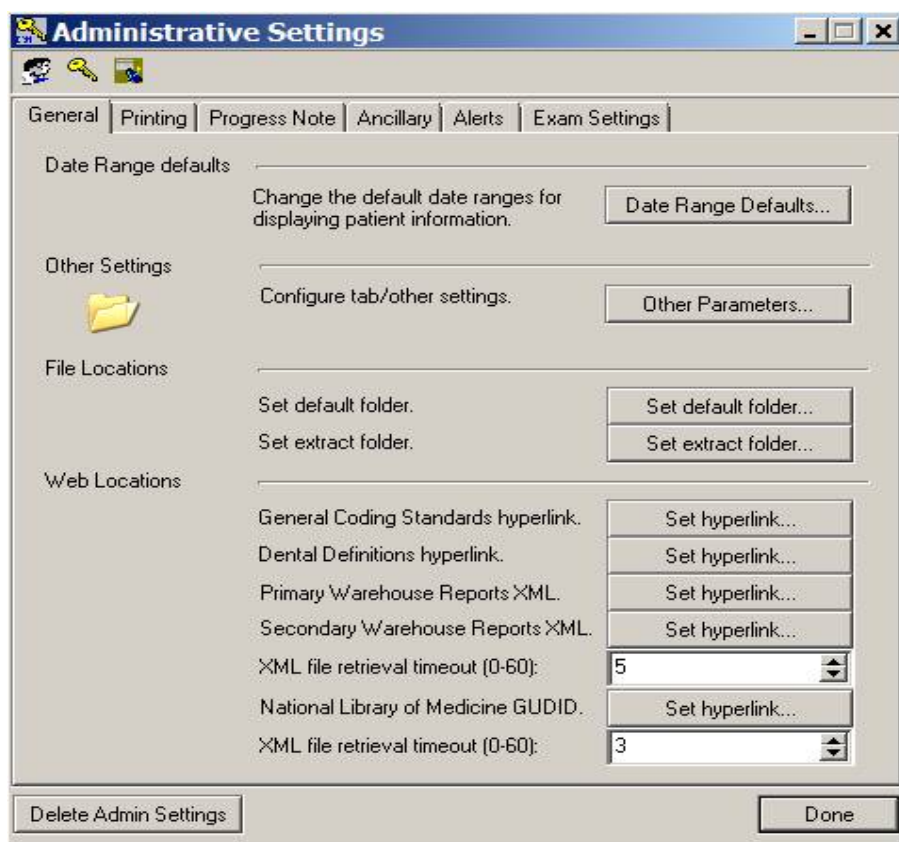
**Note:** The ADA exam codes D0145, D0171, D0190 and D0191 are NOT included with the DRM Plus **Exam** tab functionality when entered in DRM Plus by a provider.

## Administrative Toolbox

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

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

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



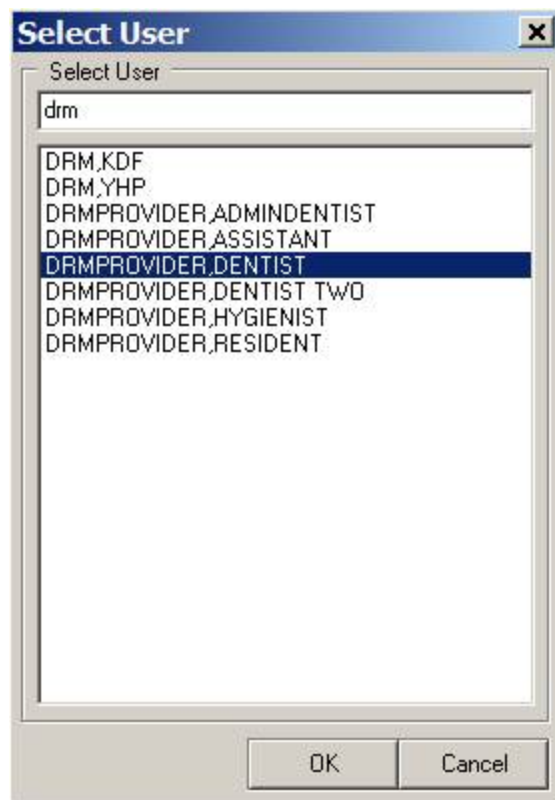
**Figure 93: Administrative Settings Screen**

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

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

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

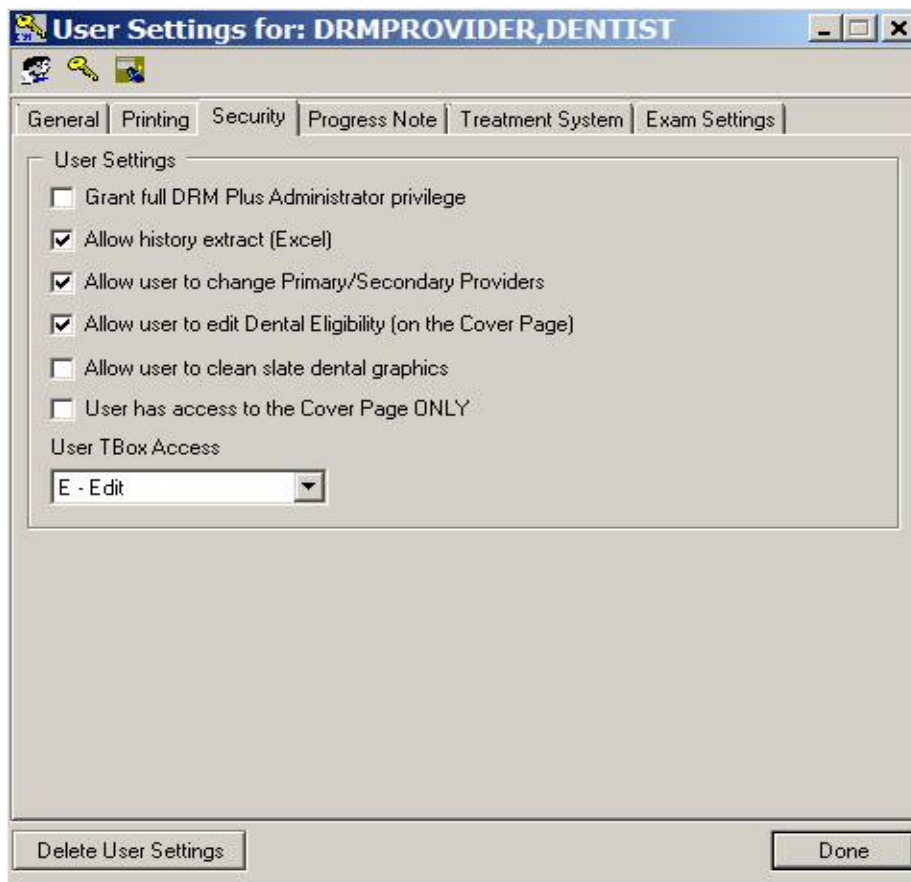
1. Click the **Double Heads** icon. The **Select User** screen displays.



**Figure 93: Select User Screen**


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






**Figure 94: Security Tab with the Administrative Toolbox**

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

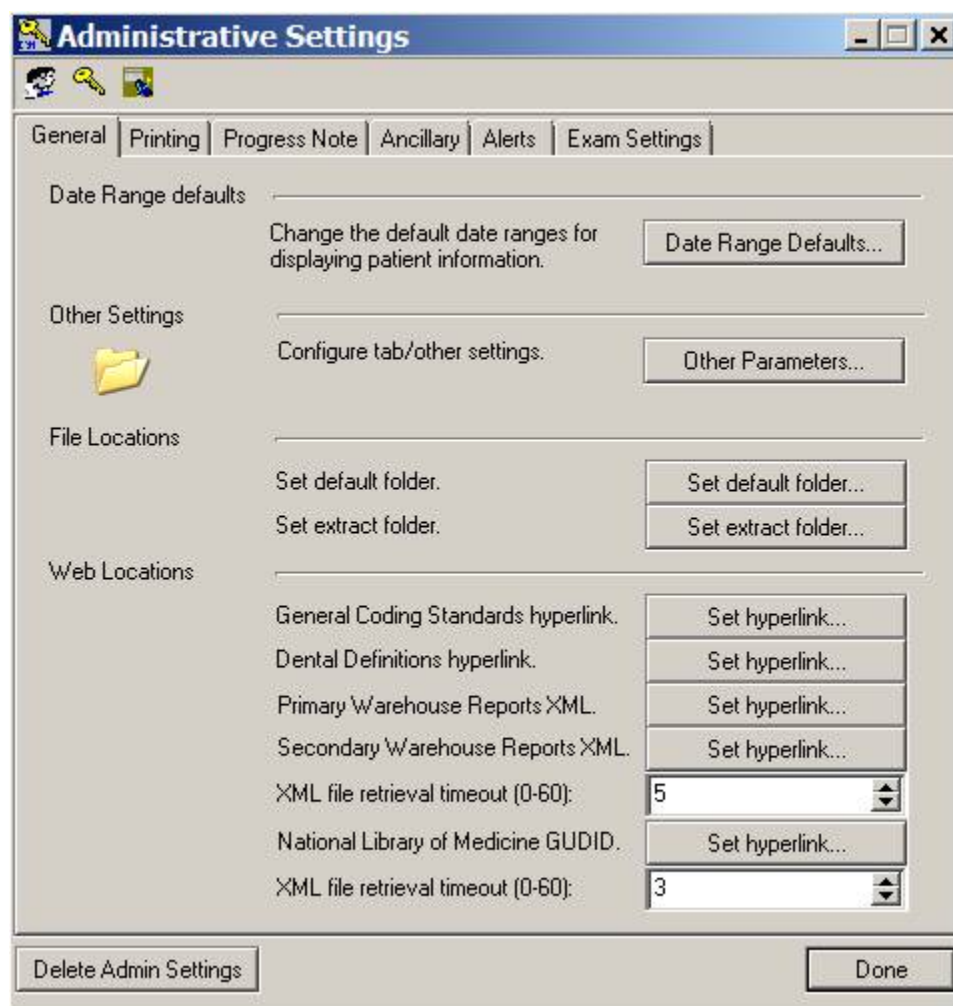
Click the **Key**  icon to return back to the main **Administrative Settings** screen.

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

## General

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

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



**Figure 95: General Tab**

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

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



To change other parameter settings:

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

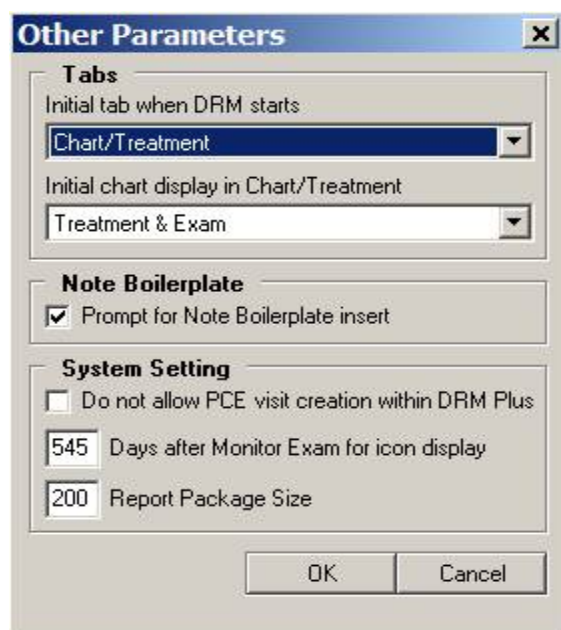


Figure 96: Other Parameters Screen

2. Use the first **Tabs** drop-down menu to change the tab that displays when the program first opens. Use the second drop-down menu to choose **Treatment & Exam** or **Periodontal Chart** for the default view of the **Chart/Treatment** tab.
3. Click the **Note Boilerplate** check box, defaulted as checked, to choose whether to be prompted for a TIU boilerplate insert. The TIU boilerplates reside in VistA and are tied to a TIU progress note title. The parameter when selected displays a screen asking the user if they would like to import a note boilerplate after they select a specific TIU progress note title.
4. Click the **System Setting** check box to determine if PCE visit creation within DRM Plus is allowed in the local dental clinic.
5. The **System Setting** allows the number of days for the **Exam Quality Indicator** to display for the entire local dental clinic. This option is unavailable in the **User Options** settings.
6. The **System Setting** also allows the **Report Package Size** value to be changed for **Adverse Events** and **Device Tracking** reports. The number represents the returns per package of report data retrieved from the VistA database.

**Note:** Please do NOT change the **Report Package Size** value unless you are having difficulty, errors or connection loss, with retrieving either of the two reports. The time required to retrieve the report data is usually NOT an issue with this setting and if the report package size is changed it will probably NOT improve the time in retrieving the report.

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

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

To set the extract folder location:

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

To set the **Web Locations**, hyperlinks:

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

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

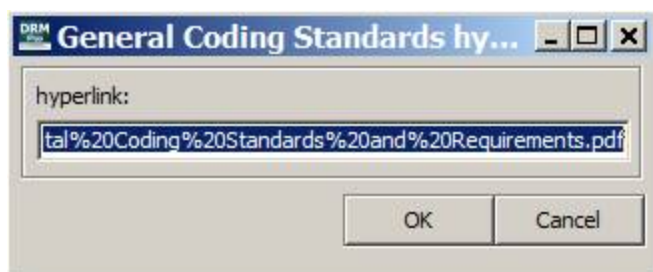


Figure 97: General Coding Standards hyperlink Screen

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

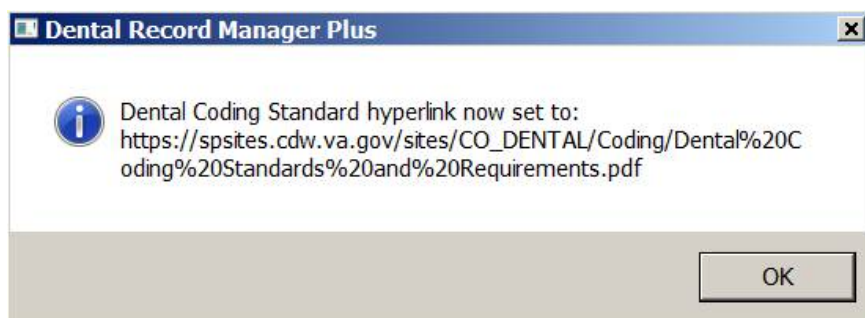
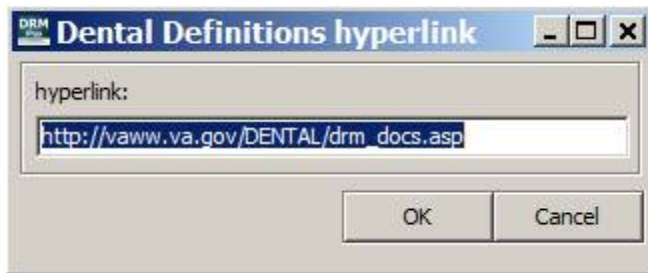


Figure 98: Confirmation Message

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

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

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



**Figure 99: Dental Definitions hyperlink Screen**

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



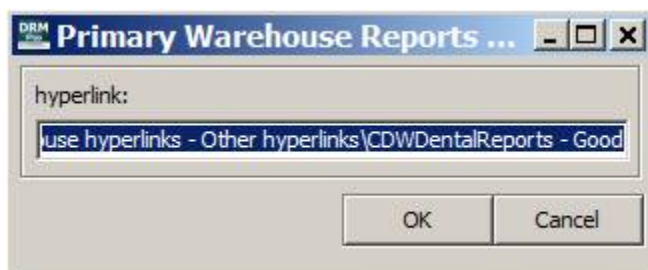
**Figure 100: Confirmation Message**

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

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

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

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



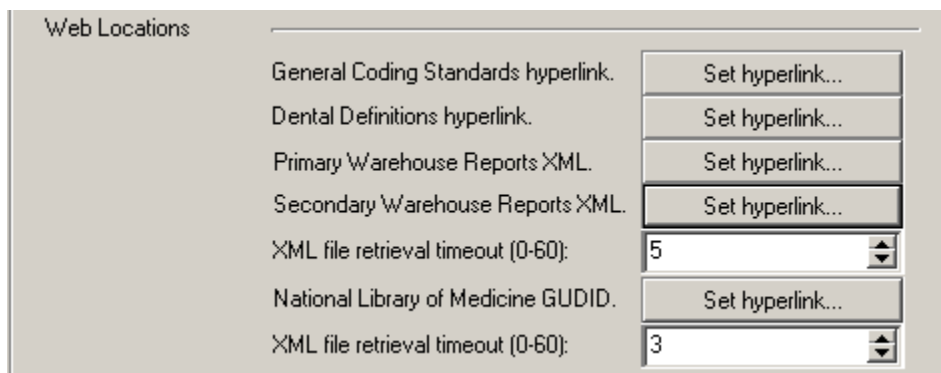
**Figure 101: Primary Warehouse Reports HML File Hyperlink**

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



**Figure 102: Confirmation Message**

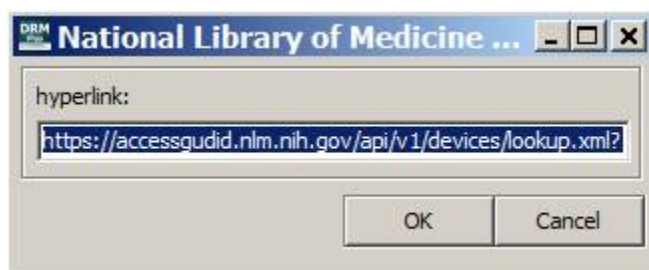
4. Click the **OK** button to close this informational screen.



**Figure 103: XML file retrieval timeout (0-60)**

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

The **National Library of Medicine GUDID** hyperlink will allow a connection and retrieval of a **UDI** (unique device identification) value. The hyperlink should be changed by the DRM Plus Administrator when instructed to do so by the VA Dental Informatics and Analytics Director.



**Figure 104: National Library of Medicine GUDID hyperlink**

Adjusting the second **XML file retrieval timeout (0-60)** field allows the retrieval timeout to be adjusted by the DRM Plus Administrator for a **UDI** value. A setting of 0 seconds does NOT mean there will NOT be a delay. Also a setting of 0 seconds may NOT allow your site time enough to connect and get the submenu, so use with caution. A setting of 3 seconds is the default. This may need to be adjusted (lengthened or shortened) based on your site's internet/network connectivity.

## ***Printing***

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

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

## ***Progress Note***

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

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

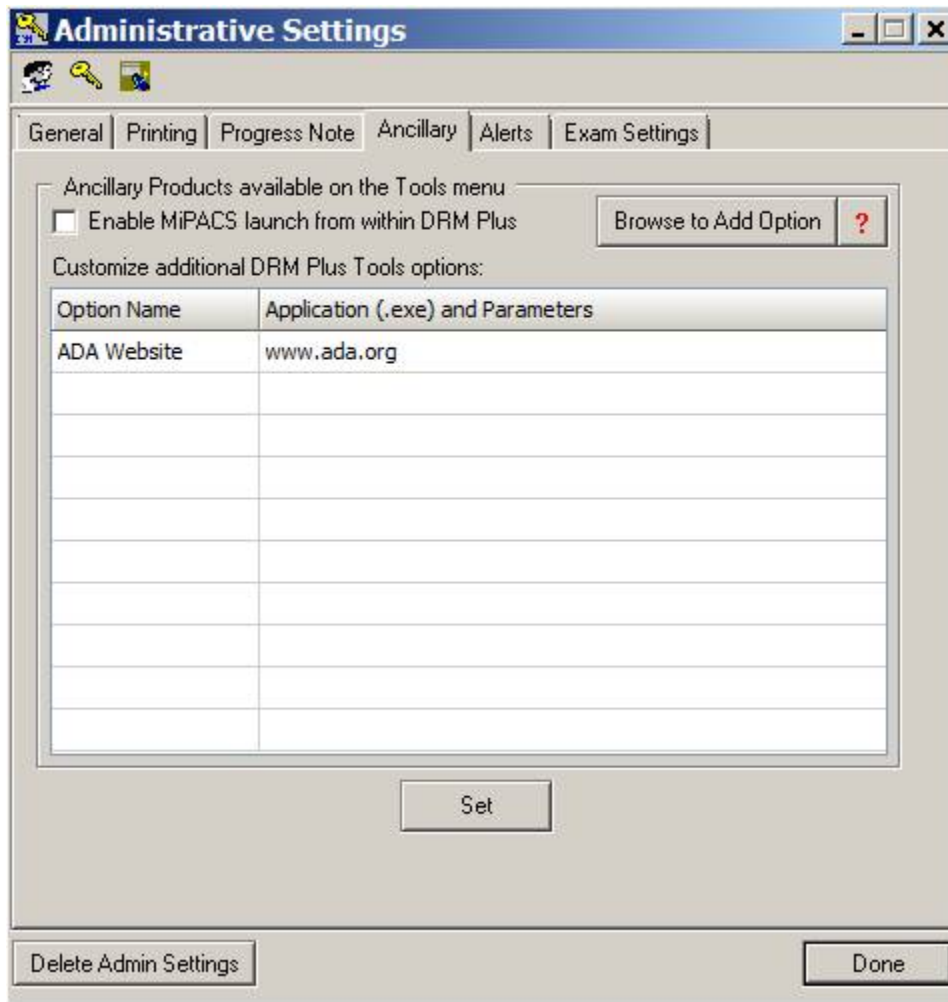
## ***Treatment System***

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

## ***Ancillary***

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

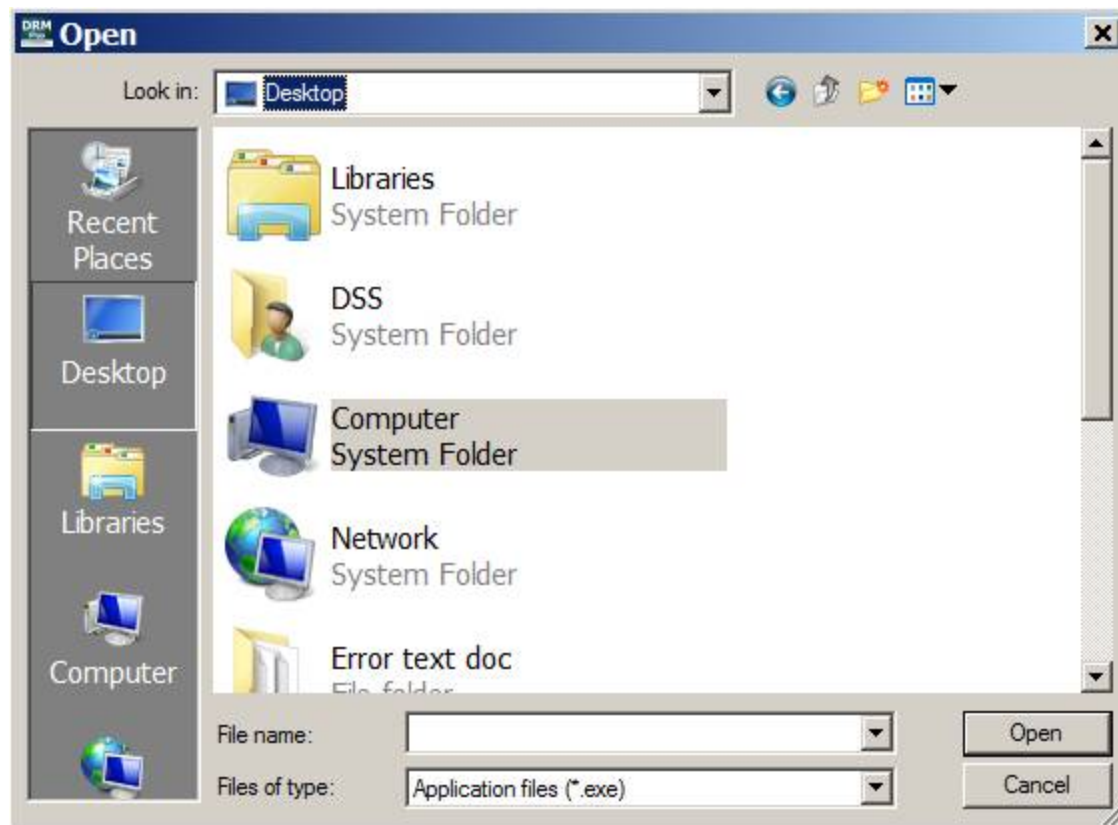


**Figure 105: Ancillary Tab**

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

To add an executable:

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



**Figure 106: Microsoft Open Browse Screen**

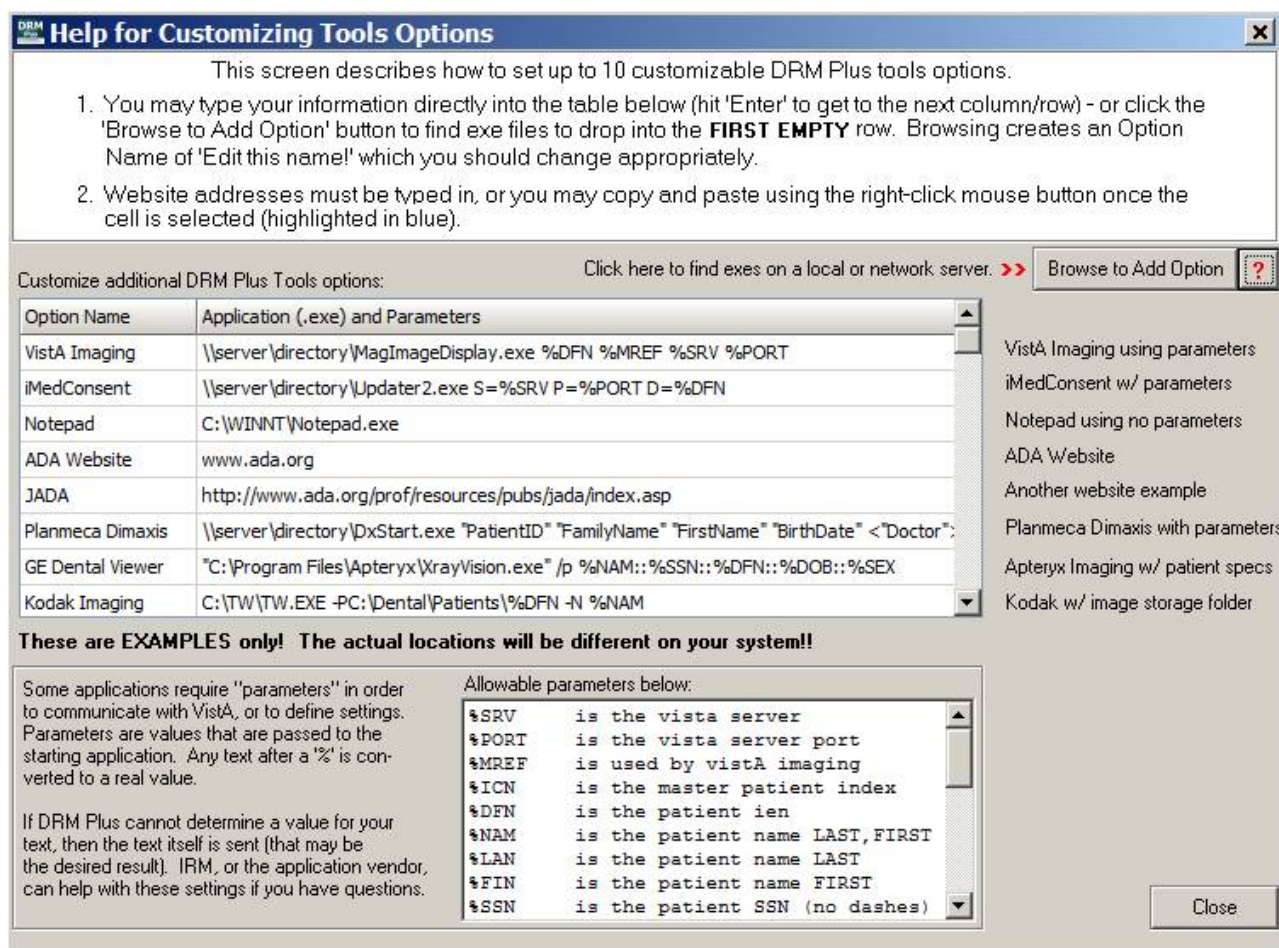
2. Navigate to the desired executable file and click the **Open** button.
3. The .exe file appears on the list.
4. Name the option by typing in the corresponding **Option Name** field.
5. Click the **Set** button to confirm the changes.
6. A confirmation screen displays. Click the **OK** button.
7. The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

To delete an executable:

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



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



**Figure 107: Help for Customizing Tools Options Screen**

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

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



## Alerts

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

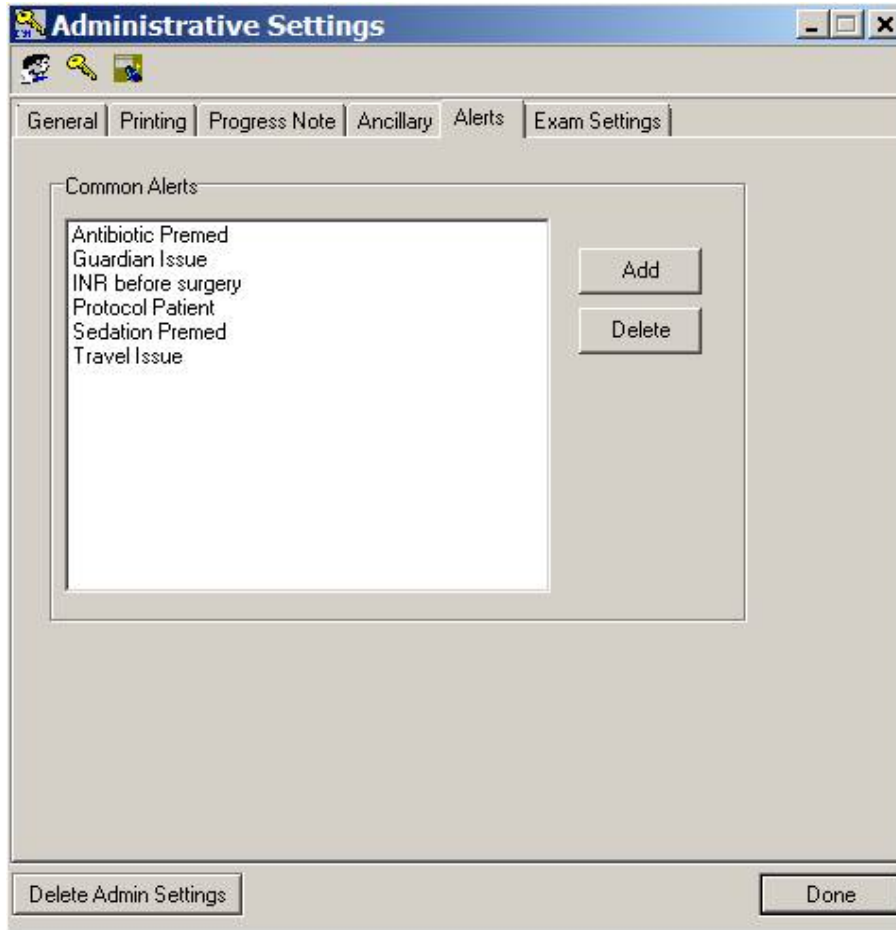


Figure 108: Alerts Tab

To add an alert:

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

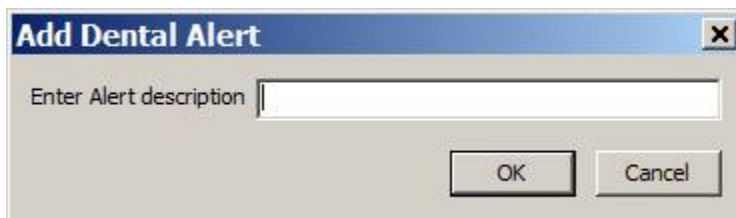


Figure 109: Add Dental Alert Screen

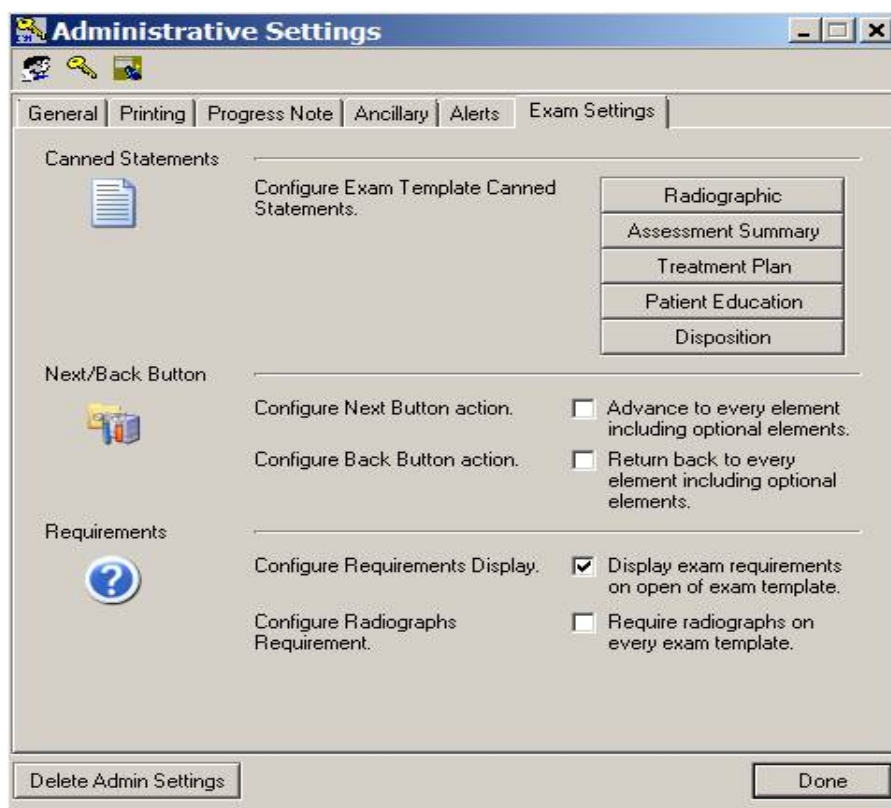
2. Type the alert name into the text box.
3. Click the **OK** button. The alert appears on the list.

To delete an alert:

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

## *Exam Settings*

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



**Figure 110: Exam Settings Tab**

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

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

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

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

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

## Panel Add/Edit

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

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

**Change Provider Panel**

**Change Primary and/or Secondary Dental Providers for a Panel**

Highlight an active provider in the list. (The providers are listed in alphabetical order.)  
Click the add button to define the appropriate provider. Click the remove button to remove the provider.

Name	ID	Type/Specialty
*Fee Basis	n/a	n/a
CPRSPHYSICIAN,ONE	03012099	STAFF DENTIST,GENERAL F
DRMPROVIDER,ADMIND...	02040001	CHIEF, DENTAL SERVICE,O
DRMPROVIDER,ASSIST...	07000002	DENTAL ASSISTANT
DRMPROVIDER,DENTIST	03010003	STAFF DENTIST,GENERAL F
DRMPROVIDER,HYGIEN...	06000006	HYGIENIST
DRMPROVIDER,ONE	03020005	STAFF DENTIST,ENDODON
DRMPROVIDER,RESIDENT	04070004	DENTIST RESIDENT OR FEL

**Primary Provider Panel Changes**

Replace Original Primary Provider  
+ [ ] X

With New Primary Provider  
+ [ ] X

**Secondary Provider Panel Changes**

Replace Original Secondary Provider  
+ [ ] X

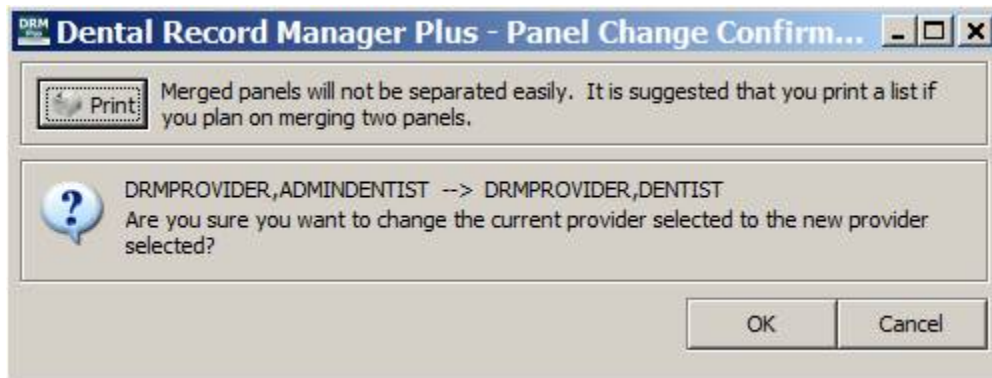
With New Secondary Provider  
+ [ ] X

☒ All Stations

OK Cancel

**Figure 111: Change Provider Panel Screen**

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



**Figure 112: Panel Change Confirmation Message**

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

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

## Provider Add/Edit

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

Dental Provider Edit

Dental Provider  
DRMPROVIDER.HYGIENIST [v] New

☐ Inactive

Provider Number  
Provider Type: 06-HYGIENIST [v]  
Provider Specialty: 00-NOT APPLICABLE [v]  
Provider Seq#: 0005  
Old Provider ID: [ ]

Dental Provider Number  
**06000005**

Person Class  
**Changes to Person Class must be performed in VistA.**  
124Q00000X (V030200)  
Dental Providers  
Dental Hygienist

Save Close

Figure 113: Dental Provider Edit Screen

### *Dental Provider Menu*

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

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

### *Provider Type Menu*

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

### *Provider Specialty Menu*

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

### *Provider Seq #*

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

### ***Dental Provider Number***

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

### ***Old Provider ID***

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

### ***Person Class***

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

The screenshot shows a window titled "Dental Provider Edit". It contains several fields and buttons. At the top, there is a "Dental Provider" dropdown menu with "DRMPROVIDER,DENTIST THREE" selected, and a "New" button. Below this is an "Inactive" checkbox. A red error message states: "Provider Number and Person Class do not appear to match!". The "Provider Number" section includes "Provider Type" (03-STAFF DENTIST), "Provider Specialty" (01-GENERAL PRACTICE), "Provider Seq#" (0007), and "Old Provider ID" (empty). A yellow box displays the calculated "Dental Provider Number" as "03010007". The "Person Class" section at the bottom has a message: "Changes to Person Class must be performed in VistA. No person class found". At the bottom of the window are "Save" and "Close" buttons.

**Figure 114: Provider Number/Person Class Flag**

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

To add a new provider:

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

Search for Provider

Enter search criteria and press Enter to view results below

Name	Initials	Title	Service

OK Cancel

**Figure 115: Search for Provider Screen**

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

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

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

## **Ancillary Tool Functions – ADA Website**

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



## Reports

The **Reports** menu has the seven following submenus: **Reports** (DRM canned reports), **Service Reports** (old DAS reports), **Data Warehouse Reports**, **Adverse Events**, **Device Tracking**, **Extract History File** (for small date range extract reports), and **Queued Extract History File** (for large date range extract reports).

## Reports

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

The screenshot shows the 'Report Selection' dialog box with the 'General' tab selected. It contains several sections for configuring the report:

- Report Type:** A group of radio buttons including 'Provider Summary' (selected), 'Clinic Summary', 'Visits by Provider', 'Visits by Clinic', 'Non Clinical Time by Provider', 'Fee Basis/Detailed Fee Basis', 'Encounter/Visits by Patient Type', and 'Recare Report'.
- Date Range:** Fields for 'Fiscal Year' (n/a), 'Start Date' (5/ 3/2017), and 'End Date' (5/ 3/2017).
- Filters:** Checkboxes for 'All Stations', 'All Providers?', 'Use Provider Name on Reports', and 'Include Distributed Provider Totals'. A 'Select Provider(s)' field is also present.
- Patient Status:** Radio buttons for 'Active', 'Inactive', 'Maintenance', and 'All Statuses' (selected).
- Transaction Status:** Checkboxes for 'Complete' (selected), 'Planned', and 'Deleted'.
- Report Category Type:** Radio buttons for '13 ADA Categories', '131 VA-DSS Prod', and 'ADA/CPT Codes' (selected).
- Search for records using:** Radio buttons for 'Visit Date' (selected) and 'Create Date'.

At the bottom right are 'OK' and 'Cancel' buttons.

**Figure 116: Report Selection Screen**

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



## General Tab

The screenshot shows a 'Report Selection' dialog box with a 'General' tab selected. The dialog has three tabs: 'General', 'Patient', and 'Planning'. Under the 'General' tab, there are two columns of radio buttons for report types: 'Provider Summary' (selected), 'Clinic Summary', 'Visits by Provider', 'Visits by Clinic', 'Non Clinical Time by Provider', 'Fee Basis/Detailed Fee Basis', 'Encounter/Visits by Patient Type', and 'Recare Report'. Below these are three dropdown menus: 'Fiscal Year' (n/a), 'Start Date' (5/ 3/2017), and 'End Date' (5/ 3/2017). There are several checkboxes: 'All Stations' (checked), 'All Providers?' (checked), 'Use Provider Name on Reports' (checked), and 'Include Distributed Provider Totals' (unchecked). A 'Select Provider(s)' text box is next to the 'All Providers?' checkbox. To the right, there are two groups of radio buttons: 'Patient Status' with 'Active', 'Inactive', 'Maintenance', and 'All Statuses' (selected); and 'Transaction Status' with 'Complete' (checked), 'Planned', and 'Deleted' (disabled). At the bottom, there are two groups of radio buttons: 'Report Category Type' with '13 ADA Categories', '131 VA-DSS Prod', and 'ADA/CPT Codes' (selected); and 'Search for records using' with 'Visit Date' (selected) and 'Create Date'. 'OK' and 'Cancel' buttons are at the bottom right.

Figure 117: General Tab

To create a report:

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

**DRM Report**

Dental Service Treatment Report - Summary Report by Provider

From Jan 01, 2017 to May 03, 2017 Station: All Dental Provider: DRMPROVIDER.ADMINDENTIST

ADA/CPT Code	I	IIC	IV	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION			1	1	30
D0140 LIMIT ORAL EVAL PROBLM FC			1	1	20
D0150 COMPREHENSVE ORAL EVALL		2	2	4	200
D0210 INTRAORAL FULL IMAGE SER		3	2	5	90
D0274 DENTAL BITEWING FOUR IM/	1	1	4	6	24
D0321 DENTAL OTHER TMJ IMAGES			1	1	20
D0330 DENTAL PANORAMIC IMAGE	1	7	17	25	250
D0364 CBCT CAPT/INTERPT PART J		1		1	30
D0365 CBCT CAPT/INTERPT MANDIB		1		1	30
D0366 CBCT CAPT/INTERPT MAXILL			1	1	30
D0367 CBCT CAPT/INTERPT MAX/M			1	1	45
D0368 CBCT CAPT/INTERPT TMJ 2+			1	1	30
D0380 CBCT CAPTURE ONLY PART J			1	1	15
D0381 CBCT CAPTURE ONLY MANDIB		1		1	15
D0382 CBCT CAPTURE ONLY MAXILL			1	1	15
D0383 CBCT CAPTURE ONLY MAX/M	1			1	15
D0384 CBCT CAPTURE ONLY TMJ 2+			1	1	15
D1110 DENTAL PROPHYLAXIS ADUL			1	1	45
D2160 AMALGAM THREE SURFACES		4	7	11	550
D2790 CROWN FULL CAST HIGH NOI			2	2	300
D3428 BONE GRAFT W/PRAD SURG-		1	2	3	30

Total Visits = 85  
All data is complete ☒ Print Totals Only

Save All to Excel Save to Excel Print All Print Close

**Figure 118: DRM Report Screen**

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

Eight report types are accessible through this tab:

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

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

There are seven check box options:

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

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

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

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

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

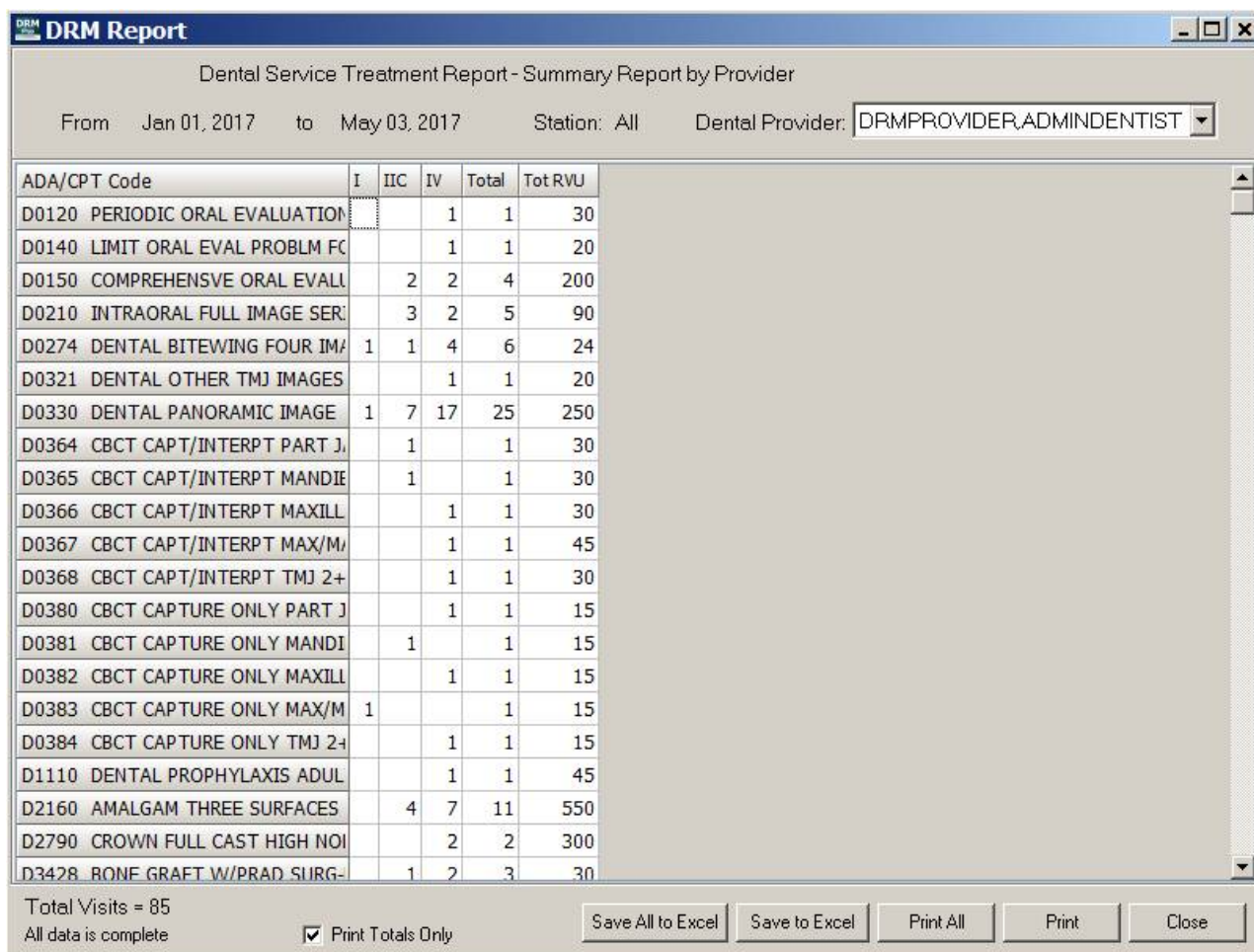
Distributed provider workload may be viewed on the **Provider Summary** or **Visits by Provider** report. When **All Providers** is checked for these provider reports, and **Include Distributed Provider Totals** is checked, the distributed provider workload is included. The report may contain providers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

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

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

## Provider Summary

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



DRM Report

Dental Service Treatment Report - Summary Report by Provider

From Jan 01, 2017 to May 03, 2017 Station: All Dental Provider: DRMPROVIDER.ADMINDENTIST

ADA/CPT Code	I	IIC	IV	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION			1	1	30
D0140 LIMIT ORAL EVAL PROBLM FC			1	1	20
D0150 COMPREHENSVE ORAL EVALL		2	2	4	200
D0210 INTRAORAL FULL IMAGE SER		3	2	5	90
D0274 DENTAL BITEWING FOUR IM	1	1	4	6	24
D0321 DENTAL OTHER TMJ IMAGES			1	1	20
D0330 DENTAL PANORAMIC IMAGE	1	7	17	25	250
D0364 CBCT CAPT/INTERPT PART J		1		1	30
D0365 CBCT CAPT/INTERPT MANDIE		1		1	30
D0366 CBCT CAPT/INTERPT MAXILL			1	1	30
D0367 CBCT CAPT/INTERPT MAX/M			1	1	45
D0368 CBCT CAPT/INTERPT TMJ 2+			1	1	30
D0380 CBCT CAPTURE ONLY PART J			1	1	15
D0381 CBCT CAPTURE ONLY MANDI		1		1	15
D0382 CBCT CAPTURE ONLY MAXILL			1	1	15
D0383 CBCT CAPTURE ONLY MAX/M	1			1	15
D0384 CBCT CAPTURE ONLY TMJ 2+			1	1	15
D1110 DENTAL PROPHYLAXIS ADUL			1	1	45
D2160 AMALGAM THREE SURFACES		4	7	11	550
D2790 CROWN FULL CAST HIGH NOI			2	2	300
D3428 BONE GRAFT W/PRAD SURG-		1	2	3	30

Total Visits = 85  
All data is complete ☒ Print Totals Only

Save All to Excel Save to Excel Print All Print Close

**Figure 119: Provider Summary**

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

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

## Clinic Summary

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

Dental Service Treatment Report - Summary Report for Clinic					
From Jan 01, 2017 to May 03, 2017 Station: All					
ADA/CPT Code	I	IIC	IV	Total	Tot RVU
D0120 PERIODIC ORAL EVALUATION			4	4	120
D0140 LIMIT ORAL EVAL PROBLM FC			1	1	20
D0150 COMPREHENSVE ORAL EVAL		2	2	4	200
D0210 INTRAORAL FULL IMAGE SER		3	4	7	126
D0274 DENTAL BITEWING FOUR IM	1	1	5	7	28
D0321 DENTAL OTHER TMJ IMAGES			1	1	20
D0330 DENTAL PANORAMIC IMAGE	1	7	20	28	280
D0364 CBCT CAPT/INTERPT PART J		1		1	30
D0365 CBCT CAPT/INTERPT MANDIB		1		1	30
D0366 CBCT CAPT/INTERPT MAXILL			1	1	30
D0367 CBCT CAPT/INTERPT MAX/M			1	1	45
D0368 CBCT CAPT/INTERPT TMJ 2+			1	1	30
D0380 CBCT CAPTURE ONLY PART J			1	1	15
D0381 CBCT CAPTURE ONLY MANDIB		1		1	15
D0382 CBCT CAPTURE ONLY MAXILL			1	1	15
D0383 CBCT CAPTURE ONLY MAX/M	1			1	15
D0384 CBCT CAPTURE ONLY TMJ 2+			1	1	15
D1110 DENTAL PROPHYLAXIS ADUL		1	2	3	135
D1206 TOPICAL FLUORIDE VARNISH			1	1	15
D2160 AMALGAM THREE SURFACES		4	13	17	850
D2790 CROWN FULL CAST HIGH NOI			2	2	300
Total Visits = 100					
All data is complete <input checked="" type="checkbox"/> Print Totals Only					
Save to Excel Print Close					

Figure 120: Clinic Summary



## Visits by Provider

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

DRM Report

Dental Service Treatment Report - Visits by Provider

From Jan 01, 2017 to May 03, 2017

Station: All

Dental Provider: DRMPROVIDER,ADMINIDENTIST

Treatment Date	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE	No.
Feb 07, 2017@09:00	FBCSAAQ,KLYSSK 3151	13		D0150 COMPREHENSVE ORAL EVALUATION	1
Feb 07, 2017@09:00	FBCSAAQ,KLYSSK 3151	13		D0210 INTRAORAL FULL IMAGE SERIES	1
-----DATE SUBTOTAL 2					
Feb 15, 2017@10:00	FBCSAAS,KQWRLK 5352	15		D0330 DENTAL PANORAMIC IMAGE	1
Feb 15, 2017@15:30	IDOSPATIENT,TWO J 1185	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
Feb 15, 2017@15:30	IDOSPATIENT,TWO J 1185	15		D9930 TREATMENT OF COMPLICATIONS	1
Feb 15, 2017@15:54	FBCSAAT,GWNWVRWVW 0467	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	2
-----DATE SUBTOTAL 5					
Feb 16, 2017@12:00	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
-----DATE SUBTOTAL 1					
Feb 22, 2017@10:03	FBCSAAT,GWNWVRWVW 0467	15		D0274 DENTAL BITEWING FOUR IMAGES	1
Feb 22, 2017@10:59	IDOSPATIENT,TWO J 1185	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
Feb 22, 2017@11:32	FBCSAAT,GWNWVRWVW 0467	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
Feb 22, 2017@14:08	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
-----DATE SUBTOTAL 4					
Feb 23, 2017@10:57	FBCSAAR,CKLRSTK 1136	15		D0330 DENTAL PANORAMIC IMAGE	1
Feb 23, 2017@10:57	FBCSAAR,CKLRSTK 1136	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
Feb 23, 2017@11:00	FBCSAAQ,KLYSSK 3151	13		D0330 DENTAL PANORAMIC IMAGE	1
Feb 23, 2017@11:00	FBCSAAQ,KLYSSK 3151	13		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
-----DATE SUBTOTAL 4					
Feb 24, 2017@16:07	FBCSAAT,GWNWVRWVW 0467	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
Feb 24, 2017@16:11	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1
-----DATE SUBTOTAL 2					
Mar 01, 2017@09:00	FBCSAAR,CKLRSTK 1136	15		D0330 DENTAL PANORAMIC IMAGE	1
Mar 01, 2017@09:00	FBCSAAR,CKLRSTK 1136	15		D6010 ENDOSTEAL IMPLANT BODY PLACE	1

Total Visits = 85

☐ Hide Subtotals

All data is complete

[Click header columns to resort]

Save All to Excel

Save to Excel

Print All

Print

Close

**Figure 121: Visits by Provider**

To create a **Visits by Provider** report, select one or more providers by pressing the <Shift> and <Ctrl> keys, or select all providers by checking the **All Providers** check box. Click the **Save All to Excel** or **Save to Excel** 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.

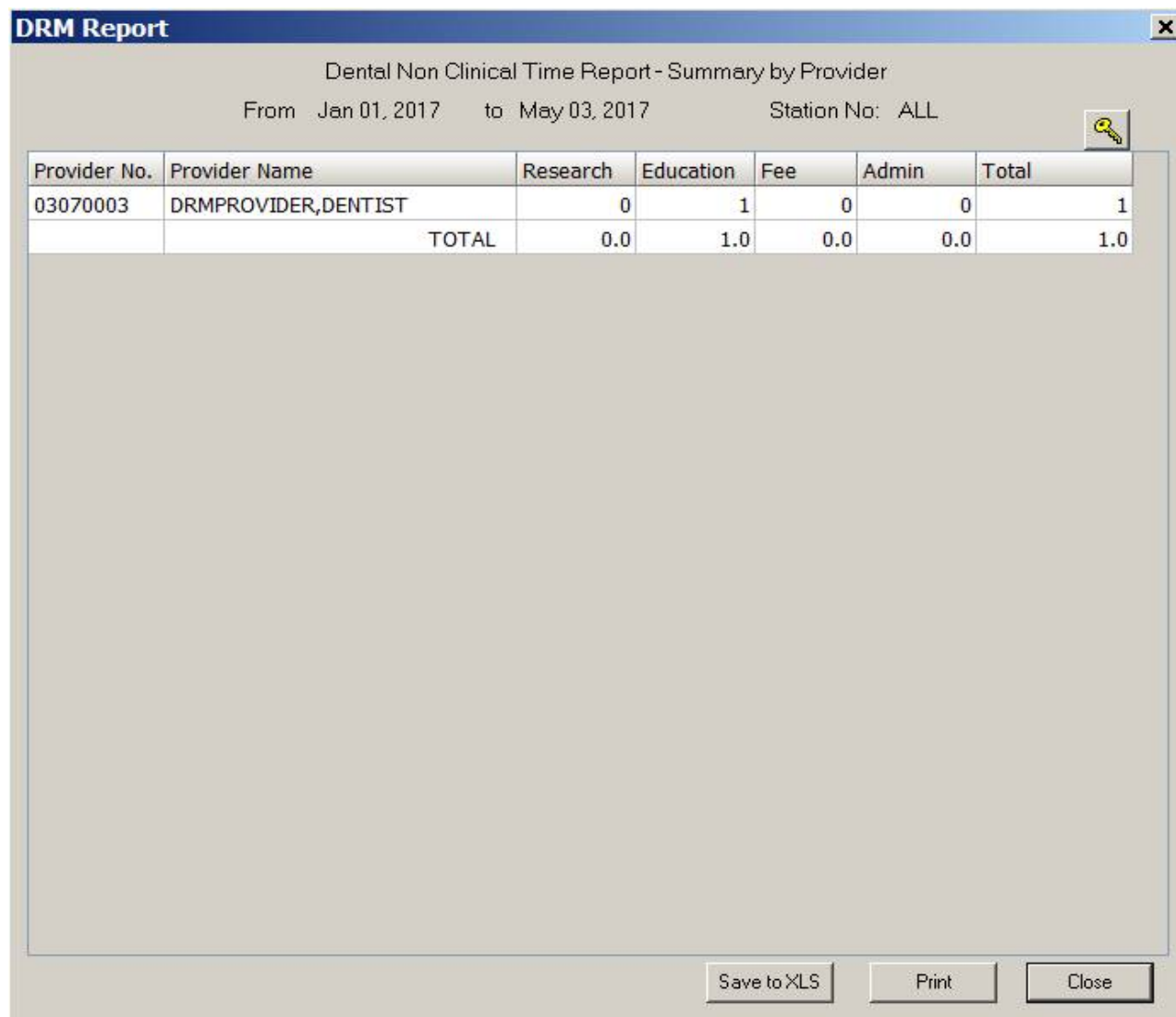
DRM Report							
Dental Service Treatment Report - Visits by Clinic							
From Jan 01, 2017 to May 03, 2017		Station: All					
Treatment Date	Prov No.	Patient Name & Last 4 SSN	Cat	Bed	ADA/CPT CODE	No.	
Feb 07, 2017@09:00	02040001	FBCSAAQ,KLYSSK 3151	13		D0150 COMPREHENSVE ORAL EVALUA	1	
Feb 07, 2017@09:00	02040001	FBCSAAQ,KLYSSK 3151	13		D0210 INTRAORAL FULL IMAGE SERIE	1	
-----DATE SUBTOTAL 2							
Feb 15, 2017@10:00	02040001	FBCSAAS,KQWRLK 5352	15		D0330 DENTAL PANORAMIC IMAGE	1	
Feb 15, 2017@15:30	02040001	IDOSPATIENT,TWO J 1185	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Feb 15, 2017@15:30	02040001	IDOSPATIENT,TWO J 1185	15		D9930 TREATMENT OF COMPLICATIO	1	
Feb 15, 2017@15:54	02040001	FBCSAAT,GWNWVRWWV 0467	15		D6010 ENDOSTEAL IMPLANT BODY PL	2	
-----DATE SUBTOTAL 5							
Feb 16, 2017@12:00	02040001	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
-----DATE SUBTOTAL 1							
Feb 22, 2017@10:03	02040001	FBCSAAT,GWNWVRWWV 0467	15		D0274 DENTAL BITEWING FOUR IMAG	1	
Feb 22, 2017@10:59	02040001	IDOSPATIENT,TWO J 1185	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Feb 22, 2017@11:32	02040001	FBCSAAT,GWNWVRWWV 0467	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Feb 22, 2017@14:08	02040001	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
-----DATE SUBTOTAL 4							
Feb 23, 2017@10:57	02040001	FBCSAAR,CKLRSTK 1136	15		D0330 DENTAL PANORAMIC IMAGE	1	
Feb 23, 2017@10:57	02040001	FBCSAAR,CKLRSTK 1136	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Feb 23, 2017@11:00	02040001	FBCSAAQ,KLYSSK 3151	13		D0330 DENTAL PANORAMIC IMAGE	1	
Feb 23, 2017@11:00	02040001	FBCSAAQ,KLYSSK 3151	13		D6010 ENDOSTEAL IMPLANT BODY PL	1	
-----DATE SUBTOTAL 4							
Feb 24, 2017@16:07	02040001	FBCSAAT,GWNWVRWWV 0467	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Feb 24, 2017@16:11	02040001	FBCSAAS,KQWRLK 5352	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
-----DATE SUBTOTAL 2							
Mar 01, 2017@09:00	02040001	FBCSAAR,CKLRSTK 1136	15		D0330 DENTAL PANORAMIC IMAGE	1	
Mar 01, 2017@09:00	02040001	FBCSAAR,CKLRSTK 1136	15		D6010 ENDOSTEAL IMPLANT BODY PL	1	
Total Visits = 100							
All data is complete							
<input type="checkbox"/> Hide Subtotals							
[Click header columns to resort]							
				Save to Excel		Print	Close

**Figure 122: Visits by Clinic**

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

### *Non-Clinical Time by Provider Report*

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



DRM Report

Dental Non Clinical Time Report - Summary by Provider

From Jan 01, 2017 to May 03, 2017 Station No: ALL

Provider No.	Provider Name	Research	Education	Fee	Admin	Total
03070003	DRMPROVIDER,DENTIST	0	1	0	0	1
	TOTAL	0.0	1.0	0.0	0.0	1.0

Save to XLS Print Close

**Figure 123: Non-Clinical Time**

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

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



### ***Fee Basis/Detailed Fee Basis Report***

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

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

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

**Figure 124: Dental Fee Basis**

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

### *Encounters/Visits by Patient Type Report*

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

Sittings/Visits Report

Encounters/Visits by Patient Type

From Jan 01, 2017 to May 03, 2017 Station No: All

	Inpatient	Inpatient	Outpatient	Outpatient	Total DES
Provider	Visits	Encounters	Visits	Encounters	Procedures
DRMPROVIDER,ADMINDENTIST			85.00	85.00	125
DRMPROVIDER,DENTIST			13.00	13.00	31
DRMPROVIDER,HYGIENIST			2.00	2.00	5
TOTAL	0.00	0.00	100.00	100.00	161

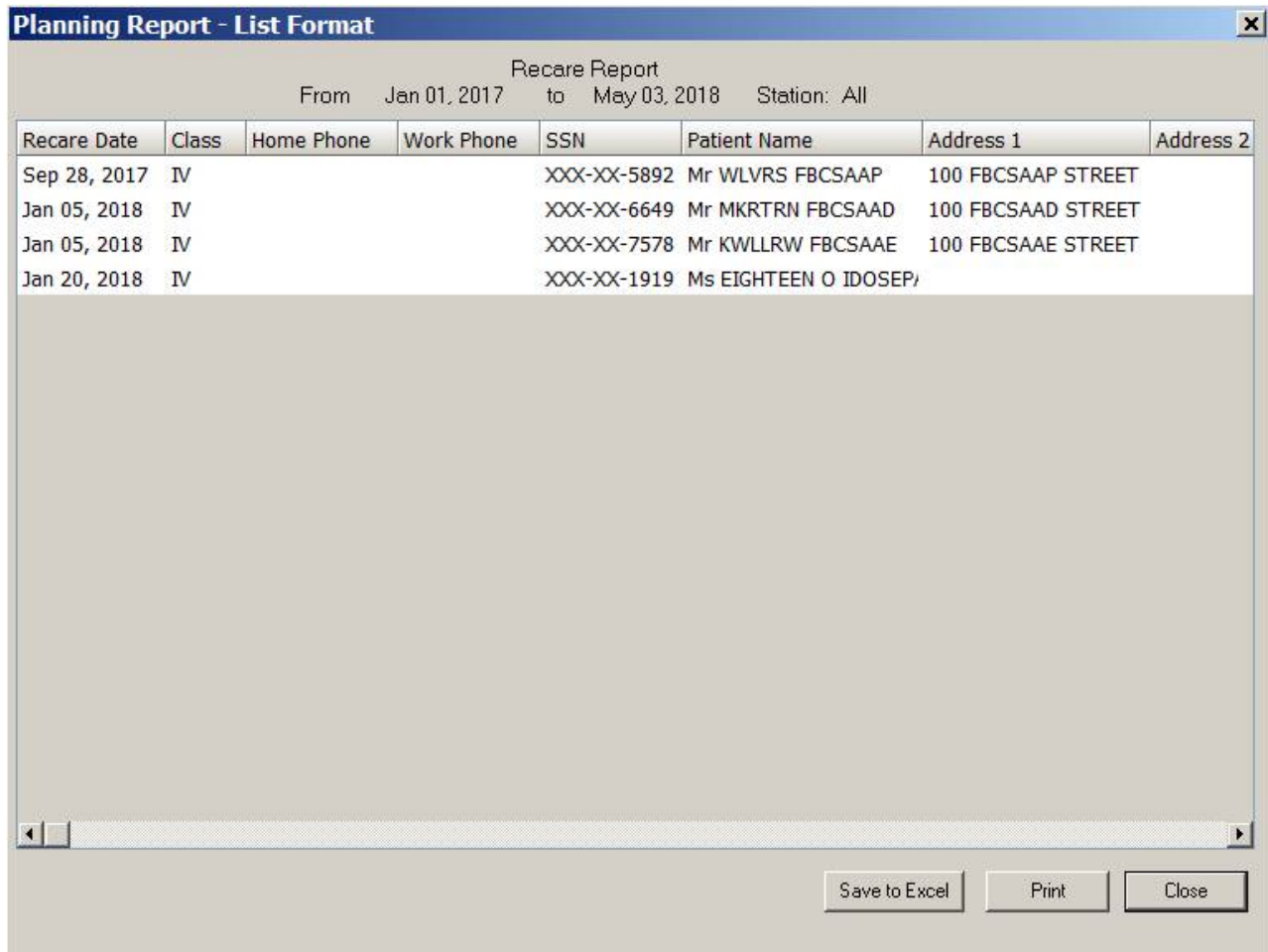
Save to Excel Print Close

**Figure 125: Encounters/Visits by Patient Type**

## Recare Report

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

**Note:** The **Recare** report is accessible for all provider working at the dental clinic to run the report.



Recare Date	Class	Home Phone	Work Phone	SSN	Patient Name	Address 1	Address 2
Sep 28, 2017	IV			XXX-XX-5892	Mr WLVRs FBCSAAP	100 FBCSAAP STREET	
Jan 05, 2018	IV			XXX-XX-6649	Mr MKRTRN FBCSAAD	100 FBCSAAD STREET	
Jan 05, 2018	IV			XXX-XX-7578	Mr KWLLRW FBCSAAE	100 FBCSAAE STREET	
Jan 20, 2018	IV			XXX-XX-1919	Ms EIGHTEEN O IDOSEP/		

Save to Excel Print Close

Figure 126: Recare Report

A list of elements in **Recare** reports include: **Recare Date**, **Patient Class**, **Home Phone**, **Work Phone**, **SSN**, **Patient Name**, **Address 1**, **Address 2**, **City**, **State**, **Zip**, **Sex**, **Last Visit**, **Last Provider**, **Primary Provider**, **Secondary Provider**, **Dental Alerts**, **Next Appointment**, **Next Appointment 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 Prophyl.**

## ***Patient Tab***

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

The screenshot shows a window titled "Report Selection" with a close button (X) in the top right corner. It has three tabs: "General", "Patient", and "Planning". The "Patient" tab is selected. Inside the "Patient" tab, there is a radio button labeled "Patient Visit List" which is selected. Below this is a text field labeled "Patient" containing the text "DRMPATIENT\_ONE (D0001)". To the right of this field is a button labeled "Patient Selection". Below the text field are three dropdown menus: "Fiscal Year" with the value "n/a", "Start Date" with the value "5/ 3/2016", and "End Date" with the value "5/ 3/2017". Below these are three checkboxes: "All Stations" (checked), "All Providers?" (checked), and "Use Provider Name on Reports" (checked). Below the checkboxes is a text field labeled "Select Provider(s)". At the bottom right of the window are two buttons: "OK" and "Cancel".

**Figure 127: Patient Tab**

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

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

The screenshot shows a software window titled "Patient Selection". At the top, there is a blue header bar with the "DRM" logo on the left and a close button (X) on the right. Below the header, a light gray bar contains the text: "Enter text within text box below and press enter to begin search. View details within information box." The main area of the window is split into two vertical sections. The left section, titled "Patient Search and Selection", contains a text input field with the placeholder text "Enter At Least One Character <Press Enter>" and a large, empty rectangular box below it for search results. The right section, titled "Information", is currently empty. At the bottom right of the window are two buttons: "OK" and "Cancel".

**Figure 128: Patient Selection Screen**

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

## Planning Tab

Use the options in the **Planning** tab to run planned reports, active patients by provider report or unfiled data by provider report.

The screenshot shows a 'Report Selection' dialog box with three tabs: 'General', 'Patient', and 'Planning'. The 'Planning' tab is selected. It contains several radio buttons for report types: 'Provider Planning' (selected), 'Planned Items List', 'Planned Non-VA Care', 'Active Patients by Provider', and 'Unfiled Data by Provider'. To the right of these are three checkboxes: 'Use Primary Provider' (checked), 'Use Secondary Provider' (unchecked), and 'Use Entered By Provider' (unchecked). Below these is a section with 'All Stations' (checked), 'All Providers?' (checked), and 'Use Provider Name on Reports' (checked). There is a text field labeled 'Select Provider(s)'. On the right side of the dialog is a 'Patient Status' section with three radio buttons: 'Active' (selected), 'Inactive', and 'Maintenance'. There are also two checkboxes: 'All Statuses' (unchecked) and 'Active/Maint' (unchecked).

Figure 129: Planning Tab

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

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

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

## Provider Planning

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

Planning Report for Primary/Secondary Providers				
Primary Provider Planning Report				
Patient Type: All Statuses			Station: All	
Provider	Patient Last Visit and Pat Cat	Next Appointment/Location		
Patient Name & Last 4 SSN	Planned Procedures		Qty	RVU
DRMPROVIDER,DENTIST				
FBCSAAE,KWLLRW 7578	Apr 24, 2017@16:00 15			
	D2160 AMALGAM THREE SURFACES PERMA		4	200
	D6010 ENDOSTEAL IMPLANT BODY PLACE		4	360
FBCSAAP,WLVRS 5892	Apr 27, 2017@14:30 15			
	D2160 AMALGAM THREE SURFACES PERMA		3	150
	D6010 ENDOSTEAL IMPLANT BODY PLACE		1	90
----- 2 Patients/TOTALS:			12	800
Unassigned				
IDOSPATIENT,TWO J 1185	Mar 06, 2017@15:22 15			
	D2160 AMALGAM THREE SURFACES PERMA		4	200
	D6010 ENDOSTEAL IMPLANT BODY PLACE		2	180
FBCSAAB,MWLYSSK 2428	Apr 18, 2017@16:00 15			
	D2160 AMALGAM THREE SURFACES PERMA		7	350
	D2750 CROWN PORCELAIN W/ H NOBLE M		4	600
FBCSAAC,DKNRWL 0553	Apr 19, 2017@12:00 15			
	D2160 AMALGAM THREE SURFACES PERMA		2	100
	D6010 ENDOSTEAL IMPLANT BODY PLACE		1	90
FBCSAAD,MKRTRN 6649	Apr 24, 2017@14:00 15			

**Figure 130: Primary Provider Planning**

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



## Planned Items List

The **Planned Items List** report contains most of the same information as the existing **Provider Planning** report. However this report is in a sortable list format. Clicking the first three headers **Provider**, **Patient Name & Last 4 SSN** or **Planned Procedures** allows the provider to re-sort these columns.

The **Provider Planning** report contains the **Provider**, **Patient Name & Last 4 SSN**, **Planned Procedures**, and **Qty/RVU/Cost** data. The **Planned Items List** report will also contain a column listing the planned Non-VA care quantity procedures.

Planning Report - List Format					
Primary Provider Planning Report - List Format					
Patient Type: All Statuses			Station: All		
Provider	Patient Name & Last 4 SSN	Planned Procedures	Qty	RVU	Non-VA
DRMPROVIDER,DEN	FBCSAAE,KWLLRW 7578	D2160 AMALGAM THREE SURFACES PER	4	200	
DRMPROVIDER,DEN	FBCSAAE,KWLLRW 7578	D6010 ENDOSTEAL IMPLANT BODY PLAC	4	360	
DRMPROVIDER,DEN	FBCSAAP,WLVRS 5892	D2160 AMALGAM THREE SURFACES PER	3	150	
DRMPROVIDER,DEN	FBCSAAP,WLVRS 5892	D6010 ENDOSTEAL IMPLANT BODY PLAC	1	90	1
-----Provider SUBTOTAL : 12\1					
Unassigned	IDOSPATIENT,TWO J 1185	D2160 AMALGAM THREE SURFACES PER	4	200	
Unassigned	IDOSPATIENT,TWO J 1185	D6010 ENDOSTEAL IMPLANT BODY PLAC	2	180	
Unassigned	FBCSAAB,MWLYSSK 2428	D2160 AMALGAM THREE SURFACES PER	7	350	
Unassigned	FBCSAAB,MWLYSSK 2428	D2750 CROWN PORCELAIN W/ H NOBLE	4	600	
Unassigned	FBCSAAC,DKNRWL 0553	D2160 AMALGAM THREE SURFACES PER	2	100	
Unassigned	FBCSAAC,DKNRWL 0553	D6010 ENDOSTEAL IMPLANT BODY PLAC	1	90	
Unassigned	FBCSAAD,MKRTRN 6649	D2160 AMALGAM THREE SURFACES PER	5	250	
Unassigned	FBCSAAD,MKRTRN 6649	D2750 CROWN PORCELAIN W/ H NOBLE	6	900	
Unassigned	FBCSAAD,MKRTRN 6649	D6010 ENDOSTEAL IMPLANT BODY PLAC	3	270	
Unassigned	FBCSAAF,CKSWY 5264	D2160 AMALGAM THREE SURFACES PER	4	200	
Unassigned	FBCSAAF,CKSWY 5264	D6010 ENDOSTEAL IMPLANT BODY PLAC	3	270	1
Unassigned	FBCSAAG,BKRRY 6407	D2150 AMALGAM TWO SURFACES PERM	2	90	
Unassigned	FBCSAAG,BKRRY 6407	D2160 AMALGAM THREE SURFACES PER	2	100	
Unassigned	FBCSAAG,BKRRY 6407	D6010 ENDOSTEAL IMPLANT BODY PLAC	4	360	4
Unassigned	FBCSAAH,WLTZN 3496	D2160 AMALGAM THREE SURFACES PER	4	200	

☐ Hide Subtotals  
[Click header columns to resort]

Save to Excel

Print

Close

Figure 131: Planned Items List

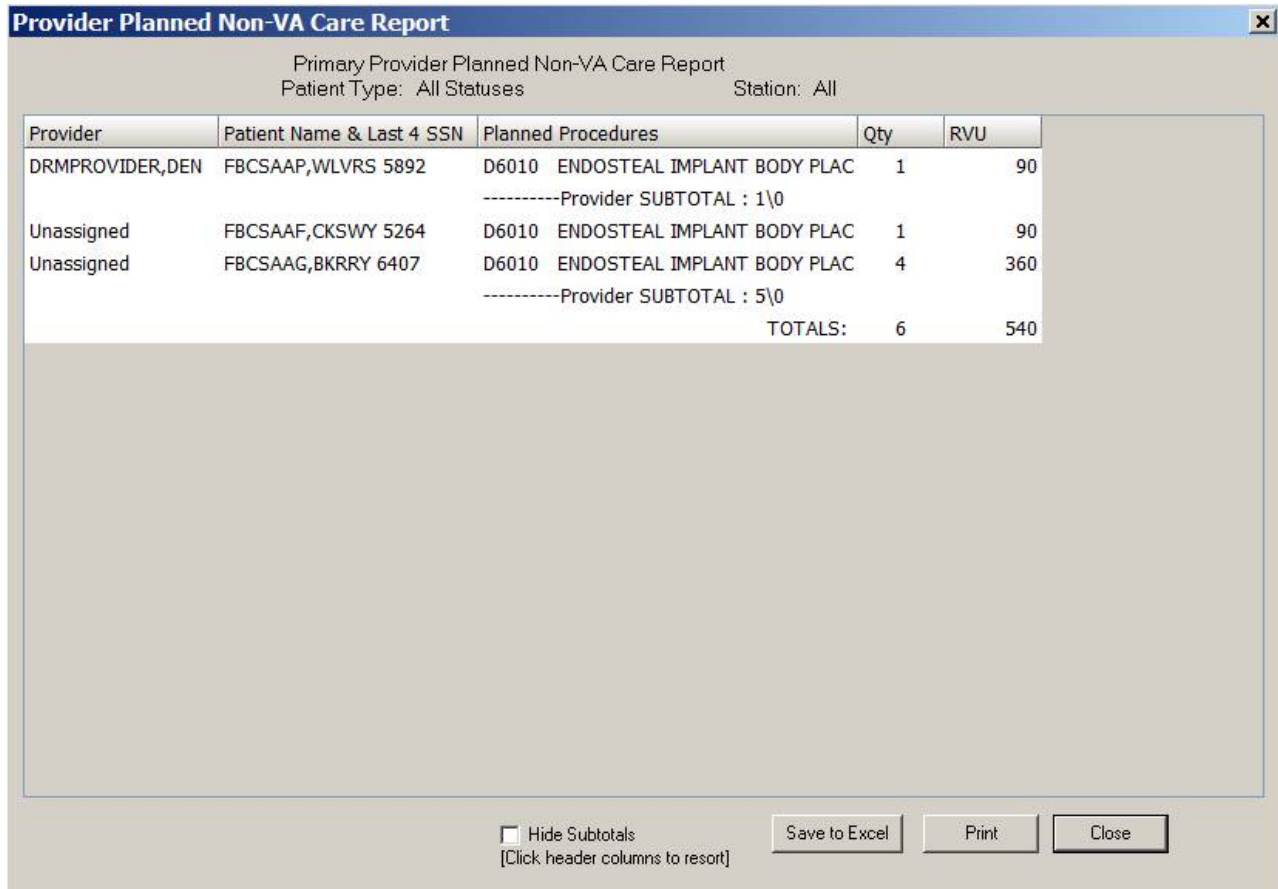
**Note:** The cost is included if it has previously been entered locally by a DRM Plus Administrator.



### *Planned Non-VA Care Report*

The **Planned Non-VA Care** report contains most of the same information as the existing **Planned Items List** report with a sortable list format. Clicking the first three headers **Provider**, **Patient Name & Last 4 SSN** or **Planned Procedures** allows the provider to re-sort by these columns.

The **Planned Non-VA Care** report contains the **Provider**, **Patient Name & Last 4 SSN**, **Planned Procedures**, and **Qty/RVU/Cost** data. However the report will only return planned Non-VA care procedures that have been filed to the VistA server the local dental clinic is using.



Provider	Patient Name & Last 4 SSN	Planned Procedures	Qty	RVU
DRMPROVIDER,DEN	FBCSAAP,WLVRS 5892	D6010 ENDOSTEAL IMPLANT BODY PLAC	1	90
		-----Provider SUBTOTAL : 1\0		
Unassigned	FBCSAAF,CKSWY 5264	D6010 ENDOSTEAL IMPLANT BODY PLAC	1	90
Unassigned	FBCSAAG,BKRRY 6407	D6010 ENDOSTEAL IMPLANT BODY PLAC	4	360
		-----Provider SUBTOTAL : 5\0		
		TOTALS:	6	540

**Figure 132: Planned Non-VA Care**

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

### Active Patients by Provider Report

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

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

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

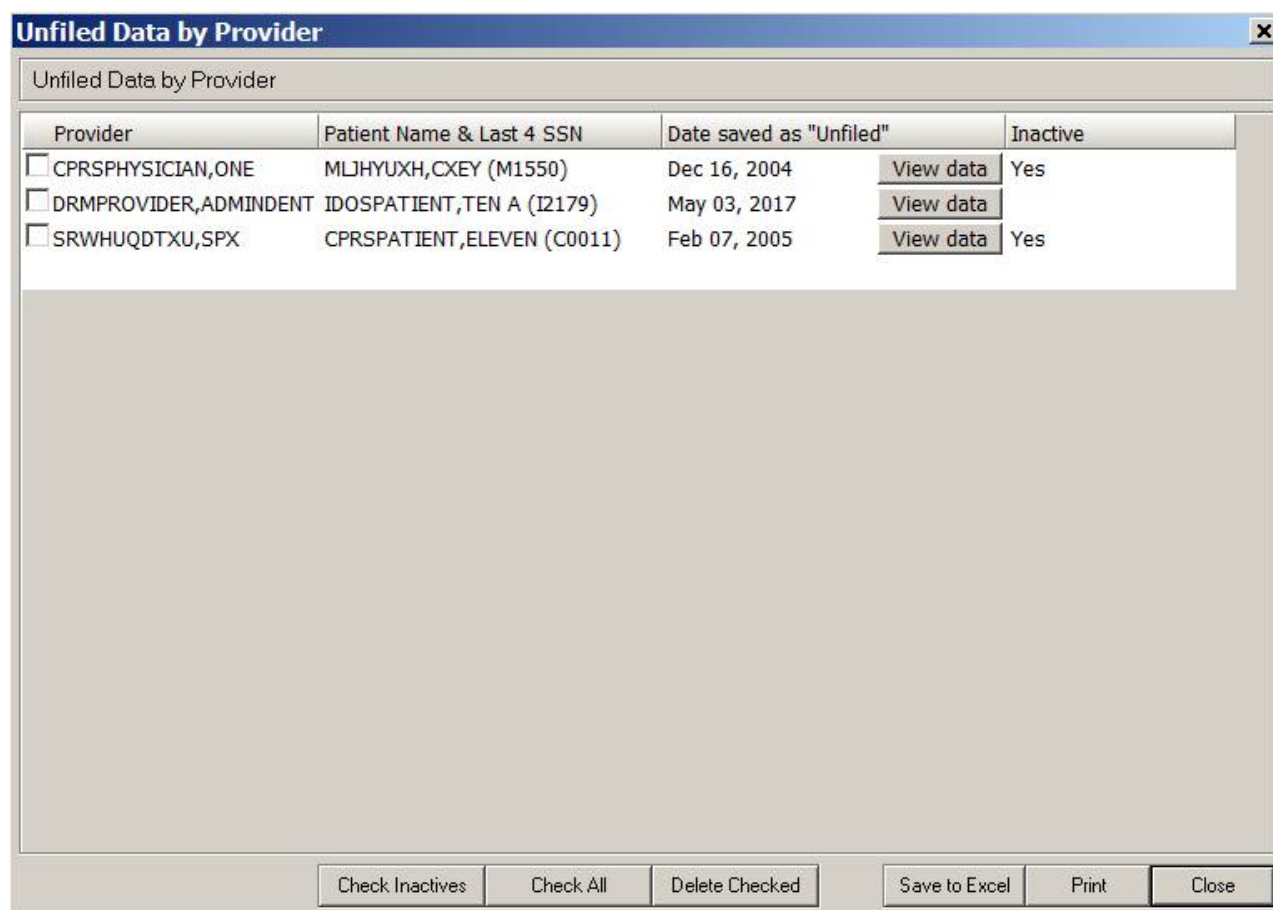
Active Patients by Provider				
All Patients by Primary Provider		(from May 03, 2016 to May 03, 2017)		Station: All
Provider	Dental Class	Patient Name & Last 4 SSN	Last Visit Date	Status
DRMPROVIDER,DENTIST	OPC, Class IV	FBCSAAE,KWLLRW (F7578)	Apr 24, 2017	Active
	OPC, Class IV	FBCSAAP,WLVRS (F5892)	Apr 27, 2017	Active
----- Provider SUBTOTAL: 2.00				
Unassigned	OPC, Class I	FBCSAAO,WLLRZTT (F6271)	Apr 27, 2017	Active
	OPC, Class IIC	FBCSAAO,BKRRY (F6407)	Apr 06, 2017	Active
	OPC, Class IIC	FBCSAAQ,KLYSSK (F3151)	Apr 27, 2017	Active
	OPC, Class III	FBCSAAA,SKMKNTHK (F5955)	Apr 27, 2017	Active
	OPC, Class IV	IDOSPATIENT,TWO J (I1185)	Mar 06, 2017	Active
	OPC, Class IV	FBCSAAR,CKLRSTK (F1136)	Mar 08, 2017	Active
	OPC, Class IV	FBCSAAS,KQWRLK (F5352)	Mar 10, 2017	Active
	OPC, Class IV	FBCSAAN,STZNW (F4533)	Apr 06, 2017	Active
	OPC, Class IV	FBCSAAI,XKNTHWS (F1301)	Apr 06, 2017	Active
	OPC, Class IV	FBCSAAH,WLTZN (F3496)	Apr 06, 2017	Active
	OPC, Class IV	FBCSAAK,JWSTRNK (F9184)	Apr 06, 2017	Active
	OPC, Class IV	IDOSEPATIENT,EIGHTEEN O (I1919)	Apr 11, 2017	Active
	OPC, Class IV	FBCSAAT,GWNWVRWWW (F0467)	Apr 12, 2017	Active
	OPC, Class IV	FBCSAAB,MWLYSSK (F2428)	Apr 18, 2017	Active
	OPC, Class IV	FBCSAAC,DKNRWL (F0553)	Apr 19, 2017	Active
	OPC, Class IV	FBCSAAD,MKRTRN (F6649)	Apr 24, 2017	Active
	OPC, Class IV	FBCSAAJ,TKNYK (F8801)	Apr 25, 2017	Active
Total Patients: 20				
Save to Excel			Print	Close

Figure 133: Active Patients by Provider

## Unfiled Data by Provider Report

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

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



Provider	Patient Name & Last 4 SSN	Date saved as "Unfiled"	Inactive
<input type="checkbox"/> CPRSPHYSICIAN,ONE	MLJHYUXH,CXEY (M1550)	Dec 16, 2004	Yes
<input type="checkbox"/> DRMPROVIDER,ADMIDENT	IDOSPATIENT,TEN A (I2179)	May 03, 2017	
<input type="checkbox"/> SRWHUQDTXU,SPX	CPRSPATIENT,ELEVEN (C0011)	Feb 07, 2005	Yes

**Figure 134: Unfiled Data by Provider**

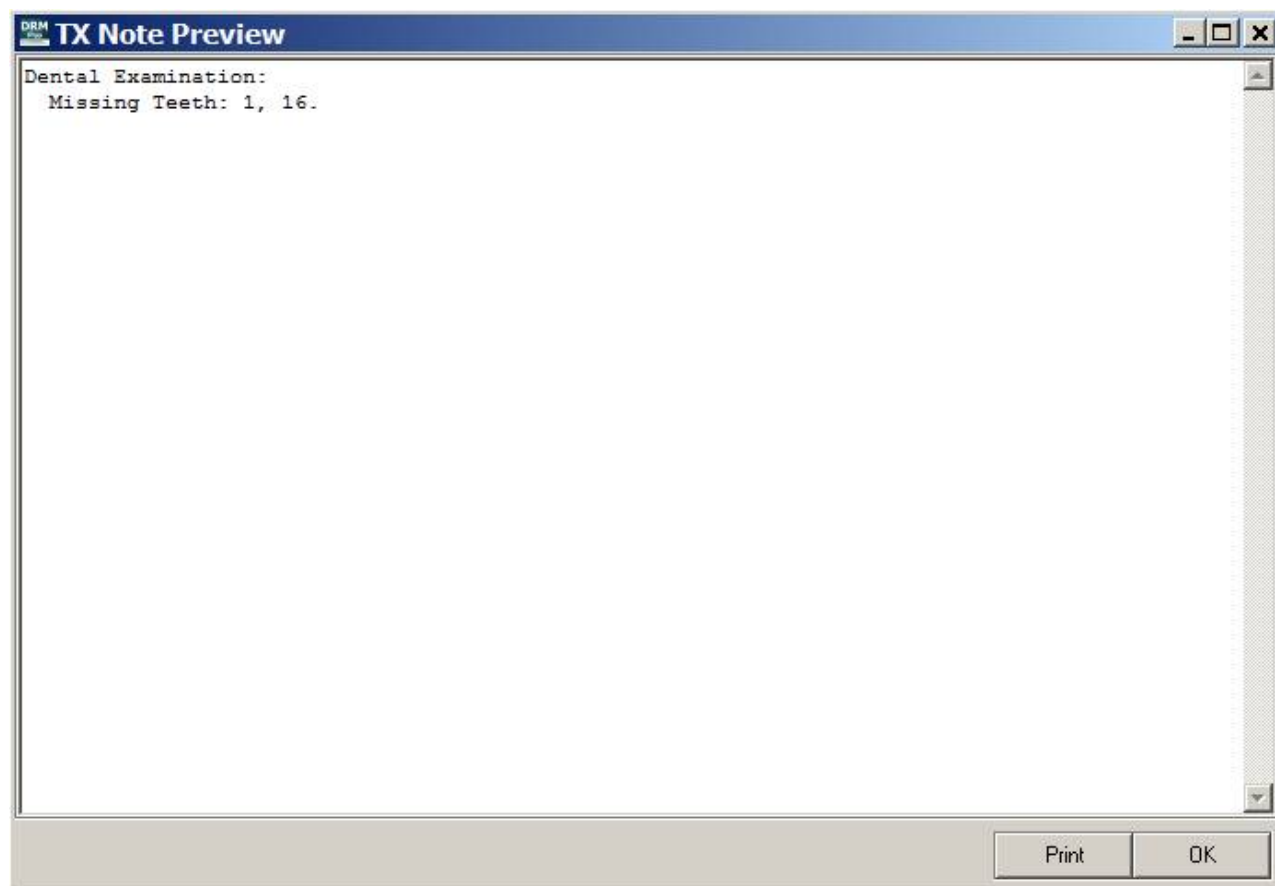
After selecting an **Unfiled Data by Provider** report, the provider needs to select the **View data** button which allows the user to display the data that was saved as unfiled data on that patient.

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

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

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

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



**Figure 135: TX Note Preview**

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

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

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

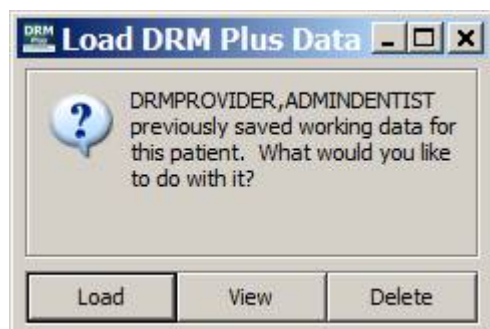


Figure 136: Load DRM Plus Data Screen

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

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

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

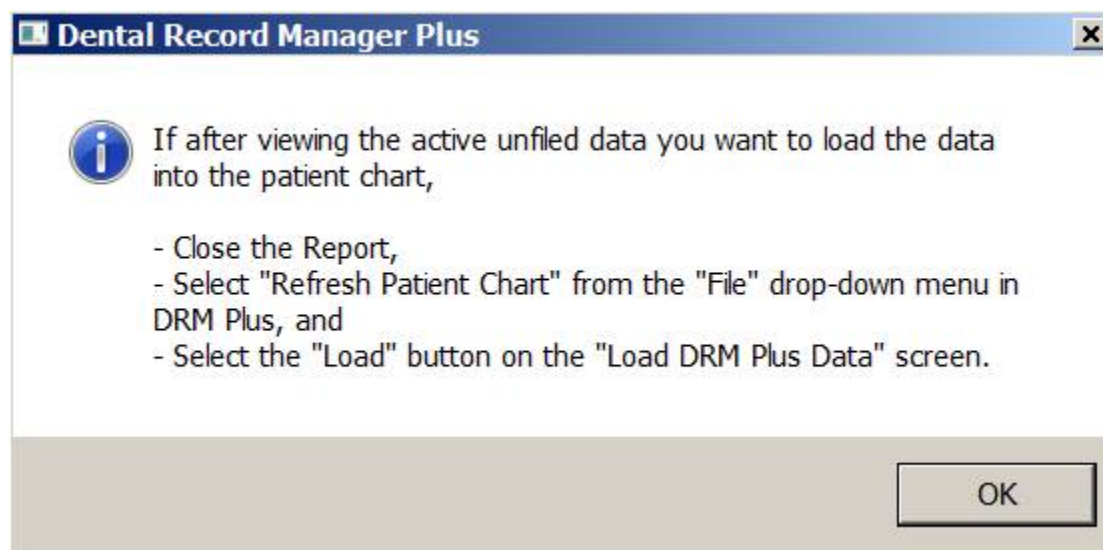


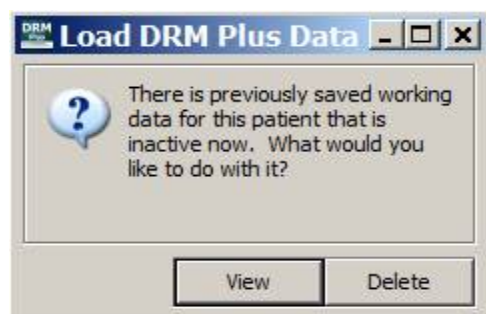
Figure 137: Instructional Steps to Load Unfiled Data

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

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

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

The following screen displays when loading the patient's chart which has inactive unfiled data by the provider or from another provider.



**Figure 138: Inactive Unfiled Saved Data**

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

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



## Service Reports

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

**Service Report Selection**

Service Reports

☒ All Reports

☐ 1: Observations per Month

☐ 2: Service Profile ADA/CPT Codes

☐ 3: Service by Product Group

☐ 4: Provider Profile ☒ Use Provider Name

☐ 5: Patient Category Profile

☐ 6: Patients by Eligibility Setting

☐ 7: Patients by Eligibility Group

☐ 8: Patients by Dental Patient Category

☐ 9: Outpatient Service by Product Group

☐ 10: Inpatient Service by Product Group

☐ 11: Distribution of Dental Services

Fiscal Year n/a

Start Date 5/ 3/2017

End Date 5/ 3/2017

☒ All Stations

☒ All Providers?

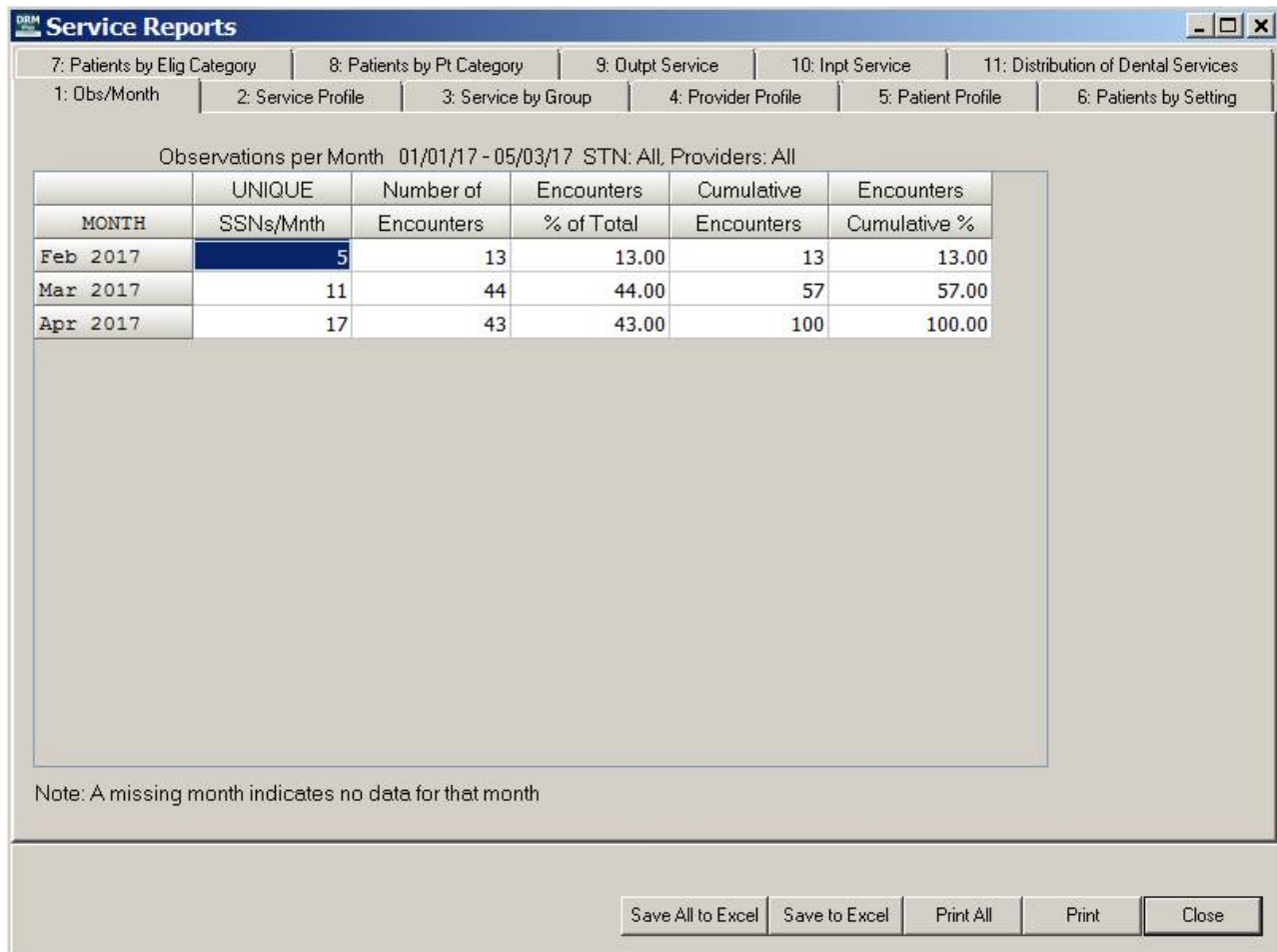
Search for records using

☒ Visit Date ☐ Create Date

OK Cancel

**Figure 139: Service Report Selection Screen**

1. Choose the desired type of service report check box(s).
2. Set the **Fiscal Year** or date range, if applicable.
3. Change the **All Station** and **All Providers** options.
4. Select the date type that is to be represented on the report.
5. Click the **OK** button.
6. The **Service Reports** screen displays with the results.



**Figure 140: Service Reports**

7. 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.
8. Save the report to Excel or print.



## Data Warehouse Reports

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



Figure 141: Reports Menu

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

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

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

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

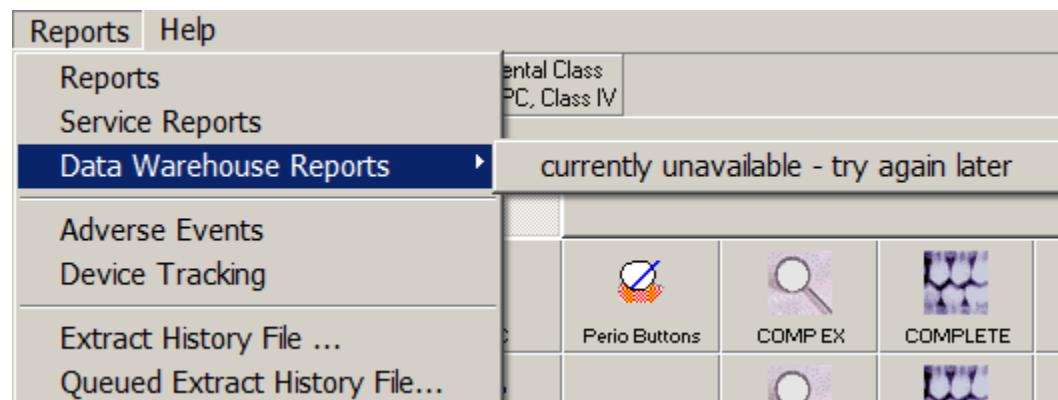
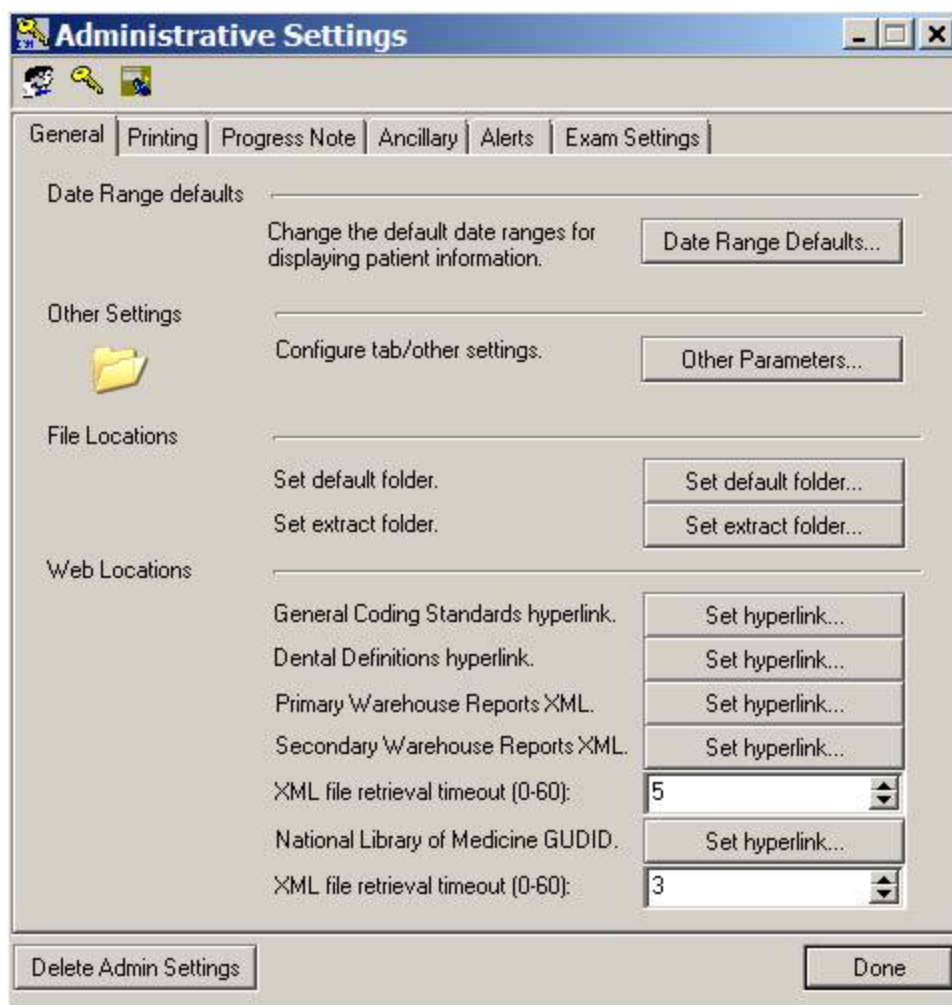


Figure 142: Data Warehouse Reports Submenu Failure

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

The first **XML file retrieval timeout (0-60)** field from the **Administrative Settings** screen is associated with Data Warehouse Reports.



**Figure 143: Administrative Toolbox Submenu - General Tab**

## Adverse Events Report

The **Adverse Events** report may be opened from the **Reports** menu by selecting the **Adverse Events** submenu which is displayed in the following dialog. The **Adverse Events** report submenu will only be active for any full DRM Plus Administrator to create a report.

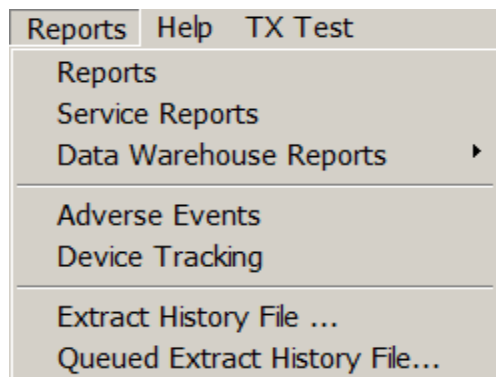
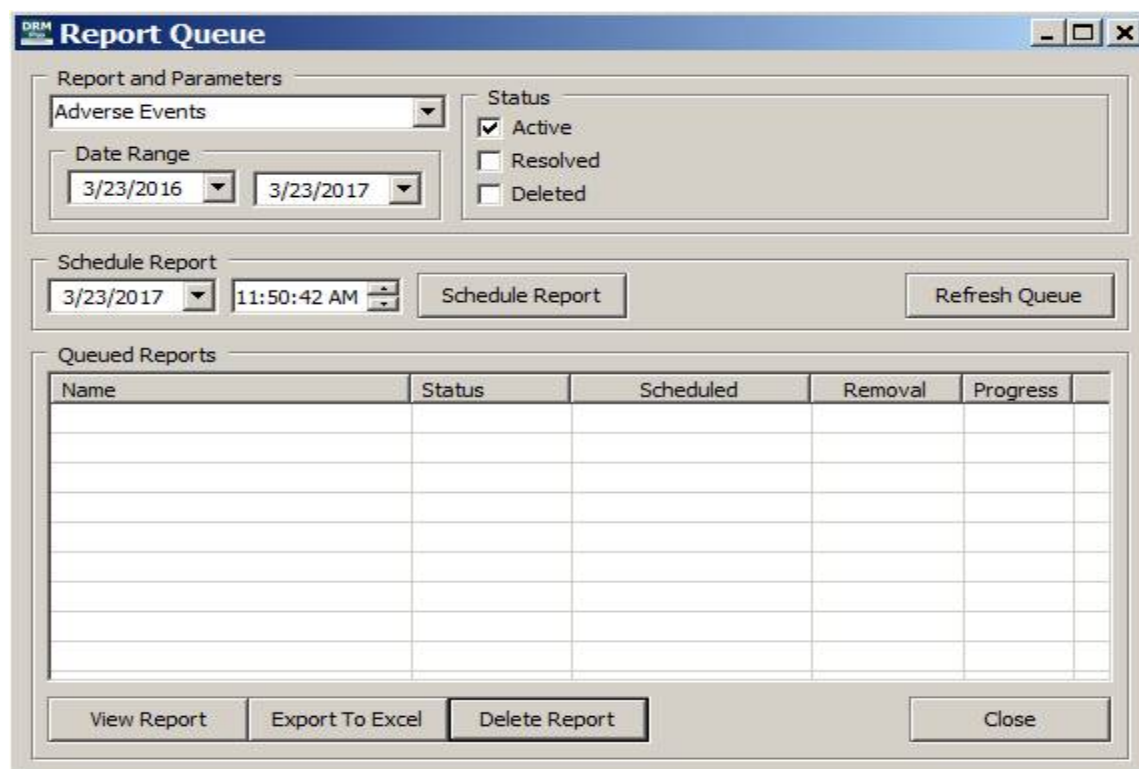


Figure 144: Reports Menu

When selecting the **Adverse Events** submenu the following **Report Queue** screen will display.



Name	Status	Scheduled	Removal	Progress

Figure 145: Report Queue

The **Report and Parameters** drop-down field allows for the selection of either the **Adverse Events** report or the **Device Tracking** report to have a new scheduled report created.

The rest of the following functionality found on the **Report Queue** screen will allow the provider to schedule a report, view a report, export a report to **Excel**, or delete a report.

- **Status** may be selected to customize the **Adverse Events** report. The default status is only the **Active** check box selected however the provider may select any combination of **Active**, **Resolved** or **Deleted** which would be included in the final report.
- **Date Range** may be selected to customize the **Adverse Events** report. The default date range is set to include the previous year from the creation date of the **Adverse Events** report.
- **Schedule Report** button when selected will create a new **Adverse Events** queued report using the **Status** and **Date Range** selections by the provider. The provider may change the schedule such as the date and/or time so the report will get generated during a time when there is little or no effect on the functionality of the workstation.
- **Refresh Queue** button would be used when the **Progress**, last column in **Queued Reports** table, is displaying any value less than 100% complete. Continue to select the **Refresh Queue** button until the **Progress** is 100% complete. Then the recent queued report may be viewed by the provider.
- **View Report** button requires one of the **Adverse Events** report to be highlighted so the provider may view the **Adverse Events** report.
- **Export to Excel** button when selected with a queued report highlighted allows the provider to export all the data from the queued report to an **Excel** document.
- **Delete Report** button when selected with a queued report highlighted will delete that queued report.
- **Close** button when selected will close the **Report Queue** screen.

To create/schedule and view the **Adverse Events** report:

1. Select any combination or all the **Status** check boxes
2. Select the **Date Range** for the **Adverse Events** report
3. Select the **Schedule Report** button
4. Select the **OK** button on the informational **Adverse Events** pop-up screen
5. May need to select the **Refresh Queue** button multiple times until the **Progress** is 100%
6. Highlight the **Adverse Events** report in the **Queued Reports** table
7. Select the **View Report** button



The following dialog displays an **Adverse Events** report with seven columns of the data displaying in the dialog. There are actually eleven columns of data in all **Adverse Events** reports so four are NOT displayed in the following dialog.

Adverse Events 3170323.115042 (03/23/2016 to 03/23/2017)						
PATIENT	VISIT	PROVIDER	CATEGORY	STATUS	ENTRY DATE	RESOLVED DATE
FBCSAAD,MKTRTN (6649)	MAR 20, 2017@12:06	DRMPROVIDER,ADMINDENTIST	5:Nerve Injury	ACTIVE	MAR 20, 2017@12:10:46	
FBCSAAC,DKNRWL (0553)	MAR 20, 2017@12:00	DRMPROVIDER,ADMINDENTIST	5:Nerve Injury	ACTIVE	MAR 20, 2017@12:01:04	
FBCSAAA,SKMKNTHK (5955)	MAR 20, 2017@11:00	DRMPROVIDER,ADMINDENTIST	9:Systemic Complication(s)	ACTIVE	MAR 20, 2017@11:51:42	
DRMPATIENT,ONE (0001)	MAR 17, 2017@14:00	DRMPROVIDER,ADMINDENTIST	3:Hard Tissue Damage	ACTIVE	MAR 17, 2017@14:23:50	
FBCSAAD,MKTRTN (6649)	MAR 13, 2017@11:17	DRMPROVIDER,ADMINDENTIST	1:Aspiration or Ingestion of Foreign Body	ACTIVE	MAR 13, 2017@11:21:19	
FBCSAAC,DKNRWL (0553)	MAR 13, 2017@10:56	DRMPROVIDER,ADMINDENTIST	7:Quality of Care Issue(s)	ACTIVE	MAR 13, 2017@11:17:39	
FBCSAAA,SKMKNTHK (5955)	MAR 10, 2017@15:58	DRMPROVIDER,ADMINDENTIST	5:Nerve Injury	ACTIVE	MAR 10, 2017@16:02:45	
FBCSAAO,WLLRZTT (6271)	MAR 10, 2017@15:30	DRMPROVIDER,ADMINDENTIST	2:Bleeding	ACTIVE	MAR 10, 2017@15:57:28	
FBCSAAT,GWNWVRWWW (0467)	MAR 10, 2017@14:06	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	ACTIVE	MAR 10, 2017@14:08:52	
FBCSAAS,KQWRLK (5352)	MAR 08, 2017@09:30	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	ACTIVE	MAR 08, 2017@09:54:59	
FBCSAAB,MWLYSSK (2428)	MAR 07, 2017@14:57	DRMPROVIDER,ADMINDENTIST	3:Hard Tissue Damage	ACTIVE	MAR 07, 2017@15:04:52	
FBCSAAS,KQWRLK (5352)	MAR 07, 2017@08:30	DRMPROVIDER,ADMINDENTIST	7:Quality of Care Issue(s)	ACTIVE	MAR 07, 2017@09:06:21	
IDOSPATIENT,TWO J (1185)	MAR 06, 2017@15:22	DRMPROVIDER,ADMINDENTIST	4:Infection	ACTIVE	MAR 06, 2017@15:23:01	
FBCSAAR,CKLRSTK (1136)	MAR 06, 2017@14:24	DRMPROVIDER,ADMINDENTIST	7:Quality of Care Issue(s)	ACTIVE	MAR 06, 2017@14:29:11	
FBCSAAQ,KLYSSK (3151)	FEB 23, 2017@11:00	DRMPROVIDER,ADMINDENTIST	7:Quality of Care Issue(s)	ACTIVE	FEB 23, 2017@11:56:54	
FBCSAAB,MWLYSSK (2428)	MAR 20, 2017@11:30	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	RESOLVED	MAR 20, 2017@11:56:44	MAR 20, 2017@11:56:44
DRMPATIENT,ONE (0001)	MAR 17, 2017@14:00	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	RESOLVED	MAR 17, 2017@14:23:50	MAR 17, 2017@14:23:50
FBCSAAP,WLVRS (5892)	MAR 10, 2017@15:04	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	RESOLVED	MAR 10, 2017@15:05:56	MAR 10, 2017@15:05:56
FBCSAAC,DKNRWL (0553)	MAR 09, 2017@12:00	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	RESOLVED	MAR 09, 2017@12:08:25	MAR 20, 2017@12:01:04
FBCSAAT,GWNWVRWWW (0467)	MAR 08, 2017@09:00	DRMPROVIDER,ADMINDENTIST	2:Bleeding	RESOLVED	MAR 08, 2017@09:27:30	MAR 10, 2017@14:08:53
FBCSAAA,SKMKNTHK (5955)	MAR 07, 2017@14:42	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	RESOLVED	MAR 07, 2017@14:55:14	MAR 07, 2017@14:55:14
FBCSAAP,WLVRS (5892)	MAR 07, 2017@09:00	DRMPROVIDER,ADMINDENTIST	9:Systemic Complication(s)	RESOLVED	MAR 07, 2017@09:22:46	MAR 10, 2017@15:05:56
FBCSAAR,CKLRSTK (1136)	FEB 23, 2017@10:57	DRMPROVIDER,ADMINDENTIST	6:Pain	RESOLVED	FEB 23, 2017@11:00:33	FEB 23, 2017@11:00:33
FBCSAAS,KQWRLK (5352)	FEB 22, 2017@14:08	DRMPROVIDER,ADMINDENTIST	6:Pain	RESOLVED	FEB 22, 2017@14:10:54	FEB 22, 2017@14:10:54
FBCSAAT,GWNWVRWWW (0467)	FEB 22, 2017@10:03	DRMPROVIDER,ADMINDENTIST	6:Pain	RESOLVED	FEB 22, 2017@10:07:02	MAR 08, 2017@09:27:30
IDOSPATIENT,TWO J (1185)	FEB 15, 2017@15:30	DRMPROVIDER,ADMINDENTIST	9:Systemic Complication(s)	RESOLVED	FEB 15, 2017@15:35:06	FEB 15, 2017@15:35:06
FBCSAAA,SKMKNTHK (5955)	MAR 14, 2017@15:00	DRMPROVIDER,HYGIENIST	8:Soft Tissue Injury/Inflammation	DELETED	MAR 14, 2017@15:05:40	MAR 21, 2017@14:17:21
FBCSAAF,CKSWY (5264)	MAR 13, 2017@14:21	DRMPROVIDER,ADMINDENTIST	1:Aspiration or Ingestion of Foreign Body	DELETED	MAR 13, 2017@14:24:44	
FBCSAAF,CKSWY (5264)	MAR 13, 2017@14:21	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	DELETED	MAR 13, 2017@14:24:44	MAR 13, 2017@14:24:44
FBCSAAD,MKTRTN (6649)	MAR 13, 2017@11:17	DRMPROVIDER,ADMINDENTIST	0:Allergy/Toxicity/Foreign Body Response	DELETED	MAR 13, 2017@11:21:19	MAR 20, 2017@12:10:46
FBCSAAA,SKMKNTHK (5955)	MAR 09, 2017@09:00	DRMPROVIDER,ADMINDENTIST	9:Systemic Complication(s)	DELETED	MAR 09, 2017@09:18:21	MAR 21, 2017@14:17:21
FBCSAAA,SKMKNTHK (5955)	MAR 08, 2017@14:30	DRMPROVIDER,ADMINDENTIST	4:Infection	DELETED	MAR 08, 2017@14:34:23	MAR 20, 2017@11:51:42
FBCSAAB,MWLYSSK (2428)	MAR 07, 2017@14:57	DRMPROVIDER,ADMINDENTIST	2:Bleeding	DELETED	MAR 07, 2017@15:04:52	MAR 20, 2017@11:56:44
FBCSAAA,SKMKNTHK (5955)	MAR 07, 2017@14:42	DRMPROVIDER,ADMINDENTIST	1:Aspiration or Ingestion of Foreign Body	DELETED	MAR 07, 2017@14:55:14	MAR 09, 2017@09:18:21

**Figure 146: Adverse Events Report**

**Note:** There are five columns containing dates in the **Adverse Events** report which are listed and explained in greater detail.

- 2<sup>nd</sup> column **VISIT** – VISIT date selected for the encounter
- 6<sup>th</sup> column **ENTRY DATE** – real time date when encounter was filed
- 7<sup>th</sup> column **RESOLVED DATE** – real time date when adverse event was edited and filed
- 8<sup>th</sup> column **VISIT DATE** – VISIT date selected for the encounter
- 9<sup>th</sup> column **LAST EDIT DATE** – real time date when adverse event was edited/removed/deleted and filed

**Note:** The **Adverse Events** report is only available for selection eight days when one is scheduled/created. After the eighth day the report will be automatically deleted and a new report will have to be scheduled/created.

**Note:** The **Adverse Events** report will contain test patient data if any has been filed in the VistA production account. Adverse event **Excel** reports should have all test patient data removed after it has been saved.

## Device Tracking Report

The **Device Tracking** report may be opened from the **Reports** menu by selecting the **Device Tracking** submenu which is displayed in the following dialog. The **Device Tracking** report submenu will only be active for a full DRM Plus Administrator to create a report.

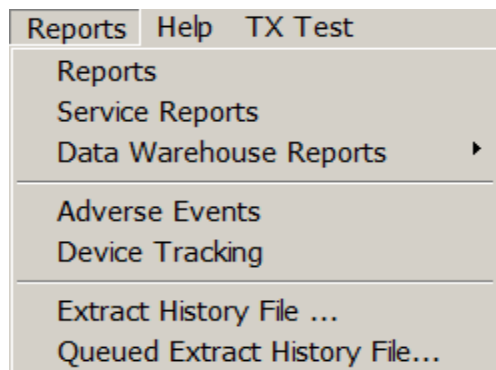


Figure 147: Reports Menu

When selecting the **Device Tracking** submenu the following **Report Queue** screen will display.

A screenshot of the 'Report Queue' dialog box. The dialog has a title bar with 'DRM Plus' and 'Report Queue'. It contains several sections: 'Report and Parameters' with a dropdown set to 'Device Tracking' and a 'Date Range' section with two date pickers set to '3/23/2016' and '3/23/2017'; a 'Status' section with checkboxes for 'Existing' (checked), 'Removed', and 'Deleted'; a 'Schedule Report' section with a date picker set to '3/23/2017', a time spinner set to '4:31:38 PM', a 'Schedule Report' button, and a 'Refresh Queue' button; and a 'Queued Reports' section with a table. The table has columns for 'Name', 'Status', 'Scheduled', 'Removal', and 'Progress'. At the bottom are buttons for 'View Report', 'Export To Excel', 'Delete Report', and 'Close'.

Figure 148: Report Queue

The **Report and Parameters** drop-down field allows the selection of either the **Device Tracking** report or the **Adverse Events** report to have a new scheduled report created.

The rest of the following functionality found on the **Report Queue** screen will allow the provider to schedule a report, view a report, export report to **Excel**, or delete a report.

- **Status** may be selected to customize the **Device Tracking** report. The default status is the **Active** check box however the provider may select any combination of **Active**, **Resolved** or **Deleted** which would be included in the final report.
- **Date Range** may be selected to customize the **Device Tracking** report. The default date range is set to include the previous year from the creation date of the **Device Tracking** report.
- **Schedule Report** button when selected will create a new **Device Tracking** queued report using the **Status** and **Date Range** selections by the provider. The provider may change the schedule such as the date and/or time so the report will get generated during a time when there is little or no effect on the functionality of the workstation.
- **Refresh Queue** button would be used when the **Progress**, last column in **Queued Reports** table, is displaying any value less than 100% complete. Continue to select the **Refresh Queue** button until the **Progress** is 100% complete. Then the recent queued report may be viewed by the provider.
- **View Report** button requires one of the **Device Tracking** report to be highlighted so the provider may view the **Device Tracking** report.
- **Export to Excel** button when selected with a queued report highlighted allows the provider to export all the data from the queued report to an **Excel** document.
- **Delete Report** button when selected with a queued report highlighted will delete that queued report.
- **Close** button when selected will close the **Report Queue** screen.

To create/schedule and view the **Device Tracking** report:

1. Select any combination or all the **Status** check boxes
2. Select the **Date Range** for the **Device Tracking** report
3. Select the **Schedule Report** button
4. Select the **OK** button on the informational **Device Tracking** pop-up screen
5. May need to select the **Refresh Queue** button multiple times until the **Progress** is 100%
6. Highlight the **Device Tracking** report in the **Queued Reports** table
7. Select the **View Report** button

The following dialog displays a **Device Tracking** report with thirteen columns of the data displaying in the dialog. There are actually twenty five columns of data in all **Device Tracking** reports so twelve are NOT displayed in the following dialog.



Dental Devices 3170323.163138 (03/23/2016 to 03/23/2017)												
DEVICE TRACKING IEN	TRANSACTION	PATIENT	PROVIDER	DATE	DESCRIPTION	TOOTH	STATUS	ENTRY DATE	REMOVED DATE	LAST EDIT PROV	LAST EDIT DATE	VISIT DATE
45	614	DRMPACHT,ONE (0001)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	6	Existing	MAR 22, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 22, 2017	MAR 22, 2017@14:00
44	624	FBSCAAQ,KMTRKH (0449)	DRMPROVIDER,ADMINIDENTIST		D7950 MANDIBLE GRAFT		Existing	MAR 20, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 20, 2017	MAR 20, 2017@12:06
43	593	FBSCAAB,MWLYSSK (2428)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	27	Existing	MAR 20, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 20, 2017	MAR 20, 2017@11:30
42		FBSCAAA,SKMNTKH (5955)	DRMPROVIDER,ADMINIDENTIST	MAR 17, 2017	bone graft on right mandibular	27	Existing	MAR 20, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 20, 2017	MAR 20, 2017@11:00
41		FBSCAAE,KWILRW (7578)	DRMPROVIDER,ADMINIDENTIST	MAR 13, 2017	no transaction entry for deletion	3	Existing	MAR 13, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 13, 2017	MAR 13, 2017@14:17
39	577	FBSCAAG,DKNRWL (0553)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	6	Existing	MAR 13, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 13, 2017	MAR 13, 2017@10:56
37	548	FBSCAAA,SKMNTKH (5955)	DRMPROVIDER,ADMINIDENTIST		D7950 MANDIBLE GRAFT		Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@15:58
36	533	FBSCAAQ,WLZRJT (6271)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	27	Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@15:30
35		FBSCAAP,WLVRS (5892)	DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	Bone graft by fee dentist		Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@15:04
33	500	FBSCAAQ,KLYSSK (3151)	DRMPROVIDER,ADMINIDENTIST		D7953 BONE REPLACEMENT GRAFT		Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@14:48
34		FBSCAAQ,KLYSSK (3151)	DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	Bone replacement graft by fee dentist	15	Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@14:48
32	289	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	11	Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@14:37
30	470	FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST		D7950 MANDIBLE GRAFT		Existing	MAR 10, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 10, 2017	MAR 10, 2017@14:06
28	494	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST		D7955 REPAIR MAXILLOFACIAL DEFECTS		Existing	MAR 09, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 09, 2017	MAR 09, 2017@09:30
27	492	FBSCAAA,SKMNTKH (5955)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	22	Existing	MAR 09, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 09, 2017	MAR 09, 2017@09:00
24	477	FBSCAAA,SKMNTKH (5955)	DRMPROVIDER,ADMINIDENTIST			27	Existing	MAR 08, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	MAR 08, 2017@14:30
23	473	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST				Existing	MAR 08, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	MAR 08, 2017@09:30
22		FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	mandibular graft by fee dentist		Existing	MAR 08, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	MAR 08, 2017@09:00
20	436	FBSCAAB,MWLYSSK (2428)	DRMPROVIDER,ADMINIDENTIST			6	Existing	MAR 07, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 07, 2017	MAR 07, 2017@14:57
18	378	FBSCAAP,WLVRS (5892)	DRMPROVIDER,ADMINIDENTIST			6	Existing	MAR 07, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 07, 2017	MAR 07, 2017@09:00
17	375	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST			2	Existing	MAR 07, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 07, 2017	MAR 07, 2017@08:30
16	339	FBSCAAR,CKRSTK (1136)	DRMPROVIDER,ADMINIDENTIST			11	Existing	MAR 06, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 06, 2017	MAR 06, 2017@14:24
14	324	FBSCAAQ,KLYSSK (3151)	DRMPROVIDER,ADMINIDENTIST			27	Existing	MAR 06, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 06, 2017	MAR 06, 2017@14:00
13	325	FBSCAAQ,KLYSSK (3151)	DRMPROVIDER,ADMINIDENTIST			3	Existing	MAR 06, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 06, 2017	MAR 06, 2017@14:00
11	305	FBSCAAP,WLVRS (5892)	DRMPROVIDER,ADMINIDENTIST			27	Existing	MAR 01, 2017		DRMPROVIDER,ADMINIDENTIST	MAR 01, 2017	MAR 01, 2017@09:30
10	284	FBSCAAQ,KLYSSK (3151)	DRMPROVIDER,ADMINIDENTIST			6	Existing	FEB 23, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 23, 2017	FEB 23, 2017@11:00
9	274	FBSCAAR,CKRSTK (1136)	DRMPROVIDER,ADMINIDENTIST			6	Existing	FEB 23, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 23, 2017	FEB 23, 2017@10:57
8	269	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST			6	Existing	FEB 22, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 22, 2017	FEB 22, 2017@11:08
7	268	FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST			11	Existing	FEB 22, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 22, 2017	FEB 22, 2017@11:32
3	252	FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST			27	Existing	FEB 15, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 15, 2017	FEB 15, 2017@15:54
1	240	IDOSPATIENT_TWO J (1185)	DRMPROVIDER,ADMINIDENTIST			6	Existing	FEB 15, 2017		DRMPROVIDER,ADMINIDENTIST	FEB 15, 2017	FEB 15, 2017@15:30
31	288	FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	1	Removed	MAR 10, 2017	MAR 13, 2017	DRMPROVIDER,ADMINIDENTIST	MAR 13, 2017	MAR 13, 2017@10:00
5	265	FBSCAAS,KQWRLL (5352)	DRMPROVIDER,ADMINIDENTIST		D6010 ENDOSTEAL IMPLANT BODY PLACE	27	Removed	FEB 16, 2017	MAR 09, 2017	DRMPROVIDER,ADMINIDENTIST	MAR 09, 2017	MAR 09, 2017@09:30
26	490	FBSCAAD,MKTRKH (6497)	DRMPROVIDER,ADMINIDENTIST			6	Removed	MAR 08, 2017	MAR 08, 2017	DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	MAR 08, 2017@15:04
25	480	FBSCAAC,DKNRWL (0553)	DRMPROVIDER,ADMINIDENTIST			2	Removed	MAR 08, 2017	MAR 08, 2017	DRMPROVIDER,ADMINIDENTIST	MAR 08, 2017	MAR 08, 2017@14:57
4	253	FBSCAAT,GWVWVRVWV (0467)	DRMPROVIDER,ADMINIDENTIST			22	Removed	FEB 15, 2017	MAR 06, 2017	DRMPROVIDER,ADMINIDENTIST	MAR 06, 2017	MAR 06, 2017@14:21

**Figure 149: Dental Devices Report**

The first two columns on the report, the **DEVICE TRACKING IEN** and the **TRANSACTION**, are numbers that don't represent any value to the provider viewing the report. However they are extremely useful when an issue results with one of the device tracking entries and we need assistance from VA OI&T to resolve the problem.

The **Device Tracking** report column of **TRANSACTION** contains the filed dental transaction IEN number from VistA identifying that transaction internally.

The **Device Tracking** report column of **DATE** only will contain information from the filed non-transaction device entry and no data from the filed transaction device entry.

The **Device Tracking** report column of **TOOTH** will display the tooth number for both the filed non-transaction device entry if entered and the filed transaction device entry if the transaction had one.

**Note:** There are five columns possible containing dates in the first half of the **Device Tracking** report and are listed below explaining the detailed date reference.

- 5<sup>th</sup> column **DATE** – date entered for a non-transaction device tracking entry
- 9<sup>th</sup> column **ACTIVE DATE** – real time date when encounter was filed
- 10<sup>th</sup> column **REMOVED DATE** – real time date when device tracking was edited and filed
- 12<sup>th</sup> column **LAST EDIT DATE** – real time date when adverse event was edited/removed/deleted and filed
- 13<sup>th</sup> column **VISIT DATE** – VISIT date selected for the encounter when adding the device tracking

**Note:** The **Device Tracking** report is only available for selection eight days when one is scheduled/created. After the eighth day the report will be automatically deleted and a new report will have to be scheduled/created.

**Note:** The **Device Tracking** report will contain test patient data if any has been filed in the VistA production account. Adverse event **Excel** reports should have all test patient data removed after it has been saved.

## Extract History File

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

**Extract History File Data**

Select Extract Options

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

Start Date: Wednesday, May 03, 2017

End Date: Wednesday, May 03, 2017

Output file selection:

Look in: c: []

Select Directory:

- C:\
- TEMP

Select File to Replace:

- April 2017.TXT

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

C:\TEMP

☒ All Stations

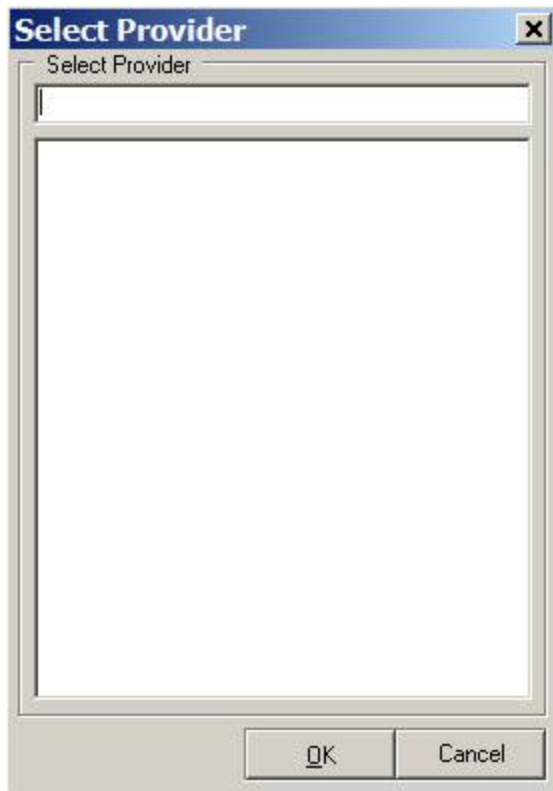
☐ Optional Select Provider

OK Cancel

**Figure 150: Extract History File Data Screen**

To extract data:

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



**Figure 151: Select Provider Screen**

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

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

## Queued Extract History File

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

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

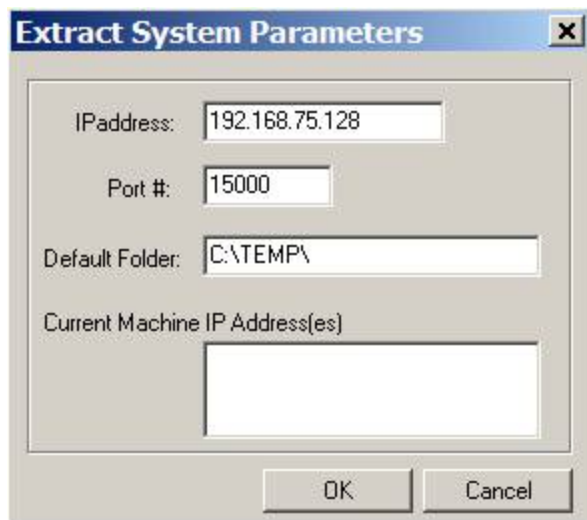
**Note:** Obtain a valid **Port #** and **IPaddress** from the local IT department to use this function. The **Port #** should be 15,000 or greater.

**Figure 152: Extract History File Data Screen**

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

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

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



**Figure 153: Extract System Parameters**

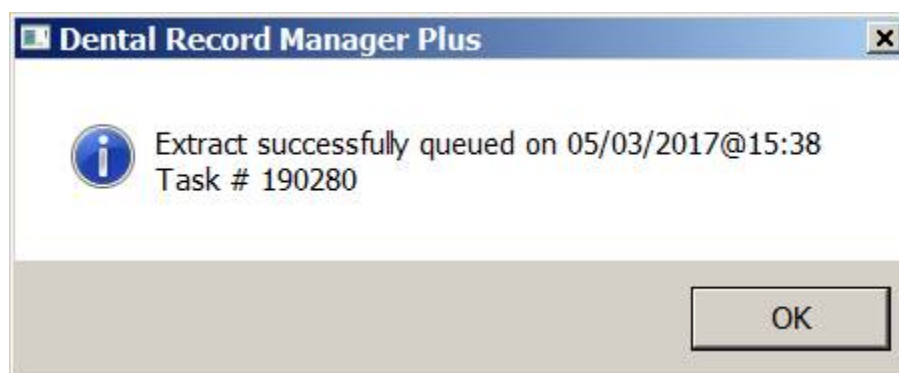
7. Enter the **IPAddress** and **Port #** number. IT can provide this information.
8. Verify the **Current Machine IP Address(es)** is correct every time.
9. Once the parameter information is entered, click the **OK** button. This extracts the data to the chosen directory folder location.

### ***Considerations and Additional Information***

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

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

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



**Figure 154: Extract Successfully Queued**

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

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

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



**Figure 155: DRM Extract Already Running**

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

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

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



## Help

Use the **Help** menu to access more information on DRM Plus. There are seven submenus: **Contents**; **Version Release Notes**; **Last Broker Call**; **VA Intranet Website**; **Find your DRM Plus Administrators**; **Have a Question, Comment or Suggestion about DRM?**; and **About**.

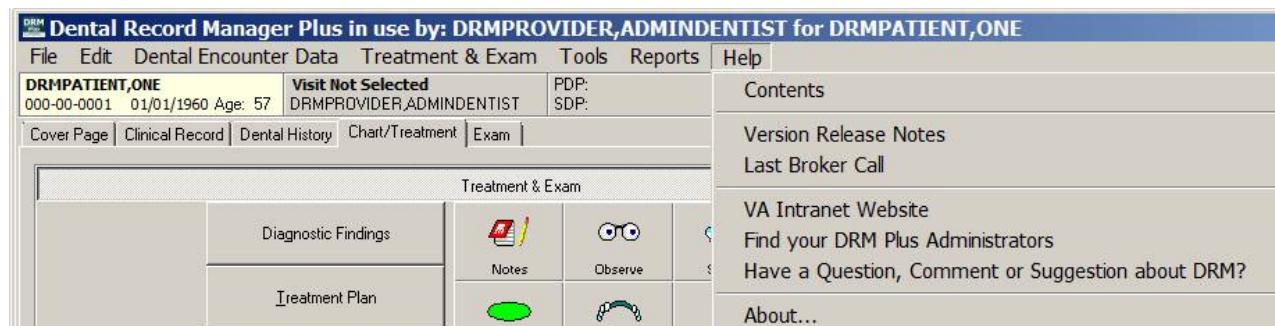


Figure 156: Help Menu

## Contents

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

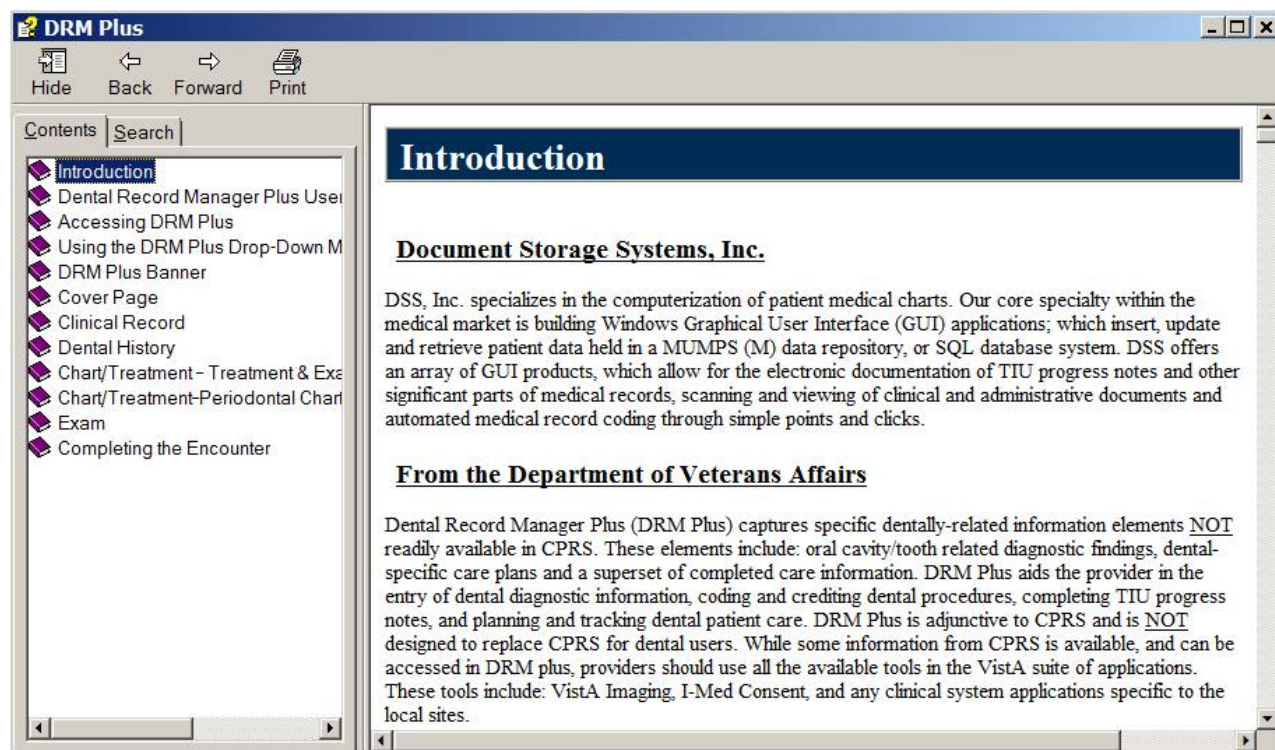


Figure 157: DRM Plus Contents Screen



## Version Release Notes

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

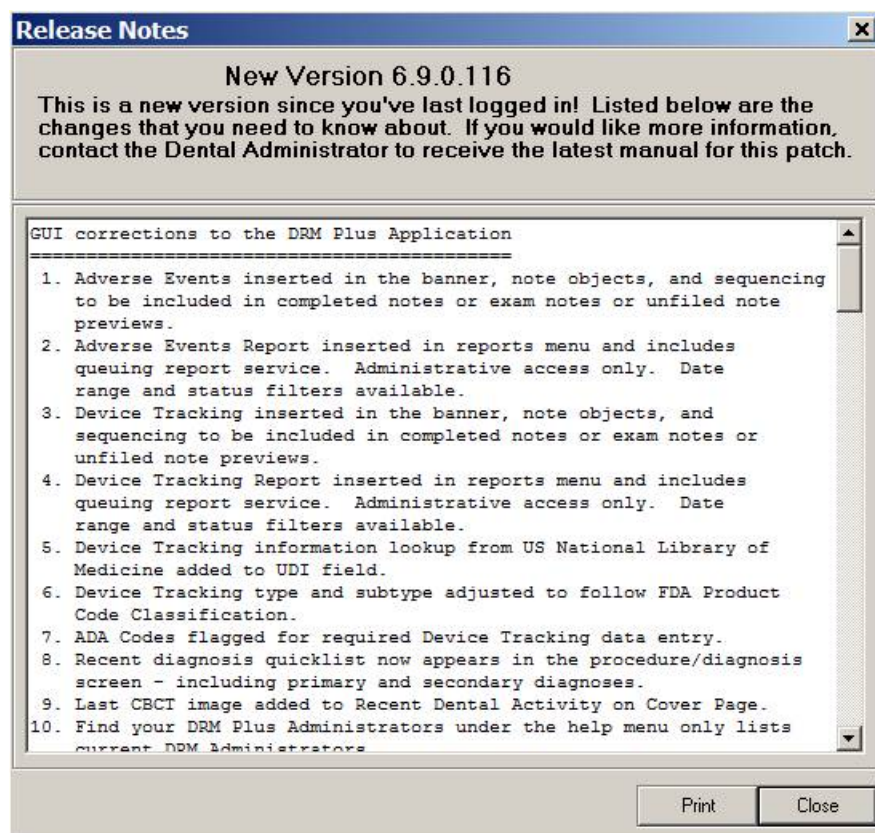
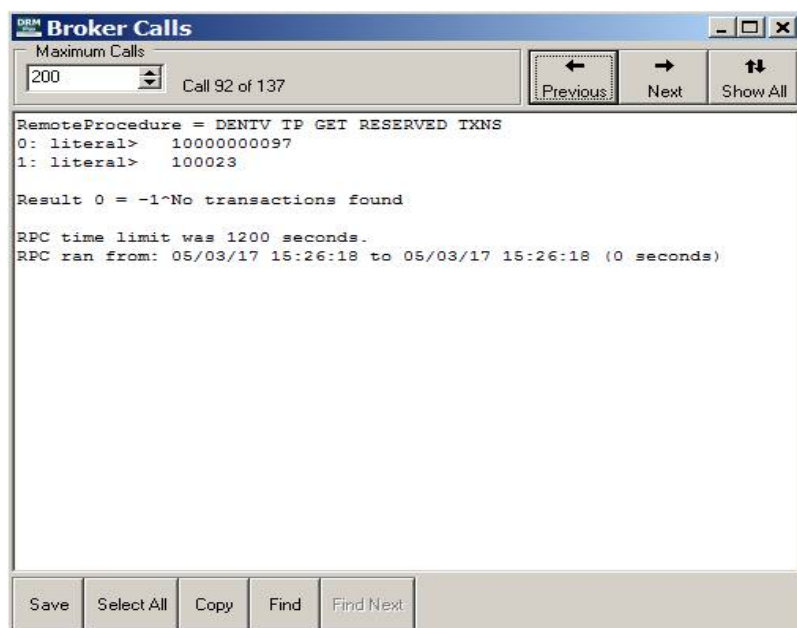


Figure 158: Release Notes Screen

## Last Broker Call

Select the submenu to see the last broker call.



**Figure 159: Broker Calls Screen**

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

## VA Intranet Website

Select the submenu to access the VA Intranet website.

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

## Find your DRM Plus Administrators

Select the submenu to display a list of all the DRM Plus administrators that have full admin functionality. The list of DRM Plus administrators may be from the local dental clinic or every dental clinic that shares the same VistA server.

## Have a Question, Comment or Suggestion about DRM?

Select the submenu and it will display a VA email screen with the **VHA Dental Software Support** group pre-selected in the 'To' email field. The provider will receive a reply from the **VHA Dental Software Support** group in response from the provider's question, comment or suggestion when requested.

## About

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



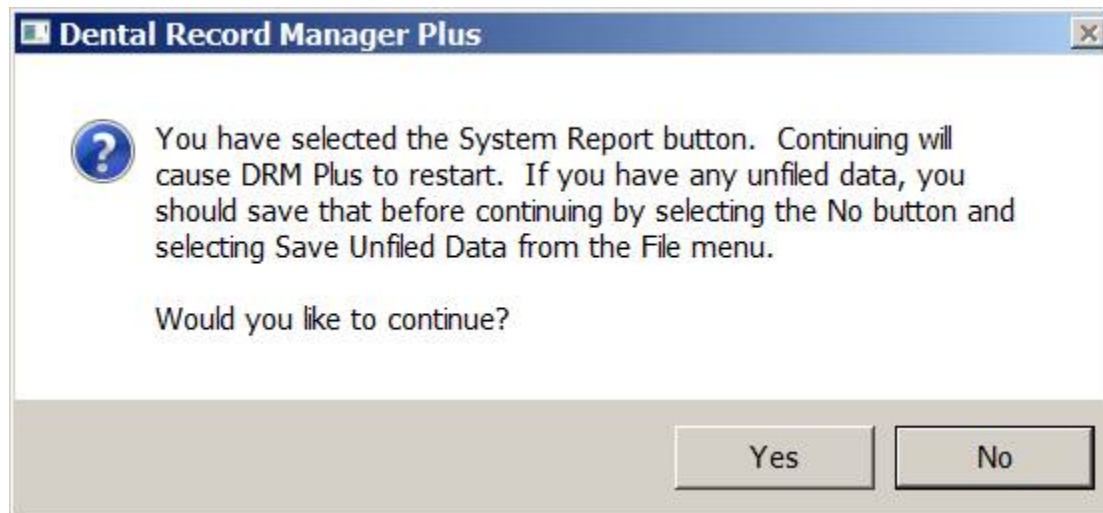
Figure 160: DRM Plus About Screen

The **System Report** button and the **Reporting Off** button are located on the **About** screen.

Both buttons are useful for **Document Storage Systems** (DSS) in helping to evaluate any issue that may have occurred in DRM Plus. It is strongly suggested NOT to select either button except when working with a DSS employee who will be helping the provider in finding details about the issue occurring in the DRM Plus application.

The **System Report** button will cause the DRM Plus application to freeze. When selecting this button any unfiled data entered this session and NOT saved as unfiled data will be lost. The provider will NOT be able to recover the unsaved unfiled data and would have to re-enter all the data after restarting the DRM Plus application.

Selecting the **System Report** button will give the provider an option NOT to continue if they desire. The following informational screen will inform the provider to select the **No** button if they would prefer NOT to lose any unsaved unfiled data recently entered this session.



**Figure 161: System Report Informational Screen**

Selecting the **Yes** button from the informational screen will freeze the DRM Plus application and give the provider an error system report. All unsaved unfiled data at this point will be lost. The provider may select the **restart application** button to re-launch DRM Plus and continue with their dental charting.

The default **Reporting Off** button will NOT affect the provider's work process during this session unless they experience an error using the application. The only visible change the provider may notice when the button is selected will be changing the button's name to **Reporting On**.

When the button displays **Reporting On** then the madExcept application, system report, will become inactive. The madExcept system report is explained in detail when reading the **madExcept Application** appendix from the DRM Plus manuals.

**Note:** The **Reporting On** button's name will change back to the default **Reporting Off** button's name each time DRM Plus is closed and relaunched.

# DRM Plus Banner

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



Figure 162: DRM Plus Banner

## Patient Information

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

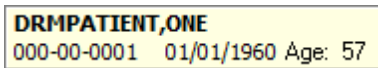


Figure 163: Patient Inquiry Button

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

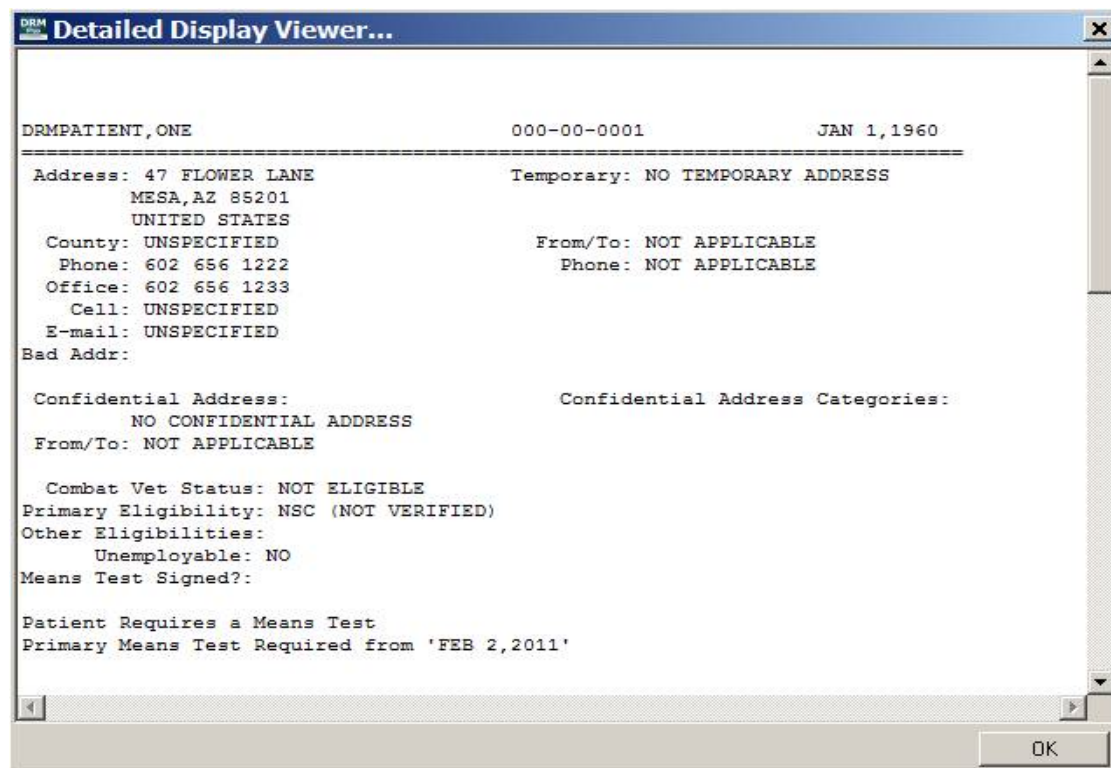


Figure 164: Patient Inquiry Screen

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



## Visit Information

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

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

### **Visit Not Selected**

DRMPROVIDER,ADMINDENTIST

**Figure 165: Provider/Visit Button**

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

Provider and Location for Current Activities		
Encounter Provider		
DRMPROVIDER,ADMINDENTIST CHIEF, DENTAL SERVICE, ORAL		
BLUYLUI,CXLY		
CPRSPHYSICIAN,ONE STAFF DENTIST,GENERAL PRA		
CXYTHYSDYX,LAKHUS		
DRMPROVIDER,ADMINDENTIST CHIEF, DENTAL SERVICE, ORAL		
DRMPROVIDER,ASSISTANT DENTAL ASSISTANT		
DRMPROVIDER,DENTIST THREE STAFF DENTIST,GENERAL PRA		
DRMPROVIDER,DENTIST TWO STAFF DENTIST,ENDODONTICS		
DRMPROVIDER,DENTIST STAFF DENTIST,PROSTHODON		
Encounter Location		
< Select a visit from the tabs below...>		
My Clinic Visits   Dental Visits   All Visits   Admissions   New Visit		
V	Apr 28, 2017@15:00	DENTAL
V	Mar 22, 2017@14:00	DENTAL
V	Mar 17, 2017@14:00	DENTAL

**Figure 166: Provider and Location for Current Activities Screen**

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

## Dental Provider Information

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

PDP: DRMPROVIDER\_ADMINDE  
SDP: DRMPROVIDER\_RESIDENT

**Figure 167: Designate Dental Providers Button**

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

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

Name	ID	Type/Specialty
*Fee Basis	n/a	n/a
CPRS PHYSICIAN, ONE	03012099	STAFF DENTIST, GENERAL P
DRMPROVIDER_ADMIN...	02040001	CHIEF, DENTAL SERVICE, OR
DRMPROVIDER_ASSIS...	07000002	DENTAL ASSISTANT
DRMPROVIDER_DENTI...	03010003	STAFF DENTIST, GENERAL P
DRMPROVIDER_HYGIE...	06000006	HYGIENIST
DRMPROVIDER_ONE	03020005	STAFF DENTIST, ENDODONT
DRMPROVIDER_RESID...	04070004	DENTIST RESIDENT OR FELI

**Figure 168: Designated Dental Providers Screen**

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

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



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

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

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

## Vitals Button

This section of the banner contains a **Vitals** button to launch the **Enter Vitals** screen, which will add specific vitals to the patient's VistA database. Only the blood pressure, pulse and general pain maybe added using the **Enter Vitals** screen.






**Figure 169: Vitals Button**

After selecting the **Vitals** button from the banner the **Enter Vitals** screen will display for the provider to enter and save three specific vitals to the VistA database. After entering any of the three possible vitals select the **OK** button to save to the VistA database.

**Figure 170: Enter Vitals Screen**

## Adverse Events Button

The **Adverse Events** (AE) button in the banner when selected will launch a screen where an adverse event may be entered and filed with an encounter for the selected patient's chart.

<b>DRMPATIENT,ONE</b>	<b>Visit Not Selected</b>	PDP:	  	Dental Class OPC, Class IV
000-00-0001 01/01/1960 Age: 57	DRMPROVIDER,ADMINIDENTIST	SDP:		

**Figure 171: Adverse Events Button on DRM Plus Banner**

The **AE** button, displayed as a yellow button in the banner screen above, only results as a yellow icon when at least one **Active** adverse event entry has been filed with the patient's chart. Selecting the **AE** button will open the following **Adverse Events** screen. When only filed **Resolved** entries are listed in the **History** section of the **Adverse Events** screen then the **AE** button in the banner will remain the same background color as the banner.

## To add an adverse event:

1. Select the drop-down arrow on the **Select Category and Provider Details** window
2. Select one of the twelve categories from the list
3. View the blue **Categories with Examples** window with the category listed at the top
4. Add or provide detailed text into the upper text window about the adverse event
5. Select the correct **Status** radio button (Resolved or Remain Active)
6. Select the **Add** button to temporary save the new adverse event
7. May add multiple adverse events this session if desired
8. When all adverse events have been added select the **Done** button to save as unfiled data
9. Filing an encounter is required when adding any adverse event during this session

The screenshot shows the 'Adverse Events' window. It has a title bar with a question mark and a close button. The main area is divided into several sections:

- Select Category and Provide Details:** A dropdown menu for selecting a category, a status section with 'Resolved' (selected) and 'Remain Active' radio buttons, and an 'Examples' button.
- Text Area:** A large text area for entering details about the adverse event.
- Display Options:** Checkboxes for 'Display Resolved' (checked) and 'Display Deleted'.
- Add Button:** A button to save the new adverse event.
- History Table:** A table showing a list of previously added adverse events.
- Categories with Examples:** A list of twelve categories with their corresponding examples.
- Buttons:** 'Delete', 'Done', and 'Cancel' buttons at the bottom.

**History Table:**

Visit	Provider	Category	Status	Details
MAR 17, 20...	DRMPROVIDER.ADM...	Hard Tissue Damage	Active	Bone/mandible fr...
MAR 17, 20...	DRMPROVIDER.ADM...	Allergy/Toxicity/For...	Resolved	Nitrous oxide toxi...

**Categories with Examples:**

- Allergy/Toxicity/Foreign Body Response examples:**
  - Drug – drug interaction
  - Allergic reaction to dental materials
  - Nitrous oxide toxicity
  - Intravascular injection
  - Hypochlorite injury
- Aspiration or Ingestion of Foreign Body examples:**
  - Swallowed restoration/prosthesis
  - Aspiration of teeth
  - Required bronchoscopy/tracheostomy due to aspiration
- Bleeding examples:**
  - Excessive surgical or post-surgical bleeding
  - Vascular damage
  - Hematoma
  - Anesthetic complication resulting in bleeding
- Hard Tissue Damage examples:**
  - Bur injury to adjacent tooth
  - Bone/mandible fracture during extraction
  - Root fracture/perforation during restorative treatment
  - Oral/antral fistula
- Infection examples:**
  - Post-surgical infection
  - Deep space infection requiring additional treatment
  - Sinusitis due to unintended sinus manipulation
  - Medication induced candidiasis
- Nerve Injury examples:**
  - Mandibular nerve injury

**Figure 172: Adverse Events Screen**

**Note:** The **Add** button from the **Select Category and Provide Details** section will temporary save each adverse event that may be entered this session. The name on the button will change to **Save Changes** when a filed adverse event is selected from the **History** table and edited by the provider. After all the adverse events have been added/edited/deleted during this session select the **Done** button to save all adverse events as unfiled data.

**Note:** There is one trigger, completed procedure (D9930), which will automatically open the **Adverse Events** screen when selected this session. The trigger occurs when the provider selects the **Next** button, which will automatically open the **Adverse Events** screen. The completed procedure D9930 is only suggested to include an adverse event associated with the procedure however NOT required for an adverse event to be entered and filed. Selecting the **Cancel** button will allow the provider to complete the encounter without adding an adverse event.

## To edit a filed Active adverse event:

1. Highlight the filed **Active** adverse event entry from the **History** table
2. May edit or add to the **Provider Details** in the upper text window
3. Or may change the **Status** radio button (to **Resolved**)
4. Select the **Save Changes** button to temporary save the edited adverse event
5. Select the **OK** button on the informational **Adverse event edited** screen
6. When all adverse events have been added select the **Done** button to save the unfiled data
7. Filing an encounter is required when editing any adverse event during this session

**Figure 173: Adverse Events Screen**

**Note:** Only a filed **Active** adverse event may be edited. When trying to edit a filed **Resolved** adverse event the provider will get a screen informing them they can NOT edit any item that is not **Active**.

The **Display Resolved** check box is defaulted as checked when opening the **Adverse Events** screen. The provider may uncheck the **Display Resolved** check box if the provider doesn't want the **History** table to display any resolved adverse events. The provider may select the **Display Deleted** check box to see if there are any deleted adverse events filed for the patient's chart. Any newly entered resolved and deleted adverse event will be required to be filed with an encounter before that adverse event will be permanently viewable with either of these check boxes.

## To delete a filed adverse event:

1. Highlight the adverse event in the **History** table
2. Select the **Delete** button to temporary save the deleted adverse event
3. Select the **OK** button on the informational **Adverse event deleted** screen
4. When all adverse events have been entered select the **Done** button to save the unfiled data
5. Filing an encounter is required when deleting an adverse event this session

The **Delete** button selection for any filed adverse event may only be completed by a full DRM Plus Administrator. The deleted adverse event requires an encounter to be filed to complete the process. When selecting the **Delete** button as a non-admin provider the following screen will display.



**Figure 174: Not DRM Plus Administrator Informational Screen**

**Note:** All deleted adverse events will display as a line through the entry in the **History** table when selected by any DRM Plus provider that would want to view them.

When the **Cancel** button is selected before the **Done** button while the **Adverse Events** screen is open then the add/edit/delete entries will NOT be saved. The **Cancel** button will undo any action taken with any new entries by the provider when adding a new adverse event, modifying a filed adverse event, or deleting a filed adverse event. All recent adverse event data entered while the **Adverse Events** screen was open will be lost and will need to be re-entered again if the **Cancel** button is selected.

**Note:** When the **Done** button has been selected and any saved adverse events were entered in error during this session follow one of the methods that follow to remove them. The only way to remove the adverse event this session would be by selecting the **Delete** button from the **Adverse Events** screen and then the **Done** button or refresh the patient's chart and don't save the unfiled data that has been entered up to this time.

Each header on the **History** table is selectable for sequence reorder of the data listing in each column. When the header is selected, a horizontal bar triangle displays and informs the provider the directional order of data in that header column. In the next dialog the **Visit** column selected would display the oldest visit at the top with the more recent visits following in sequence.

History					
Visit	Provider	Category	Status	Details	
MAR 17, 20...	DRMPROVIDER_ADM...	Hard Tissue Damage	Active	Bone/mandible fr...	
MAR 17, 20...	DRMPROVIDER_ADM...	Allergy/Toxicity/For...	Resolved	Nitrous oxide toxi...	

**Figure 175: History Section on Adverse Events Screen**

The **Examples** button will open and close the right half of the screen labeled **Categories with Examples** in the header. This blue view-only window allows the provider to view common examples associated with each category that is listed as an adverse event. The common examples in the blue window that may be viewed are NOT an exclusive list.

The next dialog does NOT display the blue **Categories and Examples** view-only window because the **Examples** button was selected. Select the **Examples** button again and the blue view-only window will display.

Visit	Provider	Category	Status	Details
MAR 17, 20...	DRMPROVIDER.ADM...	Hard Tissue Damage	Active	Bone/mandible fr...
MAR 17, 20...	DRMPROVIDER.ADM...	Allergy/Toxicity/For...	Resolved	Nitrous oxide toxi...

Figure 176: Adverse Events Screen without Categories and Examples

## Device Tracking Button

The **Device Tracking** (DT) button in the banner when selected will launch a screen allowing device tracking identifiers to be entered and then filed with an encounter for this patient's chart.

<b>DRMPATIENT,ONE</b> 000-00-0001 01/01/1960 Age: 57	<b>Visit Not Selected</b> DRMPROVIDER.ADMIDENTIST	PDP: SDP:	Dental Class OPC, Class IV
---	--	--------------	-------------------------------

Figure 177: Device Tracking Button on DRM Plus Banner





- Selecting the **Display All Findings** check box displays all the unfiled/ filed diagnostic finding transaction(s) for the patient's chart.
- Selecting the **Display All Completed Care** check box displays all the unfiled/ filed completed care transaction(s) for the patient's chart.
- Selecting the **Display All "No Transactions"** check box, inactive until the first no transaction device has been added and filed, displays all the filed **No Transactions** for the patient's chart.
- Any combination of one or three check boxes selected would result in the **Transactions** table displaying the accumulation of transactions/non-transactions from the check boxes that were selected.

### To add completed procedure device identifiers:

1. Enter one of the 26 trigger completed procedures from the **Treatment & Exam** screen this session
2. Select the **DT** button from the banner or select the **Next** button when completing the encounter
3. Highlight the completed procedure transaction in the **Transactions** table to add device identifiers
4. Required to enter at least one device identifier with this completed procedure transaction
5. Select the **Save Entry** button to save the new device identifiers to the completed procedure transaction
6. Select the **OK** button on the informational **Device identifiers saved** screen
7. Select the **Done** button to save all the device identifier(s) during this session
8. Filing an encounter is required when adding device identifier(s) this session

The screenshot shows the 'Device Tracking' window with a 'Transactions' table and a 'Device Identifiers' form.

**Transactions Table:**

Date	Code	Description	Tooth	Surf
3/22/2017	D6010	ENDOSTEAL IMPLANT BODY PLACE	6	

Below the table are three checkboxes: ☐ Display All Findings, ☐ Display All Completed Care, and ☐ Display All "No Transactions".

**Device Identifiers Form:**

UDI: (01)00889024020016(17)201031(10)63192162

Type: Prosthetic Devices

Subtype: Endosseous dental implant

Manufacturer: ZIMMER DENTAL INC.

Reference: TSVTWB13

Lot: 63192162

Serial Number:

Details: Tapered Screw-Vent®  
Ø4.7mm x 13mm, Ø4.5mm

Buttons: Add, Save Entry, Delete Entry, Done, Cancel.

**Device Instructions and Examples:**

Highlight the transaction that placed the device. Enter the Unique Device Identifiers (UDI) and click the lookup to fill in the details. Then click Save Entry.

The easiest way of recording the UDI is to scan it from the barcode labeled on the packaging. There are several types of barcodes. The DataMatrix (similar to the QRcode) has become more popular recently.

There are 3 issuing agencies for UDI. GS1, HIBCC, and ICCBBA. Sometimes the UDI barcode will be labeled with one of those identifiers.

Lookup values are returned from the U. S. National Library of Medicine. Retrieval may require several lookup attempts depending on network traffic.

If there is not a successful response, check to see that the correct barcode/UDI is being scanned or entered. If these are correct, then it is possible the information is not available from the National Library of Medicine and the information will need to be entered manually.

UDI - unique device identification  
DI - device identifier fixed portion of UDI  
PI - production identifier lot, serial, expiration, manufacturer  
UDI = DI + PI  
example:  
(01)00614141999996(17)100101(10)123ABC(21)1234567890  
DI = (01)00614141999996  
PI = (17)100101(10)123ABC(21)1234567890


FDA website on UDI Basics.

Figure 179: Device Tracking Screen with Completed Transaction Entry



Any unfiled/filed Diagnostic Finding transaction or any other unfiled/filed completed procedure transaction, which is NOT one of the 26 trigger completed procedures, may have device identifier(s) added and filed following the steps listed previously. Use the two check boxes at the bottom of the **Transactions** table; **Display All Findings** and **Display All Completed Care** to display the transactions to be associated with new **Device Identifiers**.

The easiest way for recording the **UDI** (unique device identification) is to scan it using the barcode labeled on the packaging. There are several types of barcodes. The DataMatrix (similar to the QRcode) has become more popular recently. There are three issuing agencies for **UDI** details; GSI, HIBCC, and ICCBBA. Sometimes the **UDI** barcode will be labeled with one of those identifiers.

The **UDI** icon  at the end of the **UDI** field in the **Device Identifiers** window allows importing of a few or many **Device Identifiers**. After the UDI has been entered, the provider may select the **Enter** key or select the **UDI** icon to import the field values found in the **UDI**. The imported field values come from the U.S. National Library of Medicine. The retrieval may require several import attempts depending on the network traffic.

**Note:** The drop-down field lists of (**Types:**) and (**Sub-Types:**) in the **Device Identifiers** section is information obtained from the FDA.

When the **Cancel** button is selected before the **Done** button while the **Device Tracking** screen is open then the add/edit/delete entries will NOT be saved. The **Cancel** button will undo any action taken with any new entries from the provider when adding new device identifiers, modifying filed device identifiers, or deleting filed device identifiers. Any recent device identifier data entered this session will be entirely lost and will need to be re-entered again.

Under certain circumstances there may be a reason why device identifiers should NOT be filed with a dental transaction. The **No Transaction** section, right below the **Transactions** section, which includes the **Add** button on the **Device Tracking** screen will allow the following.

### **To add non-transaction device identifiers:**

1. Select the **DT** button in the banner
2. Select the **Add** button from the **No Transaction** section
3. Data may be entered into **Date**, **Description** or **Tooth** fields
4. **Description** field is the only required data needed for entry
5. Required to enter at least one device identifier with the non-transaction entry
6. Select the **Save Entry** button to save the new device identifiers to the non-transaction entry
7. Select the **OK** button on the informational **Device identifiers saved** screen
8. Select the **Done** button to save all the device identifier(s) during this session
9. Filing an encounter is required when adding device identifier(s) this session

When adding a new **No Transaction** entry after selecting the **Add** button; the button will become a **Cancel** button. Selecting the **Cancel** button will NOT save any data entered into **No Transaction** fields or device identifier fields. Any **No Transaction** field data and device identifier data will need to be re-entered.

The next **Device Tracking** screen will display the **No Transaction** filed in the **Display All “No Transactions”** view screen. Highlighting the non-transaction entry displays the device identifiers filed with the non-transaction entry.

The **Transactions** table displays a green (check-mark) icon in the first column, which identifies the non-transaction entry having saved unfiled **Device Identifiers**.

The screenshot shows the 'Device Tracking' window. The 'Transactions' table has a green checkmark icon in the first column for the entry dated 03/22/2017, with the description 'Bone graft material on mandibular' and tooth number 30. Below the table are filters for 'Display All Findings', 'Display All Completed Care', and 'Display All "No Transactions"' (which is checked). A 'No Transaction' section allows adding a new entry with a date, description, and tooth number. The 'Device Identifiers' section includes fields for UDI, Type, Subtype, Manufacturer, Reference, Lot, and Serial Number, along with a 'Details' field and a 'Removed' checkbox. A 'Device Instructions and Examples' panel on the right provides guidance on UDI recording and lookup. At the bottom are 'Done' and 'Cancel' buttons, and a link to the 'FDA website on UDI Basics'.

Icon	Date	Code	Description	Tooth	Surf
✓	03/22/2017		Bone graft material on mandibular	30	

☐ Display All Findings   
 ☐ Display All Completed Care   
 ☒ Display All "No Transactions"

No Transaction   
 Date: 03/22/2017   
 Description: Bone graft material on mandibular   
 Tooth: 30

Add   
 UDI:   
 Type: Prosthetic Devices   
 Subtype: Bone grafting material   
 Manufacturer:   
 Reference:   
 Lot:   
 Serial Number:   
 Details: Bone graft material on mandibular around the tooth #30 region by fee dentist.   
 Deleted Entry   
 Save Entry   
 Removed

Done   
 Cancel   
[FDA website on UDI Basics.](#)

**Device Instructions and Examples**  
 Highlight the transaction that placed the device. Enter the Unique Device Identifiers (UDI) and click the lookup to fill in the details. Then click Save Entry.  
 The easiest way of recording the UDI is to scan it from the barcode labeled on the packaging. There are several types of barcodes. The DataMatrix (similar to the QRcode) has become more popular recently.  
 There are 3 issuing agencies for UDI. GS1, HIBCC, and ICCBBA. Sometimes the UDI barcode will be labeled with one of those identifiers.  
 Lookup values are returned from the U. S. National Library of Medicine. Retrieval may require several lookup attempts depending on network traffic.  
 If there is not a successful response, check to see that the correct barcode/UDI is being scanned or entered. If these are correct, then it is possible the information is not available from the National Library of Medicine and the information will need to be entered manually.  
 UDI - unique device identification  
 DI - device identifier    fixed portion of UDI  
 PI - production identifier    lot, serial, expiration, manufacturer  
 UDI = DI + PI  
 example:  
 (01)00614141999996(17)100101(10)123ABC(21)1234567890  
 DI = (01)00614141999996  
 PI = (17)100101(10)123ABC(21)1234567890

**Figure 180: Device Tracking Screen with No Transaction Entry**


**Note:** The only way to delete any filed **No Transaction** entry has to be done in the **Device Tracking** screen. The **No Transaction** may have been filed by mistake on a patient's chart or filed to the wrong patient's chart. Deleting the encounter on the wrong patient's record will NOT delete the **No Transaction** entry if one was filed with that encounter.

The following explains the meaning of the icons found in the **Device Tracking** screen. The first column icons from any of the multiple Transactions views may be displayed as either a green ✓ icon, red ➡ icon or a blue i icon.




The green ✓ icon represents unfiled/filed device identifier(s) filed with a transaction or non-transaction found in all four views. The green ✓ icon also may represent a filed transaction or non-transaction as a **Removed** device tracking entry.









The red ➡ icon represents any of the 26 trigger completed procedures having NO device identifier(s) filed with the completed procedure transaction. The red ➡ icon will only be displayed in the default view or when the **Display All Completed Care** check mark has been selected.

The blue i icon represents all other unfiled/filed completed procedures or diagnostic findings. These completed procedures/findings are left up to the provider if they would prefer to file a device identifier(s) with the transaction. These completed procedure/finding transactions are NOT identified for any device tracking entry by the VHA Office of Dentistry.

**Note:** The red  icon will display for any of the 26 unfilled/trigger completed procedures identified by the VHA Office of Dentistry. When one of the 26 trigger completed procedures is entered during the current session it will force the provider to the Device Tracking screen when the provider selects the **Next** button when trying to complete the encounter. Then it will be up to the provider to decide if they want to save any device identifiers to the unfilled completed transaction or NOT. The **Cancel** button on the Device Tracking screen may be selected to complete the encounter by NOT entering any device identifiers to the trigger completed procedure. The **DT** icon button in the banner will also display as a yellow icon informing the provider at least one trigger completed procedure having no device identifiers associated with it is in the **Device Tracking** screen.

**Note:** The 26 unfilled/trigger completed procedures identified by the VHA Office of Dentistry are suggested to have device identifiers associated with them however they are NOT required to have device identifiers.

Each header at the top of the **Transactions** table is selectable for sequence order of data listed in that column. When the header is selected, a horizontal bar triangle displays and informs the provider the directional order of data in that header column. In the next dialog the **Icon** column, first column, selected displays the red  icon, green  icon and then blue  icon from top to bottom.

Transactions						
	Date	Code	Description	Tooth	Surf	
	3/22/2017	D3428	BONE GRAFT W/PRAD SURG-FIRST	3		
	3/22/2017	D6010	ENDOSTEAL IMPLANT BODY PLACE	6		
	3/22/2017	D1110	DENTAL PROPHYLAXIS ADULT			
	3/22/2017		Missing	16		
	3/22/2017		Missing	11		
	3/22/2017		Missing	6		
	3/22/2017		Missing	1		
	3/17/2017	D0210	INTRAORAL FULL IMAGE SERIES			

**Figure 181: Transaction Section on Device Tracking Screen**

Here is how to **Remove** filed device identifiers for a transaction or non-transaction. The provider will be required to highlight the filed completed procedure transaction, the filed diagnostic findings transaction, or the filed non-transaction to label the device identifiers as removed.

### To remove filed device identifiers for a transaction or non-transaction:

1. Find the filed transaction or non-transaction that should be marked as **Removed**
2. Highlight the filed transaction or non-transaction listed on the **Transactions** table
3. Select the **Removed** check box in lower left corner of the **Device Tracking** screen
4. Select the **Save Entry** button to save the transaction or non-transaction marked as **Removed**
5. Select the **OK** button on the informational **Device identifiers edited** screen
6. Select the **Done** button to save all the **Device Tracking** entries during this session
7. Filing an encounter is required when removal of a device tracking entry this session

Here is how to delete device identifiers that were filed to a transaction or non-transaction. The provider will be required to highlight the filed completed procedure transaction, the filed diagnostic findings transaction, or the filed non-transaction that should be deleted.

### To delete the filed device identifiers for a transaction or non-transaction:

1. Find the filed transaction or non-transaction where the device identifiers should be deleted
2. Highlight the filed transaction or non-transaction listed on the **Transactions** table
3. Select the **Delete Entry** button to save the deleted device identifiers for transaction or non-transaction
4. Select the **OK** button on the informational **Device identifiers deleted** screen
5. Select the **Done** button to save all the **Device Tracking** entries during this session
6. Filing an encounter is required when deleting device identifiers this session

Only a full DRM Plus Administrator is able to delete device identifiers filed to a transaction or non-transaction. When selecting the **Delete** button as a non-admin provider the following informational screen will display.

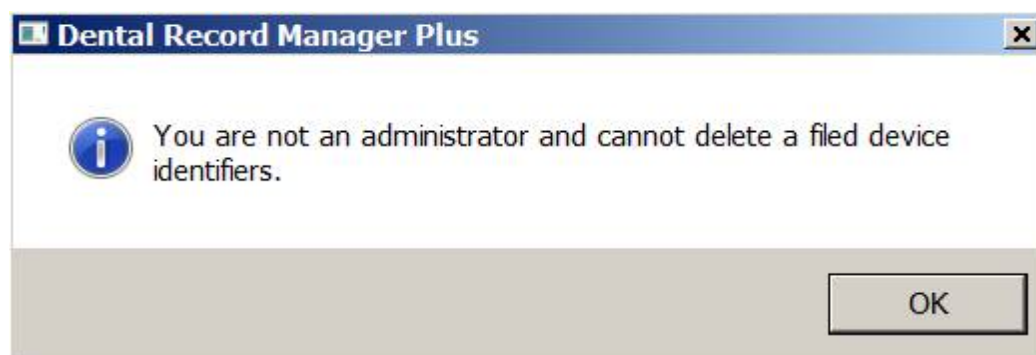


Figure 182: Not DRM Plus Administrator Informational Screen

The **Examples** button will display and hid the right half of the screen labeled **Device Instructions and Examples** as the header. This blue view-only window allows the provider to view device instructions and examples of the **UDI** (unique device identification) information.

The next **Device Tracking** screen doesn't display the blue **Device Instructions and Examples** view-only window because the **Examples** button was selected. Select the **Examples** button again and the blue view-only window will display.

**Figure 183: Device Tracking Screen without Device Instructions and Examples**

**Note:** The [FDA website on UDI Basics](#) address found on the bottom of the **Device Instructions and Examples** view-only window will launch the U.S. FOOD & DRUG ADMINISTRATION website that will explain the UDI, unique device identifier, in greater detail.

**Note:** If there is not a successful response, check to see that the correct barcode/UDI is being scanned or entered. If these are correct, then it is possible the information is not available from the National Library of Medicine and the information will need to be entered manually.

## **Dental Class Information**

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

**Figure 184: Dental Class Button**

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

## Clean Slate

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



Figure 185: Clean Slate Banner Notification

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


## Icons

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



Figure 186: DRM Plus Banner Icons

## General Coding Standards


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

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

## Patient Flags

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

### Clinical Reminders

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




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




Figure 187: 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 on the CPRS cover sheet. If clinical reminder(s) displaying in the list cannot be resolved by the end-user, contact local IT for assistance.

## Consult

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

## Exam Quality Indicator

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

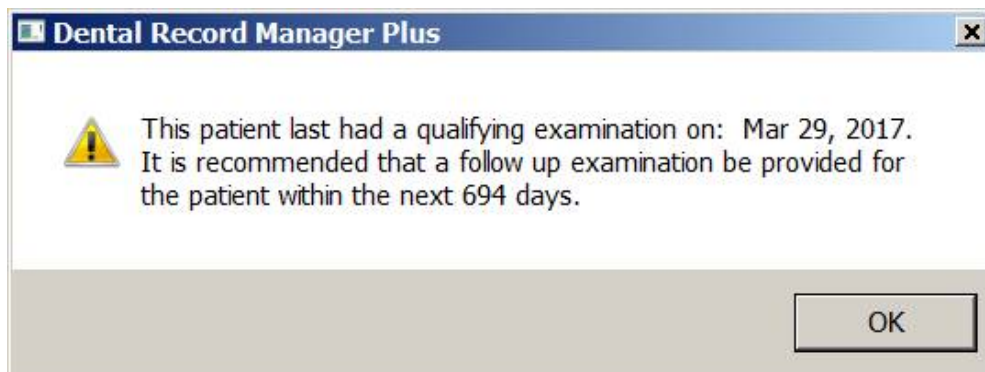



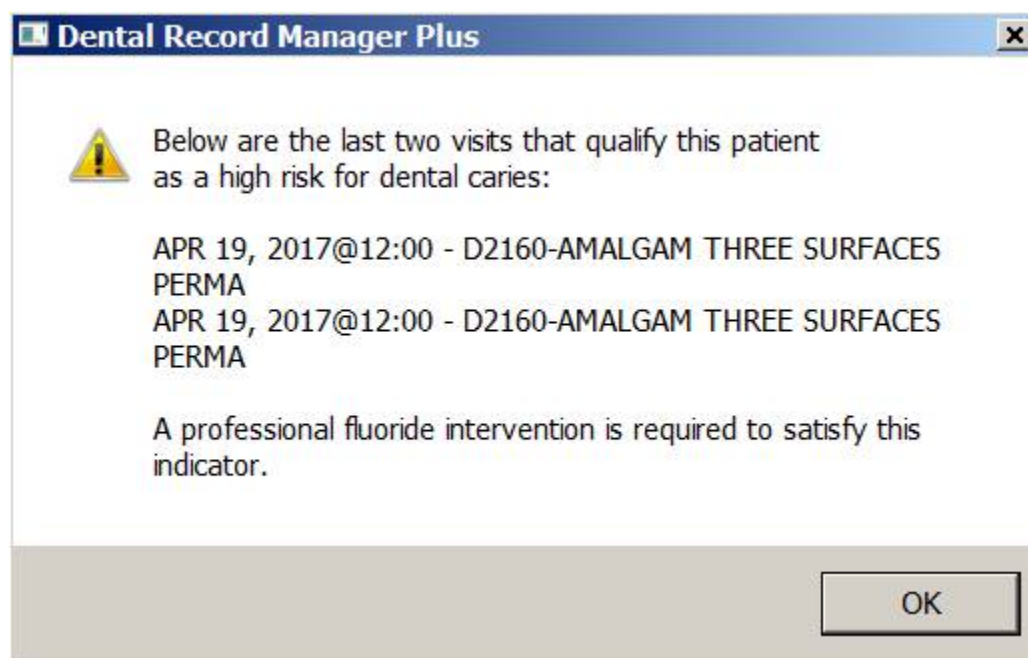
Figure 188: Exam Quality Indicator Screen

Click the **OK** button and the informational screen will close. For more information, see the Cover Page chapter of this manual.

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

## Fluoride Quality Indicator

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




**Figure 189: Fluoride Quality Indicator Screen**

Click the **OK** button and the informational screen will close. After the patient's chart has been loaded and the **Fluoride Quality Indicator** icon is selected the DRM Plus **Cover Page** tab display after clicking the **OK** button. For more information, see the Cover Page chapter of this manual.

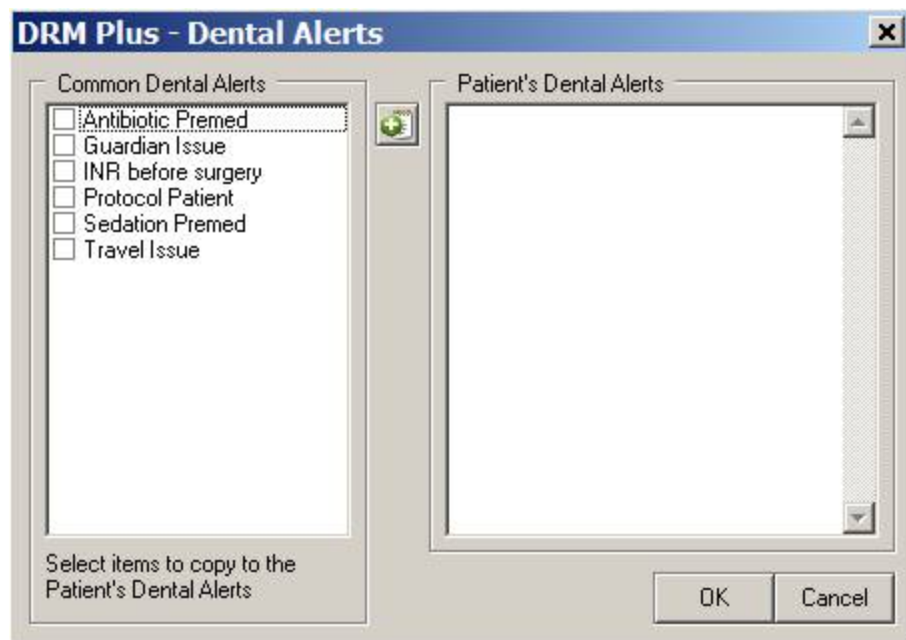
**Note:** The **Exam Quality Indicator** and **Fluoride Quality Indicator** only are active for VA dental care under **Class I, IIA, IIC** or **IV** classification. These dental classes are eligible for any necessary dental care to maintain or restore oral health and masticatory function, including repeat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

## Alerts

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


To add an alert:

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



**Figure 190: Dental Alerts Screen**

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

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

To view the alerts:

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



**Figure 191: Dental Alerts Screen without Common Dental Alerts**

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

# Cover Page

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

**Dental Record Manager Plus in use by: DRMPROVIDER,ADMINISTRATOR for DRMPATIENT,ONE**

File Edit Dental Encounter Data Treatment & Exam Tools Reports Help

DRMPATIENT,ONE 000-00-0001 01/01/1960 Age: 57 Visit Not Selected DRMPROVIDER,ADMINISTRATOR FOP: DRMPROVIDER,ADMINISTRATOR SDP: Dental Class OPC, Class IV

Cover Page Clinical Record Dental History Chart/Treatment Exam

**Dental Eligibility**  
 Dental Class: 15-OPC, Class IV  
 Service Connected Teeth/Service Trauma:  
 Adjunctive Medical Condition(s): Add/Edit AMC  
 Eligibility Expiration Date: Anticipated Rehab Date: Save

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

**Case Management**  
 Status: Active  
 Suggested Recare Date: Save

**Recent Dental Activity**  
 Last Qualifying Exam:  
 Last Comprehensive Exam:  
 Last Brief Exam: Apr 28, 2017  
 Last Periodontal Exam:  
 Last Panorax Image: Apr 28, 2017  
 Last Full Mouth Image: Mar 17, 2017  
 Last Bitewing Image:  
 Last CBCT Image:  
 Last Prophylaxis:  
 Last Visit: Apr 28, 2017  
 Last Provider: DRMPROVIDER,ADMINISTRATOR

**Fluoride Indicator Prescription Date**  
 Save

**Dental Alerts**  
 Antibiotic Premed

**Notes**  
 Save

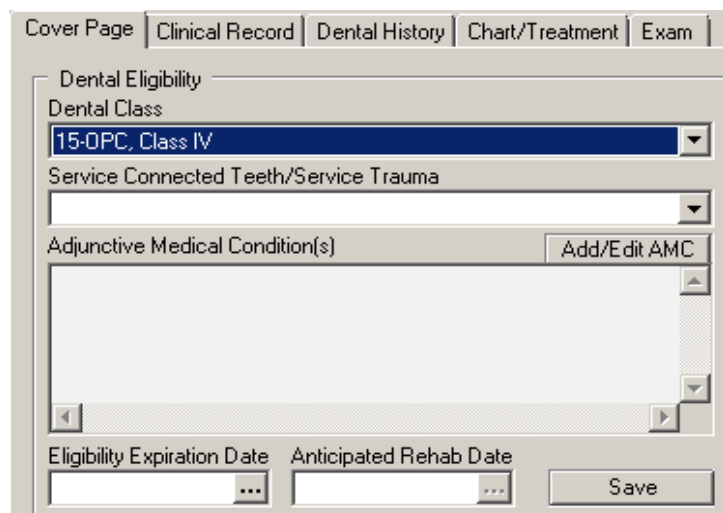
**Filed Planned Care**  
 Save

127.0.0.1

**Figure 192: Cover Page Tab Screen**

## Dental Eligibility

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



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

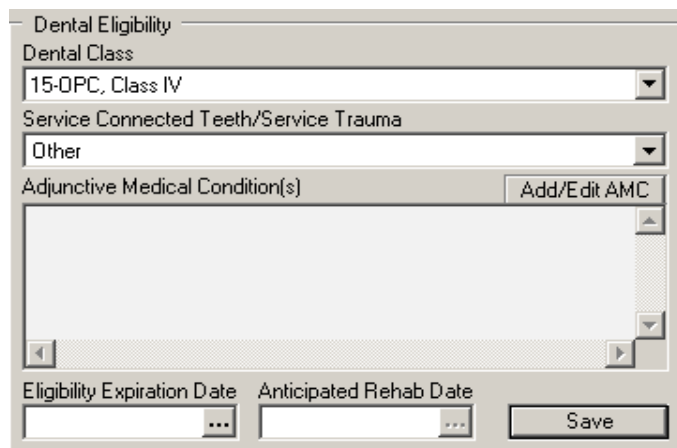
Figure 193: Dental Eligibility Section

### 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 saved/filed with the patient's chart.

### Service Connected Teeth/Service Trauma

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



This screenshot is similar to Figure 193, but the "Service Connected Teeth/Service Trauma" dropdown menu now shows "Other" selected. The "Dental Class" remains "15-OPC, Class IV". The "Adjunctive Medical Condition(s)" text area is empty. The date pickers and the "Save" button are also visible.

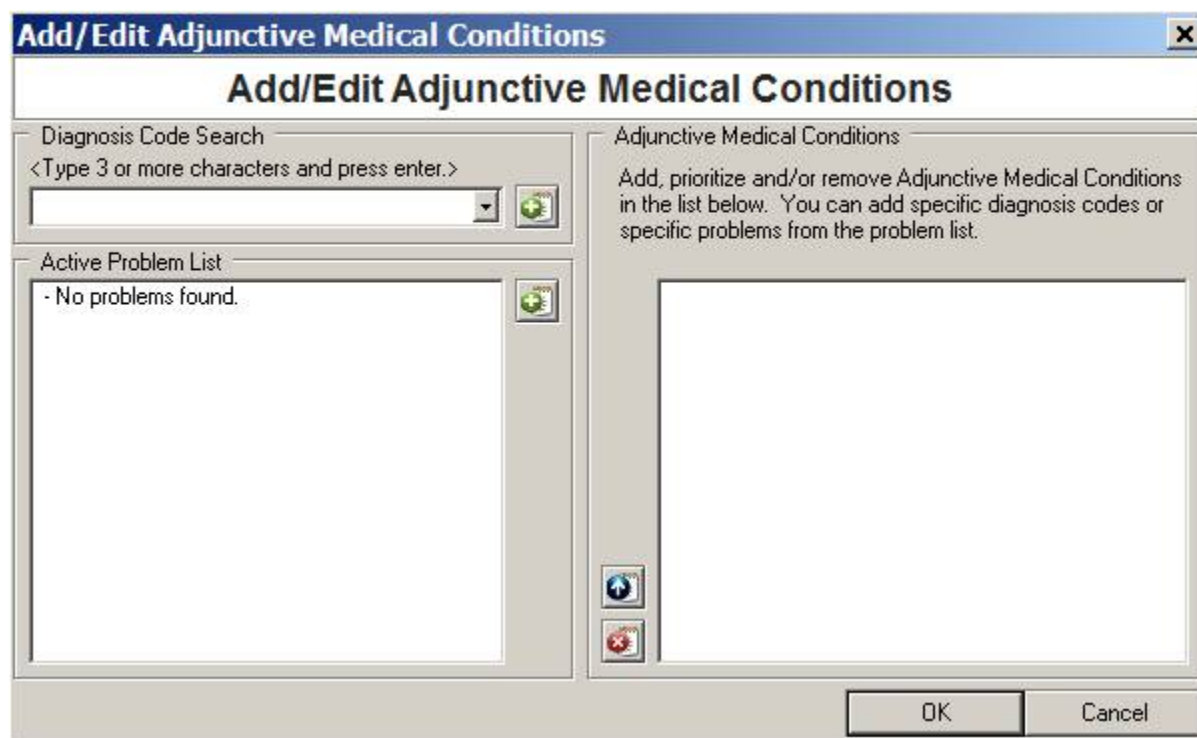
Figure 194: Service Connected Teeth/Service Trauma



## Adjunctive Medical Condition(s)

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

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



**Figure 195: Add/Edit Adjunctive Medical Conditions Screen**

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

**Note:** The **Diagnosis Code Search** field on the **Add/Edit Adjunctive Medical Conditions** screen only allows for CPT diagnosis code search and entry and NOT for SNOMED codes. Use the **Active Problem** section in CPRS to search for SNOMED codes if desired. SNOMED codes may be added to the **Active Problem** section in CPRS and then selectable in the **Add/Edit Adjunctive Medical Conditions** screen.

## Eligibility Expiration Date

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

To change the eligibility expiration date:

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



Figure 196: Select Date/Time Screen

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

## Anticipated Rehab Date

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

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

## Demographics

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

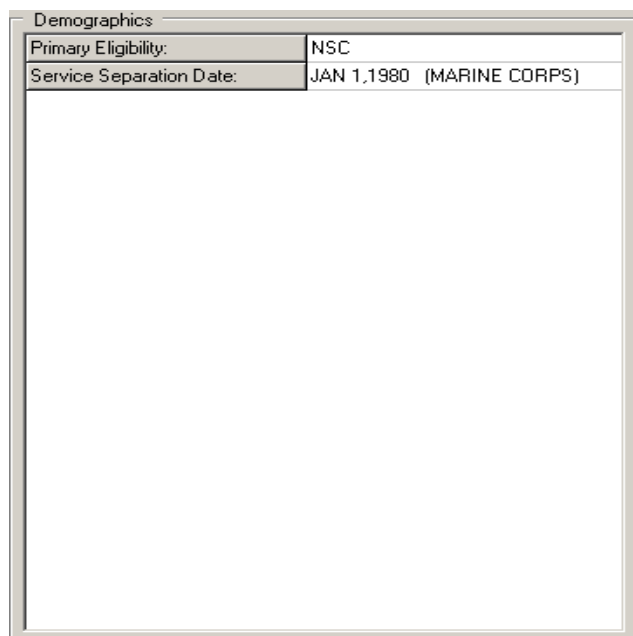


Figure 197: Demographics Section

## Case Management

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

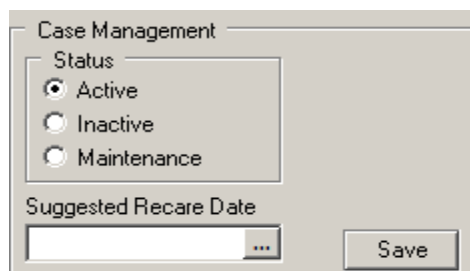


Figure 198: Case Management Section

### **Status**

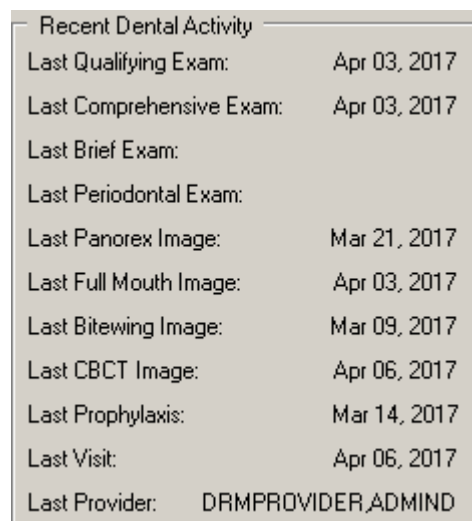
Change the **Status** of the patient by clicking the appropriate radio button.

### **Suggested Recare Date**

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

## **Recent Dental Activity**

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

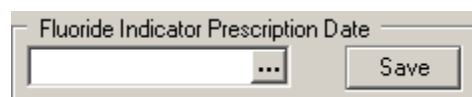


Recent Dental Activity	
Last Qualifying Exam:	Apr 03, 2017
Last Comprehensive Exam:	Apr 03, 2017
Last Brief Exam:	
Last Periodontal Exam:	
Last Panorex Image:	Mar 21, 2017
Last Full Mouth Image:	Apr 03, 2017
Last Bitewing Image:	Mar 09, 2017
Last CBCT Image:	Apr 06, 2017
Last Prophylaxis:	Mar 14, 2017
Last Visit:	Apr 06, 2017
Last Provider:	DRMPROVIDER,ADMIND

**Figure 199: Recent Dental Activity Section**

## **Fluoride Indicator Prescription Date**

Add a fluoride indicator prescription date here.



Fluoride Indicator Prescription Date

...

**Figure 200: Fluoride Indicator Prescription Date Section**

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

To delete the prescription date:

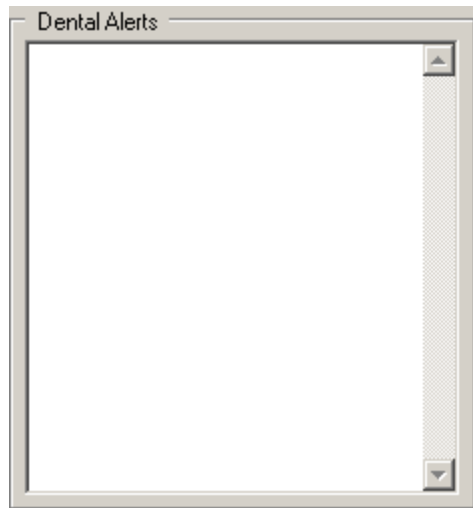
1. Click the date to place the cursor in the field.
2. Delete the date.
3. Click the **Save** button to file.

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

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

## **Dental Alerts**

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

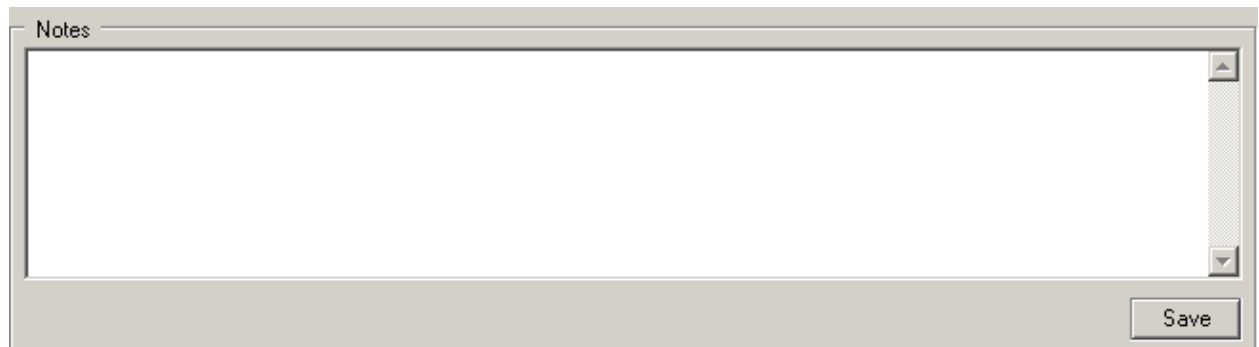


**Figure 201: Dental Alerts Section**

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

## **Notes**

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

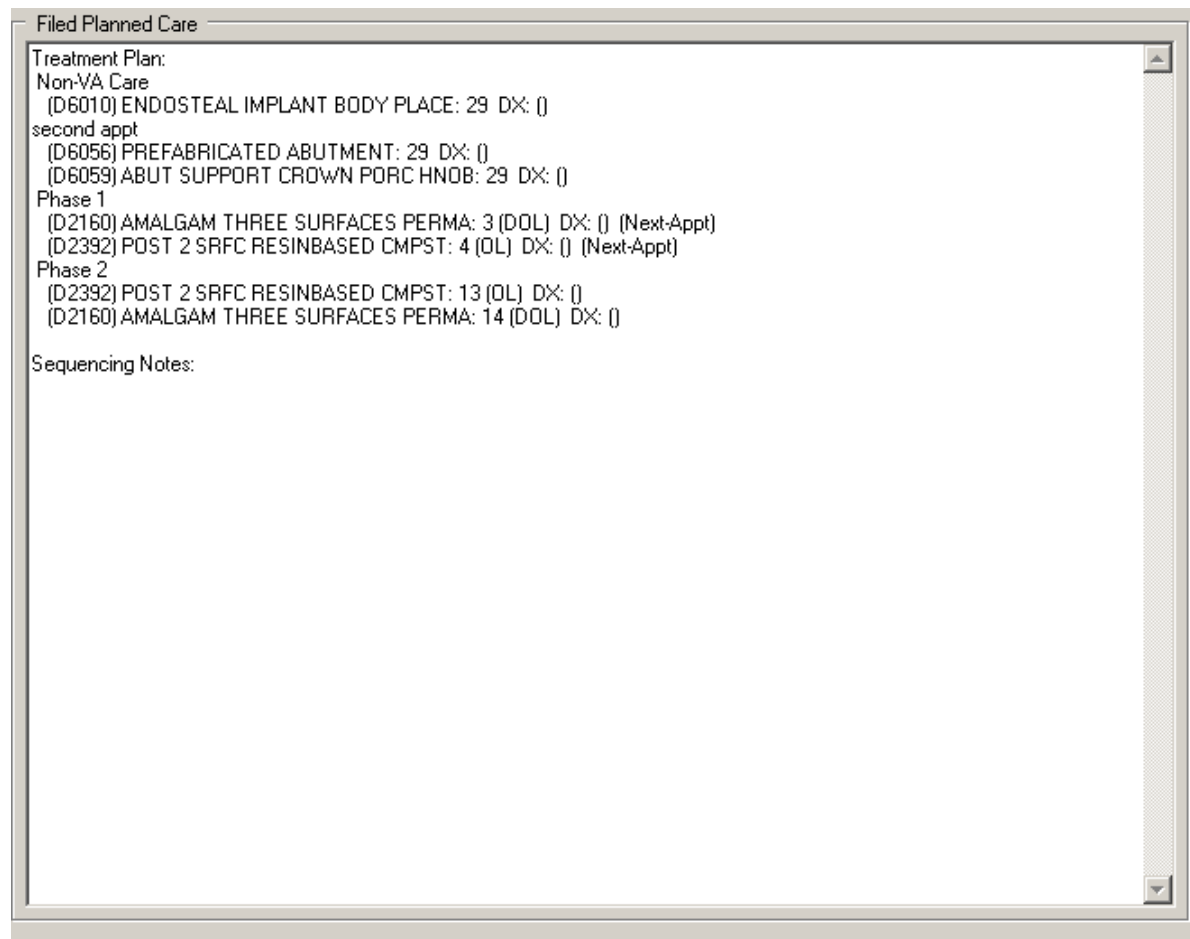


**Figure 202: Notes Section**

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

## **Filed Planned Care**

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



The screenshot shows a window titled "Filed Planned Care" with a scrollable text area containing the following information:

Treatment Plan:  
Non-VA Care  
(D6010) ENDOSTEAL IMPLANT BODY PLACE: 29 DX: ()  
second appt  
(D6056) PREFABRICATED ABUTMENT: 29 DX: ()  
(D6059) ABUT SUPPORT CROWN PORC HNOB: 29 DX: ()  
Phase 1  
(D2160) AMALGAM THREE SURFACES PERMA: 3 (DOL) DX: () (Next-Appt)  
(D2392) POST 2 SRFC RESINBASED CMPST: 4 (OL) DX: () (Next-Appt)  
Phase 2  
(D2392) POST 2 SRFC RESINBASED CMPST: 13 (OL) DX: ()  
(D2160) AMALGAM THREE SURFACES PERMA: 14 (DOL) DX: ()  
Sequencing Notes:

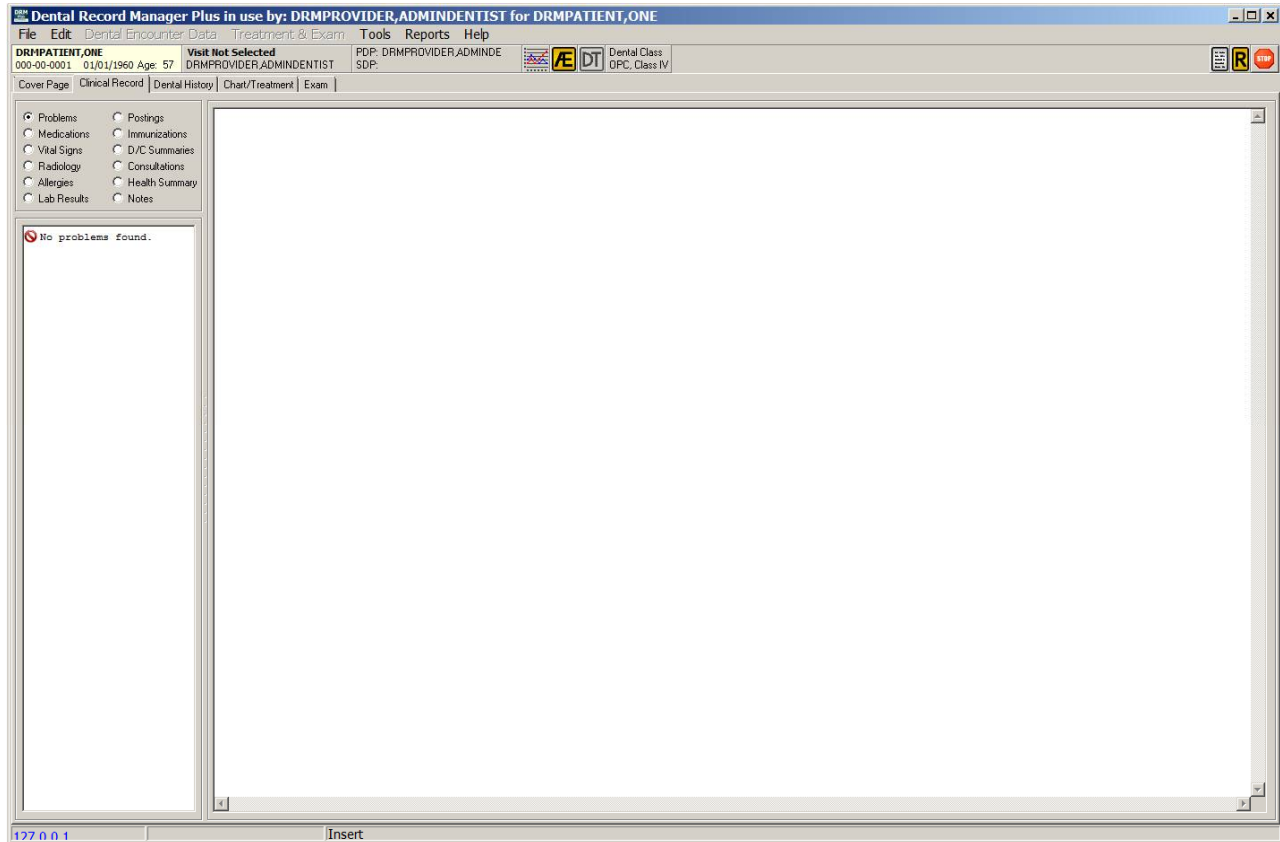
**Figure 203: Filed Planned Care**

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



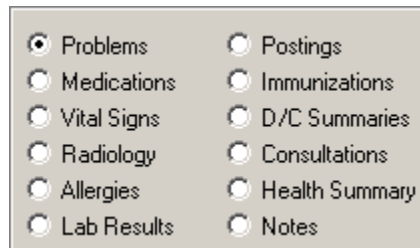
# Clinical Record

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



**Figure 204: Clinical Record Tab**

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



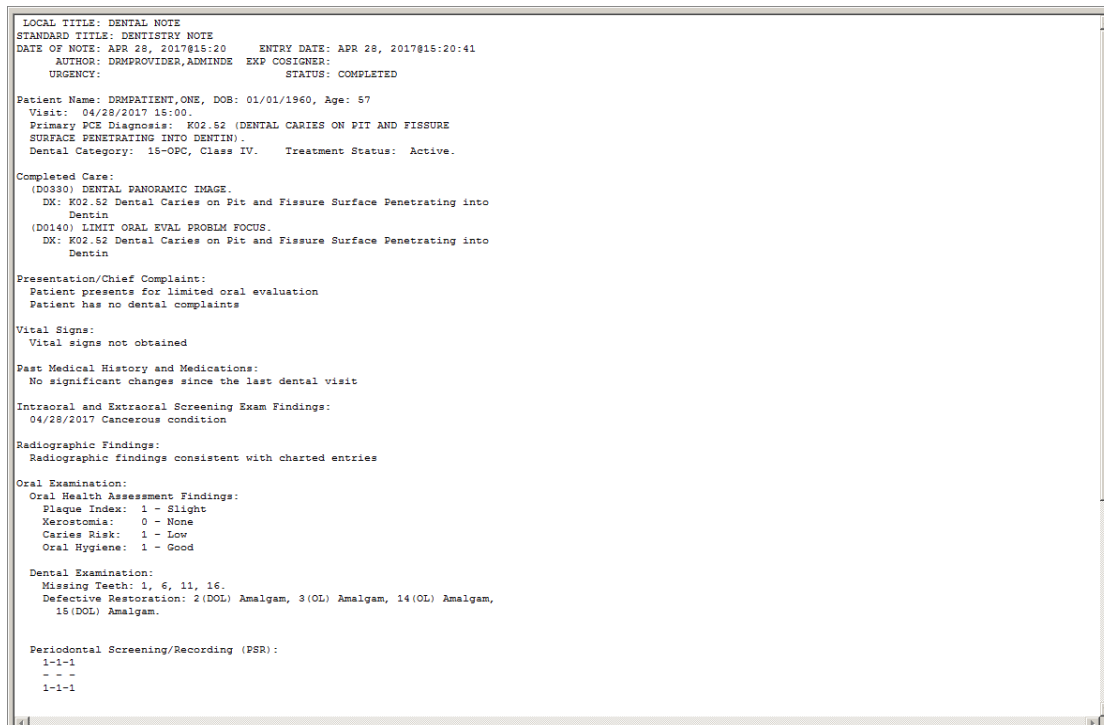
**Figure 205: Clinical Record Radio Buttons**

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



**Figure 206: Clinical Record Selection Window**

3. Select/highlight a TIU note entry. Details of the TIU note display on the right side of the screen.



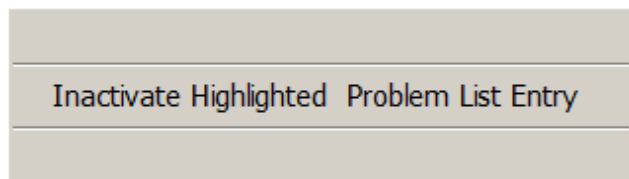
**Figure 207: Clinical Record TIU Note Window**

## Problems

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

To inactivate a problem:

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



**Figure 208: Inactivate Highlighted Problem List Entry Button**

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

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

## Consultations

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

To filter consultations by status, service or date range:

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



**Figure 209: Consultations Filter Menu**

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

## Notes

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

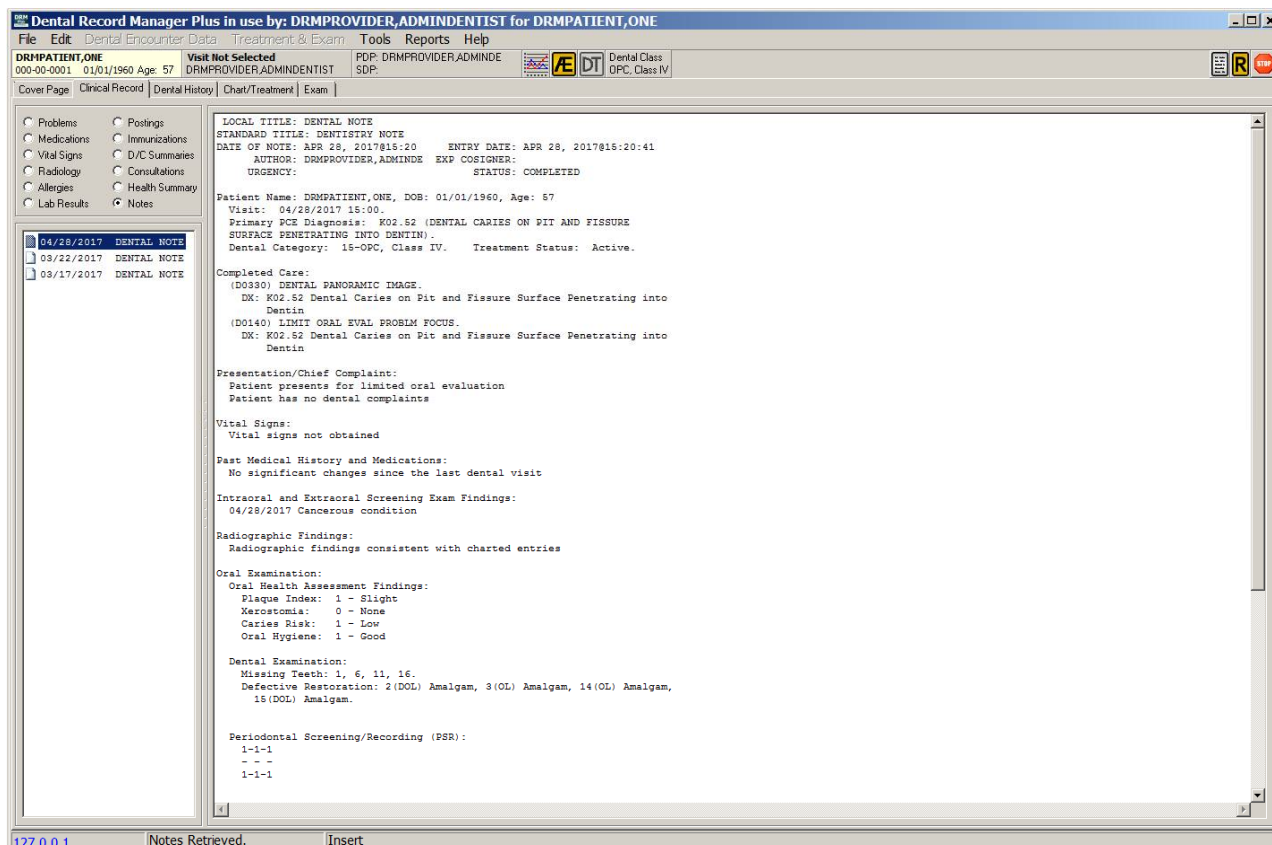


Figure 210: All TIU Completed Notes List

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

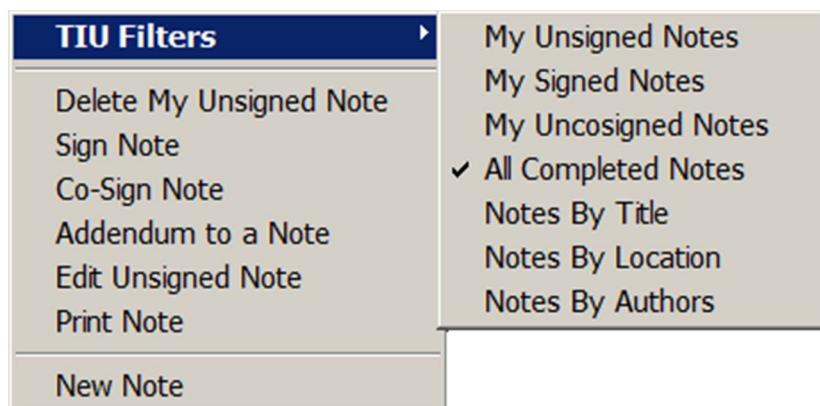
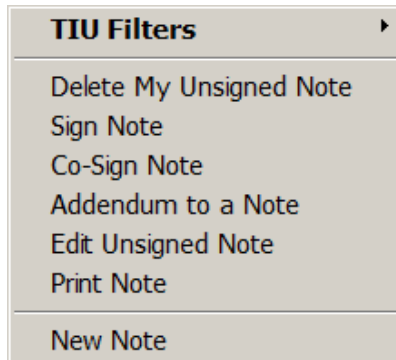


Figure 211: TIU Filters Submenus

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



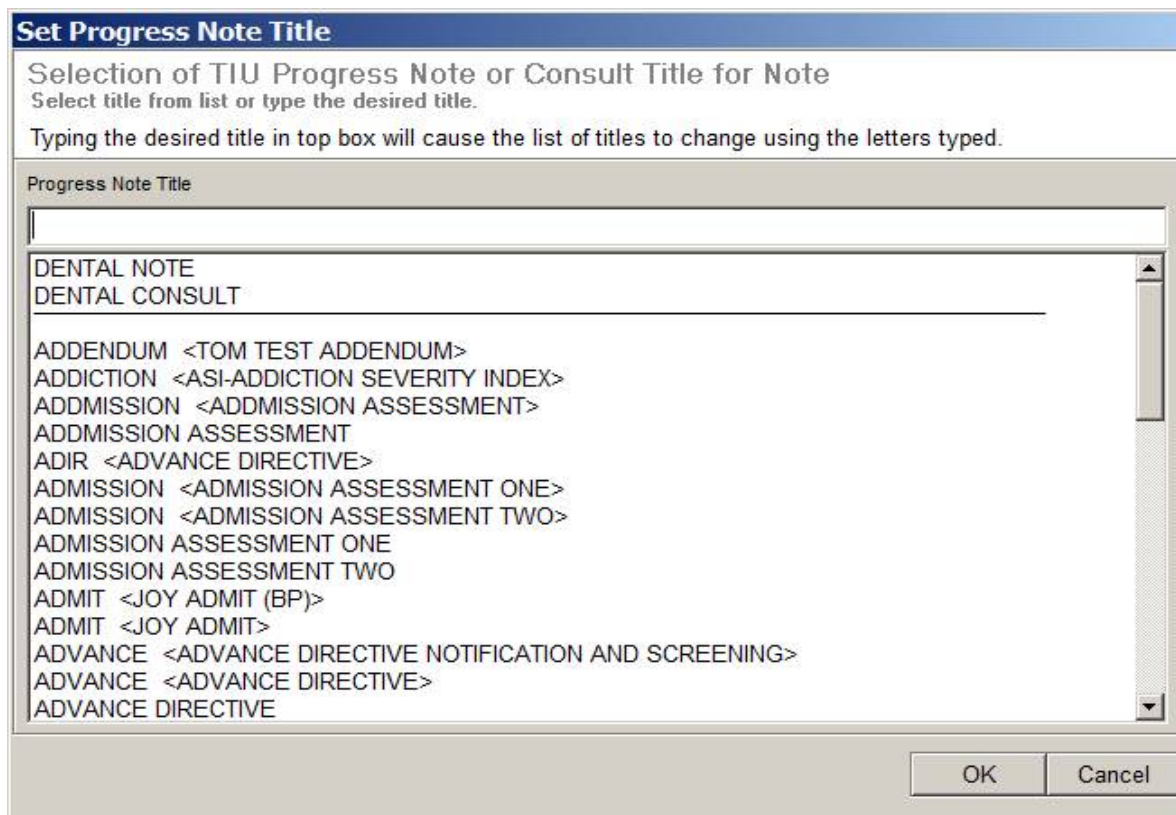
**Figure 212: Note Functions Menu**

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

## Adding a New TIU Progress Note

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

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



**Figure 213: Set Progress Note Title Screen**

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

Dental Record Manager Plus in use by: DRMPROVIDER,ADMINDENTIST for DRMPATIENT,ONE

File Edit Dental Encounter Data Treatment & Exam Tools Reports Help

DRMPATIENT,ONE 000-00-0001 01/01/1960 Age: 57 Visit Not Selected DRMPROVIDER,ADMINDENTIST PDP: DRMPROVIDER,ADMINDENTIST SDP: DRMPROVIDER,ADMINDENTIST Dental Class DPC, Class IV

Cover Page Clinical Record Dental History Chart/Treatment Exam

Problems Medications Vital Signs Radiology Allergies Lab Results Postings Immunizations D/C Summaries Consultations Health Summary Notes

Note Title: DENTAL NOTE Change Title

Create Historic Visit All Admissions (A) Visits (V)

Encounter/Visits: All

Note Date/Time: Thursday, May 04, 2017 8:57:56 AM

Change Author: DRMPROVIDER,ADMINDENTIST Change Location:

04/28/2017 DENTAL NOTE  
03/22/2017 DENTAL NOTE  
03/17/2017 DENTAL NOTE

Finish CNT Navigator

Electronic Signature Code

127.0.0.1 Insert

**Figure 214: New TIU Progress Note without Any Procedures**

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

**Note:** Historical notes may be entered using this option.

## Adding a New TIU Progress Note Addendum

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

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

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

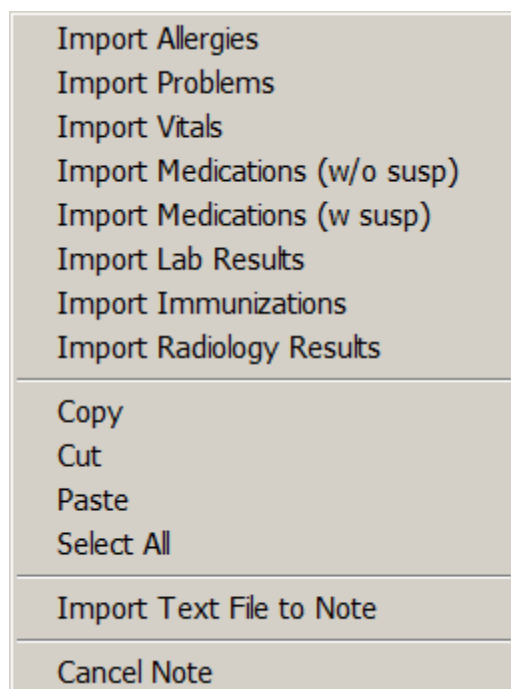


Figure 215: Import Menu Information Screen

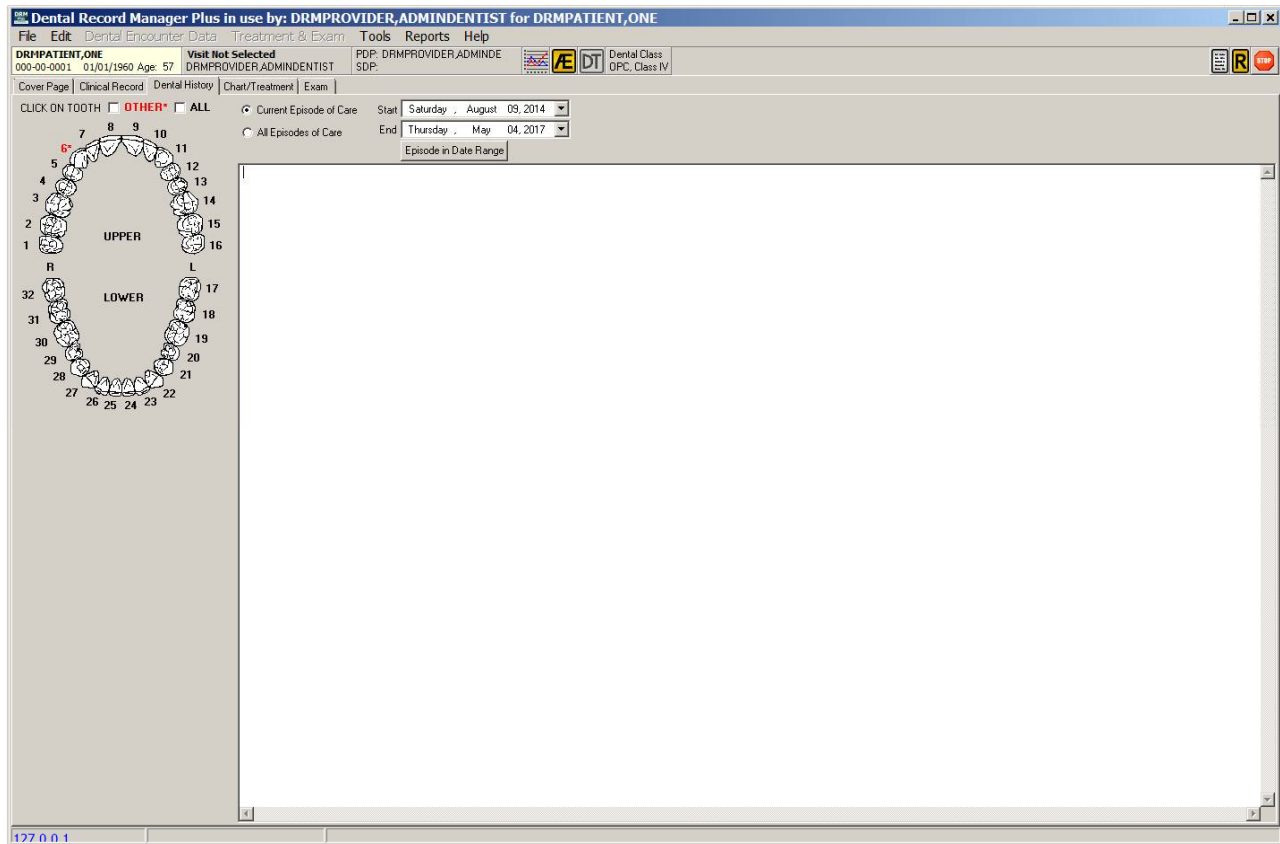
6. Enter the provider's **Electronic Signature** and click the **Finish** button to add the addendum.
7. A confirmation screen displays. Click the **OK** button.

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



# Dental History

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



**Figure 216: Dental History Tab**

## Viewing Dental Information by Tooth

To view dental information by tooth:

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

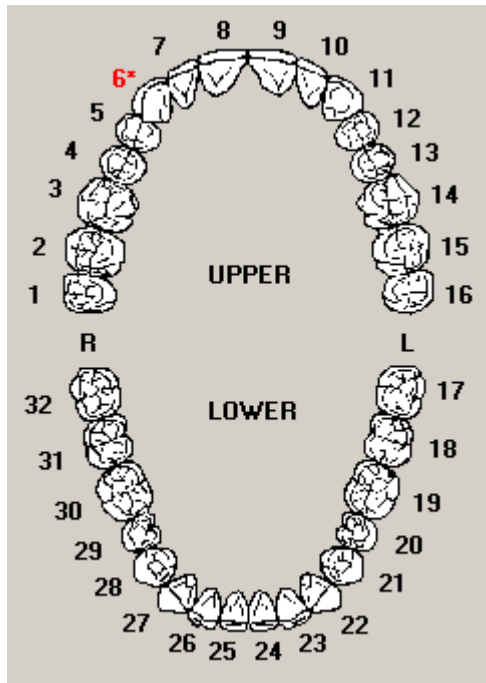


Figure 217: Dental History Teeth Diagram

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

## Viewing Other Dental History Information

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

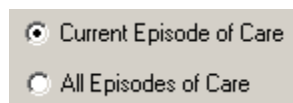
## Viewing All Dental History Information

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

## Viewing Dental History Information by Episode of Care

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

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



The image shows two radio buttons. The first is selected and is labeled "Current Episode of Care". The second is unselected and is labeled "All Episodes of Care".


**Figure 218: Episode of Care Radio Buttons**

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

## Episode in Date Range

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

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



The image shows a date range selection interface. It has two drop-down menus: "Start" with the value "Tuesday , August 09, 2016" and "End" with the value "Thursday , May 04, 2017". Below these is a button labeled "Episode in Date Range".

**Figure 219: Episode in Date Range**

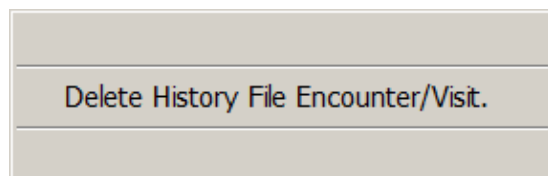
2. Use the calendar screen to choose the desired start and end dates.
3. Click the **Episode in Date Range** button. The results display on the right side of the screen.
4. Select the **tooth** or **teeth**, or the **Other** or **All** check boxes to view the desired information.

## Deleting an Encounter

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

To delete an encounter:

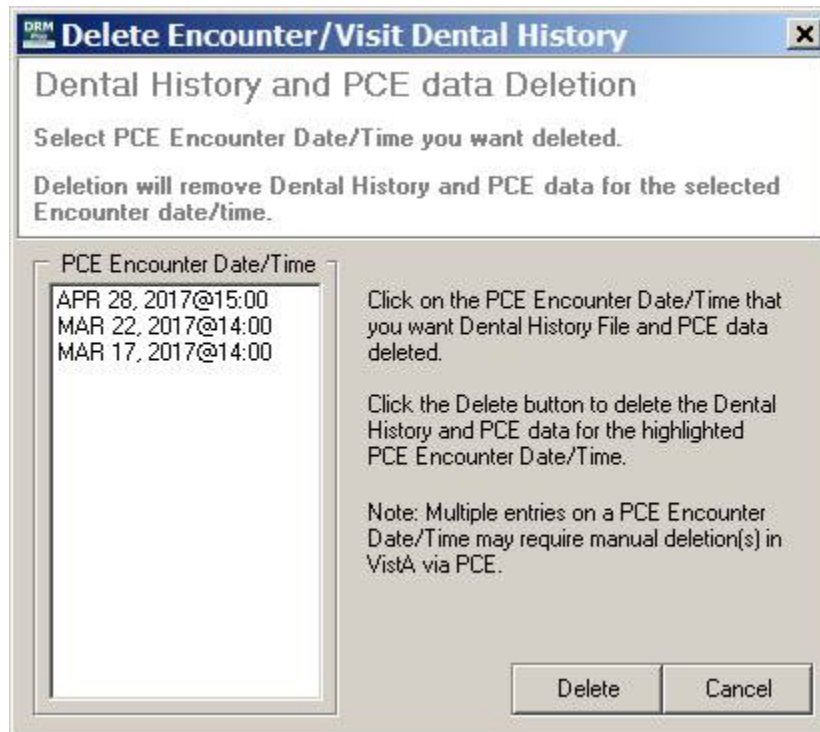
1. Right-click in the large **window** on the tab. A pop-up button displays.



The image shows a button with the text "Delete History File Encounter/Visit." inside a rectangular frame.

**Figure 220: Delete History File Encounter/Visit Button**

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



**Figure 221: Delete Encounter/Visit History Screen**

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

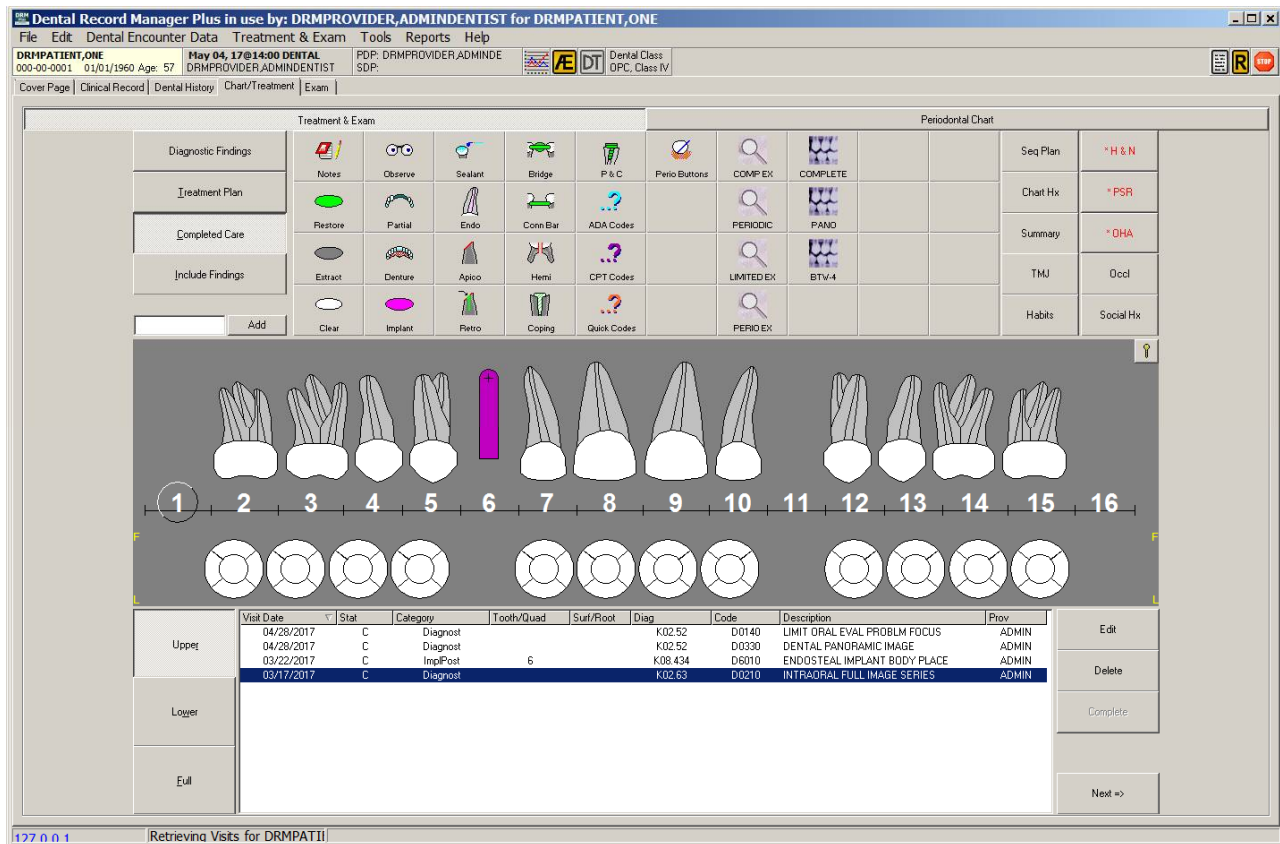
Completed care transactions can also be deleted via the **Chart/Treatment – Treatment & Exam** screen. Please see the Deleting Completed Care Line Item(s) section, in the Chart/Treatment – Treatment & Exam chapter of this manual, for more information.

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

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

# Chart/Treatment – Treatment & Exam

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



**Figure 222: Chart/Treatment Tab Displaying Treatment & Exam Screen**

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



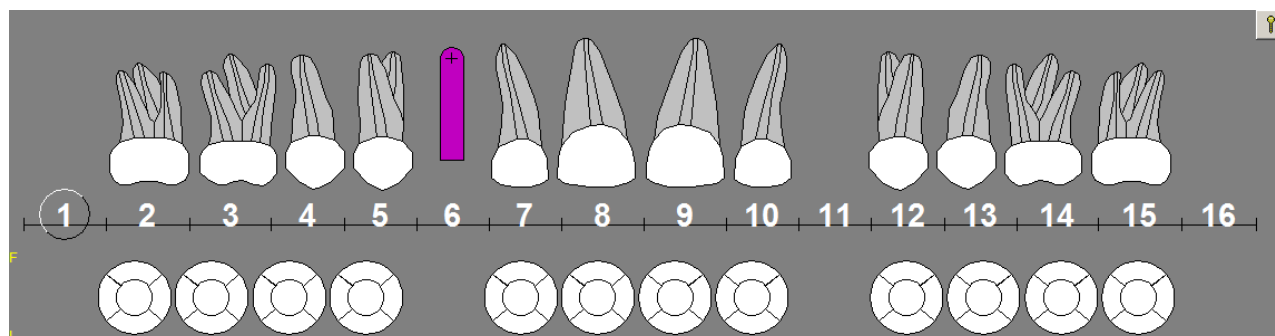
**Figure 223: Diagnostic Findings, Treatment Plan, Completed Care and Include Buttons**

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

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

**Figure 224: Treatment & Exam Specialty Buttons**

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



**Figure 225: Completed Care Graphic Display**

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

	Visit Date	Stat	Category	Tooth/Quad	Surf/Root	Diag	Code	Description	Prov	
Upper	04/28/2017	C	Diagnost			K02.52	D0140	LIMIT ORAL EVAL PROBLM FOCUS	ADMIN	Edit
	04/28/2017	C	Diagnost			K02.52	D0330	DENTAL PANORAMIC IMAGE	ADMIN	
	03/22/2017	C	ImplPost	6		K08.434	D6010	ENDOSTEAL IMPLANT BODY PLACE	ADMIN	
	03/17/2017	C	Diagnost			K02.63	D0210	INTRAOAL FULL IMAGE SERIES	ADMIN	
Lower										Delete
Full										
										Complete
										Next =>

**Figure 226: Completed Care Transaction Table**

## Diagnostic Findings

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

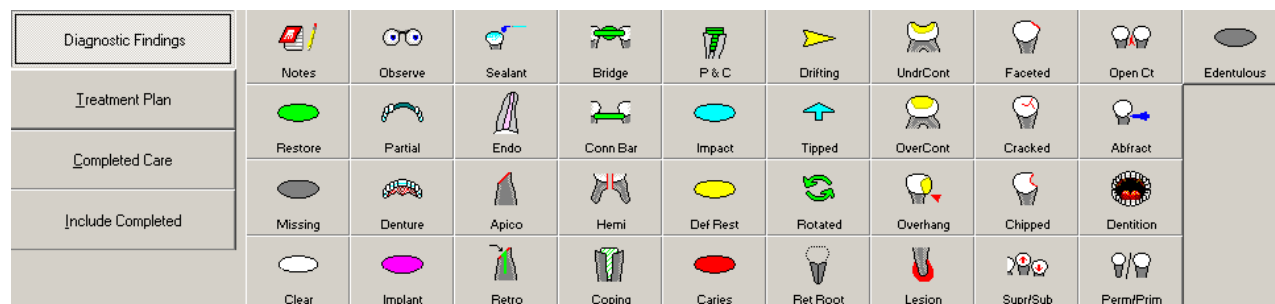


Figure 227: Diagnostic Findings Button with Icons

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

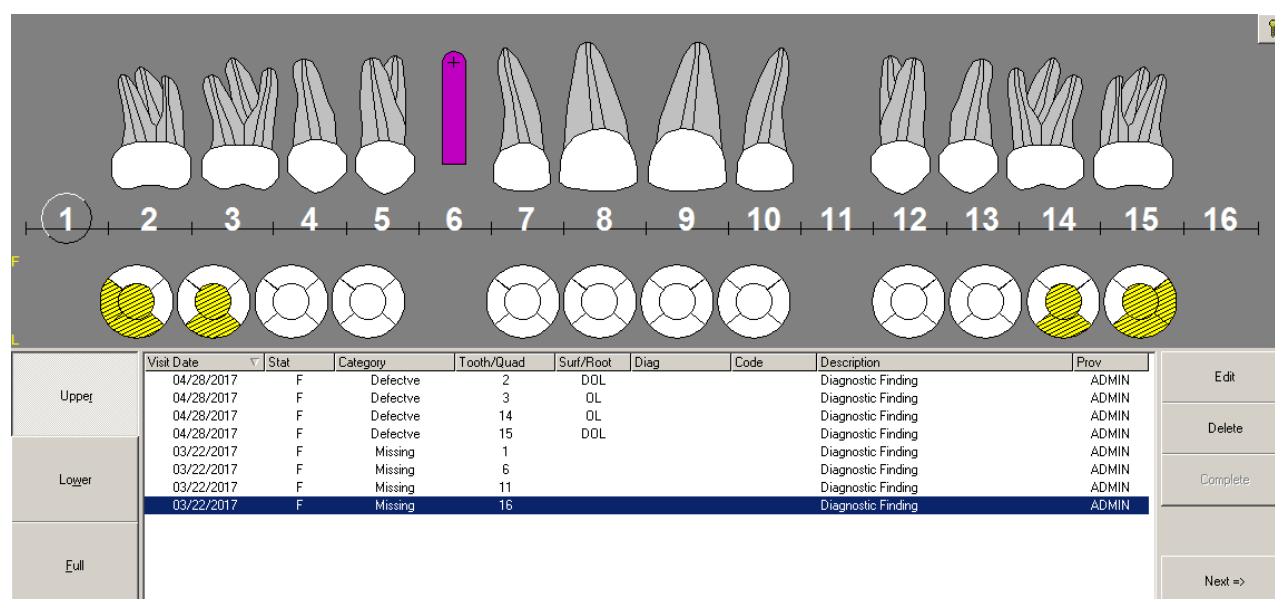


Figure 228: Diagnostic Findings Graphic Chart and Transaction Table

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

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



## Editing Diagnostic Finding Descriptions

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

To edit a diagnostic finding description:

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

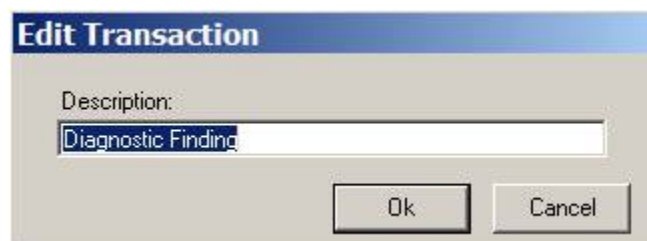


Figure 229: Edit Transaction Screen

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

## Deleting a Diagnostic Finding

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

To delete a diagnostic finding:

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

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

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

## Treatment Plan

### Entering a Treatment Plan

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

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

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



Figure 230: Treatment Plan Button with Icons

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

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



Figure 231: Code Details Screen

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

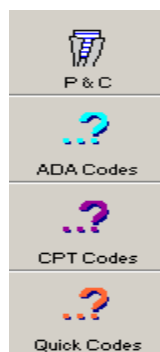
**Note:** When surface modifiers are required for a procedure code, they must be entered using uppercase letters (**M, O, D, F, B, L, and I**). When root modifiers are required for a procedure code, they must be entered using lowercase letters (**r, b, l, d, and m**).

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

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

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

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



**Figure 232: ADA, CPT and Quick Codes Icons**

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

The screenshot shows a software window titled 'Please select the code:'. It has a 'Filter:' text box at the top. Below it is a 'Codes:' section containing a table with two columns: 'Code' and 'Description'. The table lists various dental procedure codes and their descriptions. At the bottom of the window are four buttons: 'Category', 'Multi-Add', 'Add', and 'Exit'.

Code	Description
D0100	DIAGNOSTIC
D1100	PREVENTIVE
D2100	RESTORATIVE
D3000	ENDODONTICS
D4200	PERIODONTICS
D5100	REMOVABLE
D5900	MAXILLOFACIAL PROSTH
D6000	IMPLANT SERVICES
D6200	FIXED PROSTHODONTICS
D7100	SURGERY
D8000	ORTHODONTICS
D9000	ADJUNCTIVE
D0100	DIAGNOSTIC

**Figure 233: Procedure Code Selection Screen**

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

	Code	Description	Area	Tooth	Surfaces
1.	<input checked="" type="checkbox"/> D2140	AMALGAM ONE SURFACE PERM			

Ok Cancel

**Figure 234: Code Details Screen**

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

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

## Editing a Treatment Plan Description

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

Description:

AMALGAM ONE SURFACE PERMANEN

Ok Cancel

**Figure 235: Edit Transaction Screen**

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

## Deleting a Treatment Plan

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

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

## Completing a Treatment Plan

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

**Completed Care Code: D2140, in use by: DRMPROVIDER,ADMINDENTIST, for: DRMPATIENT,ONE**

**Includes all adhesives (amalgam bonding agents), liners, bases. If pin(s) used also include code D2951.**

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

Note: Previously filed Diagnosis Code(s) are listed in the lower right checklist box.

☒ Tooth#/Surface(s): 3 / L

☐ K02.52--DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRATING INTO DENTIN  
☐ K02.62--DENTAL CARIES ON SMOOTH SURFACE PENETRATING INTO DENTIN  
☐ K02.7--DENTAL ROOT CARIES  
☐ K03.0--EXCESSIVE ATTRITION OF TEETH  
☐ K03.1--ABRASION OF TEETH  
☐ K03.81--CRACKED TOOTH  
☐ K08.51--OPEN RESTORATION MARGINS OF TOOTH  
☐ K08.52--UNREPAIRABLE OVERHANGING OF DENTAL RESTORATIVE MATERIALS  
☐ K08.530--FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL  
☐ K08.531--FRACTURED DENTAL RESTORATIVE MATERIAL WITH LOSS OF MATERIAL  
☐ K08.54--CONTOUR OF EXISTING RESTORATION OF TOOTH BIOLOGICALLY INCOMPATIBLE WITH ORAL HEALTH  
☐ K08.56--POOR AESTHETIC OF EXISTING RESTORATION OF TOOTH  
☐ S02.5XA--FRACTURE OF TOOTH (TRAUMATIC), INITIAL ENCOUNTER FOR CLOSED FRACTURE  
☐ K02.53--DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRATING INTO PULP  
☐ K02.63--DENTAL CARIES ON SMOOTH SURFACE PENETRATING INTO PULP

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

Primary	Selected Procedure(s)	Selected Diagnosis(es)

☐ K08.434--PARTIAL LOSS OF TEETH DUE TO CARIES, CLASS IV  
☐ K02.63--DENTAL CARIES ON SMOOTH SURFACE PENETRATING INTO PULP

General Coding Standards ☒ File in PCE ☒ File in Dental History

OK Cancel

**Figure 236: Diagnosis Code Screen**

4. Select the planned treatment procedure on the left side of the screen (default is all selected) and the diagnosis code(s) are mapped 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. The diagnosis codes in the lower section comprise the diagnosis quicklist which have been filed with every encounter for this patient's chart during the past 24 months. This should help the provider decrease the entry time for searching and locating past diagnoses that may still be relevant for the patient's visit.

6. Notice the **File in PCE** check box. If the completed treatment is NOT to be filed in **PCE**, uncheck this box.
7. Click the **OK** button.
8. The planned procedure is removed from the transaction table and is now part of **Completed Care** transactions for the patient.

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

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

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

## Completed Care

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



**Figure 237: Completed Care Button Active with Icons**

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

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

## **Entering Completed Care**

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

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

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

## Editing Completed Care Description

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

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

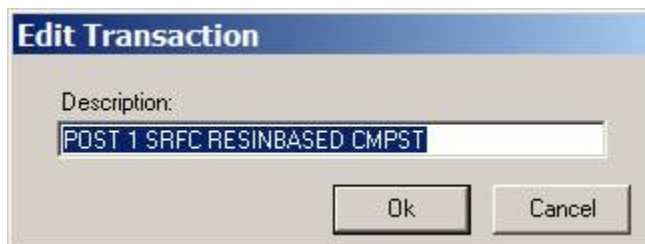


Figure 238: Edit Transaction Screen

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

## Deleting a Completed Care

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

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



**PCE Select Primary data**

You have deleted a procedure from DRM Plus/PCE which caused the Primary Diagnosis and/or Primary Provider to be deleted.  
Please select a new Primary Dx and/or Provider.  
[Failure to do so may leave the PCE Visit in an 'Action Required' status.]

Please select a Primary Diagnosis for the visit on Mar 17, 2017@14:00

Select	DX Code	Description
<input checked="" type="checkbox"/>	K02.52	DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRAT
<input type="checkbox"/>	K03.1	ABRASION OF TEETH
<input type="checkbox"/>	K02.7	DENTAL ROOT CARIES
<input type="checkbox"/>	K02.63	DENTAL CARIES ON SMOOTH SURFACE PENETRATING INTO

Cancel OK

**Figure 239: PCE Select Primary Data Screen**

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









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

### **Include “Completed”/Include “Findings and Completed”/Include “Findings”**

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

## Perio Buttons Icon

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

 Perio Buttons	 COMPEX	 COMPLETE		
	 PERIODIC	 PANO		
	 LIMITED EX	 BTW-4		
	 PERIO EX			

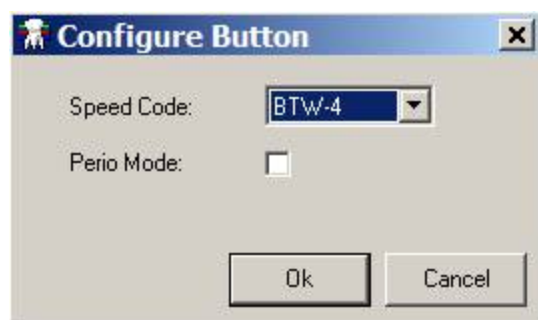
**Figure 240: Perio Buttons and Speed Code Icons**

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

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

To change the location of the speed code icon:

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



**Figure 241: Configure Button Screen**

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

## Seq Plan/Sequencing Button

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

The screenshot shows the 'Tx Planning/Sequencing' window. It features a tree view on the left under 'Planned Treatment' with the following structure:

- Unsequenced Treatment
  - Non-VA Care
    - D7950 - MANDIBLE GRAFT
  - Phase 1
  - Phase 2
    - D2150 - AMALGAM TWO SURFACES PERMANE [14/DOL]
    - D2160 - AMALGAM THREE SURFACES PERMA [15/DOL]

To the right of the tree is a table with three columns: 'Next Appt.', 'Complete', and 'Delete'. Each row in the tree has a corresponding row of checkboxes in this table.

Planned Treatment	Next Appt.	Complete	Delete
Unsequenced Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-VA Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D7950 - MANDIBLE GRAFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phase 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phase 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D2150 - AMALGAM TWO SURFACES PERMANE [14/DOL]	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D2160 - AMALGAM THREE SURFACES PERMA [15/DOL]	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the right side of the window, there are nine buttons: 'Add Phase', 'Add Sub-phase', 'Add Non-VA Care Phase', 'Copy Non-VA Care Phase to Clipboard', 'Copy All to Clipboard', 'Print', 'Save & Exit', 'Save', and 'Cancel'. At the bottom, there is a text area for 'Additional Dental Treatment Plan Notes' with a timestamp and a message: '[09:28 AM 05/25/2017 ADMIN] Adding an additional planned note. Select the F5 key first and then enter text data.'

**Figure 242: Tx Planning/Sequencing Screen**

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

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

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

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

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

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

## Plan a Treatment Sequence

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

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

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

## Complete a Planned Treatment in the Sequencing Screen

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

## Deleting a Planned Treatment in the Sequencing Screen

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

## Chart Hx (History) Button

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

The screenshot shows the 'Tx History' window with an 'Appointments' dropdown set to '05/25/2017'. The dental chart displays teeth 1-16 on the top arch and 17-32 on the bottom arch. Teeth 2 and 3 are highlighted with green shading. A purple vertical bar is positioned between teeth 5 and 6. Below the chart is a table of transactions.

Visit Date	Stat	Category	Tooth/Quad	Surf/Root	Diag	Code	Description	Prov
04/28/2017	C	Diagnost			K02.52	D0140	LIMIT ORAL EVAL PROBLEM FOCUS	ADMIN
04/28/2017	C	Diagnost			K02.52	D0330	DENTAL PANORAMIC IMAGE	ADMIN
03/22/2017	C	ImpPost	6		K08.434	D6010	ENDOSTEAL IMPLANT BODY PLACE	ADMIN
03/17/2017	C	Restored	2	DOL	K02.52	D2160	AMALGAM THREE SURFACES PERMA	ADMIN
03/17/2017	C	Restored	3	OL	K02.7	D2150	AMALGAM TWO SURFACES PERMANE	ADMIN

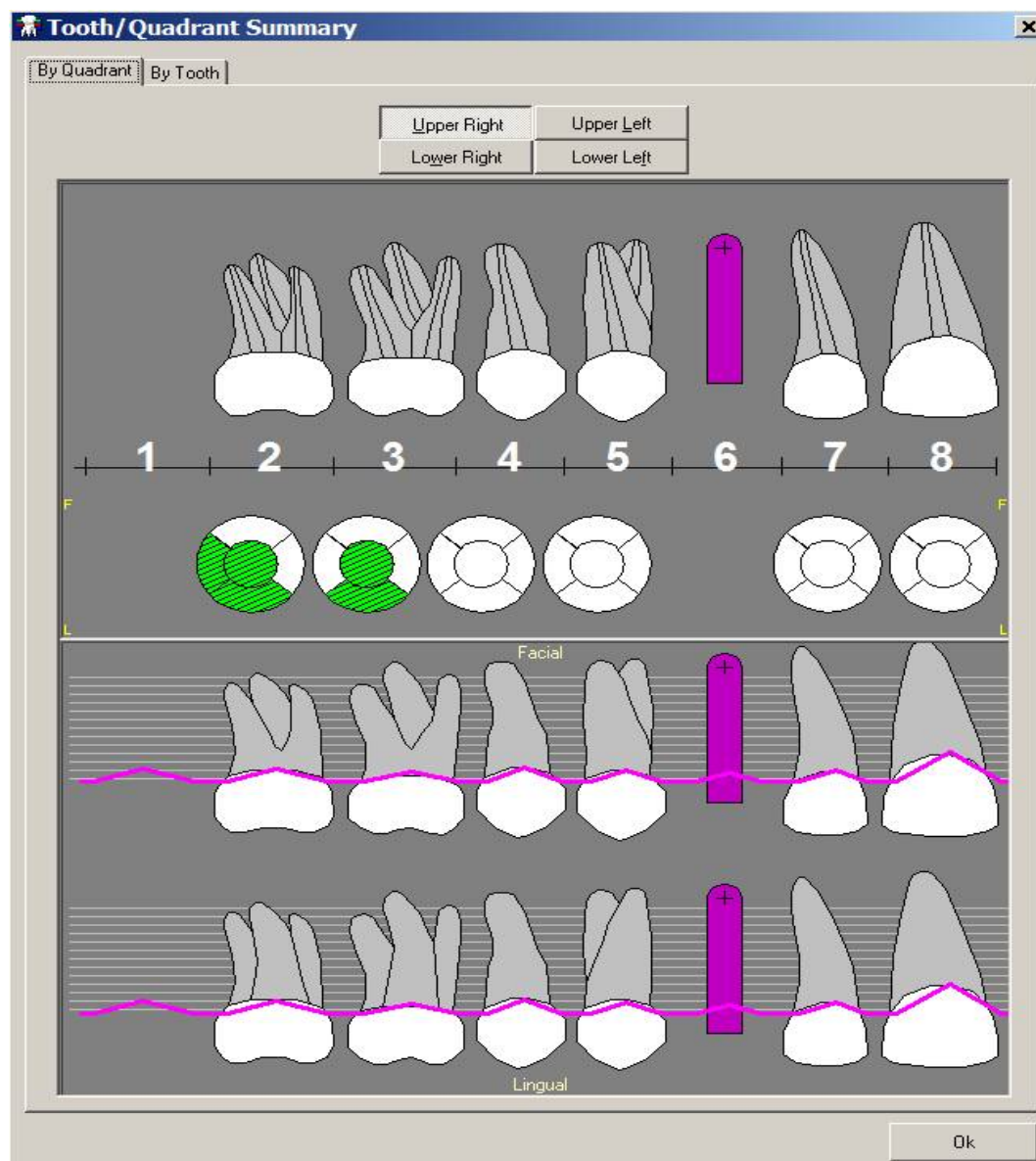
**Figure 243: Tx History Screen**

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

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

## Summary Button

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



**Figure 244: Tooth/Quadrant Summary Screen**

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



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

## H&N Button

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

Date	Provider	Type	Description
04/28/2017	ADMIN	INITIAL	Cancerous condition

**Figure 245: Head and Neck Findings Screen**

To enter an **H&N** finding:

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



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

**H & N Detail**

Initial Finding

Date	Provider	Description
05/25/2017	ADMIN	<<Enter description>>

Common Findings

Progress

☐ Resolved

Save

Cancel

**Figure 246: H&N Detail Screen**

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

To add new details of an **H&N** finding:

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

**H & N Detail**

Initial Finding

Date	Provider	Description
04/28/2017	ADMIN	Cancerous condition

Common Findings

Progress

Date	Provider	Description
05/25/2017	ADMIN	<<Enter description>>

☐ Resolved

Save

Cancel

**Figure 247: H&N Detail Screen with Progress Description**

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

To delete a lesion:

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

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

## **PSR Button**

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



The screenshot shows a software window titled "Periodontal Screening/Recording...". At the top left, there is a label "Exam Date:" followed by a dropdown menu showing "05/26/2017" and a "New" button. Below this is a large rectangular area containing six text boxes arranged in two rows of three. The top row is labeled "Sextant #1:", "Sextant #2:", and "Sextant #3:". The bottom row is labeled "Sextant #6:", "Sextant #5:", and "Sextant #4:". Each text box contains the number "1". At the bottom of the window are three buttons: "Definitions", "Ok", and "Cancel".

**Figure 248: Periodontal Screening/Recording (PSR) Screen**

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

To enter new information:

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

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

## OHA (Oral Health Assessment) Button

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

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

**DRM Plus - Oral Health Assessment**

Date: 04/28/2017 [New] [Definitions]

**Clinical Findings**

☐ Patient has no remaining functional teeth, roots or implants.

**Plaque Index**

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

**Xerostomia**

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

**Caries Risk**

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

**Oral Hygiene**

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

Date	Provider	NFT	PI	X	CR	OH
04/28/2017	ADMIN		1	0	1	1

[OK] [Cancel]

[VA Dental Definitions](#)

**Definitions Panel**

**PLAQUE INDEX**

0 - None:  
No Plaque in the gingival area.

1 - Slight:  
A film of plaque adhering to the free gingival margin and adjacent area of the tooth. The plaque may be recognized only by running a probe across the tooth surface.

2 - Moderate:  
Moderate accumulation of soft deposits within the gingival pocket and on the gingival margin and/or adjacent tooth surface that can be seen by the naked eye.

3 - Heavy:  
Abundance of soft matter within the gingival pocket and/or on the gingival margin and adjacent tooth surface.

**XEROSTOMIA**

0 - None:  
None.

1 - Slight:  
Moist mucosa with limited flow and no pooling of saliva. Patient may report subjective dryness and/or stale breath.

2 - Moderate:  
In addition to slight symptoms, initially moist mucosa but dries during oral examination. Saliva may be thick and ropery. Patient may reports difficulty with dry foods, altered taste

**Figure 249: Oral Health Assessment (OHA) Screen**

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

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

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

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

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

The screenshot shows the 'DRM Plus - Oral Health Assessment' window. At the top, there is a 'Date' dropdown set to '04/28/2017' and buttons for 'New' and 'Definitions'. Below this is a 'Clinical Findings' section with a checkbox for 'Patient has no remaining functional teeth, roots or implants.' The main area contains four radio button groups: 'Plaque Index' (0 - None, 1 - Slight, 2 - Moderate, 3 - Heavy, 4 - Not Recorded), 'Xerostomia' (0 - None, 1 - Slight, 2 - Moderate, 3 - Significant, 4 - Not Recorded), 'Caries Risk' (0 - Edentulous, 1 - Low, 2 - Moderate, 3 - High, 4 - Not Recorded), and 'Oral Hygiene' (0 - Excellent, 1 - Good, 2 - Fair, 3 - Poor, 4 - Not Recorded). At the bottom left is a table with columns: Date, Provider, NFT, PI, X, CR, OH. The first row contains: 04/28/2017, ADMIN, , 1, 0, 1, 1. At the bottom right is a 'Definitions Panel' with a scroll bar. It contains definitions for 'PLAQUE INDEX' (0 - None, 1 - Slight, 2 - Moderate, 3 - Heavy) and 'XEROSTOMIA' (0 - None, 1 - Slight, 2 - Moderate). At the very bottom are 'OK' and 'Cancel' buttons, and a hyperlink 'VA Dental Definitions'.

Date	Provider	NFT	PI	X	CR	OH
04/28/2017	ADMIN		1	0	1	1

**Figure 250: OHA Definitions Displaying Plaque Index/Xerostomia**

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

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

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

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

## **TMJ Button**

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

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

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

DRM Plus - TMJ

Date: 05/26/2017 [New]

History

☐ Patient reports no symptoms associated with TMJ.

☒ Patient reports symptoms associated with TMJ's:

☐ History of trauma ☐ Popping/Clicking ☐ Pain upon opening

☐ Spontaneous pain ☐ Crepitus ☐ Pain upon chewing

☐ Limited opening

☐ Other:

Clinical Findings

0 (mm) Max Incisal Opening [Popping/Clicking]

0 (mm) Left Lateral [Crepitus]

0 (mm) Right Lateral [Pain to manipulation]

☐ Other: [Deviation upon opening]

[OK] [Cancel]

**Figure 251: TMJ Screen**

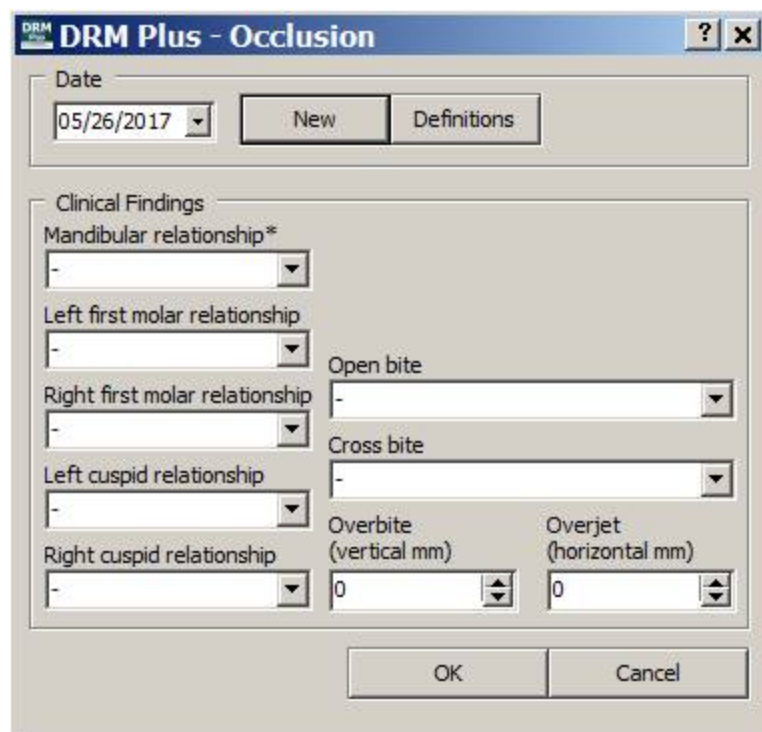
The **Clinical Findings** section has three numerical fields to enter a millimeter value and four drop-down menu options in selecting popping/clicking, crepitus, pain to manipulation, and deviation upon opening. The **Other** check box allows an unlimited text field for additional text information if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



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

## Occl (Occlusion) Button

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



**Figure 252: Occlusion Screen**

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



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

The screenshot shows the 'DRM Plus - Occlusion' window. At the top, there's a 'Date' field set to '05/26/2017' and buttons for 'New' and 'Definitions'. Below this is a 'Clinical Findings' section with several drop-down menus: 'Mandibular relationship\*', 'Left first molar relationship', 'Right first molar relationship', 'Left cuspid relationship', and 'Right cuspid relationship'. To the right of these are fields for 'Open bite', 'Cross bite', 'Overbite (vertical mm)', and 'Overjet (horizontal mm)'. At the bottom are 'OK' and 'Cancel' buttons. On the right side, the 'Definitions Panel' is expanded, showing 'ANGLE'S CLASSIFICATION' with three classes: Class I, Class II, and Class III. At the bottom of the panel is a hyperlink 'VA Dental Definitions'.

**Figure 253: Occlusion Angle's Classification Definitions**

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

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

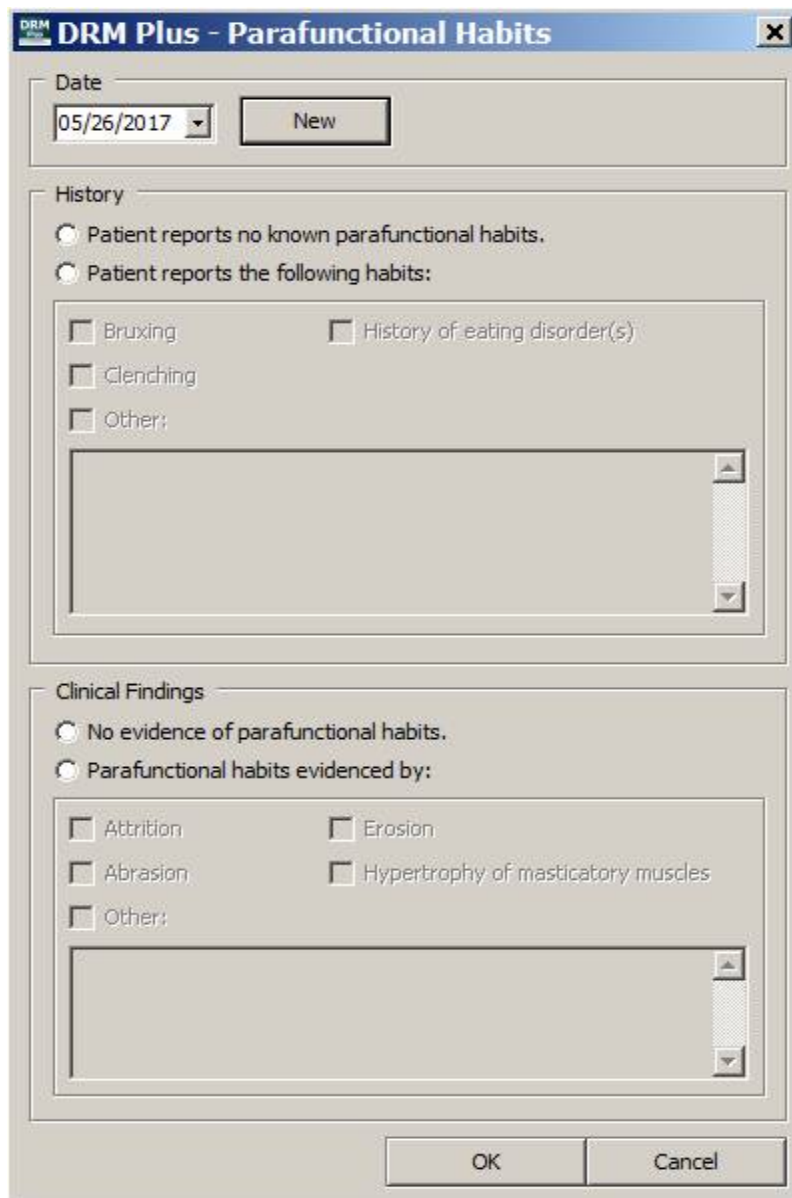
**Note:** If NOT immediately directed to the website when selecting the hyperlink, please notify the Help Desk.

## **Habits (Parafunctional) Button**

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

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

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



The screenshot shows a software window titled "DRM Plus - Parafunctional Habits". At the top, there is a "Date" field with a dropdown menu showing "05/26/2017" and a "New" button. Below this is a section labeled "History" containing two radio buttons: "Patient reports no known parafunctional habits." and "Patient reports the following habits:". Under the second radio button, there are four checkboxes: "Bruxing", "History of eating disorder(s)", "Clenching", and "Other:". Below these checkboxes is a large text area for additional information. The "Clinical Findings" section also has two radio buttons: "No evidence of parafunctional habits." and "Parafunctional habits evidenced by:". Under the second radio button, there are four checkboxes: "Attrition", "Erosion", "Abrasion", and "Hypertrophy of masticatory muscles". Below these checkboxes is another large text area. At the bottom of the window are "OK" and "Cancel" buttons.

**Figure 254: Parafunctional Habits Screen**

## **Social Hx (Social History) Button**

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

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

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

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

**Figure 255: Social Hx (History) Screen**

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

## Multiple Filings to Same Modal on Same Day

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

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

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

**DRM Plus - Oral Health Assessment**

Date: 05/26/2017 [New] [Definitions]

**Clinical Findings**

☐ Patient has no remaining functional teeth, roots or implants.

**Plaque Index**

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

**Xerostomia**

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

**Caries Risk**

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

**Oral Hygiene**

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

Date	Provider	NFT	PI	X	CR	OH
05/26/2017	HYG		2			1
04/28/2017	ADMIN		1	0	1	1

[OK] [Cancel]

[VA Dental Definitions](#)

**Definitions Panel**

**PLAQUE INDEX**

0 - None:  
No Plaque in the gingival area.

1 - Slight:  
A film of plaque adhering to the free gingival margin and adjacent area of the tooth. The plaque may be recognized only by running a probe across the tooth surface.

2 - Moderate:  
Moderate accumulation of soft deposits within the gingival pocket and on the gingival margin and/or adjacent tooth surface that can be seen by the naked eye.

3 - Heavy:  
Abundance of soft matter within the gingival pocket and/or on the gingival margin and adjacent tooth surface.

**XEROSTOMIA**

0 - None:  
None.

1 - Slight:  
Moist mucosa with limited flow and no pooling of saliva. Patient may report subjective dryness and/or stale breath.

2 - Moderate:  
In addition to slight symptoms, initially moist mucosa but dries during oral examination. Saliva may be thick and ropery. Patient may reports difficulty with dry foods, altered taste

Figure 256: Provider HYG Filed OHA Data First Today

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

**DRM Plus - Oral Health Assessment**

Date: 05/26/2017 [New] [Definitions]

**Clinical Findings**

☐ Patient has no remaining functional teeth, roots or implants.

**Plaque Index**

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

**Xerostomia**

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

**Caries Risk**

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

**Oral Hygiene**

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

Date	Provider	NFT	PI	X	CR	OH
05/26/2017	ADMIN		2	0	2	1
04/28/2017	ADMIN		1	0	1	1

[OK] [Cancel]

[VA Dental Definitions](#)

**Definitions Panel**

**PLAQUE INDEX**

0 - None:  
No Plaque in the gingival area.

1 - Slight:  
A film of plaque adhering to the free gingival margin and adjacent area of the tooth. The plaque may be recognized only by running a probe across the tooth surface.

2 - Moderate:  
Moderate accumulation of soft deposits within the gingival pocket and on the gingival margin and/or adjacent tooth surface that can be seen by the naked eye.

3 - Heavy:  
Abundance of soft matter within the gingival pocket and/or on the gingival margin and adjacent tooth surface.

**XEROSTOMIA**

0 - None:  
None.

1 - Slight:  
Moist mucosa with limited flow and no pooling of saliva. Patient may report subjective dryness and/or stale breath.

2 - Moderate:  
In addition to slight symptoms, initially moist mucosa but dries during oral examination. Saliva may be thick and ropey. Patient may reports difficulty with dry foods, altered taste

**Figure 257: Provider ADMIN Edited and Second Filed OHA Data Today**

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

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



# Chart/Treatment – Periodontal Chart

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

**Dental Record Manager Plus in use by: DRMPROVIDER,ADMINISTRATOR for DRMPATIENT,ONE**

File Edit Dental Encounter Data Treatment & Exam Tools Reports Help

DRMPATIENT,ONE May 25, 17@09:00 DENTAL DRMPROVIDER,ADMINISTRATOR DRMPROVIDER,ADMINISTRATOR Dental Class DPC, Class IV

Cover Page Clinical Record Dental History Chart/Treatment Exam

**Treatment & Exam**

History \*PSR\* Compare Stats Summary \*OHA\* \*H & N\* Notes

Pocket FGM MGJ Bleeding Delayed Suppns Mobility Furcation Clear

0 1/4 1 1 1/2 2 2 1/2 3

Cal Undo Keyboard Mode [F10] Adv Back =>

**Periodontal Chart**

Upper Facial

Upper Lower Full Facial Lingual Auto Advance

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

	1	2	3	4	5	6	7	8
<b>Pocket</b>		4 4 4	4 3 3	3 2 2	2 3 4	- - -	4 3 2	2 2 2
<b>Bleeding</b>		B b			B		b	
<b>Suppuration</b>								
<b>FGM</b>		- - -	- - -	- - -	- - -	- - -	- - -	- - -
<b>MGJ</b>		- - -	- - -	- - -	- - -	- - -	- - -	- - -
<b>Furcation</b>		- - -	- - -	- - -	- - -	- - -	- - -	- - -
<b>Attachment</b>		4 4 4	4 3 3	3 2 2	2 3 4	- - -	4 3 2	2 2 2
<b>Attach Chg</b>								
<b>Mobility</b>		0 1/2	-	-	0 1/2	-	0 1/2	-


Next =>

**Figure 258: Periodontal Chart Screen**

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

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

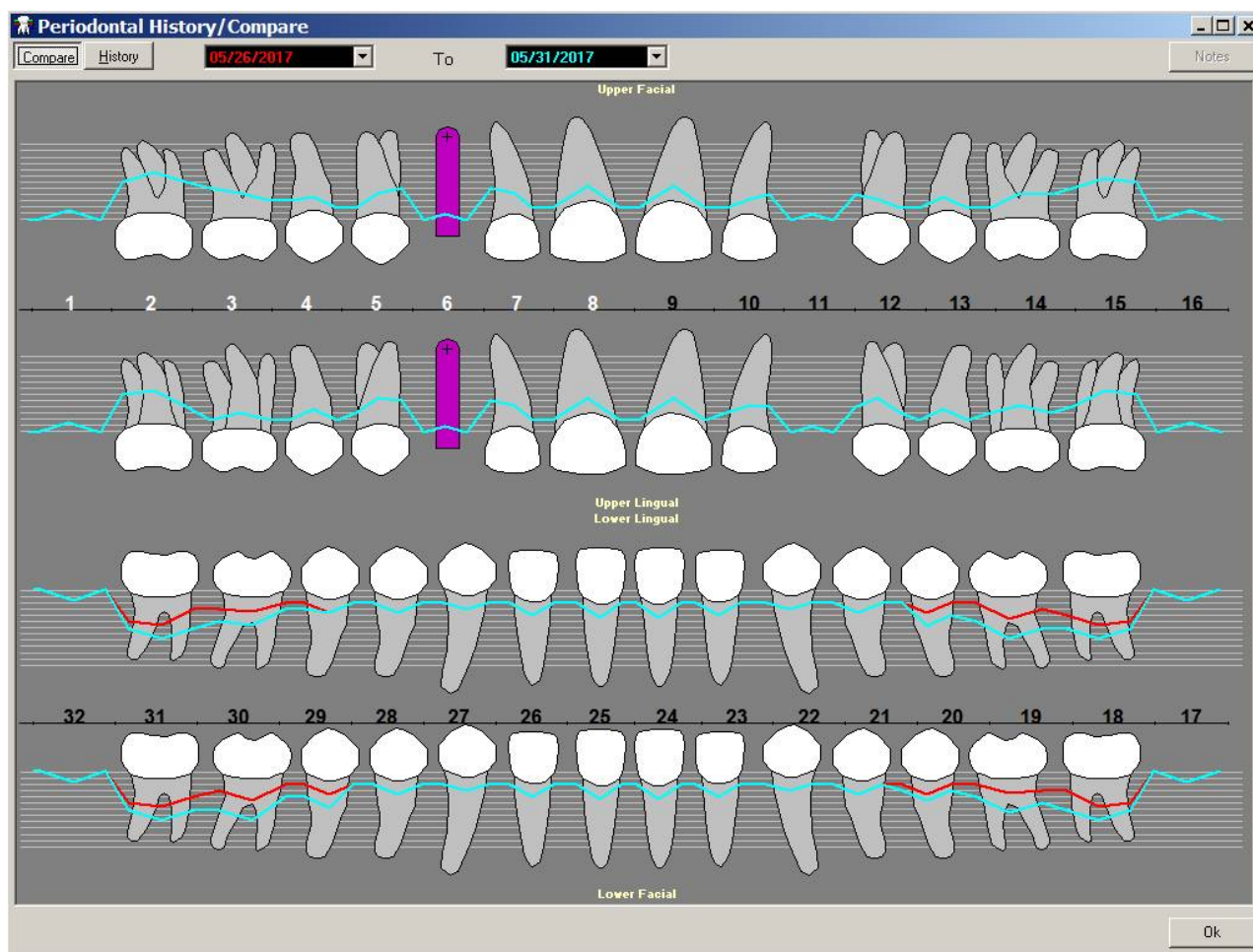
The center of the screen features the tooth/arch graphic. Clicking various areas in combination with the condition-specific icons located in the top center of the screen enters information into the patient's chart.

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

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

## History and Compare Buttons

Clicking the **History** or **Compare** buttons display similar perio screens. Use the **Compare** function to compare two periodontal charts that have been filed previously to the patient's chart.



**Figure 259: Periodontal History/Compare Screen – Compare Viewable**

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



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

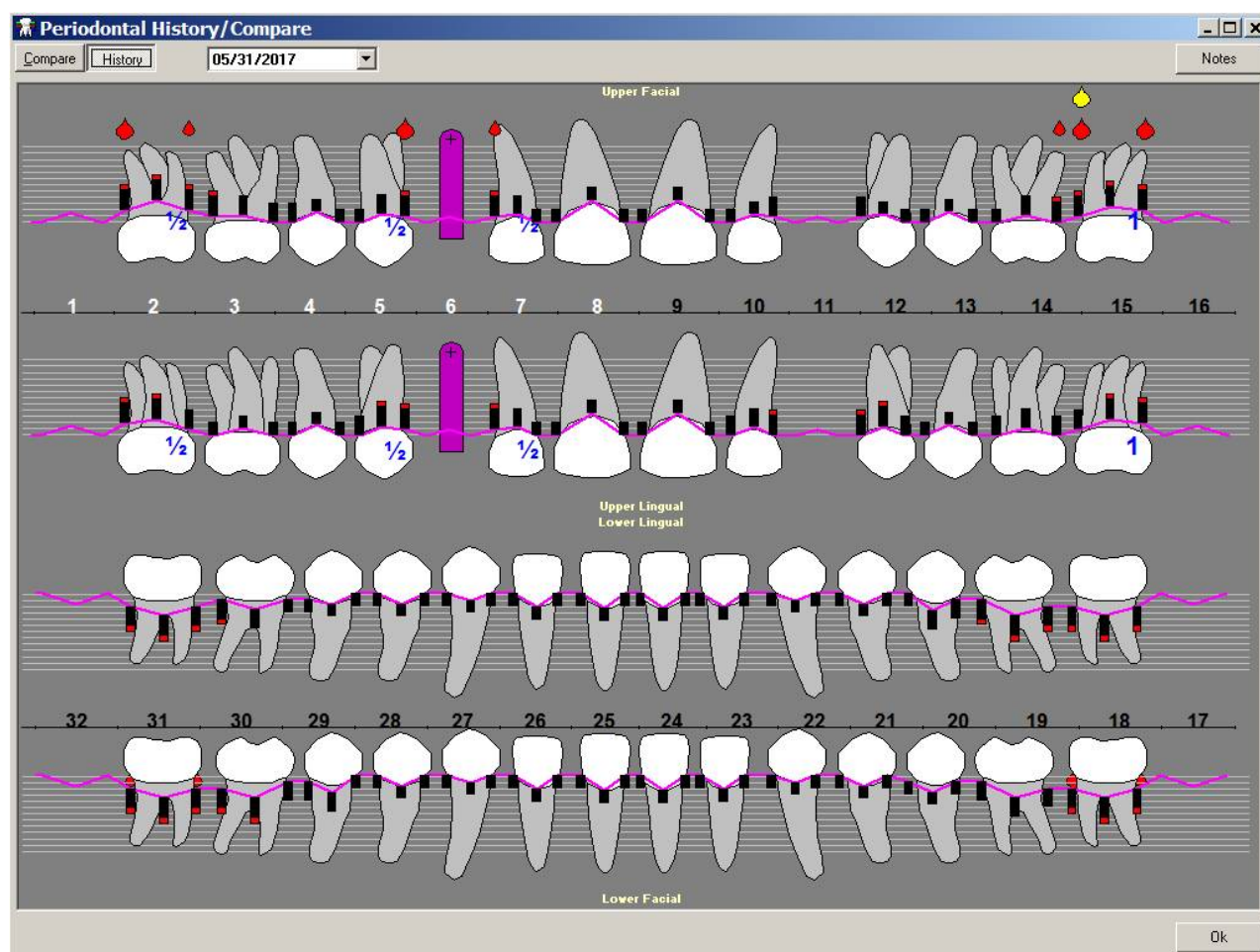


Figure 260: Periodontal History/Compare Screen - History Viewable

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

## Summary Button

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

## H&N Button

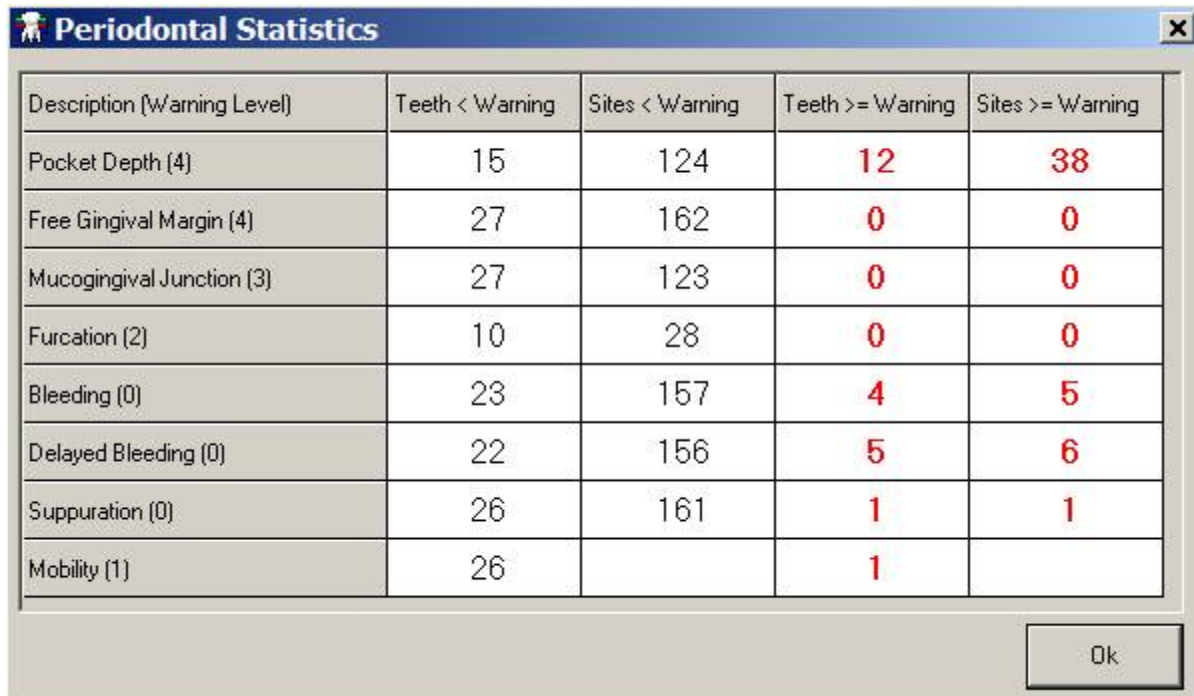
See the **H&N Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

## PSR Button

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

## **Stats Button**

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



The screenshot shows a window titled "Periodontal Statistics" with a close button (X) in the top right corner. The window contains a table with five columns: "Description (Warning Level)", "Teeth < Warning", "Sites < Warning", "Teeth >= Warning", and "Sites >= Warning". The table lists eight conditions: Pocket Depth (4), Free Gingival Margin (4), Mucogingival Junction (3), Furcation (2), Bleeding (0), Delayed Bleeding (0), Suppuration (0), and Mobility (1). The values for "Teeth >= Warning" and "Sites >= Warning" are displayed in red text. An "Ok" button is located at the bottom right of the window.

Description (Warning Level)	Teeth < Warning	Sites < Warning	Teeth >= Warning	Sites >= Warning
Pocket Depth (4)	15	124	12	38
Free Gingival Margin (4)	27	162	0	0
Mucogingival Junction (3)	27	123	0	0
Furcation (2)	10	28	0	0
Bleeding (0)	23	157	4	5
Delayed Bleeding (0)	22	156	5	6
Suppuration (0)	26	161	1	1
Mobility (1)	26		1	

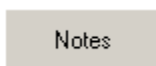
Figure 261: Periodontal Statistics Screen

## **OHA (Oral Health Assessment) Button**

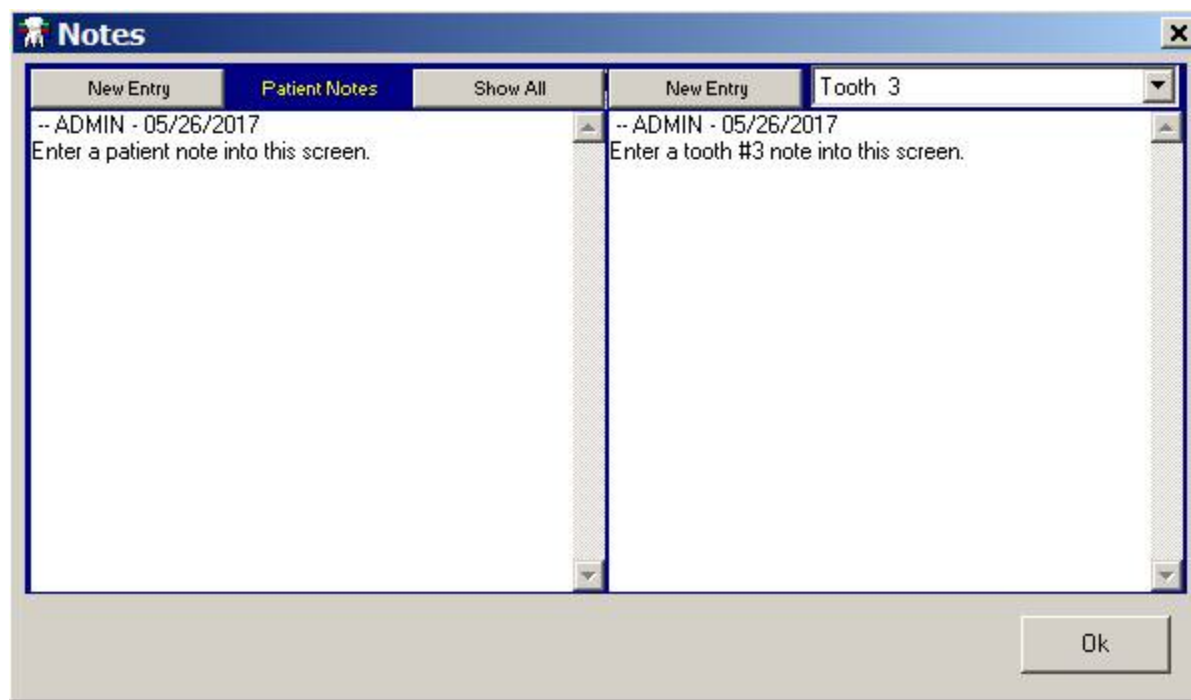
See the **OHA Button** section in the Chart/Treatment – Treatment & Exam chapter of this manual.

## Notes Button

Use the **Notes** button



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



**Figure 262: Notes Screen**

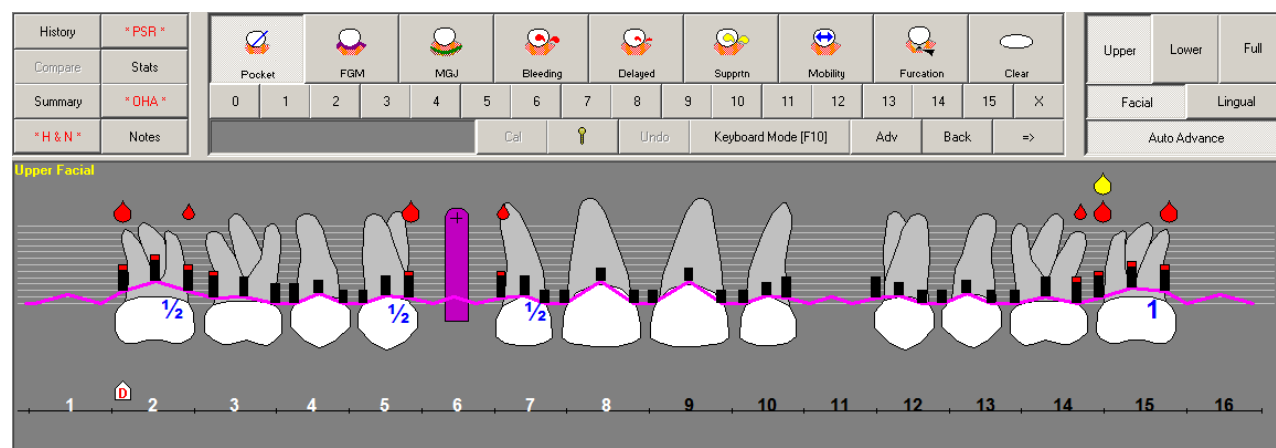
Choose between creating a more general note on the patient by using the tools on the left side of the screen, or a note about a specific tooth on the right side of the screen.

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

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

## Entering Periodontal Information

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



**Figure 263: Periodontal Condition-Specific Icons and Periodontal Graphical Chart**

To enter periodontal information:


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

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


## **Other Tools**

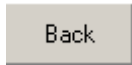
The last line of buttons in the top center of the screen features several tools.

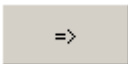
**Key** button  displays keyboard shortcuts.

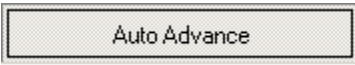
**Undo** button  removes the last action performed on the screen. This action is limited to the last nine actions performed.

**Keyboard Mode** button  switches the program to keyboard mode.

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

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

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

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

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

# Exam

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

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

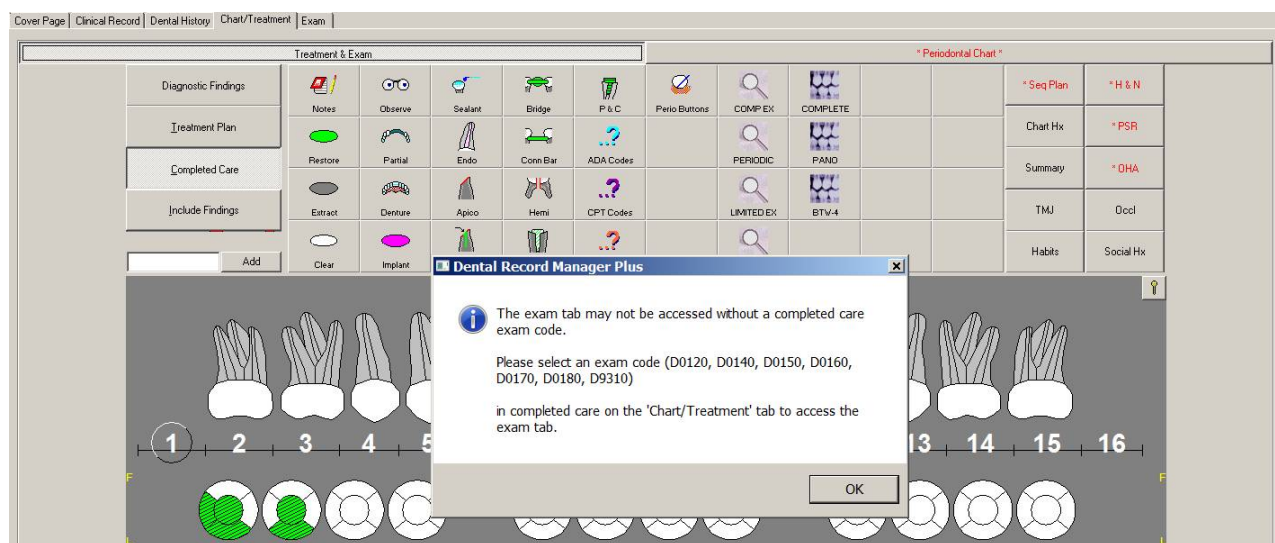





Figure 264: Exam Tab Message

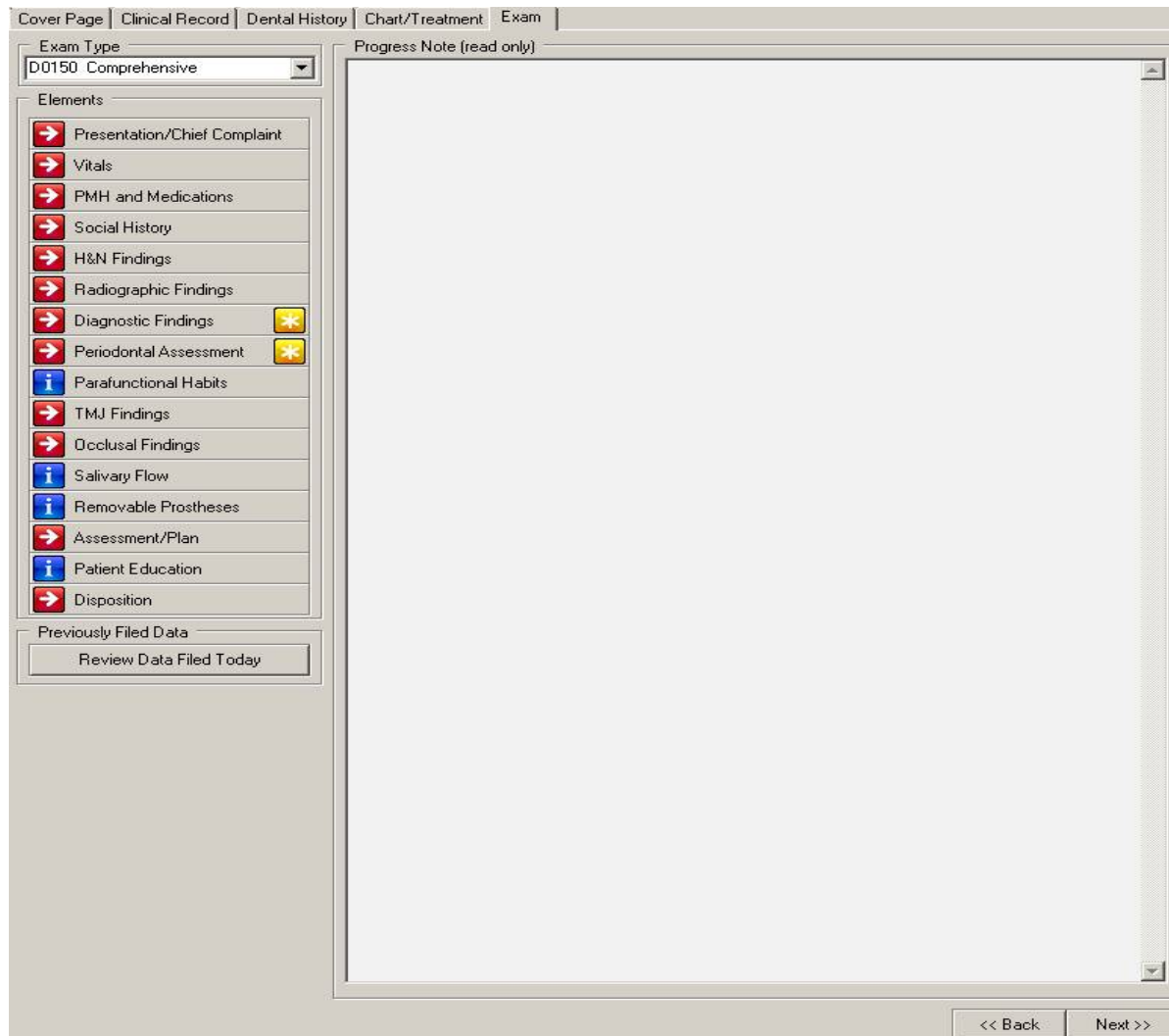
Entering the exam/consult procedure activates the **Exam** tab and displays the procedure in the **Exam Type** drop-down menu. One way to change the exam/consult procedure after selecting it and determining it was incorrect is to use the drop-down menu located on the **Exam** tab. Another way to change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

Selecting the exam/consult code from the **Completed Care** screen triggers all of the elements on the

**Exam** tab with a required  icon or optional  icon. When these elements are satisfied, a completed  icon displays. Some elements automatically pull data from the modals when entered from the **Chart/Treatment** tab.

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

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




**Figure 265: Exam Tab**

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

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

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

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

**Note:** The  icon on the right of the element button displays when there was previously filed data on the same day and that data is associated with the element it is displayed on.



## Exam Elements

### Presentation/Chief Complaint Element

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

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

**Figure 266: Presentation/Chief Complaint Element Screen**

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

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

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

## Vitals Elements

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

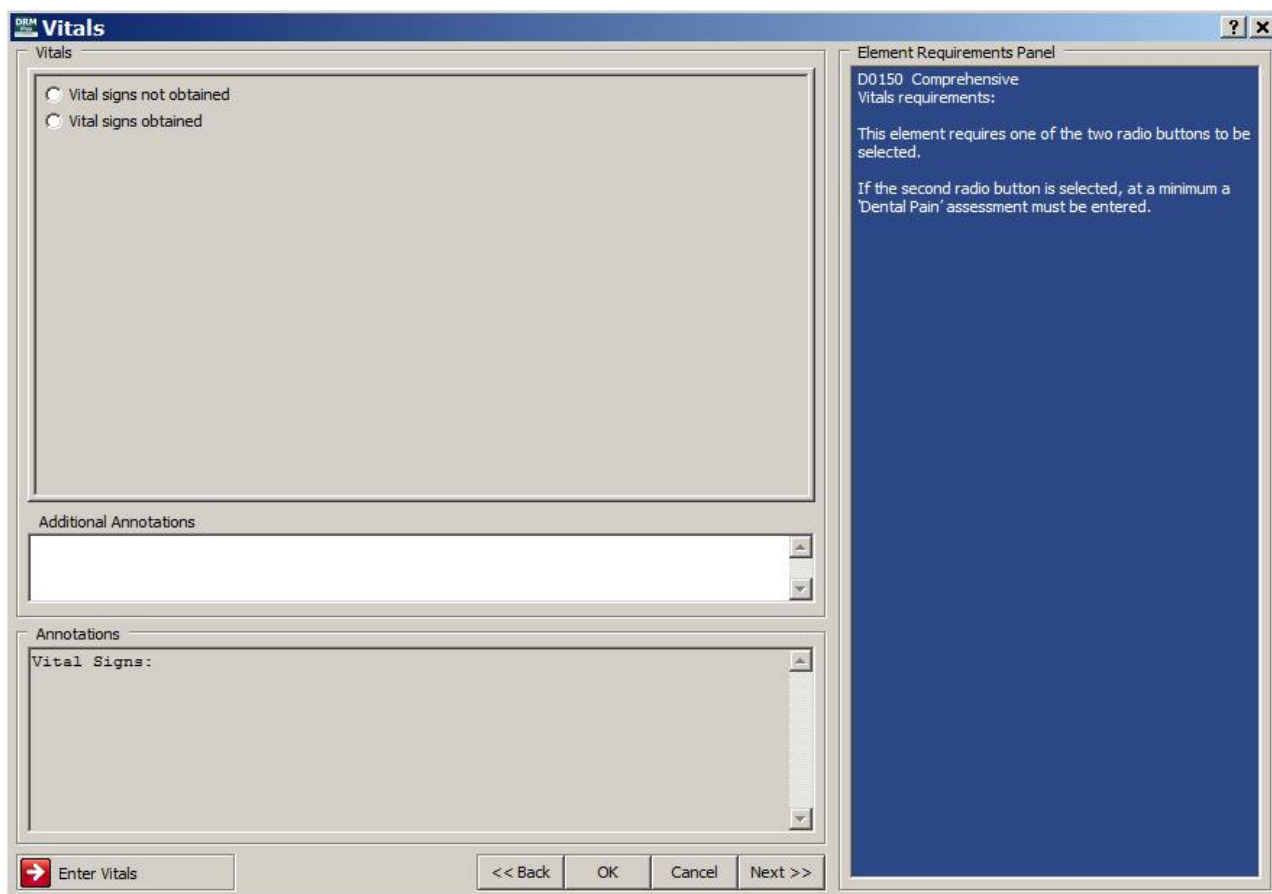



Figure 267: Vitals Element Screen

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

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

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

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

## PMH (Past Medical History) and Medications Element

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

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

The screenshot shows the 'PMH and Medications' window. The 'PMH Options' section has three radio buttons: 'Patient is new to clinic', 'No significant changes since the last dental visit', and 'Significant changes are noted since the last dental visit'. Below this is a table with 'YES' and 'NO' columns and a list of conditions: Hypertension, Diabetes, Head and neck cancer, Prosthetic joint, Bisphosphonates, Cardiac condition, Respiratory condition, and Excessive bleeding. To the right of this table is an 'Imports' section with checkboxes for 'Active Problem List', 'Medications (not including suspended)', 'Medications (including suspended)', 'Allergies', and 'Dental Alerts', along with a 'Select ALL Imports' button. Below the table is an 'Additional Annotations' text box. At the bottom is an 'Annotations' section with a text box containing 'Past Medical History and Medications:'. On the right side of the window is an 'Element Requirements Panel' with a blue background, containing text about the requirements for this element. At the bottom of the window are buttons for '<< Back', 'OK', 'Cancel', and 'Next >>'.

Figure 268: PMH and Medications Element Screen

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

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

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

## Social History Element

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

Figure 269: Social History Element Screen

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

## H&N (Head and Neck) Findings Element

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

**H&N Findings**

You have not completed the following section: Head and Neck Findings

You can do this in the Chart/Treatment tab of DRM Plus.

Alternately, you can click on the button below for the specific section.

Additional Annotations

Annotations

**Element Requirements Panel**

D0150 Comprehensive H&N Findings requirements:

This element will require one new H&N finding or historical entry using the H&N Findings screen.

The "Screening Negative" button on this element's screen will allow a new negative screening entry directly into the element and import it into the H&N Findings screen for the patient's permanent record.

H&N Findings Screening Negative << Back OK Cancel Next >>

Figure 270: H&N Findings Element Screen

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

## Radiographic Findings Element

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

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

**Radiographic Findings**

Radiographic Findings

☐ No radiographs obtained this visit

☐ Patient declined radiographs

☐ Radiographic findings consistent with charted entries

☐ Radiographs reviewed, findings noted below:

☐ No radiographic caries noted

☐ No apparent bony pathology noted

Additional Annotations

Annotations

Radiographic Findings:

Element Requirements Panel

D0150 Comprehensive Radiographic Findings requirements:

This element will require at least one check box selected from the top six.

The provider may select any combination of the top six check boxes for the patient's record.

The selection of the fourth check box in the left column requires a text description about radiographic findings and/or selection of at least one pre-defined statement.

<< Back OK Cancel Next >>

**Figure 271: Radiographic Findings Element Screen**

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

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

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



## Diagnostic Findings Element

The **Diagnostic Findings** element is required for all seven exam/consult procedures. All exam/consult codes are required as appropriate for new and updated findings. The second check box only displays after data is entered from at least one **Chart/Treatment** findings screen that satisfies this option. Informational screens advise the user of any missing requirements for a specific exam code.

The **NFT**, no functional teeth, check box when selected in the **OHA** screen, bypasses all requirements in this element for all exam/consult procedures. The **OHA** screen may be opened from the **Chart/Treatment** tab or by selecting the **OHA** button in the lower left area of this screen.

- **D0120:** Requires a **Plaque Index** entry from the **OHA** screen. Also requires the selection of a **Mobility** radio button, as it pertains to the patient.
- **D0150:** Requires at least one entry from the **Diagnostic Findings** screen or the first check box of no apparent pathology selected. Requires a **Plaque Index** entry from the **OHA** screen. Also requires the selection of a **Mobility** radio button, as it pertains to the patient.
- **D0180:** Requires an **Oral Hygiene** entry from the **OHA** screen.

**Diagnostic Findings**

Diagnostic Findings

Charting

☐ Dentition exhibits no apparent evidence of dental pathology at this visit

Screening Negative

H&N Findings

Parafunctional Habits

TMJ Findings

Occlusal Findings

Other:

Tooth Mobility

☐ Tooth Mobility Not Assessed

☐ No Significant Tooth Mobility Noted

☐ Tooth Mobility Noted (see Periodontal charting)

☐ Tooth Mobility Noted:

Additional Annotations

Annotations

Diagnostic Findings

Oral Health Assessment

<< Back

OK

Cancel

Next >>

**Element Requirements Panel**

D0150 Comprehensive Diagnostic Findings requirements:

This element requires complete exam findings charted.

This element requires an entry in Diagnostic Findings section of the Chart or the first statement of no apparent pathology.

The second check box becomes viewable and will only display after new patient findings are entered into any other DRM Plus findings screen.

This element requires the second check box to have a Plaque Index entry from the OHA screen.

This element requires one of the four radio buttons for Tooth Mobility. If "Tooth Mobility Noted" is selected, then details must be entered.

When the OHA check box "Patient has no remaining functional teeth, roots or implants" is selected this element will be satisfied.

Figure 272: Diagnostic Findings Element Screen

The user can enter any additional information regarding the patient into the **Additional Annotations** free text window. Right-click this window to import a text file, if desired. All information entered into this element displays in the read-only **Annotations** window. Once the element is complete, click the **Next** button to move on to the next element.



## Periodontal Assessment Element

The **Periodontal Assessment** element is required for the D0120, D0150 and D0180 exams. The D0120 and D0150 exams required at least one selection from the **Periodontal General Assessment** section. The **Detailed Assessment** button allows the user to enter additional perio data; however, this is optional for the D0120 and D0150 exam codes.

The **Include Last Perio Chart** check box defaults as unchecked if the provider wants to import the last filed periodontal chart into this element. The **Include Last Perio Chart** check box, when selected, satisfies the requirements for this **Periodontal Assessment** element for the D0140, D0160, D0170, and D9310 procedures. When any new perio data has been added to the perio chart during this session, that data imports into this element and satisfies the same four exam/consult procedures as stated previously.

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

**Periodontal Assessment**

Periodontal General Assessment

☐ Good Periodontal Health

	Acute	Chronic	Generalized	Localized	Slight	Moderate	Severe	Aggressive
<input type="checkbox"/> Gingivitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Gingival Enlargement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Generalized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Localized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Peri-implantitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

☐ Include Last Perio Chart

Additional Annotations

Annotations

PSR Oral Health Assessment << Back OK Cancel Next >>

**Element Requirements Panel**

D0150 Comprehensive Periodontal Assessment requirements:

This element requires at least one selection from the Periodontal General Assessment section.

The "Detailed Assessment" button allows the user to enter additional periodontal data; however, this is optional for this exam code.

The "Include Last Perio Chart" check box will include the last periodontal chart when selected.

When the OHA check box "Patient has no remaining functional teeth, roots or implants" is selected this element will be satisfied.

Figure 273: Periodontal Assessment Element Screen

The D0180 exam requires one selection from the **Periodontal General Assessment** section as well. The **Periodontal Detailed Assessment** section is optional and has optional text boxes with each selection if more descriptive detail is needed.

The D0180 exam also requires the first four rows in the **Additional Periodontal Detail** section to have at least one selection. The **Additional Periodontal Comments** text box is optional in this section. When the **Other** check box is selected from the **Past Periodontal Tx History** options, data entry is required in the **Additional Periodontal Comments** text box.

**Periodontal Assessment**

Periodontal General Assessment

☐ Good Periodontal Health

	Acute	Chronic	Generalized	Localized	Slight	Moderate	Severe	Aggressive
<input type="checkbox"/> Gingivitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Gingival Enlargement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Generalized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Localized Periodontitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Peri-implantitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Periodontal Detail Assessment

☐ Mucogingival defect

☐ Failed implant

☐ Alveolar ridge defect

Additional Annotations

Annotations

PSR Oral Health Assessment << Back OK Cancel Next >>

**Element Requirements Panel**

D0150 Comprehensive Periodontal Assessment requirements:

This element requires at least one selection from the Periodontal General Assessment section.

The "Detailed Assessment" button allows the user to enter additional periodontal data; however, this is optional for this exam code.

The "Include Last Perio Chart" check box will include the last periodontal chart when selected.

When the OHA check box "Patient has no remaining functional teeth, roots or implants" is selected this element will be satisfied.

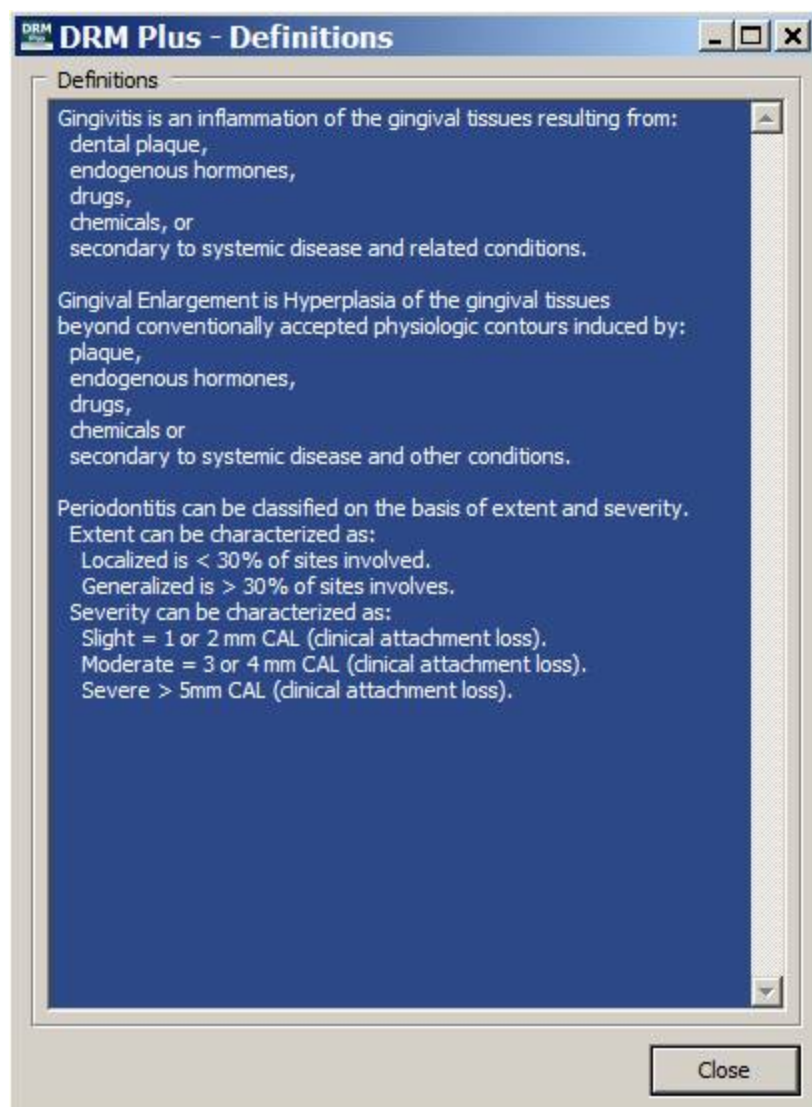
**Figure 274: Periodontal Detailed Assessment Button Selected**

**Note:** The D0180 exam code does NOT allow the user to select the **Brief Assessment** button from this screen.

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

The provider may open the **OHA** screen or the **PSR** screen using the buttons in the lower left area of this screen or the **Chart/Treatment** tab to enter an OHA finding or a PSR exam. The **Periodontal Chart** button on the middle right side of this screen allows access to that chart to enter any new findings for this session.

The following dialog displays the VA Office of Dentistry perio definitions when selecting the **Definitions** button.



**Figure 275: VA Dentistry Periodontal Definitions**

## Parafunctional Habits Element

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

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

The screenshot shows the 'Parafunctional Habits' window. The main area contains the following text:

You have not completed the following section: Parafunctional Habits

You can do this in the Chart/Treatment tab of DRM Plus.

Alternately, you can click on the button below for the specific section.

Below the text is an 'Additional Annotations' text box and an 'Annotations' list box.

On the right, the 'Element Requirements Panel' displays:

D0150 Comprehensive Parafunctional Habits requirements:

This element is optional.

However if you choose to enter any data for this element, please note:

The minimal requirement is to enter at least one historical or one clinical finding from the Parafunctional Habit screen.

The bottom of the window has a navigation bar with a 'Parafunctional Habits' button, '<< Back', 'OK', 'Cancel', and 'Next >>' buttons.

**Figure 276: Parafunctional Habits Element Screen**

Additional information regarding the patient may be entered into the **Additional Annotations** free text window. The user can right-click in this window to import a text file, if desired. All information entered into this element displays in the read-only **Annotations** window. Once this element is complete, click the **Next** button to move on to the next element.

## TMJ Findings Element

This element is required for the D0120, D0150 and D0180 exams. It requires new TMJ findings entered from the **TMJ** screen, which can be opened either by clicking the **TMJ** button from the **Chart/ Treatment** tab, or the **TMJ Findings** button located in the bottom left portion of this element.

The minimum requirement to enter a new TMJ exam finding is to select at least one historical or clinical finding from the **TMJ** screen. Additional information regarding the patient can be entered into the **Additional Annotations** free text window. The user can right-click in this window to import a text file, if desired.

The screenshot shows a software window titled "TMJ Findings". The main area contains instructional text: "You have not completed the following section: TMJ Findings. You can do this in the Chart/Treatment tab of DRM Plus. Alternately, you can click on the button below for the specific section." Below this text are two input areas: "Additional Annotations" (a single-line text box) and "Annotations" (a multi-line list box). To the right is a blue "Element Requirements Panel" with text: "D0150 Comprehensive TMJ Findings requirements: This element requires new TMJ Findings entered from the TMJ screen. The minimal requirement for entering a new TMJ exam is to choose at least one 'History', or one 'Clinical Findings'." The bottom of the window features a row of buttons: a red arrow button labeled "TMJ Findings", and navigation buttons "<< Back", "OK", "Cancel", and "Next >>".

**Figure 277: TMJ Findings Element Screen**

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

## Occlusal Findings Element

The **Occlusal Findings** element is required for every D0150 and D0180 exams. Occlusal findings must be entered into, and imported from the **Occlusion** screen when completing one of these exams. The **Occlusion** screen can either be opened by clicking the **Occl** (Occlusion) button from the **Chart/Treatment** tab, or by clicking the **Occlusal Findings** button in the bottom left corner of this screen.

From the **Clinical Findings** section, the **Mandibular relationship\*** is the only required field. All data from the last filed occlusion exam imports into the screen with a new exam, which requires the provider to remove and/or add correct data for the new exam.

**Occlusal Findings**

Occlusal Findings

You have not completed the following section: Occlusal Findings

You can do this in the Chart/Treatment tab of DRM Plus.

Alternately, you can click on the button below for the specific section.

Additional Annotations

Annotations

**Element Requirements Panel**

D0150 Comprehensive  
Occlusal Findings requirements:

This element requires Occlusal Findings entered from the Occlusion screen.

In the "Clinical Findings" section, the drop-down menu option 'Mandibular relationship' is the only required field.

All data from the last filed Occlusion exam will import into the screen when a new exam is selected allowing the provider to accept or change findings for the current exam.

Occlusal Findings    << Back    OK    Cancel    Next >>

**Figure 278: Occlusal Findings Element Screen**

Enter additional information regarding the patient in the **Additional Annotations** free-text window, which offers right-click functionality to import text files, if desired. All information entered into this element displays in the read-only **Annotations** window. When the element is complete, click the **Next** button to move on to the next element.



## Salivary Flow Element

The **Salivary Flow** element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The second radio button; **Clinically abnormal salivary quantity and/or quality noted**, requires a statement to be entered in the text box.

The **Xerostomia** value and description imports for viewing on this **Salivary Flow** element screen if entered from the **OHA** screen during this session.

**Salivary Flow**

☐ Clinically normal salivary quantity and quality noted

☐ Clinically abnormal salivary quantity and/or quality noted:

NOTE: Xerostomia may be entered in Oral Health Assessment (OHA) in addition to any comments made here.

Additional Annotations

Annotations

Salivary Flow Findings:

Element Requirements Panel

D0150 Comprehensive Salivary Flow requirements:

This element is optional.

However if you choose to enter any data for this element, please note:

The minimal requirement is to select one of the two radio buttons in the element.

The second radio button option requires a text entry in the text box.

<< Back OK Cancel Next >>

i Oral Health Assessment

**Figure 279: Salivary Flow Element Screen**

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



## Removable Prostheses Element

The **Removable Prostheses** element is optional for all seven exam/consult types. This element requires one of the top three radio buttons to be selected when entering data. If the user selects the third radio button, **Patient presents with removable prosthesis(es)**, the user must then select one of either the **Maxillary** or **Mandibular** radio buttons: **Partial** or **Complete**. Only one is required and, once selected, it pens two more radio buttons: **Satisfactory** or **Unsatisfactory**.

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

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

**Removable Prostheses**

Removable Prostheses

☐ Patient has no removable prosthesis(es)

☐ Patient's prostheses not evaluated at this time

☐ Patient presents with removable prosthesis(es):

**Maxillary**

☐ Partial ☐ Complete

☐ Satisfactory ☐ Unsatisfactory

☐ Occlusion ☐ Retention

☐ Stability ☐ Esthetics

**Mandibular**

☐ Partial ☐ Complete

☐ Satisfactory ☐ Unsatisfactory

☐ Occlusion ☐ Retention

☐ Stability ☐ Esthetics

☐ Other Prostheses;

Additional Annotations

Annotations

Removable Prostheses Findings:

Element Requirements Panel

D0150 Comprehensive Removable Prostheses requirements:

This element is optional.

However if you choose to enter any data for this element, please note:

The minimal requirement is to select one of the top three radio buttons in the element.

The selection of the third radio button will allow the selection of another radio button listed in a maxillary or mandibular column.

Only one selection of a maxillary or mandibular radio button is allowed which is followed by another selection of a satisfactory or unsatisfactory radio button.

When selecting the unsatisfactory option there may be up to four possible descriptive words for selection or a text box to enter something that may not be listed.

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.

<< Back OK Cancel Next >>

Figure 280: Removable Prostheses Element Screen

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

## Assessment/Plan Element

The **Assessment/Plan** element, comprised of an assessment and planned section, is required for all seven exam/consult procedures. The top assessment section is optional for the completion of this element.

The **Treatment Plan** section requires one of the four check boxes or only one pre-defined statement to be selected to complete the element. The first check box, **Include charted treatment plan**, loads automatically and imports the patient's newly entered and/or past planned treatment.

Up to twelve pre-defined statements for the **Assessment Summary** and twelve **Treatment Plan** statements can be selected from this screen. The check boxes found in the pre-defined statement windows have three national assessment and three national planned statements pre-loaded; however, all twelve statements from either can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

**Assessment/Plan (review/edit)**

Assessment/Plan (review/edit)

Assessment Summary

- ☐ No urgent dental needs or acute dental infections noted on examination.
- ☐ No contraindications for planned procedure(s).
- ☐ Dentition in satisfactory repair and function.
- ☐ Clinic wide Assessment Summary pre-defined statement entered.
- ☐ First end-user Assessment Summary pre-defined statement entered.
- ☐ Second end-user Assessment Summary pre-defined statement entered.

Treatment Plan

- ☒ Include charted treatment plan
- ☐ Referred to assigned dentist for further treatment planning
- ☐ No treatment required at this time
- ☐ Final treatment plan to be completed at a later time
- ☐ Reviewed risks/benefits/alternatives associated with the proposed treatment plan. Patient agrees to
- ☐ Adequate dentition for mastication. Replacement of missing teeth is not indicated.
- ☐ Patient is not eligible for replacement of teeth through VA.

Additional Annotations

Annotations

Assessment/Plan:

Planned Procedures:

Non-VA Care

(D7950) MANDIBLE GRAFT: . DX: ( ) .

Phase 2

(D2150) AMALGAM TWO SURFACES PERMANE: 14(OL) . DX: ( ) . (Next-  
Appt)

(D2160) AMALGAM THREE SURFACES PERMA: 15(DOL) . DX: ( ) . (Next-  
Appt)

Treatment Plan

<< Back OK Cancel Next >>

**Element Requirements Panel**

D0150 Comprehensive Assessment/Plan (review/edit) requirements:

In the "Assessment Summary" section, the text box and pre-defined statements are optional. It is highly recommended at a minimum an appropriate pre-defined statement is selected for detail.

The "Treatment Plan" section requires one of the four check boxes, and/or one pre-defined statement to be selected.

Planned data will import automatically and the check box will appear preselected if there is any previously planned data present.

Figure 281: Assessment/Plan Element Screen

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

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

**Note:** The **Assessment/Plan** element imports incomplete when it is saved as unfiled data and reloaded. The provider is required to review/edit this element again at this time.

## Patient Education Element

The **Patient Education** element is optional for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button opens a text box that requires specific information regarding the patient or one pre-defined statement may be selected.

Up to twelve pre-defined statements on patient education can be selected from this screen. The check boxes found in the pre-defined statements window have two national patient education statements pre-loaded; however, all twelve statements can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

**Patient Education**

Patient Education

☐ No barriers to learning identified

☐ Barriers to learning identified:

☐ Reviewed risks/benefits/alternatives associated with the proposed treatment plan. Patient agrees to

☐ Patient received post operative care instructions and verbally indicates understanding.

Additional Annotations

Annotations

<< Back OK Cancel Next >>

**Element Requirements Panel**

D0150 Comprehensive Patient Education requirements:

This element is optional.

However if you choose to enter any data for this element, please note:

The minimal requirement is to select one of the two radio buttons in the element.

The selection of the second radio button will open a text box that requires a text description about barriers to learning and/or selection of at least one pre-defined statement.

**Figure 282: Patient Education Element Screen**

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

## Disposition Element

The **Disposition** element is required for all seven exam/consult procedures. This element requires one of the two radio buttons to be selected when entering data. The selection of the second radio button, **Next visit**, requires at least one of the following; one selection of the eight date ranges, a text description about the next visit typed in the text box, or one selection from the pre-defined statements.

The **Next Appointment** check boxes, if selected in the **Tx Planning/Sequencing** screen, import automatically into the **Annotations** view window of this element.

Up to twelve pre-defined statements on disposition can be selected from this screen. The check boxes found in the pre-defined statements window have four national disposition statements pre-loaded; however, all twelve statements can be created locally. The DRM Administrator has priority over all other users and may add or delete all twelve, if desired.

The screenshot shows the 'Disposition' window with the following components:

- Disposition** section:
  - Radio buttons: ☐ No follow up appointment indicated, ☐ Next visit:
  - Next visit date ranges (checkboxes):
    - within 1 week, 1-2 weeks, 2-4 weeks, 1-2 months
    - 2-3 months, 3-4 months, 4-6 months, recall
  - Text box for next visit description.
  - Pre-defined statements (checkboxes):
    - ☐ Patient has no eligibility for VA dental benefits and was recommended to the private sector for routine
    - ☐ Patient to return to dental clinic for continuing care.
    - ☐ Patient to be scheduled for continuing development of treatment plan.
    - ☐ Patient provided instructions for obtaining fee dental care subject to VA authorization of proposed tre
- Additional Annotations** section: A large text box for additional information.
- Annotations** section: A read-only window showing the following text:

```
Disposition:
Next Appointment:
(D2150) AMALGAM TWO SURFACES PERMANE: 14(OL) Amalgam
(D2160) AMALGAM THREE SURFACES PERMA: 15(DOL) Amalgam
```
- Element Requirements Panel** (right sidebar):
  - Header: D0150 Comprehensive Disposition requirements:
  - Text: This element requires one of the two radio buttons to be selected when entering data.
  - Text: The selection of the second radio button will require at least one of the following:
    - one selection of the eight date ranges or
    - a text description about the next visit typed in the text box or
    - one selection of the pre-defined statements.
- Buttons at the bottom: << Back, OK, Cancel

Figure 283: Disposition Element Screen

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

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

## Import Previously Filed Data Screen

When any provider has filed patient dental data previously that day in any of the following screens: **Social History, OHA, TMJ, Parafunctional Habits, Occlusion, Diagnostic Findings, Head and Neck Findings, PSR or Periodontal Chart**; then that data may be imported by a second provider entering an exam encounter that same day. The second provider, after selecting an exam code and then selecting the **Exam** tab, has the following **Import Previously Filed Data** screen display. This screen allows the provider an option to import the data into his exam template to satisfy some possible requirement from the exam code that they may have selected.

Selecting the check boxes of any or all previously filed data that day imports that data into their present exam template session. There is a **Check ALL the above** check box at the bottom of the screen which allows all that day's filed data to be imported into this new TIU progress note. After selecting the desired check boxes, the provider click the **Import** button to incorporate this data into the current exam template. If none of the data should be imported into the current exam template, then select the **Cancel** button.

DRM Plus - Import Previously Filed Data

Previously Filed Today

☐ Diagnostic Finding(s) were filed earlier today

Dental Examination:  
Missing Teeth: 17, 32.

☐ Periodontal Charting was filed earlier today

Periodontal Charting  
(This is textual display of periodontal findings. Please see DRM Plus for perio charting graphic.)

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
F(SUP)																S
F(BLD)	B	b				B	b									b
F(FGM)	222	1				1	1			1	1					112
F(PD)	444	433	322	234		432	222	222	223			322	222	234	444	
(MOB)	0.5				0.5		0.5									1
L(PD)	443	222	222	344		432	222	222	334			443	222	333	344	
L(FGM)	211					1	1									112

TOOTH 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

F(FGM) 1 1

F(PD) 444 332 222 222 222 222 222 222 222 222 222 222 222 222 223 344

L(PD) 443 322 222 222 222 222 222 222 222 222 222 222 222 222 233 444



L(FGM) 1 1

KEY: B=Bleeding b=Delayed Bleeding S=Suppuration  
+=Pocket/MQJ > 3 +=FGM coronal to CEJ  
(Periodontal chart may be a composite of entries from different dates)

☐ Check ALL the above.

Import Cancel

Figure 284: Import Previously Filed Data Screen

The  icon on the right of the element button displays when there was previously filed data the same day and that data is associated with the element. The **Diagnostic Findings** element informs the provider, by displaying the  icon, there is one or any combination of diagnostic findings and periodontal charting filed earlier the same day by another provider.

Below the element icons located on the left side of the **Exam** tab, there is a **Review Data Filed Today** button. This button only displays when data was filed to the VistA database earlier that day by all providers working with this patient. This button allows the provider to open the **Import Previously Filed Data** screen to make edits or corrections by the present provider on what was filed previously that day.

**Note:** The **yellow asterisk** icon will always display when vitals have been entered for this patient during a 24 hours range from the **Visit** date and taken anywhere in the hospital for this patient.



# Completing the Encounter

Click the **Next** button, located in the bottom right corner of both the **Treatment & Exam** and **Periodontal Chart** screens, to begin completing the encounter for the patient's chart. If there was no provider/visit/date in the banner, imported or selected, when the patient's chart was opened and **NOT** one completed transaction selected; then clicking the **Next** button brings up the **Provider and Location for Current Activity** screen to select/enter a visit. After selecting one procedure code the **File Data Option** screen displays, which is explained later in this chapter. In addition, if the system finds possible duplicate procedure codes in the planned and completed transactions, the **Potential Duplicate Transaction** screen displays.

To complete the patient encounter with completed transactions:

1. Click the **Next** button on the bottom right corner of either the **Treatment & Exam** or **Periodontal Chart** screens.
2. The **Filing Options** screen displays.

**Dental Record Manager Plus in use by: DRMPROVIDER,ADMINDENTIST for DRMPATIENT,ONE**

File Edit Dental Encounter Data Treatment & Exam Tools Reports Help

DRMPATIENT,ONE May 31, 17:09:00 DENTAL PDP: DRMPROVIDER,ADMINDENTIST Dental Class  
000-00-0001 01/01/1960 Age: 57 DRMPROVIDER,ADMINDENTIST SDP: 15-OPC, Class IV

Cover Page Clinical Record Dental History Chart/Treatment Exam

**Filing Options**  
☒ File Data With a Note  
☐ File Data With a Note Addendum  
☐ File Data Without a Note

**Visit Date/Time**  
05/31/2017 09:00

**Suggested Recare Date**

**Encounter Dental Class**  
15-OPC, Class IV

**Disposition**  
☒ Active  
☐ Inactive  
☐ Maintenance

**Primary PCE Diagnosis**  
Select a primary PCE diagnosis by clicking on a checkbox below.

Select	Diagnosis	Diagnosis Description	Send Dx to CPRS Problem List	Additional Information	Procedure	Procedure Description
<input checked="" type="checkbox"/>	K08.530	FRACTURED DENTAL RESTORATIVE...	<input type="checkbox"/>	Tooth: 14 / Surface: OL	D2150	AMALGAM TWO SURFACES PERMA...
<input type="checkbox"/>	K08.530	FRACTURED DENTAL RESTORATIVE...	<input type="checkbox"/>	Tooth: 15 / Surface: DOL	D2160	AMALGAM THREE SURFACES PERMA...

**Service Connection**  
☐ Encounter is associated with service-connected condition  
☐ Southwest Asia Conditions (SWAC) ☐ Ionizing Radiation Treatment ☐ Combat Veteran ☐ Agent Orange Treatment ☐ Head and Neck  
☐ Military Sexual Trauma ☐ PROJ 112/SHAD

**Additional Providers**  
Add ... Remove

**Additional Signers**  
Add ... Remove

**Station**  
500 500BZ

Return to Chart <= Back Next => Finish

Figure 285: Filing Options Screen

3. Select the correct **Filing Option**. The information displayed in the **Visit Date/Time** and the **Disposition** defaults can be changed. The **Encounter Dental Class** defaults if saved on the cover page. Select the **Suggested Recare Date** if applicable to the patient.
4. Select the **Primary PCE Diagnosis** for the encounter, unless there is only one no matter how many transactions there are which defaults checked.
5. Provider may select the diagnosis to be sent to the patient's problem list.



6. Enter the locally required information for service connection.
7. Enter the optional information of **Additional Providers** or **Additional Signers** on this screen. Please see the **Additional Providers/Additional Signers** section, found later in this chapter, for more information.
8. Select the appropriate facility (station) by clicking the appropriate radio button.
9. Click the **Next** button.
10. The **Dental Class Discrepancy** screen may display, if the encounter dental class and cover page dental class do NOT match. This does NOT stop the user from completing the encounter.
11. The **Set Progress Note Title** screen displays. Note that this screen does NOT display if the **File Data with a Note Addendum** or **File Data Without a Note** options were selected from the filing options.

**Set Progress Note Title**

Selection of TIU Progress Note or Consult Title for Note  
Select title from list or type the desired title.

Typing the desired title in top box will cause the list of titles to change using the letters typed.

Progress Note Title

DENTAL NOTE  
DENTAL CONSULT

ADDENDUM <TOM TEST ADDENDUM>  
ADDICTION <ASI-ADDICTION SEVERITY INDEX>  
ADMISSION <ADMISSION ASSESSMENT>  
ADMISSION ASSESSMENT  
ADIR <ADVANCE DIRECTIVE>  
ADMISSION <ADMISSION ASSESSMENT ONE>  
ADMISSION <ADMISSION ASSESSMENT TWO>  
ADMISSION ASSESSMENT ONE  
ADMISSION ASSESSMENT TWO  
ADMIT <JOY ADMIT (BP)>  
ADMIT <JOY ADMIT>  
ADVANCE <ADVANCE DIRECTIVE NOTIFICATION AND SCREENING>  
ADVANCE <ADVANCE DIRECTIVE>  
ADVANCE DIRECTIVE

OK Cancel

**Figure 286: Set Progress Note Title Screen**

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

**Figure 287: Progress Note Screen**

15. Ensure the information on the screen is correct. Enter the electronic signature and click the **Finish** button. An electronic signature is **NOT** required to file the note as unsigned. Please see the **Electronic Signature** section, found later in this chapter, for more information.
16. The **Change Provider** screen displays.

**Figure 288: Change Provider Screen**

17. Click the **Yes** button to change the provider. The **Search for Provider** screen displays. If **No** is selected, a screen displays. Please see step 19.



## Potential Duplicate Transactions Screen

If the system detects that a possible duplicate transaction exists, the **Potential Duplicate Transactions** screen displays, when the **Next** button on the **Treatment & Exam** or **Periodontal Chart** screens is clicked.

These transactions have already been **PLANNED** for the following teeth:

Tooth	Surface	ADA Code	Description	Keep	Delete
14	d	D3330	END THXPY MOLAR TOOTH	<input type="checkbox"/>	<input checked="" type="checkbox"/>

These are the **COMPLETED** transactions you just entered:

Tooth	Surface	ADA Code	Description	Keep	Delete
14	OL	D2150	AMALGAM TWO SURFACES PERMANE	<input checked="" type="checkbox"/>	<input type="checkbox"/>

☐ Keep Planned    ☐ Let Me Decide  
☒ Keep Completed    ☐ Keep All

Process and Go Back    Cancel    Process and Continue

**Figure 291: Potential Duplicate Transactions! Screen**

A list of planned transactions for a tooth, along with the procedure code and the description, are listed in the top portion of the screen. Completed transactions taken during this encounter are listed in the bottom portion of the screen, with elements that match other planned transactions for the same tooth.

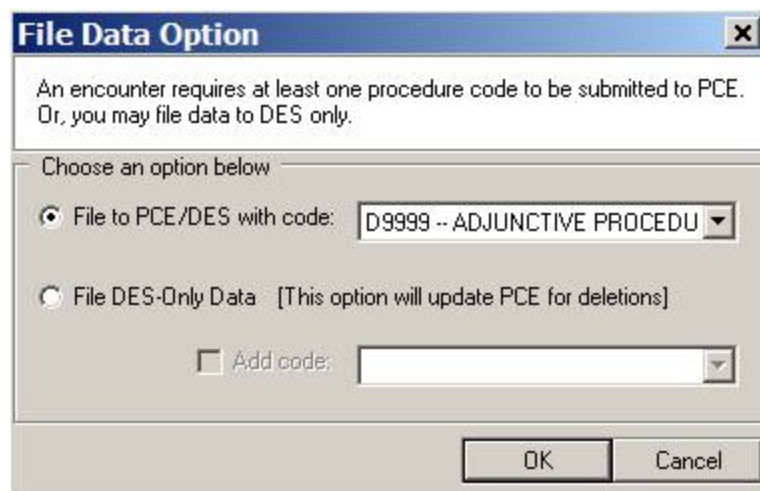
The radio buttons on the lower left portion of the screen designate which information is kept or discarded. The **Keep Planned** radio button keeps the planned transaction and deletes the conflicting completed transaction entered during the encounter. The **Keep Completed** radio button keeps the completed transaction entered during this encounter and deletes the planned transaction. The **Let Me Decide** radio button clears all check boxes and allows for picking and choosing among the planned and completed transactions. **Keep All** allows all conflicting procedure codes that are planned and completed to be processed.

After clicking the desired radio button and selecting, if necessary, which transactions are kept and/or discarded, click the **Process and Go Back**, **Cancel** or **Process and Continue** buttons to continue completing the encounter. **Process and Go Back** processes the procedure codes and returns to the **Treatment & Exam** or **Periodontal Chart** screen. **Cancel** displays the **Periodontal Chart** or **Treatment & Exam** screen without processing any information. **Process and Continue** processes the procedure codes and continues updating the TIU progress note. The **Filing Options** screen displays. Continue completing the encounter from this point, as outlined previously in this chapter.

**Note:** The system does NOT present a user with the **Potential Duplicate Transactions** screen when the potential duplicate is a tooth-related radiographic procedure.

## **File Data Option Screen**

If no procedure code has been entered as completed treatment on the **Completed Care** screen and the user clicks the **Next** button, the **Provider and Locations for Current Activities** screen displays if no visit is present in the banner. When the visit is present or after one has been selected then the **File Data Option** screen displays.



**Figure 292: File Data Option Screen**

Click the appropriate radio button to designate whether the data is to be filed to PCE/DES with a procedure code, or to file to DES-Only data.

### **File to PCE/DES with Code**

To file data to PCE/DES with a procedure code:

1. The **Provider and Location for Current Activities** screen displays. Select the correct visit.
2. Click the **File to PCE/DES with code** radio button on the **File Data Option** screen.
3. The program defaults to **D4999** if entering this screen from the **Periodontal Chart**, and **D9999** if entering from **Treatment & Exam**.
4. If the default procedure code is incorrect, click the code drop-down menu and select the desired procedure code.
5. Click the **OK** button.
6. The **Diagnosis Code** screen displays.
7. Select the procedure code on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does NOT appear, use the **Additional Diagnosis Code Search** to find a different diagnosis code.

## File to DES-Only Data

To file to DES-Only data:

1. The **Provider and Location for Current Activities** screen displays. Select the correct visit.
2. Click the **File to DES-Only Data** radio button.
3. If a procedure code is desired (NOT required), check the **Add code** check box and use the drop-down menu to select a procedure code.
4. The **Diagnosis Code** screen displays.
5. Select the procedure code on the left side of the screen (default is all selected) and the diagnosis code(s) on the right side. If the correct diagnosis code does NOT appear, use the **Additional Diagnosis Code Search** to find a different diagnosis code.

## Filing Options Screen

The **Filing Options** screen is divided into ten main sections: **Filing Options, Visit Date/Time, Encounter Dental Class, Disposition, Suggested Recare Date, Primary PCE Diagnosis & Send DX to CPRS Problem List, Service Connection, Additional Providers, Additional Signers and Station.**

### Filing Options

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

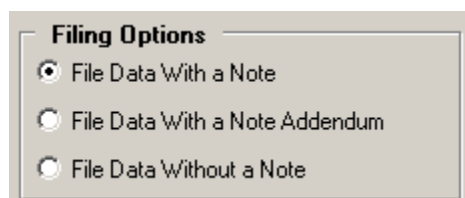


Figure 293: Filing Options

The options are: **File to Data with a Note, File Data With a Note Addendum** and **File Data Without a Note**. The **File Data Without a Note** creates no TIU progress note.

### Visit Date/Time

Adjust the **Visit Date/Time** using this function. The program defaults to whatever was entered on the **Provider and Location for Current Activities** screen.

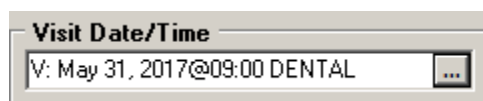


Figure 294: Visit Date/Time

To change the visit date and time:

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



- Choose the correct provider and appointment from the **Provider and Location for Current Activities** screen and click the **OK** button. Please see the Dental Encounter Data section in the Using DRM Plus Drop-Down Menus chapter of this manual, for further information.

## Encounter Dental Class

Use the drop-down menu to change the **Encounter Dental Class** for this encounter.

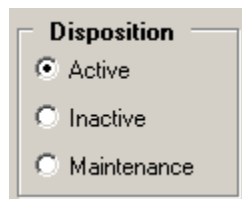


The screenshot shows a window titled "Encounter Dental Class" with a drop-down menu. The selected option is "15-OPC, Class IV".

Figure 295: Encounter Dental Class

## Disposition

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

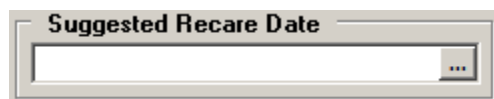


The screenshot shows a window titled "Disposition" with three radio buttons: "Active" (selected), "Inactive", and "Maintenance".

Figure 296: Disposition

## Suggested Recare Date

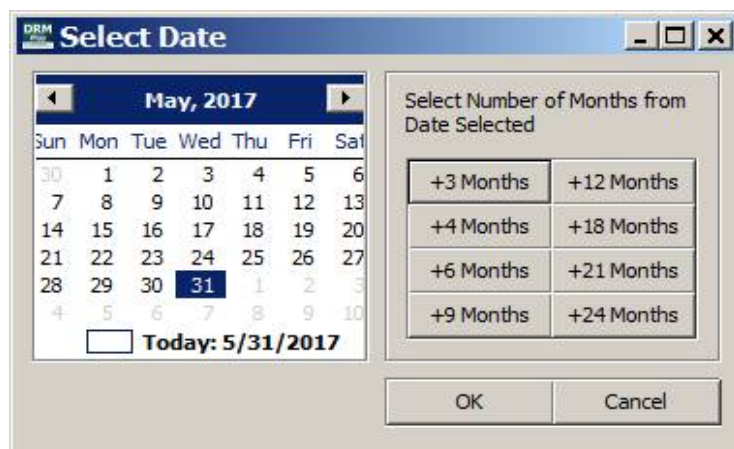
Use the **Ellipsis (...)** button to add/change the suggested recare date.



The screenshot shows a window titled "Suggested Recare Date" with a text field and an ellipsis button (...).

Figure 297: Suggested Recare Date

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



The screenshot shows a window titled "Select Date" with a calendar for May 2017. The date 5/31/2017 is selected. To the right, there is a section titled "Select Number of Months from Date Selected" with a grid of buttons: +3 Months, +12 Months, +4 Months, +18 Months, +6 Months, +21 Months, +9 Months, and +24 Months. At the bottom are "OK" and "Cancel" buttons.

Figure 298: Select Date Screen



Select the date from the calendar or select the number of additional months from the date selected first on the calendar and then click the **OK** button.

## Primary PCE Diagnosis & Send Dx to CPRS Problem List

This window features a list of the diagnosis codes with descriptions, selections to send diagnosis to CPRS problem list, procedure codes with descriptions, and additional information.

Select the primary PCE diagnosis by clicking the check box under the **Select** column in the **Primary PCE Diagnosis** window. If there is only one diagnosis, or several of the exact same diagnosis, the selection is checked by default. All encounters require only one primary diagnosis filed to VistA PCE.

Select diagnoses to **Send Dx to CPRS Problem List** by clicking the check box in that column.

Select	Diagnosis	Diagnosis Description	Send Dx to CPRS Problem List	Additional Information	Procedure	Procedure Description
<input checked="" type="checkbox"/>	K02.53	DENTAL CARIES ON PIT AND FISSURE	<input type="checkbox"/>	Tooth: 31 / Surface: DOL	D2160	AMALGAM THREE SURFACES PERMANENT
<input checked="" type="checkbox"/>	K02.53	DENTAL CARIES ON PIT AND FISSURE	<input type="checkbox"/>	Tooth: 30 / Surface: OL	D2150	AMALGAM TWO SURFACES PERMANENT

Figure 299: Primary PCE Diagnosis Window

The **Primary PCE Diagnosis** window allows one completed transaction at a time to be deleted when using the **Delete Highlighted Transaction** button.

First highlight the completed transaction that should be deleted and then select the **Delete Highlighted Transaction** button located in the upper right corner of the window.



Figure 300: Transaction Deletion Screen

The resulting pop-up will display asking are sure you want to proceed. Selecting the **Yes** button will delete that completed transaction.

## Service Connection

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

Figure 301: 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
<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <div style="text-align: right; padding-right: 5px;"> <input type="button" value="Add ..."/>  <input type="button" value="Remove"/> </div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div> <div style="text-align: right; padding-right: 5px;"> <input type="button" value="Add ..."/>  <input type="button" value="Remove"/> </div>

**Figure 302: Additional Providers/Additional Signers**

To add a provider or signer:

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

[illegible]

### Figure 303: Search for Provider Screen

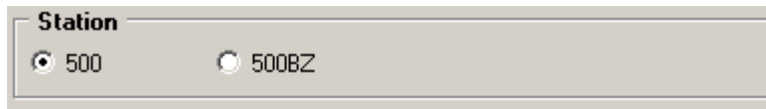
3. Enter the name into the text box and press <Enter>.
4. Select the correct name from the results and click the **OK** button.
5. The provider displays on the **Additional Provider/Signer** window. Repeat as necessary.

To remove a Provider/Signer:

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

## Station

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

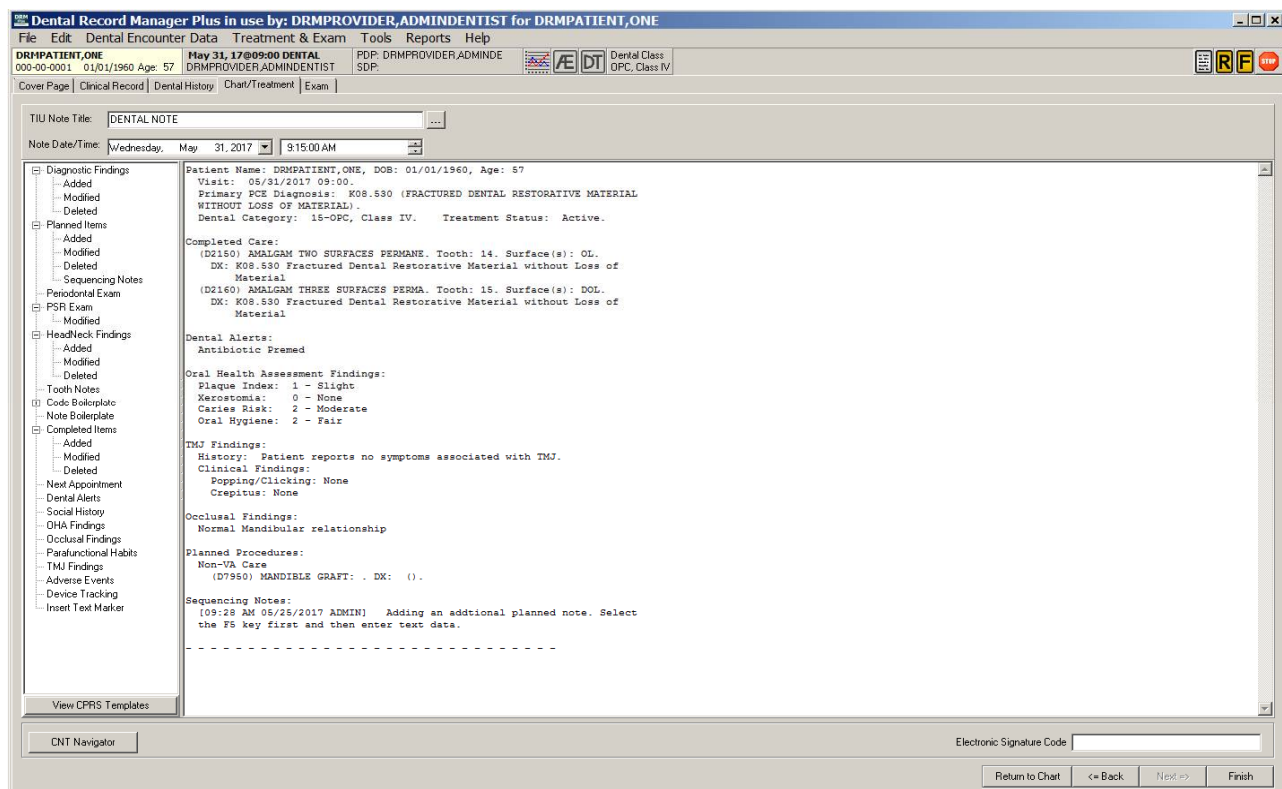


The image shows a 'Station' selection window. It has a title bar 'Station' and two radio buttons below it. The first radio button is labeled '500' and is selected. The second radio button is labeled '500BZ' and is not selected.

Figure 304: Station

## Progress Note Screen

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



The screenshot shows the 'Dental Record Manager Plus' software interface. The title bar indicates it is in use by 'DRMPROVIDER,ADMINISTRATOR for DRMPATIENT,ONE'. The menu bar includes File, Edit, Dental Encounter Data, Treatment & Exam, Tools, Reports, and Help. The status bar shows patient information: DRMPATIENT,ONE, 000-00-0001, 01/01/1960, Age: 57, DRMPROVIDER,ADMINISTRATOR, FOP: DRMPROVIDER,ADMINDE, SDP: . The main window is titled 'DENTAL NOTE' and shows a patient encounter for 'Wednesday, May 31, 2017' at '9:15:00 AM'. The patient name is 'DRMPATIENT,ONE', DOB is '01/01/1960', and Age is '57'. The visit is '05/31/2017 09:00'. The primary PCE diagnosis is 'K08.530 (FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL)'. The dental category is '15-OPC, Class IV', and the treatment status is 'Active'. The completed care section lists two procedures: 'D2150 AMALGAM TWO SURFACES PERMANE. Tooth: 14. Surface(s): OL. DX: K08.530 Fractured Dental Restorative Material without Loss of Material' and 'D2160 AMALGAM THREE SURFACES PERMA. Tooth: 15. Surface(s): DOL. DX: K08.530 Fractured Dental Restorative Material without Loss of Material'. The dental alerts section lists 'Antibiotic Premed'. The oral health assessment findings section lists 'Plaque Index: 1 - Slight', 'Xerostomia: 0 - None', 'Caries Risk: 2 - Moderate', and 'Oral Hygiene: 2 - Fair'. The TMJ findings section lists 'History: Patient reports no symptoms associated with TMJ', 'Clinical Findings: Popping/Clicking: None', and 'Crepitus: None'. The occlusal findings section lists 'Normal Mandibular relationship'. The planned procedures section lists 'Non-VA Care (D7950) MANDIBLE GRAFT: . DX: ( )'. The sequencing notes section lists '[09:28 AM 05/25/2017 ADMIN] Adding an additional planned note. Select the F5 key first and then enter text data.' The interface includes a left sidebar with a tree view of categories like Diagnostic Findings, Planned Items, Periodontal Exam, PSR Exam, Head/Neck Findings, Tooth Notes, Code Boilerplate, Note Boilerplate, Completed Items, Next Appointment, Dental Alerts, Social History, OHA Findings, Occlusal Findings, Parafunctional Habits, TMJ Findings, Adverse Events, Device Tracking, and Insert Text Marker. At the bottom, there is a 'View CPRS Templates' button, a 'CNT Navigator' button, and an 'Electronic Signature Code' field with buttons for 'Return to Chart', '<= Back', 'Next >=', and 'Finish'.

Figure 305: Progress Note Screen

Use the **Ellipsis (...)** button to change the TIU progress note title here if needed. Use the **up** and **down arrows** to change the **Note Date/Time** if desired. From this screen, the user can also: view and/or import DRM Plus objects, view and import CPRS templates, launch the **CNT Navigator** (DSS clinical note templates), view the patient's TIU progress note, import VistA medical information, and add an electronic signature.

In addition to the imports that can be made into a TIU progress note, free-texting for narrative may also be entered prior to filing the note by the user.

## Viewing/Importing DRM Object/Progress Note

To view/import DRM objects:

1. Click the **View DRM Plus Objects** button (defaulted) below the tree on the left side of the screen.
2. Double-click the DRM object and it displays in the viewer on the right side of the screen. The DRM object imports where the cursor is positioned.
3. Information can be added or deleted by typing directly into the progress note on the right side of the screen.

## Viewing/Importing CPRS Templates

To view/import CPRS templates:

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

## Importing VistA Medical Information

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

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

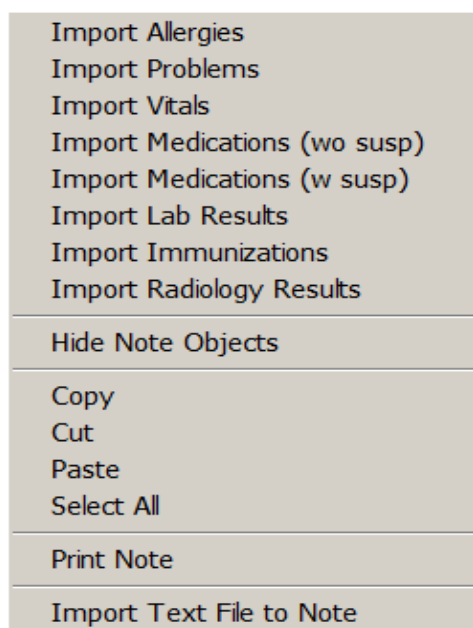


Figure 306: Import Menu Screen

3. Choose the information that is to be imported from the top half of the menu.
4. The information displays in the progress note where the cursor was positioned.

## Other Options in the Import Menu

- **Hide Note Objects:** Hides or closes the objects tree on the left side of the screen and enlarges the progress note viewer.
- **View Note Objects:** Undoes the hide note objects.
- **Copy:** Copies selected text in the progress note.
- **Cut:** Cuts selected information in the progress note.
- **Paste:** Pastes information into the progress note.
- **Select All:** Selects all text in the progress note.
- **Print Note:** Prints the progress note.
- **Import Text File to Note:** Navigates to a text file to import into a note. See the User Options section in the Using DRM Plus Drop-Down Menus chapter of this manual for more information on automatically setting the location for this text file.

## Accessing Dental CNTs

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

## Electronic Signature

Enter the **Electronic Signature Code** and click the **Finish** button to complete the TIU progress note. Clicking the **Finish** button without entering an electronic signature leaves the patient TIU progress note status as unsigned.

## Progress Note Addendum

When the **File Data With Note Addendum** option has been chosen, the **Progress Note** screen displays slightly different. The functions are the same as in the previously shown progress note screen with the additions of selecting the **Note Categories** radio button options and with the parent note displaying in the upper right window.

**Figure 307: Progress Note Addendum Screen**

The notes associated with the selected **Note Categories** appear in the narrow window below the note categories area. Use the drop-down menu below the note categories to filter the results. Click a parent note to view details in the upper right window of the screen.

Finish the process of filing the encounter with a note addendum, which displays in the lower right window of the screen.



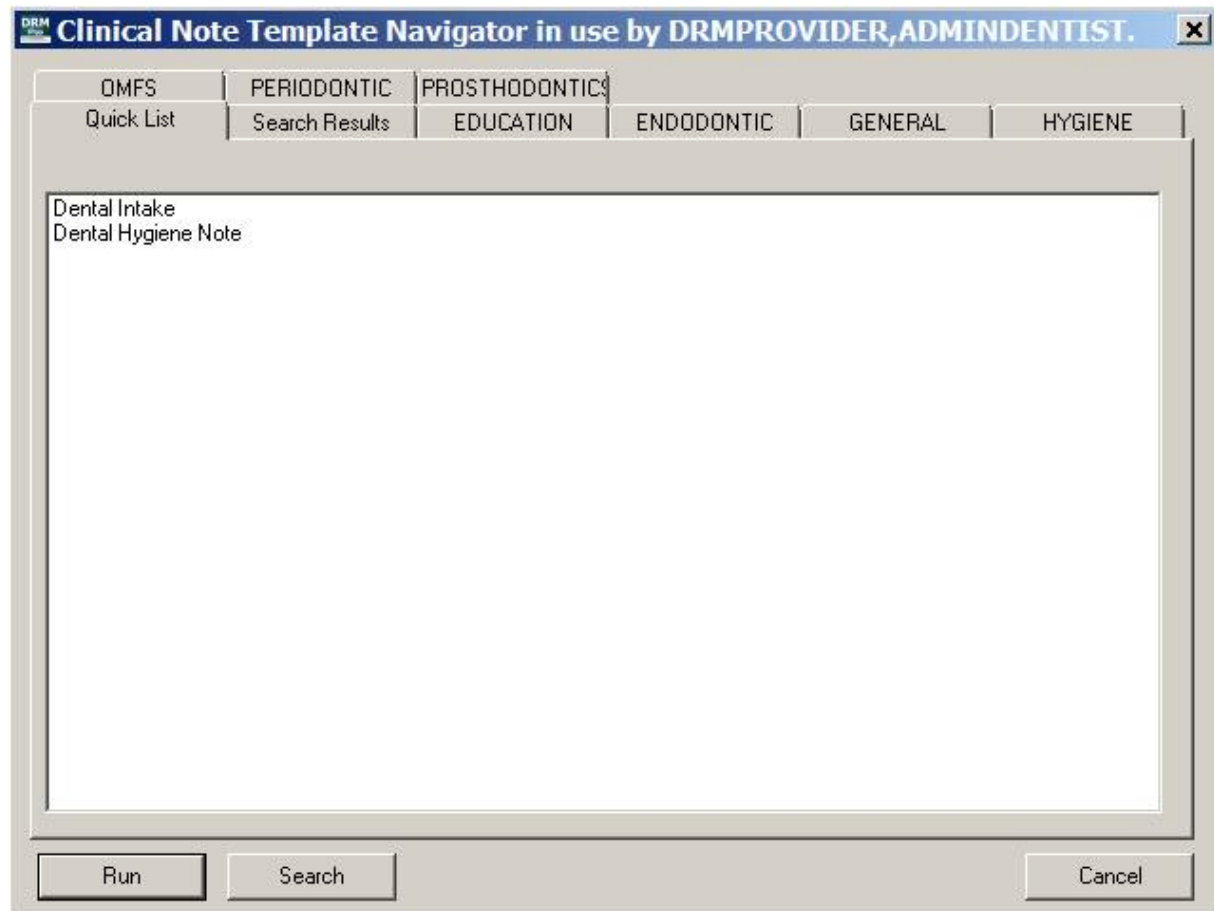
## CNT Navigator

Clicking the **CNT Navigator** button displays up a directory of clinical note templates in use, as a tool, to assist the user in writing a note, or additional information to a note. The **CNT Navigator** button is located on the bottom left side of the **Progress Note** screen. These are Document Storage Systems (DSS) product clinical note templates, and may NOT function unless they are mapped correctly, which requires IT assistance.



**Figure 308: CNT Navigator Button**

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



**Figure 309: Clinical Note Template Navigator Screen**

To access a CNT:

1. Click any of the tabs.
2. A listing of CNTs specific to the selected tab displays. Either double-click the desired template, or click once to select it and then click the **Run** button.

## Navigating Within CNTs

To navigate within a CNT:

1. Point and click within the windows, tabs, drop-down arrows, check boxes, and radio buttons. Each navigational method provides the user with a different method of entering or selecting information.

The screenshot shows a software window titled "Dental Hygiene Progress Note" with a menu bar (File, Tools, Help). The "Vital Signs" section contains input fields for Temp., Pulse, Systolic, Patient Sex (Male/Female), Height, Resp., Diastolic, BMI, Age, Weight, Pain, SP02%, and BSA, each with a "Date/Time" label. The "Chief Complaint" section has buttons for "Click for Normal", "Select from Pick List", and "Clear Text", followed by a list box containing: Headache, Pain to heat, Pain to cold, Pain to pressure, Toothache, Swelling, Pain with Postural Changes, Teeth Sensitive to Chewing, and Minimal to No Relief from OTC Pain Medication. Below this is a "Pre-Medication" dropdown menu and a checkbox. The "ASA" section has radio buttons for 1, 2, 3, and 4. The bottom toolbar includes buttons for Open, Save, Reminders, Preview, Cancel, Finish, Prev, 1 of 6, and Next.

Figure 310: Navigating Within CNT

2. Preview the note by clicking the **Preview** button.
3. Click the **Return** button to continue writing the note.

**Preview Note (Not Connected To VISTA).**

MEDICATIONS:  
Ibuprofen

ALLERGIES:  
Sulfa

ORAL HYGIENE:  
Fair.

CALCULUS ASSESSMENT:  
Slight.

ORAL ASSESSMENT:  
Caries.

ANESTHETIC:  
1.8 ml. of Lidocaine 2% with epinephrine 1:100,000.

REACTION TO TREATMENT:  
Fairly well.

RECAP PLAN:  
6 months.

TREATMENT NEEDED:  
Oral Hygiene

Accept Note

Return To Form

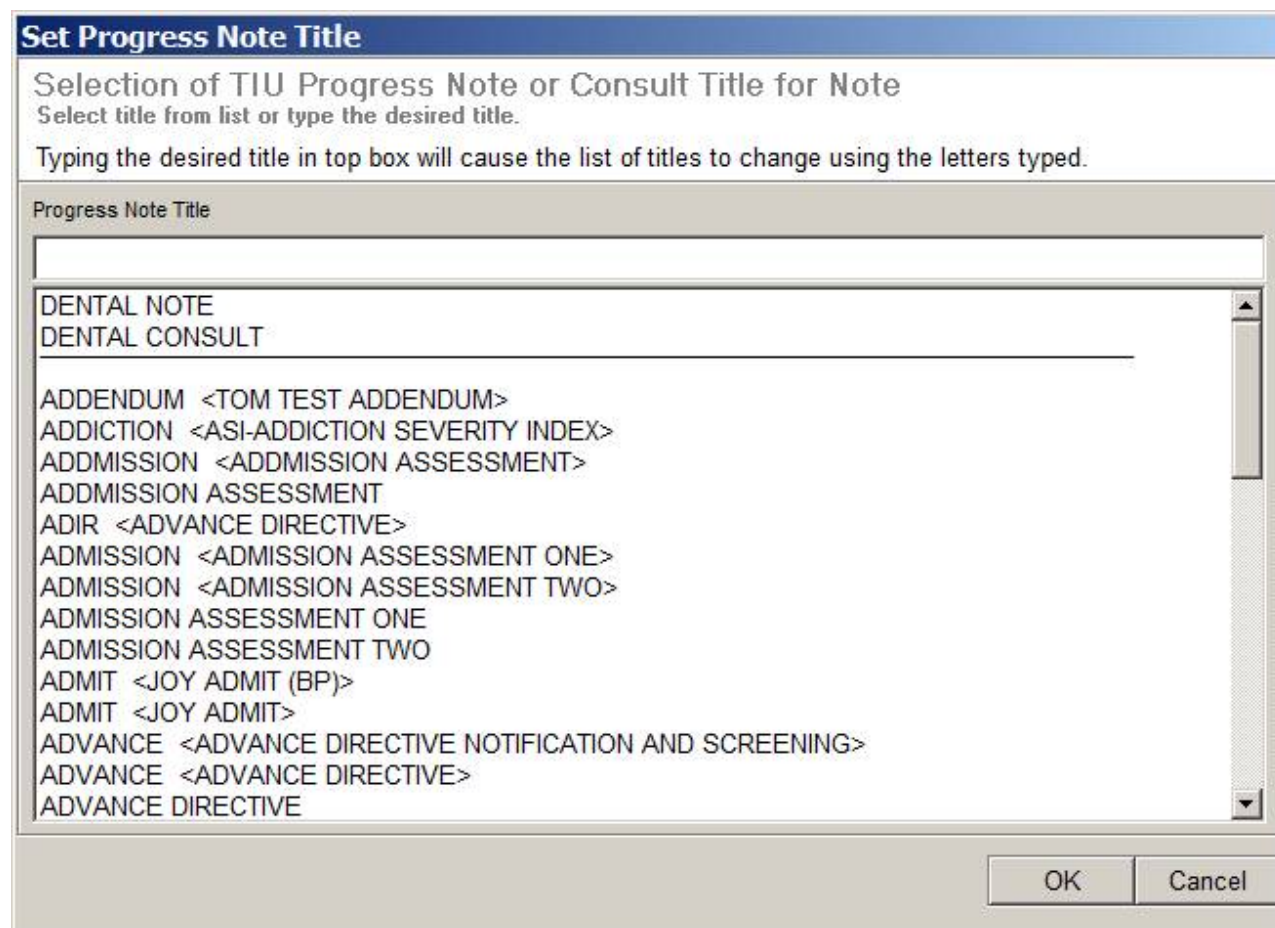
Integration:  
☒ Send to Clipboard.  
☐ Send to TIU/PCE.

**Figure 311: Preview Note**

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

## Consult Notes

The option to complete a consult displays after the **Filing Options** screen, during the process of completing a patient encounter, when the **Set Progress Note Title** screen displays.



The screenshot shows a software window titled "Set Progress Note Title". Inside the window, there is a header section with the text "Selection of TIU Progress Note or Consult Title for Note" and a sub-instruction "Select title from list or type the desired title." Below this, a note states: "Typing the desired title in top box will cause the list of titles to change using the letters typed." The main area of the window is a list box labeled "Progress Note Title" at the top. The list box contains a scrollable list of titles, including "DENTAL NOTE", "DENTAL CONSULT", "ADDENDUM <TOM TEST ADDENDUM>", "ADDICTION <ASI-ADDICTION SEVERITY INDEX>", "ADMISSION <ADMISSION ASSESSMENT>", "ADMISSION ASSESSMENT", "ADIR <ADVANCE DIRECTIVE>", "ADMISSION <ADMISSION ASSESSMENT ONE>", "ADMISSION <ADMISSION ASSESSMENT TWO>", "ADMISSION ASSESSMENT ONE", "ADMISSION ASSESSMENT TWO", "ADMIT <JOY ADMIT (BP)>", "ADMIT <JOY ADMIT>", "ADVANCE <ADVANCE DIRECTIVE NOTIFICATION AND SCREENING>", "ADVANCE <ADVANCE DIRECTIVE>", and "ADVANCE DIRECTIVE". At the bottom right of the window are two buttons: "OK" and "Cancel".

**Figure 312: Set Progress Note Title Screen**

To complete the consult:

1. Choose the consult title from the **Set Progress Note Title** screen.
2. The patient's pending consults display on the screen.

**Set Progress Note Title**

Selection of TIU Progress Note or Consult Title for Note  
Select title from list or type the desired title.

Typing the desired title in top box will cause the list of titles to change using the letters typed.

Progress Note Title

DENTAL NOTE  
**DENTAL CONSULT**  
 ADDENDUM <TOM TEST ADDENDUM>  
 ADDICTION <ASI-ADDICTION SEVERITY INDEX>  
 ADMISSION <ADMISSION ASSESSMENT>

The above title must be associated with a consult request. Select one of the following or chose a different title.

Consult Request	Date	Service	Procedure	Status	# Notes
07/17/2014	14.24	DENTAL		PENDING	0

OK Cancel

**Figure 313: Set Progress Note Title with Pending Consult**

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

## Resident Filing as Cosigners or Distributed Providers

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

To add a distributed provider:

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

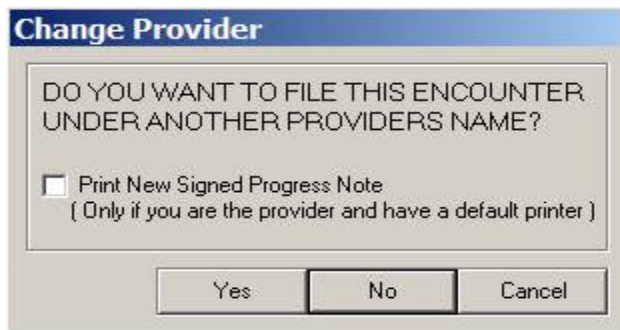


Figure 314: Change Provider Screen

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

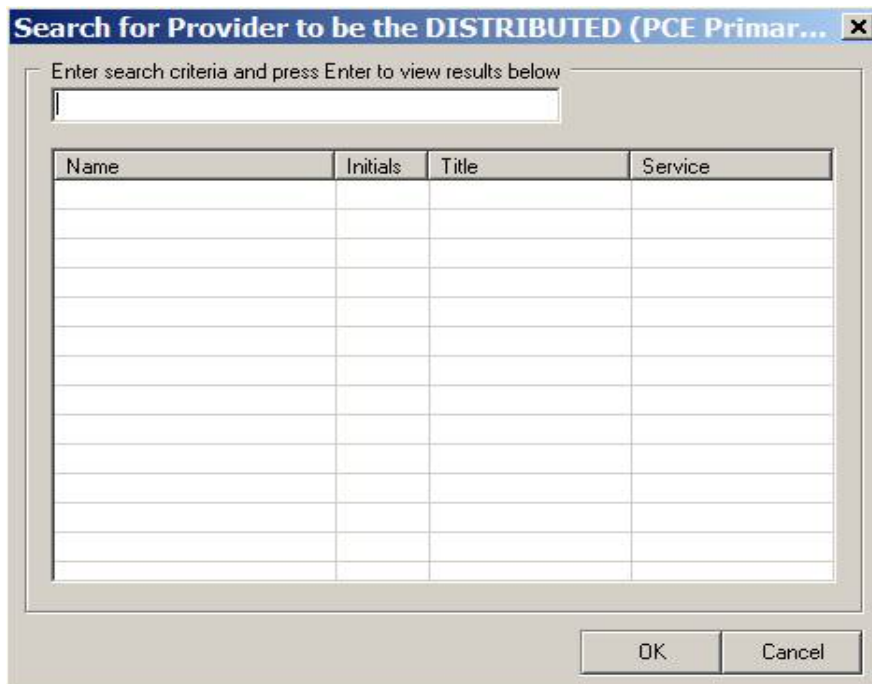


Figure 315: Search for Distributed Provider Screen



5. Enter the search terms in the text box and press the <Enter> key.
6. Choose the provider from the search results and click the **OK** button.
7. An information screen displays confirming that the information was filed.

**Note:** VA dental gives credit/RVU time to the resident actually performing the procedures, all of which is filed to DES; to meet the VA requirement that the attending (distributed) gains credit for the encounter, this has to be filed in PCE.

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

Cache TRM:3816 (CACHE)

File Edit Help

PCE Update Encounter May 31, 2017@10:31:42 Page: 1 of 2

DRMPATIENT, ONE 000-00-0001 Clinic: DENTAL

Encounter Date 5/31/2017 10:00 Clinic Stop: 180 DENTAL

1 Encounter Date and Time: MAY 31, 2017@10:00

2 Provider: DRMPROVIDER, ADMINDENTIST PRIMARY Dental/Dentist/Oral & Maxill

3 Provider: DRMPROVIDER, RESIDENT TWO Dental/Dental Resident

4 ICD-10 Code or Diagnosis: K02.52 Dental caries on pit and fissure  
surface penetrating into dentin

Provider Narrative: DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRATING  
INTO DENTIN

Primary/Secondary ICD-10 Diagnosis for the Encounter: PRIMARY

5 CPT Code: D2160 AMALGAM THREE SURFACES PERMA

Primary ICD-10 Diagnosis: K02.52 Dental caries on pit and fissure  
surface penetrating into dentin

+ Next Screen		- Prev Screen		?? More Actions	
ED	Edit an Item	TR	Treatment	DD	Display Detail
DE	Delete an Item	IM	Immunization	DB	Display Brief
EN	Encounter	PE	Patient Ed	IN	Check Out Interview
PR	Provider	ST	Skin Test	CR	Contra/Refusal Event
DX	Diagnosis (ICD)	XA	Exam	QU	Quit
CP	CPT (Procedure)	HF	Health Factors		

Select Action: Next Screen//

**Figure 316: PCE Encounter Information in VistA**



## Appendix A – Glossary of VA Terms

ADPAC	Automated Data Processing Applications Coordinator
AICS	Automated Information Collection System; formerly Integrated Billing, the program that manages the definition, scanning and tracking of Encounter Forms.
APPOINTMENT	A scheduled meeting with a provider at a clinic; an appointment can include several encounters involving other providers, tests, procedures, etc.
CBOC	Community Based Outpatient Clinic
CC	Coordinating Committee
CFO	Chief Financial Officer
CHECKOUT PROCESS	Part of the Medical Administration (PIMS) appointment processing. The checkout process documents administrative and clinical data related to the appointment.
CIO	Chief Information Officer
CIR	Corporate Information Repository
CIRN	Clinical Information Resource Network
CLINICIAN	A doctor or other provider in the medical center authorized to provide patient care.
CNT	Clinical Note Template (Used to format TIU progress notes)
CPR	Cardiopulmonary Resuscitation
CPRS	Computerized Patient Record System
CPT	Common Procedure Terminology
CQI	Continuous Quality Improvement
DAS	Dental Activity System (also called AMIS)
DES	Dental Encounter System (also called DES)
DHCP	Decentralized Hospital Computer Program (See: VistA)
DNR	Do Not Resuscitate
DOD	Department of Defense
DRG	Diagnostic Related Group
DSS	Decision Support System
DSS	Document Storage Systems, Inc.

DVA	Department of Veterans Affairs
EDI	Electronic Data Interchange
ELC	Executive Leadership Council
EMR	Electronic Medical Record
ENCOUNTER	A contact between a patient and a provider who has responsibility for assessing and treating the patient at a given contact, exercising independent judgment. A patient can have multiple encounters per visit.
ENCOUNTER FORM	A paper form used to display and collect data pertaining to an outpatient encounter, developed by the AICS package.
EPISODE OF CARE	Many encounters for the same problem constitute an episode of care. An outpatient episode of care may be a single encounter, or can encompass multiple encounters over a long period of time.
FEMA	Federal Emergency Management Agency
FIM	Federal Independence Measure
FRP	Federal Response Plan
GAF	Global Assessment of Functioning
GPRA	Government Performance and Results Act
GUI	Graphic User Interface
HEALTH SUMMARY	A Health Summary is a clinically-oriented, structured report that extracts multiple kinds of data from VistA and displays it in a standard format.
HR IGA	Human Resources Office of Intergovernmental Affairs
INPATIENT VISIT	Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient.
IOM	Institute of Medicine
ISDA	Intensity Severity Admission Discharge (criteria)
IT	Information Technology
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LAN	Local Area Network
MVV	Mission Vision Values
MAC	Management Assistance Council
MCCR	Medical Care Cost Recovery
MDS	Minimum Data Set

NHCU	Nursing Home Care Unit
OERR	Order Entry Results Reported
OSHA	Occupational Safety & Health Administration
OUTPATIENT ENCOUNTER	Outpatient encounters include scheduled appointments and walk-in unscheduled visits
OUTPATIENT VISIT	The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician's office, hospital medical center) within one calendar day.
PACS	Picture Archiving and Communications System
PAI	Patient Assessment Instruction
PCE	Patient Care Encounter
PI	Prevention Index
PM	Performance Management
PROCEDURE	A test or action done for or to a patient that can be coded with the CPT coding process.
PROVIDER	The entity which furnishes health care to a consumer.
PSA	Patient Service Area
PTSD	Post Traumatic Stress Disorder
RM	Risk Management
RPM	Resource Planning Methodology
SD	Standard Deviation
SMI	Seriously Mentally Ill
SSC	Shared Service Center
TIU	Text Integrated Utility
TQI	Total Quality Management
UM	Utilization Management
UNC	Universal Naming Convention. Used in place of Drive letters.
VA	Department of Veteran Affairs
VAVS	Veterans Administration Voluntary Service
VHA	Veterans Healthcare Administration
VISN	Veterans Integrated Service Network
VISIT	The visit of a patient to one or more units of a facility within one calendar day.

VistA	Veterans Information System Technology Architecture, the new name for DHCP.
VSO	Veterans Service Organization

## Appendix B – Common Application Functions

Microsoft Windows tools are used in DRM Plus. Left-clicking, right-clicking, double-clicking, drop-down arrows, radio buttons, check boxes, text boxes, highlighting and scroll bars are used throughout DRM Plus. Certain buttons and clicking options are common to most screens and are discussed below.

**OK:** Clicking the **OK** button is used to finalize a selection or end a process. The open screen is closed, and the user is moved to another screen.

**Cancel:** Clicking the **Cancel** button cancels the action taken on a screen and returns the user to the previous screen.

**Next:** Clicking the **Next** button moves the user to the next screen.

**Back:** Clicking the **Back** button moves the user to the previous screen.

**Add:** Clicking the **Add** button adds a selected item to a function.

**Edit:** Clicking the **Edit** button allows the user to edit a selection.

**Delete:** Clicking the **Delete** button allows the user to delete a selection.

**Reset:** Clicking the **Reset** button resets changed settings to their original settings during this session.

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

**Browse Buttons:** Clicking the **Browse** button moves the user to a previously-programmed selection screen.

**Radio Buttons:** Clicking a **radio button** displays a dot in the button, designating a specific option. Only one radio button is allowed for a section in a group.

**Check boxes:** Clicking a **check box** works the same as a radio button, however multiple selections may be added from one group.

**Text Boxes:** Clicking in a text box allows the user to type text into the box.

**Drop-Down Arrows:** Clicking these **arrows** displays a menu of selections.

**Selection Arrows:** Clicking these **arrows** allows a selected item to be moved from one dialogue box to another.

**Search Boxes:** Typing selection criteria in a search box causes the criteria to be matched to a master file. Matches are displayed, allowing the user to highlight the desired selection for further action. DRM Plus requires the user to press the <Enter> key after entering the criteria.

**Sorting:** Clicking a Transaction table column heading sorts the table, usually in ascending order, depending on the current view. Clicking the column heading a second time returns the table to its original view.

**Highlighting:** Clicking an item results in its being highlighted, and selected for the next action to be completed.

**Shift Key:** Generally, holding the <Shift> key down allows for selection of multiple consecutive items in Windows applications.

**Control Key:** Generally, holding the <Ctrl> key down allows for selection of multiple items in Windows applications.

**Keyboard Use:** When a letter or a button name is underlined (Add or Speed Code) the keyboard can be used to activate the button. The action required is to press and hold the <Alt> key, then press the underlined letter.

## Appendix C – Hints and Notes

### Save Unfiled Data

If the user has entered any data and attempts to close DRM Plus, or switch to a different patient, DRM Plus displays a screen prompting the user to save the current patient's entries. Clicking the **Yes** button initiates the save unfiled data function.

When the user has saved unfiled data and no longer needs this data for the patient, there are two options to eliminate this saved, unfiled data. The first is to select the **Delete** button when opening the patient's chart; a dialogue screen asks the user if they want to load the saved data. The second option is to delete the saved unfiled data from the **Unfiled Data by Provider** report.

### Dental Class Displayed on Banner

The patient's **Dental Class** displays in the banner area, only if the information was entered on the cover page in the **Dental Eligibility/Dental Class** field by a DRM Plus Administrator. As soon as the **Dental Class** is selected, it displays in both fields: the dental class field on the **Cover Page** tab screen, and the **Dental Class** box in the DRM Plus banner.

### Diagnostic Findings

**Diagnostic Findings** are NOT updated automatically from **Completed Care** entries for any encounter. Any **Completed Care** entries that are filed need to be entered as **Diagnostic Findings** during a patient's future dental examination.

Always mark teeth missing in **Diagnostic Findings** before entering **Partials, Dentures, Implants** or **Bridge** findings. DRM Plus works best when missing teeth or edentulous arch(es) are entered before any other findings. **Dentition** is always entered first on a new patient before any dental data is entered in DRM Plus, if the patient is a juvenile.

**Diagnostic Findings** may be deleted after the encounter has been filed by a user. If this happens after the encounter has been filed, the deleted findings are removed from the graphic; however, the text entry remains in the transaction table with a line through it. DRM Plus Administrators can completely remove any **Diagnostic Finding** entry from the transaction table, unless the entry was already deleted by a user.

### Treatment Plan

For implant procedures entered in the **Treatment Plan** screen, and if a related finding of **Missing** has NOT been entered, DRM Plus does NOT allow this corrective planned treatment procedure to be entered.

It is recommended to use the **Include Findings and Completed** button to temporarily combine screens of the planned treatment with the findings and NOT use the automatic **Include** parameter in DRM Plus. The automatic **Include** parameter is the original default in DRM Plus when the user is viewing the **Treatment Plan** screen. End-users may edit this parameter by accessing the **Treatment & Exam** menu → **Show Configuration** submenu → **Tx & Exam** tab → **Display Defaults** drop-down menu → remove check marks in check boxes.



## **Multi-Add Screen**

Small buttons [<] and [>] have been added to the **Procedure Code** selection screen to enable the user to move the screen to the other half of the graphic chart. This may be necessary to see what is beneath, especially when entering multi-add codes.

Missing teeth display as white text on a blue background. This can help the user visualize the mouth while entering multi-add codes. The missing teeth are still selectable if needed for the procedures partial, denture, implant or bridge.

## **Ranged Codes**

Certain codes, designated as ranged codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted and can only be used with hard coded DRM Plus icons. These icons are **Partial, Bridge, Conn Bar** and some **Denture** procedure codes. These icons are only found with the **Treatment Plan** and **Completed Care** screens. When other options are utilized for selecting these CPT procedure codes, when using the **ADA Codes** icon or **Add** box, the ranged codes are disabled and cannot be selected.

## **Speed Codes**

**Speed Codes** do NOT have multi-add or suggestion links functionality. The multi-add and suggestion links functionalities work with the **Quick Codes** icon, **ADA Codes** icon, **CPT Codes** icon, using the **Add** box to select a procedure code. Some of the DRM Plus standard icons allow multi-add functionality. Speed codes are only used with the **Treatment Plan** and **Completed Care** view screens for selecting a procedure code.

**Speed Codes** that include codes violating coding compliance rules need to be edited or deleted.

## **Tx Planning/Sequencing Screen**

There is a maximum of nine phases which may be added to the sequenced planned treatment for one patient. There are an unlimited number of sub-phases possible in each phase. There is only one **Non-VA Care** phase that may be added however with an unlimited number of sub-phases.

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

End-users are able to re-size and move the **Tx Planning/Sequencing** screen in all directions. DRM Plus allows users to drag and drop multiple procedures at one time by pressing the <Shift> and <Ctrl> keys.

Users may add or modify the **Treatment Plan** and **Tx Planning/Sequencing** screen and file the changes without having to click the **Next** button and create a TIU progress note as long as no new completed transactions, perio, PSR or Head & Neck data are entered. In addition, the most recent dental encounter must have an **Active** status for this feature to work. Clicking the **Save & Exit** button from the **Tx Planning/Sequencing** screen files any changes made, and minimizes DRM Plus. Any new planned entries added have the same visit date as the latest active TIU progress note filed for the patient.

If the completed care screen is set as the display default in DRM Plus, transactions completed from the sequencing screen may require a refresh for those transactions to display in the **Completed Care** screen. Selecting the **Diagnostic Findings** button or the **Treatment Plan** button and then reselecting the **Completed Care** button refreshes the application.

## **Completed Care**

Completed procedures that have been filed can only be deleted by a DRM Plus Administrator. If an end-user, who does NOT have this administrative parameter option, highlights an entry in the **Completed Care** transaction table and clicks the **Delete** button, a screen stating that the transaction cannot be deleted displays. When a DRM Plus Administrator deletes an entry from DRM Plus, appropriate procedures must be followed to correct any associated entry filed in VistA TIU or possible VistA PCE.

In those rare cases where pre-existing charted care does NOT allow the user to click and select a procedure code via the graphic chart, the user may enter the desired code via the **ADA Codes** icon.

If one or more of the procedures entered with multi-add functionality require an assignment of a different diagnosis code, deselect the procedure code by clicking the check box of the procedure description located on the upper left side of the **Diagnosis Code** screen. The deselected procedure code no longer appears highlighted, and is removed from the table at the bottom of the screen, indicating that it does NOT associate with the selected diagnosis code. Click the **OK** button at the bottom of the screen, and the remaining unchecked procedure code(s) recycle and appear highlighted in the **Diagnosis Code** screen for the user to assign a diagnosis code. This process of recycling continues until all procedure codes added with the multi-add functionality have a diagnosis code assigned by the user.

## **Periodontal Chart**

The **History** button maintains graphical entries from previous perio examinations; therefore, any prior perio exam graph may be viewed with the **History** button, selected from the **Periodontal Chart** screen. The **Periodontal History/Compare** screen may be vertically extended to view any data that is NOT visible.

To use the **Furcation** icon, the cursor shield must be positioned at the root location where an entry in the graphics would be appropriate.

The **X** button located at the end of the pre-defined measurement scale results in a null entry in the transaction table for **Pocket, FGM, MGJ, Mobility** and **Furcation** entries. This null entry only works when the specific icon is active for **Pocket, FGM, MGJ, Mobility** and/or **Furcation**. The null entry remains as a “.” mark in the transaction table, and there is no entry in the TIU progress note.

If the error is recognized immediately, the **Undo** button may be clicked. Otherwise, place the cursor shield on the pocket where the incorrect value was entered. If the value is for **Pocket, FGM, MGJ, Mobility** or **Furcation**; the incorrect value can be replaced by entering the correct value.

A zero entry results in no graphical view; however, it results in a zero entry in the transaction table and TIU progress note, since it is a measurement. If no recording should be present for a given icon, a null entry can be created by clicking the **X** button. If the incorrect entry is for **Bleeding, Delayed Bleeding** or **Suppuration**; click the identical icon again to remove the graphic display and transaction table entry.

When perio data is imported into the TIU progress note, it has each tooth displayed with each surface and condition shown in the vertical column, under the tooth number. The key at the bottom of the perio data explains certain symbols. There may be a statement at the bottom of the perio data, which informs other providers that this TIU progress note contains perio data from the current exam, as well as data that has NOT changed from at least one previous exam. If the **Clear** icon was used at the beginning of the perio exam, then only data from this current exam is imported into the note.

Warning levels can be changed by the end-user and then displayed. The pocket depth warning level should be the same for the perio chart graphics, and for the pocket depth warning level listed on the **Statistics** tab. The pocket depth warning level on the **Statistics** tab must be the same as the pocket depth warning level in the **Periodontal** tab. Both of these tabs are found by utilizing the **Treatment & Exam** menu → **Show Configurations** submenu.

## **Completing the Encounter**

Selecting any **Service Connection** check box sends a flag to PCE for the encounter.

DRM Plus is now aligned with CPRS for patients who are **Combat Veteran** service connected. If appropriate, the Combat Veteran option defaults to a check (**Yes**) in DRM Plus. To remove the check (change to **No**), click the check box to the left of the **Combat Veteran** field. The check is removed.

VistA has co-signature functionality, and is checked by CPRS and DRM Plus. Both GUIs also have additional signer functionality. Additional signers are NOT required, but may be added to a TIU progress note by a provider. Do NOT confuse additional signers with co-signers. Co-signers are built into VistA by facility management based on business rules. If the software detects that a co-signer is required, a screen displays, requesting a co-signature. A provider may need a co-signer for one or all TIU progress notes.

Since most sites require residents to enter a co-signer, the co-signer defaults as the distributed provider in PCE. If there is no co-signer (i.e., no note exists when using **File Data Without a Note**, or the resident is NOT required to have a co-signer) then the resident, or user filing resident data, must enter the distributed provider prior to filing. When the encounter is filed to VistA PCE, the resident becomes the secondary provider and the distributed (attending) provider becomes the primary provider for the encounter. All procedures and diagnoses are assigned to the distributed provider in VistA PCE.

VA Dental wants to give credit/RVU time, etc. to residents who actually perform the procedures, and all of this is filed to VistA DES. However, to meet the VA requirement that gives credit for the encounter to the attending (distributed), requires this to be filed in VistA PCE.

DRM Plus users may import a **TIU Note Boilerplate** into a patient's TIU progress note. If the **Note Boilerplate** parameter is set with a check mark, an informational screen displays when selecting a TIU progress note or consult title, if that title has a note boilerplate associated with it. The informational screen allows a user to select **Yes** or **No** to the question of importing the note boilerplate. If this parameter is NOT set with a check mark then the note boilerplate imports into the patient's TIU progress note without an opportunity to decline this action. This parameter is located under the **Tools** menu → **User Options** submenu → **General** tab → **Other Parameters** button.

CPRS templates automatically import into a patient's TIU progress note if the TIU note/consult title selected is associated with a CPRS template and there is no option for the user to decline this template import. When the template displays or opens, complete or fill-in the appropriate information on the template and close or finish it. The information entered on the template imports into the patient's TIU progress note. **Please note:** DRM Plus does NOT support **Reminder Dialog** or **COM objects** CPRS templates.

There are generally two types of TIU progress notes created using DRM Plus: 1) using the **Exam** tab or 2) NOT using the **Exam** tab. A TIU progress note created using the **Exam** tab sequences DRM Plus objects in the order designed and approved by the VA Dental Exam Committee. The sequencing of DRM Plus objects in the **Note Objects Sequence** parameter screen is overwritten by the **Exam** tab sequence design when the **Exam** tab is used. TIU progress notes created without using the **Exam** tab sequence DRM Plus objects in the order set by the user in the **Note Objects Sequence** parameter screen. This parameter is located by selecting the following: **Tools** menu → **User Options** submenu → **Progress Note** tab → **Set Note Sequence** button. The **Note Boilerplate** in the list of **Note Objects Sequence** parameter screen includes both TIU **Note Boilerplates** and supported CPRS templates.

All DRM Plus data objects displayed in the left narrow window of the **Progress Note** screen may be imported into the TIU progress note automatically. This depends on whether the parameters are activated by the end-user. However, most of the data objects are NOT allowed to be de-selected by the end-user for the automatic importing process. These parameters are located by selecting **Tools** menu → **User Options** submenu → **Progress Note** tab → **Progress Note Data** button.

DRM Plus **Code Boilerplates** are listed individually with the DRM Plus objects on the **Progress Note** screen. DRM Plus users who have created code boilerplates can now import them into a TIU progress note by clicking the desired **Code Boilerplate** object, listed with DRM Plus objects. Using the cursor, set the object where it is sequenced in the TIU progress note, then double-click to import the object.

Text files may be created and saved in a preferred directory. Right-click in a **Progress Note** window and click **Import Text File** option to navigate to and open the saved file. The file is then placed in the TIU progress note as designated by the cursor placement.

Follow these steps to set up a file for importing:

1. Create a folder in an appropriate directory (usually a server drive).
2. From the **Tools** menu → **User Options** submenu → **Set File Folder** button, navigate to the folder created in Step 1. Set the folder by double-clicking it.
3. Create a text file from the **Tools** menu → **Windows Notepad** submenu and save it as a .txt file in the designated folder from Step 1.

If the user clicks the **Finish** button before the provider's electronic signature is entered, the dental data is filed in Vista (PCE, DES and TIU) as an unsigned progress note, and may be viewed with CPRS. If the electronic signature is entered before clicking the **Finish** button, the dental data is filed as a signed progress note in Vista (PCE, DES and TIU).

When the user clicks the **Finish** button, a prompt may display if there are no planned items, and if the patient status is **Active**. Correctly identifying the patient's status is important for reporting. The user should click the proper radio button (**Active**, **Inactive** or **Maintenance**) and then click the **OK** button.

## **Reports – Non-Clinical Time by Provider**

The **Non-Clinical Time by Provider** report displays an approximate numerical unit of days (1 day = 8 hours). Accumulation of less than 4 hours results in rounding down to the nearest whole number day, and accumulation of 4 or greater hours round up to the nearest whole number day.

## **Code Boilerplates**

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

If a DRM Plus Administrator creates a code boilerplate in their **Administrative Toolbox** submenu, then every user may use the code boilerplate by entering the name of that code boilerplate to their parameter. Enter the name precisely as it was entered by the DRM Plus Administrator and click the **OK** button in the end-user's **User Settings** screen. This action imports the administrative code boilerplate to the end-user's code boilerplates.

## **Last Broker Call**

The **Last Broker Call** submenu is used by the IT or ADPAC personnel to document problems. It is NOT usually accessed by providers.

## **Recent Dental Activity**

This section on the **Cover Page** tab displays the most recent visit date for selected types of procedure codes. Hover the cursor over the heading to display all of the ADA procedure codes; the following list comprise the procedure codes for each heading.

- **Last Qualifying Exam** = D0120, D0150 or D0180
- **Last Comprehensive Exam** = D0150 or D0160
- **Last Brief Exam** = D0120, D0140 or D0170
- **Last Periodontal Exam** = D0180
- **Last Panorex Image** = D0330
- **Last Full Mouth Image** = D0210
- **Last Bitewing Image** = D0270, D0272, D0273, D0274 or D0277
- **Last CBCT Image** = D0364, D0365, D0366, D0367, D0368, D0380, D0381, D0382, D0383, D0384
- **Last Prophylaxis** = D1110, D4341, D4342, D4346, D4355 or D4910
- **Last Visit** = the last dental visit date the encounter was filed on.
- **Last Provider** = the provider that filed the last encounter.

## Appendix D – Icon Definitions

### Diagnostic Findings

The following table explains the actions required to enter a **Diagnostic Finding**:

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore	As many as required	As many as required	No	Material or surfaces	Graphic in green
Missing	As many as required	No	As many as required	Selected Roots	Graphic for roots is outlined
Observe	As many as required	No	As many as required	Selected Roots	Tooth outlined in red
Partial	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	None	Graphic allows root condition graphics to show. Graphic in purple.
Implant	As many as required	No	No	None	Graphic in violet
Sealant	No	As many as required	No	None	Graphic in green
Endo	No	No	Yes	Materials and roots	Graphic color denotes material
Apico	No	No	Yes	Select roots	Graphic in red
Retro	No	No	Yes	Selected roots and materials	Requires Apico to be present. Graphic denotes material
Bridge					See special instructions
Conn Bar					See Special Instructions
Hemi	No	No	As many as required	Selected roots	Graphic in dark gray

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Coping	Yes	No	No	None	Graphic in green
P&C	No	No	As many as required	Selected roots and materials	Graphic in green and denotes material
Impact	As many as required	As many as required	As many as required	Selected surfaces and roots	Graphic in light blue, roots in blue-green
Def Rest	Yes	As many as required	Yes	Selected surfaces, roots and materials	Graphic in yellow, denotes material
Caries	Yes	As many as required	As many as required	Selected surfaces and roots	Graphic in red, root caries initiates description box
Drifting	Yes	No	No	Direction	Graphic is yellow arrow to the left of tooth
Tipped	Yes	No	No	Direction	Graphic is light blue arrow to left of tooth
Rotated	Yes	No	No	Direction	Graphic is green arrow to left of tooth
Ret Root	No	No	As many as required	None	Graphic removes crown
UndrCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow
OverCont	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Overhang	No	As many as required	No	Selected surface	Graphic is red and yellow
Lesion	No	No	As many root surfaces as required	Selected roots	Can also click implant. Graphic is a red circle.
Faceted	No	As many as required	No	Selected surfaces	Graphic is red and yellow



ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Cracked	No	As many as required	As many as required	Selected surfaces and roots	Graphic is red and yellow
Chipped	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Supr/Sub	Yes	No	No	Direction	Graphic is red arrow
Open Ct	Yes	No	No	None	Graphic is red arrow to right of tooth
Abfract	No	Facial or lingual	No	None	Graphic is blue arrows
Dentition	No	No	No	Dentition box	Converts graphic to juvenile. Must be done before other entries
Perm/Prin	Yes	No	No	Dentition Box	Designate selected tooth as primary or permanent
Edentulous	Any tooth	No	No	None	Graphic removes all teeth and roots in arch

**Note:** Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, display graphically on all screen views. These items are, if entered from the **Diagnostic Findings** screen: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen: extract, hemi section, implant and observe.

## **Treatment Plan**

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection box	Graphic in Blue
Extract	Yes	No	Yes	Code Selection Box	Graphic in shadow
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete	Graphic allows root condition graphics to show
Denture	Any tooth	No	No	Code Selection box	Graphic allows root condition graphics to show.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in blue, no root graphic
Endo	No	No	Yes	Code Selection Box	Graphic in blue
Apico	No	No	Yes	Code Selection Box	Graphic in red
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in blue.
Bridge (1)				Code Selection Box	See special instructions.
Conn Bar (1)				Code Selection Box	See special instructions

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

Certain codes associated with these icons are defined as ranged codes. Ranged codes can only be entered by clicking the proper icon button. The **ADA Codes** icon, **CPT Codes** icon, **Quick Codes** icon or **Speed Code** icons are NOT allowed for entering ranged codes.

To designate a root restoration, click the **Restore** icon. Click the tooth surface that corresponds to the root surface. Using a tooth note, or the description edit feature in the transaction table, explain the root restoration.

**Note:** Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, appear graphically on all screen views. If these items are entered from the **Diagnostic Findings** screen, they are: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen, they are: extract, hemi section, implant, and observe.

## **Completed Care**

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore (2)	Yes	As many as required	No	Code Selection Box	Graphic in Green
Extract	Yes	No	Yes	Code Selection Box	Tooth disappears. Root graphic in dark gray.
Observe	As many as required	No	No	None	Tooth outlined in red
Partial (1)	As many as required	No	No	Cancel or Complete. Then Code Selection box.	Graphic allows root condition graphics to show. Graphic in purple.
Denture	Any tooth	No	No	Code Selection Box	Graphic allows root condition to show. Graphic in blue-purple.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in green. No root graphic.
Endo	No	No	Yes	Code Selection Box	Graphic in pink.
Apico	No	No	Yes	Code Selection Box	Graphic in red.
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in green.
Bridge (1)				Code Selection Box	See Special Instructions

ICON	CLICK TOOTH	CLICK SURFACE	CLICK ROOT	POP-UP SCREEN	ADDITIONAL COMMENTS
Conn Bar (1)				Code Selection Box	See Special Instructions
Hemi	No	No	As many as required	Code Selection Box	Graphic in gray
Coping	Yes	No	No	Code Selection Box	Graphic in green
P&C	No	No	As many as required	Code Selection Box	Graphic in green
Perio But- tons	No	No	No	None	No Graphic. See Speed Code instructions.

Certain codes associated with these icons are defined as ranged codes. Ranged codes can only be entered by clicking the proper icon button. The **ADA Codes** icon, **CPT Codes** icon, **Quick Codes** icon or **Speed Code** icons are NOT allowed for entering ranged codes.

To designate a root restoration, click the **Restore** icon. Click the tooth surface that corresponds to the root surface. Using a tooth note, or the description edit feature in the transaction table, explain the root restoration.

**Note:** Certain **Diagnostic Findings** or **Completed Care** procedures, once entered, appear graphically on all screen views. If these items are entered from the **Diagnostic Findings** screen, they are: missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the **Completed Care** screen, they are: extract, hemi section, implant, and observe.

## Special Descriptions – Bridge Icon

Place the cursor on the first tooth included in the bridge and **drag** the cursor to the last tooth in the range of teeth included in the bridge so that the 'bar' drawn for the bridge is **one continuous line** encompassing all of the areas (teeth, whether missing or not) included in the bridge. The Code Selection screen displays, with the lowest number tooth selected, as shown below.

Code	Description
D6750	RET CROWN PORCLN HIGH NOBLE
D6751	RET CROWN PORCLN BASE METAL
D6752	RET CROWN PORCLN NOBLE METAL
D6780	RET CROWN 3/4 HIGH NOBLE
D6781	RET CROWN 3/4 BASE METAL
D6782	RET CROWN 3/4 NOBLE METAL
D6783	RET CROWN 3/4 PORC/CERAMIC
D6790	RET CROWN FULL HIGH NOBLE

**Figure 317: Procedure Code Selection Screen**

Select the appropriate code and click the **Add** button. The **Procedure Code** selection screen moves to the first pontic tooth. Select the appropriate code and click the **Add** button again. Continue this process until all required teeth and codes have been selected. Click the **Finished** button once the selection process is complete.

**Note:** The << and >> buttons may be clicked to move backward or forward to different teeth for code selection. The **Reset** button, when activated by using the << and >> buttons, clears all previously entered codes for the selected tooth.

## **Special Descriptions – Conn Bar Icon**

This functionality works for all three view screens of **Diagnostic Findings**, **Treatment Plan** and **Completed Care**. Place the cursor on the first tooth location and drag it to the final tooth location. When entering a connector bar from the **Treatment Plan** screen or the **Completed Care** screens, the **Procedure Code** selection screen displays, with no tooth selected. DRM Plus defaults to the correct connector procedure code, depending on what conditions the connector bar was entered on. Click the **OK** button to complete the connector bar entry.

## **Special Descriptions – Notes Icon**

Please see the **Notes** section in the Chart/Treatment – Periodontal Chart chapter of this manual. This icon works the same for all three **Treatment & Exam** screen views.

Items to consider on tooth notes:

- Teeth designated as primary show in the tooth drop-down menu with the appropriate letter without a number. A tooth designation for **Supernumerary** teeth is displayed after tooth #32 in the drop-down menu.
- When a tooth-specific note has been entered, the tooth number in the graphical chart on the **Diagnostic Findings**, **Treatment Plan**, **Completed Care** and **Periodontal Chart** screens displays in yellow.
- Previously entered notes (tooth/patient note) appear disabled. The note appears disabled if it was saved as unfiled data and DRM Plus is closed and reopened. It also becomes disabled when an assistant saves unfiled data to a provider. When the provider re-opens DRM Plus to complete the encounter, they may edit-delete the note (tooth/patient note) by clicking the **New Entry** button. This activates the disabled entry so the provider is able to modify or delete the note before the encounter is finished.
- After entering any new dental data into **Patient Notes** or **Tooth Notes** windows select the **Notes** icon to save and close the **Notes** screen. Closing the **Notes** screen before opening any other screen in DRM Plus is the only action that saves the data entered into the **Notes** screen.



# Appendix E – Create Reports in MS Excel and Access

## Developing Excel Reports

To open Excel:

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

To open a saved file:

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

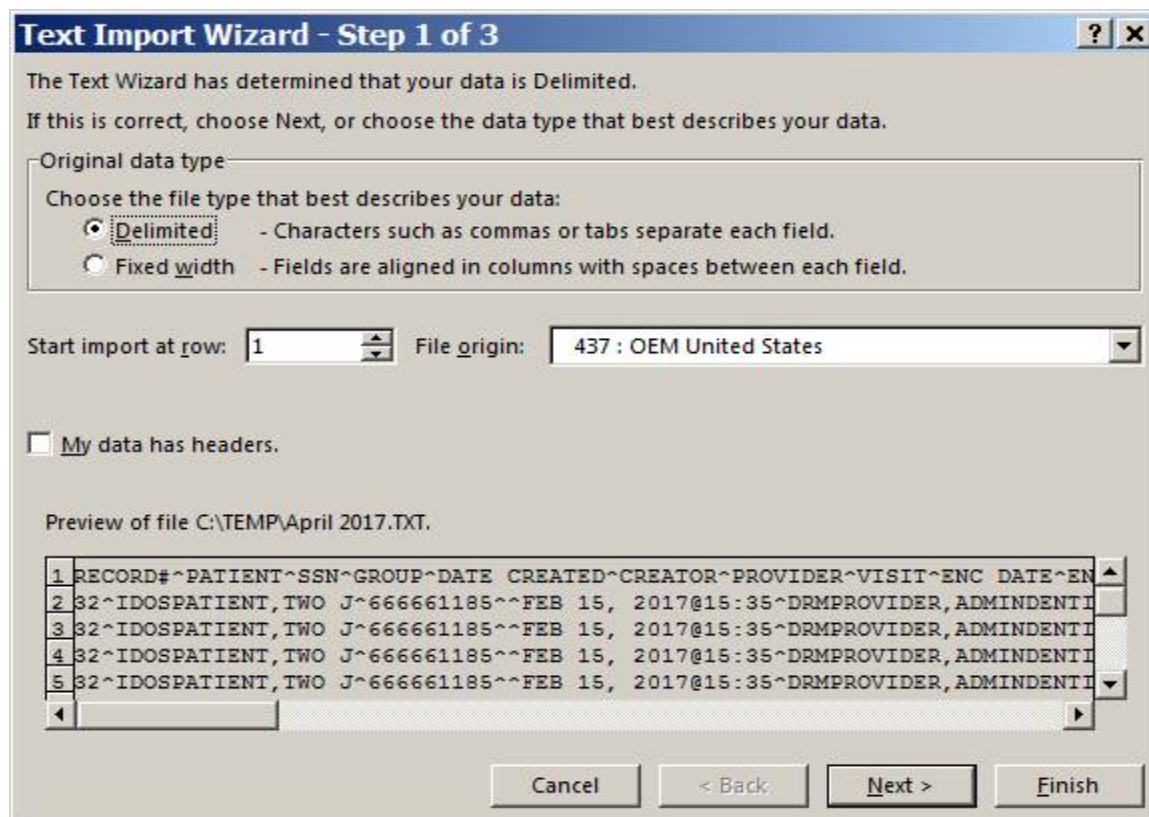
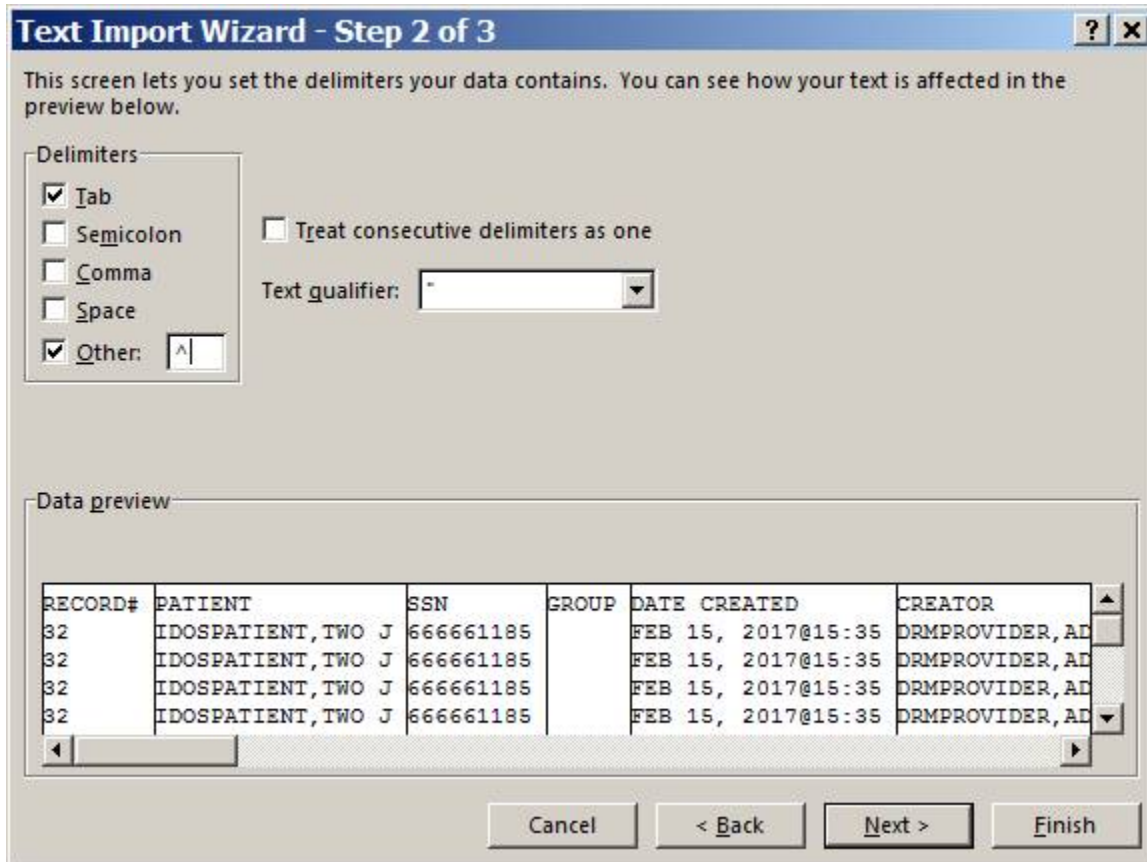


Figure 318: Developing Excel Spreadsheet Reports

6. Click the **Delimited** radio button.

- Click the **Next** button. Another screen displays.



This screen lets you set the delimiters your data contains. You can see how your text is affected in the preview below.

**Delimiters**

☒ **T**ab  
☐ **S**emicolon  
☐ **C**omma  
☐ **S**pace  
☒ **O**ther: ^

☐ Treat consecutive delimiters as one

Text qualifier: \*

**Data preview**

RECORD#	PATIENT	SSN	GROUP	DATE CREATED	CREATOR
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD

Buttons: Cancel, < Back, Next >, Finish

**Figure 319: Delimiters Options**

- The **T**ab check box is checked by default.
- Click the **O**ther check box.
- Type a ^ (<Shift> + <F6>) within the window beside **O**ther. Then click the **Next** button.
- Click the **Next** button. A similar screen displays.

**Text Import Wizard - Step 3 of 3** [?] [X]

This screen lets you select each column and set the Data Format.

Column data format

☒ General  
☐ Text  
☐ Date: MDY  
☐ Do not import column (skip)

'General' converts numeric values to numbers, date values to dates, and all remaining values to text.

Advanced...

Data preview

General	General	General	General	General	General
RECORD#	PATIENT	SSN	GROUP	DATE CREATED	CREATOR
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD
32	IDOSPATIENT,TWO J	666661185		FEB 15, 2017@15:35	DRMPROVIDER,AD

Cancel < Back Next > Finish

Figure 320: Text Import Wizard Final Screen

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



## Deleting Columns or Rows

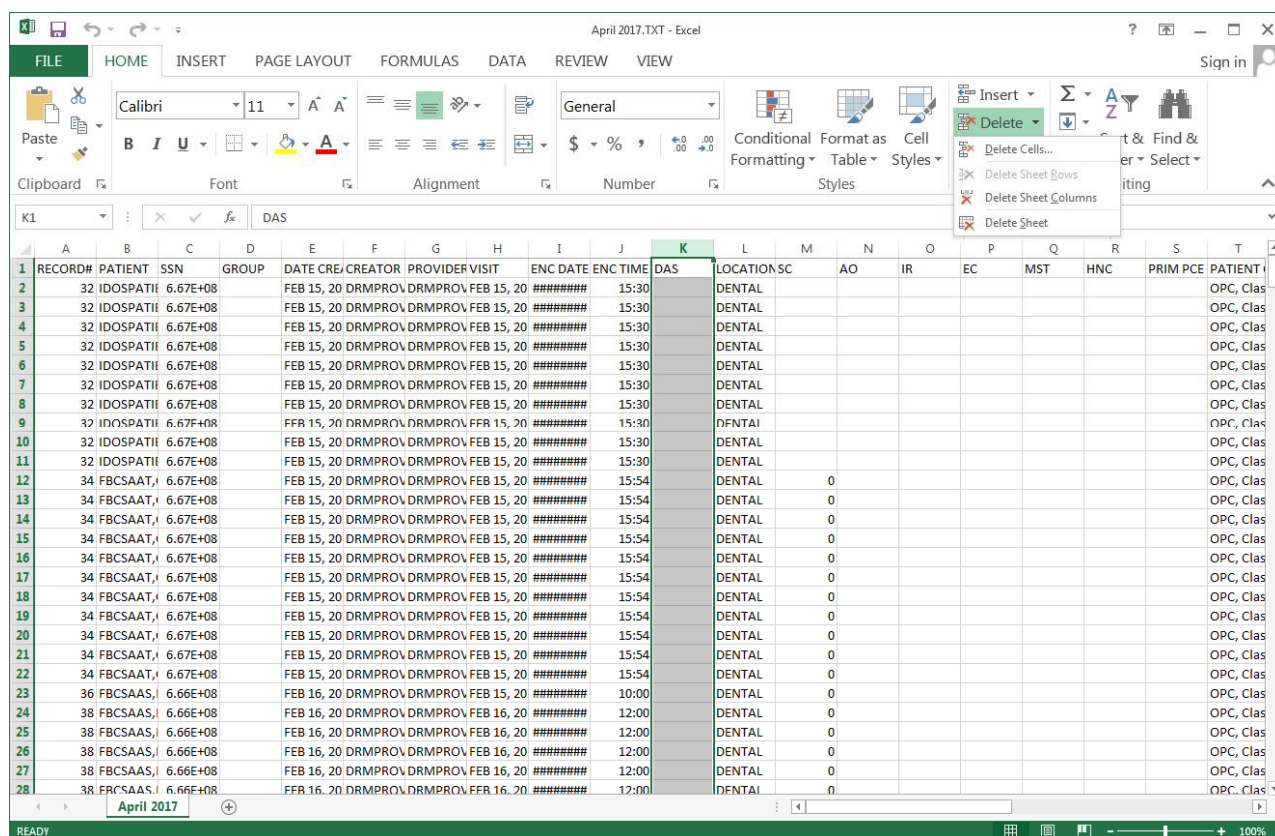


Figure 322: Creating Custom Reports in Excel - Deleting Columns or Row

To delete a column or row:

1. Click the column or row header. This highlights the column or row for deletion.
2. Click the **Home** 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 **Home** menu. The following is displayed.



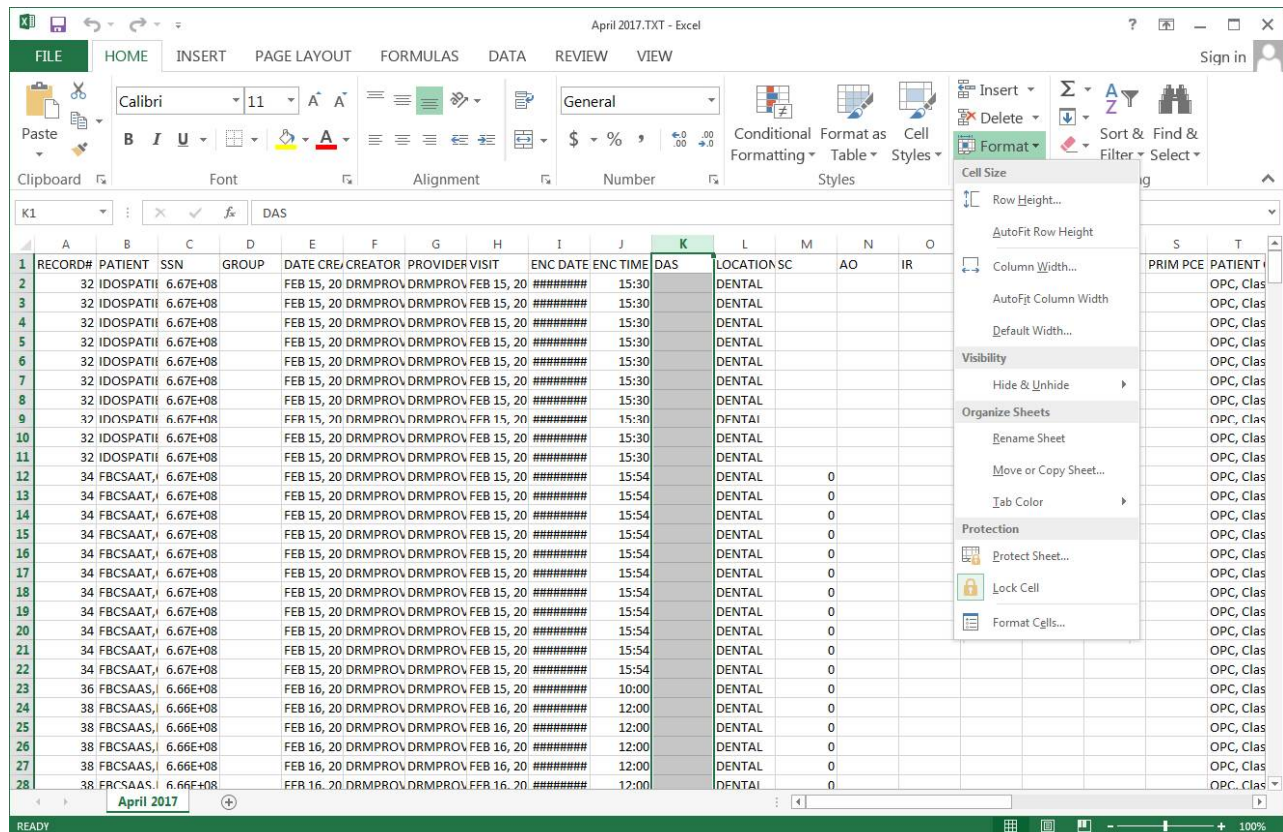


Figure 323: Field Formatting Options

Click **Format** button and then the Format Cells submenu. The following screen displays.

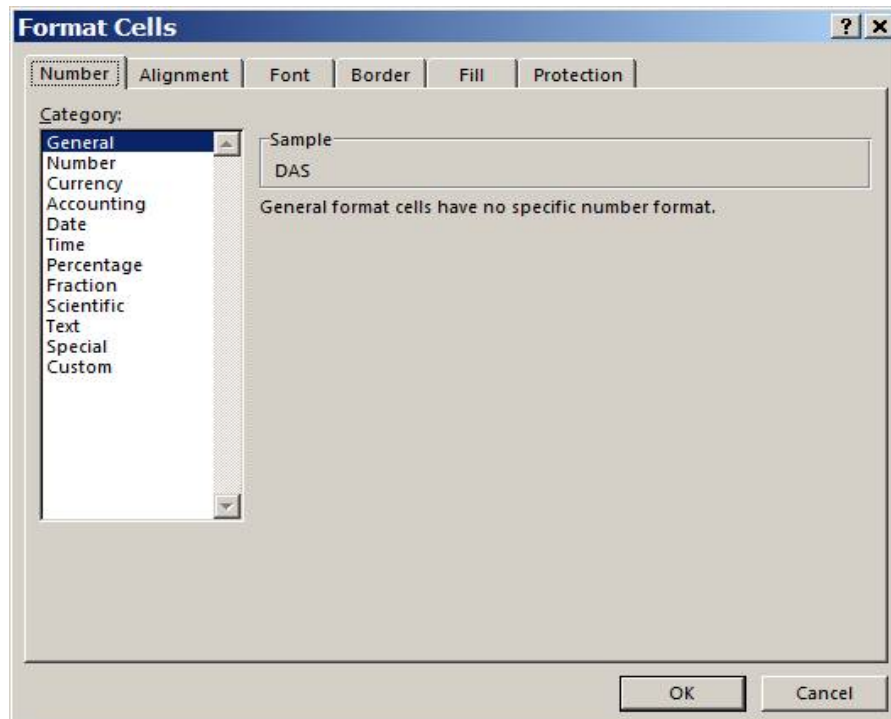
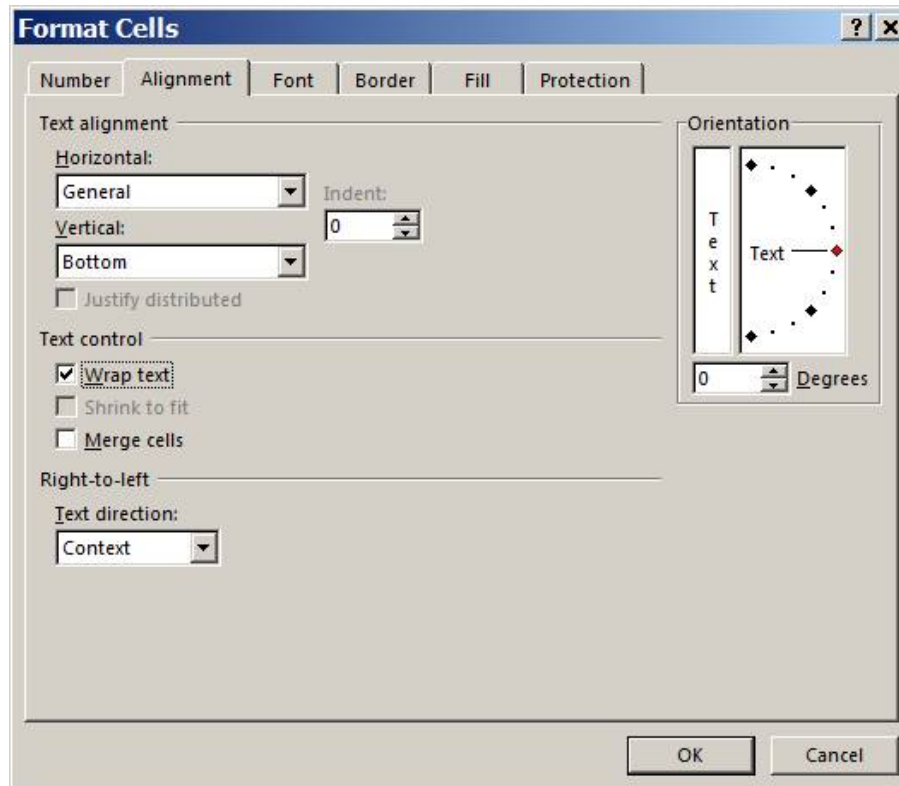


Figure 324: Format Cells

Select the desired option, then enter the desired changes.

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



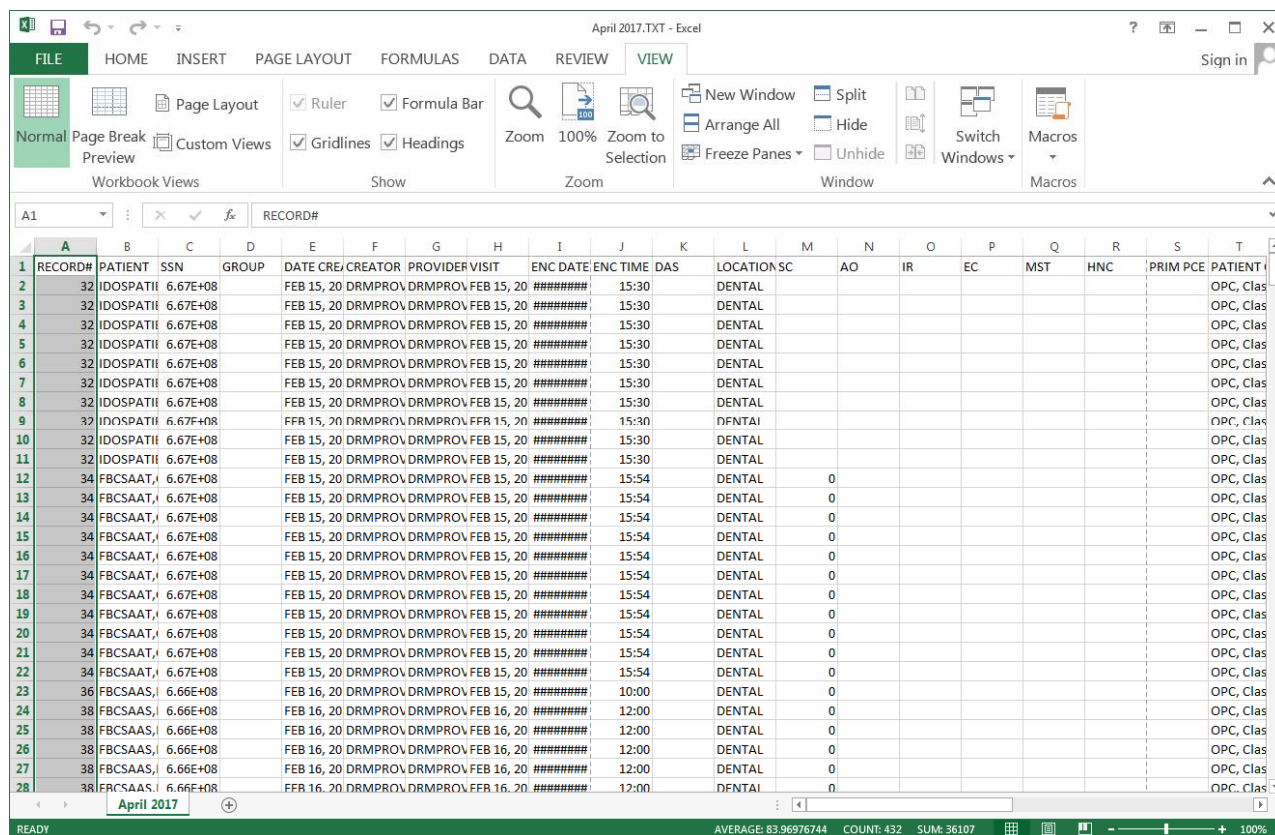
**Figure 325: Text Alignment Options**

Click the **Wrap text** check box. Click the **OK** button to complete the process.



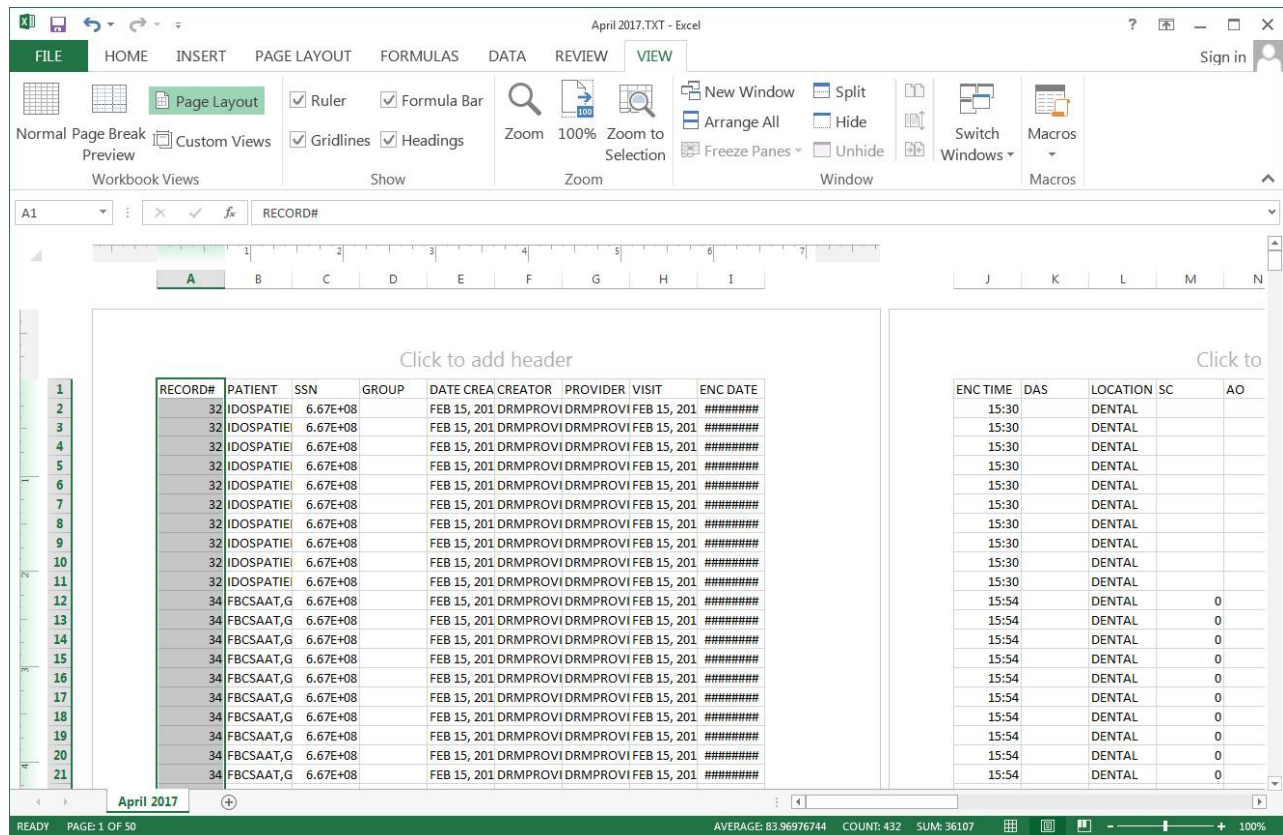
## Creating a Header for a Report

1. Click the **View** menu.
2. Click **Page Layout** button.



**Figure 326: Header and Footer Option**

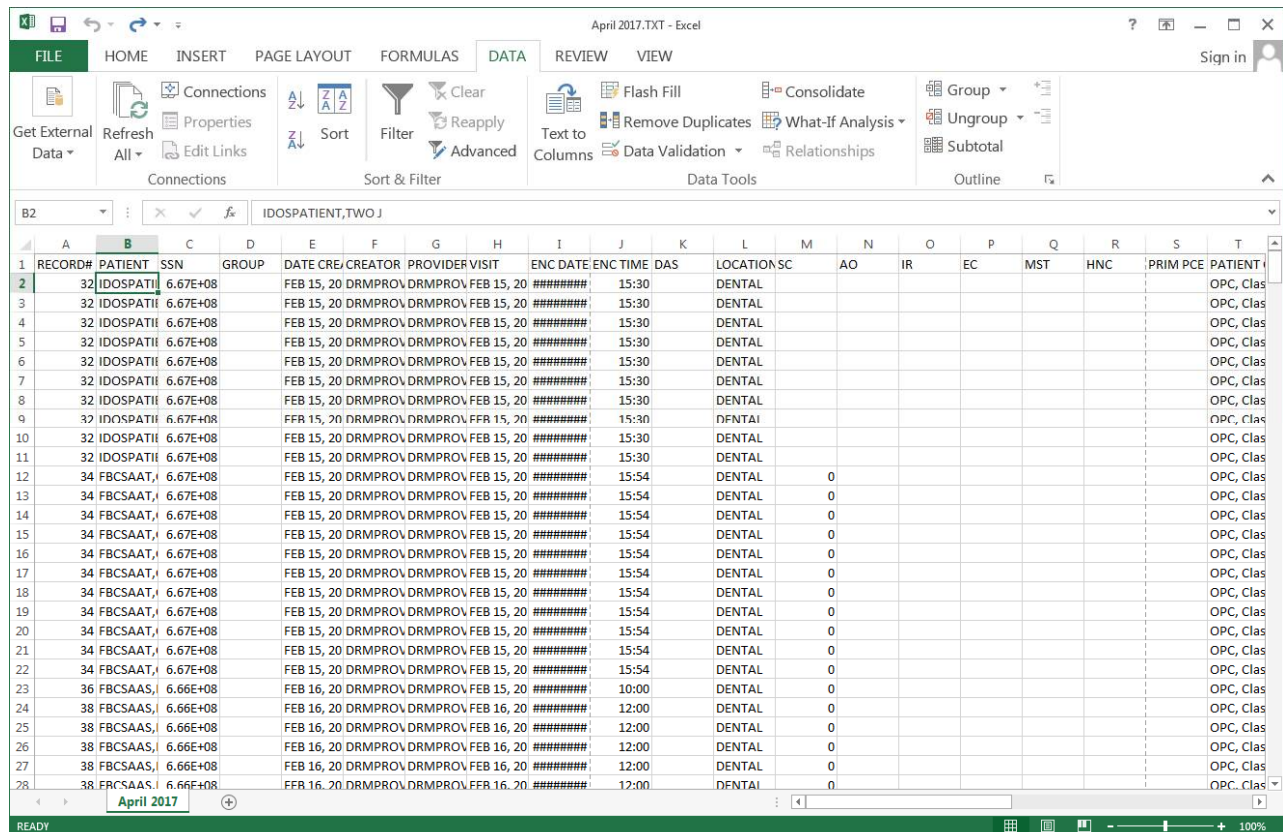
Selecting the Page Layout button results in the following screen display.



**Figure 327: Page Layout Screen**

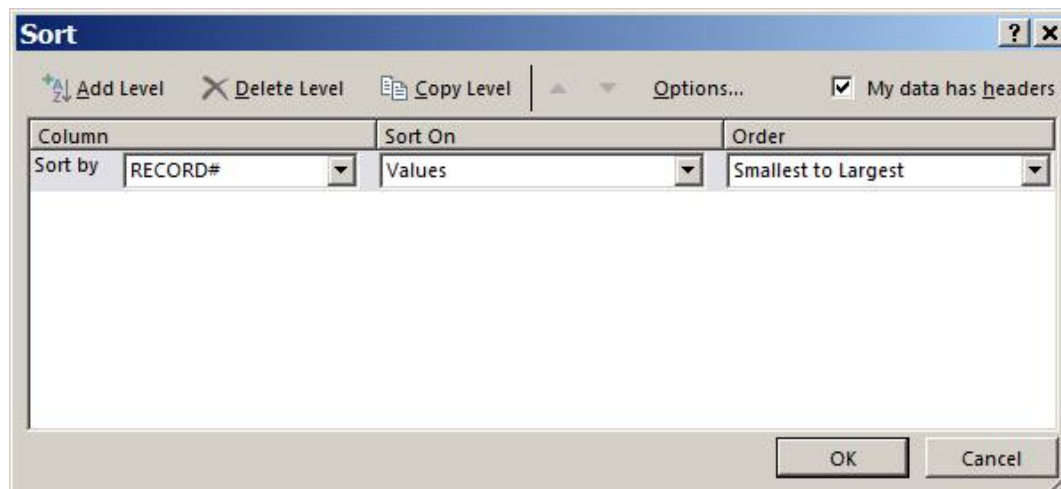
Click in the field labeled 'Click to add header' to enter a header or scroll to the field labeled 'Click to add footer' to enter a footer.





**Figure 329: Sorting Data**

The Sort screen displays.



**Figure 330: 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.





## Pull Down Options

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

Below is a sample report:

FILEHOMEINSERTPAGE LAYOUTFORMULASDATAREVIEWVIEW

Get External DataRefreshAllConnectionsPropertiesEdit LinksConnectionsSort & FilterFilterClearReapplyAdvancedText to ColumnsFlash FillRemove DuplicatesData ValidationRelationshipsConsolidateWhat-If AnalysisGroupUngroupSubtotalOutline

April 2017.TXT - Excel

Sign in

A1

123

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

1		RECORD#	PATIENT	SSN	GROUP	DATE	CREATOR	PROVIDER	VISIT	ENC DATE	ENC TIME	DAS	LOCATION	SC	AO	IR	EC	MST	HNC
2		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
3		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
4		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
5		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
6		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
7		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
8		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
9		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
10		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
11		32	IDOSPATII	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:30		DENTAL						
12		32 Total		320															
13		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
14		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
15		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
16		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
17		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
18		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
19		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
20		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
21		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
22		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
23		34	FBCSAAT,	6.67E+08		FEB 15, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	15:54		DENTAL		0				
24		34 Total		374															
25		36	FBCSAAS,	6.66E+08		FEB 16, 20	DRMPROV	DRMPROV	FEB 15, 20	#####	10:00		DENTAL		0				
26		36 Total		36															
27		38	FBCSAAS,	6.66E+08		FEB 16, 20	DRMPROV	DRMPROV	FEB 16, 20	#####	12:00		DENTAL		0				
28		38	FBCSAAS,	6.66E+08		FEB 16, 20	DRMPROV	DRMPROV	FEB 16, 20	#####	12:00		DENTAL		0				

April 2017

READYCOUNT: 93100%

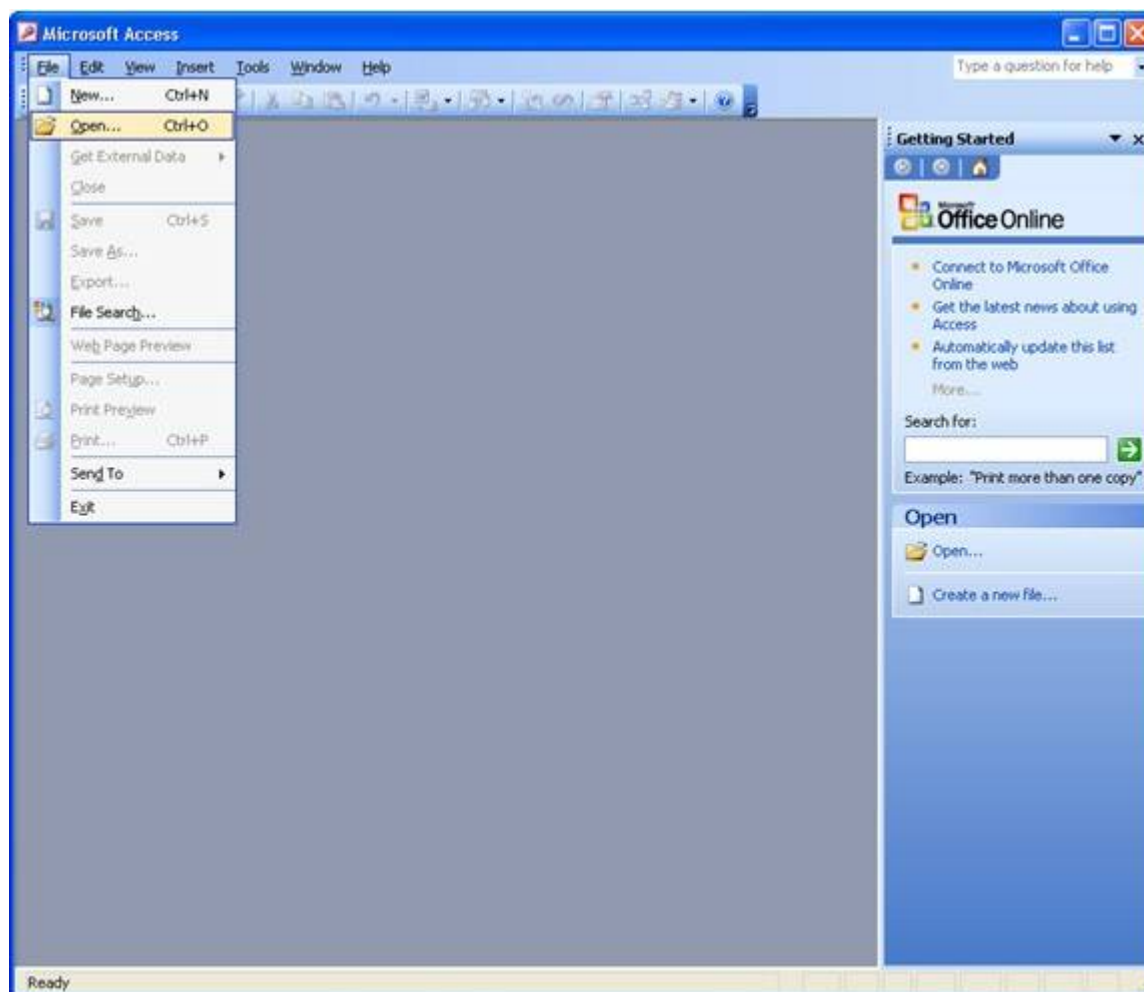
Figure 333: Sample of History File

## Importing the DRM Plus Extract Text File into an Access Report

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

To import a DRM Plus extract file into Microsoft Access:

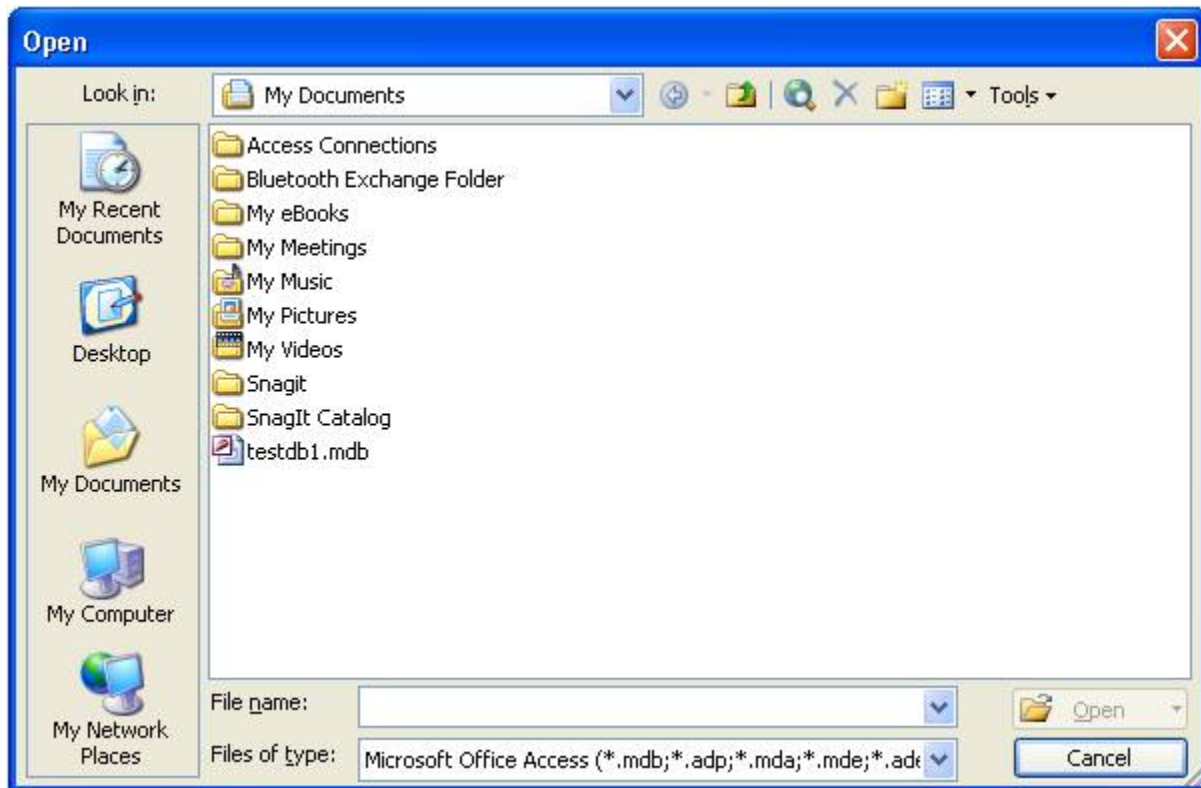
1. Open Microsoft Access. Click the **File** drop-down menu and choose the **Open** option.



**Figure 334: Import Extract File into Microsoft Access**

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





**Figure 335: Open File**

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



Figure 336: Link Text Wizard

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

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

Link Text Wizard

What delimiter separates your fields? Select the appropriate delimiter and see how your text is affected in the preview below.

Choose the delimiter that separates your fields:

☐ Tab ☐ Semicolon ☐ Comma ☐ Space ☒ Other: ^

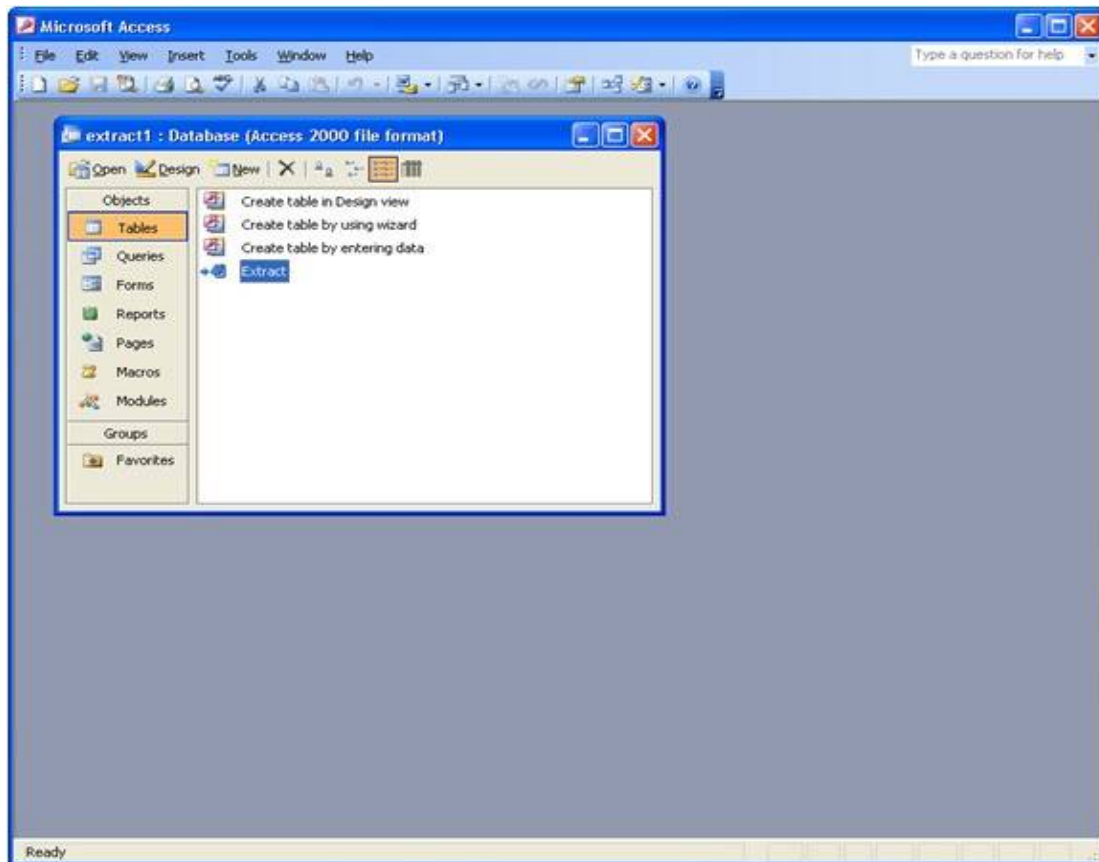
☐ First Row Contains Field Names Text Qualifier: {none}

RECORD#	PATIENT	SSN	GROUP	DATE CREATED	CREATOR	PROVIDE

Advanced... Cancel < Back Next > Finish

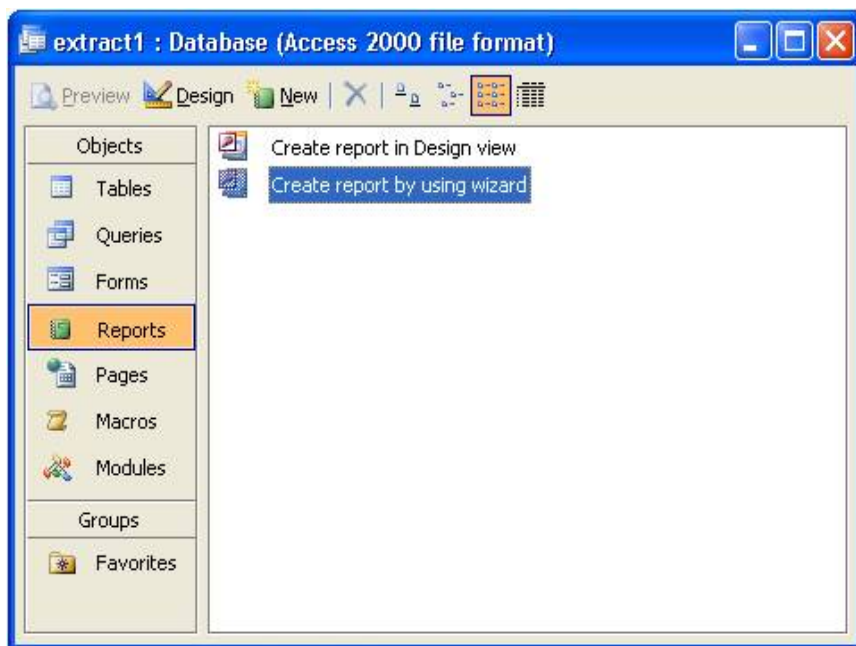
Figure 337: Link Text Wizard

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



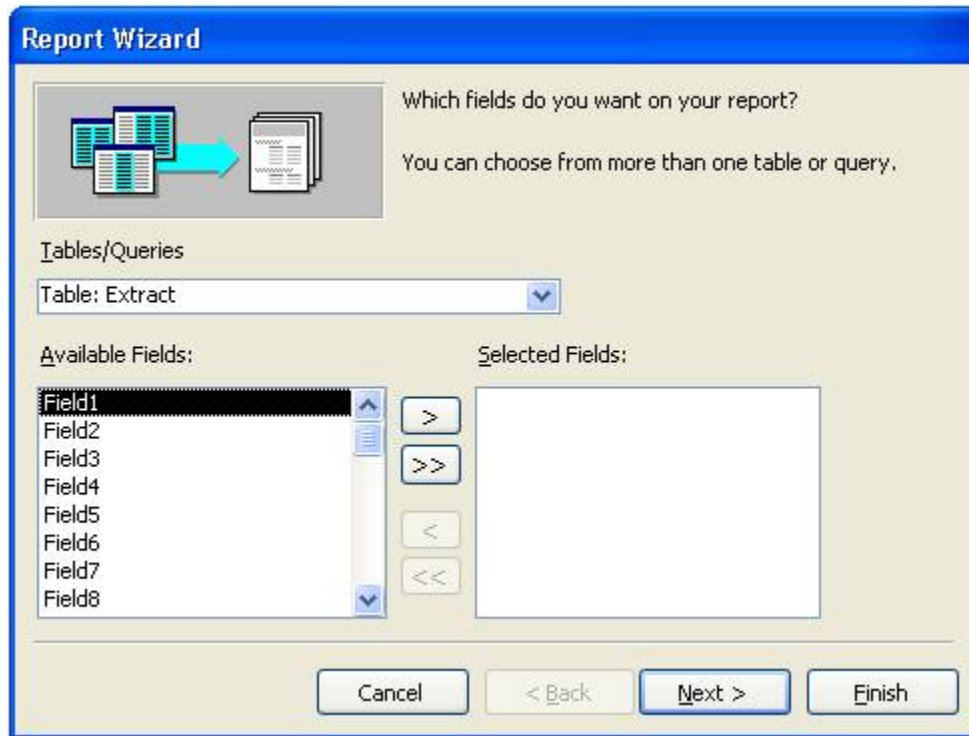
**Figure 338: File in Access Database Screen**

12. Click the **Reports** option, which displays on the remaining screen.
13. Highlight and double-click the **Create report by using wizard** feature.



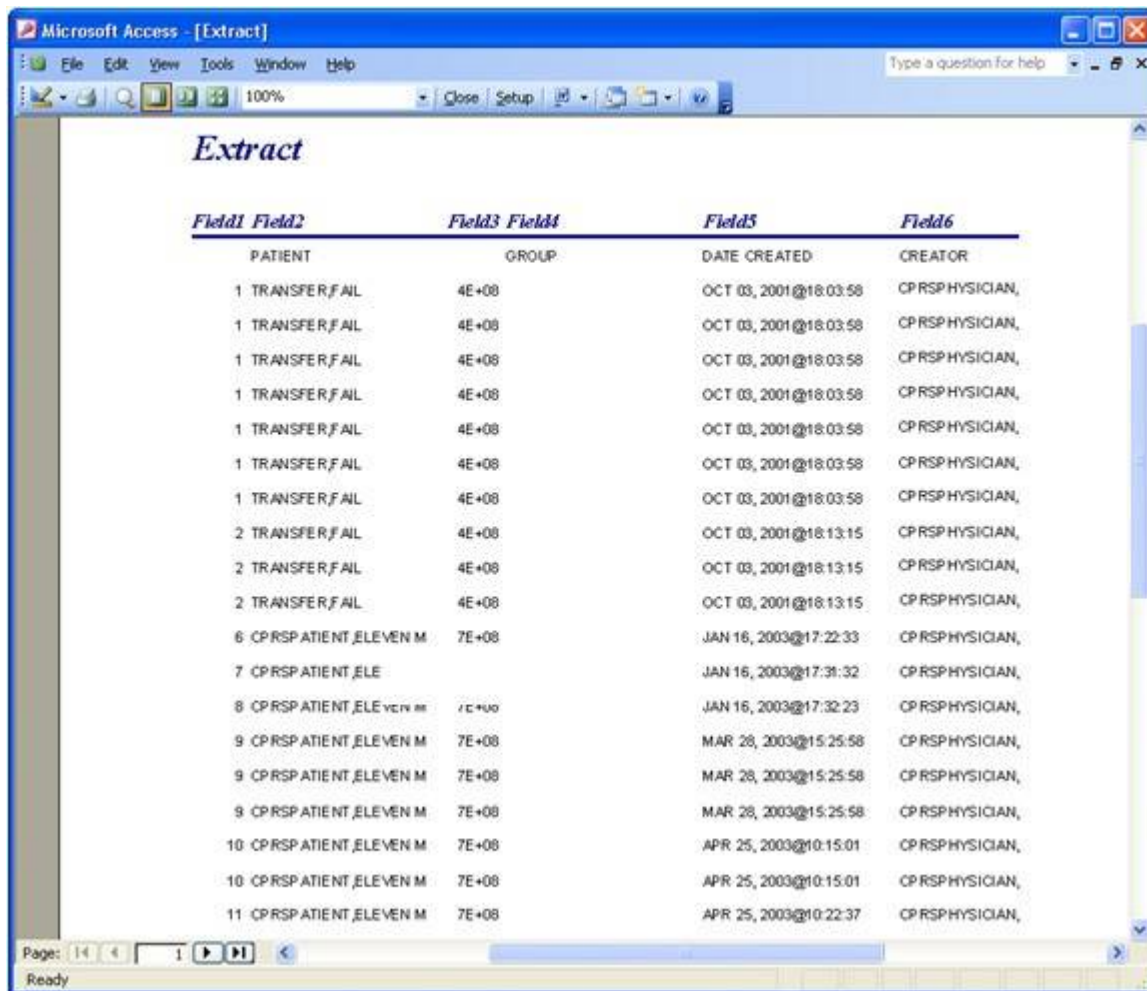
**Figure 339: Create Report By Using Wizard**

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



**Figure 340: Choose Desired Fields for Report**

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



Field1	Field2	Field3	Field4	Field5	Field6
	PATIENT		GROUP	DATE CREATED	CREATOR
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
1	TRANSFER FAIL	4E+08		OCT 03, 2001@18:03:58	CPRSPHYSICIAN,
2	TRANSFER FAIL	4E+08		OCT 03, 2001@18:13:15	CPRSPHYSICIAN,
2	TRANSFER FAIL	4E+08		OCT 03, 2001@18:13:15	CPRSPHYSICIAN,
2	TRANSFER FAIL	4E+08		OCT 03, 2001@18:13:15	CPRSPHYSICIAN,
6	CPRSPATIENT_ELEVEN M	7E+08		JAN 16, 2003@17:22:33	CPRSPHYSICIAN,
7	CPRSPATIENT_ELE			JAN 16, 2003@17:31:32	CPRSPHYSICIAN,
8	CPRSPATIENT_ELEVEN M	7E+08		JAN 16, 2003@17:32:23	CPRSPHYSICIAN,
9	CPRSPATIENT_ELEVEN M	7E+08		MAR 28, 2003@15:25:58	CPRSPHYSICIAN,
9	CPRSPATIENT_ELEVEN M	7E+08		MAR 28, 2003@15:25:58	CPRSPHYSICIAN,
9	CPRSPATIENT_ELEVEN M	7E+08		MAR 28, 2003@15:25:58	CPRSPHYSICIAN,
10	CPRSPATIENT_ELEVEN M	7E+08		APR 25, 2003@10:15:01	CPRSPHYSICIAN,
10	CPRSPATIENT_ELEVEN M	7E+08		APR 25, 2003@10:15:01	CPRSPHYSICIAN,
11	CPRSPATIENT_ELEVEN M	7E+08		APR 25, 2003@10:22:37	CPRSPHYSICIAN,

**Figure 341: Customized Microsoft Access Report**

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

## Importing the DRM Plus Extract Excel File into Access Database

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

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

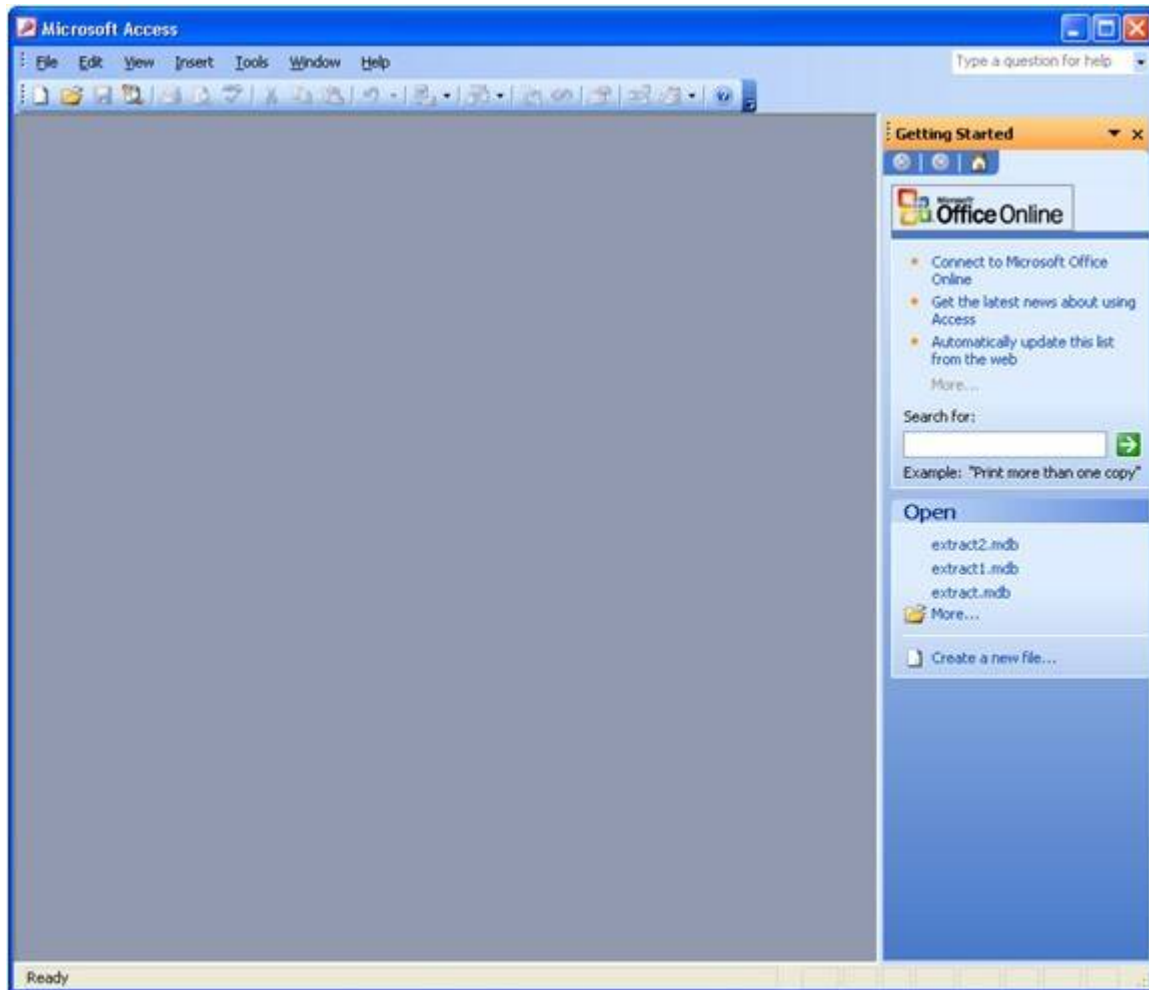
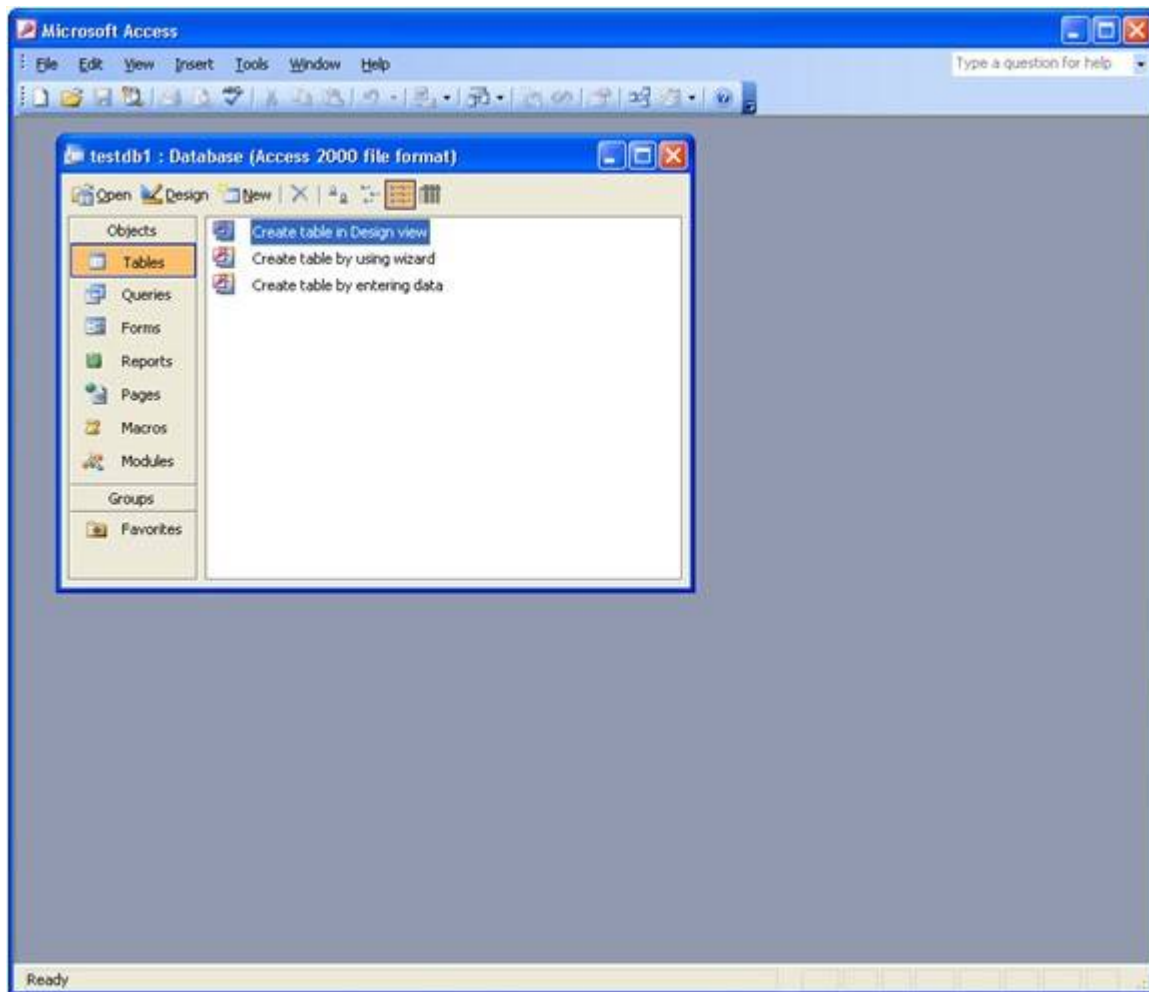


Figure 342: Import Excel File in Microsoft Access

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



Upon saving the database, the following screen displays.



**Figure 343: Microsoft Access Tables Window**

To import an extract Excel file:

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

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

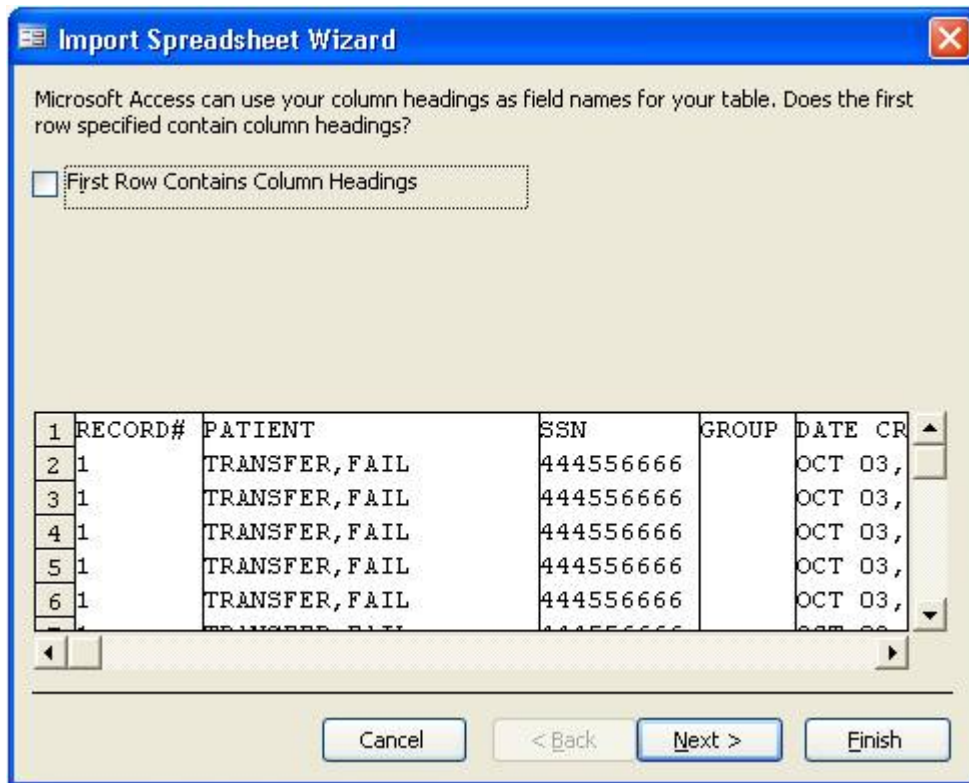
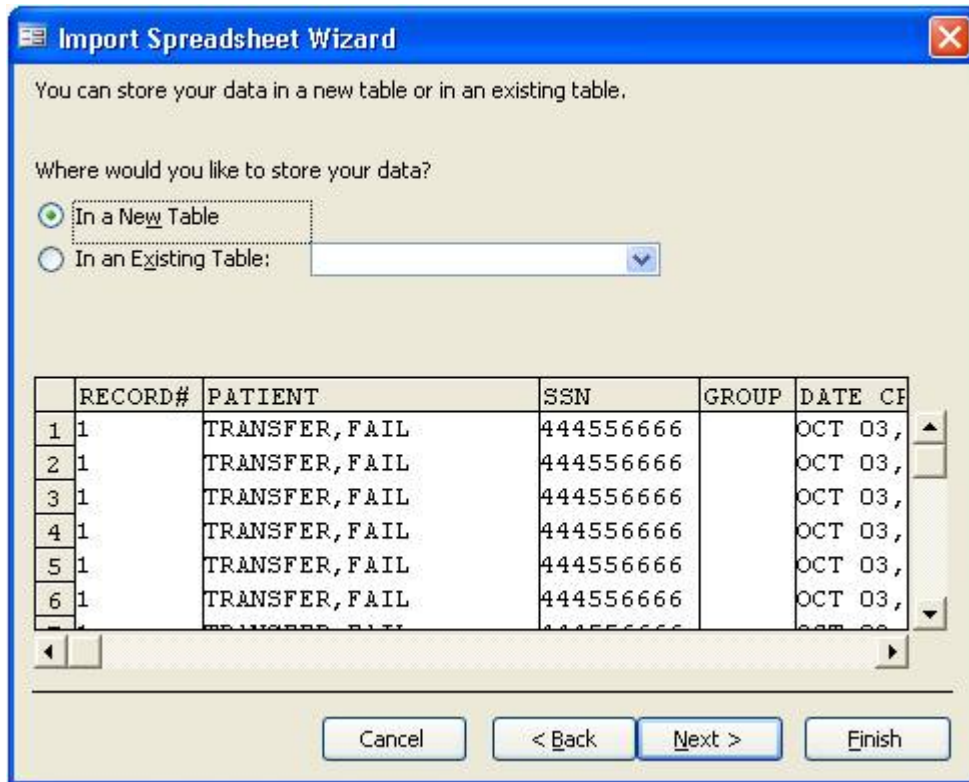


Figure 344: Import Spreadsheet Wizard

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



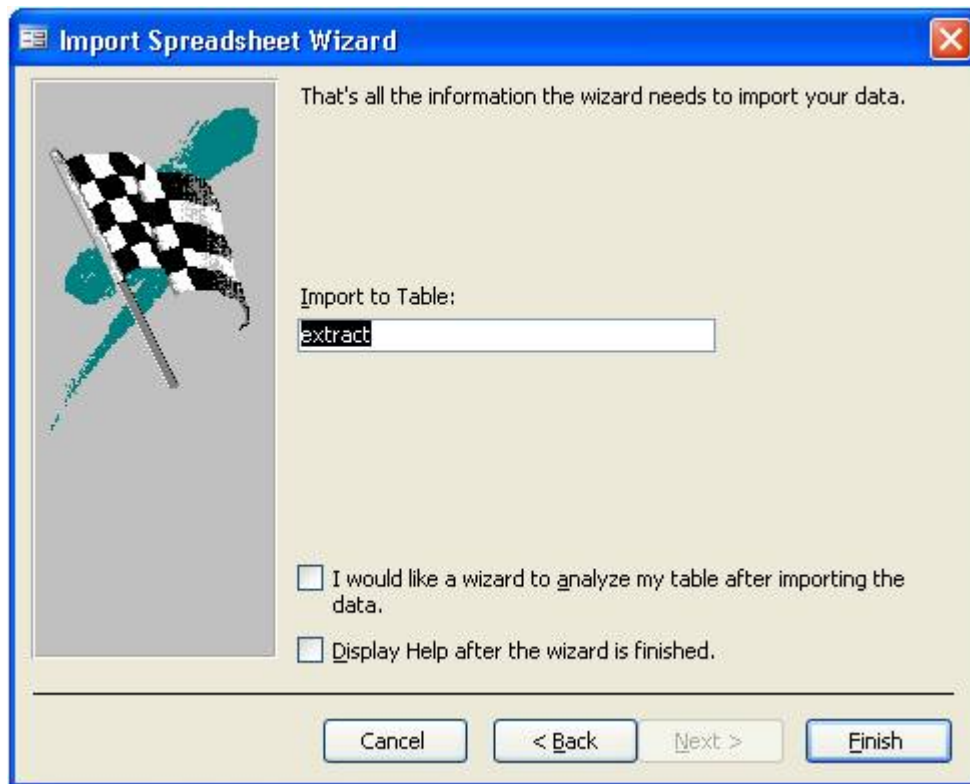
The dialog box is titled "Import Spreadsheet Wizard" and contains the following elements:

- Text: "You can store your data in a new table or in an existing table."
- Text: "Where would you like to store your data?"
- Radio button: "In a New Table" (selected)
- Radio button: "In an Existing Table:" followed by a dropdown menu.
- Table with 6 columns: RECORD#, PATIENT, SSN, GROUP, DATE, and CF. The table contains 6 rows of data.
- Buttons: "Cancel", "< Back", "Next >", and "Finish".

	RECORD#	PATIENT	SSN	GROUP	DATE	CF
1	1	TRANSFER, FAIL	4445566666		OCT 03,	
2	1	TRANSFER, FAIL	4445566666		OCT 03,	
3	1	TRANSFER, FAIL	4445566666		OCT 03,	
4	1	TRANSFER, FAIL	4445566666		OCT 03,	
5	1	TRANSFER, FAIL	4445566666		OCT 03,	
6	1	TRANSFER, FAIL	4445566666		OCT 03,	

Figure 345: Select Defaults for Storing Data

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



**Figure 346: Import to Table**

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

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

# Appendix F – Using the Keyboard to Enter Periodontal Data

## Overview

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

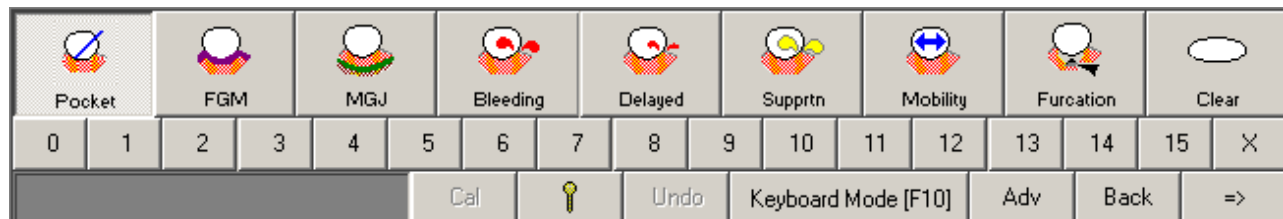


Figure 347: Keyboard Mode Button on Periodontal Chart Screen

When this button is clicked, all of the icons are disabled and the keyboard is activated. The keyboard functions are described in this section.

## Navigating the Periodontal Screen

Use the following key strokes to change the screen views.

### Arch Views

The screen moves from the existing view to any of the other views by using the following keys:

**U** = Upper

**L** = Lower

**N** = Lingual

**F** = Facial

**F11** = Full (This screen must be closed by using the mouse.)

### Cursor Movement

There are four options for moving the cursor to select a tooth/surface.

**Enter:** Moves the cursor one surface in the direction of the higher numbered tooth.

**Backspace:** Moves the cursor one surface in the direction of the lower numbered tooth.

**">" with or without the <Shift> key:** Moves the cursor one surface in the direction of the higher numbered tooth.

**"<" with or without the <Shift> key:** Moves the cursor one surface in the direction of the lower numbered tooth.

Press the <A> key to toggle the **Auto Advance** function on or off.

## Entering Data

Entering data from the keyboard requires the cursor to be placed on the desired tooth/surface. The user must then select the desired condition and enter the data values in the appropriate manner.

**Note:** All numeric values must be entered with two digits (1 = 01, 2 = 02 and 10 = 10). Entering FGM and Mobility require the values to have a prefix (see below).

**K = Pocket:** Press the <K> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

**G = FGM:** Press the <G> key and with the cursor in the correct position, enter a plus sign (+) and a two digit value, or just a two digit value. Then move the cursor to the next surface.

**J = MGJ:** Press the <J> key and with the cursor in the correct position, enter a two digit value. Then move the cursor to the next surface.

**B = Bleeding:** Press the <B> key with the cursor in the correct position.

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

**S = Suppuration:** With the cursor in the correct position, press the <S> key.

**O = Mobility:** Press the <O> key with the cursor in the correct position and enter a two digit value. For a value of 1 1/2, 2 1/2, etc., enter the two digit value preceded by a plus sign “+”.

**I = Furcation:** Press the <I> key with the cursor in the correct position and enter a two digit value. Move the cursor to the next surface.

**R = Reset:** Pressing the <R> key resets all values to zero (use this functionality with extreme caution).

**Ctrl Z = Undo.**

## Special Buttons

Viewing the Special Buttons screen requires pressing the following keys:

**H** = History

**C** = Compare

**M** = Summary

**E** = Head & Neck

**P** = PSR

**Q** = Stats

**Note:** Displaying these screens using the keyboard turns off the keyboard function for these screens. The mouse is required to navigate these screens.

## Other Functions

**Z** = Cal and **X** = Lock

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

## Appendix G – 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	Maxillofacial Prosthetics	Fixed Prosthodontics	Fixed Prosthodontics
D5130	D5934	D6205	D6782
D5140	D5935	D6210	D6783
D5211		D6211	D6790
D5212		D6212	D6791
D5213		D6214	D6792
D5214		D6240	D6793
D5221		D6241	D6794
D5222	Implant Services	D6242	D6920
D5223	D6055	D6245	
D5223	D6068	D6250	
D5224	D6069	D6251	
D5225	D6070	D6252	
D5226	D6071	D6253	
D5281	D6072	D6545	
D5820	D6073	D6548	
D5821	D6074	D6549	
D5863	D6075	D6600	
D5864	D6076	D6601	
D5865	D6077	D6602	
D5866	D6112	D6603	
	D6113	D6604	
	D6114	D6605	
	D6115	D6606	
	D6116	D6607	
	D6117	D6608	
	D6194	D6609	
		D6610	
		D6611	
		D6612	
		D6613	
		D6614	
		D6615	
		D6624	
		D6634	
		D6710	
		D6720	
		D6721	
		D6722	
		D6740	
		D6750	
		D6751	
		D6752	
		D6780	
		D6781	



## Appendix H – Active-Inactive Maintenance Control

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

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

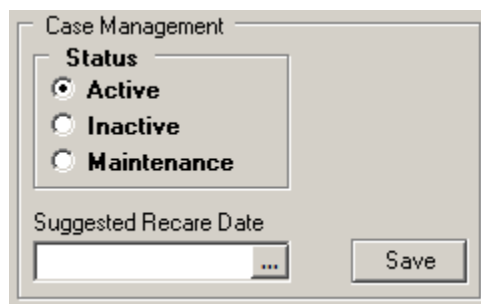


Figure 348: Case Management Status

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**.

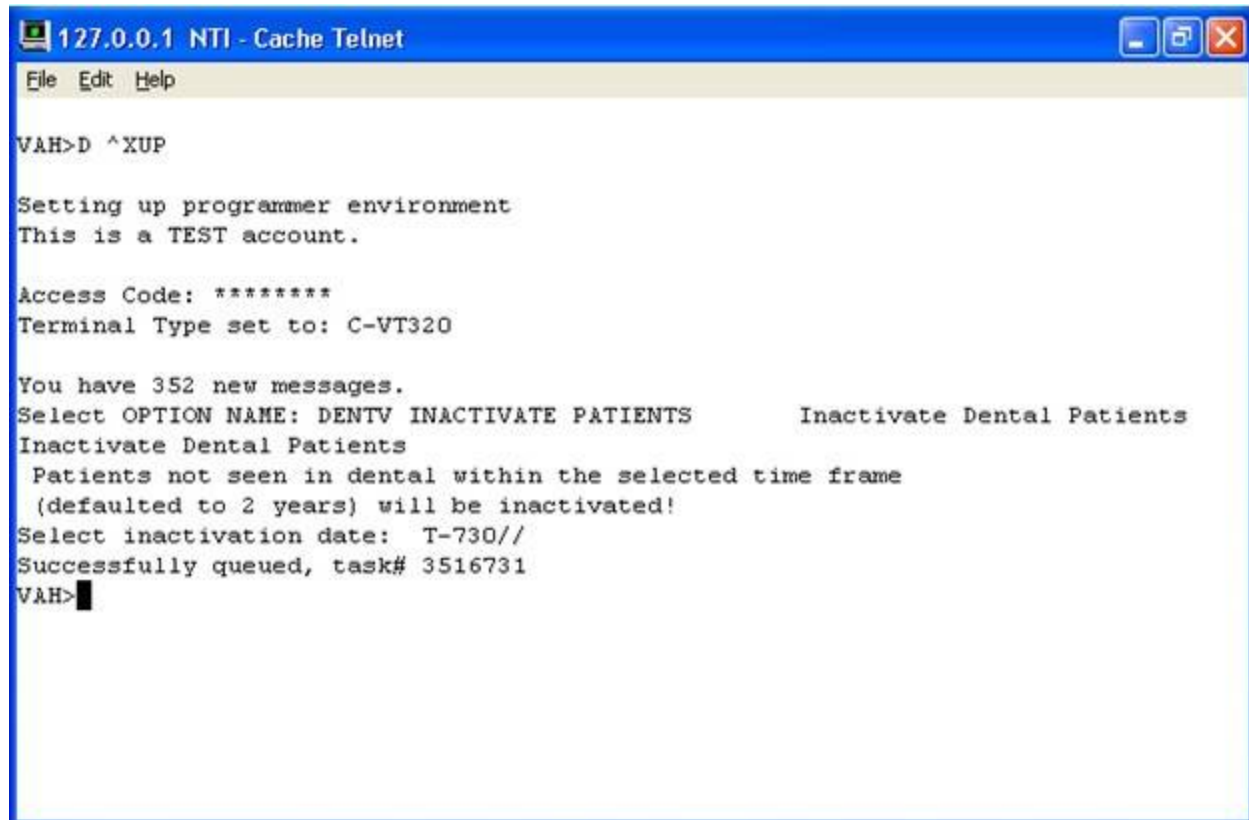
Here are some likely scenarios and the recommended use of this control:

- 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 re-care date; there is no statutory requirement for the VA to meet that recommendation.
- A **Class V** patient has had their necessary dental care completed. Upon completion of care, their status is changed to **[Inactive]**. The provider can choose whether or not to recommend and enter a re-care date; there is no statutory requirement for the VA to meet that recommendation.
- A newly enrolled Veteran is eligible for dental care. Limited capacity requires they be placed on the EWL. Their dental eligibility information should be entered in DRM Plus and thus by opening the patient in DRM Plus as a new patient their status is set to **[Active]**. Patients on the EWL should always be recorded as **[Active]** until their care is complete. If it is likely the patient may have a significant wait for care, it is suggested the **Recommended Recare Date** be set to the approximate date the patient's dental care is initiated to avoid automatic inactivation of the patient after 24 months.
- A **Class I/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 re-care date; there is no statutory requirement for the VA to meet that recommendation. The patient's status is changed to **[Active]** upon a new application for care.
- Necessary emergent care has been provided a patient with no other dental eligibility. Once all clinically proper follow-up care is complete, the patient's status is changed to **[Inactive]**.

## Appendix I – Option to Set Dental Patients to Inactive Status

A new option that IT may run (or may give as a secondary VistA option to DRM Plus users) allows the user to check the system for patient activity, and set patients without current encounters to **Inactive** status.

Use the **OPTION NAME: DENTV INACTIVE PATIENTS** and then select an inactivate date (defaulted to 2 years).



```
127.0.0.1 NTI - Cache Telnet
File Edit Help

VAH>D ^XUP

Setting up programmer environment
This is a TEST account.

Access Code: *****
Terminal Type set to: C-VT320

You have 352 new messages.
Select OPTION NAME: DENTV INACTIVATE PATIENTS      Inactivate Dental Patients
Inactivate Dental Patients
  Patients not seen in dental within the selected time frame
  (defaulted to 2 years) will be inactivated!
Select inactivation date: T-730//
Successfully queued, task# 3516731
VAH>
```

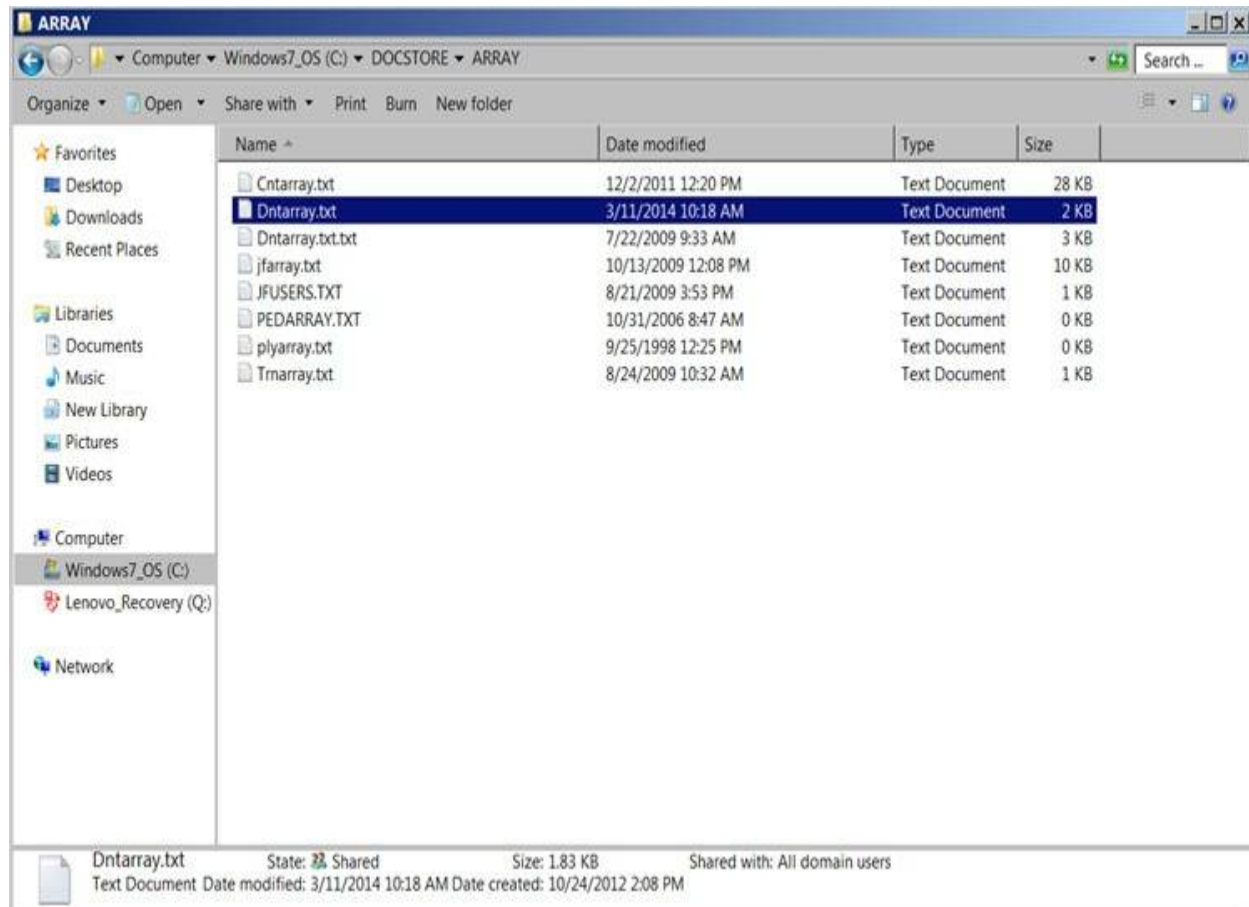
Figure 349: VistA Option to Set an Inactivation Date

## Appendix J – How to Map Dental CNTs

**Note:** These procedures require IT assistance. The dental staff should provide these instructions to IT.

In order to confirm that the CNTs are mapped correctly:

1. Open the `\DOCSTORE\Array\dntarray.txt` file located on the server to confirm that within the dntarray.txt file, the patch for each CNT is correct.



**Figure 350: Map Dental CNTs from dntarray.txt file**

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

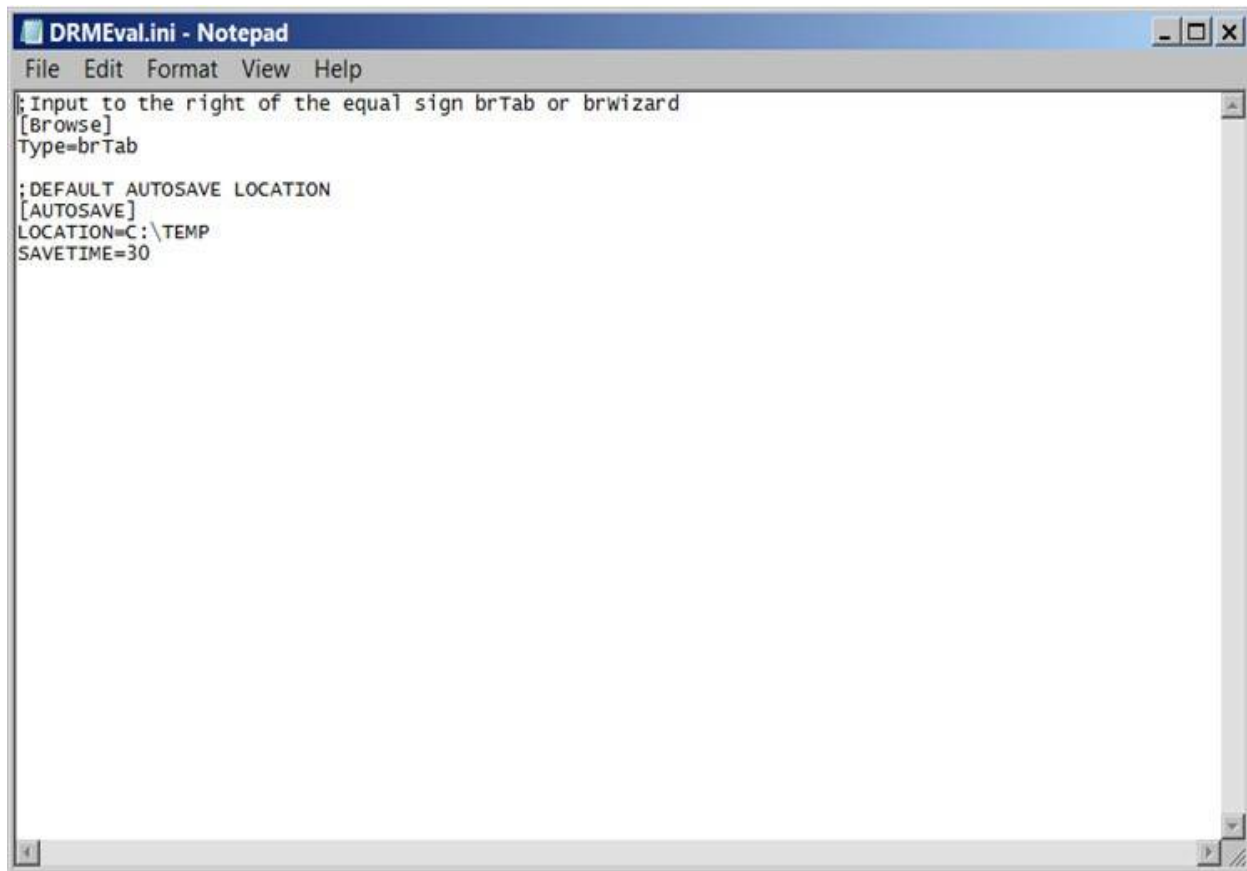


Figure 351: DRMEval.ini File

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

## Appendix K – Recommendations for Coding of Prosthetic Appliance

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

Taking workload credit for the undeliverable prosthetic appliances should occur:

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

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

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

To file workload credit:

1. Enter code(s) in the **Completed Care** screen.
2. Select the correct previously filed **Visit Date/Time** associated with this addendum.
3. Click the **Next** button and select the **File Data With a Note Addendum** radio button.





## Appendix L – Business Use of DRM Plus

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

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

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

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

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

### **Local Policy and Practice**

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

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

### **National Policy and Practice Coding Standards**

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

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

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

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

## Appendix M – Data Security

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

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

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

The amount of information and the context in which it is found can affect its value. Some information is confidential only at certain times (i.e., contracting or economic forecast information, which is sensitive until its publication or release date, after which it is made public). Current information is generally more valuable than older information.

When protecting data, all employees and contractors have a responsibility to:

- Be familiar with VA security policies, procedures, rules and regulations (i.e., know what to do, how to do it and why).
- The user should ask a supervisor or ISO any questions about these security responsibilities.

The user is responsible for:

- Reporting known or suspected incidents immediately to the ISO.
- Using VA computers only for lawful and authorized purposes.
- Choosing good passwords and changing them every 90 days. Do not write down or share log-in information with anyone, including Help Desk.
- Complying with safeguards, policies and procedures to prevent unauthorized access to VA computer systems.
- Recognizing the accountability assigned to the user's UserID and password. Each user must have a unique ID to access the VA systems. Recognize that UserIDs are used to identify an individual's actions on VA systems and the Internet. Individual user activity is recorded, including sites and files accessed on the Internet (recorded as the files go through the firewall).
- Ensuring that data is backed up, tested and stored safely.
- Not generating or sending offensive or inappropriate email messages, graphical images or sound files. Limit distribution of email to only those who need to receive it. Realize that the user is identified as a user of the VA computer systems when logged on to the Internet.
- Using authorized virus scanning software on the workstation or PC and home computer. Know the source before using discs or downloading files. Scan files for viruses before execution.
- Complying with terms of software licenses and only using VA-licensed and authorized software. Do not install single-license software on shared hard drives or servers.
- Complying with terms of software licenses and using only VA-licensed and authorized software. Do not install single-license software on shared hard drives or servers.

- Knowing data and properly classifying and protecting it, as well as inputs and outputs, according to their sensitivity and value. Label sensitive media, use a screen saver with a password, logoff when leaving the work area, and secure that sensitive information is removed from hard disks sent out for maintenance. Do not send sensitive information over the Internet unless it has been encrypted.
- Learning as much as possible about information security to assist the user's ISO. Numbers alone make users the most important security asset. Compared to one ISO for a system, users offer a chance for numerous eyes and ears to remain alert to potential threats to information systems.

## Appendix N – madExcept Application

The **madExcept** application is a tool that has been added to DRM Plus to assist with error reporting from the field and implementing a fix in the application. In order to be prepared to use this tool if an error occurs while using DRM Plus, please review the following directions:

Select all the **OK** buttons from any traditional error screen that may display in DRM Plus. There may be more than one traditional error screen or there may be none, but no matter how many, select the **OK** button on all. If any informational screen displays asking if the provider 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 system report**’ button (first button from the left) as displayed:



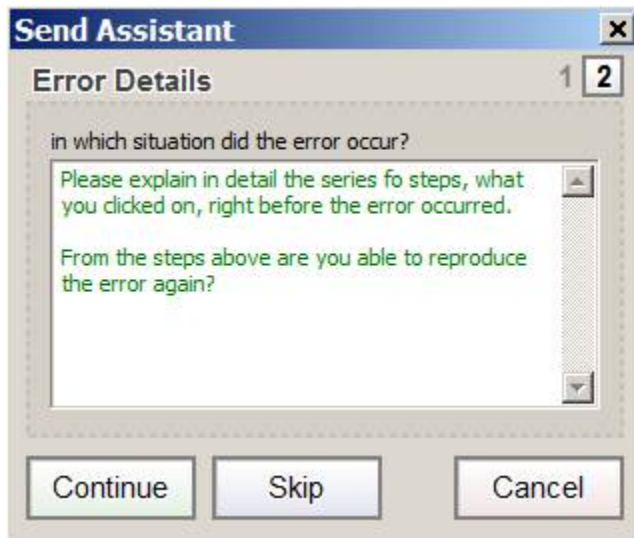
Figure 353: DENTALMRMTX.EXE screen

After selecting the ‘**send system report**’ button, the **Contact Information** screen will appear. The screen asks for contact information so enter provider’s name and VA email address. Select the **Continue** button on the **Contact Information** screen to move on to the next step.

The image shows a dialog box titled "Send Assistant". Inside, there is a section titled "Contact Information" with two sub-sections labeled "1" and "2". Under "1", there is a text field labeled "your name:" with the placeholder text "your name". Under "2", there is a text field labeled "your email:" with the placeholder text "name@va.gov". Below these fields is a checkbox labeled "remember me" which is checked. At the bottom of the dialog box are three buttons: "Continue", "Skip", and "Cancel".

Figure 354: Contact Information screen

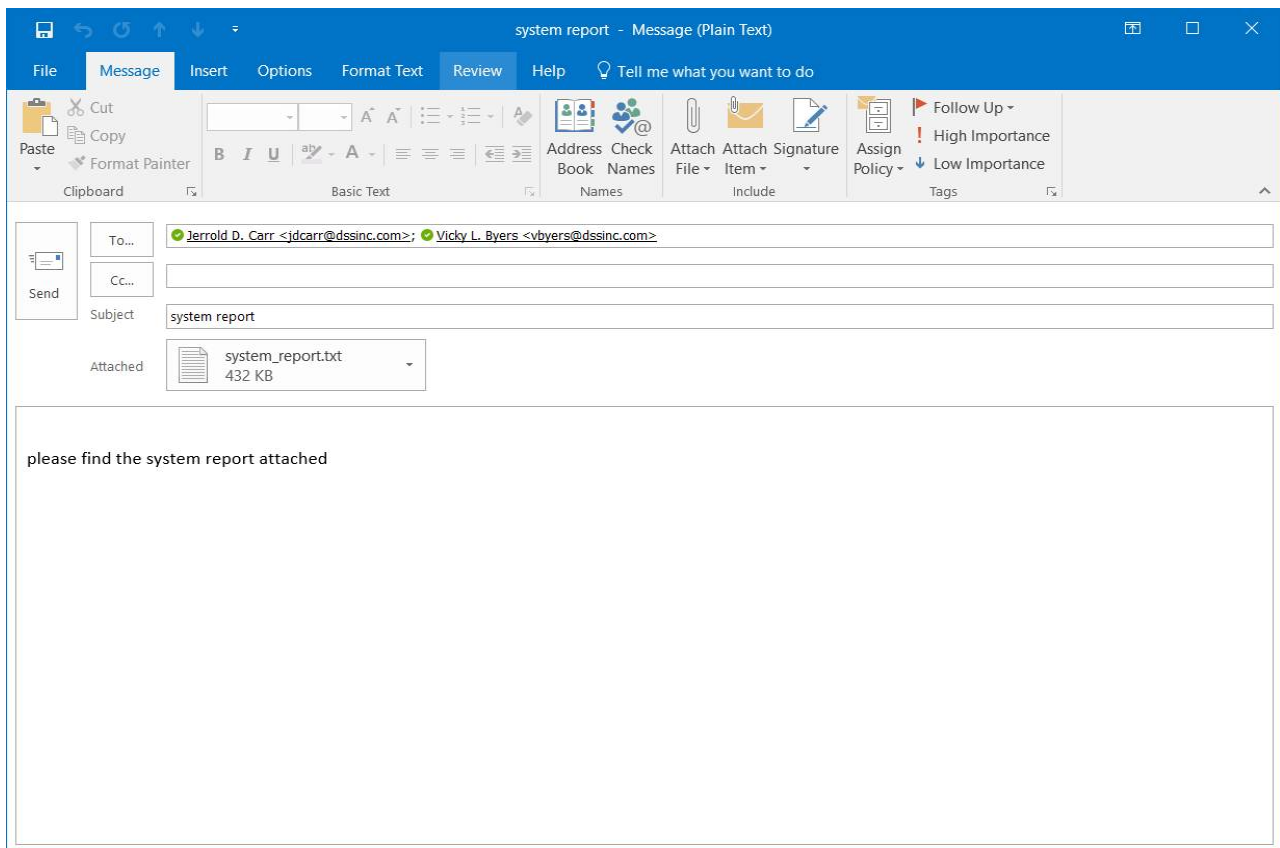
The **Error Details** screen will immediately appear. Add information in the in the **Error Details** screen providing as much information as possible. If known, list every click that occurred prior to the error message. The more details listed; the easier it will be to reproduce the error and fix it.



**Figure 355: Error Details Screen**

Select the **Continue** button from the **Error Details** screen which will launch an email.

The following screen will open the provider’s email screen. The example used is MS Outlook. The email address of both Vicky Byers and J.D. Carr will populate the ‘To’ field and the system report will be attached.



**Figure 356: 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 please 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 provider may add any other individuals as recipients (To and CC) in the email address fields as appropriate. Additional information may be included by entering that information in the email address window.

Click on the **Send** button from the email screen.

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

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

# Periodontal Keyboard Shortcuts Tear-Out

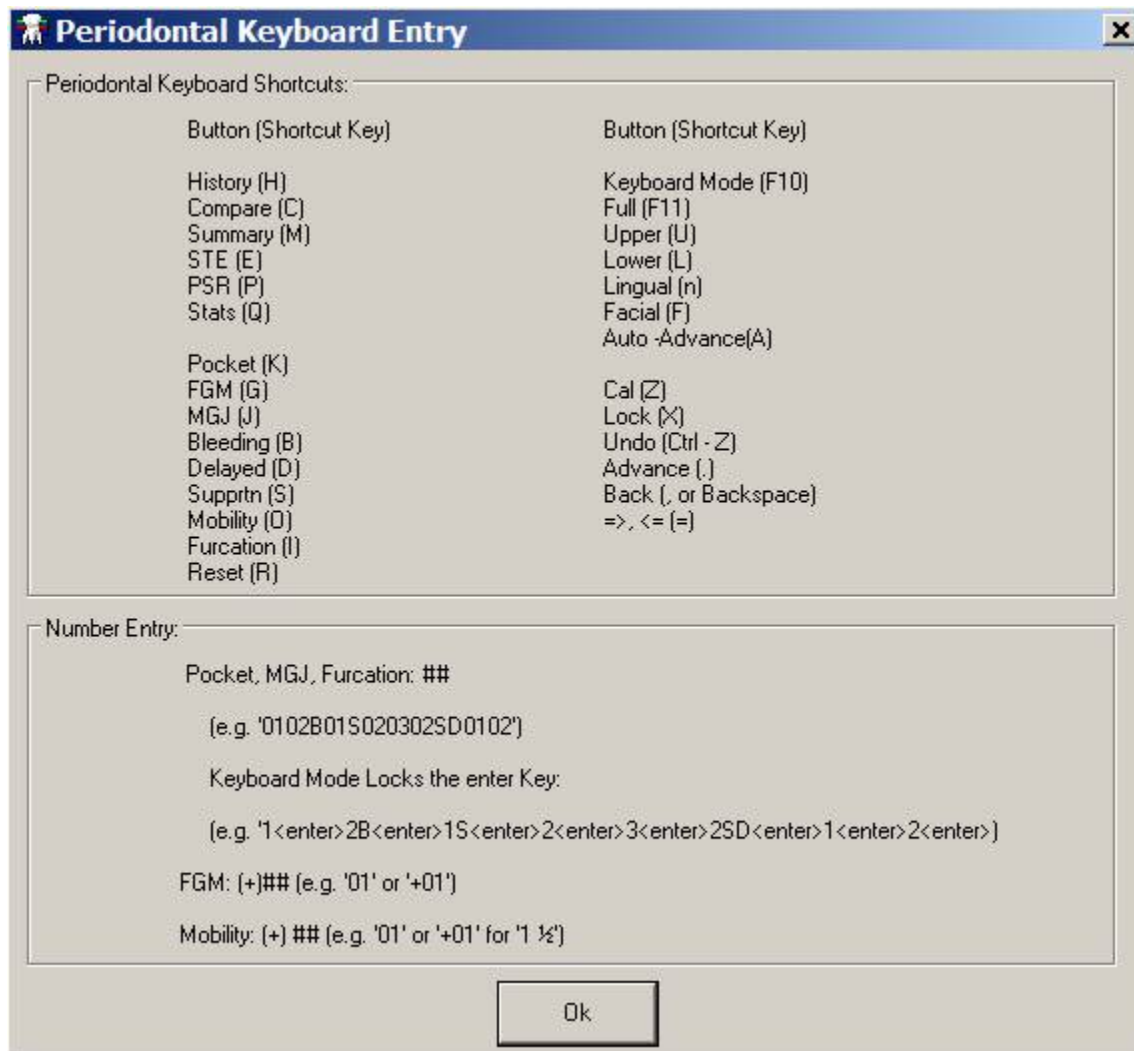


Figure 357: Periodontal Keyboard Entry Screen