



DRM Plus

User Manual

Version 4.7



*@2000 – 2006 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 Veteran Affairs facilities for over six years. DSS is located at 12575 U.S. Highway One, Suite 200, Juno Beach, FL 33408.

World Wide Web: www.dssinc.com.

DSS DRM Plus program is a trademark of Document Storage Systems, Inc. Outlook, Internet Explorer and Windows are registered 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

Table of Figures	5
Introduction	10
<u>Document Storage Systems, Inc.</u>	10
<u>From the Department of Veterans Affairs</u>	10
<u>Background</u>	10
<u>Introduction</u>	11
<u>Quality Improvement/Performance Measures and Benefits</u>	13
<u>Benefits</u>	13
<u>Customer Support</u>	13
Technical Overview	14
<u>DRM Plus Creates Encounter Information</u>	15
Launching DRM Plus.....	16
<u>Overview</u>	16
Common Application Functions	18
<u>Overview</u>	18
Using DRM Plus	20
<u>Using the Treatment & Exam Screen</u>	20
<u>Using the Diagnostic Findings Screen</u>	25
<u>Procedures for Saving Unfiled Diagnostic Findings</u>	33
<u>Using the Treatment Plan Screen</u>	35
<u>Procedures for Saving Unfiled Treatment Plan</u>	51
<u>Entering Treatment Plan Procedures with a Related Diagnosis</u>	54
<u>Sequencing the Treatment Plan</u>	59
<u>Entering Completed Care from the Tx Planning/Sequencing Screen</u>	66
<u>Using the Completed Care Screen</u>	68
<u>Changing the Diagnosis or Designating a Secondary Diagnosis</u>	80
<u>Procedures for Saving Unfiled Completed Care</u>	83
<u>Synchronization of Planned and Completed Care</u>	86
Using the Periodontal Chart Screen	88
<u>Using the Condition Specific Icons</u>	91
<u>Initiating Progress Note from the Perio Screen</u>	94
<u>Using the Special Buttons Displayed on the Perio Screen</u>	97
Completing the Encounter Data & Progress Note	104
<u>Selecting a Default Location</u>	107
<u>Primary Diagnosis and Other Options Screen</u>	108
<u>Service Connection/Additional Providers/Additional Signers/Station Screen</u>	111
<u>Set Progress Note Title Screen (Or Respond to a Consult Request)</u>	114
<u>Progress Note Screen</u>	116
<u>Capturing the Distributed (Attending) Provider for residents</u>	122
Creating a Progress Note Addendum	124
<u>With or Without Passing Information to PCE/DES</u>	124
Adding a Note – For Informational Purposes Only	130
Using the Special Buttons	132
<u>Notes Icon Button</u>	132
<u>H & N (Head & Neck) Button</u>	134

<u>History Button</u>	140
<u>Summary Button</u>	141
<u>PSR Button (Periodontal Screening/Recording)</u>	143
<u>Plaque Button</u>	143
Using the DRM Plus Menu Bar.....	144
<u>File Menu Options</u>	144
<u>Edit Menu Options</u>	147
<u>Dental Encounter Data Menu Options</u>	147
<u>Treatment & Exam Menu Options</u>	149
<u>Tools Menu Options</u>	166
<u>Help Menu Options</u>	181
Patient Inquiry.....	187
Using the Cover Page Tab	188
Using the Clinical Record Tab	192
Using the Dental History Tab.....	197
Appendix A – Glossary of VA Terms	199
Appendix B – Data Security	203
Appendix C – Using the Keyboard to Enter Periodontal Data	205
Appendix D – Using the CNT Navigator	209
<u>Navigating within CNT's</u>	211
Appendix E – Range Codes	213
Appendix F – Business Use of the DRM Plus Software	214
<u>Local policy and practice</u>	214
<u>National policy and practice-Coding Guidelines</u>	214
<u>National Business Practices – Fee Basis</u>	215
Appendix G – Active-Inactive-Maintenance Control.....	216
Periodontal Keyboard Shortcuts: Tear-Out	219

Table of Figures

Figure 1: Technical Overview Map.....	14
Figure 2: Dental Encounter System.....	15
Figure 3: Launching DRM Plus.....	16
Figure 4: Treatment Plan View	17
Figure 5: Treatment and Exam Screen	20
Figure 6: Graphic Chart and Icon Display.....	22
Figure 7: Patient Alerts & Coding.....	22
Figure 8: General Coding Guidelines	23
Figure 9: Dental Alerts	23
Figure 10: Active Dental Patient Alerts Area.....	24
Figure 11: Entering Diagnostic Findings.....	25
Figure 12: Diagnostic Findings after entering crown on tooth #3	26
Figure 13: Diagnostic Findings Screen.....	29
Figure 14: Diagnostic Findings Transaction Table.....	30
Figure 15: No Completed Care Procedures Entered screen.....	31
Figure 16: File to PCE/DES with code.....	31
Figure 17: File DES-Only Data.....	32
Figure 18: Save Unfiled Data.....	33
Figure 19: Save Confirmation box	33
Figure 20: Search for Provider Criteria	34
Figure 21: Search for Provider Results.....	34
Figure 22: "Unfiled data saved successfully" messages	35
Figure 23: Treatment Plan Screen	36
Figure 24: Special Descriptions – Bridge code	38
Figure 25: Restoration Example	40
Figure 26: Multi-Add Function	41
Figure 27: Missing teeth displayed in the multi-add box	42
Figure 28: Transaction Table with Text View.....	43
Figure 29: Ranged Code Warning	44
Figure 30: ADA Codes/Description Screen	44
Figure 31: Selecting ADA Code.....	45
Figure 32: Code Details Box	45
Figure 33: Planned Procedure in Transaction Table.....	46
Figure 34: Using Filter with Text in the ADA Code/Description screen	47
Figure 35: Add Box	48
Figure 36: Using the Filter with d02 in the Add box	48
Figure 37: No Completed Care Procedures Entered screen.....	49
Figure 38: File to PCE/DES with code.....	49
Figure 39: File DES-Only Data.....	50
Figure 40: Save Unfiled Data	51
Figure 41: Save Unfiled Data confirmation message	51
Figure 42: Search for Provider	52
Figure 43: Choose Desired Provider	52
Figure 44: "Unfiled data saved successfully" messages	53
Figure 45: User Option screen.....	54
Figure 46: Treatment Plan tab	55
Figure 47: Making Diagnosis/ICD9 Screen Option Default.....	56
Figure 48: Diagnosis/ICD 9 Screen results from Multi-Add Feature	57
Figure 49: Primary Diagnosis in the Transaction Table of Treatment Plan	58
Figure 50: Sequencing the Treatment Plan.....	59
Figure 51: No planned treatments items.....	59
Figure 52: Unsequenced Treatment.....	60

Figure 53: Creating Phases	60
Figure 54: Tx Planning/Sequencing in Phases	61
Figure 55: Creating Sub-phases.....	62
Figure 56: Sub-phase	62
Figure 57: Procedure and Sub-phase displayed.....	63
Figure 58: Assigning Next Appointment.....	63
Figure 59: Tx & Exam tab.....	64
Figure 60: Sequencing "Save and Exit".....	65
Figure 61: "Save and Exit" message.....	65
Figure 62: Entering Completed Care from Tx/Planning Sequencing Screen	66
Figure 63: Treatment Plan Screen	67
Figure 64: Using the Completed Care Screen	68
Figure 65: Special Descriptions Bridge Icon.....	71
Figure 66: Selecting an ADA Code	72
Figure 67: Using the Multi-Add Function	73
Figure 68: Administrative Guidelines in Filing Options/Diagnosis screen	74
Figure 69: Missing teeth displayed in the multi-add box	75
Figure 70: Using the ADA Codes Icon.....	76
Figure 71: Display Code Details	76
Figure 72: Code Details box.....	77
Figure 73: Filing Option/Diagnosis screen	77
Figure 74: Transaction Table with Entered ADA Code	78
Figure 75: Using the Add box	79
Figure 76: Designating a New Primary or Secondary Diagnosis	80
Figure 77: Designating Additional Diagnosis Codes	81
Figure 78: Changing the Diagnosis with Multi-Add Feature	82
Figure 79: Save Unfiled Data	83
Figure 80: Save Unfiled Data confirmation box.....	83
Figure 81: Search for Provider	84
Figure 82: Select Provider	84
Figure 83: "Unfiled data saved successfully" messages	85
Figure 84: Potential Duplicate Transactions screen	86
Figure 85: Changing the Periodontal Chart Screen View.....	88
Figure 86: Periodontal Chart Confirm Reset box	89
Figure 87: Selecting Teeth/Locations or Using the Auto Advance	90
Figure 88: Using the Condition Specific Icons.....	91
Figure 89: Measurement Scale	92
Figure 90: Initiating Progress Note from the Perio Screen.....	94
Figure 91: File to PCE/DES with code.....	94
Figure 92: File to DES Only with a Code.....	95
Figure 93: Displaying Perio Exam Findings in the Progress Note	96
Figure 94: Special Buttons Displayed on the Perio Screen	97
Figure 95: Periodontal History Screen	98
Figure 96: Periodontal History Screen by Date	99
Figure 97: Periodontal History/Compare.....	100
Figure 98: Periodontal Screening/Recording (PSR).....	101
Figure 99: Periodontal Statistics.....	101
Figure 100: Summary by Quadrant	102
Figure 101: Summary by Tooth.....	103
Figure 102: Completing the Encounter Data and Progress Note 1 st screen	104
Figure 103: Select Visit Date/Time	105
Figure 104: Establish New PCE Visit	105
Figure 105: Select Location.....	106
Figure 106: New PCE Visit not allowed	106
Figure 107: Selecting a Default Location.....	107
Figure 108: Filing Options	108

Figure 109: Dental Category	109
Figure 110: Disposition and Primary Diagnosis.....	110
Figure 111: Completing the Encounter Data and Progress Note 2 nd screen	111
Figure 112: Search for Provider for Additional Providers/Signers.....	112
Figure 113: Select Additional Provider/Signers	113
Figure 114: Set Progress Note Title Screen.....	114
Figure 115: Select Consult Title	115
Figure 116: Progress Note 3 rd & Final Screen	117
Figure 117: Import CPRS Medical Information	118
Figure 118: Prompt to complete dental episode of care	119
Figure 119: Progress Note signed and finished	120
Figure 120: Search for Provider	121
Figure 121: "Dental encounter record successfully created" message.....	121
Figure 122: Prompt for Distributed Provider (for residents filing w/o a cosigner).....	122
Figure 123: Filing error - data NOT filed to DES/PCE or Dental	122
Figure 124: PCE Encounter information on VistA.....	123
Figure 125: Warning when using different provider than original Progress Note.....	123
Figure 126: Creating a Text Addendum without an ADA code	124
Figure 127: Addendum to a Note	125
Figure 128: "Note Successfully Appended" message	126
Figure 129: File a Note Addendum to PCE/DES	127
Figure 130: Original Progress Note – yellow window	128
Figure 131: Appended Note – White window	129
Figure 132: Adding a Note for Informational Purposes Only	130
Figure 133: Select New Note.....	130
Figure 134: Choose the Note Title	131
Figure 135: Enter Notation or Informational Data	131
Figure 136: Completed message.....	131
Figure 137: Using the Note icon.....	132
Figure 138: H&N (Head & Neck) Button	134
Figure 139: H&N Detail Screen	135
Figure 140: Common H&N Findings	135
Figure 141: Select Appropriate Description	136
Figure 142: Updated H&N Detail Screen.....	137
Figure 143: Adding a New Observation	138
Figure 144: Multiple Lesions	139
Figure 145: Treatment & Exam History Notes.....	140
Figure 146: Summary of Quadrant when Completed Care is selected	141
Figure 147: Summary by Tooth.....	142
Figure 148: Periodontal Screening/Recording (PSR)	143
Figure 149: Plaque Button.....	143
Figure 150: File Menu	144
Figure 151: File Administrative Time	144
Figure 152: File Fee Basis.....	145
Figure 153: Print Options	146
Figure 154: Edit Menu.....	147
Figure 155: Dental Encounter Data Menu	147
Figure 156: New PCE Visit option disabled.....	148
Figure 157: New PCE Visit not allowed	148
Figure 158: Treatment & Exam Menu.....	149
Figure 159: Configuration Options – Tx & Exam tab	150
Figure 160: Charting Configuration Periodontal Tab.....	151
Figure 161: Charting Configuration Report Tab	152
Figure 162: Charting Configuration Speed Codes Tab.....	153
Figure 163: Edit Speed Code.....	153
Figure 164: Speed Code Named.....	154

Figure 165: Highlight Desired CPT Code	154
Figure 166: Speed Code's ADA code	154
Figure 167: Choose Icon	155
Figure 168: Finalization Screen.....	155
Figure 169: Newly Created Speed Code	156
Figure 170: Configure Speed Code in non-Perio Mode	157
Figure 171: Speed Code Icon in Completed Care Screen.....	158
Figure 172: Speed Code Details for XRAYS	158
Figure 173: No Codes Designated Require Modifier Entries	159
Figure 174: Charting Configuration Suggestion Links Tab	160
Figure 175: Select Primary ADA Code	160
Figure 176: Linked Codes for D0140.....	161
Figure 177: Select Second Code to Be Linked	161
Figure 178: D0274 is Linked to D0140.....	161
Figure 179: ADA Code Suggestions	162
Figure 180: Charting Configuration Statistics Tab.....	162
Figure 181: Warning Levels	163
Figure 182: Charting Configuration H&N Tab	163
Figure 183: Enter Desired H&N Findings.....	164
Figure 184: Add/Edit Personal Quick List	164
Figure 185: Manage Personal Quick List	164
Figure 186: Add Selected Codes to Quicklist.....	165
Figure 187: Filter View	165
Figure 188: Tools Menu	166
Figure 189: VistA User Inquiry.....	167
Figure 190: Date Range Defaults	168
Figure 191: Other Parameters.....	169
Figure 192: Initial tab when DRM Plus starts	170
Figure 193: Initial chart display in Chart/Treatment	170
Figure 194: Set File Folder.....	171
Figure 195: Set Extract Folder.....	172
Figure 196: Page Setup.....	173
Figure 197: Progress Note Data Options	174
Figure 198: Note Objects Sequence	175
Figure 199: New Code Boilerplate	176
Figure 200: New Boilerplate Name	176
Figure 201: Code Boilerplate Text – PROPHY	177
Figure 202: Find CPT Code	177
Figure 203: Find CPT Code, Enter ADA Code	177
Figure 204: Code Boilerplate Text – PROPHY with ADA Code.....	178
Figure 205: Code Boilerplate Text – PROPHY with text.....	178
Figure 206: Code Boilerplate	179
Figure 207: Treatment Plan tab	179
Figure 208: Tools Menu Ancillary Section	180
Figure 209: Help Menu	181
Figure 210: Help Contents Button.....	182
Figure 211: Enhanced Help Items: Content, Index, Find	182
Figure 212: Help Book Sub-topics	183
Figure 213: Select Book Sub-topic.....	183
Figure 214: Print Help Sub-Topic Information	184
Figure 215: Help Topic Search.....	184
Figure 216: Version Notes.....	185
Figure 217: Broker Calls	185
Figure 218: About	186
Figure 219: Patient Inquiry.....	187
Figure 220: Cover Page tab	188

Figure 221: Add Medical Conditions Problem List tab.....	189
Figure 222: Add Medical Conditions Code Search Tab.....	189
Figure 223: Save Cover Page data.....	190
Figure 224: Editing User Options.....	191
Figure 225: Other Parameters default tab when DRM starts	191
Figure 226: Clinic Record Tab	192
Figure 227: Active Problems Displayed.....	193
Figure 228: All Completed Notes Displayed.....	194
Figure 229: New Note	195
Figure 230: TIU Filter	196
Figure 231: Dental History Tab.....	197
Figure 232: Tooth-Specific Procedure History.....	198
Figure 233: Using the Keyboard to Enter Periodontal Data	205
Figure 234: Navigating the Periodontal Screen	206
Figure 235: Periodontal Keyboard Entry.....	208
Figure 236: CNT Navigator.....	209
Figure 237: Using the CNT Navigator	210
Figure 238: Navigating Within CNT	211
Figure 239: Preview Note.....	212
Figure 240: Finish and Accept Note When Completed	212
Figure 241: Case Management Status	216

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 GUI (*Graphical User Interface*) applications that insert, update and retrieve patient data that is held in an M (MUMPS) data repository or SQL database system. DSS' array of GUI products allow for the electronic documentation of Progress Notes and other significant parts of medical records, scanning and viewing of clinical and administrative documents and automated medical record coding through simple points and clicks.

From the Department of Veterans Affairs

The Veterans Health Administration Office of Dentistry in conjunction with Document Storage Systems Inc. implemented the Dental Record Manager (DRM) throughout the VA in 2001. DRM has now been significantly improved to include computerization of the provider's Treatment Plan. DRM has been renamed DRM Plus. The principal objective of DRM Plus provides staff the ability to electronically capture meaningful data for patient encounters. This in-turn creates a more accurate, more inclusive, more efficient and less costly data storage process. DRM Plus does not replace the existing VistA Dental package, but rather, acts as 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.

Background

In 1997, Document Storage Systems, Inc., in conjunction with the VA, developed a dental software package titled the Dental Record Manager (DRM). The Dental Record Manager is a nationally purchased software product and is installed in all VA dental clinics. Future plans for DRM included the computerization of the patient's Diagnostic Findings, Completed Care Treatment Plan and Periodontal Chart. The planning for these enhancements has been a joint VA/DSS effort. DRM Plus is a combination of DRM and these major enhancements. Document Storage Systems and Discus Dental Software worked together to develop DRM Plus. In September, 2003, the VA purchased a national license for DRM Plus. DRM Plus was fully implemented by September 30, 2005.

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 assess patient dental conditions, and develop and maintain the Treatment Plan. The DRM Plus program is an application that uses “RPC Broker” technology that 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.

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

DRM Plus introduces two new areas for recording and charting patient information – Treatment & Exam and Periodontal Chart. The patient’s Diagnostic Findings, Treatment Plan and Completed Care can be recorded and maintained within the Treatment & Exam screen. The patient’s periodontal conditions can be recorded and maintained within the Periodontal Chart screen.

The Treatment & Exam screen replaces the DRM Encounter/Note screen and incorporates many advanced features. These features are included and available in both the Treatment & Exam and the Periodontal Chart areas. The new areas use advanced graphic capabilities that allow providers to “see” the patient’s dental history and needs. Some of these features are summarized below:

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

The Periodontal Chart tab is used to record and measure the various levels of periodontal related conditions of patients. To record and/or measure these levels, condition-specific icons are used. Numerous icons use a pre-defined numbering chart to determine the level of condition for that particular tooth or a part of that tooth.

A periodontal statistics chart is also available with warning levels. A summary chart is available via specific tooth or quadrant.

The Cover Page is a new tab which contains demographic, historical and planned dental activity. This page was created to help users make administrative and/or care decisions for patients.

The page is split up into different sections:

1. Dental Eligibility data can be edited only by users who have been set up by the administrator to allow eligibility edits.
2. Case Management allows the user to edit the patient status which will update the status for the last encounter. There is a new status entry called Maintenance. This field will default for the encounter.
3. Notes of a general nature may be entered for the patient.
4. Demographics data is retrieved for the patient and displayed if available.
5. Recent Dental Activity displays the most recent date for selected types of procedures.
6. Dental Alerts displays the same alert data available from the Alerts button without having to hover or click on the button.
7. Planned Care displays the sequencing screen information.

Quality Improvement/Performance Measures and Benefits

DRM Plus supports the VA Administration's 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 efficient data capture methods included in this product eliminates unnecessary paperwork and administrative functions. Additional quality improvement benefits and sample performance measures include:

- Performance 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 healthcare 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.

Benefits

Eliminates providers' frustration with the multiple data entries required for each patient interaction is eliminated, thus creating efficiencies and improving job satisfaction.

Installation and implementation of DRM and DRM Plus resulted in increased accuracy in the billing of insurance companies for reimbursement of dental visits, consults and procedures.

Customer Support

DRM Plus is supported in the same manner as any other nationally supported software product. Problems should be reported to the local site ADPAC and/or IRM help desk, who in turn utilize the **Remedy** system to log and track problems. Help desk support is provided from 8:00 AM to 7:00 PM Eastern 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.

Technical Overview

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

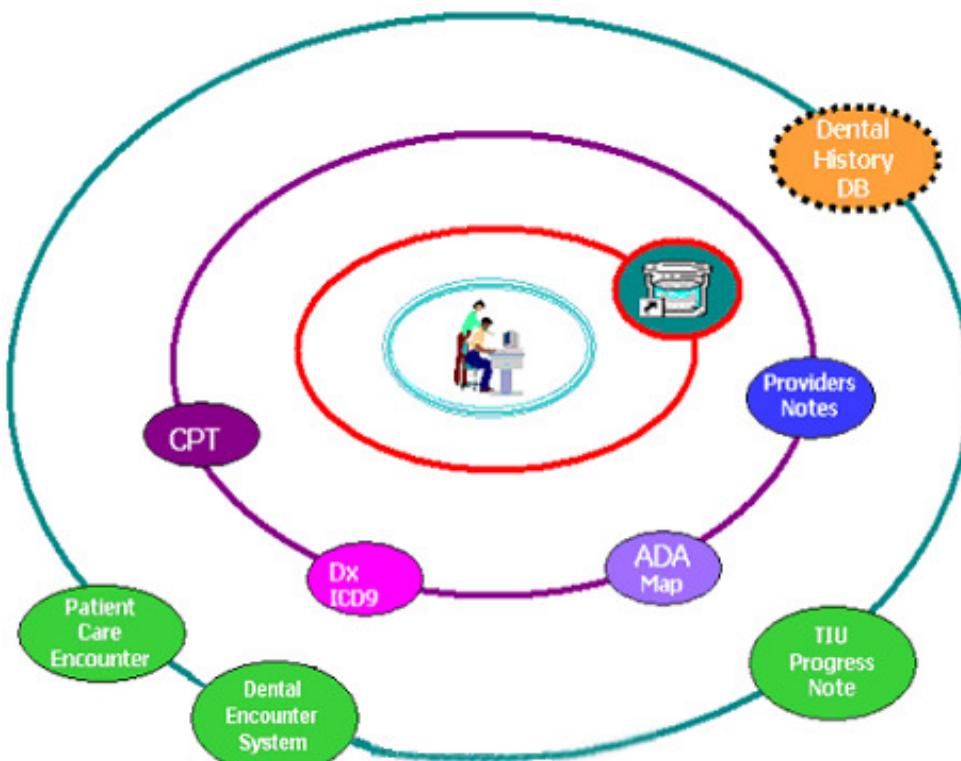


Figure 1: Technical Overview Map

DRM Plus Creates Encounter Information

When a provider completes an encounter, DRM Plus creates PCE, DES, Dental History, and Progress Note information in VistA.

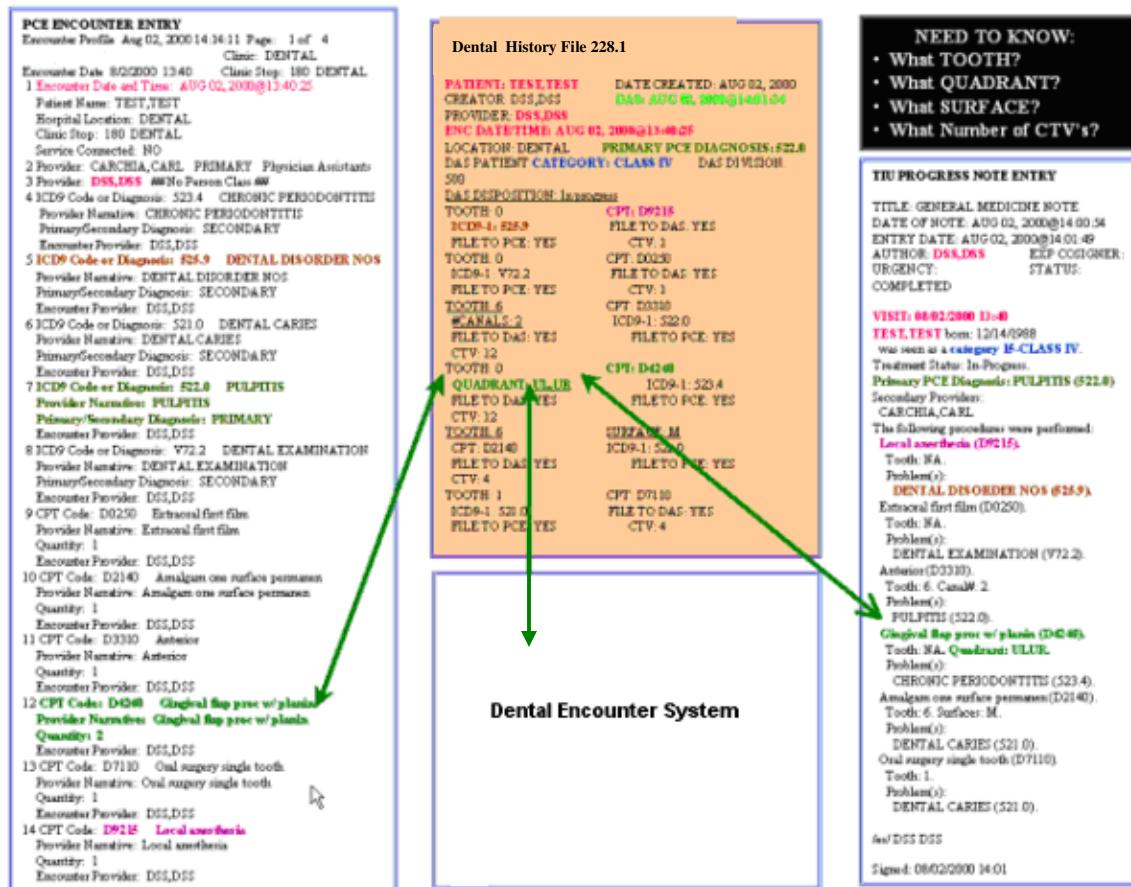


Figure 2: Dental Encounter System

In this example, CPT code D4240 is highlighted to show the relationship between the data that is created in PCE to the DES data entry. The example also shows the Dental History file entry and the TIU Progress Note data that is generated by the DRM Plus.

Launching DRM Plus

Overview

DRM Plus is designed to work in sync with VistA/CPRS. DRM Plus must be launched from within CPRS and any new patient selection must also be done from within CPRS. Launch CPRS, select the desired patient, and then click on Tools in the menu bar. Click the DRM Plus option as shown below.

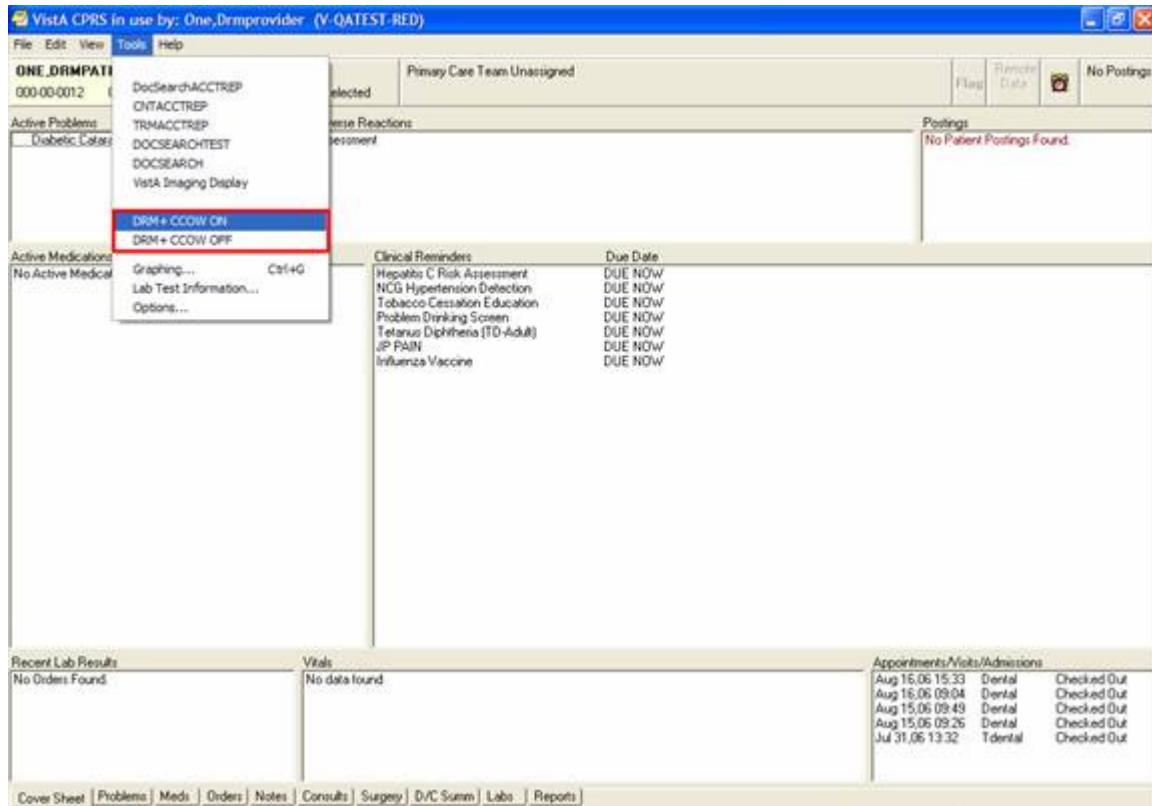


Figure 3: Launching DRM Plus

DRM Plus opens to the Chart/Treatment tab/Treatment Plan view unless the default is changed. The Treatment Plan view is shown below.

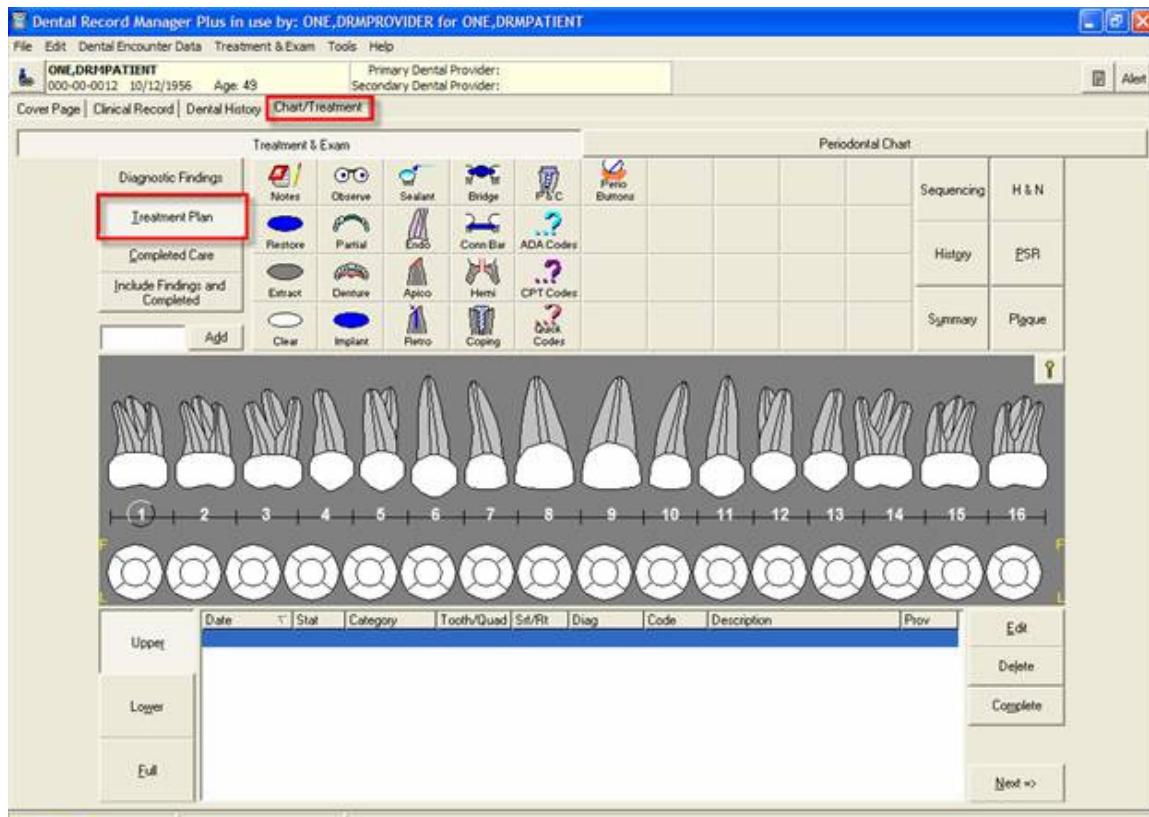


Figure 4: Treatment Plan View

Depending on the installation options selected by your facility, the user will either be automatically launched into DRM Plus without having to sign-on again. The IT department has set the Auto Sign-on option to “Yes”, allowing users multiple VistA sign-ons automatically.

Or:

Be prompted with a VistA Sign-on screen. Please note that your IT department has determined, due to security reasons, not to allow the auto sign-on option at your facility. The VistA sign-on screen will reappear requiring a second sign-on.

Note: The patient selected in CPRS will automatically be retrieved in either case.

Common Application Functions

Overview

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 button and clicking options are common to most screens and are discussed below.

OK – Clicking these buttons 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 these buttons cancel the actions taken on a screen and return the user to a preceding screen.

Next – Clicking these buttons move the user to the next screen.

Back – Clicking these buttons move the user to the previous screen.

Add – Clicking on these buttons adds a selected item to a function.

Edit – Clicking on these buttons allows a selection to be edited.

Delete – Clicking on these buttons allows a selection to be deleted.

Reset – Clicking these buttons reset changed settings to their original settings.

Finish – Same as OK.

Browse Buttons – Clicking on these buttons moves the user to a previously programmed selection screen.

Radio Buttons – Clicking in a radio button displays a dot in the button and designates a specific option.

Checkboxes – Clicking in a checkbox works the same as a radio button.

Text Boxes – Clicking in a textbox allows the user to type in the box.

Drop-Down Arrows – Clicking on these arrows displays a menu of selections.

Selection Arrows – Clicking on 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 hit the Enter key after entering the criteria.

Sorting – Clicking on a Transaction Table column heading will sort the table. Generally in ascending order dependent on the current view. Clicking the column heading a second time returns the table to the original view.

Highlighting – Clicking on a selection that results in it being highlighted means that it is selected for the next action to be initiated.

Shift Key – Generally, holding the shift key down allows for selection of multiple items as in Windows applications.

Control Key – Generally, holding the shift key down allows for selection of multiple items as in Windows applications.

Keyboard Use – When a letter of a button name is underlined (Add or Speed Code), the user may use the keyboard to activate the button. The action required is to depress and hold the Alt key and strike the underlined letter.

Using DRM Plus

Using the Treatment & Exam Screen

Overview

When DRM Plus is launched, the Treatment & Exam screen is displayed. The Treatment and Exam screen is the main DRM Plus screen and allows multiple functions. The user may enter Diagnostic Findings, develop and maintain the Treatment Plan, and enter Completed Care procedure codes and diagnoses from this screen. The screen's menu options allow the user to configure DRM Plus for specific preferences. The menu bar also provides other useful options (See "Using the DRM Plus Menu Bar"). The functions that can be performed on the Treatment & Exam screen will be discussed in this section of the manual. The Treatment & Exam screen is displayed below.

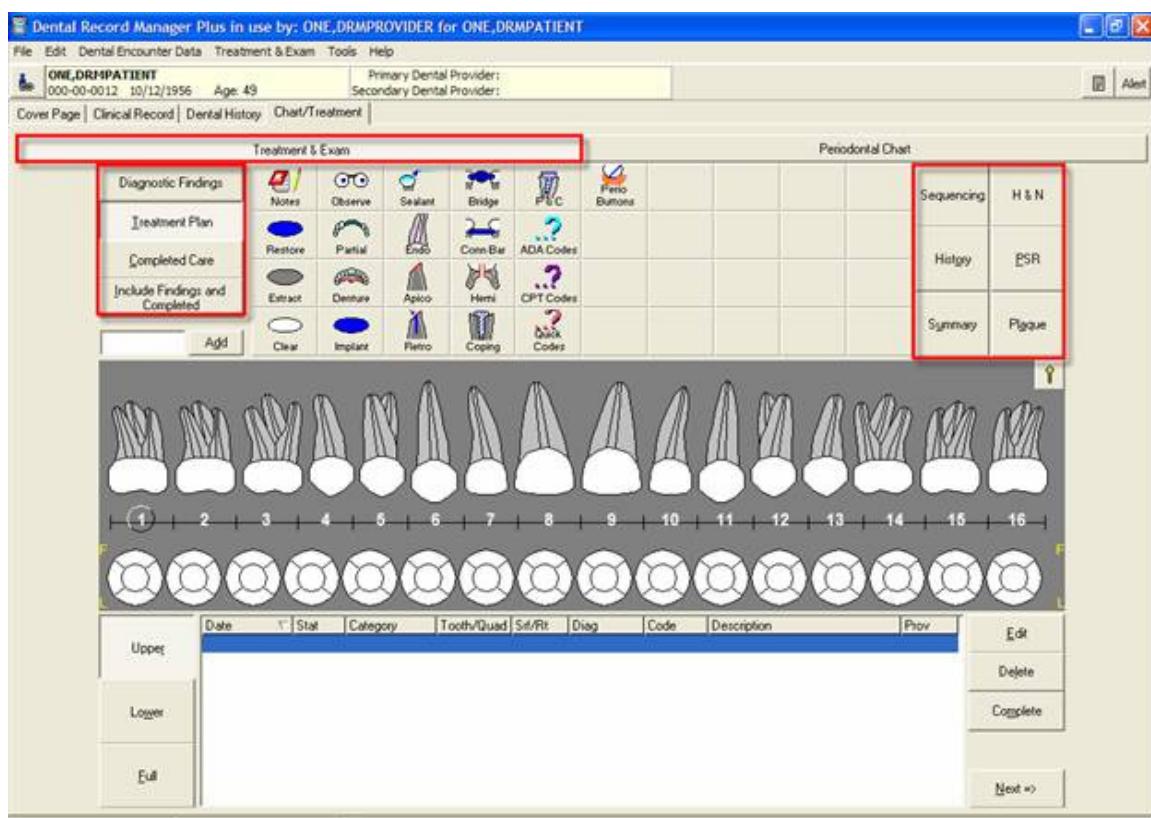


Figure 5: Treatment and Exam Screen

Treatment & Exam Screen Views

The four buttons located on the upper left side of the screen (highlighted) are Diagnostic Findings, Treatment Plan, Completed Care and Include (Combining Views). The screen defaults to the Treatment Plan view. This default can be changed using the appropriate Treatment Exam menu option.

The Diagnostic Findings view is used to enter the findings of an examination.

The Treatment Plan view is used to develop and/or change the Treatment Plan and is able to complete a Treatment Plan item into Completed Care.

The Completed Care view is used to enter procedure codes and diagnoses for Completed Care.

Combining Views (Include _____ button)

The Diagnostic Findings and the Completed Care views can be combined. This is accomplished by selecting the “Include Completed” button with the Diagnostic Findings view displayed.

The Treatment Plan view can be combined with the Diagnostic Findings and Completed Care views. This is accomplished by selecting the “Include Findings and Completed” button with the Treatment Plan view displayed.

The Completed Care view can be combined with previously recorded Diagnostic Findings by clicking the “Include Findings” button with the Completed Care view displayed.

Note: See “Using the DRM Plus Menu Bar,” in the manual or go directly to Treatment & Exam menu option, Show Configuration option, and Tx & Exam tab for other view combination options.

Screen Geography

The charting and recording areas for the Diagnostic Findings, Treatment Plan, or Completed Care views are each divided into three sections: upper, middle, and lower.

The upper section includes the graphic icons used to initiate the recording of conditions and procedures.

The middle section includes the graphic chart of the upper or lower arches and the tooth surfaces. Graphic displays will begin with the implementation of DRM Plus.

The lower section includes a transaction table that shows a text view of recorded conditions and procedures by date. Upon implementation of DRM Plus, the transaction table defaults to show all transactions for all episodes of care. Users may select a specific view. See “Using the DRM Plus Menu Bar,” in the manual or go directly to Treatment & Exam menu option, and Filter View options.

The lower section also includes the buttons used to change the view in the graphic chart. Clicking the Upper, Lower or Full buttons located to the left side of the transaction table changes the graphic chart view accordingly.

If Full is selected, it becomes a full mouth graphic. No editing, additions, or deletions are allowed in the Full screen view. To close the full screen graphic and return to the Treatment & Exam screen, click on the “X” located in the upper right corner or click OK.

Graphic Chart and Icon Display

Icons can be used to initiate the recording of Diagnostic Findings, Treatment Plan and Completed Care procedures. Each of these three areas displays a different set of icons, although all of the icons come from a common base set and behave similarly. Procedures or conditions will have different color/design coding schemes that are associated with the icons. These color coding schemes are used to identify entries in the graphic chart. To display the master color coding/design scheme, click on the small key icon on the right side of the Treatment & Exam screen. The following screen will be displayed:

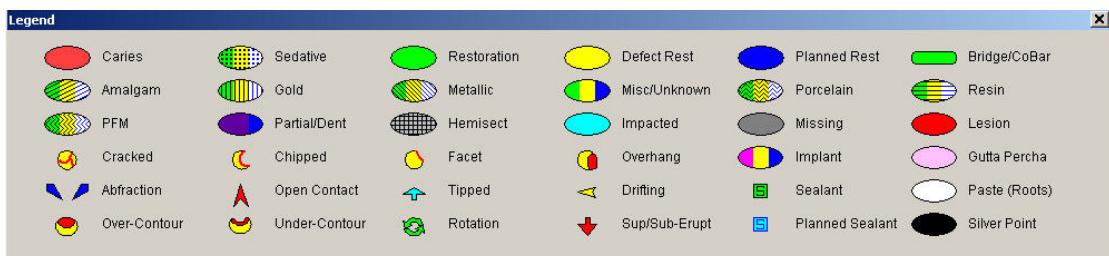


Figure 6: Graphic Chart and Icon Display

Special Buttons and Tabs

The tabs are Clinical Record, Dental History and Chart/Treatment. The special buttons are Sequencing, H&N, History, PSR, Summary and Plaque. The use of these tabs and buttons is discussed in the “Using the Special Buttons” section of this manual.

Patient Alerts & Coding Reference Guidelines



Figure 7: Patient Alerts & Coding

Patient dental alerts and the coding reference guidelines can also be accessed here.

Clicking on the “General Coding Guidelines” button gives the user access to the General Coding Guidelines screen as illustrated below.

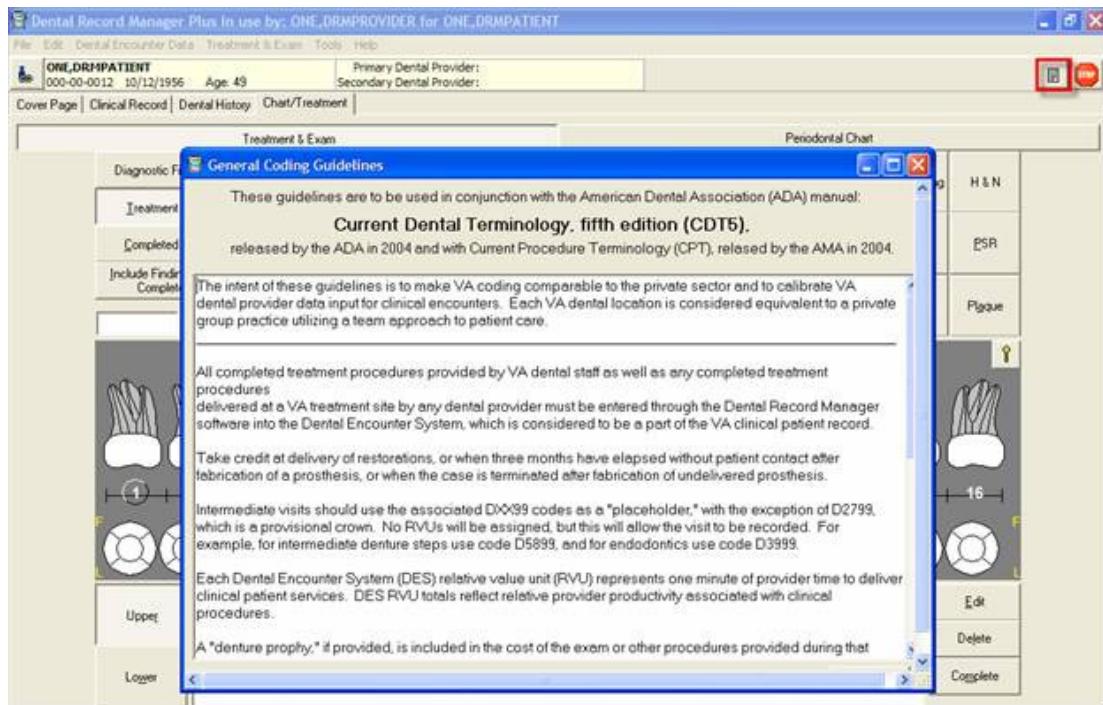


Figure 8: General Coding Guidelines

The intent of these guidelines is to make VA coding compatible to the private sector and to calibrate VA dental provider data input for clinical encounters.

Clicking on the “Alerts” button gives the user access to the patient Dental Alerts screen as illustrated below:

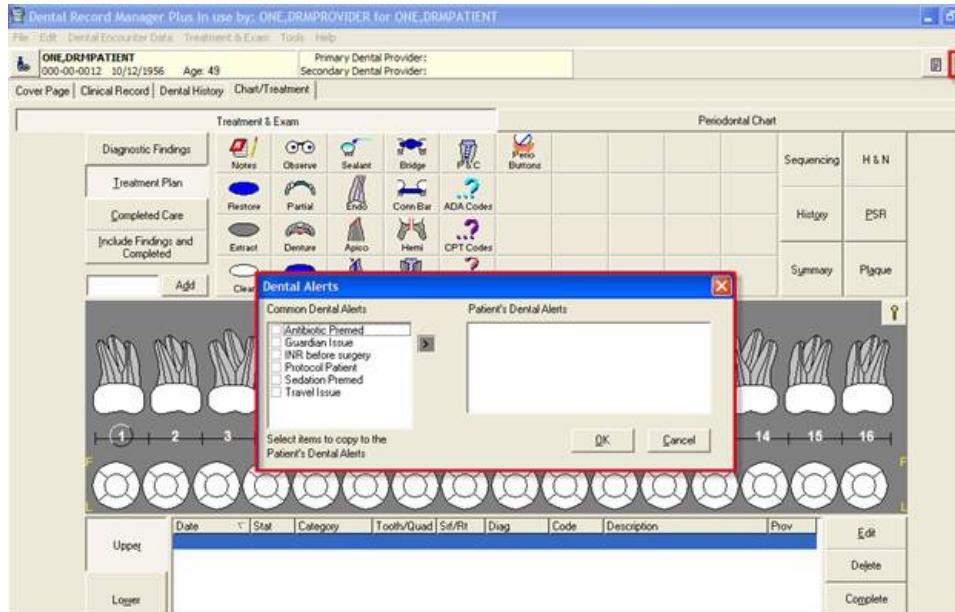


Figure 9: Dental Alerts

When activating patient dental alerts, the user can place a check mark in the box located next to the appropriate dental alert. Clicking on the right arrow will move the selected dental alert into the active Patient Dental Alerts area. The user can also free text any appropriate information in the Patient Dental Alerts area. Clicking on the “OK” button will confirm the selection.

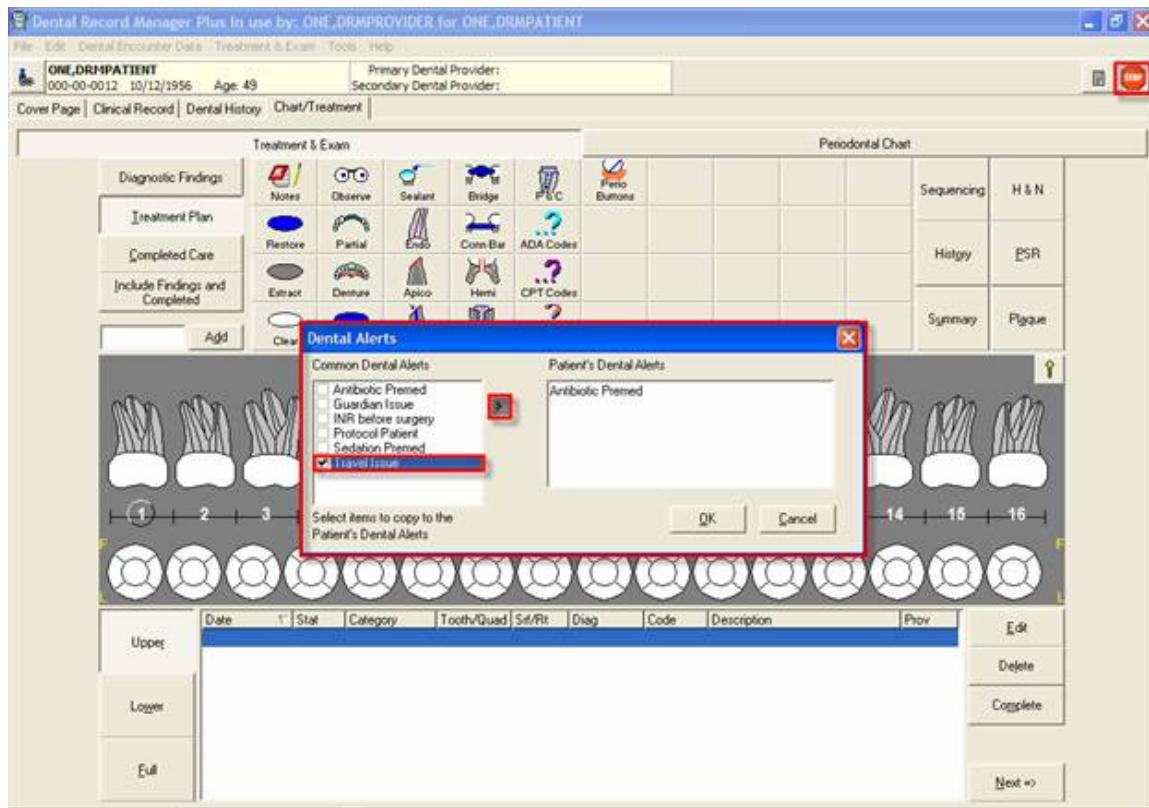


Figure 10: Active Dental Patient Alerts Area

Note: When dental alerts have been activated for a patient, the “Alerts” button will display a stop sign as illustrated above.

Using the Diagnostic Findings Screen

Overview

The Diagnostic Findings screen is used to record the findings of an examination. All entries for Diagnostic Findings are initiated by clicking on a graphic icon. After the icon is clicked, a graphic chart entry must be made by clicking on a tooth(s), a surface(s) or a root(s) on the graphic. The Bridge and the Conn Bar icons require a specific action as explained later. After the graphic chart entry is complete, the entry will appear in the transaction table at the bottom of the screen as well as on the graphic chart.

To enter a preexisting crown for tooth #3 the Restore icon is selected and then click on the anatomical crown in the graphic chart (this graphic chart is very point specific on where you click). In the screen shot following it shows that tooth #3 has been selected because there is a circle around the #3. A Select Material pop up box will allow you to choose the correct material of this preexisting crown.

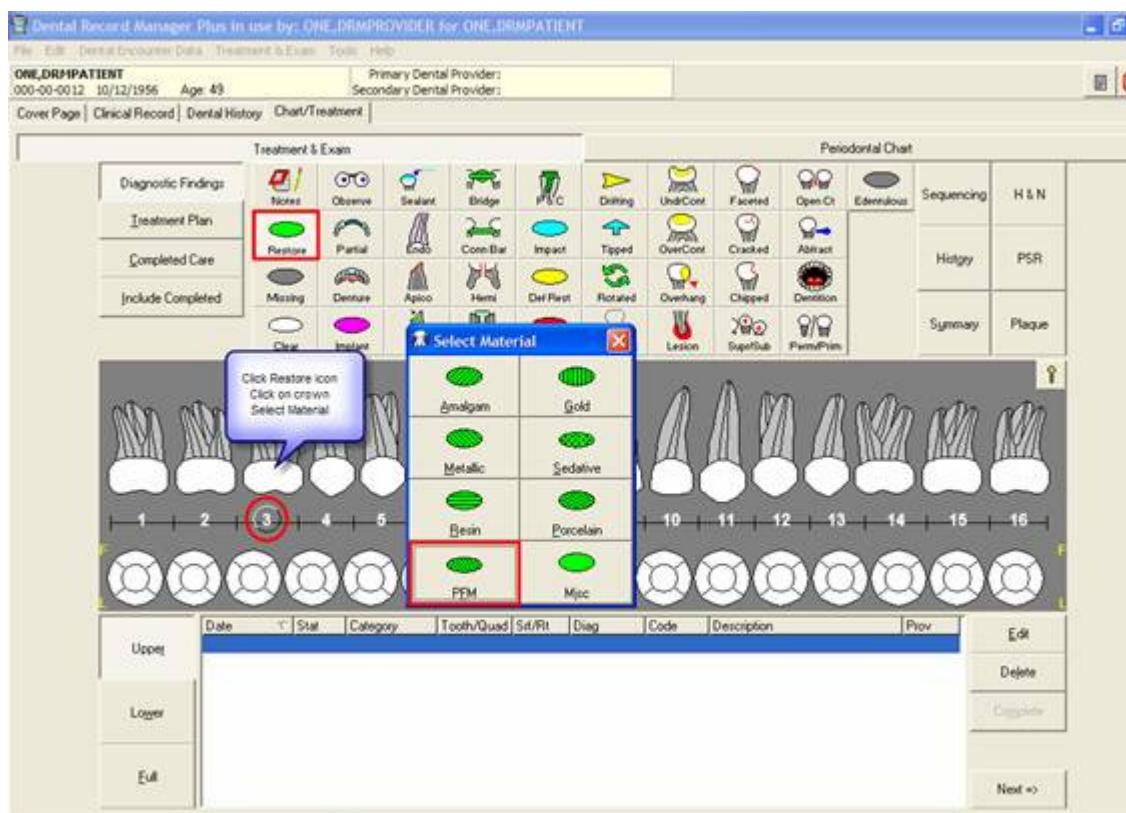


Figure 11: Entering Diagnostic Findings

Note: The Diagnostic Findings are not updated automatically from Completed Care entries. Any Completed Care entries will need to be entered as Diagnostic Findings during the patient's next dental exam.

Selecting PFM as the material for the crown will result in the following screen shot. Notice the new entry in the transaction table at the bottom of the screen.

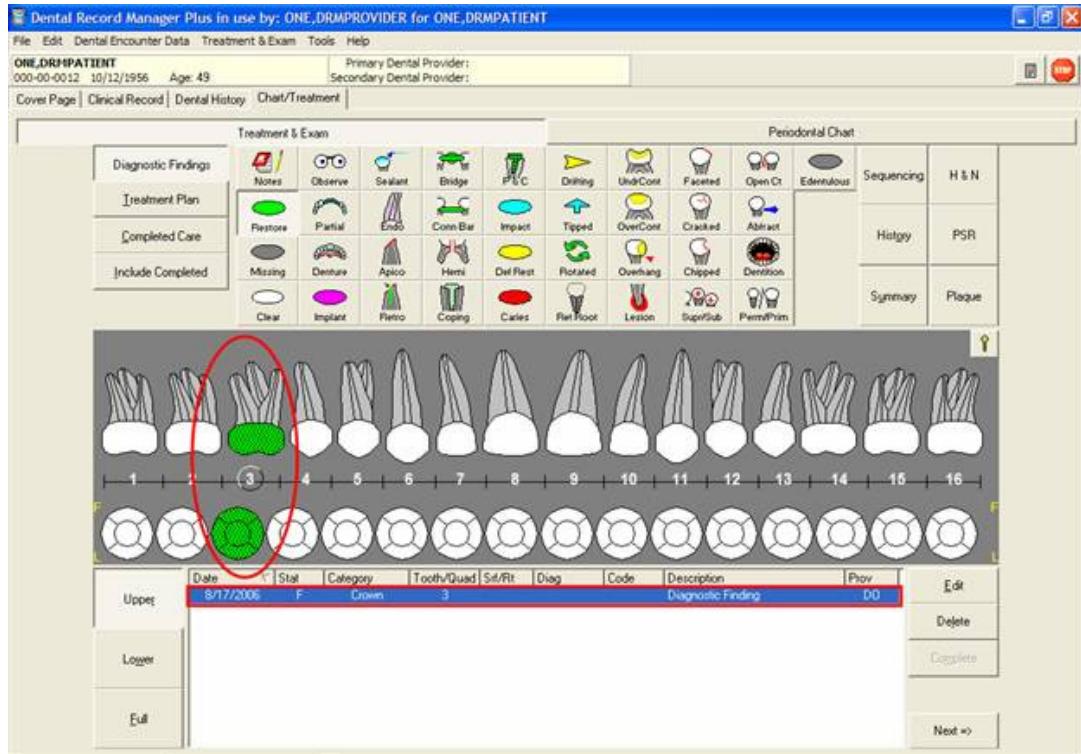


Figure 12: Diagnostic Findings after entering crown on tooth #3

Continue clicking first on the icon you need to enter the Diagnostic Finding and then second the user needs to click the appropriate point specific tooth(s), surface(s) or root(s) in the graphic chart that the finding is associated with. Any findings entered during an examination will result in no CPT codes or Diagnostic codes associated with data entry since they are preexisting conditions.

Special Descriptions - Bridge icon - Place the mouse on the first abutment and drag to the second abutment. A dialogue box will be displayed with the lowest number tooth selected. Choose the appropriate material and click abutment. The dialogue box will now display the next tooth, choose the appropriate material and click pontic. Continue this process until all teeth have been given the appropriate designations. Click OK to complete the process.

Using the Clear Icon or the Delete Button - The Clear icon appears in all screen views of the Treatment & Exam screen. If an error is made while entering Diagnostic Findings, Treatment Plan, or Completed Care entries, it can be erased by using the Clear icon. Click the Clear icon and then click the tooth area in the graphic chart that contains the error. The graphics and text associated with the erroneous entry will disappear from the graphic chart and the transaction table.

Another method to erase erroneous entries is to highlight the entry in the transaction table and click the "Delete" button located on the right side of the table. This action deletes the entry from the table and the graphic chart. Completed Care entries that have been finalized and associated with a Progress Note may only be deleted by a DRM Plus application administrator.

The following table explains the actions required to enter a Diagnostic Finding:

ICON	CLICK TOOTH	CLICK SURFACE(S)	CLICK ROOT(S)	POP-UP SCREEN	ADDITIONAL COMMENTS
Restore	As many as required	As many as required	No	Materials or Surfaces	Graphic in Green
Missing	As many as required	No	As many as required	Selected Roots	Graphic for roots in dark grey.
Observe	As many as required	No	No	No	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 material	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 grey
Coping	Yes	No	No	None	Graphic in green
P&C	No	No	As many as required	Selected roots and materials	Graphic in green and denotes material
Impact	As many as required	As many as required	As many as required	Selected surfaces/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 the tooth
Tipped	Yes	No	No	Direction	Graphic is light blue arrow to the left of the tooth
Rotated	Yes	No	No	Direction	Graphic is green arrows to the left of the tooth
Ret Root	No	No	As many as required	None	Graphic removes crown
Undr Cont	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 surfaces	Graphic is red and yellow
Lesion	No	No	As many root surfaces as required	Selected roots	Can also click on implant. Graphic is a red circle
Faceted	No	As many as required	No	Selected surfaces	Graphic is red and yellow
Cracked	No	As many as required	As many as required	Selected surfaces/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 the right of the 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 any other entries.
Perm/Prin	Yes	No	No	Dentition box	Designate selected tooth as primary or permanent
Edentulous	Any tooth	No	No	None	Graphic is empty for arch

Table 1: Actions Required to Enter Diagnostic Findings

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. These items, if entered from the Diagnostic Findings screen are:

- Missing
- Implant
- Impacted
- Retained root
- Hemi-section
- Dentition
- Observe

If entered from the Completed Care screen, these items are: extract, hemi section, implant, and observe.

Note: When using the Edentulous icon, if any individual teeth are not missing, highlight the teeth in the transaction table and click on the Delete button. This allows teeth that remain in the patient's mouth to be present in the DRM Plus graphic. The Clear icon does not work with the Edentulous icon.

To enter Diagnostic Findings follow these steps:

1. Click the icon that represents the finding; this will make the icon active.
2. Click the specific graphical part of the tooth associated with the finding. Data is only able to be entered on one tooth at a time with most of the icons. (Exceptions are Denture, Edentulous, and Dentition.)
3. Select the material, if allowed, of the finding.

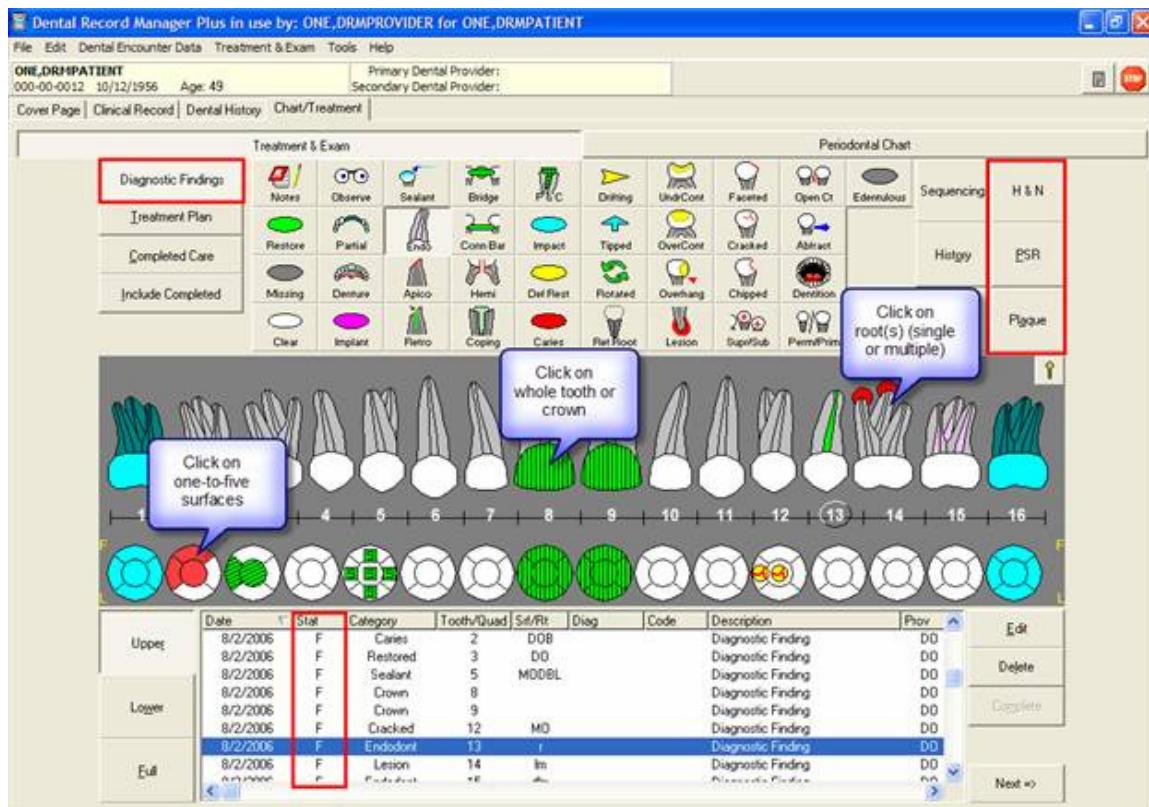


Figure 13: Diagnostic Findings Screen

Using the Special Buttons (H&N, PSR, and Plaque) can be initiated during the entry of Diagnostic Findings (Refer to the section called “Using the Special Buttons”). Diagnostic Findings are represented by the Stat ‘F’ in the Transaction Table.

Note: Always mark teeth missing before entering Partials, Dentures, Implants or Bridge findings. It works best to enter Missing or Edentulous arch before any other findings.

The transaction table, as highlighted below, provides the user with a text view of the entries recorded.

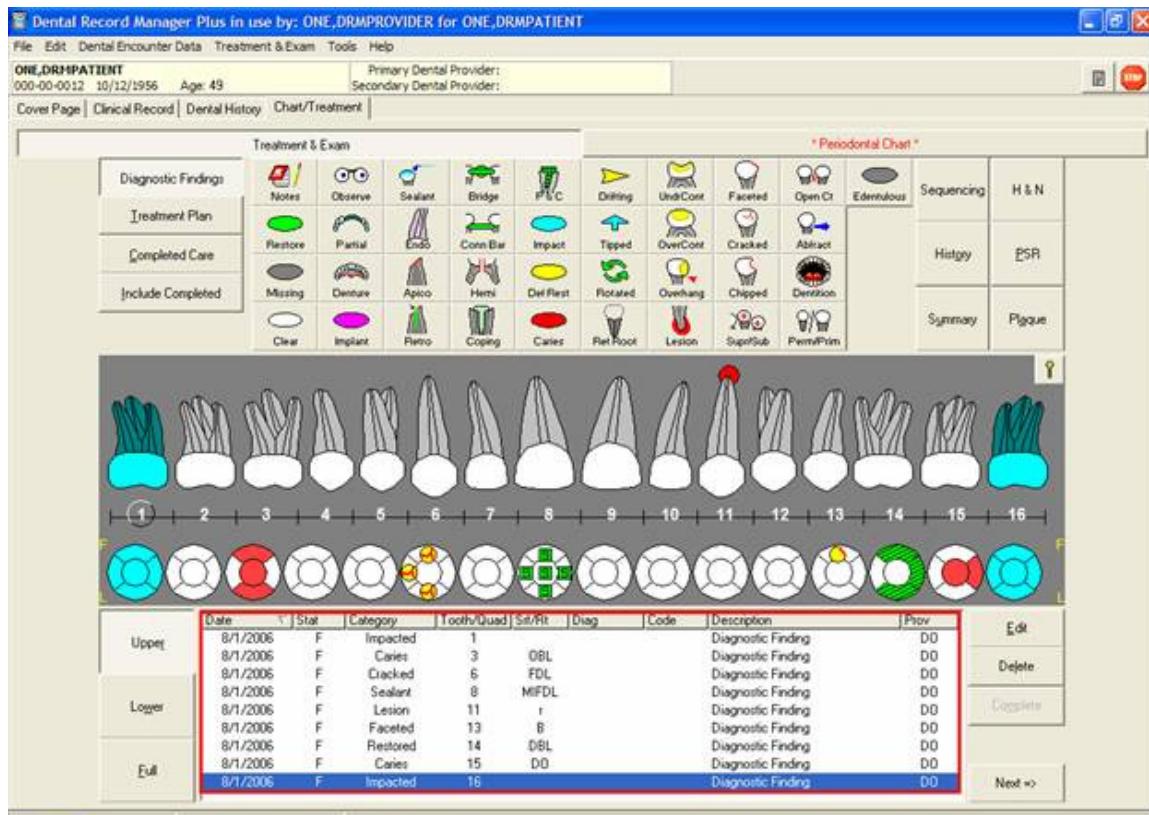


Figure 14: Diagnostic Findings Transaction Table

Diagnostic Findings are recorded with a Status (Stat) of "F". Treatment Plan entries have a Stat of "P", and Completed Care entries have a Stat of "C". Observe entries have a Stat of "O". The Category generally conforms to the procedure code category and is tied to the graphic display. The Tooth #, Surface(s), Diagnosis and procedure codes are shown. The Description is shown as Diagnosis Findings and the Provider is shown. The Edit button allows changing of the Description to display any additional information needed. This is useful to display additional information not otherwise displayed.

Note: Diagnostic Findings may be deleted after the encounter has been closed. If this happens subsequent to the day of original entry, the conditions deleted will show at the bottom of the transaction table with a "strike-through" on all subsequent visits. An administrator of DRM Plus has the ability to completely remove any Diagnostic Finding entry from the transaction table.

Note: Clicking on a Transaction Table column heading will sort the table. Generally in ascending order dependent on the current view. Clicking the column heading a second time returns the table to the original descending view.

When all Diagnostic Findings have been entered, a procedure code(s) may be entered. For all procedure code entries, the process starts by clicking on the Completed Care button and entering the code(s) using the graphic icons or any of the other ADA codes selection options (See the Completed Care portion of this manual). The DRM Plus process for entering encounter data and the Progress Note must be completed in order for the Diagnostic Findings to be permanently saved in the patient's record (Refer to the section called "Completing the Encounter Data and Progress Note"). Prior to clicking Finish on the Progress Notes screen, Diagnostic Findings may be temporarily saved using the option "Save Unfiled Data" under the File drop-down menu. From any Treatment & Exam screen, if the Next button is clicked before an ADA code has been entered, a process is begun which will allow the entering of code D9999 (the default code).

If no Completed Care procedures have been entered and the Next button is clicked, the following screen appears:

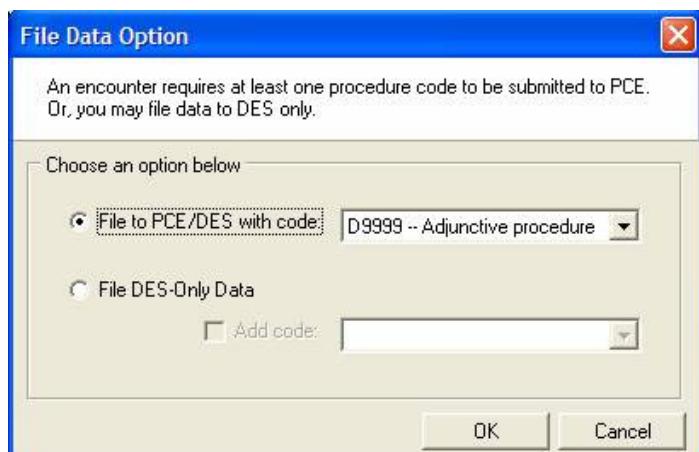


Figure 15: No Completed Care Procedures Entered screen

This File Data option box defaults to the normal filing options and code D9999. To select a different code, click on the down arrow to display the following screen:

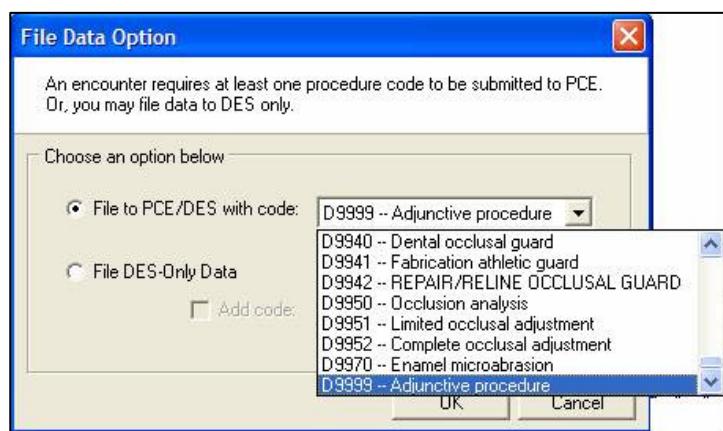


Figure 16: File to PCE/DES with code

Scroll to the appropriate code, highlight and click OK to complete the process.

If the provider needs to file to DES in a data only entry, the radio button File DES-Only Data button should be selected and the OK button clicked to begin the process of finalizing the encounter.

If the provider needs to file to DES only with a code, the Add Code box should be clicked, allowing the down arrow to be clicked and the appropriate code selected as displayed below:

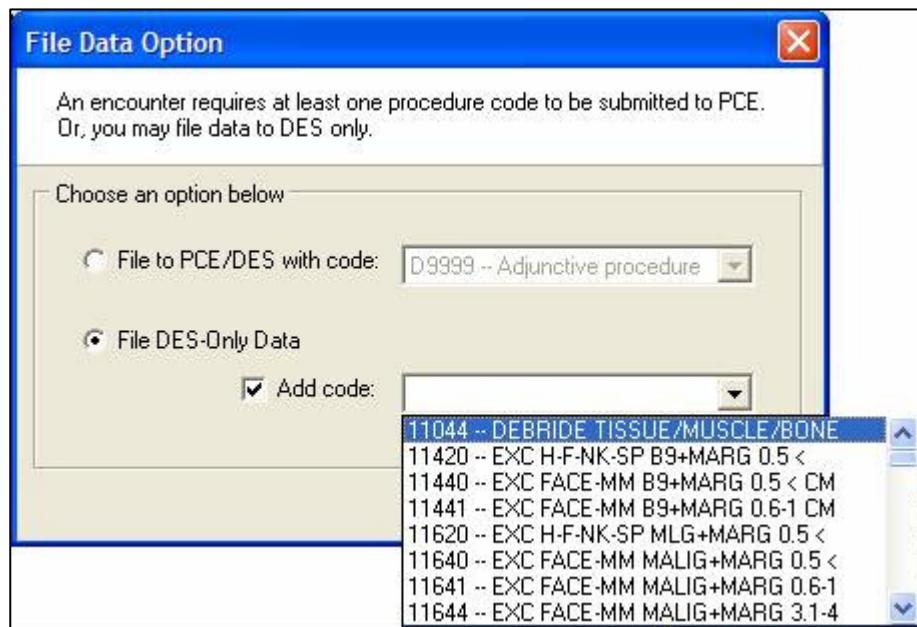


Figure 17: File DES-Only Data

Clicking on the OK button finalizes the process.

Procedures for Saving Unfiled Diagnostic Findings

Procedures for Saving Unfiled Diagnostic Findings prior to clicking Finish on the Progress Note screen are explained here.

Once the user clicks the Finish button in DRM Plus, the encounter data and the Progress Note (signed or unsigned) is passed to VistA (PCE & DES) and CPRS. DRM recognizes that a user may not be able to complete all DRM Plus entries in one computer interaction. DRM Plus also recognizes that the changes may need to be to the Diagnostic Findings after reviewing x-rays or consulting with other providers. An option is provided to deal with these issues; Save Unfiled Data. Within this option, the user can save the data either to themselves or to another provider. If the user saves the data to themselves, DRM Plus requires that the provider saving the data must be logged on to restore the data for that patient. This will occur the next time that patient's record is opened. If the user saves the data to another provider, DRM Plus requires that the provider with the stored (or saved) data must be logged on to restore the data for that particular patient. This will also occur the next time that patient's record is opened.

Click on the File drop-down menu and select the option highlighted below.

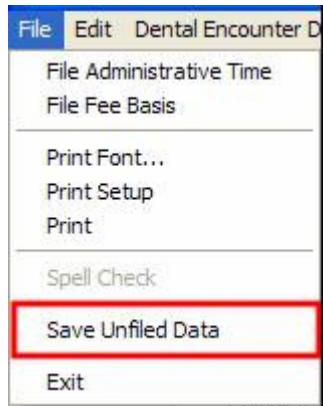


Figure 18: Save Unfiled Data

A pop-up window appears giving the user the option to designate where the data is to be saved. However, the **No** option is not available. The only available options are saving the data to a different provider or choosing **Yes** to save the data to yourself.

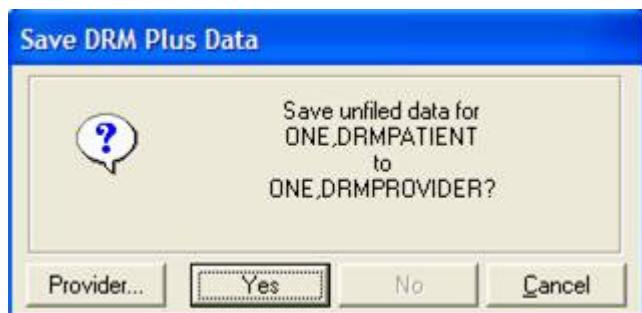


Figure 19: Save Confirmation box

When the Provider option is selected, the following screen appears:

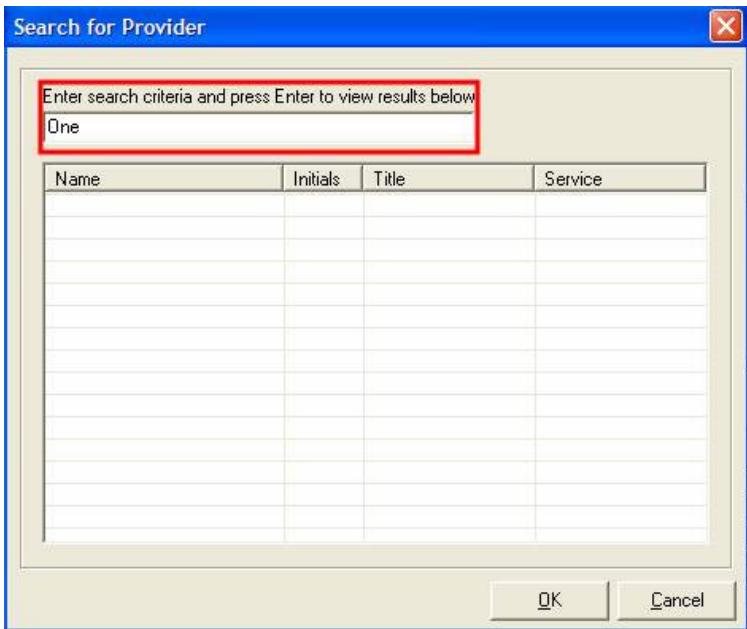


Figure 20: Search for Provider Criteria

The desired provider's name should be entered in the search criteria's box.

When the Enter key is pressed, the following box appears:

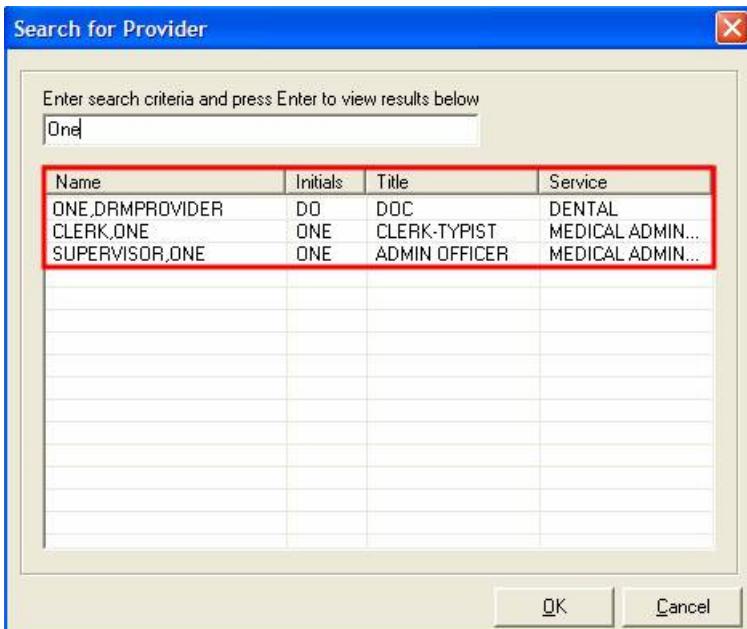


Figure 21: Search for Provider Results

Highlight the provider's name that will receive the unfiled data and click on the OK button. The next screen that appears will ask if the unfiled data should be saved to the selected provider. Click on the OK button and the designated provider now may restore the saved data.

Depending on the option selected, one of the following boxes will appear confirming that the unfiled data has been successfully saved.



Figure 22: "Unfiled data saved successfully" messages

DRM Plus will save the entries already made. The user may now close DRM Plus, minimize DRM Plus, or change DRM Plus to a different patient.

When the user re-enters DRM Plus, DRM Plus will present a dialogue box notifying the user of the saved information. Clicking "Yes" brings the saved information into the Treatment & Exam screen. The encounter can then be completed in the usual manner.

Note: If the user attempts to close DRM Plus or switch to a different patient, DRM Plus will display a pop-up box asking the user if the current patient's entries should be saved. Clicking "Yes" initiates the same save function.

The following scenarios may apply:

Scenario #1: The user has not finished all DRM Plus entries (Finish not clicked) and must leave the workstation to attend to other duties.

Scenario #2: A dental assistant has entered data during the patient encounter and wants to save the data to the dentists who can then complete the entries and Progress Note.

Using the Treatment Plan Screen

Overview

The Treatment Plan screen is used to develop and maintain the patient's Treatment Plan. Using the Include Findings and Completed button with the Treatment Plan screen is the recommended way to use this screen. All entries on the Treatment Plan screen are initiated by clicking on an

icon or by using one of the other ADA code selection options. When an icon is clicked, a graphic chart entry must be made by clicking a tooth(s), a surface(s) or a root(s) on the graphic chart. In general, Treatment Plan graphics are shown in blue. The Bridge and the Conn Bar icons require a specific action as explained later. After the graphic chart entry is complete, the entries will appear in the transaction table at the bottom of the screen with a Status (Stat) designation of "P". The entries will also be available by clicking the Sequencing button, where the Plan can be defined further. The Sequencing process will be discussed later in this section of the manual.

A Treatment Plan screen is displayed in the following screen shot. After selecting the correct icon which becomes activated (the Restore icon is active in the following screen shot), then the user will click the appropriate surface(s), crown/whole tooth, or root(s) in the graphical chart.

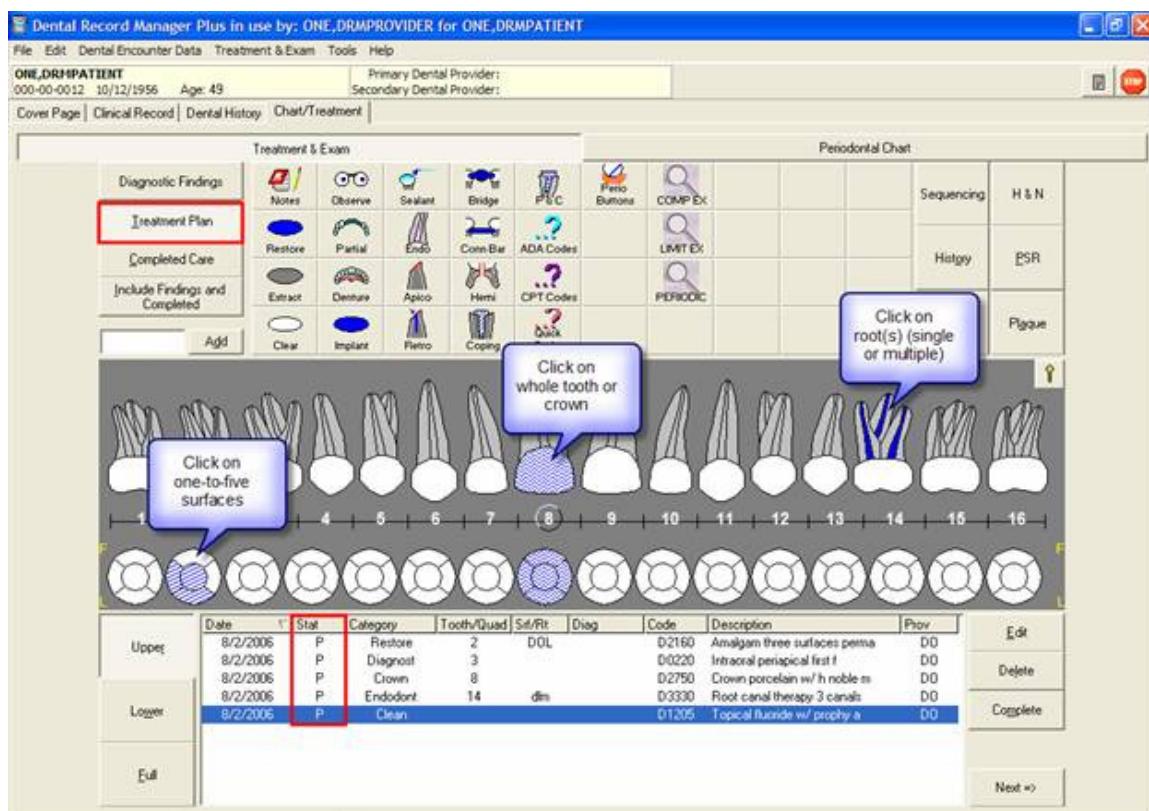


Figure 23: Treatment Plan Screen

Note: For implant procedures: If a related Diagnostic Finding of Missing has not been entered, DRM Plus will not allow the corrective Treatment Plan procedure to be entered.

The table below explains the actions required to enter Treatment Plan procedures using the graphic icons.

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, 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 blue.
Denture	Any tooth	No	No	Code Selection Box	Graphic allows root condition graphics to show. Graphic in blue
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in blue, no root graphic
Endo	No	No	Yes	Code Selection Box	Graphic in blue
Apico	No	No	Yes	Code Selection Box	Graphic in red
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in blue
Bridge (1)				Code Selection Box	See Special Instructions
Conn Bar (1)				Code Selection Box	See Special Instructions
Hemi	No	No	As many as required	Code Selection Box	Graphic in grey
Coping	Yes	No	No	Code Selection Box	Graphic in blue
P&C	No	No	As many as required	Code Selection Box	Graphic in blue
Perio Buttons	Click tooth in appropriate quadrant	No	No	Code Selection Box	No Graphic. See note below. See Speed Code instructions.

Table 2: Actions Required to Enter Treatment Plan Procedures

(1) Certain codes associated with these icons are defined as range codes. Range codes can only be entered by clicking on the icon button. The ADA Codes table, Quicklists, or Speed Code entries are prohibited.

(2) To designate a root restoration, click on the Restore icon. Click on the tooth surface that corresponds to the root surface. Using a tooth note and the Description edit feature in the transaction table, explain the root restoration.

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. These items are, if entered from the Diagnostic Findings screen, missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the Completed Care screen, these items are, extract, hemi section, implant, and observe.

Note: The Perio Buttons icon provides a unique feature. Speed Codes may be established and designated as two different sets of icons totaling 38. The Perio Buttons icon then acts as a toggle between the two sets of Speed Code icons. This feature allows each blank icon space to

accommodate two sets of Speed Codes. See Using the DRM Plus Menu Bar, Treatment & Exam button, Show Configuration option, Speed Codes tab.

Special Descriptions - Bridge icon - Place the mouse on the first abutment and drag to the second abutment. The Code Selection box will be displayed with the lowest number tooth selected.

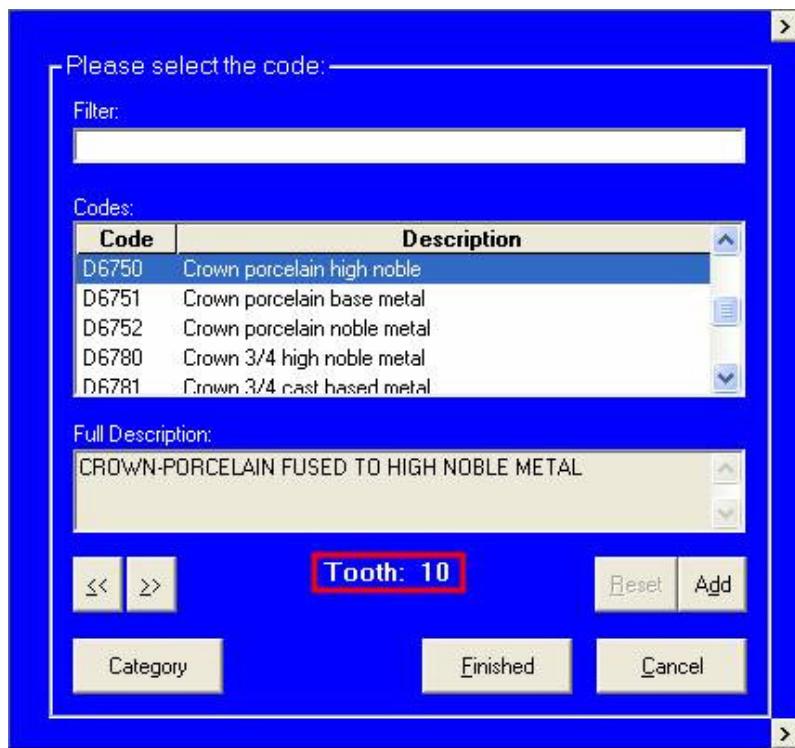


Figure 24: Special Descriptions – Bridge code

Select the appropriate code and click the Add button. The code selection box will move 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 Finish when the selection process is complete.

Note: The << and >> buttons may be clicked to move back or forward to different teeth for code selection. The Reset button, when activated by using the << and >> buttons, clears all previously entered codes for this procedure.

Special Descriptions - Conn Bar icon - Place the mouse on the first abutment and drag to the second abutment. The Code Selection box will be displayed with the lowest number tooth selected. Select the appropriate code and click the Add button with all the teeth associated with the connector bar. Click Finish when the selection process is complete.

Using the Clear Icon or the Delete Button - The Clear icon appears in all screen views of the Treatment & Exam screen. If an error is made while entering Diagnostic Findings, Treatment Plan, or Completed Care entries, it can be erased by using the Clear icon. Click the Clear icon

and then click the tooth area in the graphic chart that contains the error. The graphics and text associated with the erroneous entry will disappear from the graphic chart and the transaction table.

Another method to erase erroneous entries is to highlight the entry in the transaction table and click the “Delete” button located on the right side of the table. This action deletes the entry from the table and the graphic chart.

Note: Completed procedures that have been filed and associated with a signed or unsigned Progress Note can only be deleted by an administrator. When an administrator deletes an entry from DRM Plus, appropriate procedures must be followed to correct any associated VistA databases.

Designating the ADA Code – When a graphic icon is used to initiate the ADA code(s) selection process, the Code/Description screen shown next will be displayed after the graphic area has been clicked.

In the example illustrated on the following screen shot, a Restoration is being entered for tooth #3 by clicking on the Restore icon and then clicking on the crown of tooth #3. The crown procedure is shown in blue on tooth #3.

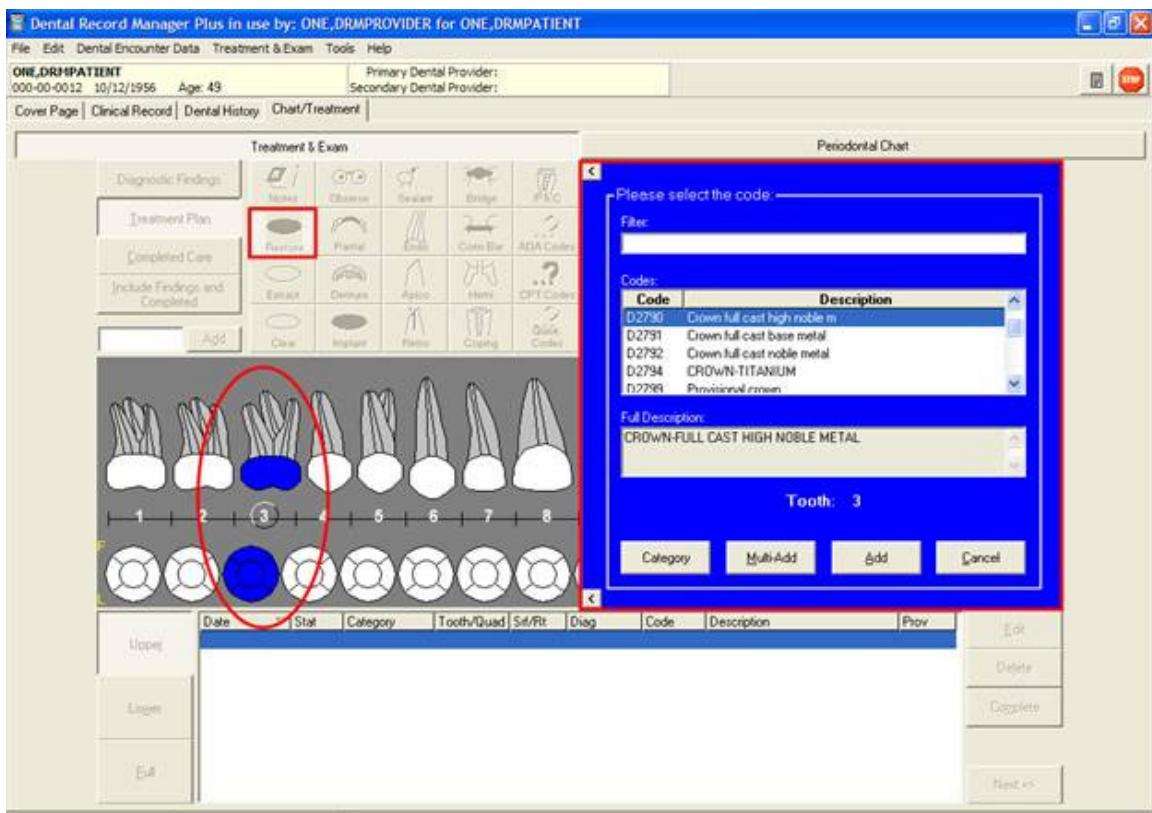


Figure 25: Restoration Example

The graphic icon clicked and the graphic chart selection determines which area of the Code/Description table is displayed in the Code Description box. In the example above the process has defaulted to code D2790. The scroll bar on the right of the box can be used to display the desired code if it is not displayed when the box is opened. Clicking the Category button will return the user to the “headings” area of the box where double-clicking on a heading will move the user to the area designated. The user may also enter search criteria, text, or numeric in the Filter search box. The Code Description box will display all matches to the search criteria. The code should be highlighted and the process completed by clicking the Add button. When Add is clicked, the box is closed and the entry is displayed on the graphic chart and in the transaction table at the bottom of the screen.

Using the Multi-Add function:

When the same procedure code is to be applied to multiple teeth, the Multi-Add button should be clicked to display the following screen:

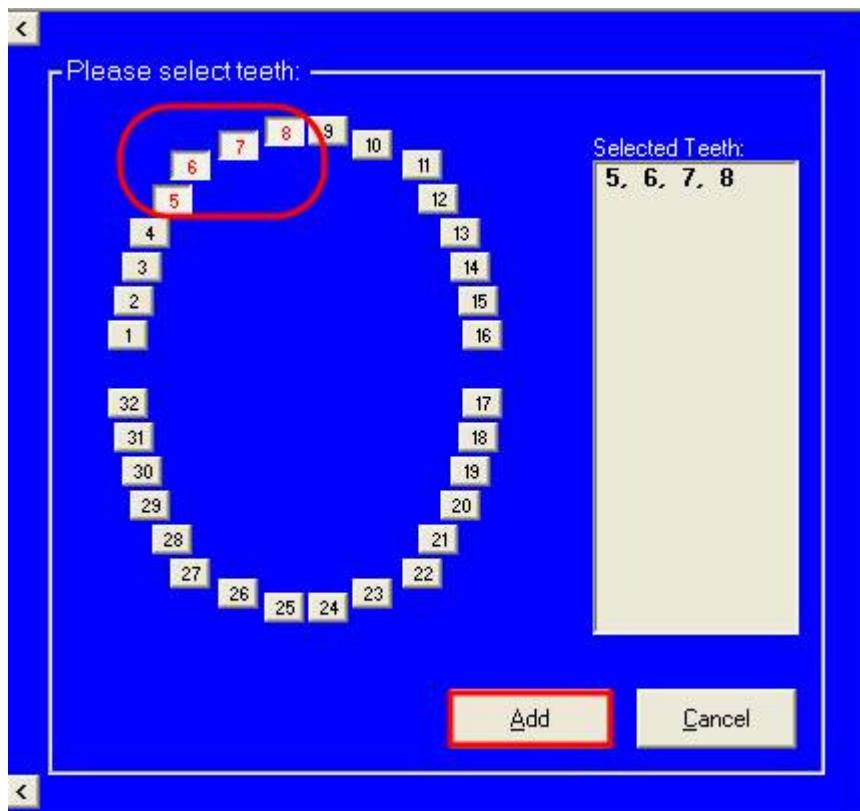


Figure 26: Multi-Add Function

Clicking on the desired teeth and clicking the Add button completes the entry for the procedure code and the selected teeth.

Note: Treatment Plan procedures can be designated with or without a related diagnosis. The option to show diagnoses with the Treatment Plan procedure will be discussed later in this section.

ADA Code and Multi-add box can be moved. Small button have been added to the ADA Codes box, CPT Codes box, Quick Codes box, and multi-add box to enable the user to move the box to the other side. This may be needed to "see" what's beneath, especially when entering multi-add codes.

Missing Teeth are visually indicated on the Multi-Add box. Missing teeth will 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.

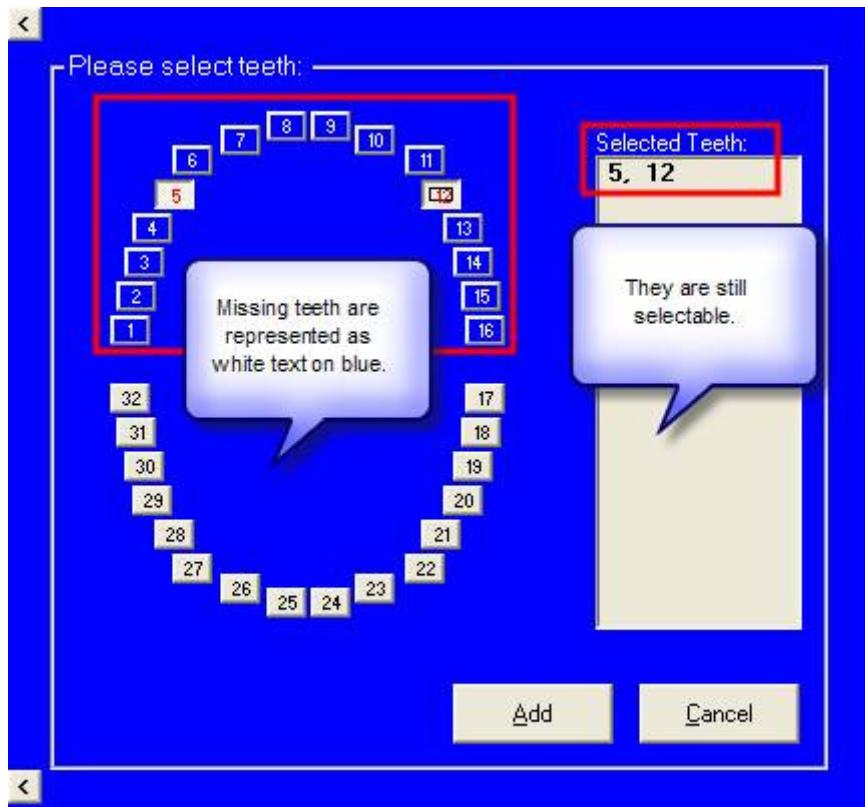


Figure 27: Missing teeth displayed in the multi-add box

The Transaction Table displayed below provides the user with a text view of the entries recorded. Treatment Plan entries are shown with a Status (Stat) of "P". The planned crown for tooth #3 is shown in blue on the graphic chart.

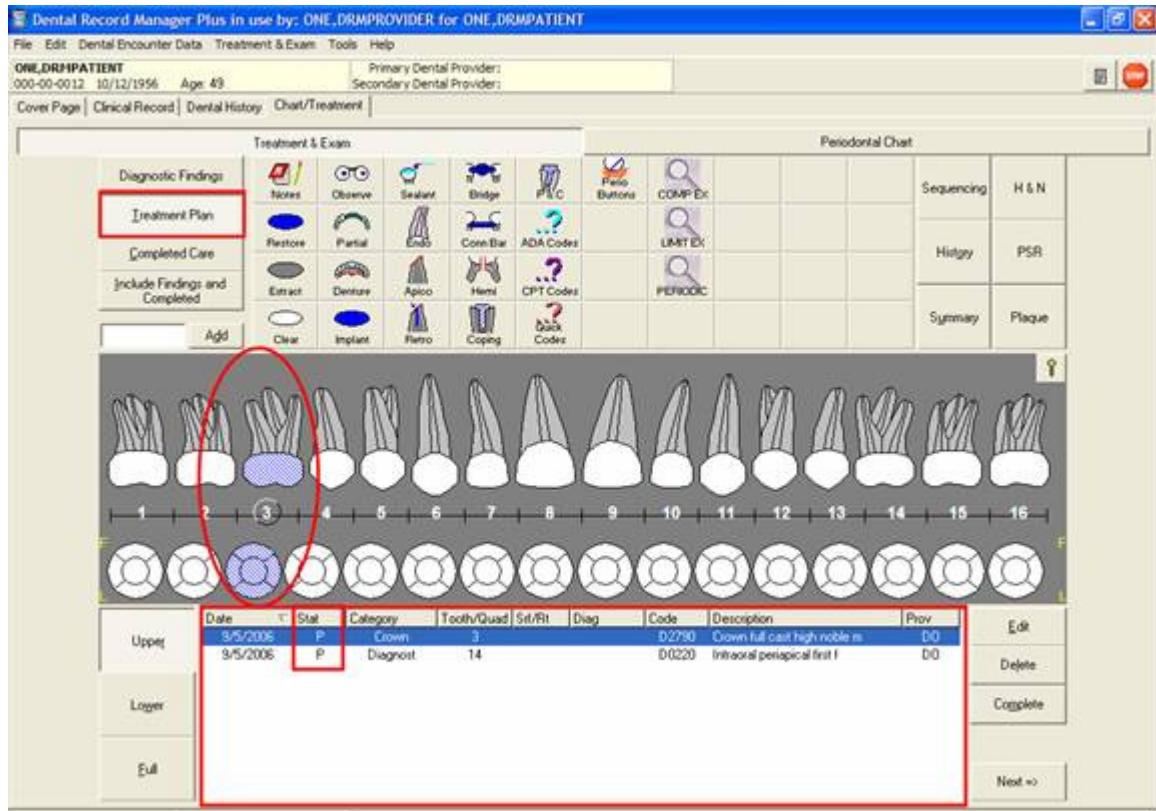


Figure 28: Transaction Table with Text View

This ADA code selection process should be repeated for as many procedures as needed. The graphic chart selection requirements will change according to the icon selected. The Table shown earlier in this section delineates these requirements.

Note: Clicking on a Transaction Table column heading will sort the table. Generally in ascending order dependent on the current view. Clicking the column heading a second time returns the table to the original descending view.

Other options for designating Treatment Plan ADA procedure codes:

Five other options exist other than using the graphic icons.

Note: Certain codes, designated as Range Codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted to icon use only for ADA code entry. When one of the five non-icon options for initiating ADA code selection is selected these codes are “grayed out” and cannot be selected. See Appendix E for a listing of the Range Codes.



Figure 29: Ranged Code Warning

Note: Certain medical codes have been officially added to the VA’s ADA table. These codes are shown after the ADA codes Category headings. Local codes may still be added by a DRM Plus administrator.

Using the ADA Codes Icon – Clicking this icon directly displays the ADA Codes/Description screen (blue screen). Locating the appropriate code can be simplified by double-clicking on a Header Title. The following screen is displayed:

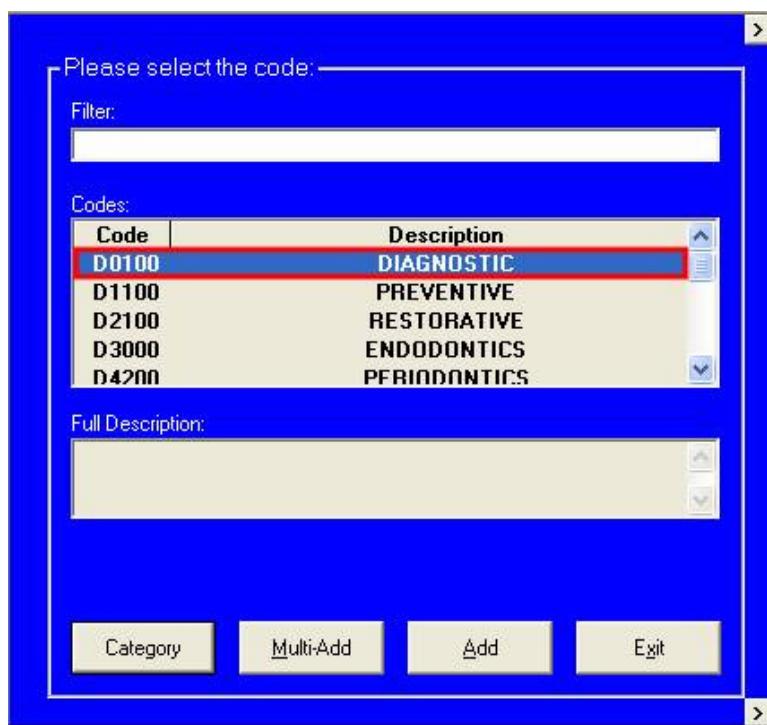


Figure 30: ADA Codes/Description Screen

The appropriate ADA code must be selected by scrolling to the code and highlighting. Use the scroll bars as needed. In this example, the code D0220 for tooth #14 is to be selected. Scrolling to

the appropriate Header (Diagnostic), double-clicking on it and highlighting the desired code, results in the following screen being displayed:

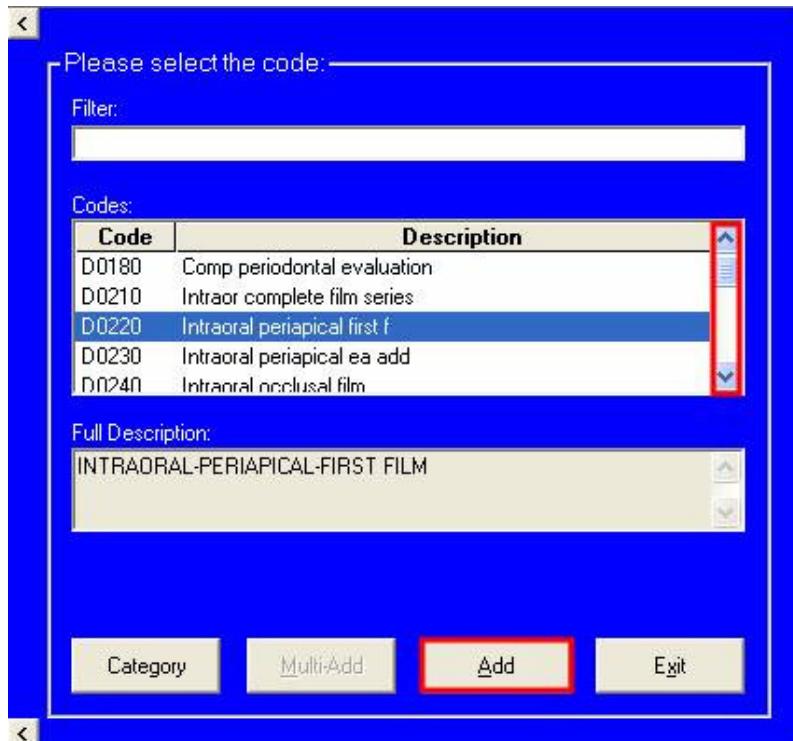


Figure 31: Selecting ADA Code

Clicking the Add button displays the Code Details box as illustrated below:

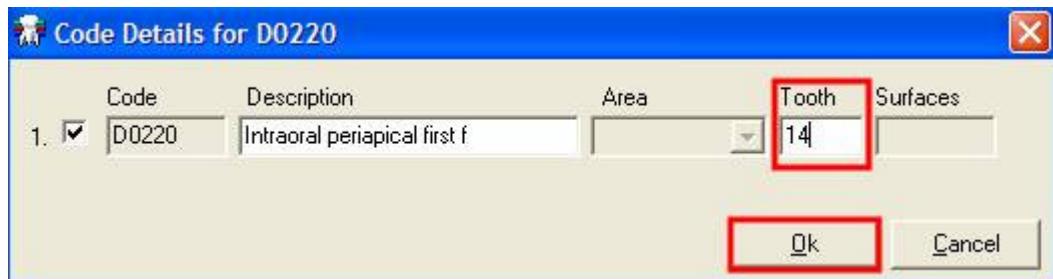


Figure 32: Code Details Box

This Code Details box allows the Tooth # to be entered. Clicking on OK moves the entry to the transaction table and the graphic chart. Once you have entered the planned procedure and have finished adding any more codes with the ADA Codes icon, click the Exit button on the ADA Codes/Description screen (blue screen) so there are no duplication procedures in the Treatment Plan. The resulting screen is displayed as illustrated in the following screen.

Note: Surfaces must be entered using Upper-Case letters. Roots must be entered using Lower-Case letters.

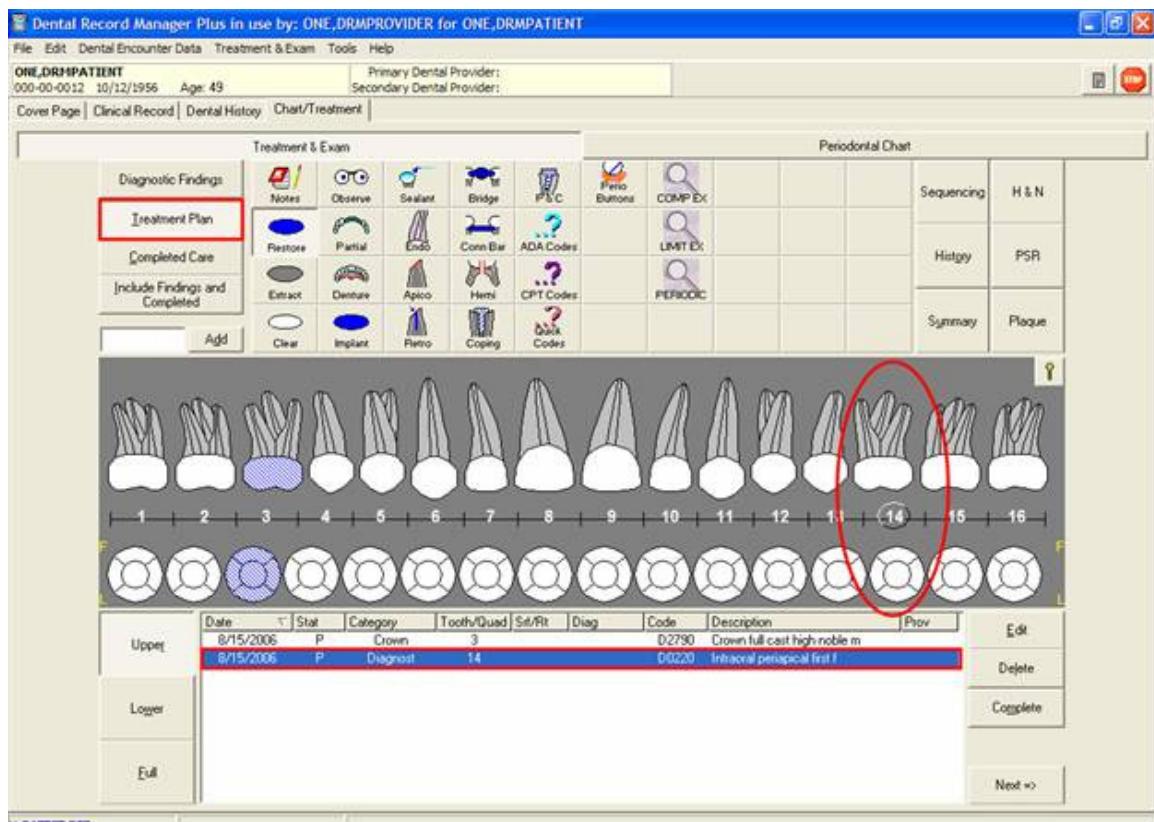


Figure 33: Planned Procedure in Transaction Table

The entry is shown in the transaction table and the planned procedure shows on tooth #14 in the transaction table. Other codes may now be selected, or clicking Exit completes the process.

Note: The Code Details screen will require different entries depending on the ADA code selected. While the entry requirements may change, the overall process remains the same. Some ADA codes do not require a Code Detail box entry.

Note: The filter box may also be used to search for a code within the ADA Codes/Description screen. For instance, a four digit number or search criteria text may be entered in the box, in this example “adjust”. When the Add button is clicked, the ADA Codes/Description screen will appear displaying those codes that match the search criteria as shown in the following screen shot:

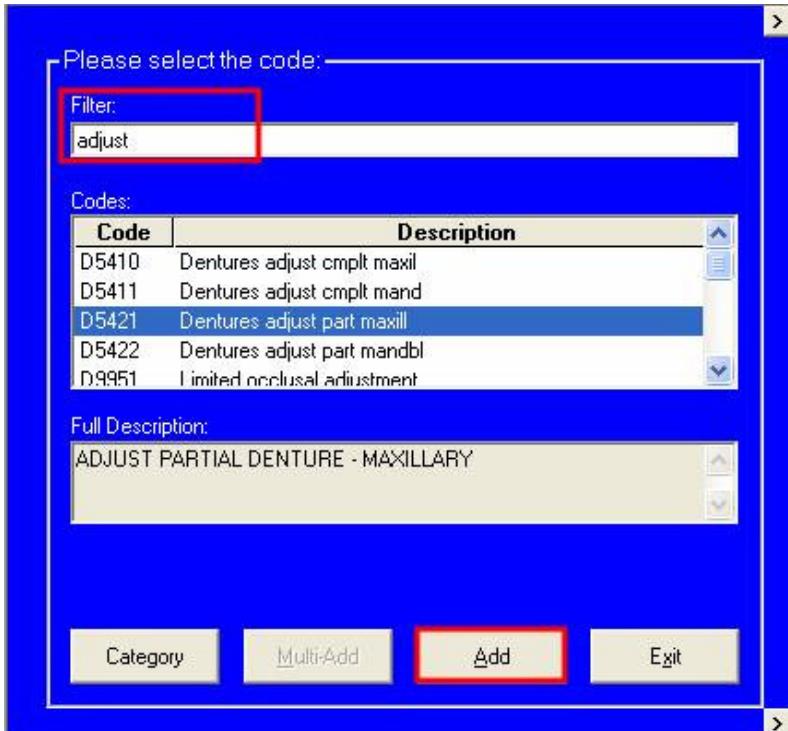


Figure 34: Using Filter with Text in the ADA Code/Description screen

Using the CPT Codes icon – CPT Codes are local medical codes needed to enter procedures planned or performed that do not have an ADA code. Allowing these codes to be selected in DRM Plus is an administrative function which is explained in the Administrative Manual. Clicking on the CPT Codes icon displays a screen showing these codes. The selection process and the other requirements are the same as using the ADA codes icon.

Using the Quick Codes icon – Users may develop a Quicklist of codes to simplify the ADA code selection process. Refer to the section called “Using the DRM Plus Menu Bar” of this manual for instructions on developing and editing a Quicklist. When the Quick Codes icon is clicked, the Quicklist codes are displayed. The selection process and the other requirements are the same as using the ADA codes icon.

Using the Speed Codes icon – Users may develop Speed Code icons to further simplify the ADA code selection process. Refer to the section called “Using the DRM Plus Menu Bar” for instructions on developing and editing Speed Code icons. The selection process skips the blue ADA Codes/Description screen which allows the user to select Multi-Add options.

Note: Speed Codes do not have Multi-Add functionality.

Using the Add Box – The Add box is located to the left of the icons area. A code, for example D0220, may be entered in this box and Add clicked. The code is immediately entered and the Code Detail box is displayed.



Figure 35: Add Box

The Add box may work like the filter box in the ADA Codes/Description screen. This box may also be used to search for a code within the ADA Code/Description screen. For instance a four digit number or search criteria text may be entered in the box, in this example “d02”. When the Add button is clicked, the ADA Codes/Description screen will appear displaying those codes that match the search criteria as shown below:

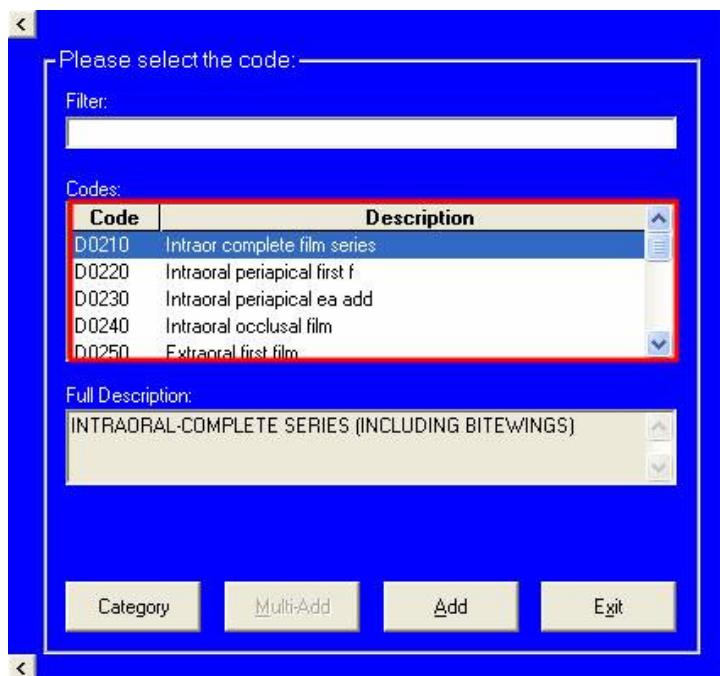


Figure 36: Using the Filter with d02 in the Add box

Completing the selection process and the other requirements are the same as when using the ADA Codes icon.

When all Treatment Plan procedures have been entered, a procedure code(s) must be entered. For all procedure code entries, the process starts by clicking on the Completed Care button and entering the code(s) using the graphic icons or any of the other ADA codes selection options (See “Use the Completed Care Screen”). When DRM Plus process for entering encounter data and the Progress Note is completed the Treatment Plan is permanently saved in the patient’s record (Refer to the section called “Completing the Encounter Data and Progress Note”).

Prior to clicking Finish on the Progress Notes screen, Treatment Plan procedures may be temporarily saved using the option “Save Unfiled Data” under the File drop-down menu. Using the Special Buttons may be initiated during the entry of the Treatment Plan (Refer to the section called “Using the Special Buttons”).

If no Completed Care procedures have been entered and the Next button is clicked, the following screen appears:

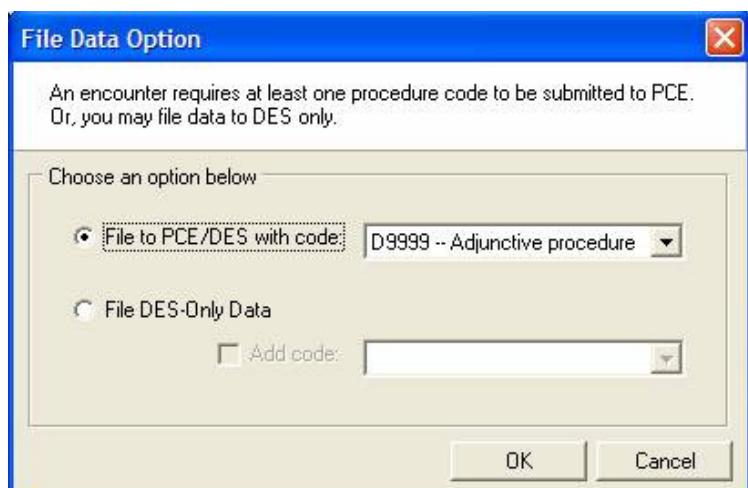


Figure 37: No Completed Care Procedures Entered screen

This File Data option box defaults to the normal filing options and code D9999. To select a different code, click on the down arrow to display the following screen:

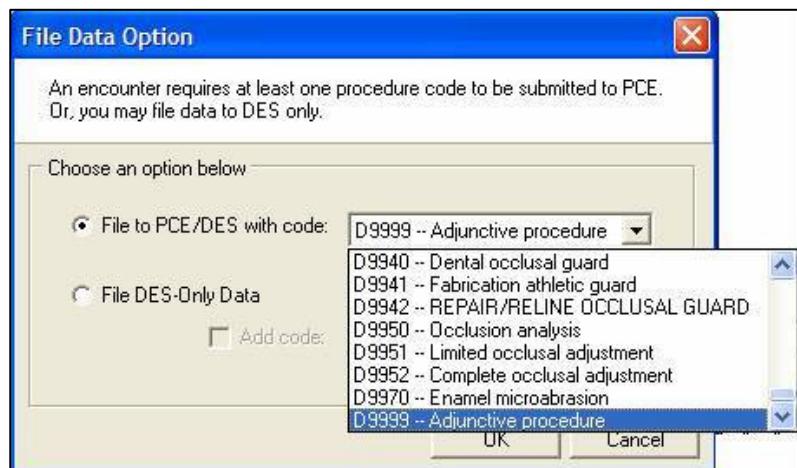


Figure 38: File to PCE/DES with code

Scroll to the appropriate code, highlight and click OK to complete the process.

If the provider needs to file to DES in a data only entry, the radio button File DES-Only Data button should be selected and the OK button clicked to begin the process of finalizing the encounter.

If the provider needs to file to DES only with a code, the Add Code box should be clicked, allowing the down arrow to be clicked and the appropriate code selected as displayed below:

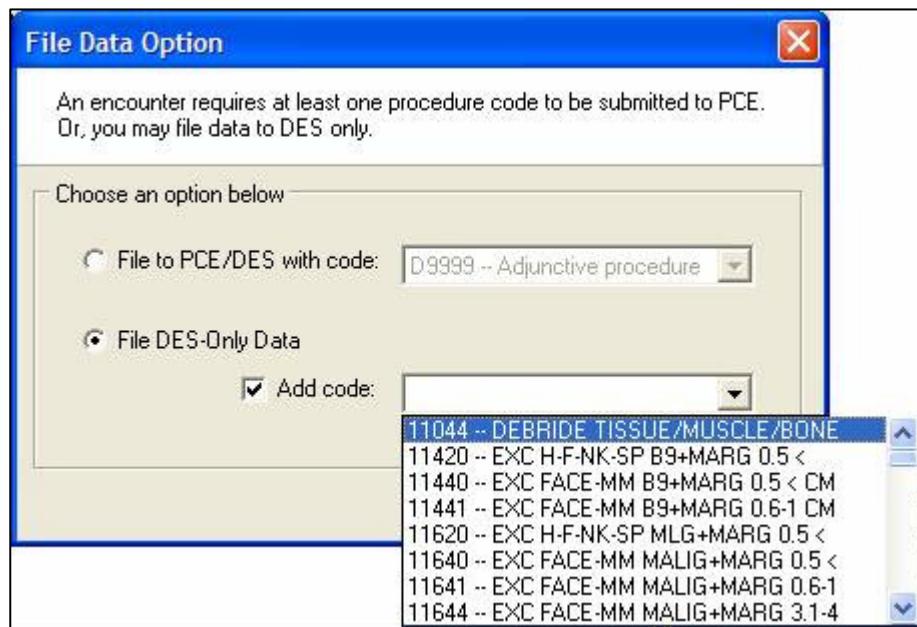


Figure 39: File DES-Only Data

Clicking on the OK button finalizes the process.

Procedures for Saving Unfiled Treatment Plan

Procedures for Saving Unfiled Treatment Plan procedures prior to clicking Finish on the Progress Note screen are explained below. Once the user clicks the Finish button in DRM Plus, the encounter data and the Progress Note (signed or unsigned) is passed to Vista (PCE & DES) and CPRS. DRM recognizes that a user may not be able to complete all DRM Plus entries in one computer interaction. DRM Plus also recognizes that the changes may need to be to the Diagnostic Findings after reviewing x-rays or consulting with other providers. An option is provided to deal with these issues; Save Unfiled Data. Within this option, the user can save the data either to themselves or to another provider. If the user saves the data to themselves, DRM Plus requires that the provider saving the data must be logged on to restore the data for that patient. This will occur the next time that patient's record is opened. If the user saves the data to another provider, DRM Plus requires that the provider with the stored (or saved) data must be logged on to restore the data for that particular patient. This will also occur the next time that patient's record is opened.

Click on the File drop-down menu and select the option highlighted below.

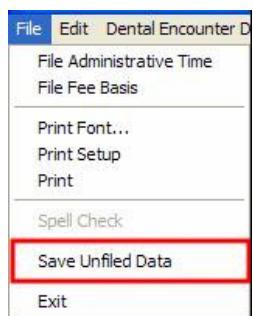


Figure 40: Save Unfiled Data

A pop-up window appears giving the user the option to designate where the data is to be saved.

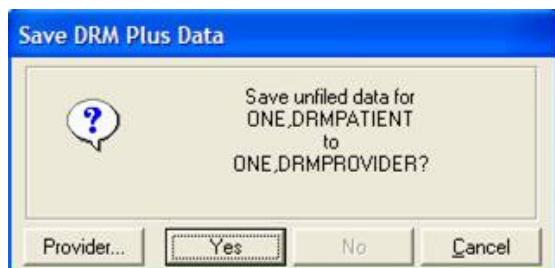


Figure 41: Save Unfiled Data confirmation message

When the Provider option is selected, the following screen appears:

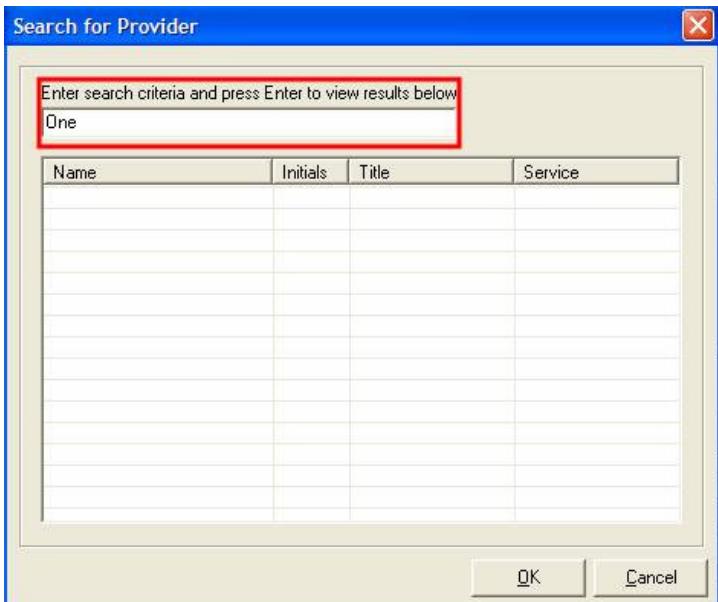


Figure 42: Search for Provider

The desired provider's name should be entered in the search criteria's box.

When the Enter key is pressed, the following box appears:

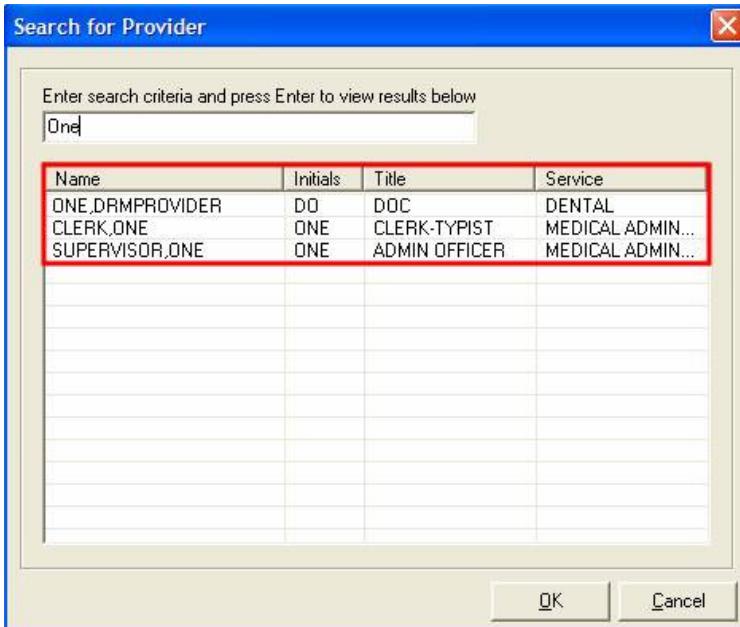


Figure 43: Choose Desired Provider

Highlight the provider's name that will receive the unfiled data and click on the OK button. The next screen that appears will ask if the unfiled data should be saved to the selected provider. Click on the OK button and the designated provider now may restore the saved data.

Depending on the option selected, one of the following boxes will appear confirming that the unfiled data has been successfully saved.



Figure 44: “Unfiled data saved successfully” messages

DRM Plus will save the entries already made. The user may now close DRM Plus, minimize DRM Plus, or change DRM Plus to a different patient. When the user re-enters DRM Plus and selects the same patient, DRM Plus will present a dialogue box notifying the user of the saved information. Clicking “Yes” brings the saved information into the Treatment & Exam screen. The encounter can then be completed in the usual manner.

Note: If the user attempts to close DRM Plus or switch to a different patient, DRM Plus will display a pop-up box asking the user if the current patient’s entries should be saved. Clicking “Yes” initiates the same save function.

The following scenarios may apply:

- **Scenario #1:** The user has not finished all DRM Plus entries (Finish not clicked) and must leave the workstation to attend to other duties.
- **Scenario #2:** A dental assistant has entered data during the patient encounter and wants to save the data to the providers who can then complete the entries and Progress Note.

Entering Treatment Plan Procedures with a Related Diagnosis

Each Treatment Plan procedure that is entered may have one designated primary diagnosis and up to four secondary diagnoses. Once the diagnoses have been designated, they will follow the procedure through the Completed Care entry if the Completed Care entry is initiated from the Sequencing screen.

To turn on the option for the Treatment Plan diagnosis, click on the Tools drop-down menu and select User Options. The following screen is displayed:



Figure 45: User Option screen

Select the Treatment System tab to display the following screen:

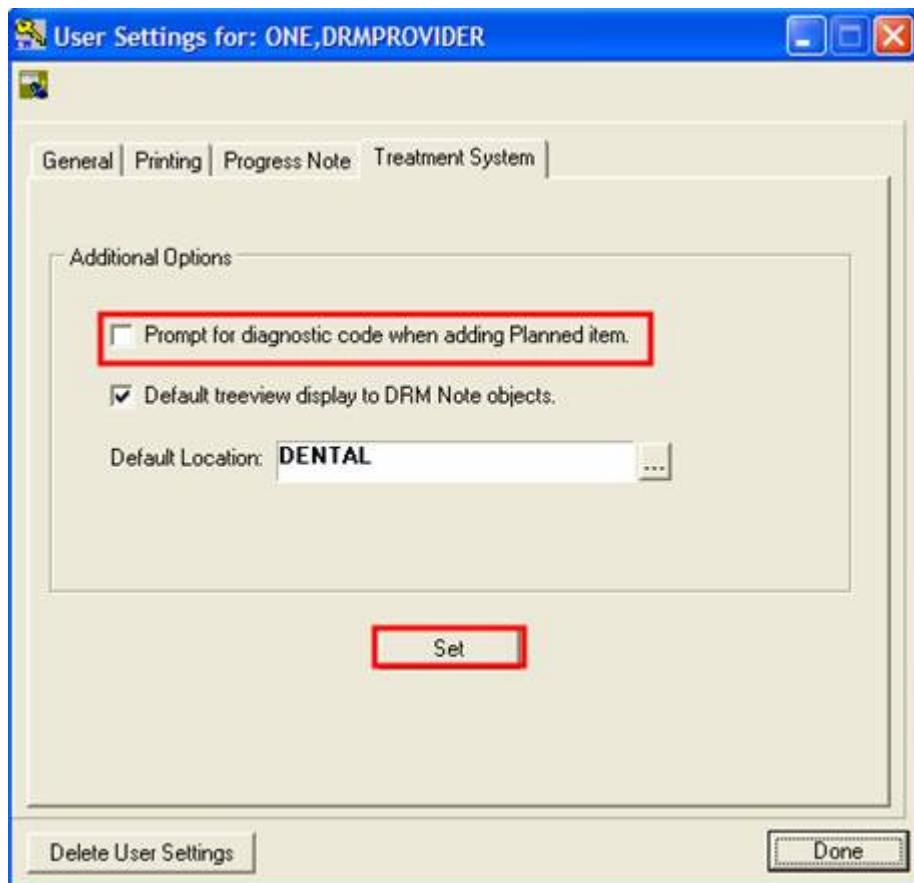


Figure 46: Treatment Plan tab

The **Treatment System** tab has a default to the second option which is used for CPRS templates to be displayed on the tree view in the Progress Note.

To change the DRM Plus default to include the diagnosis option, click on the check box next to “Prompt for diagnostic code when adding Planned item.” Click the Set button and then the Done button to complete the selection.

When the Diagnosis option is selected for each Treatment Plan procedure entered, the following screen will appear to allow the diagnosis designation:

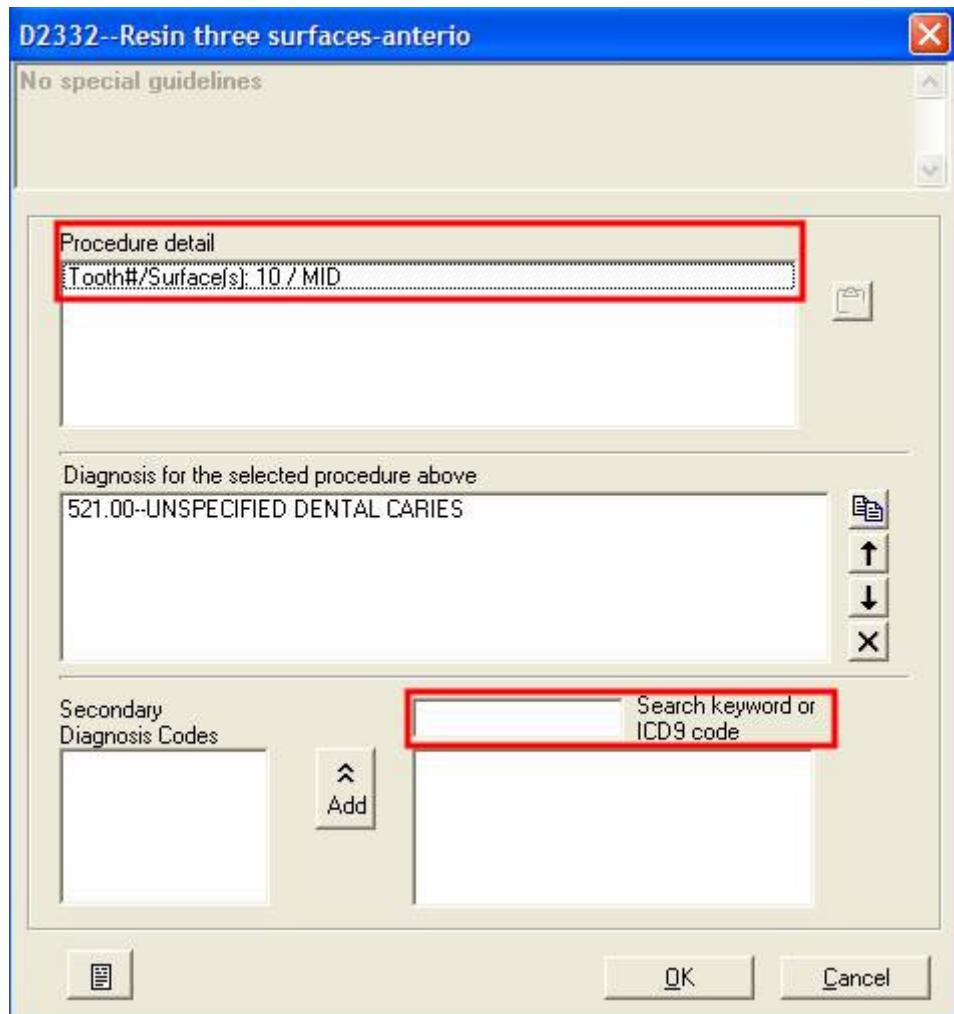


Figure 47: Making Diagnosis/ICD9 Screen Option Default

If the Multi-Add feature has been used, the diagnosis screen will appear as follows:

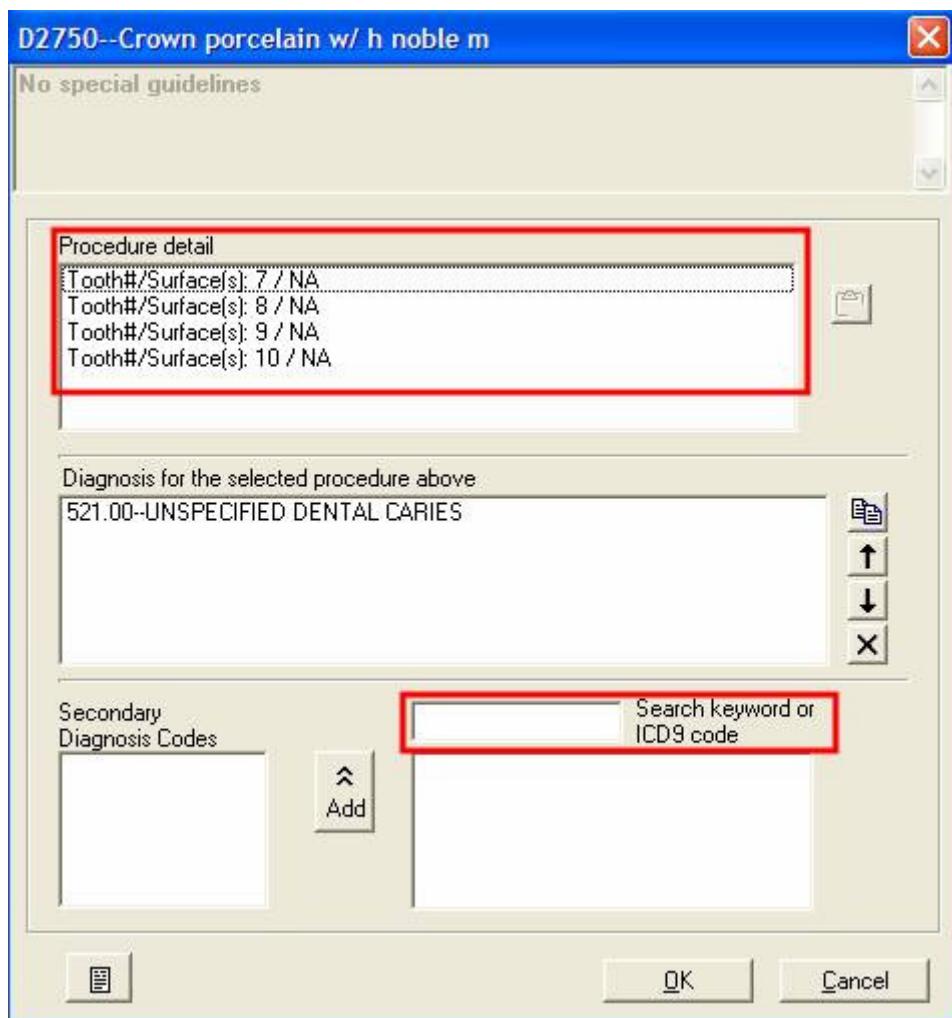


Figure 48: Diagnosis/ICD 9 Screen results from Multi-Add Feature

If the default diagnosis is appropriate, clicking the OK button completes the process. For instructions on changing the default diagnosis or adding secondary diagnoses, see the section entitled “Using the Completed Care Screen”. On the above screens, the arrows to re-order the diagnoses have been moved from the left to the right side of the screen.

Additionally, a copy function has been added to allow the diagnoses for one of the teeth to be copied to be used as the diagnoses for other teeth. To use the copy function, primary and secondary diagnoses information for one tooth must be established using the search or secondary diagnosis code boxes. Once this has been done, the copy button may be clicked, followed by highlighting a tooth in the procedure detail box and clicking on the paste button.

The designated primary diagnosis will appear in the transaction table with the other Treatment Plan procedure information as displayed below:

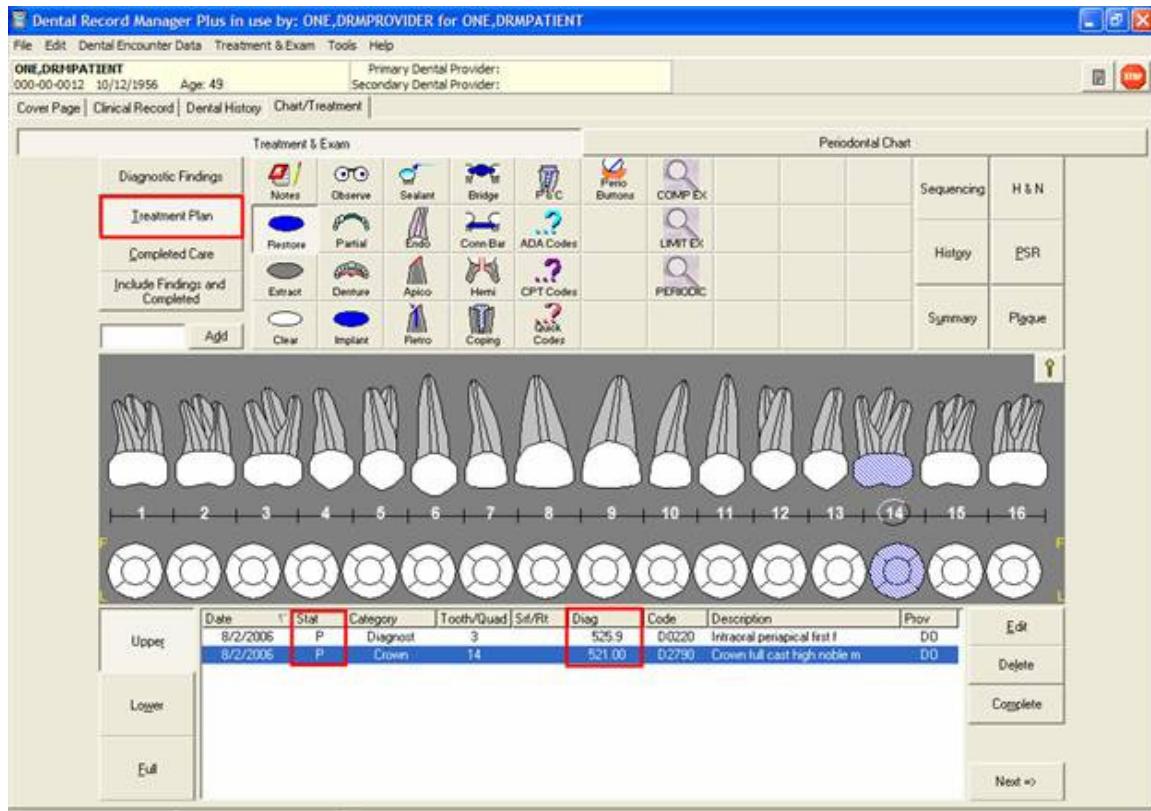


Figure 49: Primary Diagnosis in the Transaction Table of Treatment Plan

Sequencing the Treatment Plan

Overview

Once the Treatment Plan procedures have been recorded, users may initiate sequencing the procedures. Procedures can be placed in Phases and then sequenced within the designated Phase. Clicking the Sequencing button shown highlighted in the screen displayed below initiates the process.

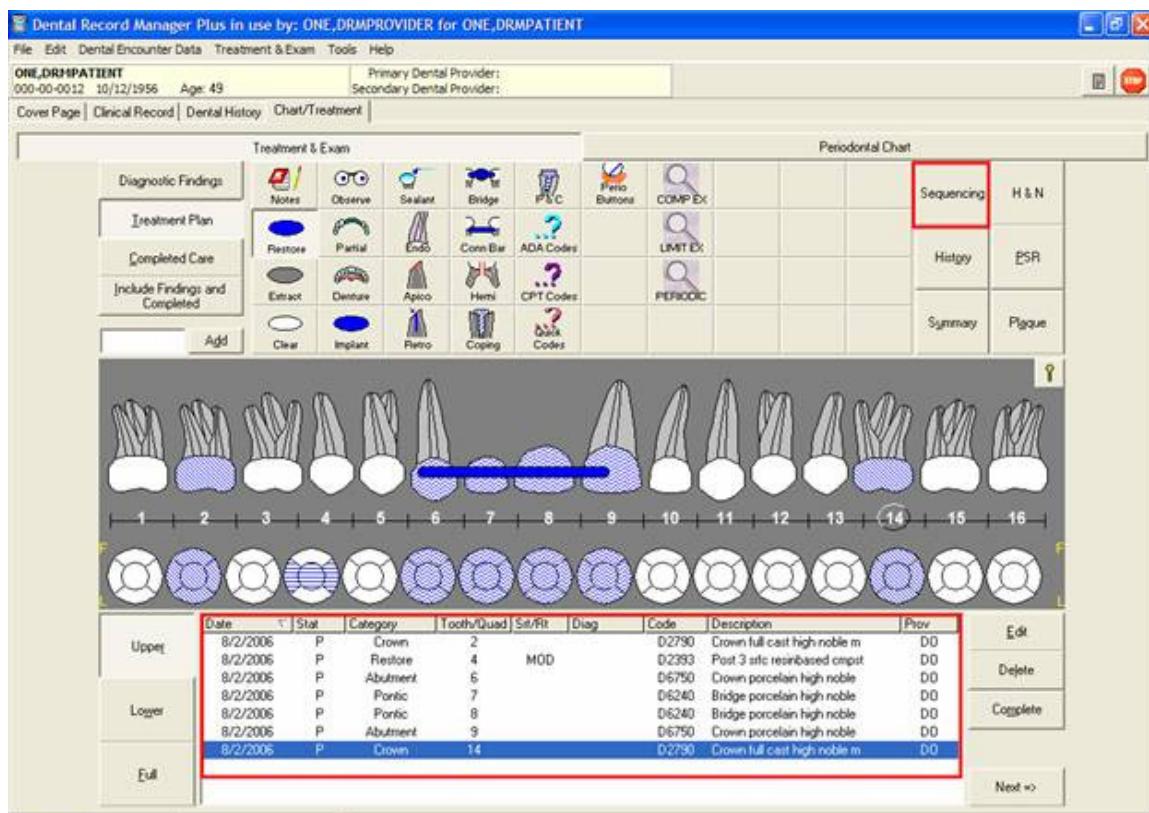


Figure 50: Sequencing the Treatment Plan

Note: If the “Sequencing” button is selected before entries have been entered into the Treatment Plan, an information box will appear stating, “There are no planned treatment items to sequence”. Click OK to Return to the Treatment Plan screen.

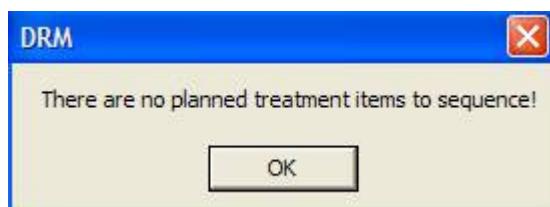


Figure 51: No planned treatments items

The following Tx Planning/Sequencing screen is displayed as illustrated on the following screen:

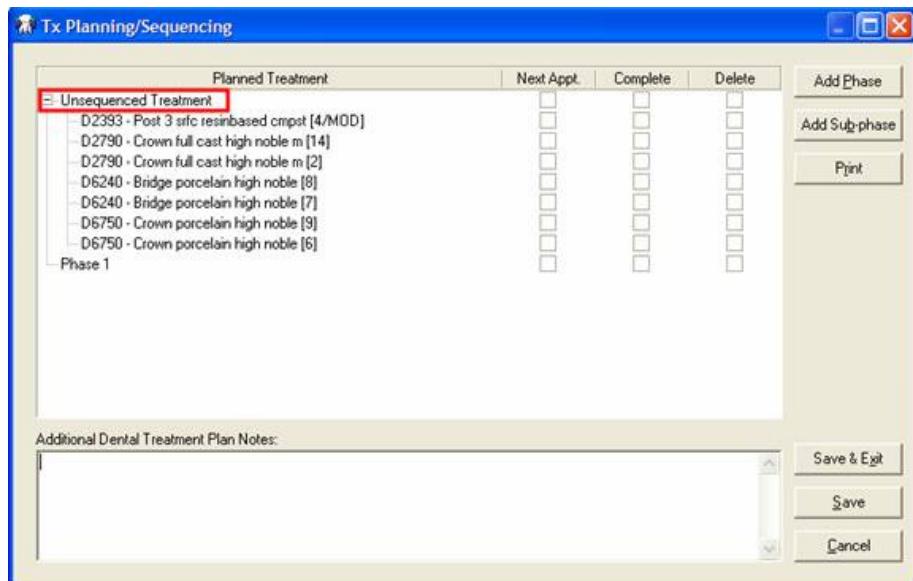


Figure 52: Unsequenced Treatment

Treatment Plan procedures that have not been “sequenced” will be displayed at the top of the screen under the heading, “Unsequenced”. Unsequenced Treatment Plan procedures may be placed in Phases. Phase 1 is automatically displayed on the screen if no previous procedures have been sequenced. If procedures have been previously sequenced, the associated Phases and the procedures will be shown.

To create Phases, click the “Add Phase” button located on the right side of the Tx Planning/Sequencing screen. Each time the New Phase button is clicked, a new (sequentially numbered) phase is added as shown in the following screen.

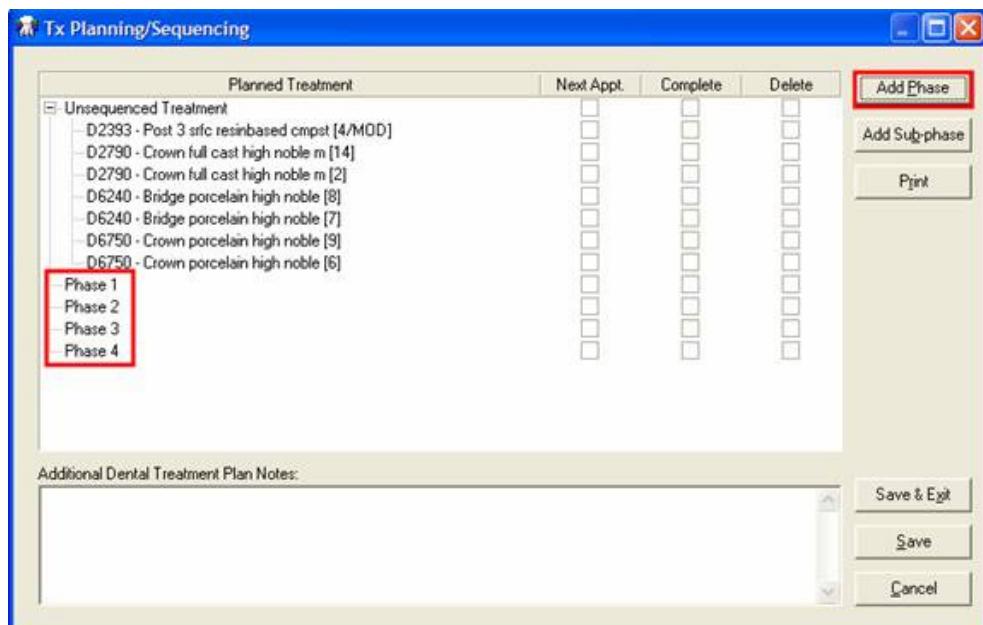


Figure 53: Creating Phases

After creating the desired number of phases, the unsequenced procedures can be placed into a phase using click and drag. Click on the unsequenced procedure and hold the left side of the mouse down. Drag the procedure until it is covering the phase and the phase has a box around it. Releasing the mouse causes the procedure to appear under the selected phase. Repeat this process as necessary to sequence all Treatment Plan procedures. The screen should appear as displayed below:

Note: Range codes (Mostly prosthetics - See Appendix E) will move as a block when one code is highlighted for click and drag.

Note: Allows the user to drag and drop multiple procedures at one time using the Shift/Ctrl keys.

Note: Resize and move the Tx Planning/Sequencing screen in all directions.

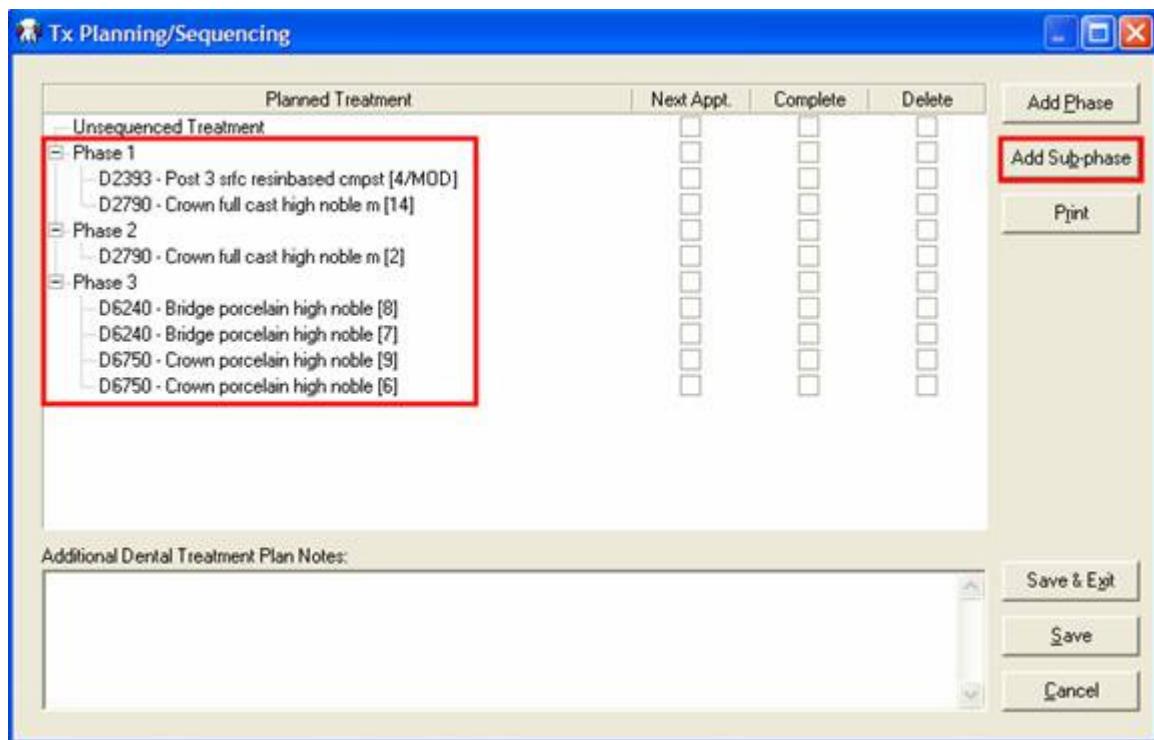


Figure 54: Tx Planning/Sequencing in Phases

The “Add Sub-phase” button may be used to create a sub-phase within a phase. To show Phase 1 as being accomplished in two appointments, highlight Phase 1 and click Add Sub-phase. The following screen is displayed:

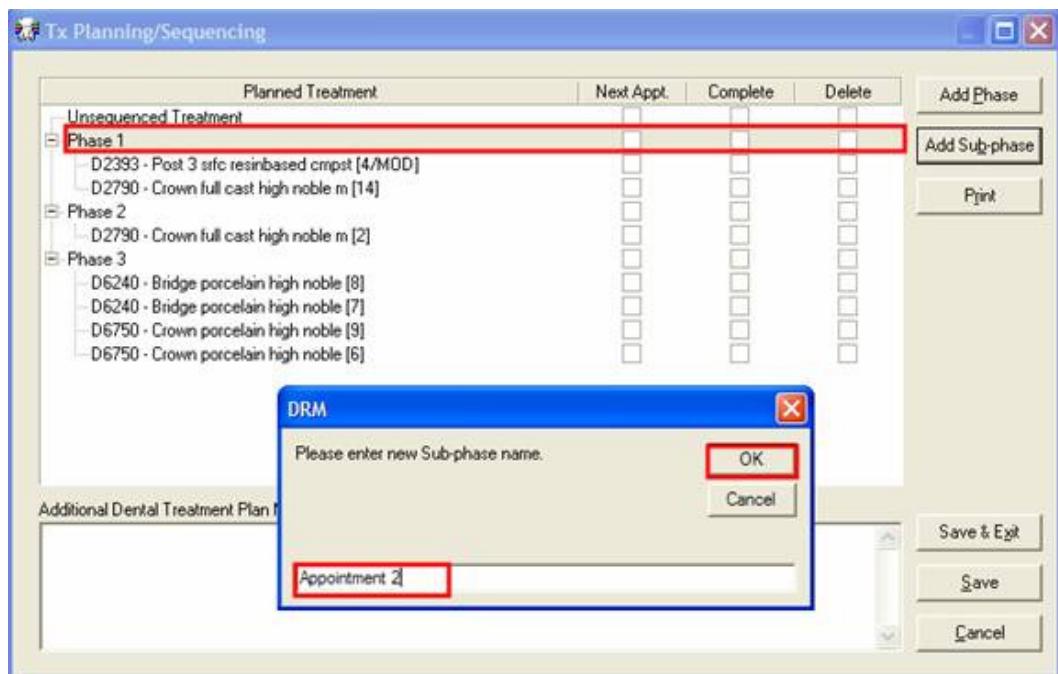


Figure 55: Creating Sub-phases

Enter the sub-phase name. For example “Appointment 2” and click OK. The following screen is displayed:

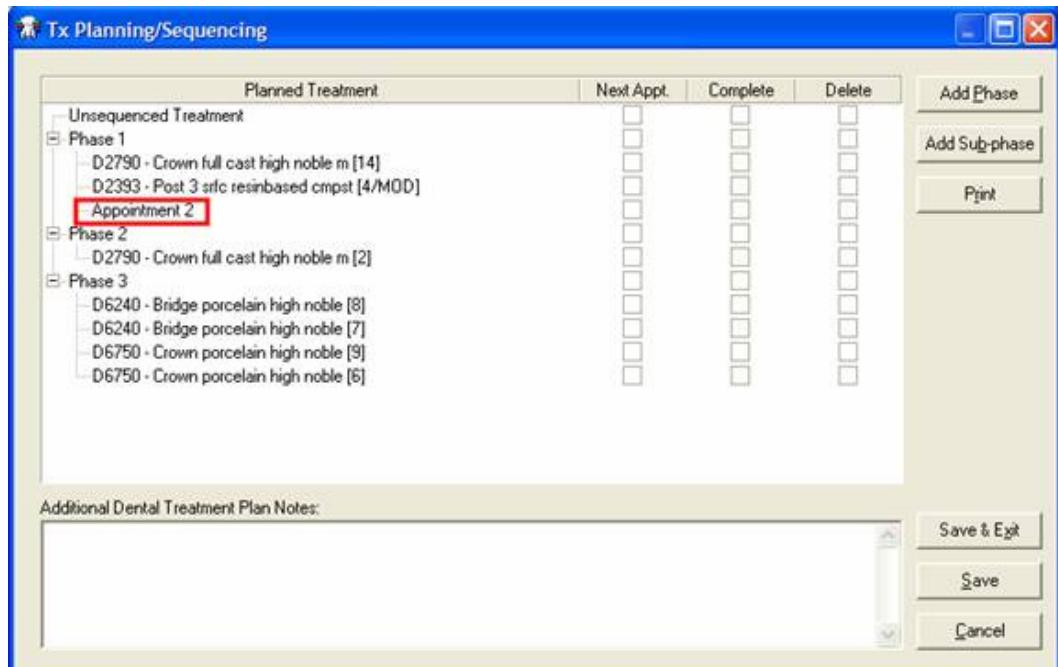


Figure 56: Sub-phase

Click and Drag the second procedure to Appointment 2. The following screen is displayed:

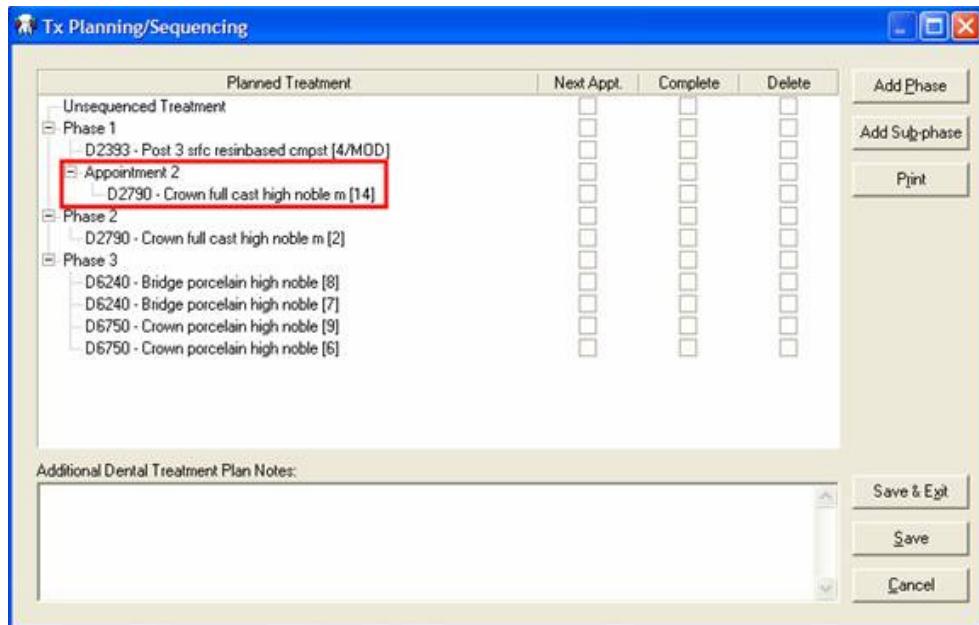


Figure 57: Procedure and Sub-phase displayed

The second procedure is now entered for Appointment 2. If no procedure is assigned to the new sub-phase, the sub-phase will not be saved when the Save button is clicked.

To use the Next Appointment button, highlight the procedure to be performed during the next appointment and click Next Appointment checkbox. The following screen is displayed:

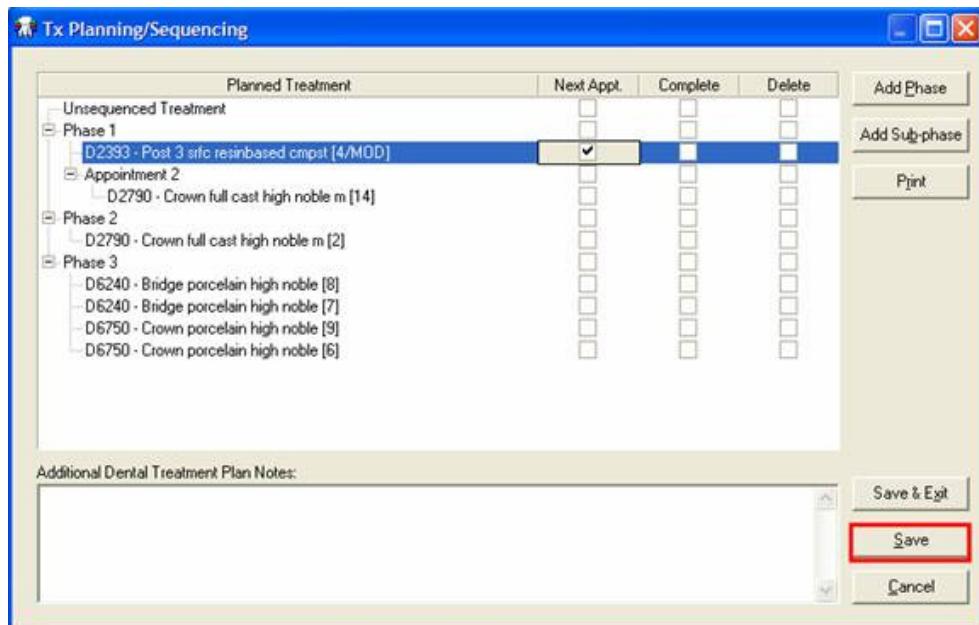


Figure 58: Assigning Next Appointment

The designated procedure is now marked with the Next Appointment arrow. This designation will show in the Progress Note.

To delete procedures, phases or sub-phases from the Treatment Plan, check the box in the Delete column that corresponds to the appropriate item. Deleting a phase or sub-phase will permanently remove those procedures. If the checkbox for a phase is selected, the phase and all of its sub-phases will be deleted.

When the sequencing process is complete, click Save at the bottom of the Tx Planning/Sequencing screen. The sequenced Treatment Plan will appear in the Progress Note.

If Save is not selected, sequencing will not reappear when the screen is reopened. If the Cancel button or the “X” button (top right of screen) are selected prior to the Save button, all sequencing work is lost.

Note: Additional Dental Treatment Plan Notes box at the bottom of the Tx Planning/Sequencing screen allows users to include additional information in the Treatment Plan.

Note: Print sequencing information from the Tx Planning/Sequencing screen.

Note: As previously discussed for entering Diagnostic Findings and Treatment Plan procedures, an ADA code must be entered as Completed Care. When all encounter data is entered and a Progress Note finalized, the Treatment Plan and the sequencing will be permanently saved in the patient's record. If all Diagnostic Findings and Treatment Plan procedures and sequencing is accomplished in one visit, entering one ADA code as Completed Care will be adequate for a finished Progress Note.

Configure Tx Planning/Sequencing screen upon entry – A parameter on the configuration page to determine whether the sequencing screen should be shown first upon entering DRM Plus. From the Treatment & Exam menu, choose the Show Configurations menu and the program defaults to Tx & Exam tab. Click the check box “Display sequencing upon entry”.

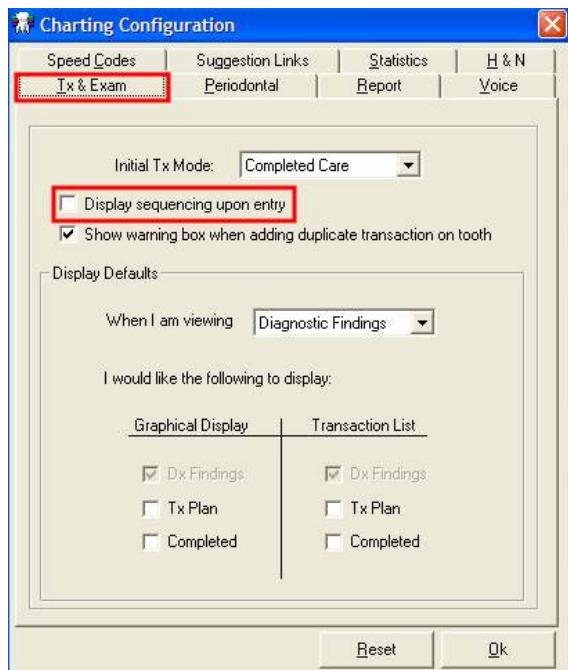


Figure 59: Tx & Exam tab

Save and Exit from Sequencing. Users may add or modify the treatment plan and file the changes without having to click "Next" through the other screens. There must be no Completed transactions, Perio, PSR or Head & Neck data and the most recent dental encounter must have an "Active" status for this feature to work. Clicking "Save and Exit" from sequencing will file any changes made and minimize DRM Plus.

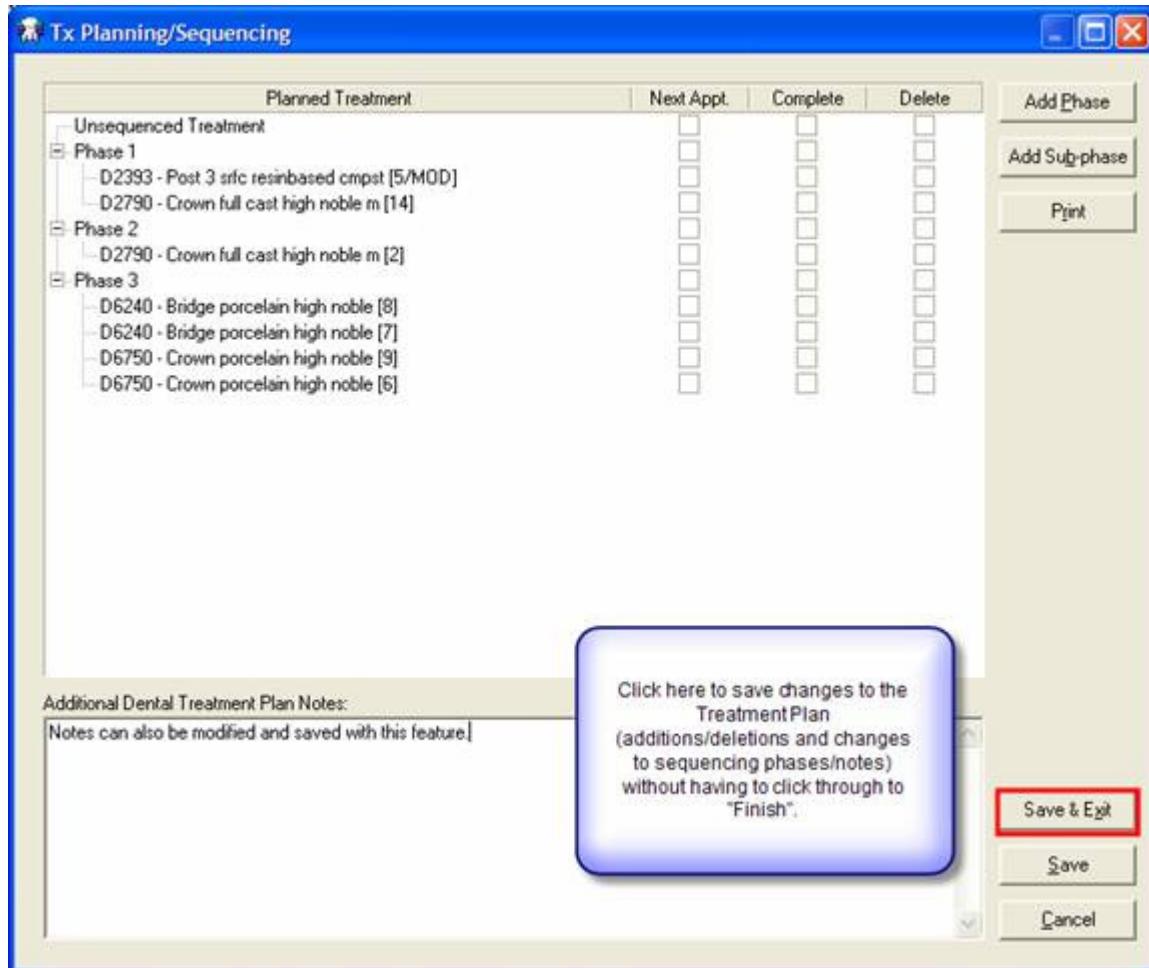


Figure 60: Sequencing "Save and Exit"

Clicking Save and Exit here will display the filing message and will "exit" (minimize) DRM Plus.



Figure 61: "Save and Exit" message

Entering Completed Care from the Tx Planning/Sequencing Screen

To complete procedures, check the box in the Complete column that corresponds with the appropriate items. This process may be repeated for as many procedures as necessary.

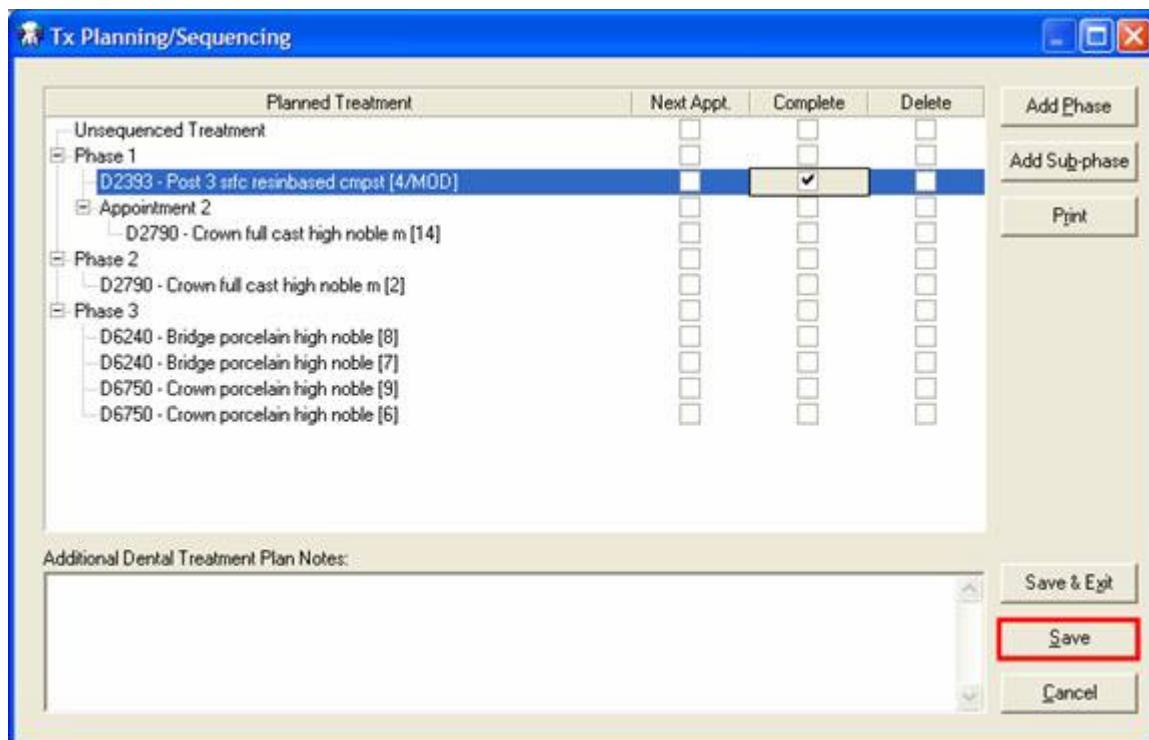


Figure 62: Entering Completed Care from Tx/Planning Sequencing Screen

Once procedures are marked as completed, they are transferred to the Completed Care screen, click the Save button to initiate the DRM Plus process for completing encounter data and entering the Progress Note. If the Save button is not clicked before entering a procedure as Completed Care, the procedure can be designated as completed from the Treatment Plan screen.

This is another method of entering Completed Care from the Treatment Plan screen. Highlight the procedure in the transaction table of the Treatment Plan and click the Complete button. This action initiates the DRM Plus process for entering encounter data into Completed Care from the Treatment Plan transaction table.

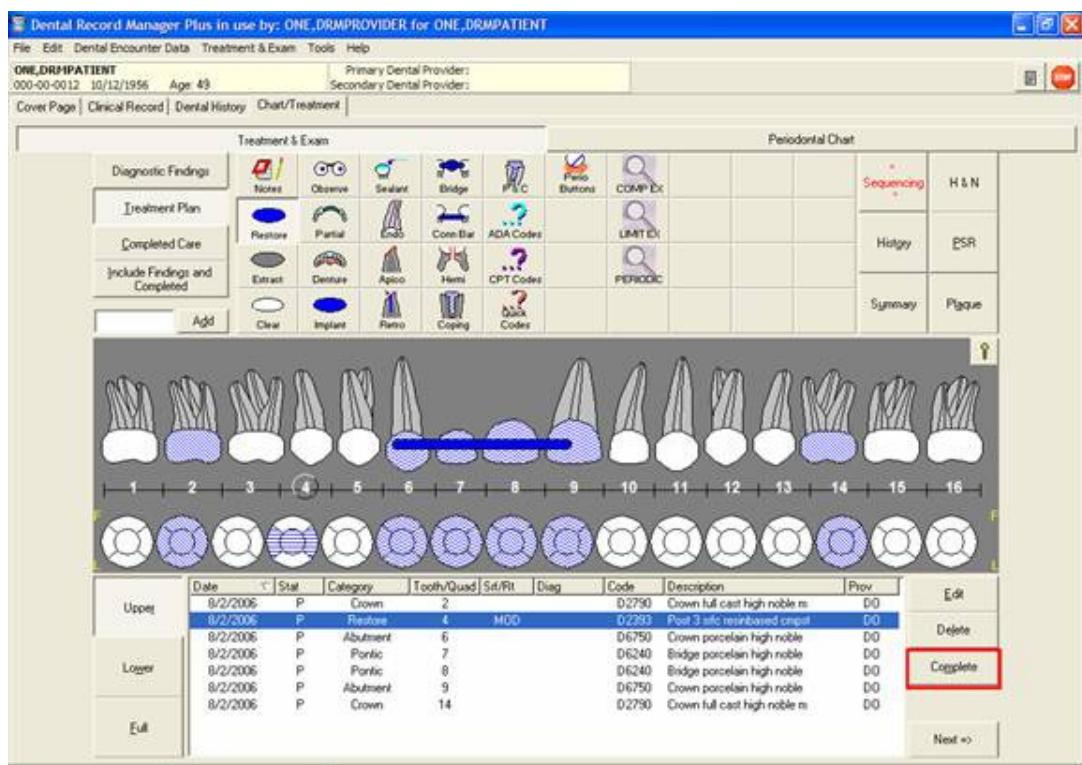


Figure 63: Treatment Plan Screen

Using the Completed Care Screen

Overview

The Completed Care screen is used to enter procedures that have been completed during the current visit. Completed procedures may also be entered from the Treatment Plan screen and the Tx Plan/Sequencing screen (See “Entering Completed Care from the Tx Planning/Sequence Screen”). All entries on the Completed Care screen are initiated by clicking on an icon or by using one of the other ADA code selection options. When an icon is clicked, a graphic chart entry must be made by clicking a tooth(s), a surface(s) or a root(s) on the graphic chart. The Bridge and the Conn Bar icons require a specific action as explained later. If one of the other ADA code selection options are used, the Code Details box may be displayed requiring tooth(s), surface(s), root(s) or other information as appropriate. Not all codes require the Code Details box. After the code selection process is complete, the entry will appear in the transaction table at the bottom of the screen with a Stat designation of “C”.

When all Completed Care entries have been entered, clicking the Next button at the bottom of the screen initiates the DRM Plus process for completing all encounter data and finalizing and filing the Progress Note in CPRS (Refer to the section called “Completing the Encounter Data and Progress Note”). Using the Special Buttons may be initiated during the entry of Completed Care (Refer to the section called “Using the Special Buttons”).

The Completed Care screen is displayed below:

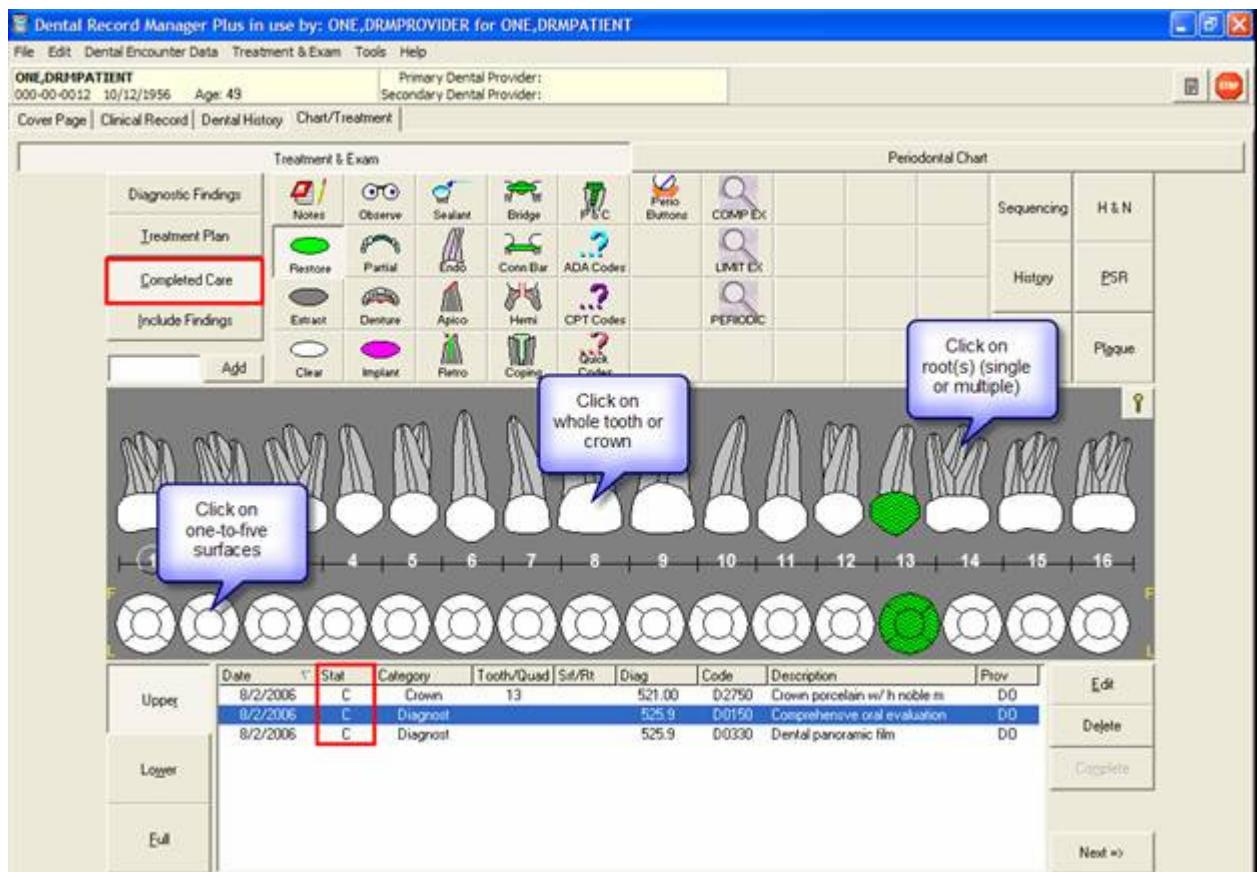


Figure 64: Using the Completed Care Screen

The table below explains the actions required to enter Completed Care procedures using the graphic icons.

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 graphics to show. Graphic in blue-purple.
Implant	Yes	No	No	Code Selection Box	Graphic in violet, Diagnostic Finding must be Missing
Sealant	No	As many as required	Yes	Code Selection Box	Graphic in green. No root graphic
Endo	No	No	Yes	Code Selection Box	Graphic in pink
Apico	No	No	Yes	Code Selection Box	Graphic in red
Retro	No	No	Yes	Code Selection Box	Requires Apico to be present. Graphic in green
Bridge (1)				Code Selection Box	See Special Instructions
Conn Bar (1)				Code Selection Box	See Special Instructions
Hemi	No	No	As many as required	Code Selection Box	Graphic in grey
Coping	Yes	No	No	Code Selection Box	Graphic in green
P&C	No	No	As many as required	Code Selection Box	Graphic in green
Perio Buttons	Click tooth in appropriate quadrant	No	No	Code Selection Box	No Graphic. See Note below. See Speed Code instructions.

Table 3: Actions Required to Enter Completed Care Procedures

(1) Certain codes associated with these icons are defined as range codes. Range codes can only be entered by clicking on the icon button. The ADA Codes table, Quicklists or Speed Code entries are prohibited.

(2) To designate a root restoration, click on the Restore icon. Click on the tooth surface that corresponds to the root surface. Using a tooth note and the Description edit feature in the transaction table, explain the root restoration.

Note: Certain Diagnostic Findings or Completed Care procedures, once entered, will appear graphically on all screen views. These items are, if entered from the Diagnostic Findings screen, missing, implant, impacted, retained root, hemi section, dentition, and observe. If entered from the Completed Care screen, these items are, extract, hemi section, implant, and observe.

Note: The Perio Buttons icon provides a unique feature. Speed Codes may be established and designated as two different sets of icons totaling 38. The Perio Buttons icon then acts as a toggle between the two sets of Speed Code icons. This feature allows each blank icon space to accommodate two sets of Speed Codes. See Using the DRM Plus Menu Bar, Treatment & Exam button, Show Configuration option, Speed Codes tab.

Note: Any ADA code found in the ADA Codes icon with text that is all upper case represents a new 2005 ADA code addition.

Special Descriptions - Bridge icon - Place the mouse on the first abutment and drag to the second abutment. The Code Selection box will be displayed with the lowest number tooth selected.

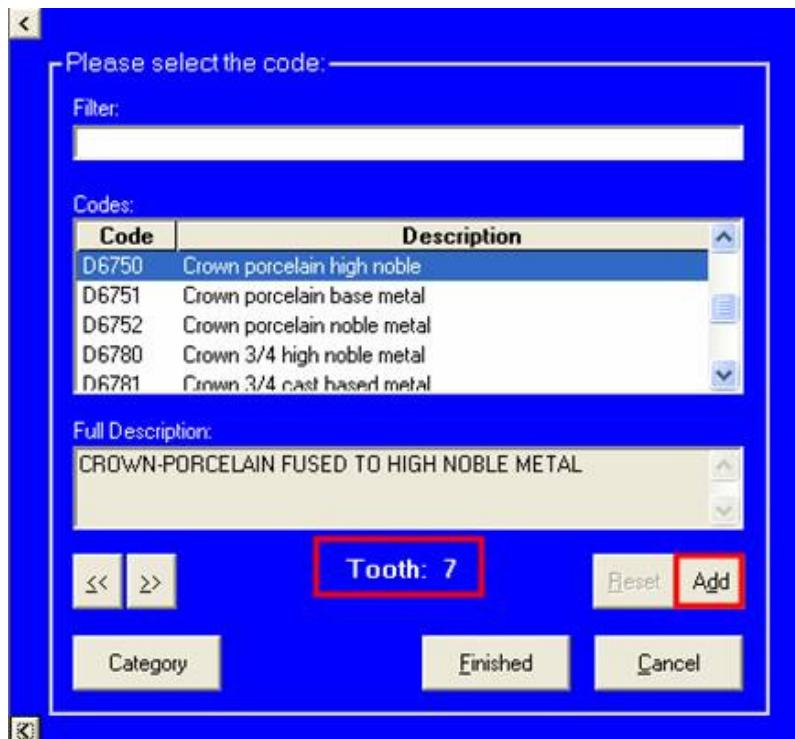


Figure 65: Special Descriptions Bridge Icon

Select the appropriate code and click the Add button. The code selection box will move 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 Finish when the selection process is complete.

Note: The << and >> buttons may be clicked to move back or forward to different teeth for code selection. The Reset button, when activated by using the << and >> buttons, clears all previously entered codes for this procedure.

Special Descriptions - Conn Bar icon - Place the mouse on the first abutment and drag to the second abutment. The Code Selection box will be displayed with the lowest number tooth selected. Select the appropriate code and click the Add button with all the teeth associated with the Conn Bar. Click Finish when the selection process is complete.

Using the Clear Icon or the Delete Button - The Clear icon appears in all screen views of the Treatment & Exam screen. If an error is made while entering Diagnostic Findings, Treatment Plan, or Completed Care entries, it can be erased by using the Clear icon. Click the Clear icon and then click the tooth area in the graphic chart that contains the error. The graphics and text associated with the erroneous entry will disappear from the graphic chart and the transaction table.

Another method to erase erroneous entries is to highlight the entry in the transaction table and click the “Delete” button located on the right side of the table. This action deletes the entry from the table and the graphic chart.

Note: Completed procedures that have been filed and associated with a signed or unsigned Progress Note can only be deleted by an administrator. If users that do not have administrative permissions highlight an entry in this category in the transaction table and hit Delete, you will get a pop-up box “Transaction cannot be deleted”. When an administrator deletes an entry from DRM Plus, appropriate procedures must be followed to correct any associated VistA databases.

Selecting an ADA Code – When a graphic icon is used to initiate the ADA code(s) selection process, the following Code/Description screen will be displayed after the graphic area has been clicked. In the example below, a restoration is being entered for tooth #3. Click the Restore icon and then click on the anatomical crown in the graphical chart. The crown procedure is shown in green on tooth #3.

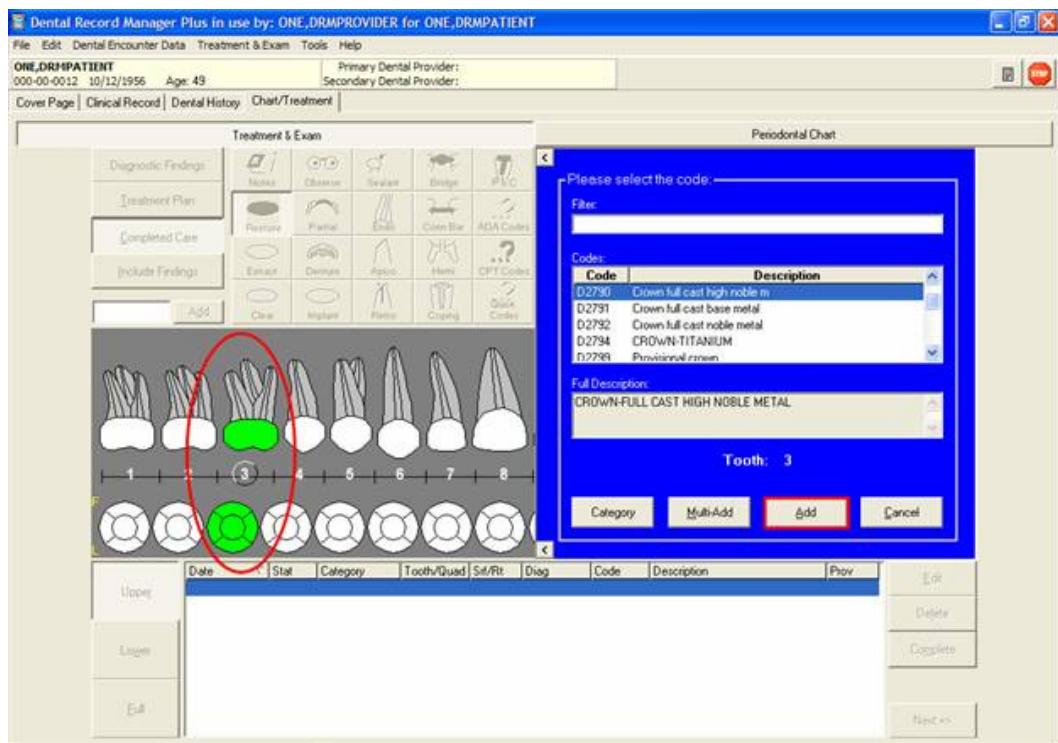


Figure 66: Selecting an ADA Code

The graphic icon clicked and the graphic chart selection determines which area of the Code/Description table is displayed in the Code Description box. In the example above the process has defaulted to code D2790. The scroll bar on the right of the box can be used to display the desired code if it is not displayed when the box is opened. Clicking the Category button will return the user to the “headings” area of the box where double-clicking on a heading will move the user to the area designated. The user may also enter search criteria, text, or numeric in the Filter search box. The Code Description box will display all matches to the search criteria. The code should be highlighted and the process completed by clicking the Add button.

Note: In those rare cases where pre-existing charted care does not allow you to click, select a procedure code via the graphic chart, enter the desired code via the ADA Codes icon option.

Using the Multi-Add function – When the same procedure code is to be applied to multiple teeth, the Multi-Add button should be clicked to display the following screen:

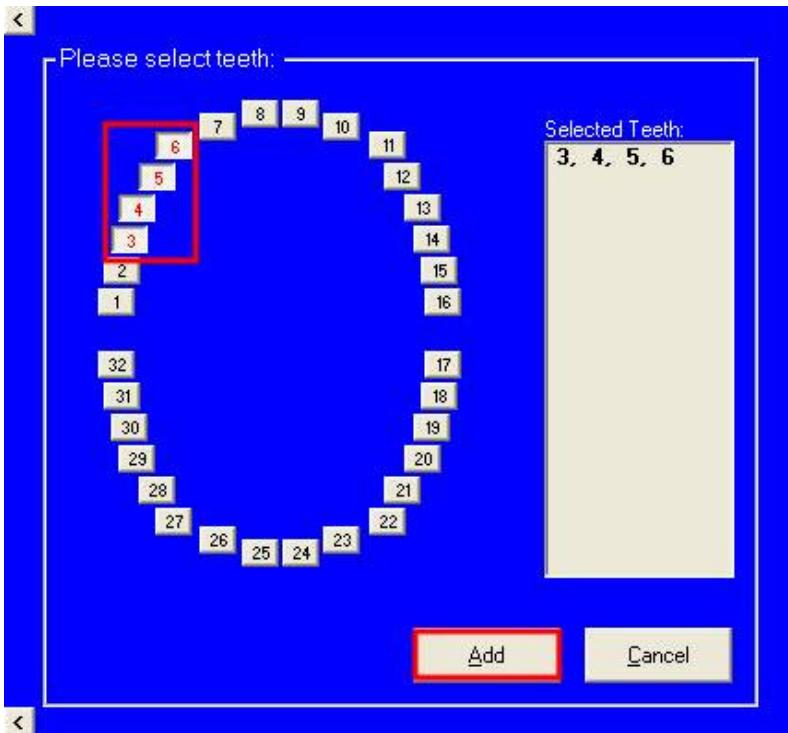


Figure 67: Using the Multi-Add Function

Clicking on the desired teeth and clicking the Add button completes the entry for the procedure code and the selected teeth.

When Add is clicked the Filing Option/Diagnosis screen is displayed as shown on the following screen shot. After the completion of the Filing Option/Diagnosis, OK is clicked and Filing Options/Diagnosis screen is closed and the entry is displayed in the transaction table at the bottom of the screen. The transaction table provides the user with a text view of the entries recorded. Completed Care entries are shown with a Stat of “C”.

ADA Code and Multi-add box can be moved. Small button have been added to the ADA Codes box, CPT Codes box, Quick Codes box, and multi-add box to enable the user to move the box to the other side. This may be needed to "see" what's beneath, especially when entering multi-add codes.

If any administrative guidelines and national coding guidelines have been set, they will display in the special guidelines area illustrated below:

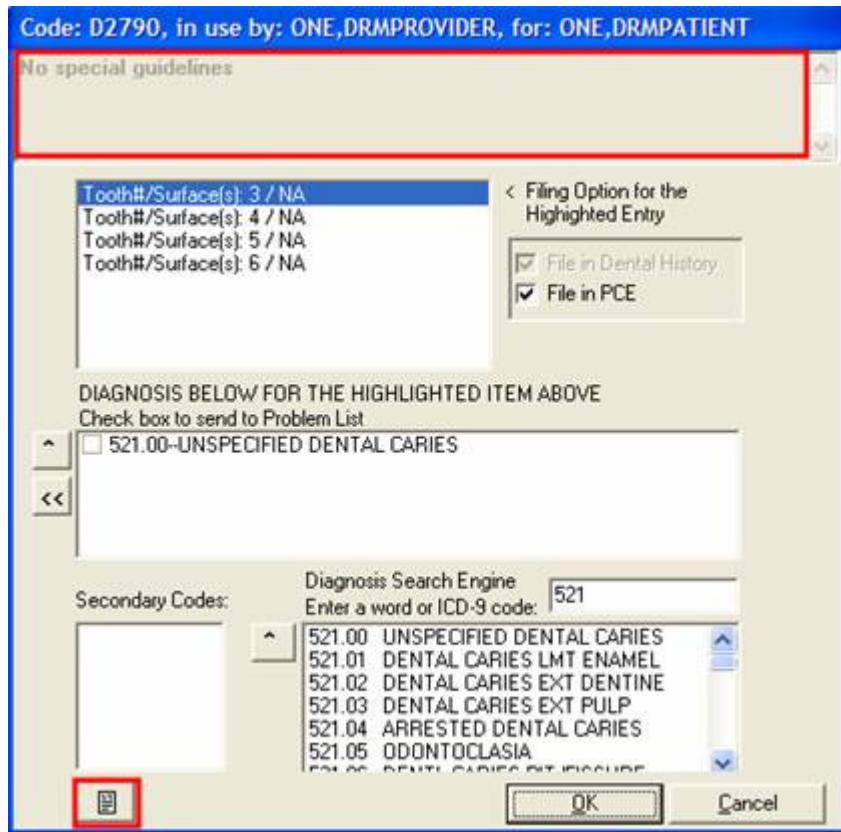


Figure 68: Administrative Guidelines in Filing Options/Diagnosis screen

Note: National Coding Guidelines icon, in the lower left hand of the Filing Option/Diagnosis screen, may be clicked and viewed.

For each Completed Care entry, regardless of the selection process used, the Filing Option/Diagnosis screen is displayed. This screen is used to verify the procedure related entries, designate the data filing option, accept or change the default diagnosis for the procedure code or add a secondary diagnosis. These functions are discussed below.

Filing Options for the Selected Procedure Code – Each entry in the Filing Option/Diagnosis screen may be filed to different systems. Designate the filing option by removing or adding a checkmark in the checkbox (only option is PCE).

File in Dental History – All entries must be filed in the Dental History. This category is appropriately “grayed out”.

File in PCE – if checked will cause highlighted entry to be filed to PCE System.

Note: This option should only be used by advanced users. Changing this option will affect the data being sent to PCE. Do not change this checkbox unless you don't want the data to be sent to PCE.

Missing Teeth are visually indicated on the Multi-Add box. Missing teeth will 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.

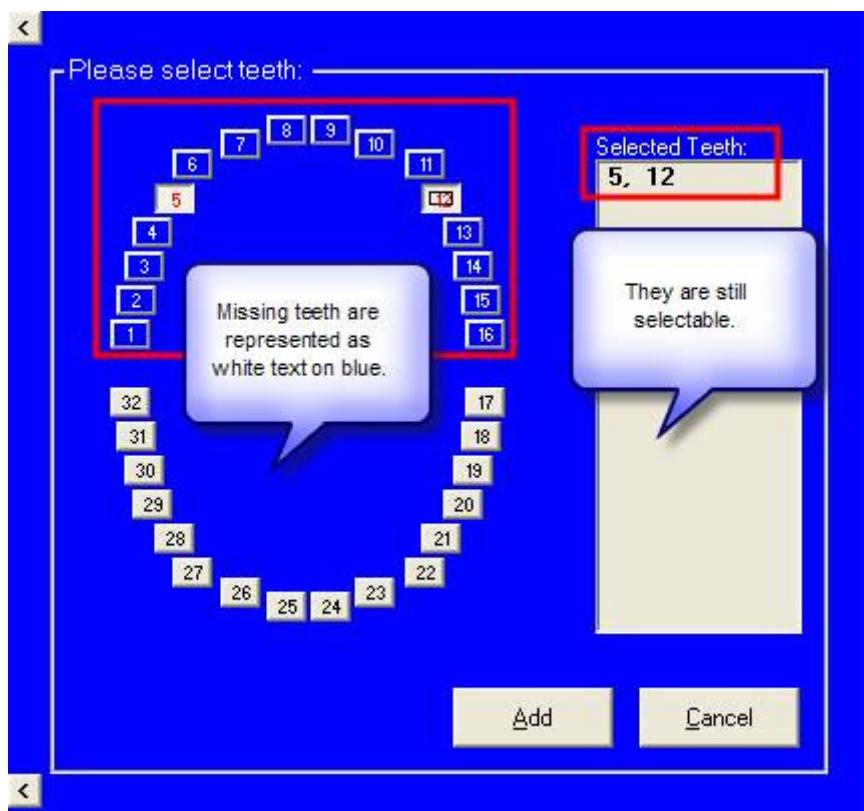


Figure 69: Missing teeth displayed in the multi-add box

Options for Designating Completed Care – There are other options for designating Completed Care ADA procedure codes. Five options exist other than using the graphic icons.

Note: Certain codes, designated as Range Codes, used for multiple teeth procedures, mostly in the prosthetics area, have been restricted to icon use only for ADA code entry. When one of the four options for initiating ADA code selection is selected, these codes are “grayed out” and cannot be selected. See Appendix E for a listing of the Range Codes.

Note: Certain medical codes have been officially added to the VA’s ADA table. These codes are shown after the ADA codes or clicking the CPT Codes icon. Local codes may still be added by a DRM Plus administrator.

Using the ADA Codes Icon – Clicking this icon directly displays the ADA Codes/Description box. The following screen is displayed:

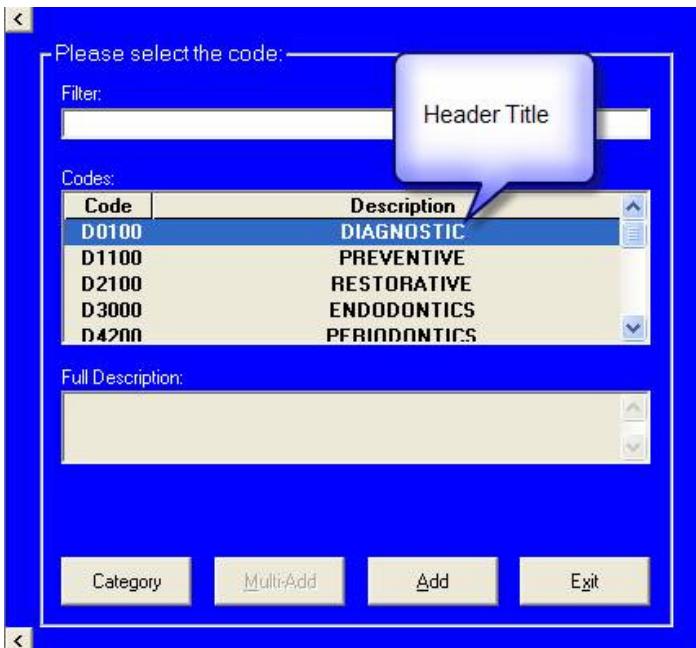


Figure 70: Using the ADA Codes Icon

The appropriate ADA code must be selected by scrolling to the code and highlighting. Locating the appropriate code can be simplified by double-clicking on a Header Title. Use the scroll bars as needed. In this example, the code D0220 is to be selected. Scrolling to the appropriate Header (Diagnostic), double-clicking on it and highlighting the desired code, results in the following screen being displayed:

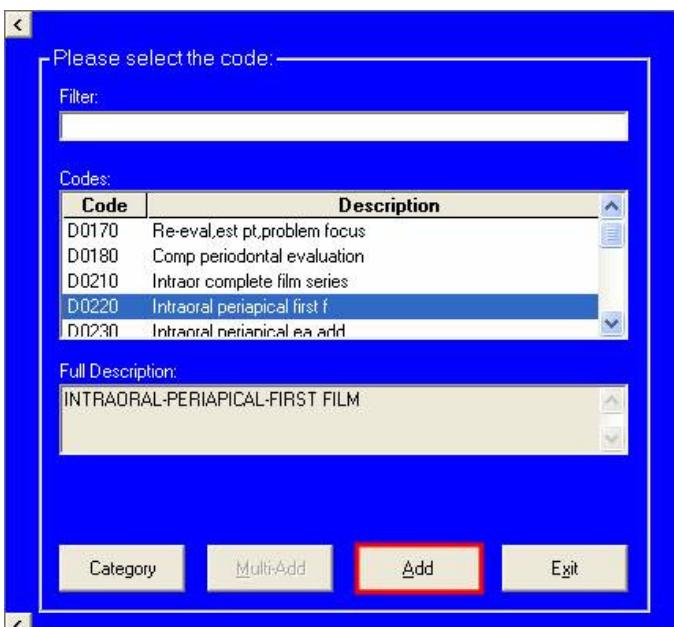


Figure 71: Display Code Details

Clicking the Add button displays the Code Details box as illustrated on the following screen shot:



Figure 72: Code Details box

This Code Details box allows the Tooth #3 to be entered. Clicking on OK moves the entry to the transaction table and the graphic chart.

Note: The Code Details box will require different entries depending on the ADA code selected. While the entry requirements may change the overall process remains the same. Some ADA codes do not require a Code Detail box entry.

Note: Surfaces must be entered using upper-case letters. Roots must be entered using lower-case letters.

The following screen is displayed:

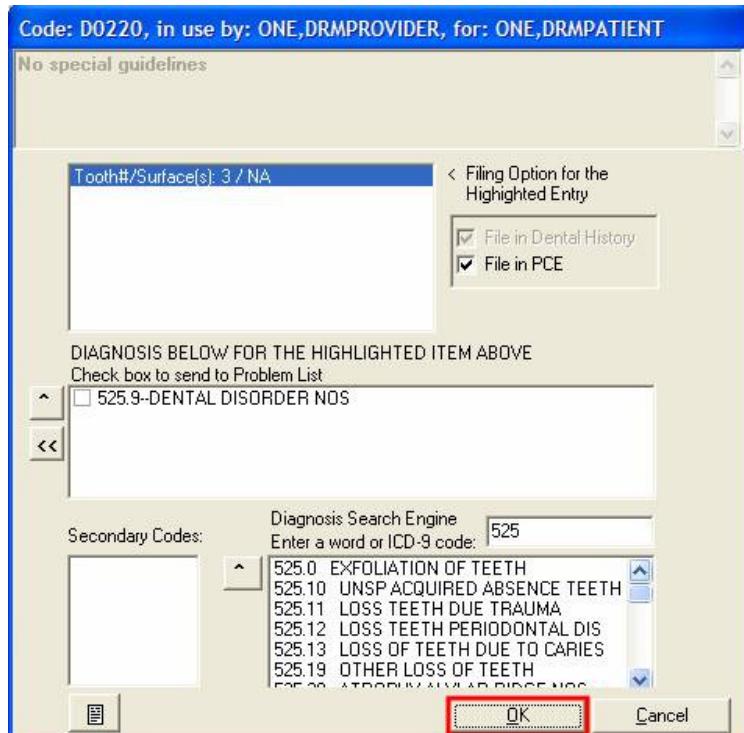


Figure 73: Filing Option/Diagnosis screen

See the discussion above for entries in this box. Assuming no changes are needed, click OK to display the following screen:

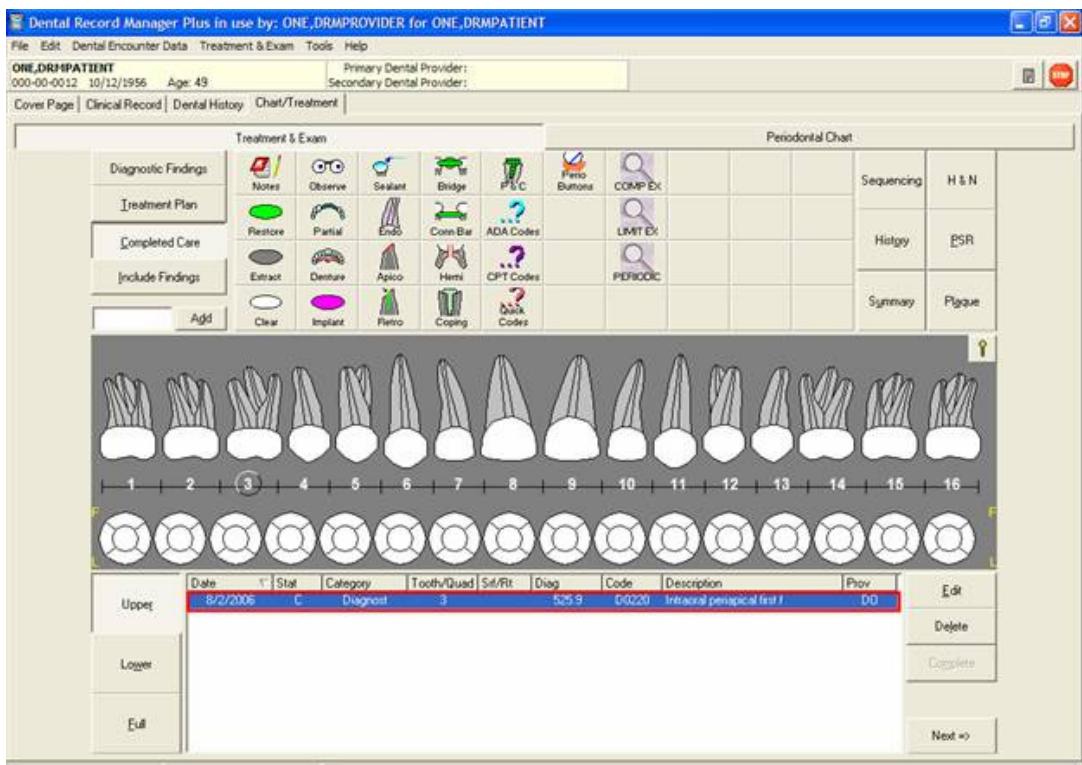


Figure 74: Transaction Table with Entered ADA Code

The entry is shown in the transaction table and the Completed Care procedure will not show on tooth #3 in the graphic chart. Repeat this process as many times as necessary to enter all required ADA codes.

Note: Clicking on a Transaction Table column heading will sort the table. Generally in ascending order dependent on the current view. Clicking the column heading a second time returns the table to the original descending view.

Using the Local Codes icon – Local Codes are medical codes needed to enter procedures planned or performed that do not have an ADA code. Allowing these codes to be selected in DRM Plus is an administrative function which is explained in the Administrative Manual. Clicking on the Local Codes icon displays a screen showing these codes. The selection process and the other requirements are the same as using the ADA codes icon.

Using the Quick Codes icon – Users may develop a Quicklist of codes to simplify the ADA code selection process. Refer to the “Using the DRM Plus Menu Bar” section of this manual for instructions on developing and editing a Quicklist. When the Quick Codes icon is clicked the Quicklist codes are displayed. The selection process and the other requirements are the same as using the ADA codes icon.

Using a Speed Codes icon – User may develop Speed Code icons to further simplify the ADA code selection process. Refer to the “Using the DRM Plus Menu Bar” section of this manual for instructions on developing and editing Speed Code icons. The selection process skips the blue ADA Codes/Description screen which allows the user to select Multi-Add options.

Note: Speed Codes do not have Multi-Add functionality.

Using the Add box – The Add box is located to the left of the icons area. A code, for example D0220, may be entered in this box and Add clicked. The code is immediately entered and the Code Detail box is displayed. This box may also be used to search for a code within the ADA Code box. For instance, a two digit number or search criteria text may be entered in the box, in this example “adjust”. The following box will be displayed:

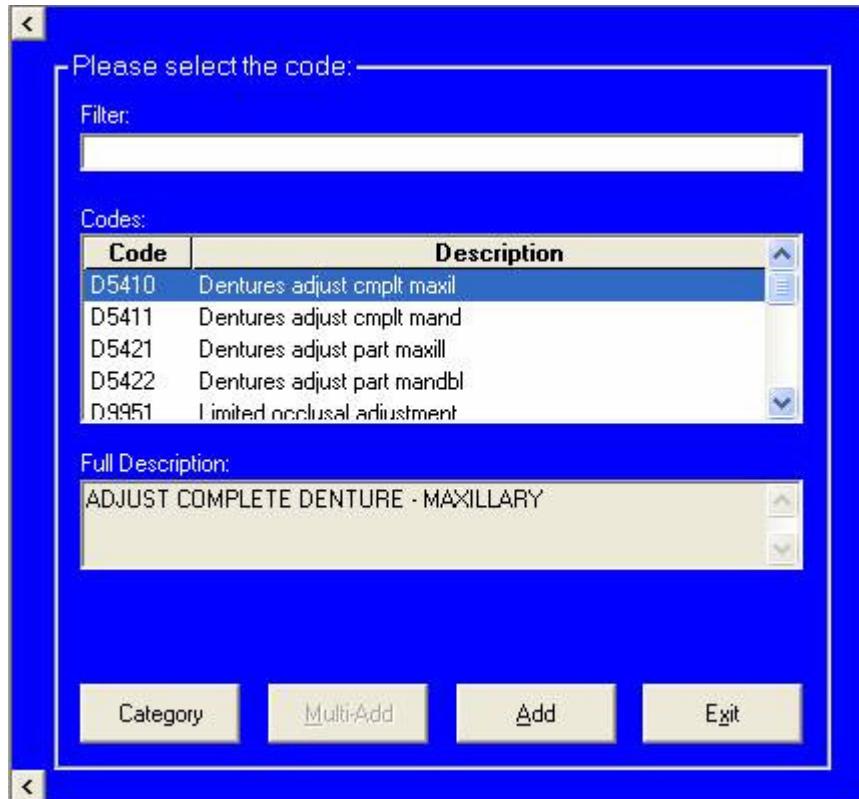


Figure 75: Using the Add box

Completing the selection process and the other requirements are the same as when using the ADA Codes icon.

When all Completed Care ADA codes have been selected, the Next button at the bottom of the screen should be clicked to initiate the DRM Plus process for entering the required encounter data and finalizing and filing the Progress Note in CPRS. Refer to the section called “Completing the Encounter Data and Progress Note” for more information.

Changing the Diagnosis or Designating a Secondary Diagnosis

The Diagnosis Box (center white box) contains the default diagnosis code for the selected procedure code. The Secondary Codes box displays other suggested diagnoses as entered by the dental administrator. To select a diagnosis from the Secondary Codes, double click on the desired diagnosis to move it to the Diagnosis Search Engine box. Use the ^ to move it to the primary Diagnosis box. Using the Diagnosis Search Engine, other diagnoses may be designated to either replace the default diagnosis or to be shown as a secondary diagnosis.

Type an ICD9 code or text related to a diagnosis in the Diagnosis Search Engine box and hit the Enter key.

Highlight the diagnosis to be added. Click on the ^ (Move up) button next to the Diagnosis Search Engine box or double click the entry to add it to the Diagnosis box. The following screen is displayed:

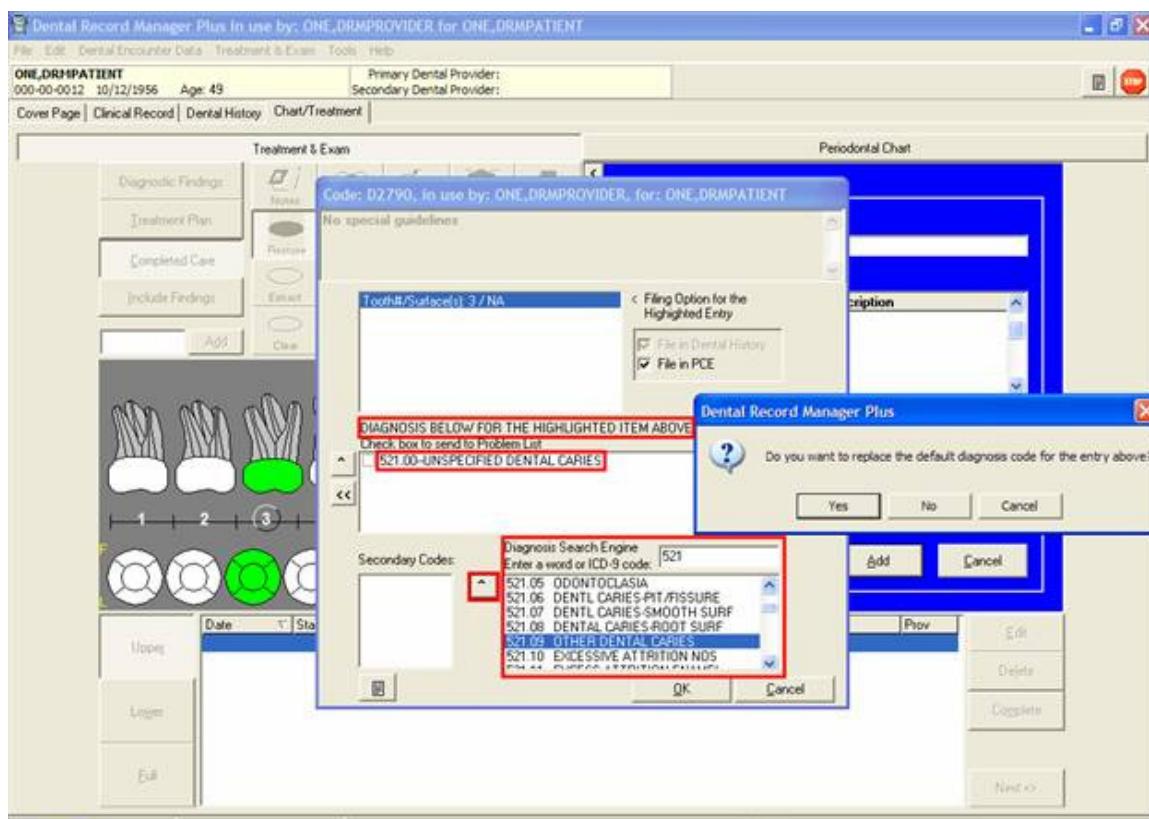


Figure 76: Designating a New Primary or Secondary Diagnosis

If a new primary diagnosis is to be designated, click Yes. If a secondary diagnosis is to be designated, click No. If you made an error, click Cancel.

If you click No, the following screen will appear:

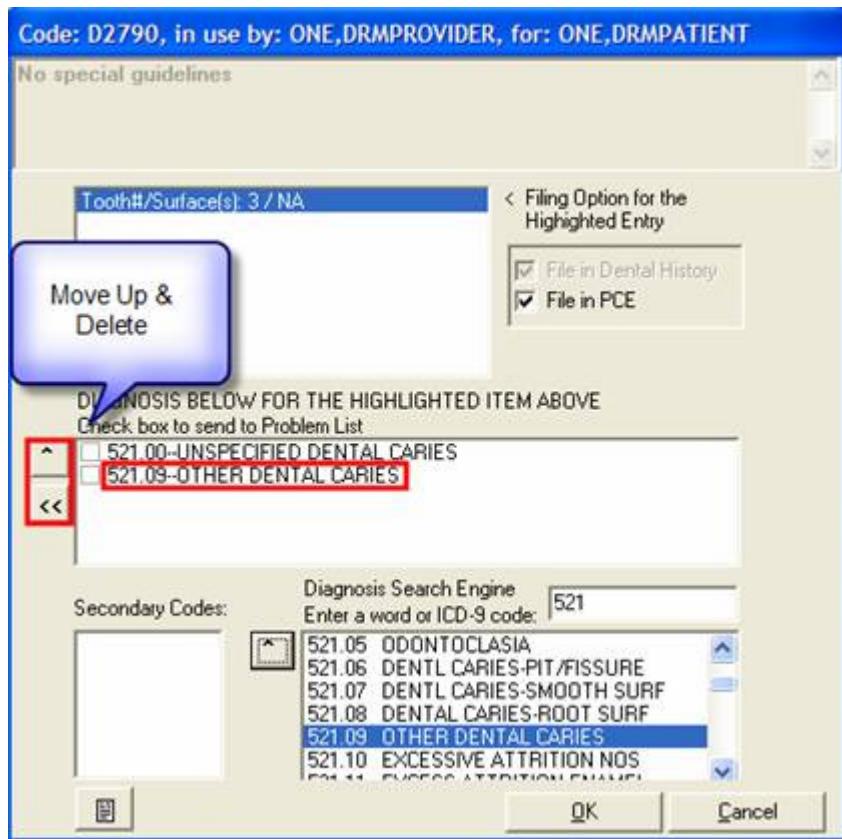


Figure 77: Designating Additional Diagnosis Codes

Up to five diagnostic codes may be added for each procedure code (one primary diagnosis and/or four secondary diagnoses).

After selection of secondary diagnoses, a secondary diagnosis may be designated as the primary diagnosis. Do the following:

Highlight the desired diagnosis. Click on the Move Up button “^” (next to center box) to move a secondary diagnosis to the top of the list, making it the primary diagnosis for this procedure code.

Note: The Delete button (<<) is used to delete any highlighted diagnosis.

Problem List - The checkbox next to the diagnosis may be checked to send this diagnosis to the Problem List when the encounter is finished.

The ADA code selection process should be repeated for as many procedures as needed. The graphic chart selection requirements will change according to the icon selected. The table shown earlier in the section delineates these requirements. Completed Care entries show in the Transaction table with a stat of “C”.

Changing the Diagnosis or Designating a Secondary Diagnosis with the Multi-Add feature –
When the Multi-Add feature has been used, the following diagnosis box will appear when a secondary diagnosis is selected:

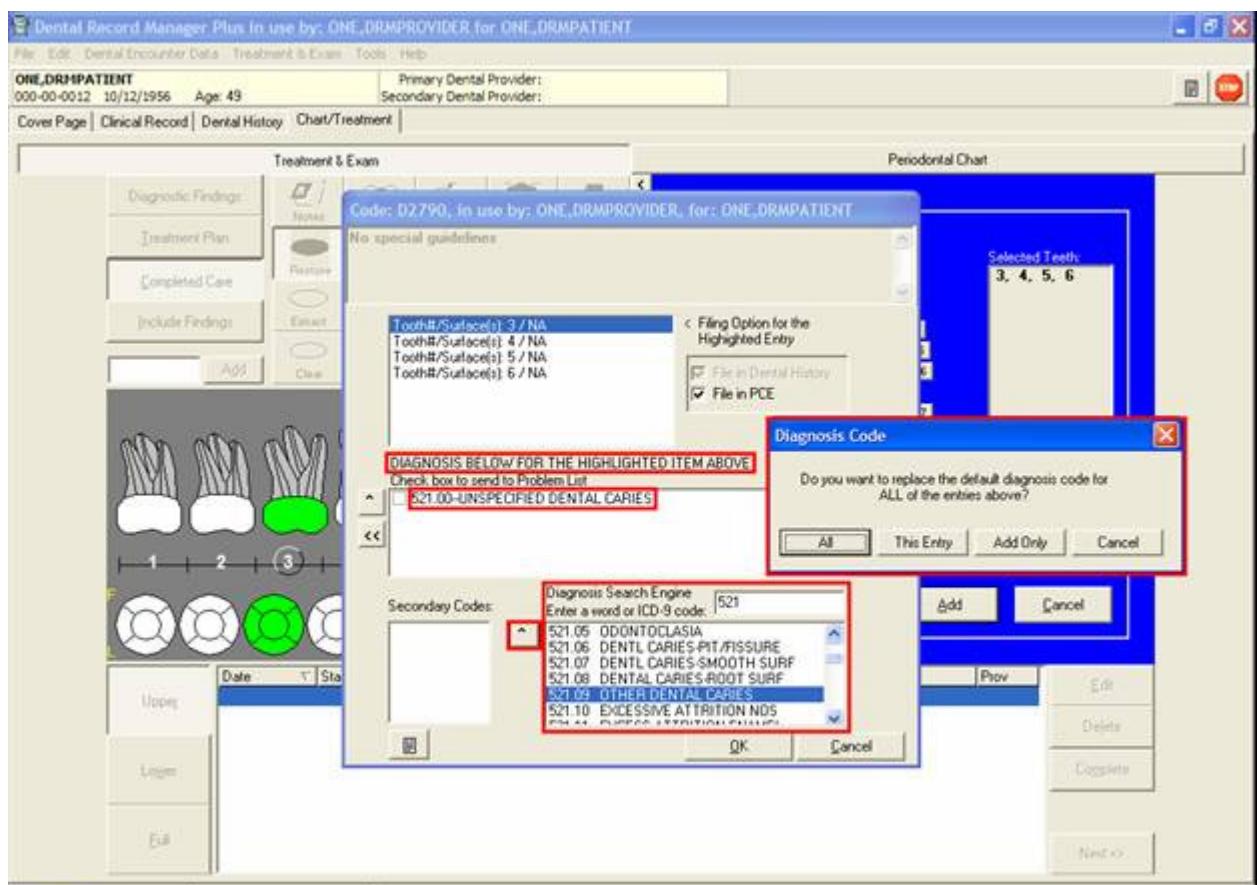


Figure 78: Changing the Diagnosis with Multi-Add Feature

Primary and secondary diagnoses can be designated for each tooth shown by highlighting the tooth (as displayed for tooth #3 in the example above) prior to making any changes or additions to the diagnosis shown in the center box. Clicking All will select the new primary diagnosis to all four procedures. Clicking This Entry will select the new primary diagnosis to this procedure only. Clicking Add Only will include the primary diagnosis with the newly selected secondary diagnosis. Clicking Cancel will close the Diagnosis Code box.

Procedures for Saving Unfiled Completed Care

Procedures for Saving Unfiled Completed Care procedures prior to clicking Finish on the Progress Note screen are explained below. Once the user clicks the Finish button in DRM Plus, the encounter data and the Progress Note (signed or unsigned) is passed to VistA and CPRS. DRM recognizes that a user may not be able to complete all DRM Plus entries in one computer interaction. DRM Plus also recognizes that the changes may need to be to the Diagnostic Findings after reviewing x-rays or consulting with other providers. An option is provided to deal with these issues; Save Unfiled Data. Within this option, the user can save the data either to themselves or to another provider. If the user saves the data to themselves, DRM Plus requires that the provider saving the data must be logged on to restore the data for that patient. This will occur the next time that patient's record is opened. If the user saves the data to another provider, DRM Plus requires that the provider with the stored (or saved) data must be logged on to restore the data for that particular patient. This will also occur the next time that patient's record is opened.

Click on the File drop-down menu and select the option highlighted below.

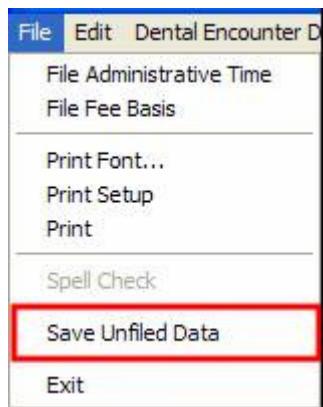


Figure 79: Save Unfiled Data

A pop-up window appears giving the user the option to designate where the data is to be saved.

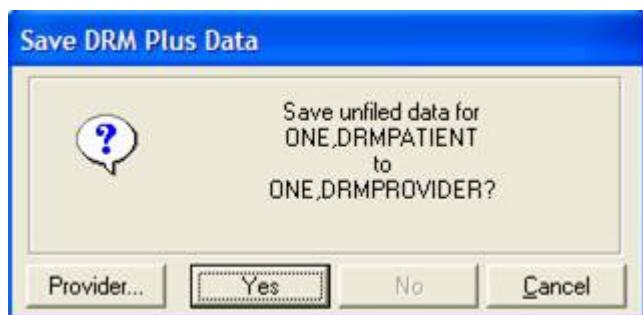


Figure 80: Save Unfiled Data confirmation box

When the Provider option is selected, the following screen appears:

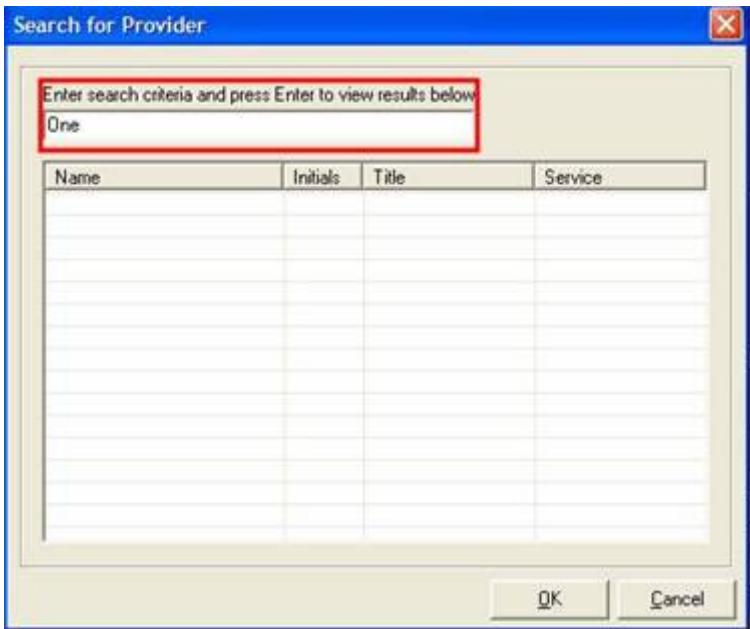


Figure 81: Search for Provider

The desired provider's name should be entered in the search criteria's box.

When the Enter key is pressed, the following screen appears:

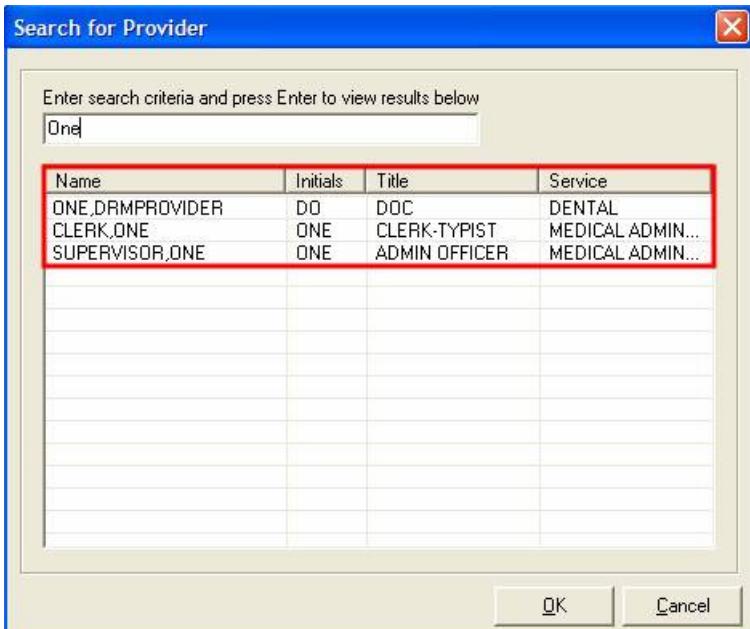


Figure 82: Select Provider

Highlight the provider's name that will receive the unfiled data and click on the OK button. The next screen that appears will ask if the unfiled data should be saved to the selected provider. Click on the OK button and the designated provider now may restore the saved data.

Depending on the option selected, one of the following boxes will appear confirming that the unfiled data has been successfully saved.



Figure 83: "Unfiled data saved successfully" messages

DRM Plus will save the entries already made. The user may now close DRM Plus, minimize DRM Plus, or change DRM Plus to a different patient.

When the user re-enters DRM Plus and selects the same patient, DRM Plus will present a dialogue box notifying the user of the saved information. Clicking "Yes" brings the saved information into the Treatment & Exam screen. The encounter can then be completed in the usual manner.

Note: If the user attempts to close DRM Plus or switch to a different patient, DRM Plus will display a pop-up box asking the user if the current patient's entries should be saved. Clicking "Yes" initiates the same save function.

The following scenarios may apply:

Scenario #1: The user has not finished all DRM Plus entries (Finish not clicked) and must leave the workstation to attend to other duties.

Scenario #2: A dental assistant has entered data during the patient encounter and wants to save the data to the dentists who can then complete the entries and Progress Note.

Synchronization of Planned and Completed Care

Exact and potential duplicate transactions will be processed by the application before filing to the database. Users should complete “planned” items either from the sequencing screen or from the transaction list, but this does not always occur which create duplicate transactions. **Exact duplicates will result in the planned item being deleted AUTOMATICALLY without user intervention!** For example, a planned D2330, Resin one surface-anterior transaction on tooth 6 and a new completed procedure of the same DCode and tooth# will result in deletion of the planned item when the user clicks 'Next'. The user will not be shown the two duplicate transactions!

Potential duplicates are any transactions which occur on the same tooth #. This may be a planned D2330, resin one surface-anterior transaction on tooth 6 with a completed D2331, Resin two surface-anterior transaction on tooth 6. Another example is a partial being replaced by a bridge.

Potential Duplicate Transactions!

These transactions have already been **PLANNED** for the following teeth:

Tooth	ADA Code	Description	Keep	Delete
6	D2330	Resin one surface-anterior	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9	D2750	Crown porcelain w/ h noble m	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9	D4341	Periodontal scaling & root	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10,13	D5213	Dentures maxill part metal	<input type="checkbox"/>	<input checked="" type="checkbox"/>

These are the **COMPLETED** transactions you just entered:

Tooth	ADA Code	Description	Keep	Delete
6	D2331	Resin two surfaces-anterior	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9...11	-----	Bridge	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Keep Planned Keep Completed Let Me Decide Back Cancel Continue

Figure 84: Potential Duplicate Transactions screen

This screen is displayed for the user to process potential duplicates. The "Keep Completed" is the default option for the Potential Duplicate Transactions screen. The user may keep everything, or selectively keep/delete when the radio button is set on 'Let Me Decide', or may quickly process (keep) all the planned items and delete the completed items by clicking the 'Keep Planned' button. The user may also click 'Keep Completed' which causes all planned items in the list to have the Delete button pre-selected and all the completed items to default to 'Keep'.

- **"Back"** processes the selections and goes back to the chart to view the changes.
- "Cancel" goes back to the chart without making any potential deletes.
- "Continue" processes the selections and goes forward to the second DRM Plus screen.

Note: "Keeping" a planned item does NOT "complete" it. If you want to complete the planned item, then you must go back to the Treatment Plan transaction table or Sequencing screen and complete from there.

Using the Periodontal Chart Screen

Overview

The Periodontal Chart screen allows the user to enter periodontal findings. The icons used in this application are condition-specific, allowing a graphic charting display as well as the identification of the periodontal exam critical elements in a periodontal table. The critical elements charted are pocket depth, FGM, MGJ, bleeding, delayed bleeding, suppuration, mobility, and furcation.

Similar to the Treatment & Exam screen, the Periodontal Chart screen is divided into three sections: upper, middle, and lower. The upper section displays the condition-specific icons with numeric values when appropriate. The upper section also displays the buttons used to change the teeth views, the cursor navigation buttons, and the special use buttons. The middle section displays the graphic chart of the upper or lower arches reflecting the recorded conditions. The lower section displays a transaction table showing the numeric and alpha representations of all recorded conditions.

Changing the Screen View

The view of the arches shown on Graphic Chart and Periodontal Table components can be changed by clicking on the appropriate buttons.

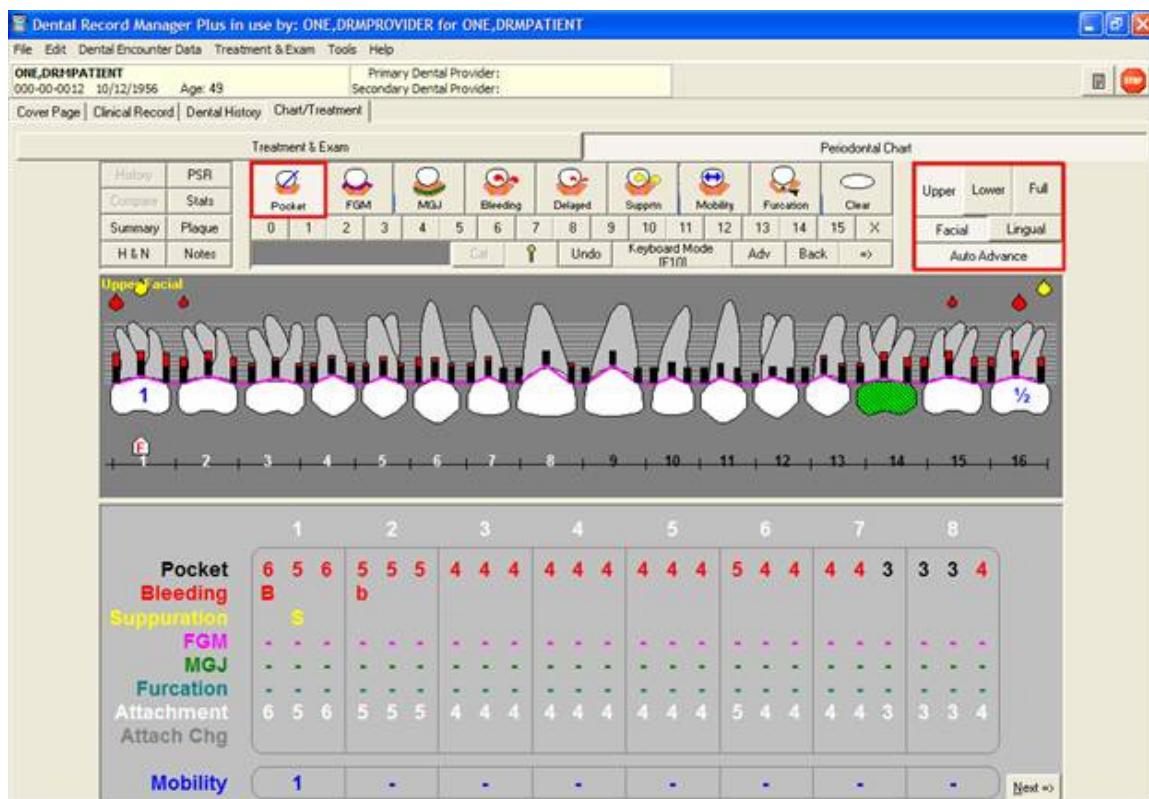


Figure 85: Changing the Periodontal Chart Screen View

When opening the Periodontal Chart screen previously entered, Diagnostic Findings and Completed Care will be displayed. The Periodontal Chart screen defaults to an Upper/Facial view. Clicking on the Upper, Lower, Facial or Lingual buttons changes the view accordingly. Clicking on the Full button displays a full mouth view. Data entry is not available on the full view screen.

Entering a New Exam – The view displays all periodontal data that has been previously entered on the last exam. If the provider does not want the previous entries to be displayed because the user is entering a new exam, the Clear button clears the entire screen and allows new entries to be made. Clearing the Perio Chart should be the first action completed before entering any data into the Periodontal Chart screen. This allows new Diagnostic Findings and Completed Care data to enter into the graphics of the Periodontal Chart screen. Clicking on the Clear button displays the following box:

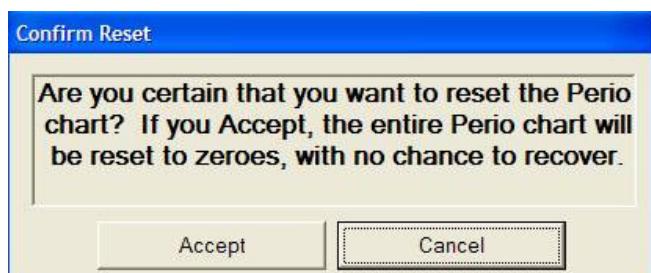


Figure 86: Periodontal Chart Confirm Reset box

Click the Accept button to display the screen without previous entries.

Note: The History button maintains the entries from previous examinations.

Note: Only one Periodontal Chart exam is allowed to be completed in a Progress Note per day. When a second exam is completed during the same 24 hour period, the Periodontal Chart history will only save the second exam. Progress Notes would still have all the data entered.

Selecting Teeth/Surfaces or Using the Auto Advance – The Periodontal Chart screen defaults to the Auto Advance feature highlighted in the next figure. This feature automatically advances the chart marker (shown by the arrow) to the next area for charting purposes. The default starting point for the chart marker is tooth #1, Pocket D. The sequence of the chart marker movements can be changed to accommodate personal preferences (See the section called “Using the DRM Plus Menu Bar”). The direction of the chart marker movement in the Auto Advance mode is determined by the selection of the “=>” button. The movement of the chart marker is effected by the condition-specific icon selection.

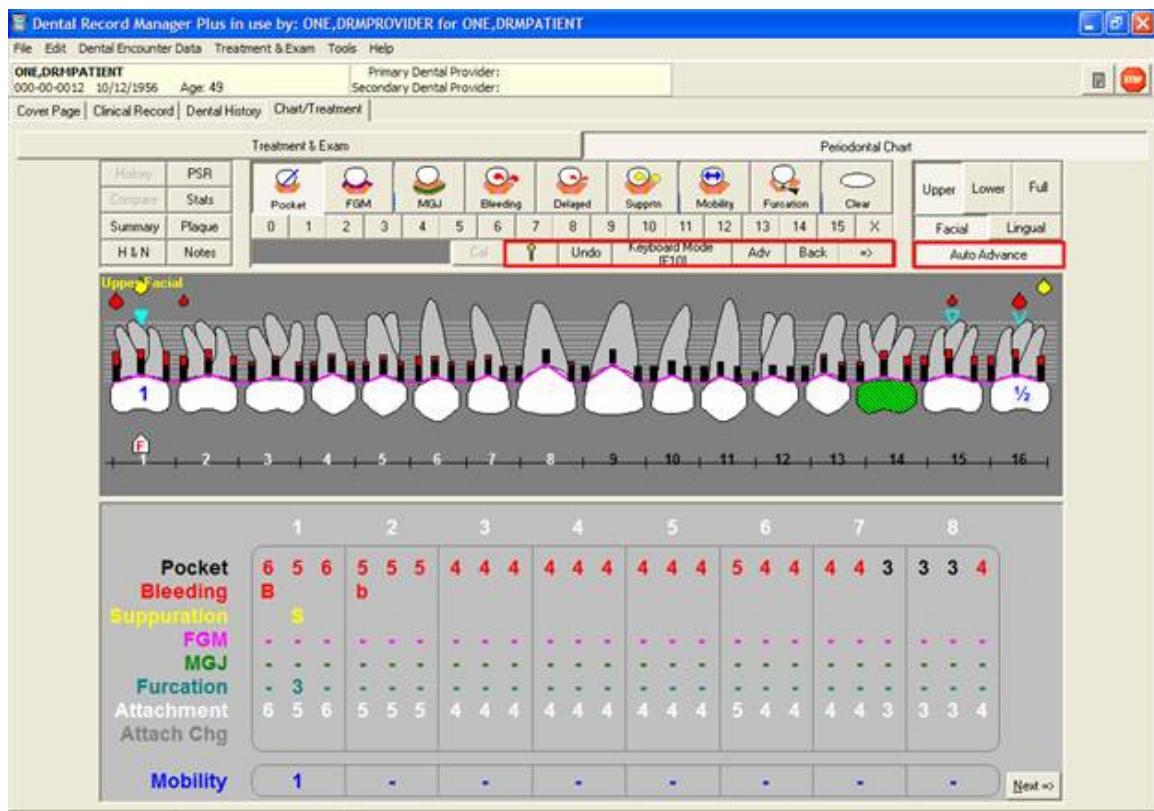


Figure 87: Selecting Teeth/Locations or Using the Auto Advance

Teeth/Locations can be selected by clicking the distal, facial/lingual or mesial pockets with the mouse or by using one of the other buttons highlighted in the screen shot above.

Adv/Back buttons – This feature, when selected, manually advances the chart marker to the next pocket of charting.

Note: The direction of advancement depends on the selection of the “<=” button.

Keyboard Mode (F10) – This feature turns off all other features and allows the movement of the chart marker to be made by using the keyboard.

Note: All data entry to the Periodontal screen may be done from the Keyboard. Instructions for this functionality are included in Appendix C.

Undo button – This feature undoes the last entry and can be repeatedly selected to undo more than one entry (limited to nine clicks).

Keyboard Entry – Clicking the Key button displays the required key strokes needed for keyboard entry.

Using the Condition Specific Icons

The nine icons highlighted in the screen shot below allow the user to chart the critical elements of a periodontal examination.

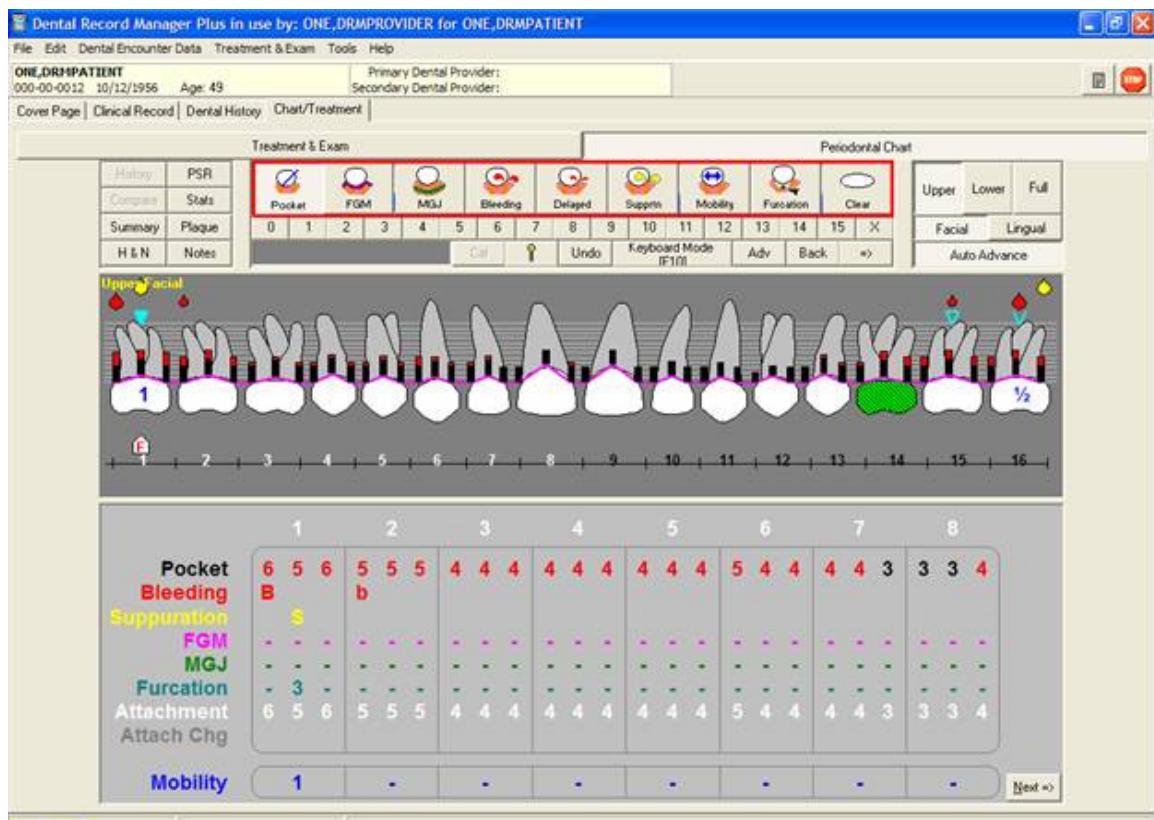


Figure 88: Using the Condition Specific Icons

The charting process begins by placing the chart marker on the appropriate tooth/surface/root. The condition specific icon is clicked and, if appropriate, the measurement value is clicked. Upon completion of this process, a graphic display is shown on the graphic chart and a value is entered in the transaction table.

Each icon uses a specific graphic display, a pre-defined measurement scale and an alpha/numeric entry in the periodontal table. The measurement scale is activated when the icon is clicked.

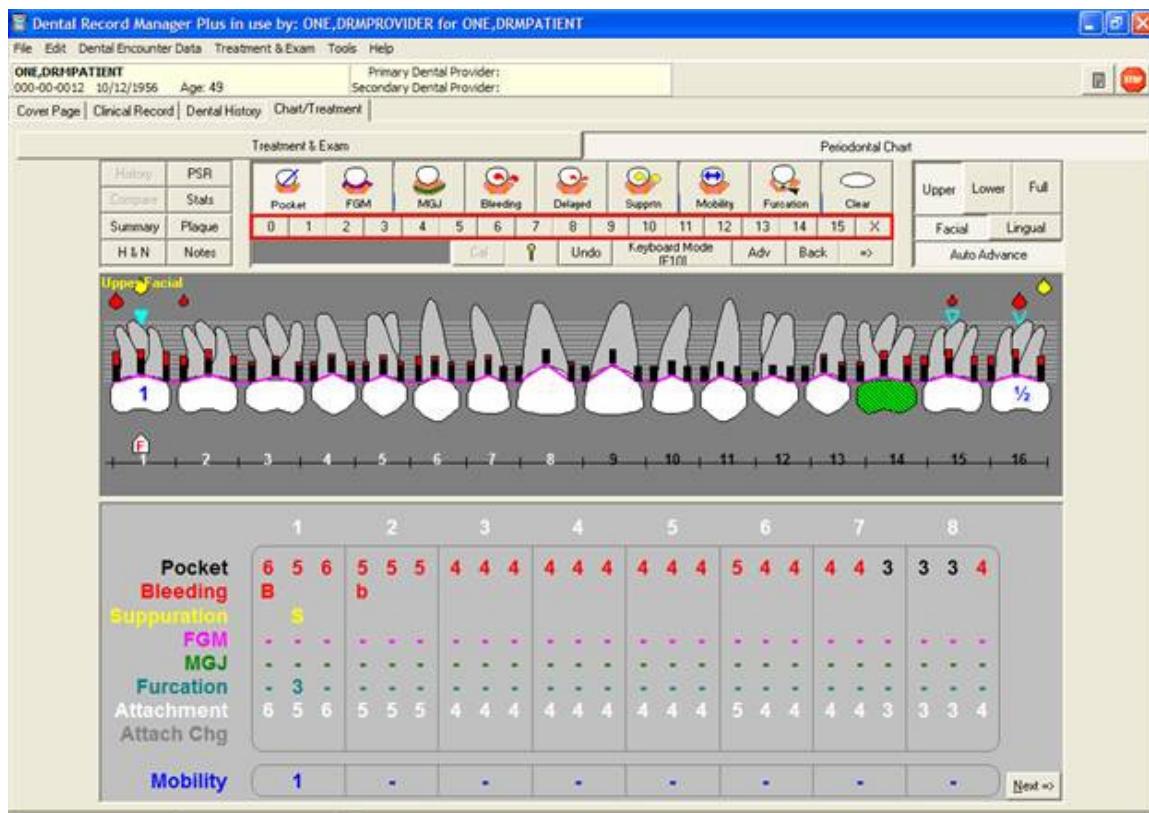


Figure 89: Measurement Scale

The “X” which is located on the Pre-defined Measurement Scale will result in a null entry in the transaction table for the Pocket, FGM, MGJ, Mobility, and the Furcation icons. This null entry only works when the specific icon is active for Pocket, FGM, MGJ, Mobility, and/or Furcation. The null entry will remain as a “–“ mark in the transaction table and no entry in the Progress Note.



The Pocket icon uses a measurement scale chart from 0 to 15 & X, which is shown in the transaction table. A bar displays the pocket depth on the graphic chart. Warning level depths can be designated for display (See the section called “Using the DRM Plus Menu Bar”).



The FGM icon uses a measurement scale of +5 to 10 & X, which is shown in the transaction table. A pink line graphic shows the values in the graphic chart.



The MGJ icon uses a measurement scale of 0 to 15 & X, which is shown in the transaction table. A green line graphic shows the values in the graphic chart.



The Bleeding icon allows a “red, oval-shaped drop” to be placed in the graphic chart at the area where the bleeding was observed. A red “B” is displayed in the transaction table.



The Delayed Bleeding icon allows a “small red, oval-shaped drop” to be placed in the graphic chart at the area where the delayed bleeding was observed. A red “b” is displayed in the transaction table.



The Suppuration icon allows a “yellow, oval-shaped drop” to be placed in the graphic chart at the area where the suppuration was observed. A yellow “S” is displayed in the transaction table.



The Mobility icon uses a measurement scale of 0 to 3 (by ½ ‘s) & X, which is shown in the transaction table. This value is displayed in the graphic chart in blue on the appropriate tooth.



The Furcation icon uses a measurement scale of 0 to 4 & X, which is shown in the transaction table. A light blue triangle graphic shows in the graphic chart depending upon the value chosen. The respective symbols are $\vee \nabla \blacktriangledown \blacklozenge$.

Correcting Entry Errors: If the error is recognized immediately the Undo button can be used. Otherwise, place the cursor 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 (zero can be entered). A zero entry will result in no graphical view; however, it will result in a zero entry in the transaction table and Progress Note. If the incorrect entry is for Bleeding, Delayed Bleeding, or Suppuration, click on the appropriate icon, the graphic display and the table entry will be removed.

Initiating Progress Note from the Perio Screen

If no Completed Care procedures have been entered on the Treatment & Exam screen, clicking Next on the Perio screen displays the following screen:

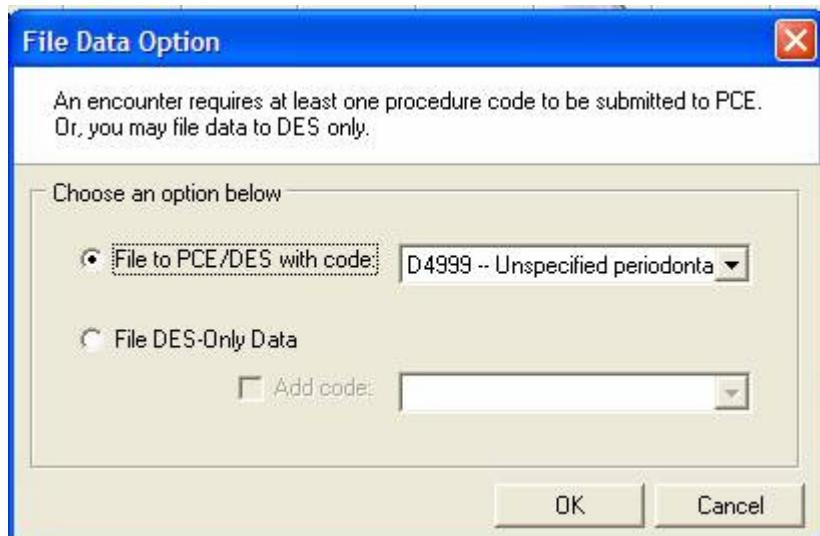


Figure 90: Initiating Progress Note from the Perio Screen

This File Data option box defaults to the normal Perio filing options and code D4999. To select a different code, click on the down arrow to display the following screen:

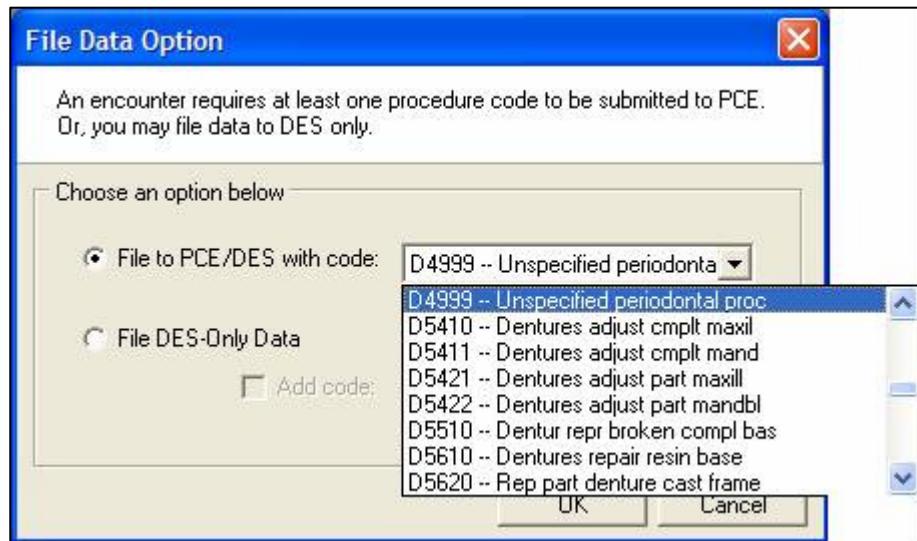


Figure 91: File to PCE/DES with code

Scroll to the appropriate code, highlight and click OK to complete the process.

If the provider needs to file to DES in a data only entry, the radio button File DES-Only Data button should be selected and the OK button clicked to begin the process of finalizing the encounter.

If the provider needs to file to DES only with a code, the Add Code box should be clicked, allowing the down arrow to be clicked and the appropriate code selected as displayed in the next figure.

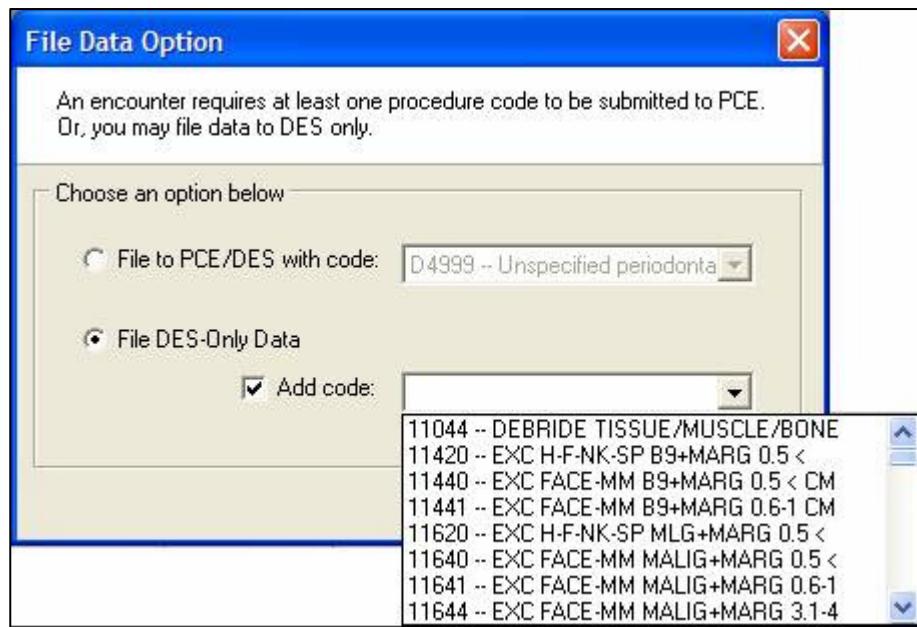


Figure 92: File to DES Only with a Code

Clicking on the OK button finalizes the process.

Displaying Perio Exam Findings in the Progress Note – Assuming a comprehensive perio exam has been performed, the exam findings will appear in the Progress Note in the following format:

Figure 93: Displaying Perio Exam Findings in the Progress Note

Each tooth is displayed with each surface and condition shown in the vertical column under the tooth number. The key at the bottom of the note explains certain symbols. The statement at the bottom of the note informs other providers that the note contains data from the current exam as well as data that has not changed from previous exams.

Note: The ability to save unfiled perio data is the same as has been discussed in the Diagnostic Findings, Treatment Plan, and Completed Care sections of this manual.

Using the Special Buttons Displayed on the Perio Screen

Eight special buttons are highlighted in the next figure. The Notes, H&N, Summary and Plaque special buttons are discussed and their use explained in the section called “Using the Special Buttons”.

The History (Periodontal), PSR, Compare, Stats and Summary special buttons will be discussed in this section because they are specifically relevant to the Periodontal Chart screen.

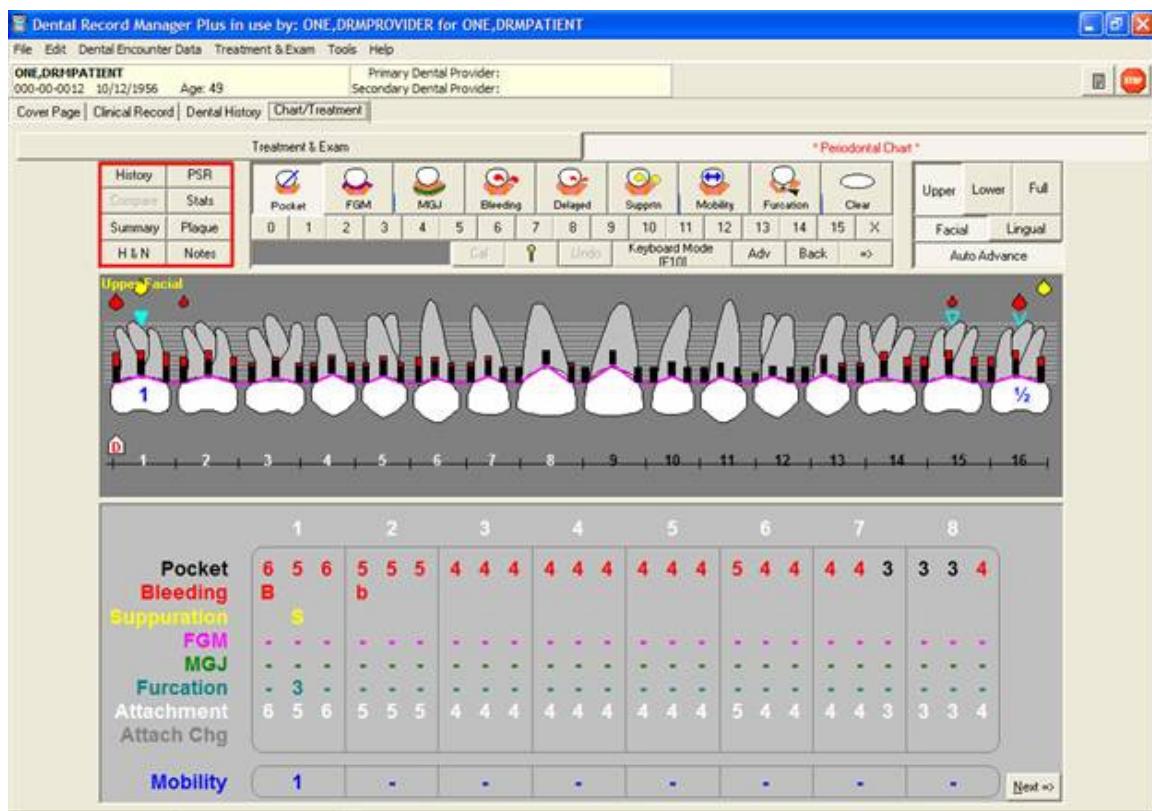


Figure 94: Special Buttons Displayed on the Perio Screen

Clicking on the History button displays the following screen:



Figure 95: Periodontal History Screen

A full mouth view is displayed showing all periodontal conditions by date selection as well as Diagnostic Findings and Completed Care (not including surfaces, roots, etc.). A Notes tab is available for viewing notes previously entered.

The date of the latest periodontal entry is shown in the highlighted drop down date box. Clicking on the drop-down arrow displays the history at previous dates.

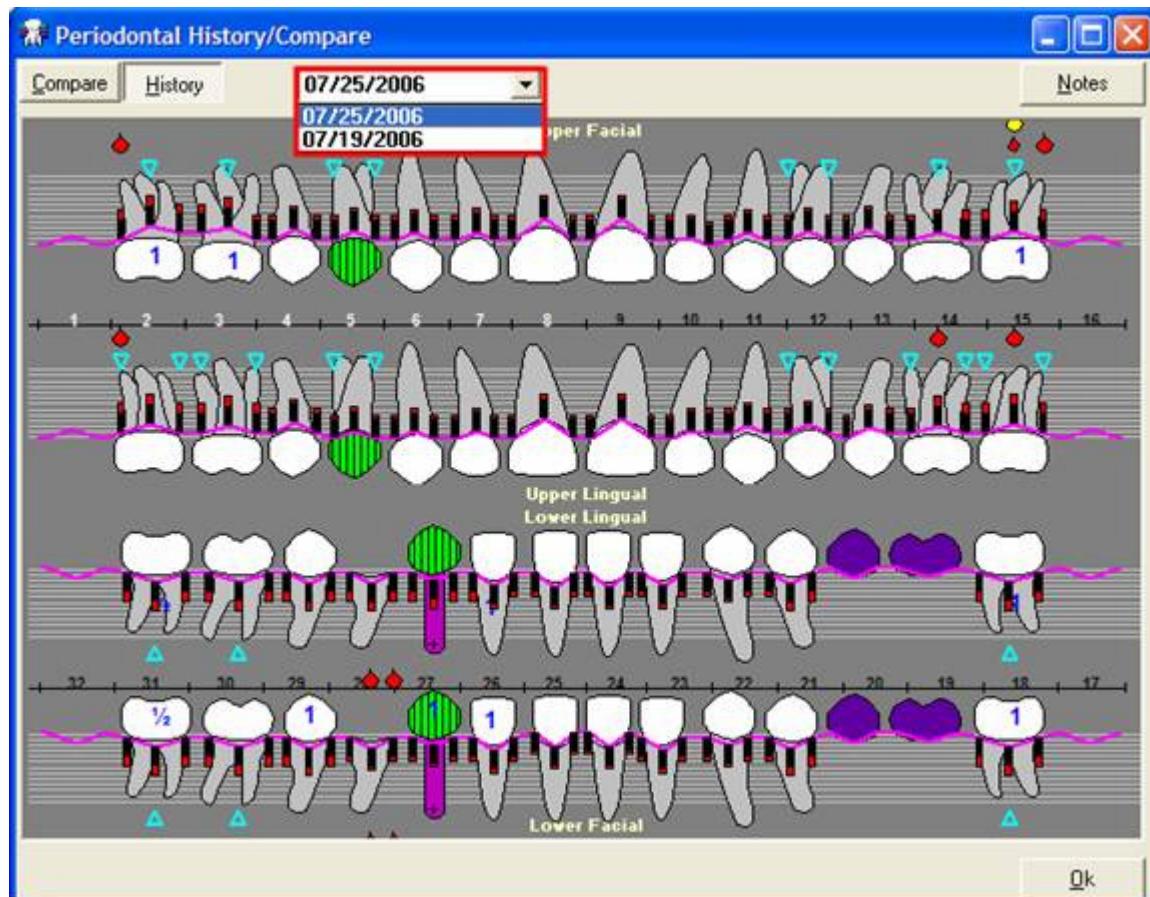


Figure 96: Periodontal History Screen by Date

Clicking on the desired date shows all Diagnostic Findings and Completed Care history (not including surfaces, roots, etc.) of that date.

Clicking on the Compare button displays the following screen, which traces the pocket depth (including attachment loss) for the selected dates. The dates for “From” and “To” comparisons may be selected by clicking on the date box.

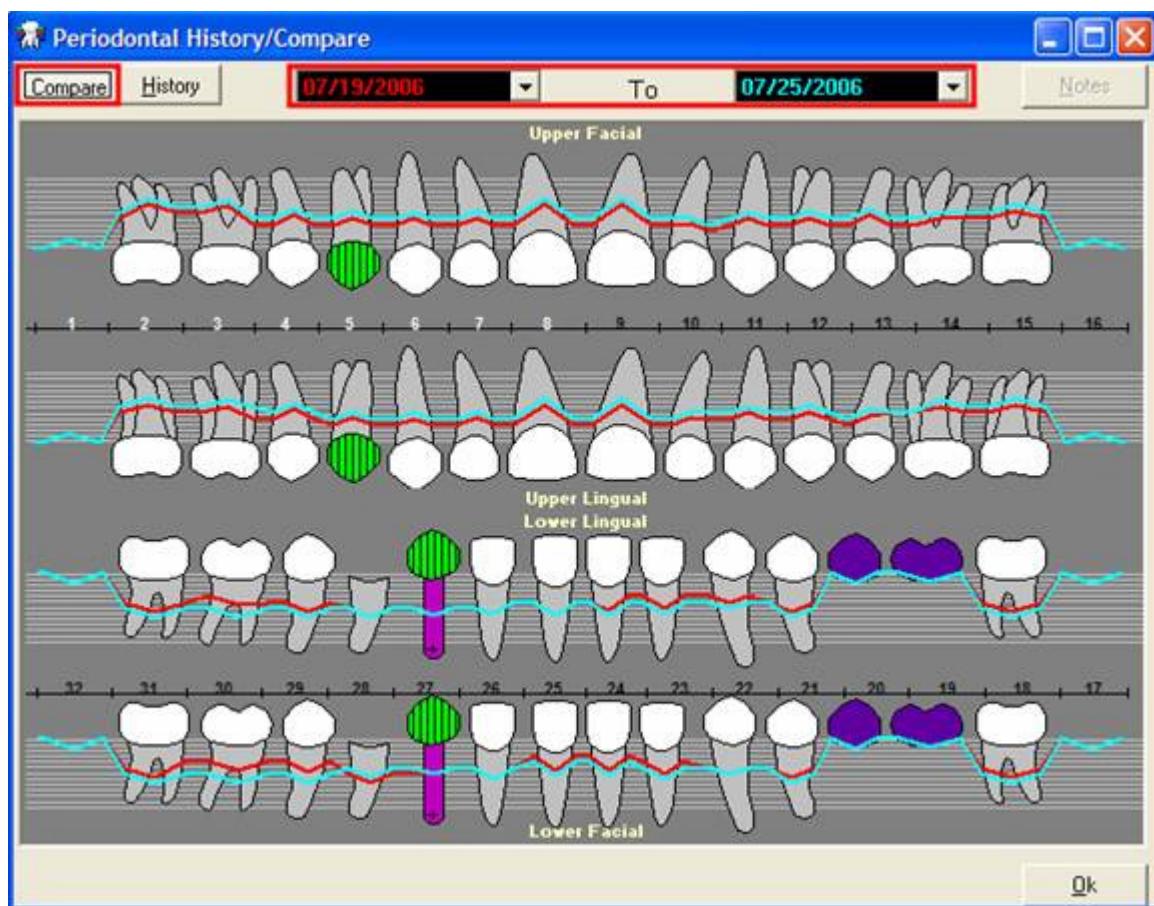


Figure 97: Periodontal History/Compare

Clicking on this Compare button on the Periodontal screen displays the same screen as when the Compare button is clicked from within the History screen.

Clicking on the PSR (Periodontal Screening/Recording) button allows recording of values for selected sextants. Clicking on the Definitions button displays a listing and description of the available values. Clicking in the Sextant boxes allows values to be entered. Clicking OK completes the process.

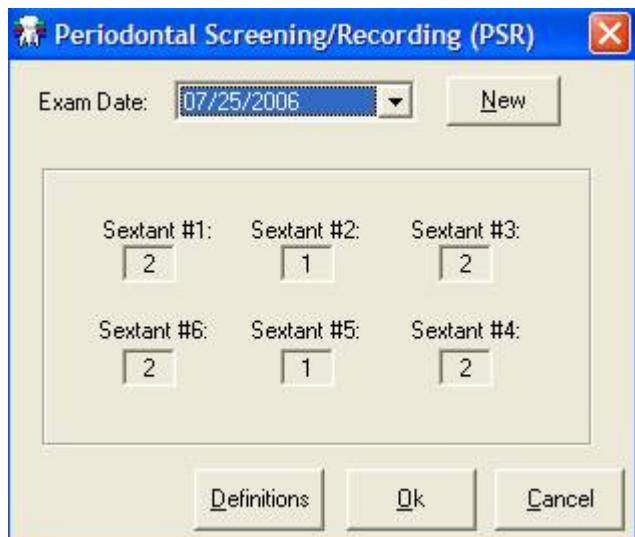


Figure 98: Periodontal Screening/Recording (PSR)

Note: This Button works the same as when it is clicked from the Treatment and Exam Screen.

Clicking on the Stats button displays the Periodontal Statistics chart illustrated below.

Description (Warning Level)	Teeth <= Warning	Sites <= Warning	Teeth > Warning	Sites > Warning
Pocket Depth (4)	0	0	26	156
Free Gingival Margin (4)	26	156	0	0
Mucogingival Junction (3)	26	114	0	0
Furcation (2)	0	0	9	26
Bleeding (0)	22	147	4	9
Delayed Bleeding (0)	25	155	1	1
Suppuration (0)	25	155	1	1
Mobility (1)	19		7	

Figure 99: Periodontal Statistics

Note: Warning levels can be changed and then displayed. The Pocket Depth warning level in the Statistics tab must be the same as the Pocket Depth Warning in the Periodontal tab. (See the section called “Using the DRM Plus Menu Bar”).

Clicking on the Summary button displays the following screen:

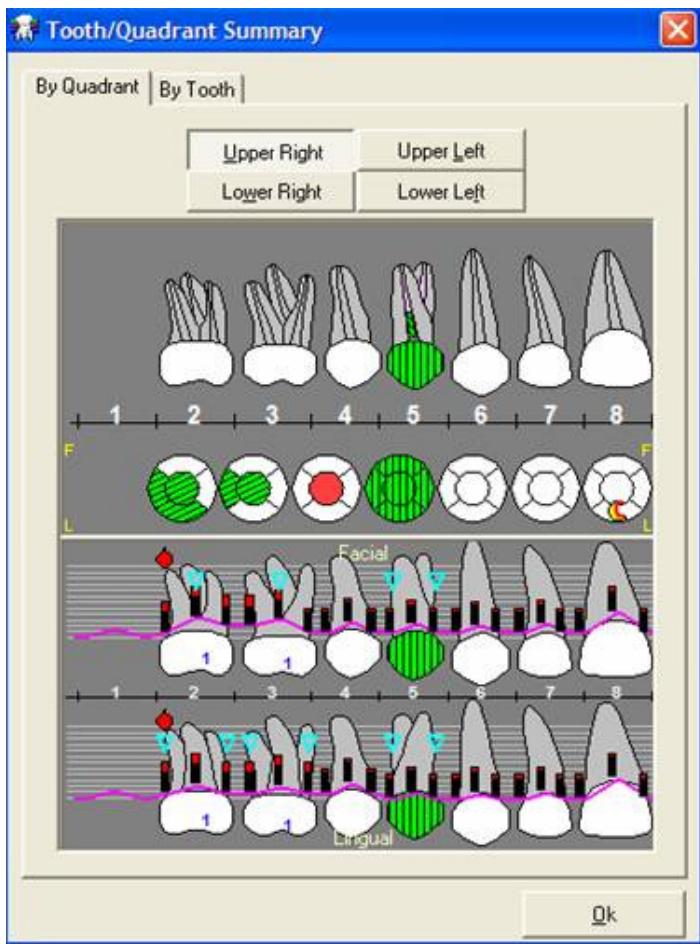


Figure 100: Summary by Quadrant

Clicking on the quadrant buttons changes the view to the desired quadrant. All entered periodontal conditions of the latest exam, Diagnostic Findings and Completed Care are displayed.

Clicking on the By Tooth tab displays the following screen:

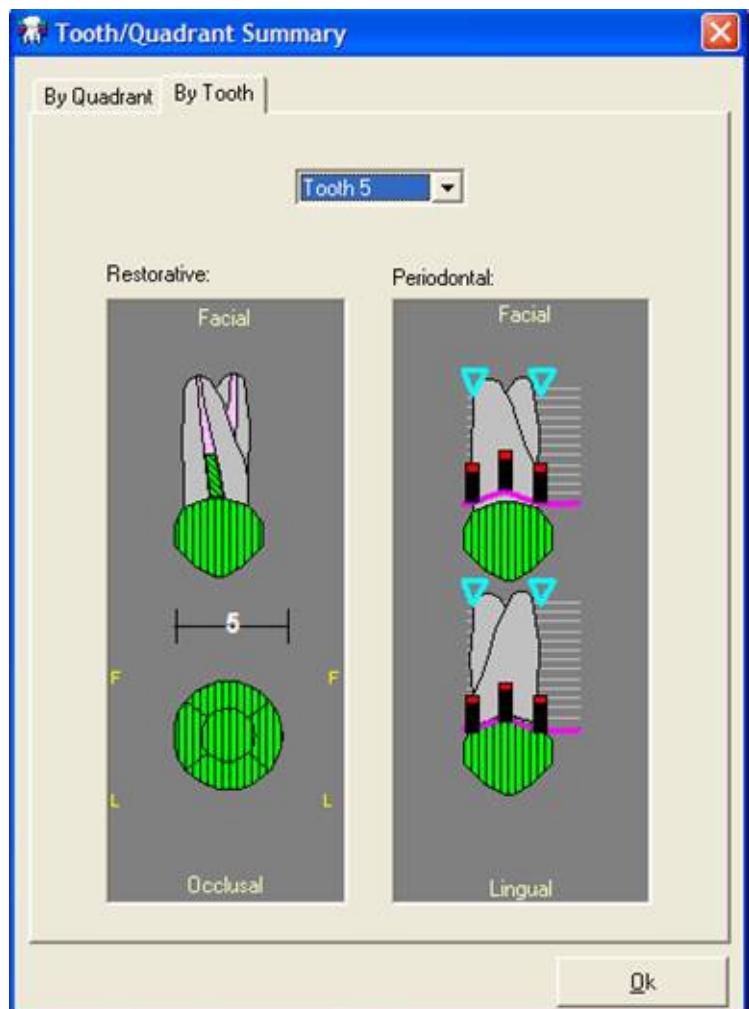


Figure 101: Summary by Tooth

Clicking on the tooth box drop down arrow allows changing the tooth view. All entered periodontal conditions of the latest exam, Diagnostic Findings and Completed Care are displayed.

Completing the Encounter Data & Progress Note

Overview:

Once all ADA codes have been entered from the Completed Care or Treatment Plan screens, the required DRM Plus process for entering encounter data and completing the Progress Note begins by clicking Next on any of these screens. This process requires the following steps:

- designating the appropriate Visit Date/Time.
- designating the appropriate Progress Note Filing Option.
- designating the patient's Dental Category.
- designating the appropriate Disposition.
- designating the Primary PCE Diagnosis for the visit.
- designating any Service Connection.
- identifying Additional Providers and Additional Signers (if any).
- designating the appropriate Station.
- selecting the Note or Consult Title.
- editing and finalizing the Progress Note.
- finishing the Note.
- dealing with any cosigner requirements.

These requirements are met by utilizing various DRM Plus screens. Entering the appropriate information on the screens is discussed in this section.

When the Next button is clicked, the following screen appears if you entered a procedure in Completed Care or completed a procedure in Treatment Plan (Tx Sequencing screen). The Potential Duplicate Transactions screen may pop up first; refer to the “Synchronization of Planned and Completed Care” section in the manual.

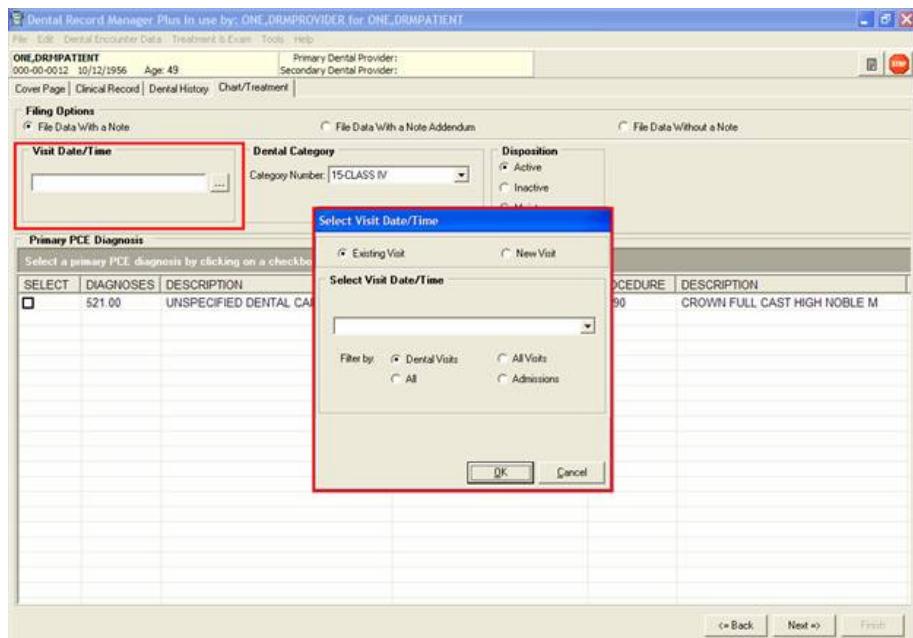


Figure 102: Completing the Encounter Data and Progress Note 1st screen

Select Visit Date/Time

By clicking the down arrow in the Visit Date/Time window, a listing of visits and admissions appears depending on the Filter by radio button selected. This screen defaults to displaying only Dental Visits. Click on the appropriate visit to associate it with the encounter.

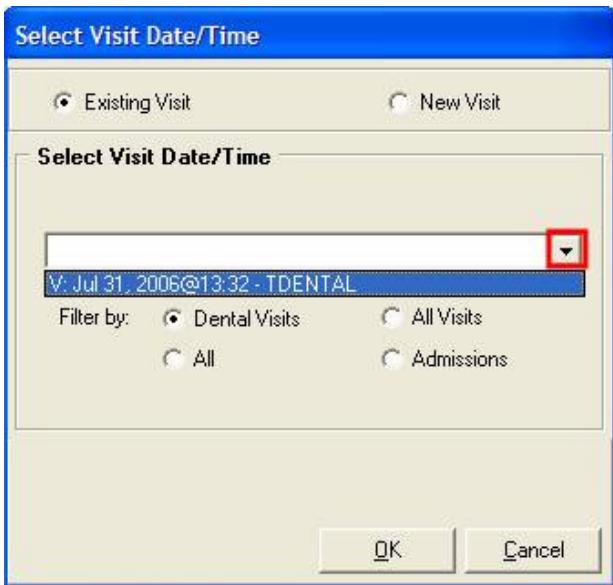


Figure 103: Select Visit Date/Time

Note: Use the scroll bar to display all visit choices.

If a New PCE Visit is to be established, click on the New Visit radio button to display the Select Visit Date/Time screen as illustrated below:

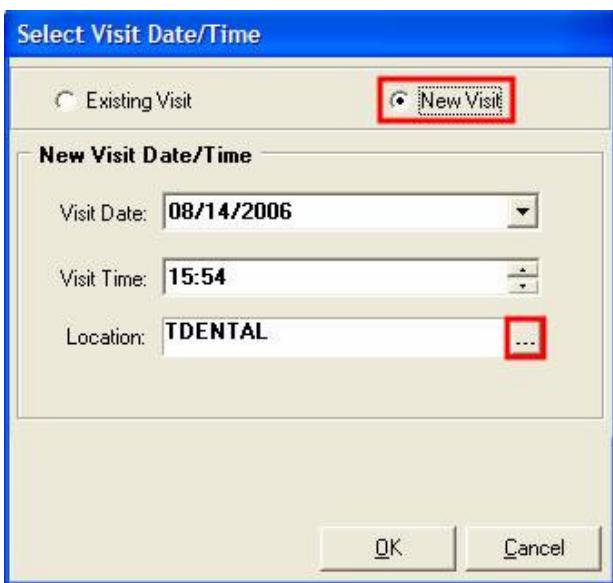


Figure 104: Establish New PCE Visit

Choose the Visit Date and Time for the New PCE Visit by using the arrows to the right of the respective boxes. To designate a location, click on the ellipse button (box with three dots) as indicated in the previous screen which displays the Section Location screens:

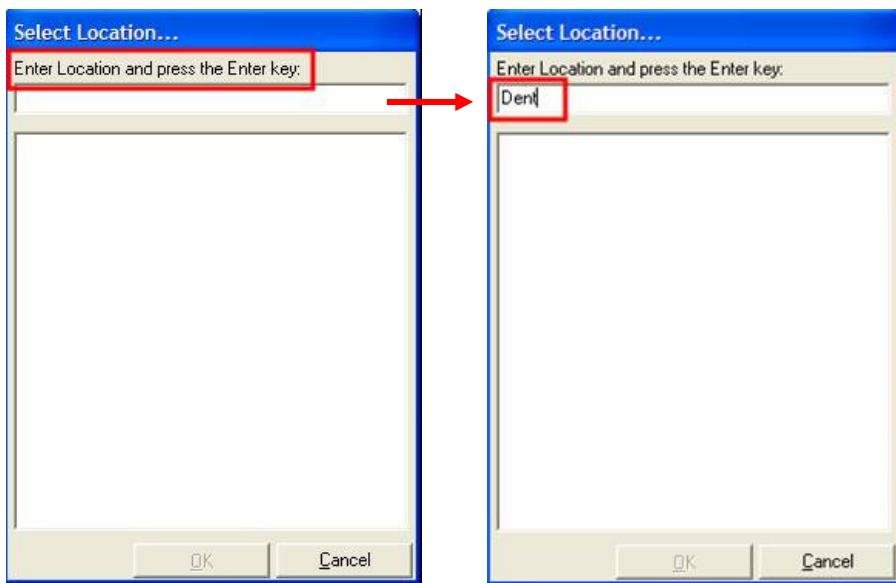


Figure 105: Select Location

- Select the location by entering the location name (enter the first three or four letters of the clinic name).
- Press Enter; a listing of clinic locations will appear.
- Highlight the clinic location for this encounter.
- Click OK to complete the process.

When PCE Visit creation is not allowed "on the fly" by the administrator of DRM Plus, then users will be forced to select an existing visit for their DRM Plus data.

The Select Visit Date/Time screen will show the selection of a New Visit is not allowed.

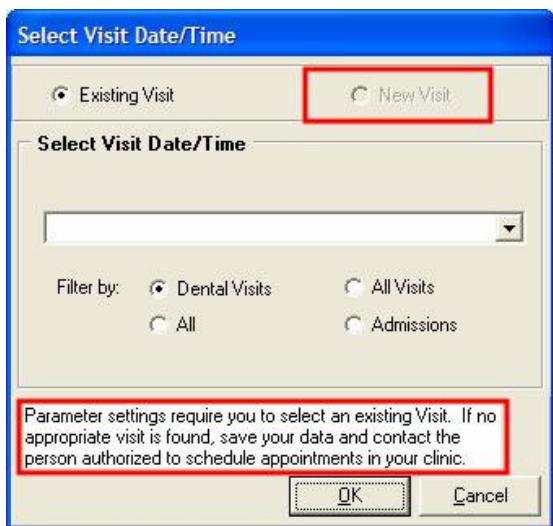


Figure 106: New PCE Visit not allowed

Selecting a Default Location

To enter the user Settings, click on the Tools menu and choose the User Options option. Then click on the Treatment System tab. To select a default location, click on the ellipse button (box with three dots) located to the right of the text area. The user can then type in the appropriate location that corresponds with new appointments when a visit has not been scheduled through the appointment management package.

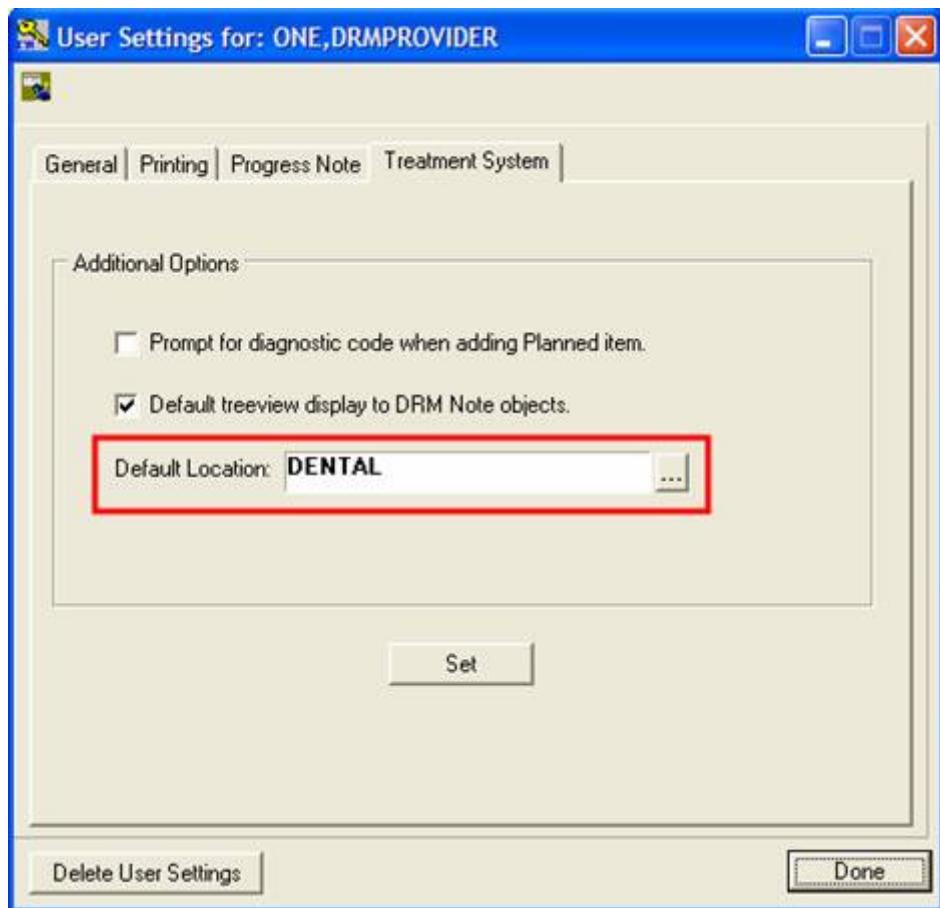


Figure 107: Selecting a Default Location

Primary Diagnosis and Other Options Screen

When OK is clicked on the Select Visit Date/Time screen the following Primary Diagnosis and Other Options Screen is displayed (first screen of Completing the Encounter). This screen requires designating the Filing Options for the Note, verification of the Visit Date/Time, designating the Dental Category, the Disposition and the Primary PCE Diagnosis for the visit.

The screenshot shows the 'Dental Record Manager Plus' application window. At the top, it displays 'ONE_DRMPATIENT' and the patient's details: '000-00-0012 10/12/1956 Age: 49'. Below this, there are tabs for 'Cover Page', 'Clinical Record', 'Dental History', and 'Chart/Treatment'. A red box highlights the 'Filing Options' section, which contains three radio buttons: 'File Data With a Note' (selected), 'File Data With a Note Addendum', and 'File Data Without a Note'. Below this, there are fields for 'Visit Date/Time' (with a dropdown arrow), 'Dental Category' (set to 'Category Number: 15-CLASS IV'), and 'Disposition' (with radio buttons for 'Active' (selected), 'Inactive', and 'Maintenance'). A large table titled 'Primary PCE Diagnosis' follows, with a header row: 'SELECT', 'DIAGNOSES', 'DESCRIPTION', 'ADDITIONAL INFORMATION', 'PROCEDURE', and 'DESCRIPTION'. One row is visible, showing '521.00' under 'SELECT', 'UNSPECIFIED DENTAL CARIES' under 'DIAGNOSES', 'Tooth: 3' under 'ADDITIONAL INFORMATION', 'D2790' under 'PROCEDURE', and 'CROWN FULL CAST HIGH NOBLE M' under 'DESCRIPTION'. At the bottom right of the form are buttons for '< Back', 'Next >', and 'Finish'.

Figure 108: Filing Options

Choose the Desired Note Filing Option by clicking on one of the following radio buttons:

File Data with a Note (default) – DES and PCE data will be created and a Progress Note in CPRS will also be created with this encounter.

File Data with a Note Addendum – DES and PCE data will be created and a Progress Note addendum in CPRS will also be created with this encounter.

File Data without a Note – only DES and PCE data will be created, a Progress Note in CPRS will not be created.

Dental Category – Clicking on the down arrow next to this box will provide the user with a listing of Dental Categories as illustrated below:

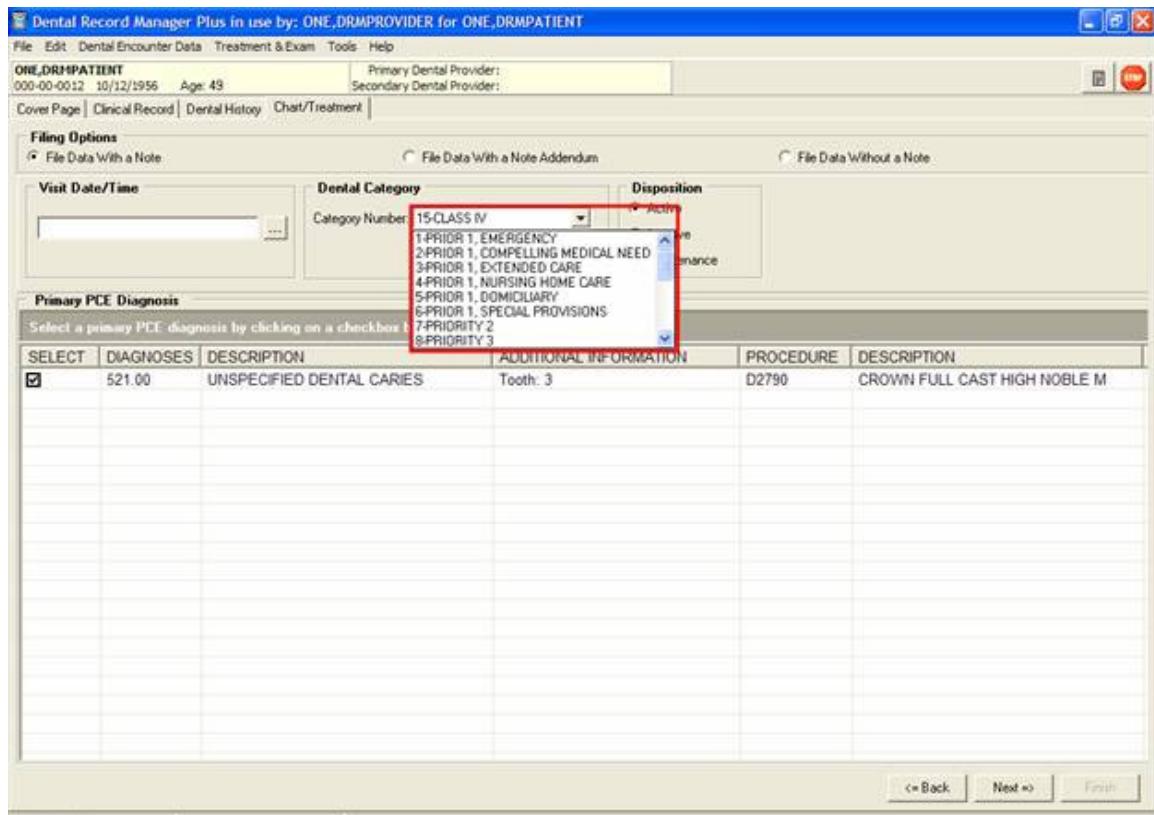


Figure 109: Dental Category

Scroll to the desired Dental Category and select it by clicking on it.

Note: The category numbers 1-8 will display for inpatients and category numbers 9-22 for outpatients.

Note: Category IIB was eliminated in DRM Patch 37.

Disposition: Designate the appropriate Disposition by clicking on the appropriate radio button. Active denotes an in-progress episode of care and inactive denotes a completed or terminated episode of care. If an active episode of care was detected by DRM Plus, Active will be displayed by default. If the inactive disposition is selected, any Diagnostic Findings and Treatment Plan procedures will remain in the patient's record. For information on the Maintenance disposition refer to Appendix G.

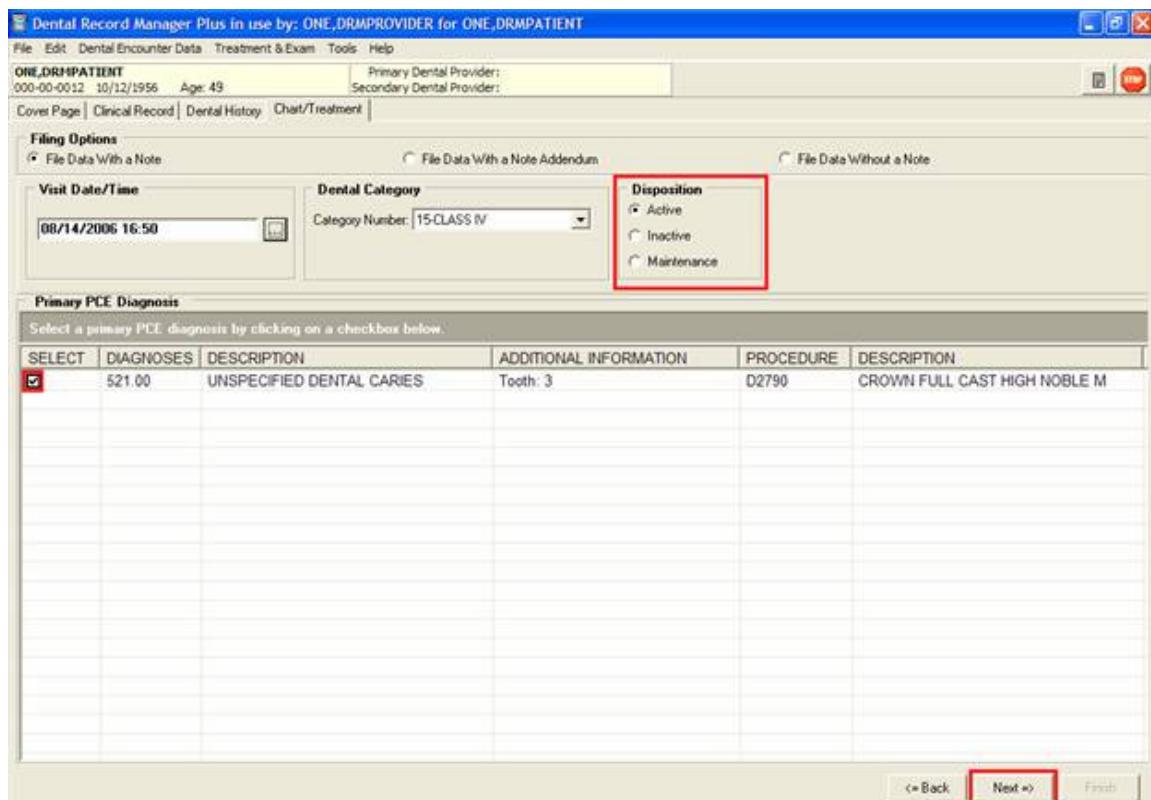


Figure 110: Disposition and Primary Diagnosis

Primary Diagnosis: Select the Primary PCE Diagnosis by clicking in the small box in the Select column next to the desired primary diagnosis. If there is only one diagnosis or many of the same diagnosis, the selection will be checked by default. All encounters require a primary diagnosis. This completes the requirements of this screen.

Click Next to move to the next screen as illustrated on the following page.

Service Connection/Additional Providers/Additional Signers/Station Screen

This is the second screen in Completing the Encounter.

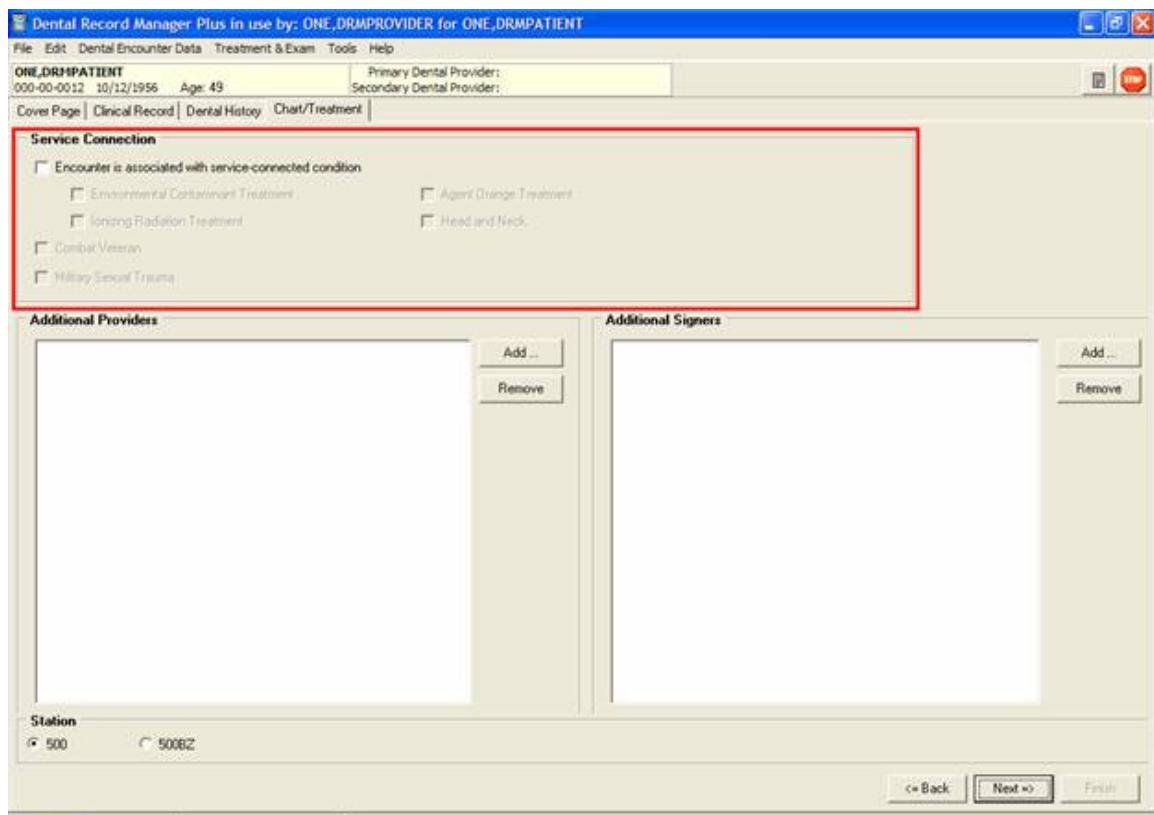


Figure 111: Completing the Encounter Data and Progress Note 2nd screen

Service Connected Condition - The VistA patient record determines which of the following check boxes are enabled:

- Encounter is associated with Service Connected condition.
- Environment Contaminant Treatment.
- Agent Orange Treatment.
- Ionizing Radiation Treatment.
- Head and Neck
- Combat Veteran
- Military Sexual Trauma.

Determine if the encounter is related to a service connected condition or any of the other fields that may be enabled and click the appropriate check box.

Additional Providers and Signers – To select additional (secondary) providers and signers, use the two large boxes on this screen. Secondary providers are providers that have assisted the primary provider with the encounter. The primary provider should add the secondary provider(s) to the PCE encounter. If the secondary provider(s) want to add information to the primary provider's Progress Note, an addendum to the primary provider's note may be added. Addendums may be added through VistA, CPRS or DRM Plus (Use the Clinical Record Tab).

VistA has a co-signature function built into CPRS. It also has an additional signers function. Additional signers are not required, but are optional entries that a provider may add to a Progress Note. Do not confuse additional signers with cosigners. Cosigners are built into CPRS by the facility management based on business rules. Cosigner requirements are controlled by the way the IT or CAC group sets up the CPRS. DRM Plus and CPRS check to see if a provider needs a Co-signature. If the software detects that a Cosigner is required, a box is displayed requesting a Cosigners name. A provider may need a Cosigner for a particular note or may require a Cosigner on all notes. Check VistA and CPRS manuals for information on how to setup Co-signature requirements if needed or check with the Clinical Application Coordinator (CAC).

Additional signers are used if a provider wants someone else to look at the Progress Note and sign off on it. The Progress Note process does not require Additional Signers. If additional providers or signers are needed, click on the appropriate Add button to display the following screen:

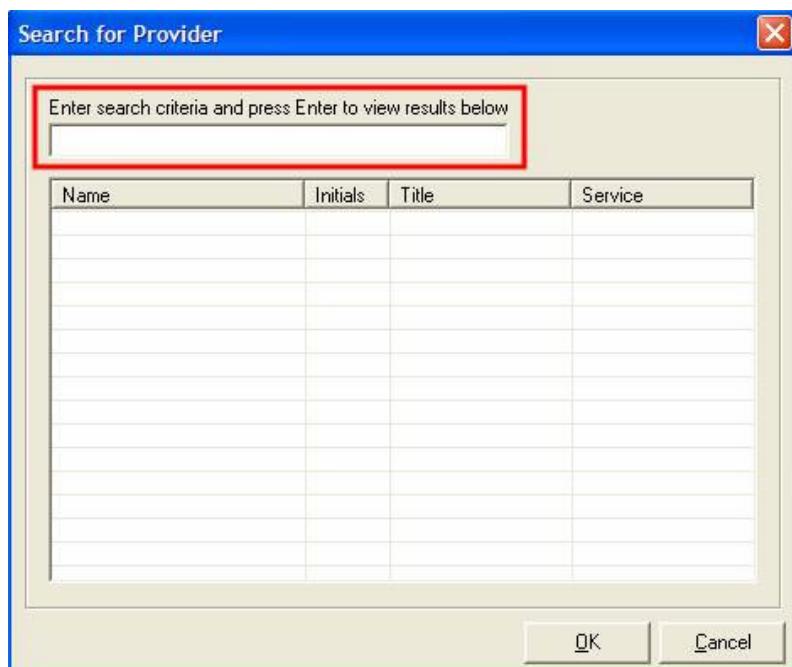


Figure 112: Search for Provider for Additional Providers/Signers

The primary provider must enter a few letters of the secondary provider's or additional signers last name in the Enter search criteria box and hit Enter to display the matching provider names. Highlight the desired provider and click OK. The additional provider or signer is entered for the encounter depending on which Add button was clicked.

The screen will appear as follows:

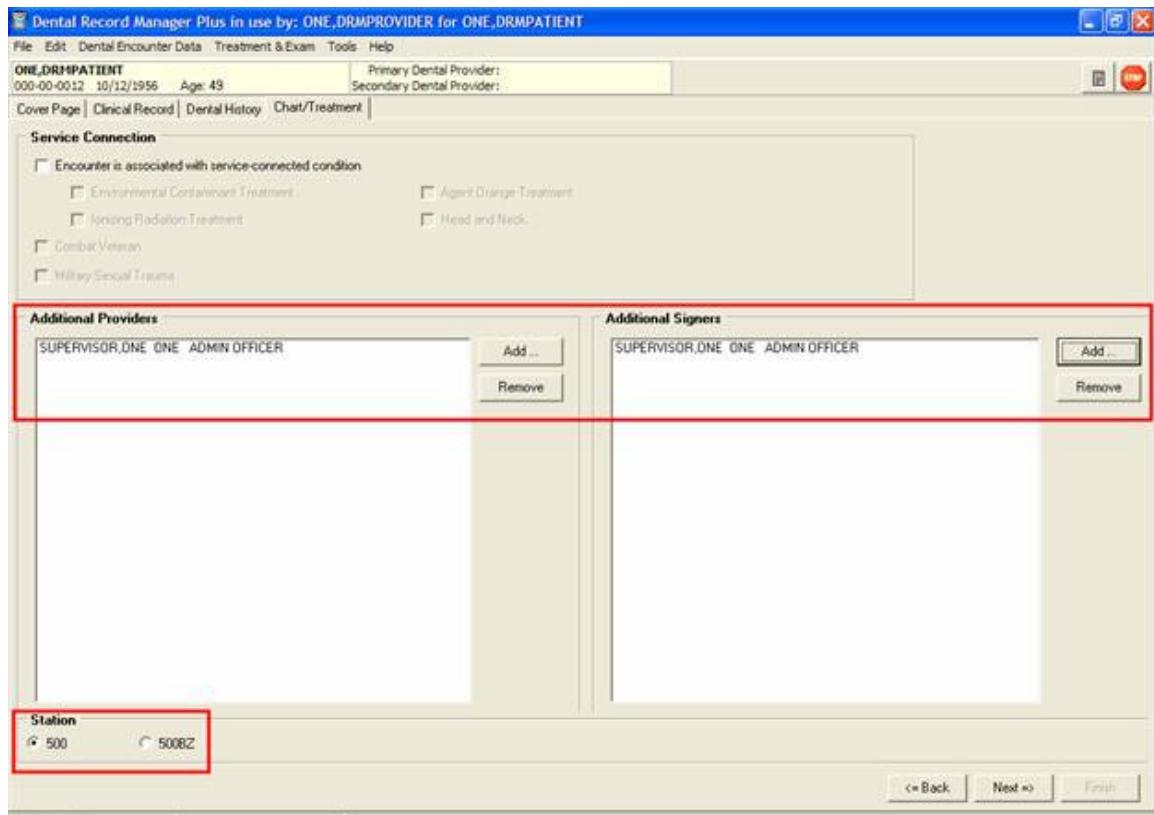


Figure 113: Select Additional Provider/Signers

Select the appropriate facility (station) by clicking the appropriate radio button. When a central VISN VistA server or satellites are connected to a central VA facility, the provider must designate the facility where the visit took place. Clicking on Next moves to the next required screen.

Set Progress Note Title Screen (Or Respond to a Consult Request)

A Note title must be selected from the screen displayed below. If a consult note title is selected, DRM Plus interfaces with CPRS to complete the response to the consult request.

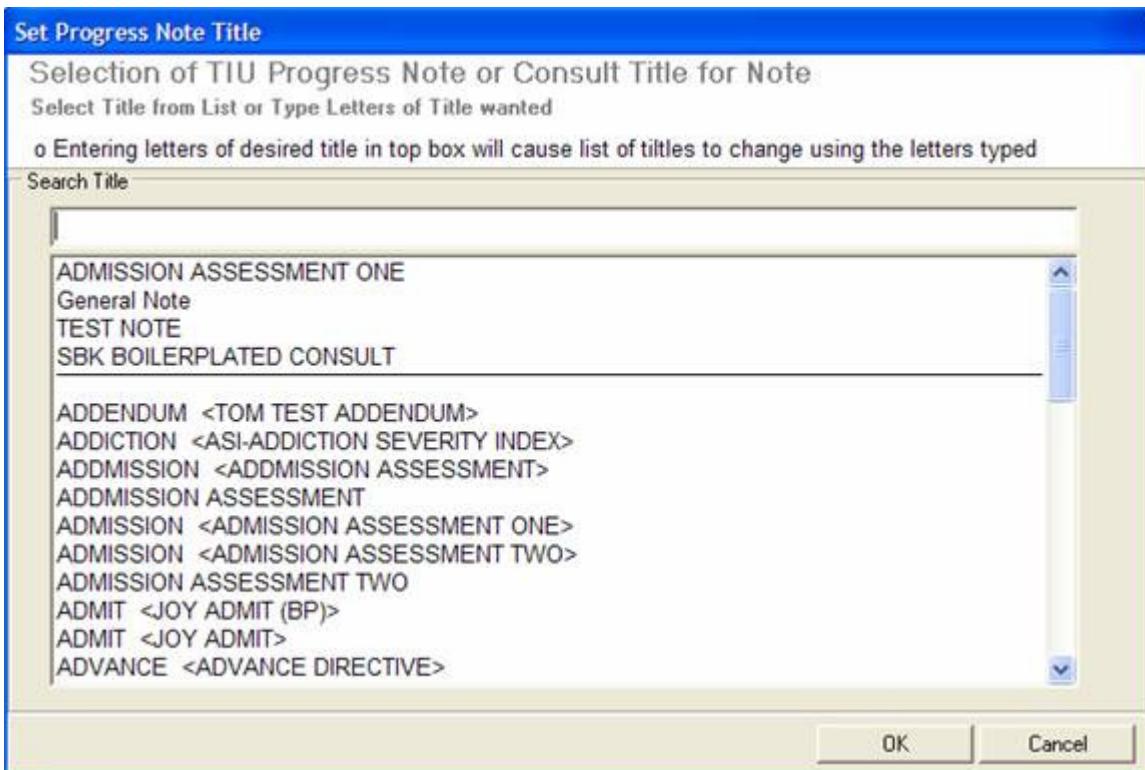


Figure 114: Set Progress Note Title Screen

Type in the search criteria, press Enter, and select the appropriate note title by highlighting it. If the note title is not a consult title, click on OK to move to the Progress Note screen.

Note: If the Note Title has an associated boilerplate, the boilerplate is automatically inserted into the body of the Progress Note, if the provider responds YES to the boilerplate message.

If the Provider is going to create a Response to a consult, a consult title must be selected from the Set Progress Note Title screen. When a consult title is selected, the following screen is displayed:

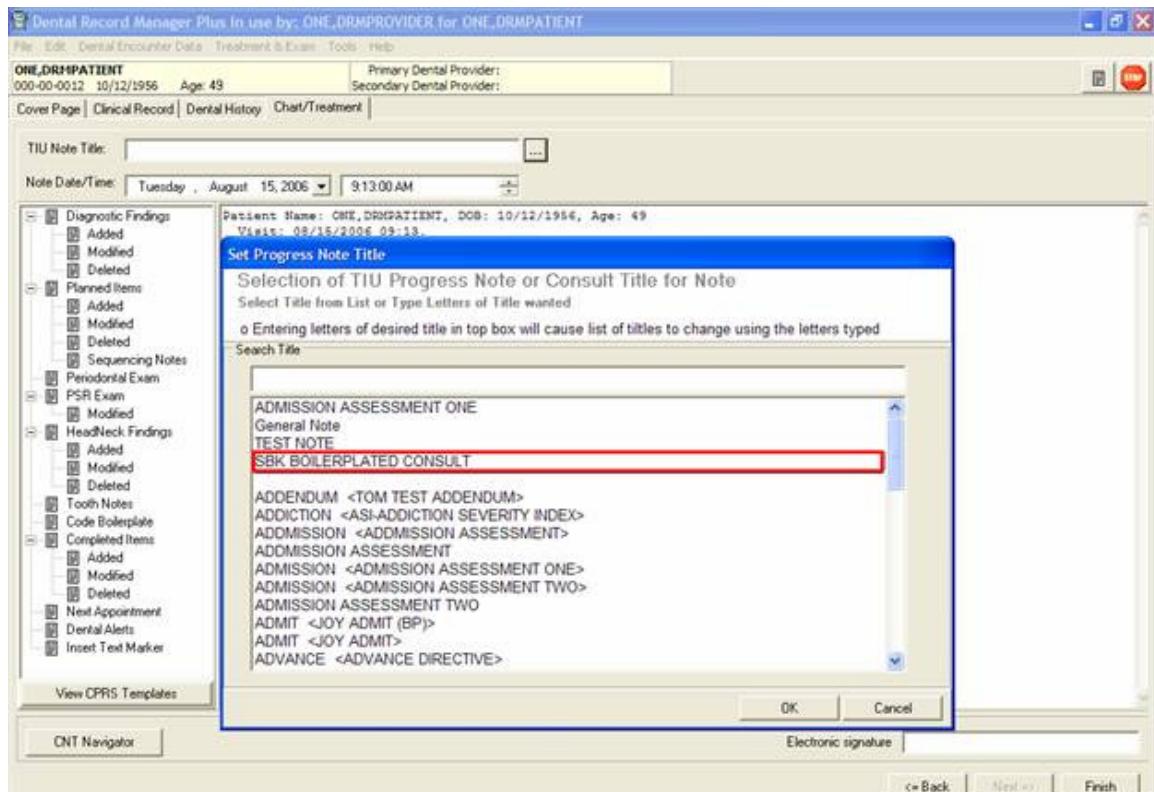


Figure 115: Select Consult Title

Progress Note Screen

This is the third and last screen of Completing the Encounter. DRM Plus automatically generates text for the Progress Note if the filing option File Data with a Note is selected. The note will contain the following items in the order listed below by default:

- Patient's basic information.
- Diagnostic Findings.
- Treatment Plan.
- Periodontal Exam.
- PSR entries.
- H&N findings.
- Tooth notes.
- Code Boilerplates
- Completed Items
- Next Appointment
- Insert Text Marker

Note: See the DRM Plus Menu Bar, Tools, User Options, Progress Note tab for user options regarding the default note settings.

The user may add text or use other tools/functions to import additional information (CNT Navigator, VistA Imports or Importing files) to finalize the Note. Additional text must be added under the Insert Text Marker heading to avoid accidental loss of text.

Note: The Insert Text Marker will automatically be imported into the Progress Note. Copying the Insert Text Marker (with or without other data) and pasting it below the original Text Marker will cause duplication of the data if the user clicks Back then Next.

The following Progress Note screen is displayed:

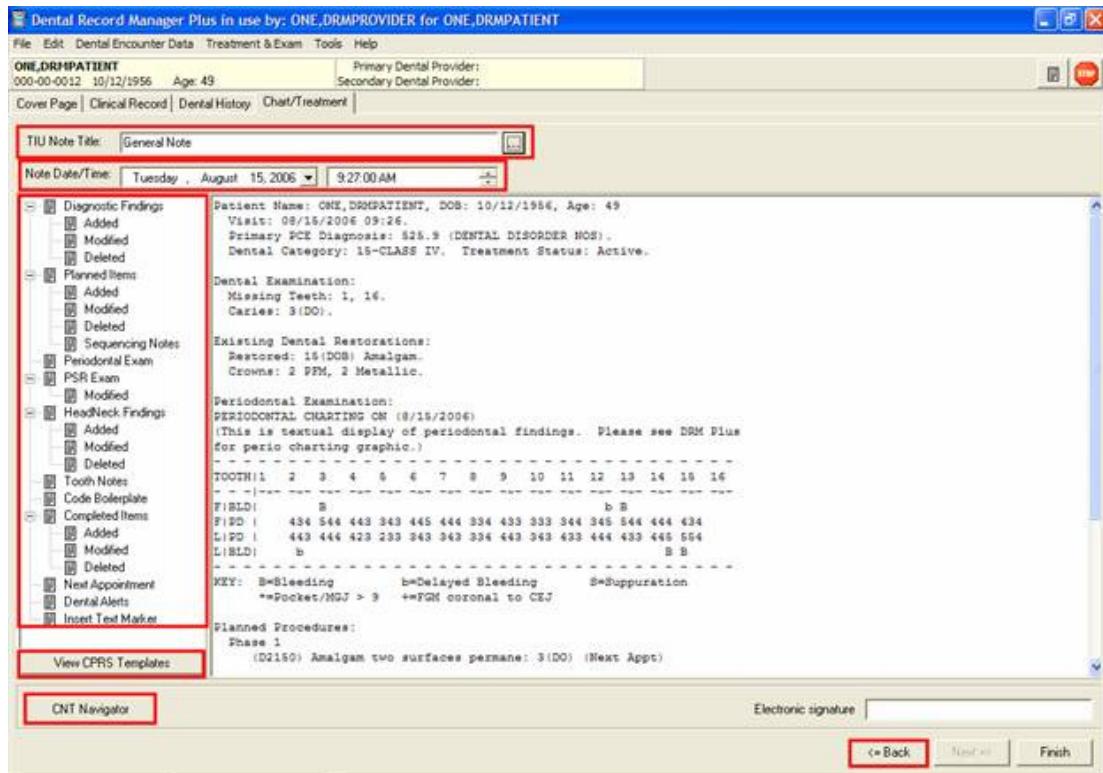


Figure 116: Progress Note 3rd & Final Screen

Note: The Progress Note data objects shown to the left of the Progress Note may be imported into the note by double-clicking on the desired object. All data objects are automatically imported if the parameter has been selected except Dental Alerts. To import Dental Alerts double-click on the Dental Alerts data object shown to the left of the Progress Note.

The screen contains the following options:

View CPRS Templates – Allows access to CPRS templates through DRM Plus.

TIU Note Title – Although previously designated, the Note title may be changed by clicking the ellipse button.

Note Date/Time – Defaults to current Date/Time but may be changed by using the appropriate arrows.

CNT Navigator – Click this button to bring up a directory of clinical note templates that may be used to add additional information to the note. See Appendix D for instructions on using this tool.

Back – To go back to any previous encounter screen and correct errors or omissions.

To Import CPRS Medical Information, using a right mouse click within the note area will provide several VistA import options. The following screen is displayed:

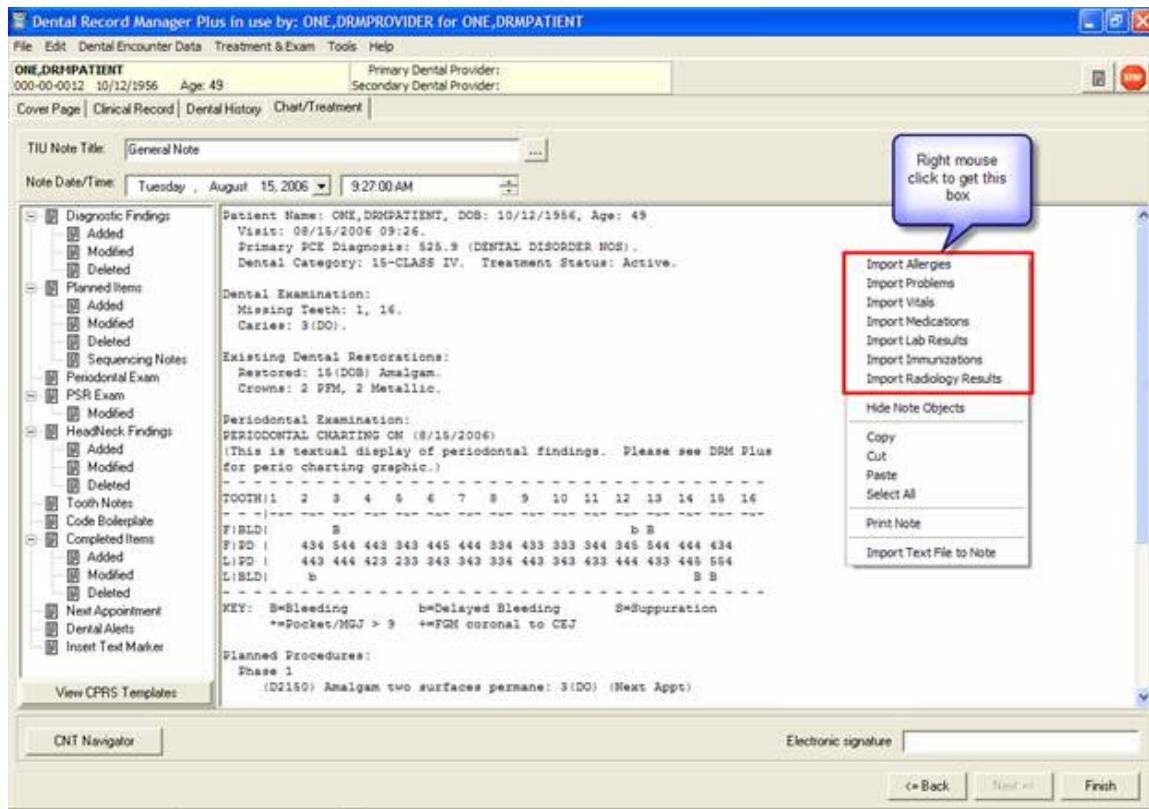


Figure 117: Import CPRS Medical Information

Import CPRS Medical Information – Clicking on the desired import option results in the selected CPRS information being added to the end of the note or to where the cursor was set last.

Hide Note Objects – Clicking this item causes the Note objects tree to be hidden from view.

View Note Objects – Note objects may be imported into the Progress Note by selecting this option. A double-left mouse click on any object listed on the left side of the screen will import the highlighted object into the note.

Copy, Cut, Paste functions may be used to edit the Progress Note.

Print Note – Clicking this option prints the unsigned note.

Import Text File to Note – Text files may be created and saved in a directory of preference. Clicking Import Text File to Note allows the user to navigate to the saved file and open it. The file is then placed in the Progress Note as designated by the cursor placement.

Follow the steps below to set up a file for importing:

1. Create a folder in an appropriate directory (usually a server drive).
2. From the DRM Plus menu bar, select Tools, then User Options, then Set File Folder and navigate to the folder created in #1 above. Set the folder by double-clicking on it.
3. Create a text file using Notepad or Word and save it as a .txt file in the designated folder.

You may now use the right-click function discussed above. The saved file may be modified and re-saved as needed.

Prompt to 'Complete' dental episode of care – When the user clicks the Finish button a new prompt may appear if there are no planned items and if the patient status is 'Active'. Correctly identifying the patient's status is important for reporting.

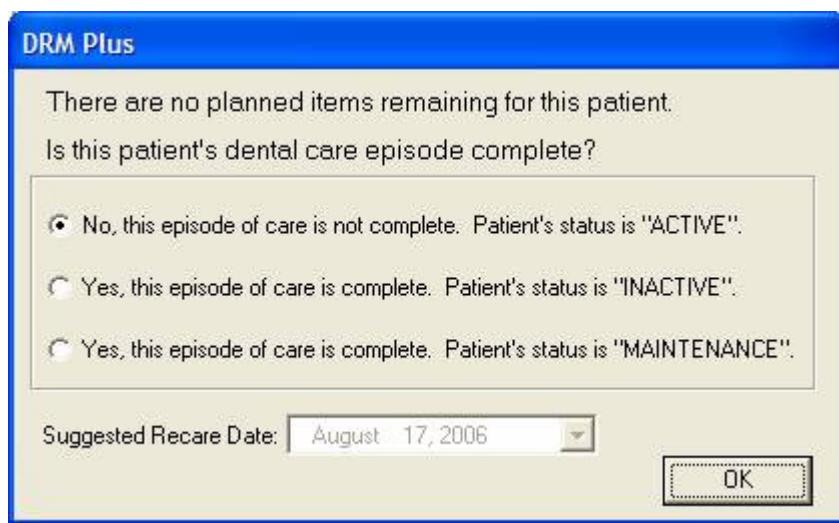


Figure 118: Prompt to complete dental episode of care

If the Finish button is clicked before the provider's electronic signature is entered the Progress Note filed in CPRS as an unsigned note. If the electronic signature is entered first the Progress Note will be filed as a signed note. When the Finish button is clicked, the following screen is displayed:

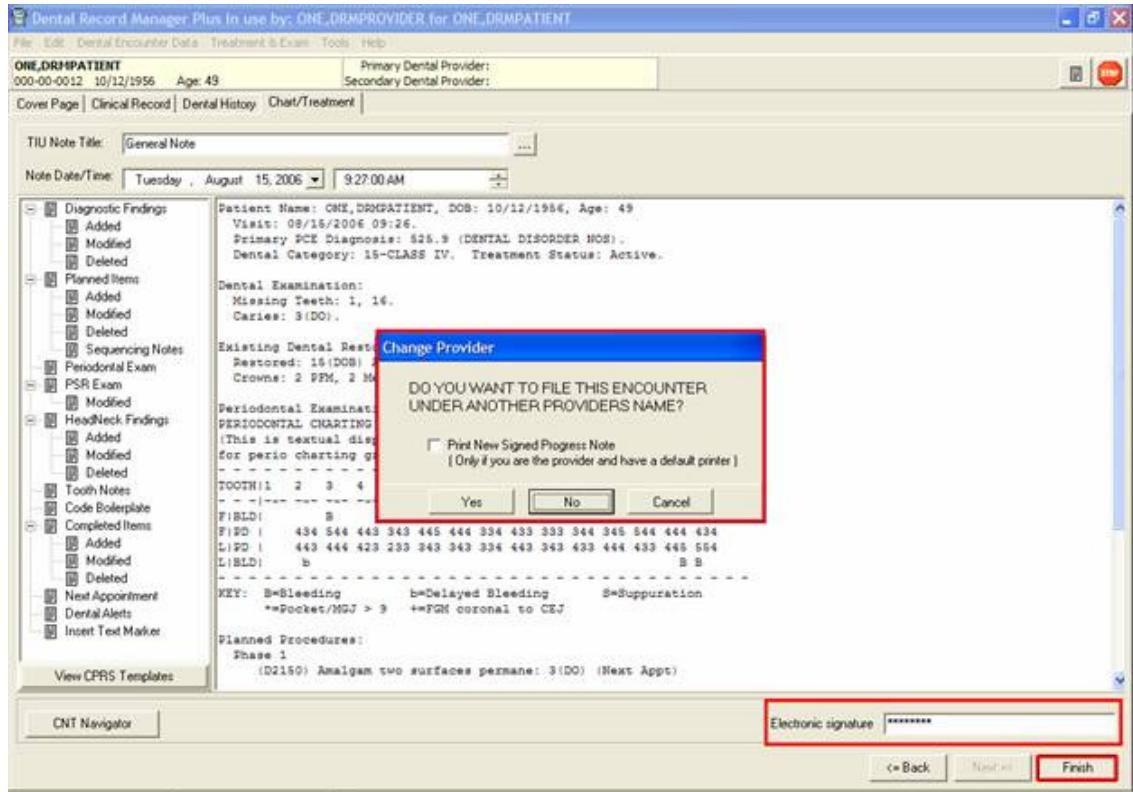


Figure 119: Progress Note signed and finished

Print Signed Progress Note – Click this checkbox to print the note when it is filed.

Select Yes – Search for Provider screen appears (when filing encounter under another provider).

Select No – Wait for processing to complete (when filing encounter to the person logged on).

Cancel – Click cancel to return to the Progress Note screen to update or correct information.

If another provider or cosigner signature is required the following box will be displayed:

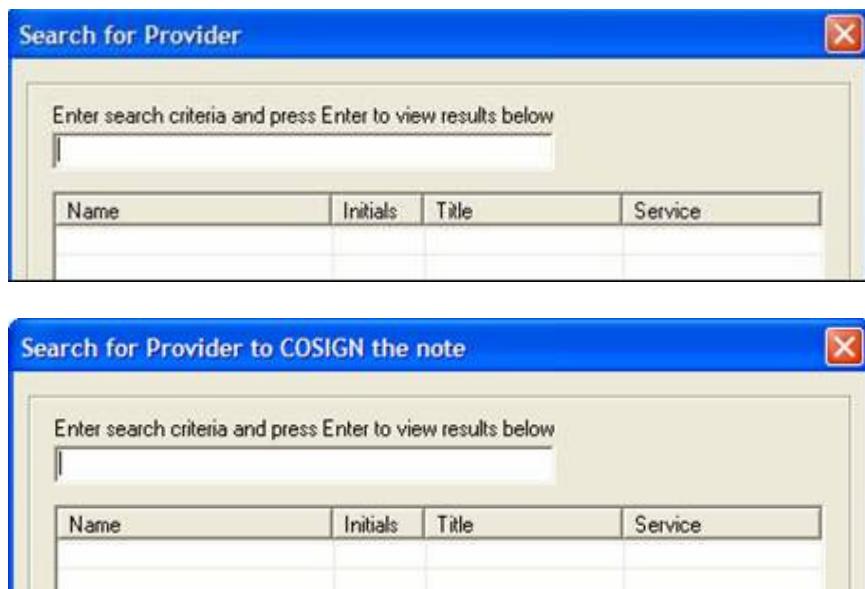


Figure 120: Search for Provider

To designate a provider signer or a cosigner, type search criteria in the selection box and press Enter. Highlight the desired provider and click OK.

The provider will receive a CPRS alert in Vista indicating that an unsigned note has been created. When the Progress Note is filed to CPRS, the patient record will be closed. Another patient may be selected after OK is clicked on the following message box:

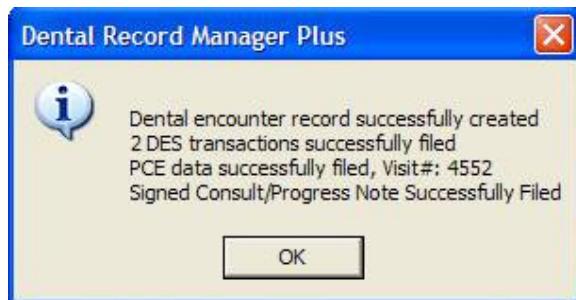


Figure 121: "Dental encounter record successfully created" message

Note: If the Finish button was clicked and some information was incorrect, a message indicating the status of the encounter is displayed. Incorrect data must be corrected before processing can be completed.

Capturing the Distributed (Attending) Provider for residents

This is a new VA Directive. Residents are those users with a Person Class of V030300, or V11550 or V115600. Since most sites require residents to enter a cosigner for the note, the cosigner will default as the distributed provider. If there is no cosigner (e.g., there is no note when using “File Data Without a Note” or the resident is not required to have a cosigner), then the resident - or the user filing data to a resident, must enter the distributed provider before filing.

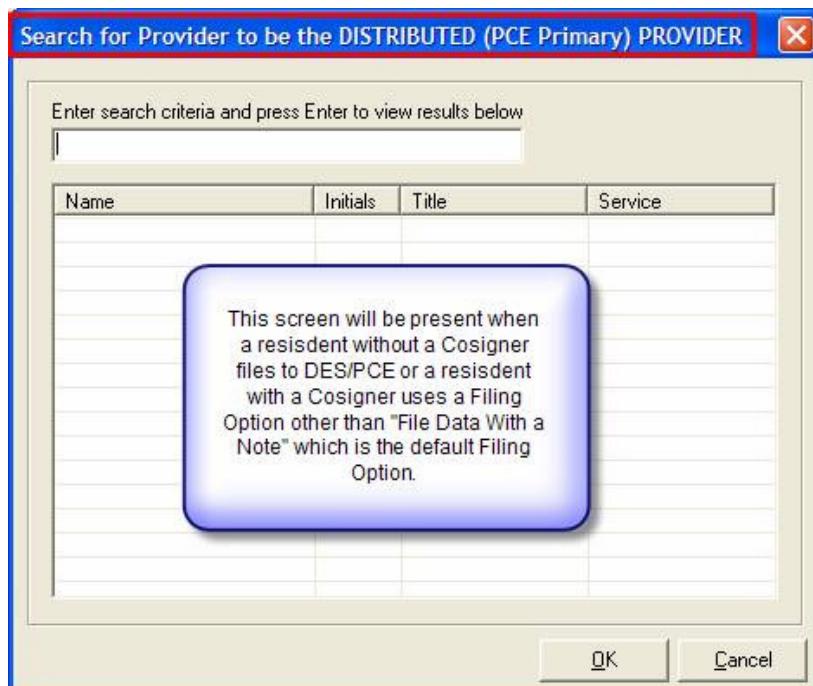


Figure 122: Prompt for Distributed Provider (for residents filing w/o a cosigner)

If the user tries to file completed data to a resident (that have no cosigning restrictions in VistA) without a distributed provider, the following error will be returned:



Figure 123: Filing error - data NOT filed to DES/PCE or Dental

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

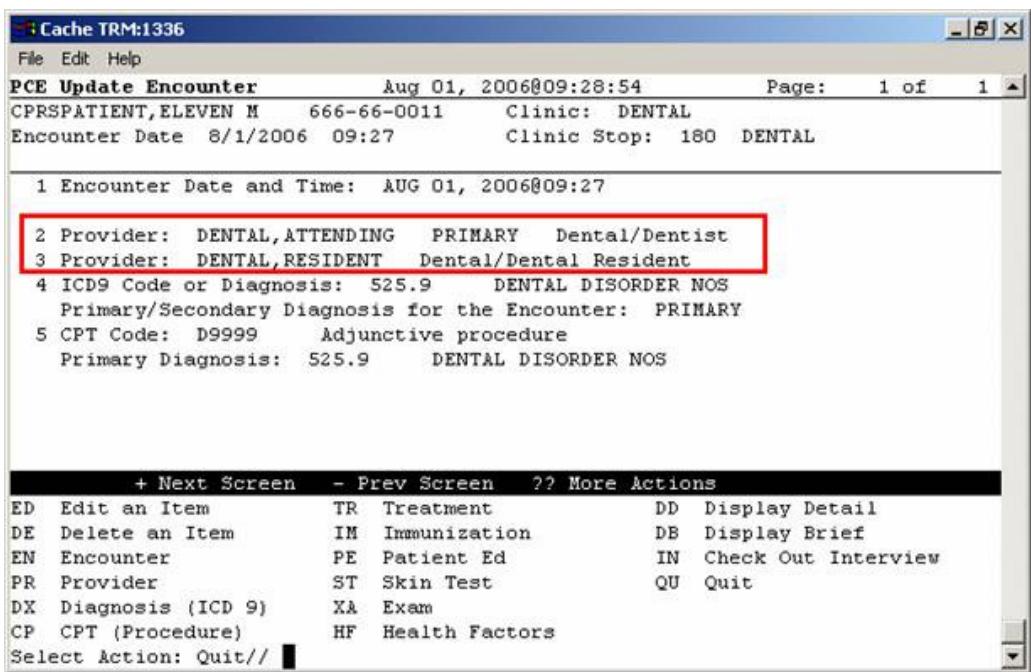


Figure 124: PCE Encounter information on Vista

If an addendum is filed by a resident to the same visit and the distributed provider is not the same as the current PCE Primary provider (the original distributed provider), then the new distributed Provider will be added as a secondary provider.

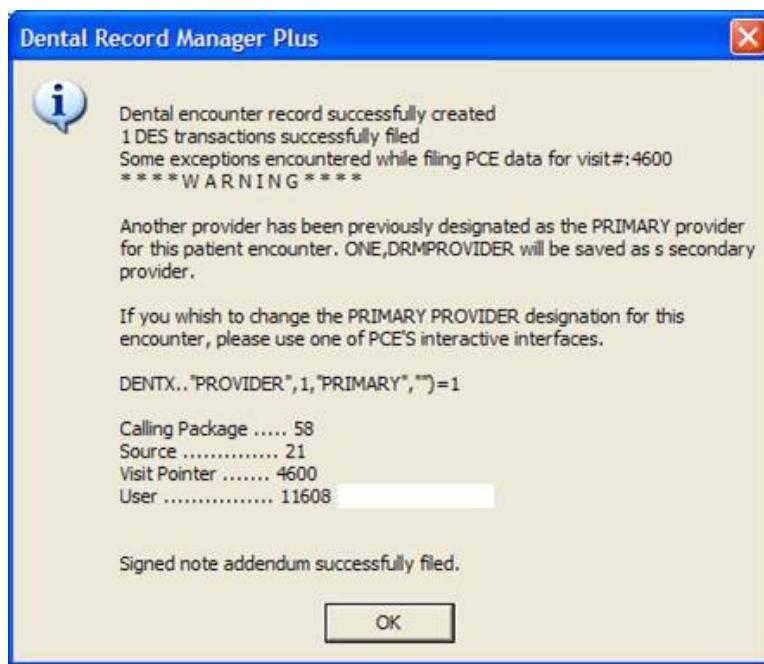


Figure 125: Warning when using different provider than original Progress Note

Creating a Progress Note Addendum

With or Without Passing Information to PCE/DES

Overview

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

To record a Note Addendum without an ADA code, click on the Clinical Record tab and then click the Notes radio button. The following screen will be displayed:

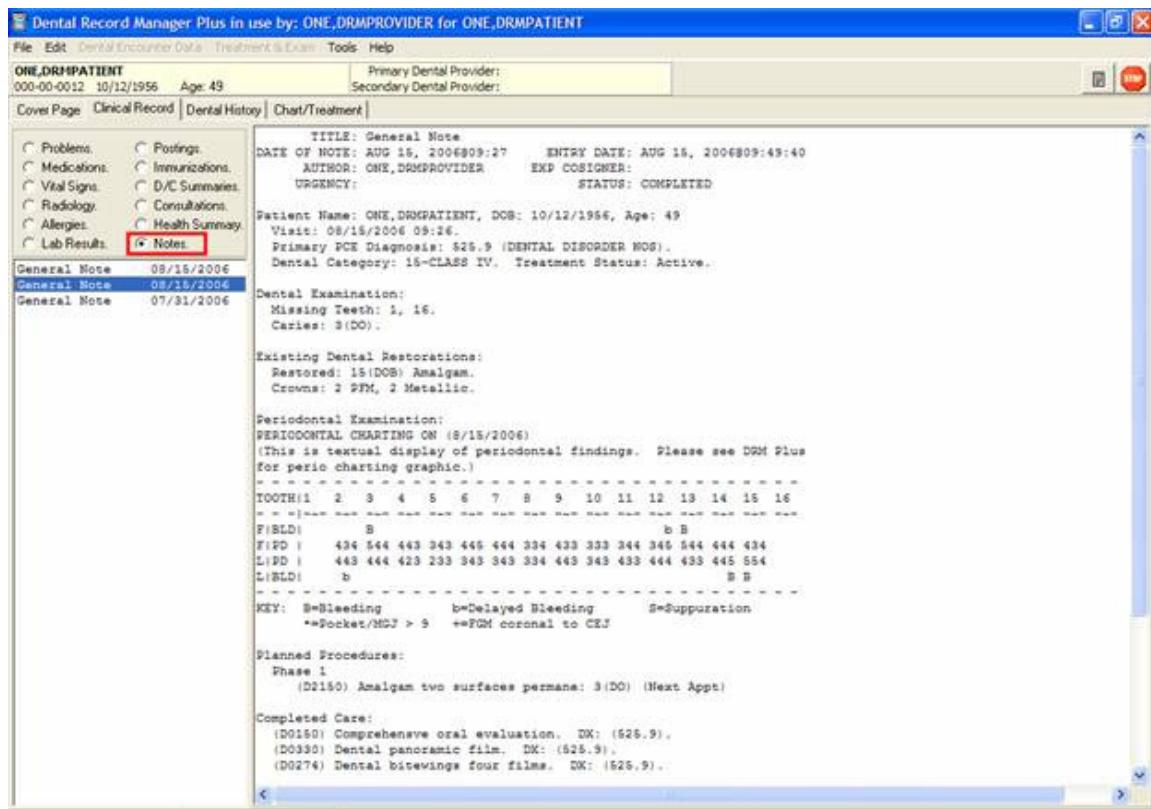


Figure 126: Creating a Text Addendum without an ADA code

Select the note to be appended.

Using your mouse, right click on the note title to display the following dialogue box:

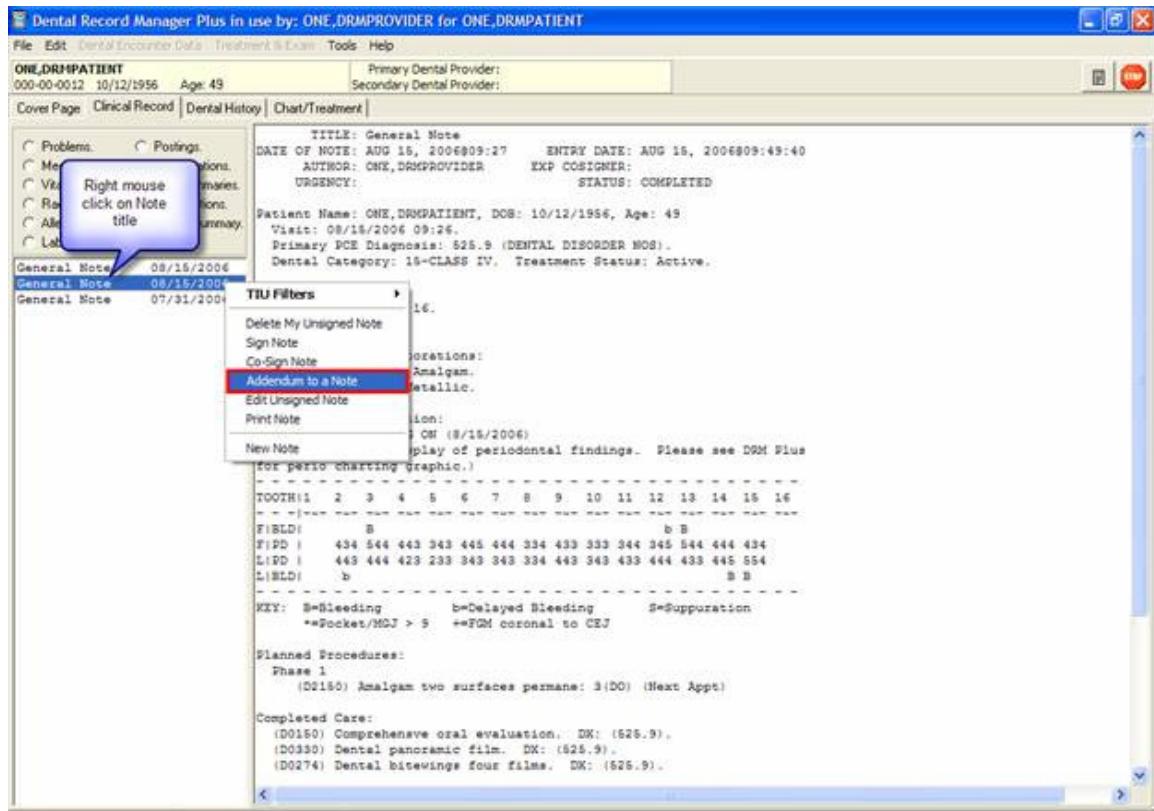


Figure 127: Addendum to a Note

Click on the Addendum to a Note option. The text portion of the screen will become available for typing the addendum. When the addendum is complete, sign in the Electronic Signature box and click Finish.

The following screen will be displayed:

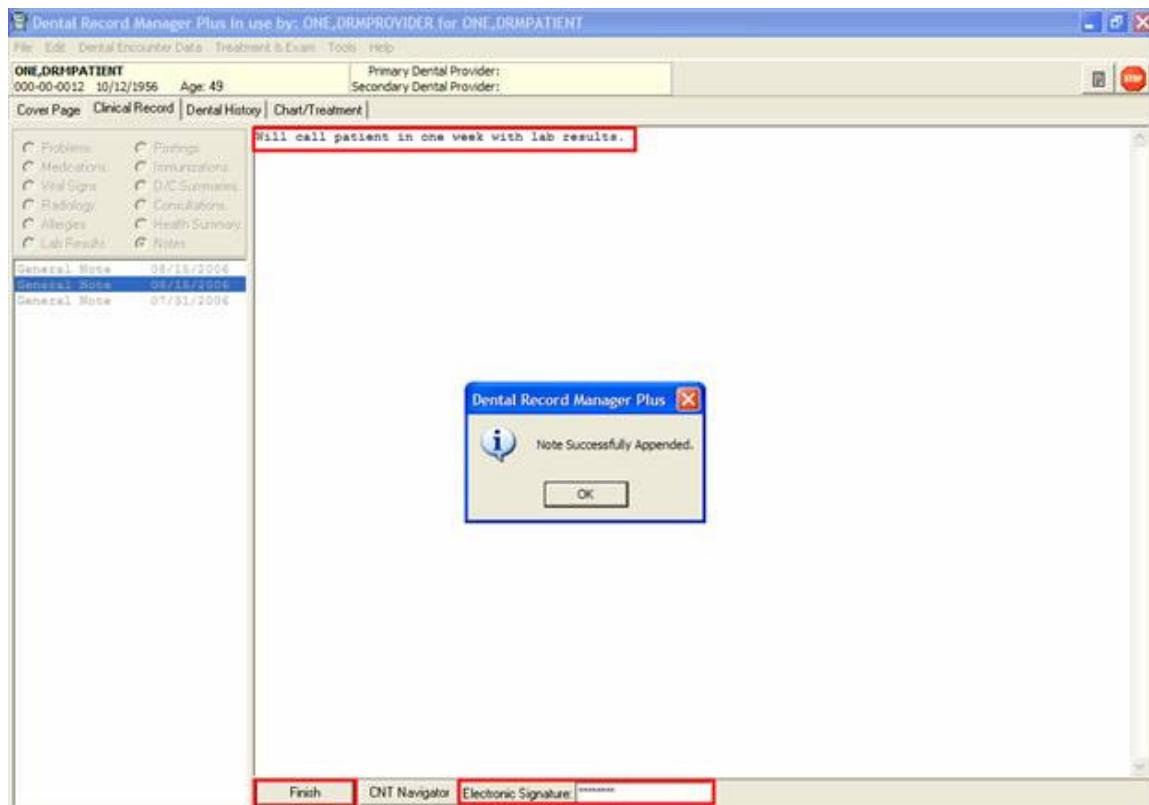


Figure 128: "Note Successfully Appended" message

Click OK to complete the process.

Note: If an error was made by selecting Addendum to a Note, right click on the Appended Note and select Cancel Note.

To create an addendum and pass the information to PCE/DES, any ADA code entry must be made through the Completed Care screen entry process. Then continue completing the encounter by clicking Next. When the Visit/Date & Time box appears, choose the appropriate visit to associate with the addendum using the drop down arrow.

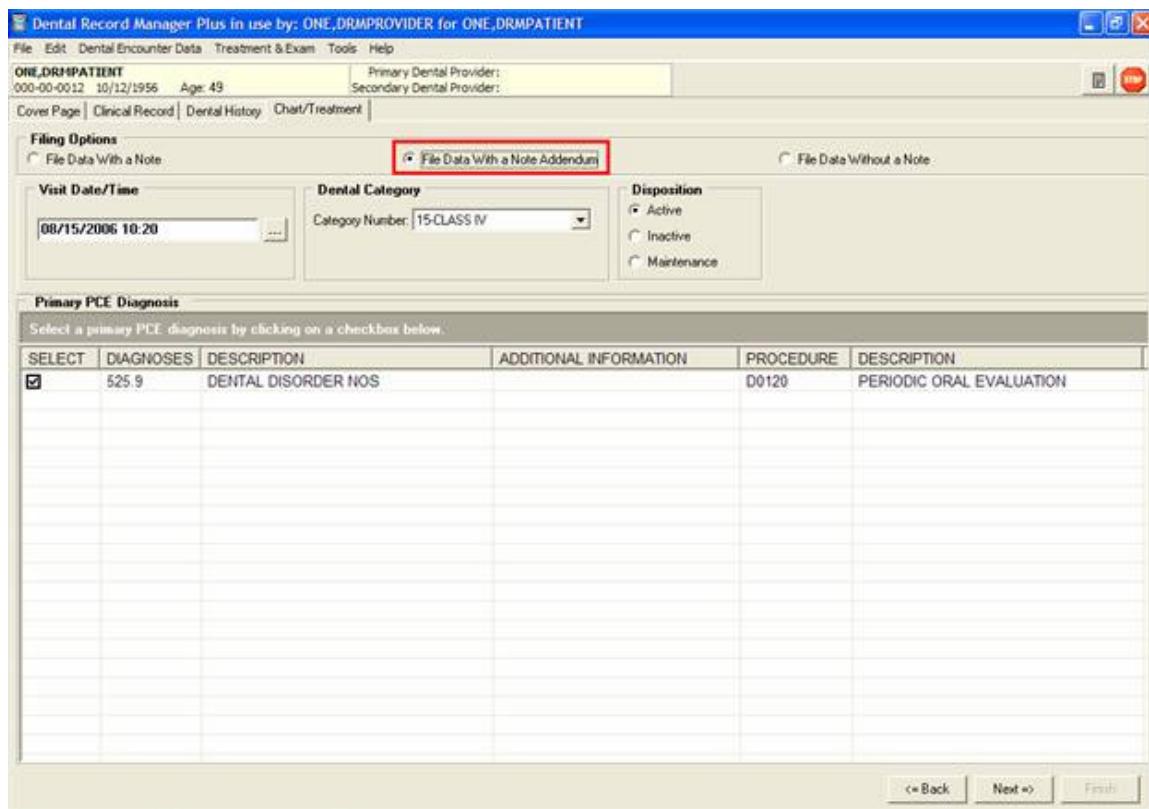


Figure 129: File a Note Addendum to PCE/DES

Select the File Data with a Note Addendum radio button. The remaining screen requirements must be entered. Click Next and complete the requirements of the next screen, Service Connection/Additional Providers/Signers and Station.

When Next is clicked from this screen, the following screen will be displayed:

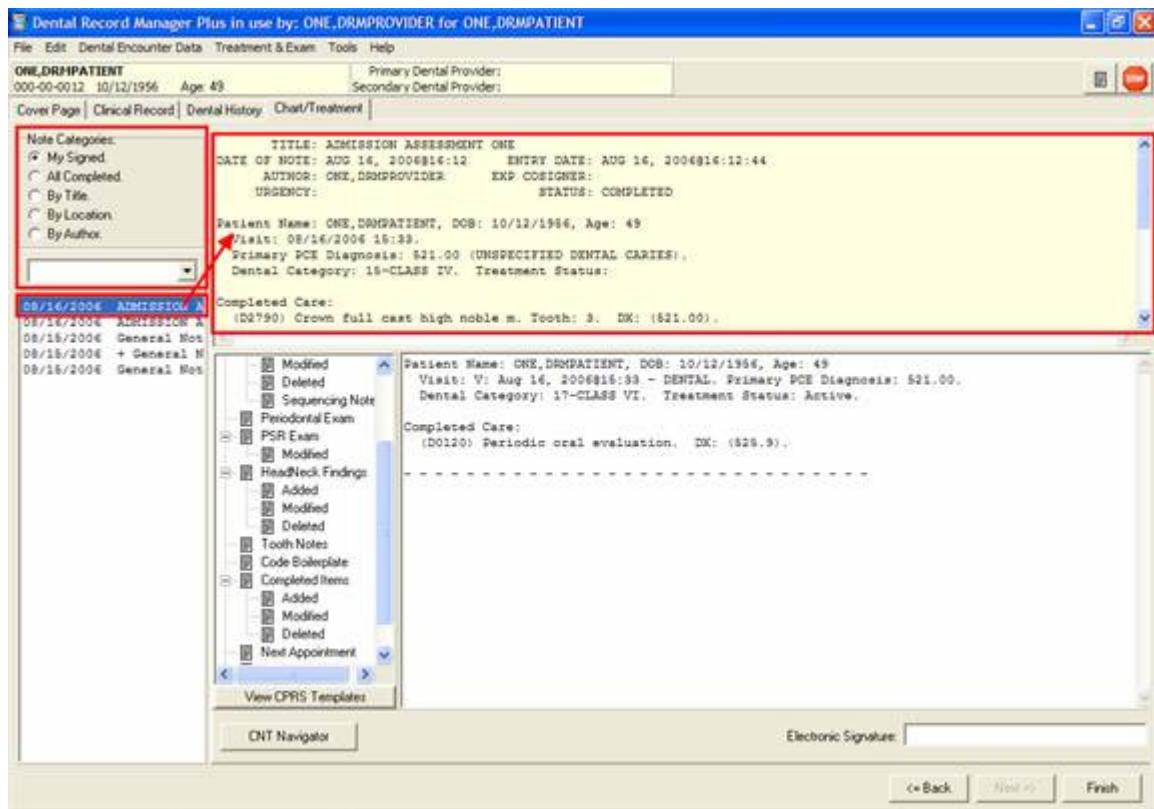


Figure 130: Original Progress Note – yellow window

The user is required to specify the signed Note to be appended. Click the appropriate note selection radio button (defaults to My Signed) and select the note to be appended. The original note will be displayed in the note information in the top yellow window.

The screen will appear as below:

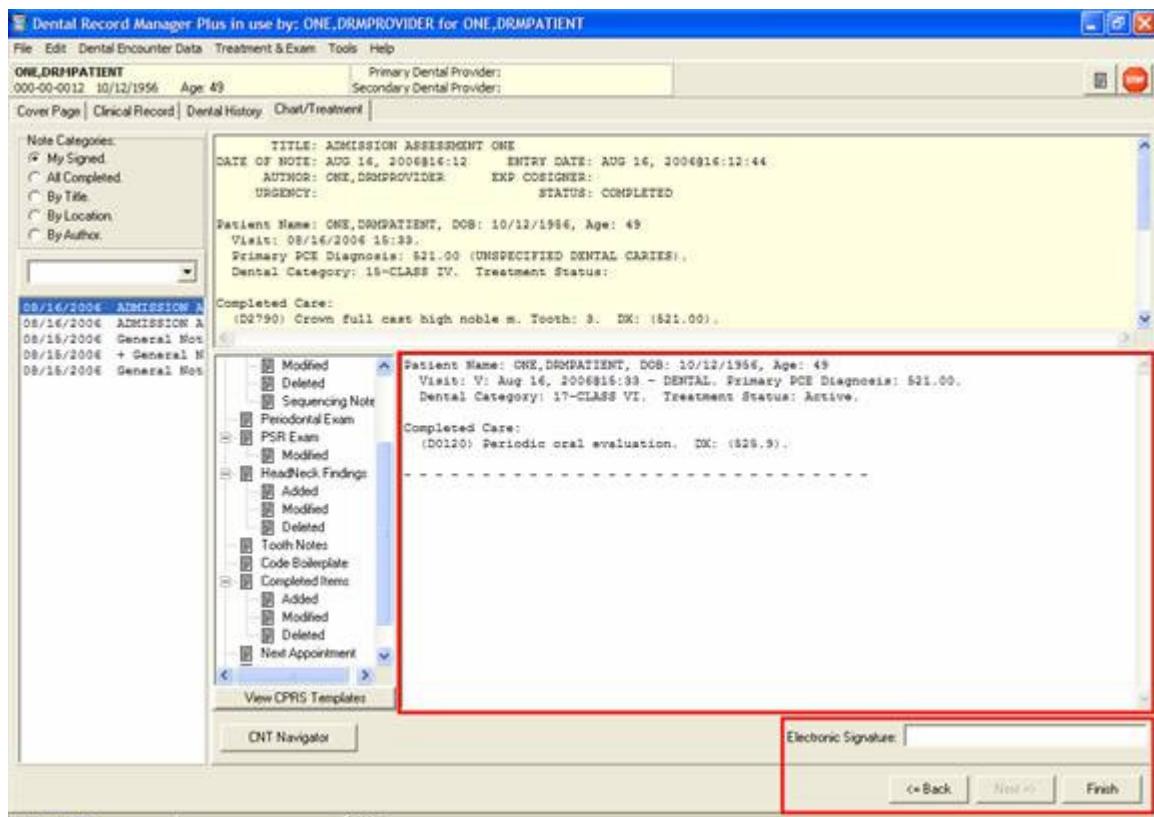


Figure 131: Appended Note – White window

The addendum standard text will appear in the white window. The addendum may now be finalized using any of the same tools used to complete any Progress Note. When the addendum is completed, add the Electronic Signature and click Finish.

As a precaution, click on the Back button at any time (prior to clicking Finish) to return to previous screens in order to change any data.

Adding a Note – For Informational Purposes Only

Once a patient is selected in CPRS, and DRM Plus has been opened, click on the Clinical Record tab.

Select the Notes radio button.

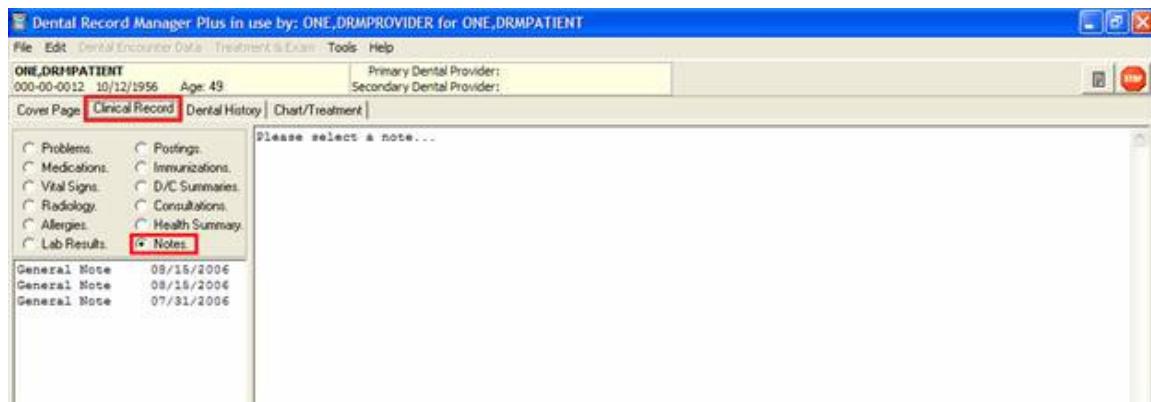


Figure 132: Adding a Note for Informational Purposes Only

With your mouse position in the left side of the note area, click on the right mouse button and select the option – New Note.

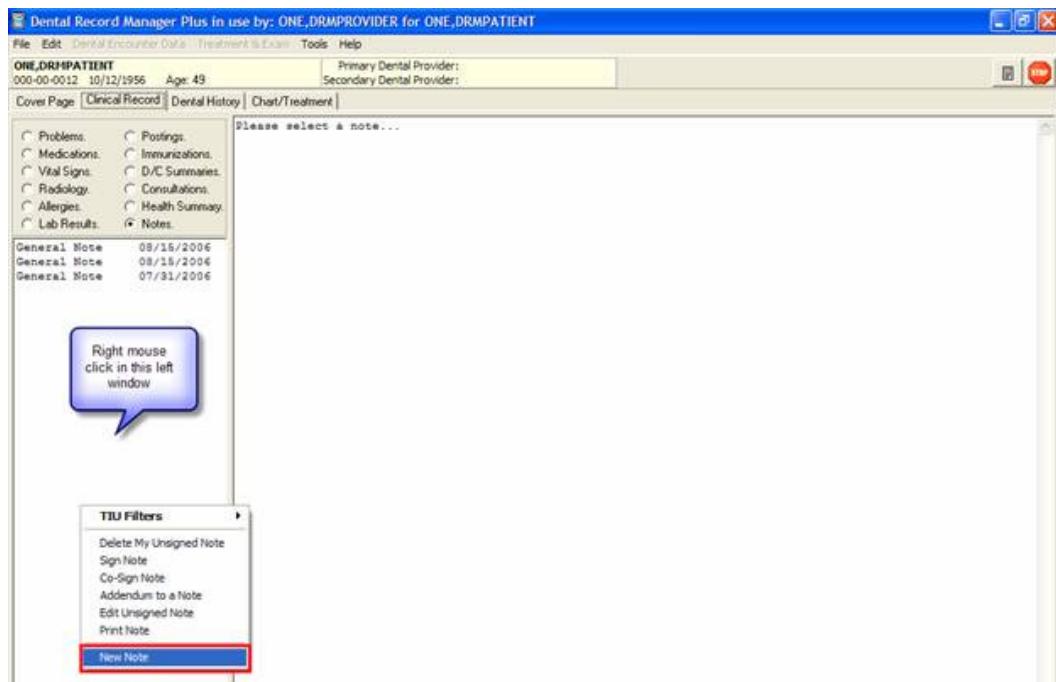


Figure 133: Select New Note

Select the appropriate Progress Note Title. The following screen will be displayed:

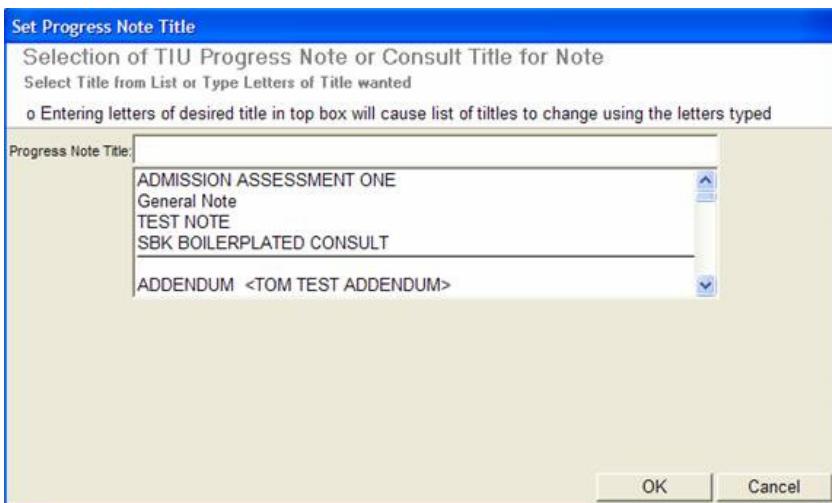


Figure 134: Choose the Note Title

Once the note title has been selected, you should check to see if “All” radio button is highlighted. You can choose the scheduled Encounter/Visits appointment.

A notation, or informational data, can be entered in the note area relative to the scheduled appointment. The note should be signed with the provider’s electronic signature and the Finish button should be selected.

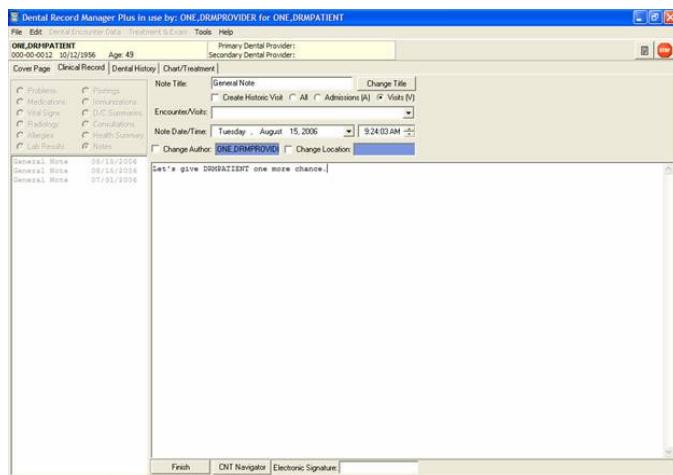


Figure 135: Enter Notation or Informational Data

Once the note has been electronically signed and the Finish button selected, you will receive the following completed message.

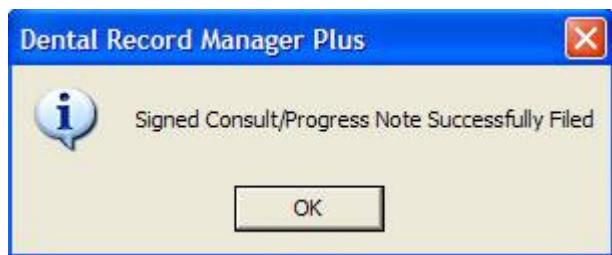


Figure 136: Completed message

Using the Special Buttons

On the Treatment & Exam and the Periodontal Chart screens several special buttons can be chosen. The special buttons are: Notes, Sequencing (not available on the Periodontal Chart screen), H&N, History, PSR, Summary, and Plaque. Two additional special buttons are available on the Periodontal screen, Compare and Stats. The Notes, History, H&N, Summary and Plaque special buttons will be discussed in this section. The Sequencing button will be discussed in conjunction with the Treatment Plan screen and the Compare and Stats buttons are discussed in conjunction with the Periodontal screen.

Note: When information has been entered in a special button area, the button descriptor turns to red and is shown in quotes.

Notes Icon Button

Clicking the Notes icon button displays the following box:

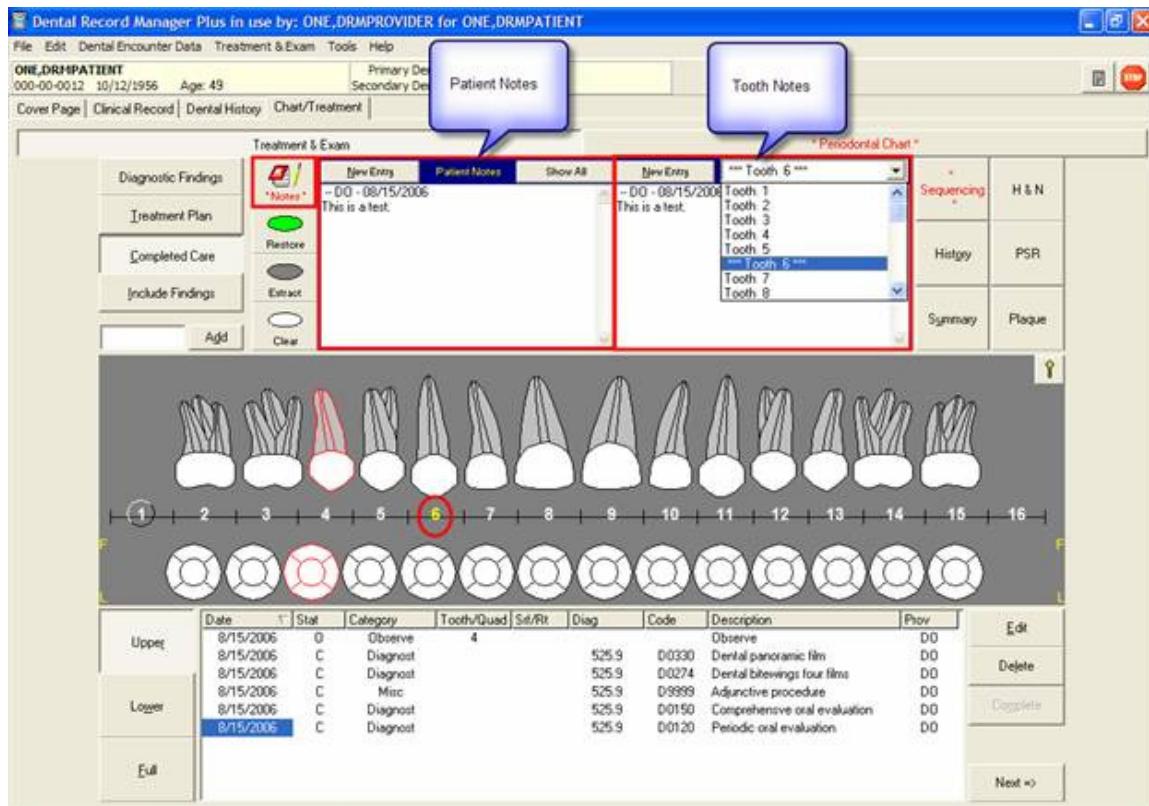


Figure 137: Using the Note icon

To display all previously entered non-tooth Patient Notes, click the "Show All" button.

To close the previously entered non-tooth Patient Notes display, click a second time on the "Show All" button.

Items to consider:

- Teeth designated as primary will show in the tooth drop down box with the appropriate letter. 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 on the Diagnostic Findings, Treatment Plan, Completed Care, and Periodontal Chart screens will be displayed in yellow.
- Previously entered Notes (tooth/patient note) before finishing the Progress Note will appear as “grayed out”. This happens when a provider saves to themselves or an assistant saves to a provider with the menu option Save Unfiled Data and DRM Plus is closed. When the provider re-opens DRM Plus to complete the Progress Note they may edit/delete the Note (tooth/patient note) by clicking New Entry button. This will activate the “grayed out” entry so the provider is able to modify or edit/delete that Note before the Progress Note is finished.
- Before you can enter a Note (tooth/patient note), you need to add a transaction in Diagnostic Findings, Treatment Plan, or Completed Care.

To create a new non-tooth patient note, click on the “New Entry” button immediately to the left of “Patient Notes.” One line of text, that includes the date of entry, will appear with the cursor positioned at the beginning of the next line. Type the text of the new note.

To create a tooth-specific note, select the down arrow on the right side of the tooth number text area and highlight the tooth that is to be associated with the note. Continue by clicking on the “New Entry” button. One line of text, that includes the date of entry, will appear with the cursor positioned at the beginning of the next line. Type the text of the new note.

To close the notes box, click the Notes icon.

Note: The notes entered in this box will appear automatically as part of the completed Progress Note for the encounter.

Note: To display any past tooth-specific note, click on the History button. Continue by clicking on the drop-down arrow of the Appointment box, top left corner of the History screen, and selecting the appropriate date the tooth-specific note was entered. As you select the date, the tooth numbers in the graph will be displayed in yellow. Once you have found the desired tooth with a yellow number, click on the Notes button in the History screen. Then use the drop-down arrow to select the tooth-specific note of interest to view the note.

H & N (Head & Neck) Button

Clicking this button allows the user to enter lesion information. The following screen is displayed:

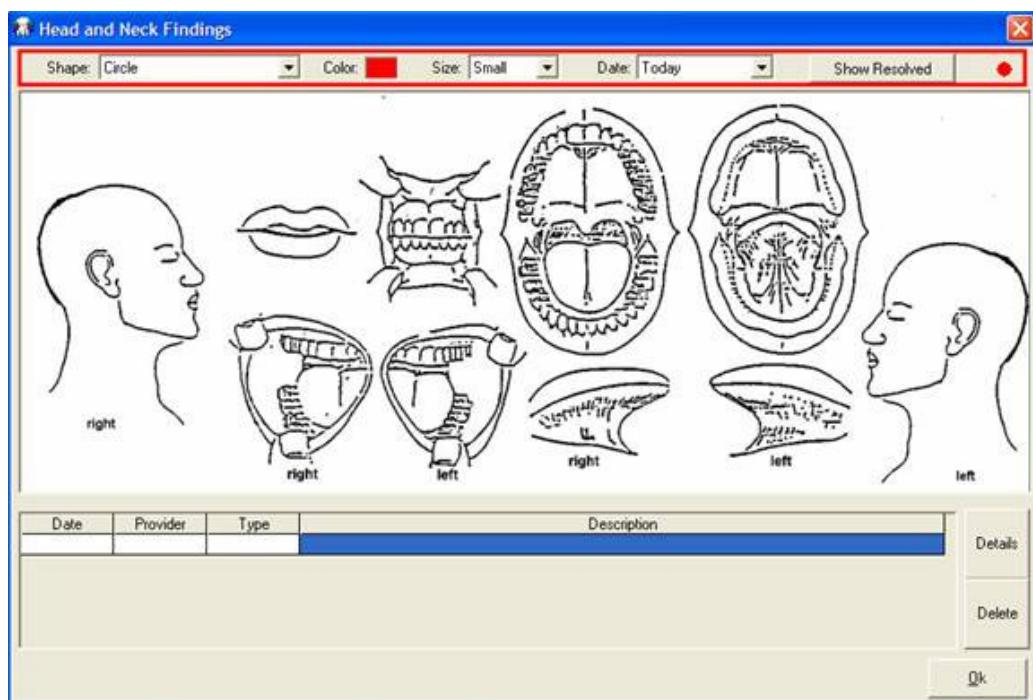


Figure 138: H&N (Head & Neck) Button

To record Head and Neck lesion findings, follow the steps below:

- **Shape** – Select the down arrow on the right side of the shape and select the desired shape by highlighting.
- **Color** – Determine the color of the recorded finding. Red is the default color.
 - If another color is desired, click on the “red” area in the color area. A color chart is displayed.
 - Select the desired color and click OK to complete the process.
- **Size** – Designate the size of the lesion. Click the down arrow in the Size area and select the appropriate size by highlighting.
- **Date** – The date box defaults to Today, which is required for new data entries the first time. After the first Progress Note entry of H&N, the date box defaults to All. The user may click the down arrow and highlight a previous exam to view the entries on a previous date.
- After these selections are made, click the graphic chart area of the screen associated with the finding.
- The designated shape, color and size will be shown on the graphic after the following screen appears and the remainder of the required information is entered.

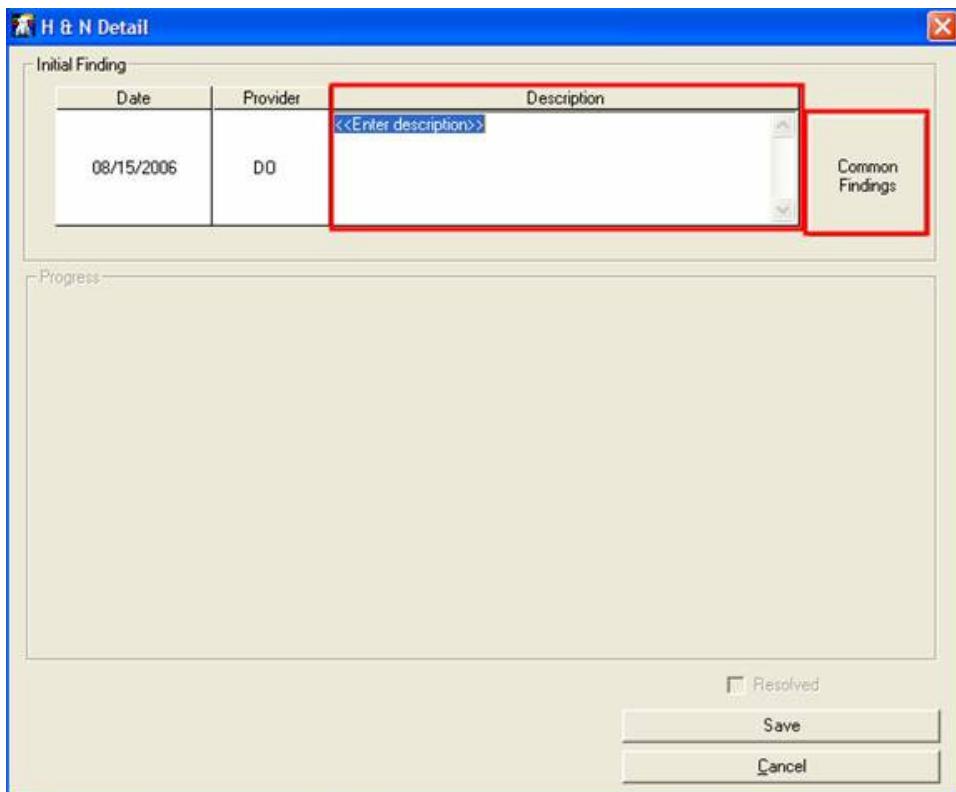


Figure 139: H&N Detail Screen

The H & N Detail screen will appear with the cursor positioned in the “Description” area. A brief description of the finding may be typed and/or click the “Common Findings” button to display the common findings dialogue box.

Clicking the “Common Findings” button displays the following screen:



Figure 140: Common H&N Findings

This Common H&N Findings box displays the descriptions that have been previously populated by the facility. Using the Common Findings descriptions is optional. (See the section called “Using the DRM Plus Menu Bar” for instructions on setting up Common Findings, only an Administrator may permanently add to Common Findings)

Chose the appropriate description by clicking the checkbox(es) and click Add. The following screen is displayed:

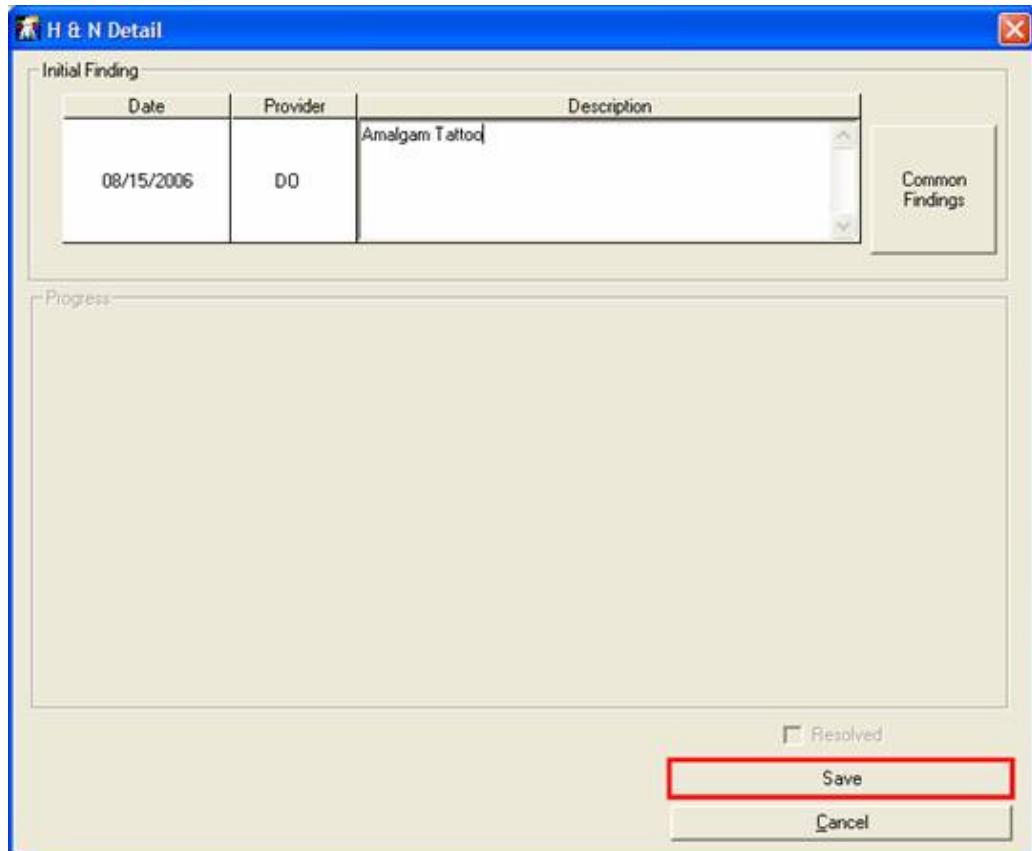


Figure 141: Select Appropriate Description

Click Save to complete this process.

When the Save button is clicked, the H&N transaction table is displayed showing the lesion graphic as shown below:

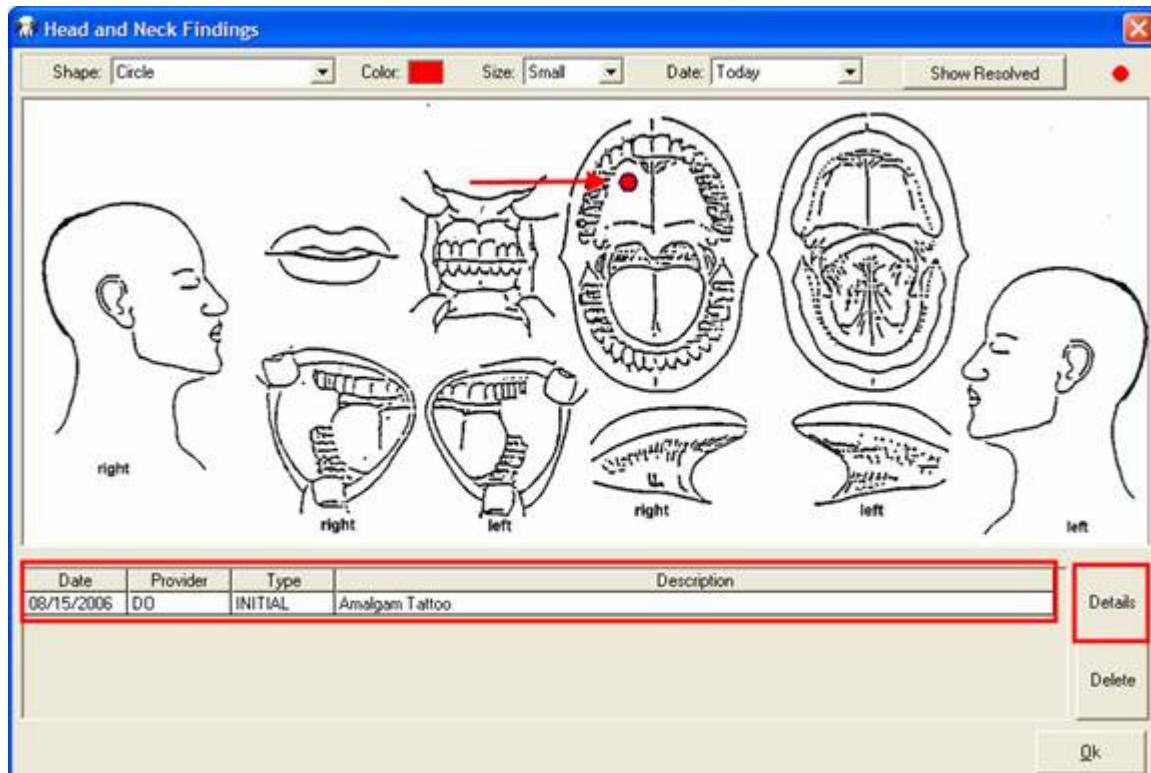


Figure 142: Updated H&N Detail Screen

The H&N entries are automatically displayed in the Progress Note for the encounter.

Clicking the Delete button deletes the highlighted entry.

Assuming a subsequent visit, after clicking on the H&N button, clicking the Details button displays the following screen:

The screenshot shows the 'H & N Detail' window. The 'Initial Finding' section contains one entry: Date 07/24/2006, Provider DO, Description Pigmented lesion. The 'Common Findings' button is visible next to the description. The 'Progress' section is empty, showing a table header with Date, Provider, and Description, and a single row with Date 08/15/2006, Provider DO, and a Description field containing '<<Enter description>>' which is highlighted with a red box. At the bottom is a toolbar with three buttons: 'Resolved' (checkbox), 'Save' (highlighted with a red box), and 'Cancel'.

Figure 143: Adding a New Observation

To enter a new description, type data into the Description textbox. Click the Save button to complete the entry.

Clicking the Cancel button returns a user to the main H&N screen.

If the Resolved checkbox is clicked, the current history of the lesion is removed from the current display.

The history of the resolved lesion may be re-displayed by clicking on the Show Resolved button on the screen below.

Multiple lesions – If multiple lesions have been entered, the Head & Neck screen will appear as follows:

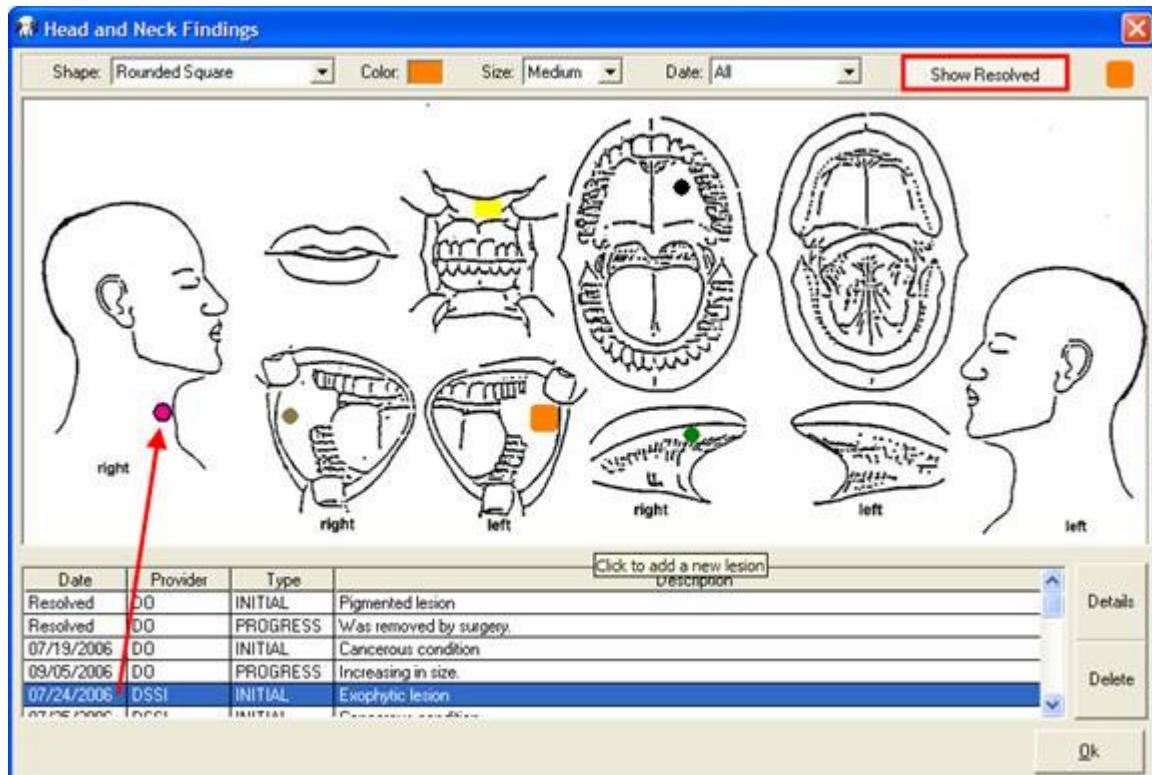


Figure 144: Multiple Lesions

The lesion highlighted in the Description box is designated in the graphic by a black circle around the lesion marker.

History Button

Clicking the History button from the Treatment & Exam screen will display the history of Completed Care. Clicking the History button from the Periodontal Charting screen will display the Periodontal history by date as well as Completed Care and Diagnostic Findings (not including surfaces, roots, etc.). Displaying the Periodontal history is discussed in the Periodontal Chart screen section of this manual. When the History button is clicked from the Treatment & Exam screen, the following screen is displayed:

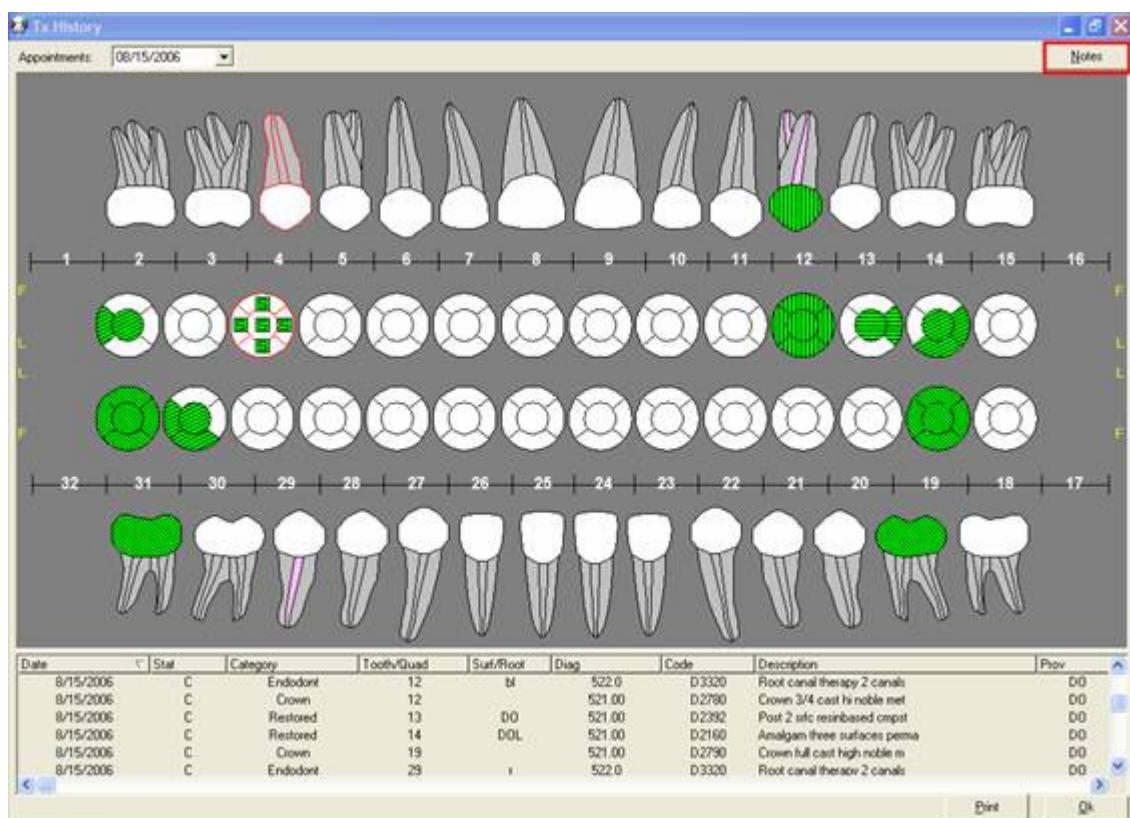


Figure 145: Treatment & Exam History Notes

This screen displays all Completed Care. Clicking on the appointments drop-down arrow allows the user to view the history at various dates.

A Notes button is available for viewing notes.

To view a previous enter tooth-specific note, select the down-arrow of the Appointment box in the top-left corner of the History screen. Highlight the previous date the tooth-specific note was entered. As you select the specific date, the tooth number in the graph will be displayed in yellow. Once you have found the desired tooth with a yellow number, click on the Notes button. Using the scroll bar, teeth appearing with "xxx" with the tooth #, will have associated notes. Highlight any of the teeth desired and the previously written notes will be displayed.

Summary Button

Click the Treatment & Exam screen first (Diagnostic Findings, Treatment Plan, or Completed Care). Then click the Summary button which displays the history of the selected screen. The upper half of the screen shows the summary of the screen that was selected.

Periodontal summary in the lower half of the screen will include the latest exam in Periodontal history, Diagnostic Findings and Completed Care (not including surfaces, roots, etc.).

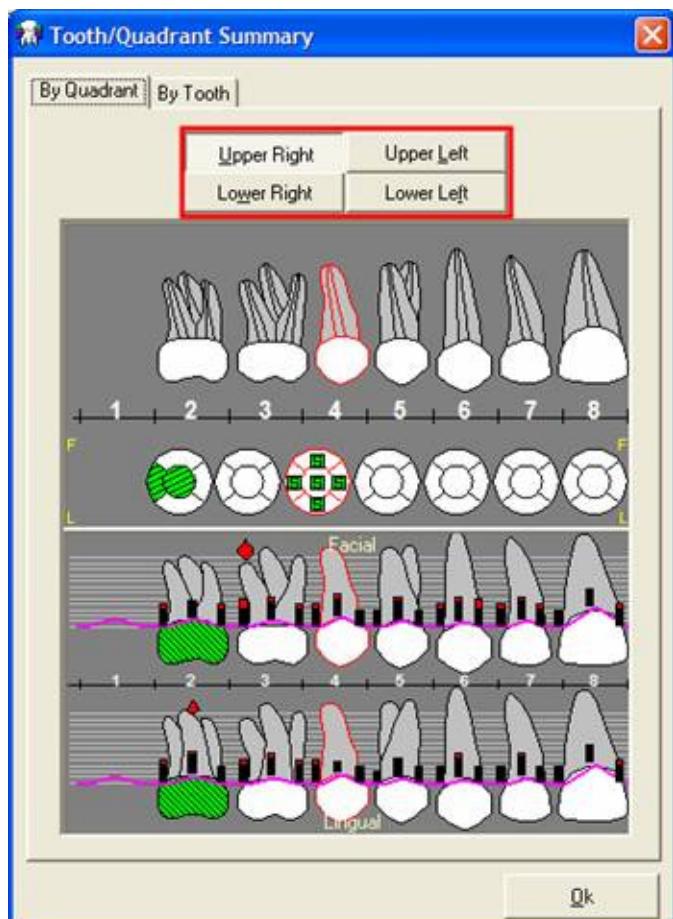


Figure 146: Summary of Quadrant when Completed Care is selected

Clicking the quadrant buttons changes the view to the desired quadrant.

Clicking the By Tooth tab displays the following screen:

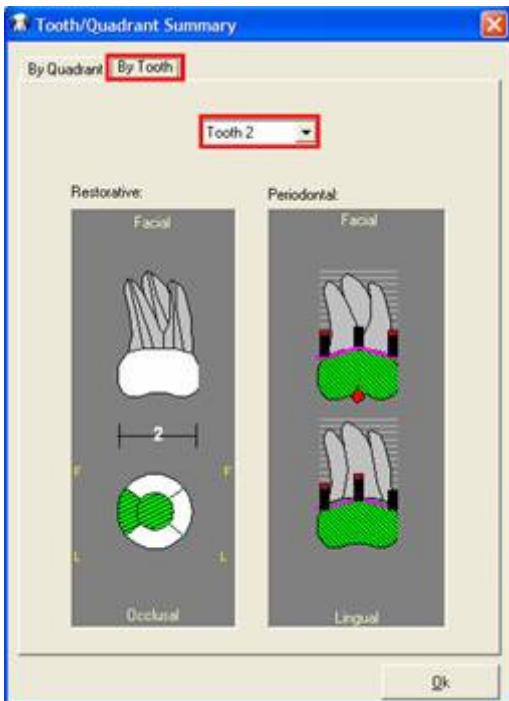


Figure 147: Summary by Tooth

Clicking the tooth box drop down arrow allows changing the tooth view. All periodontal conditions of the latest exam, Diagnostic Findings and Completed Care (not including surfaces, roots, etc.) are displayed on the right half of the screen.

On the left half of the screen, the Restorative will display the history of the selected Treatment & Exam screen.

PSR Button (Periodontal Screening/Recording)

Clicking on the PSR (Periodontal Screening/Recording) button allows recording of values for selected sextants. Clicking on the Definitions button displays a listing and description of the available values.



Figure 148: Periodontal Screening/Recording (PSR)

Clicking in the Sextant boxes allows values to be entered. Clicking OK completes the process.

Plaque Button

Clicking the Plaque button allows recording of plaque values. Clicking the Definitions button displays a listing and description of the available values. Values may be entered in tenths (example = 1.3).

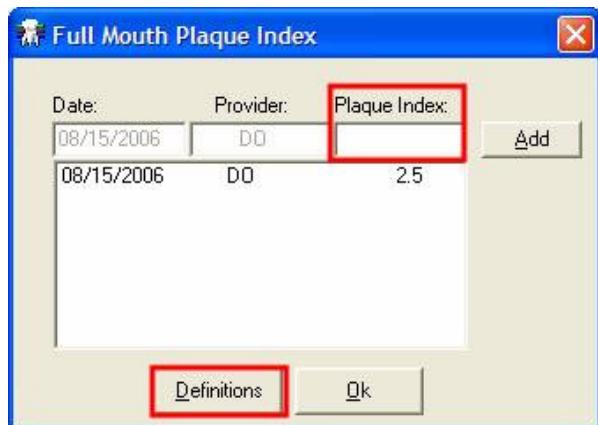


Figure 149: Plaque Button

Entering a value in the Plaque Index box and clicking the Add box sets the date and value for that visit. Clicking OK completes the process.

Note: Deleting a Plaque value during the current exam is accomplished by highlighting the Plaque entry in the Diagnostic Findings transaction table and clicking the Delete button.

Using the DRM Plus Menu Bar

The DRM Plus Menu Bar is available on all screens. Clicking on a menu displays the functions accessible in the drop-down list. Clicking on the desired option initiates the function. Each of the menu options and the related functions are explained below. Additionally a Patient Inquiry can be displayed by clicking on the patient's name.

File Menu Options

Clicking on the File drop-down menu displays the following options:

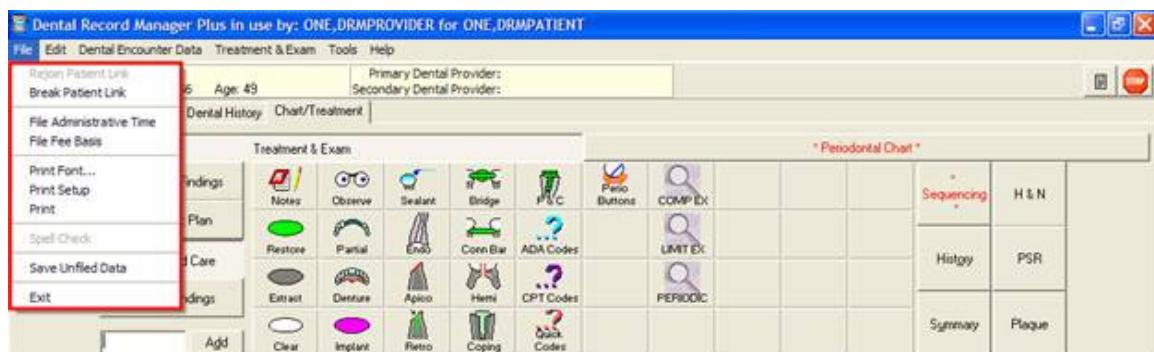


Figure 150: File Menu

Rejoin/Break Patient Link – This option turns on/off using “common patient” in CCOW.

File Administrative Time – This option allows the user to record Administrative, Fee Basis, Education and Training, and Research time in hours and minutes as permitted by the VA.

The following box appears:



Figure 151: File Administrative Time

Choose the appropriate Station by using the down arrow. Then click the appropriate radio button and enter the hours and minutes by using the down arrows or by clicking in the appropriate box and typing the entry.

Note: File Administrative Time is for local use only such as VISN/Clinic. The only way to get credit at the Central Office is using Labor Mapping accessed through Decision Support System (VA-DSS).

File Fee Basis – Allows recording if Fee Basis dollars. The following screen is displayed:

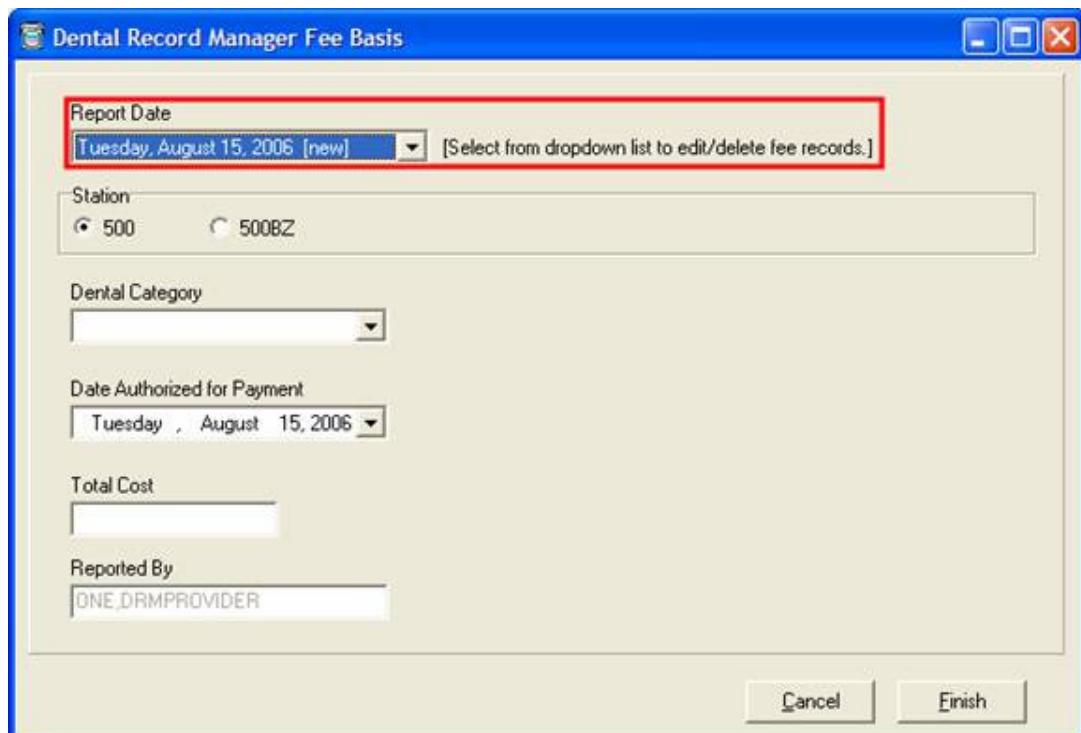


Figure 152: File Fee Basis

By filling in all of the areas on this screen Fee Basis information is recorded and filed in VistA.

Note: The user may edit/delete Fee Basis records by clicking on the drop-down arrow of Report Date. Select the correct historical date by highlighting it and the user may edit/delete that Fee Basis record. After you edit one or all fields, click Finish.

To only enter Fee Basis data inside DRM Plus, a user:

1. Does **NOT** need to be in the Dental Provider file.
2. Does **NOT** need a Person Class in VistA.
3. Does need access to CPRS.
4. Does need access to DRM Plus (DENTV DSS DRM GUI secondary menu option).
5. Does **NOT** need admin access.

If the user does not have an eight digit provider Id (#1 above) in the Dental Provider file, they cannot run any reports.

Print Font – If permitted, this option allows users to set individual print fonts for those areas that are available for printing.

Print Setup – If permitted, allows users to select a printer, paper size and source, and orientation of printing from within printable areas.

Print – If permitted, allows users to print from the printable areas. Within selected printable areas, selecting the print option displays associated screens that include prompts for printing. In areas not designated for printing, the Print option will be grayed out (ghosted). The following screen is displayed when Print is selected:

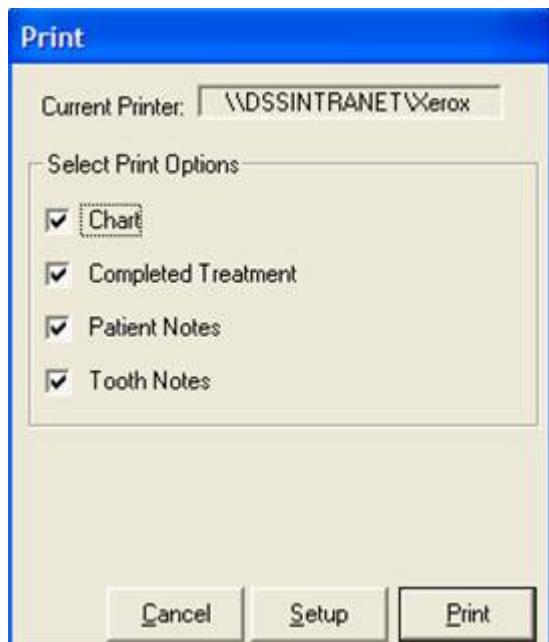


Figure 153: Print Options

The Print options are dependent on the screen displayed when the option is chosen. In the above example, the Completed Care screen was open. If the Treatment Plan screen had been opened, the Treatment Plan would display as the option for printing.

Note: If no other screens are included with the active screen, the Select Print options will print out the following:

- **Chart** – prints the graphical chart of Completed Care
- **Completed Treatment** – prints the transaction table of Completed Care
- **Patient Notes** – prints the patient notes
- **Tooth Notes** – prints the tooth notes

Spell Check – Allows users to spell check the patient Progress Note or addendum before filing in CPRS. The Spell Check option exists only in the areas of unsigned Progress Notes or unsigned addendums.

Save Unfiled Data – See the Diagnostic Findings, Treatment Plan, or Completed Care sections of this manual for instructions on using this option.

Exit – Allows user to exit DRM Plus.

Edit Menu Options

Clicking on the Edit drop-down menu displays the following options:

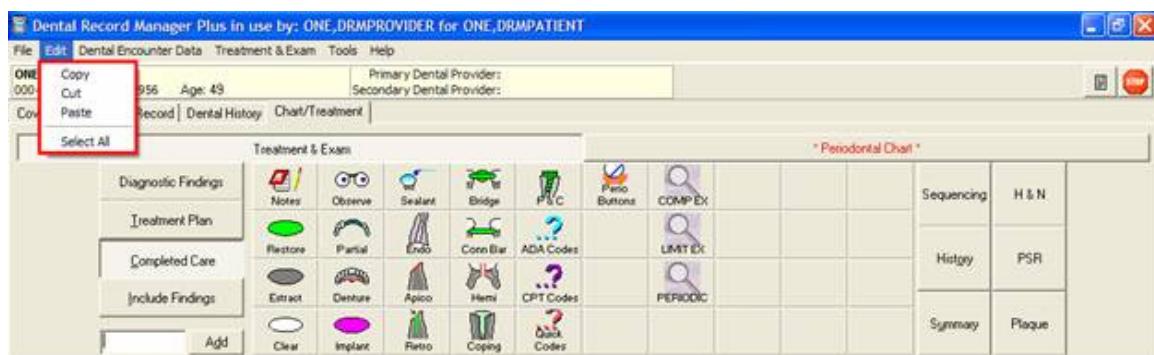


Figure 154: Edit Menu

Copy – Allows users to copy highlighted text to the computer clipboard and paste the text elsewhere while leaving the original copied text in place.

Cut – Allows users to cut (remove) highlighted text and move the text to the computer clipboard in order to paste elsewhere.

Paste – Allows users to paste (place) information from the computer clipboard (copied or cut) to a desired area of the computer or to a document.

Dental Encounter Data Menu Options

Clicking on the Dental Encounter drop-down menu displays the following options:

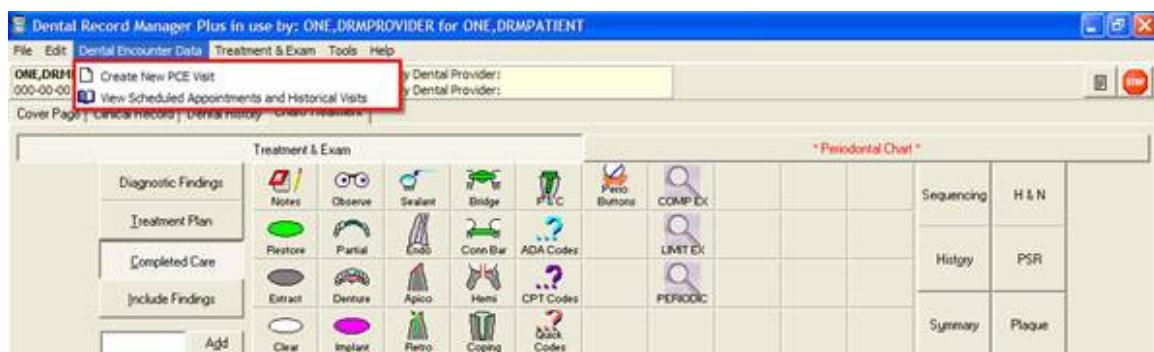


Figure 155: Dental Encounter Data Menu

Create New PCE Visit – Allows users to create a New PCE Visit by following the prompts in the subsequent screens that are displayed. The location can be set up as a default, refer to “Selecting a Default Location.”

Note: Does not update Appointment Manager in VistaA.

When PCE Visit creation is not allowed "on the fly" by the administrator of DRM Plus, then users will be forced to select an existing visit for their DRM Plus data. If the administrative parameter is set, then the option Create New PCE Visit will be disabled.

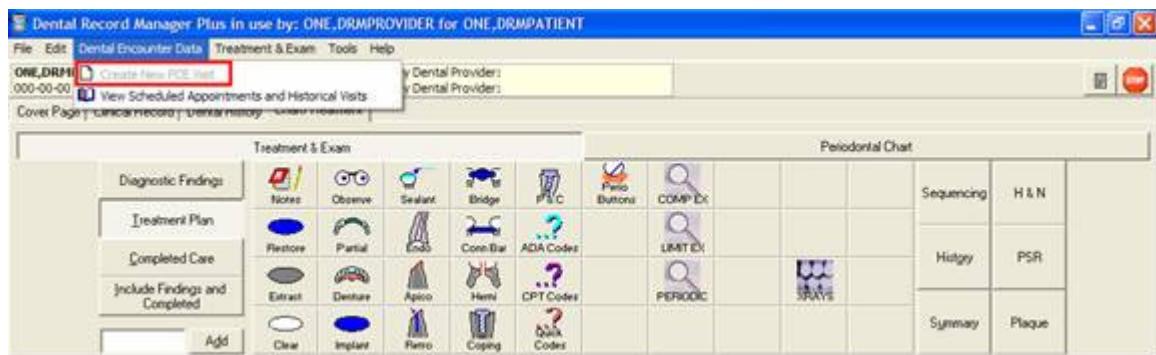


Figure 156: New PCE Visit option disabled

The Select Visit Date/Time screen also changes if the administrative parameter is set which is shown in the following screen shot.

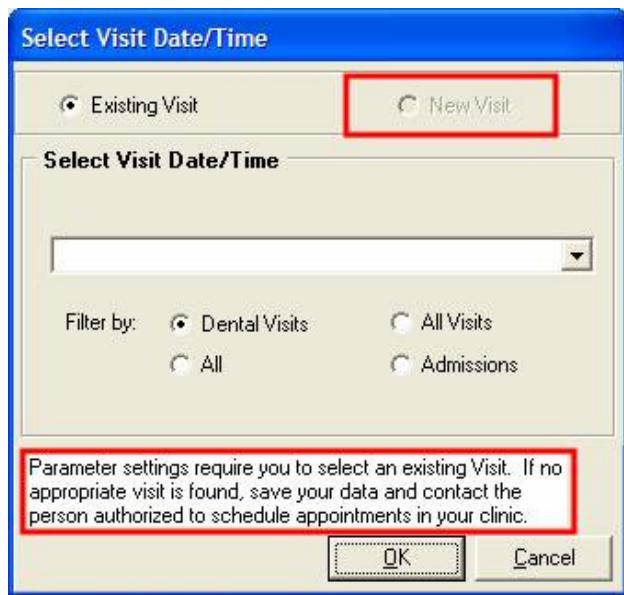


Figure 157: New PCE Visit not allowed

View Scheduled Appointments and Historical Visits – Allows users to view scheduled appointments, historical visits, and hospital admissions.

Treatment & Exam Menu Options

Clicking on the Treatment & Exam drop-down menu displays the following options:

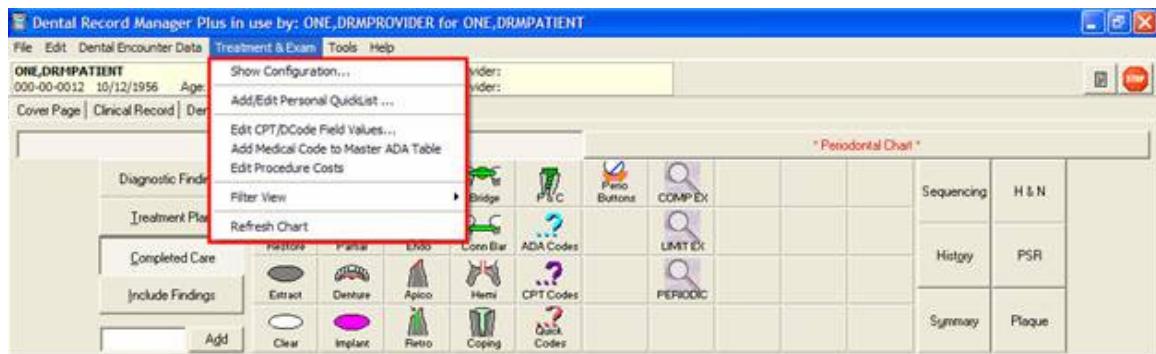


Figure 158: Treatment & Exam Menu

Show Configuration – Allows users to change some application settings from the default settings to different settings based on individual needs.

Add/Edit Personal Quicklist – Allows users to develop and maintain a Quicklist for frequently used ADA codes (allows Multi-Add functionality).

Edit CPT Code Field Values – Discussed in the Administrative Manual.

Add Medical Code to Master ADA Table – Discussed in the Administrative Manual.

Edit Procedure Costs – Discussed in the Administrative Manual.

Filter View – Allows users to set episode of care and date range views.

Using the Show Configuration options – This function provides a major tool for the user to configure DRM Plus to meet specific needs. Clicking on the Show Configuration option displays the following screen. The Tx & Exam tab is the default setting.

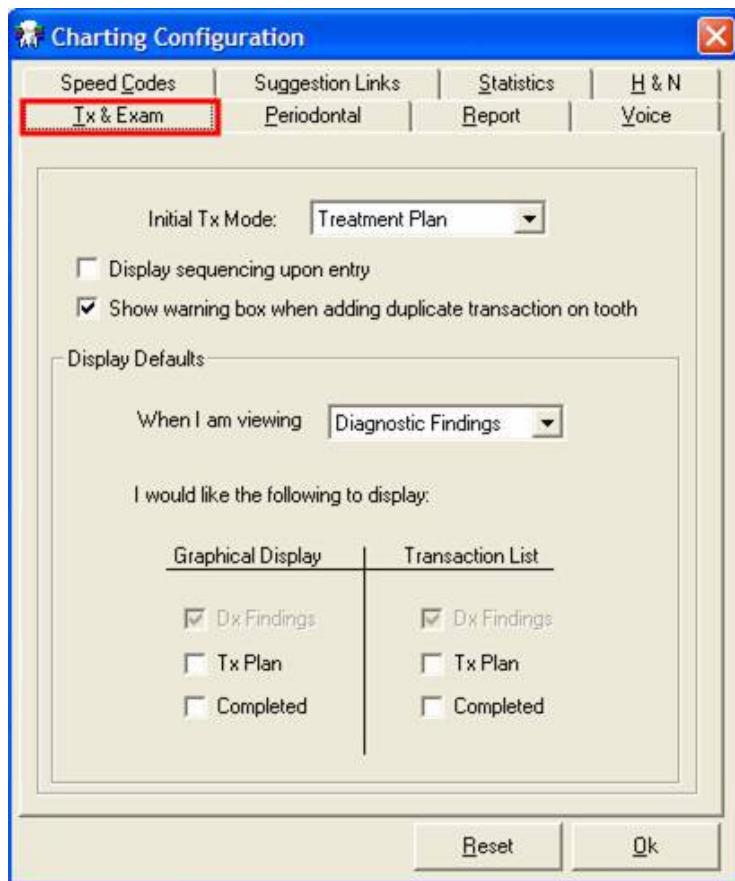


Figure 159: Configuration Options – Tx & Exam tab

Each of the tabs on this screen displays options for adjusting default settings.

Tx & Exam tab – The Tx & Exam tab presents the following options:

- **Initial Treatment Mode** – Click on the down arrow to set the initial view for the Treatment & Exam screen.
- **Displaying Defaults** – Click the down arrow and select the desired Treatment & Exam screen view. Use the checkboxes to designate the Graphical Display and the Transaction List preferences. Repeat this process for each Treatment & Exam screen view. Click OK to save the new preferences.

Note: The provider may choose to display Sequencing screen upon entry by clicking the checkbox.

Note: The “Show warning box when adding duplicate transactions on tooth” will be a default setting.

Periodontal tab – Clicking on the Periodontal tab displays the following screen and the displayed options.

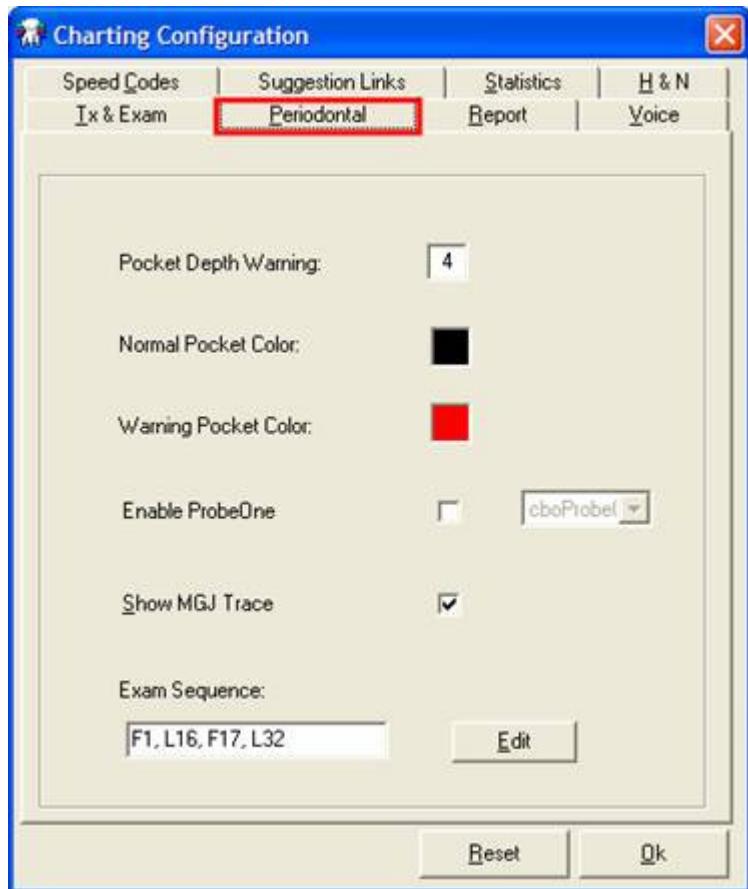


Figure 160: Charting Configuration Periodontal Tab

Clicking in each of the checkboxes begins to process of setting the preferences for the options displayed. Follow the subsequent prompts and screens.

Note: The Enable ProbeOne option is disabled at this time.

Exam Sequence - Click the Edit button to display and select the Exam Sequence preference. Click OK to save the new preferences. Clicking Reset returns the Perio sequence to the original default.

Note: Warning levels can be changed and then displayed. The Pocket Depth warning level in the Statistics tab must be the same as the Pocket Depth Warning in the Periodontal tab. (See the section called “Using the DRM Plus Menu Bar”).

Report tab – Clicking on the Report tab displays the following screen and the displayed options.

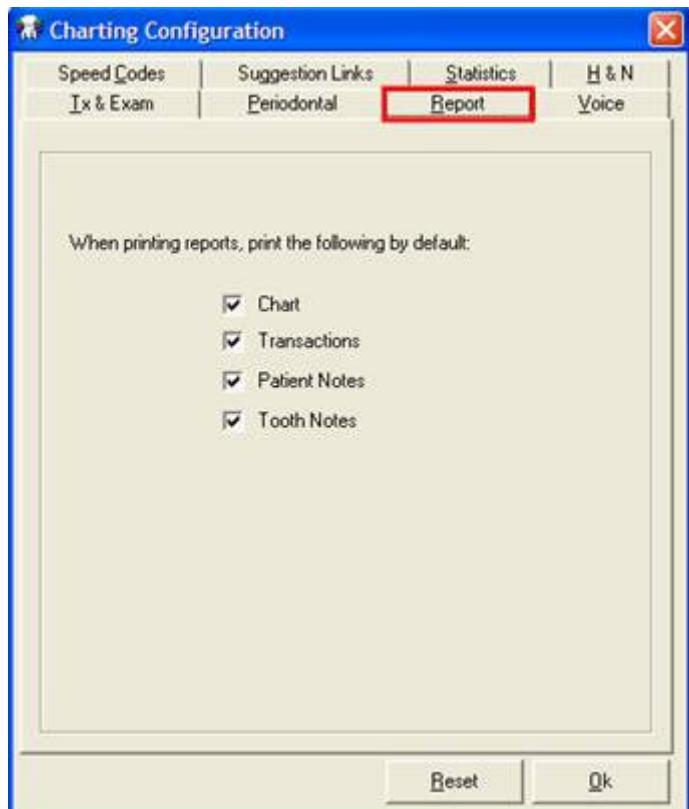


Figure 161: Charting Configuration Report Tab

Click in the checkboxes to designate the new preferences which will allow the options to be available from the Print option in the File drop-down menu.

Click OK to save the new preferences.

Voice tab – This function is not in enabled at this time.

Speed Codes tab – Clicking this tab allows selection of ADA codes to be assigned to a new icon on the Treatment Plan and Completed Care views of the Treatment & Exam screen.

When the Speed Code tab is clicked, the following box is displayed:

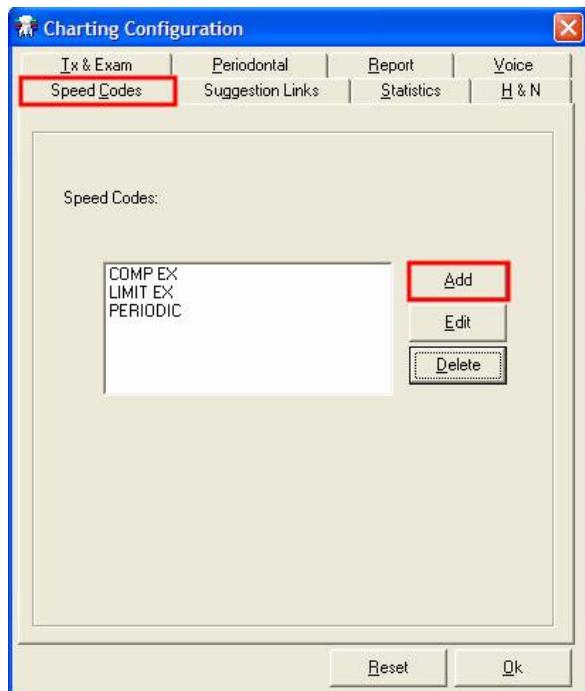


Figure 162: Charting Configuration Speed Codes Tab

To initiate the process for designating the ADA Codes to be grouped under a new icon, click the Add button. The following screen is displayed:

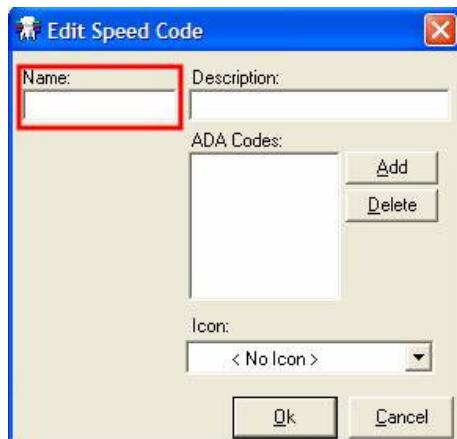


Figure 163: Edit Speed Code

Click in the Name box and designate a Name for the new icon. In this example, XRAYS will be the name. Click in the Description box and type in a description (optional). In this example, Common will be typed. This will show when the cursor hovers over the new icon.

The Speed Code's name and description will appear as in the following screen:

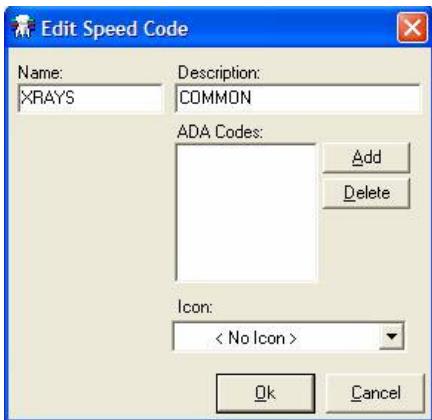


Figure 164: Speed Code Named

The process of designating the desired ADA codes begins by clicking the Add button. The following box is displayed:

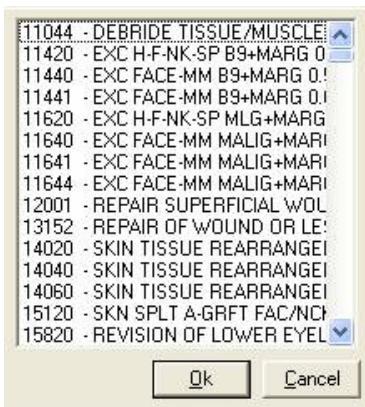


Figure 165: Highlight Desired CPT Code

Highlight the desired code and click Ok. The Speed Code's ADA code will appear as indicated in the following screen:



Figure 166: Speed Code's ADA code

Multiple codes may be added. Repeat the code selection process until all desired codes appear in the ADA Codes box.

An icon graphic can be chosen by using the drop-down arrow next to the Icon box. The following screen will be displayed:

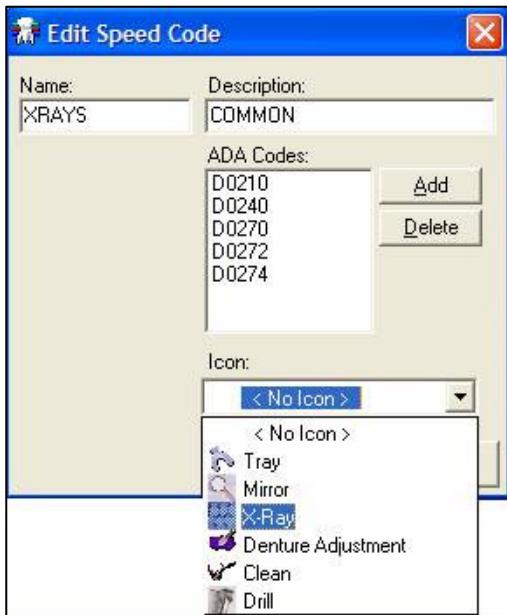


Figure 167: Choose Icon

Highlight the desired icon. Click on Ok to begin the finalization of this process. The Speed Code's icon will appear as displayed in the following screen:

Note: Several codes have been selected.

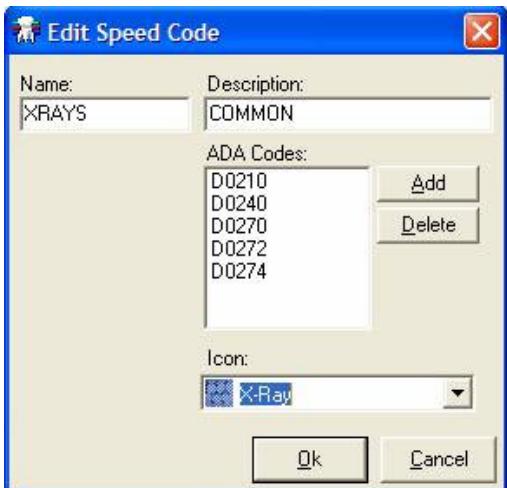


Figure 168: Finalization Screen

Click Ok again.

The Speed Code appears as displayed in the following screen:

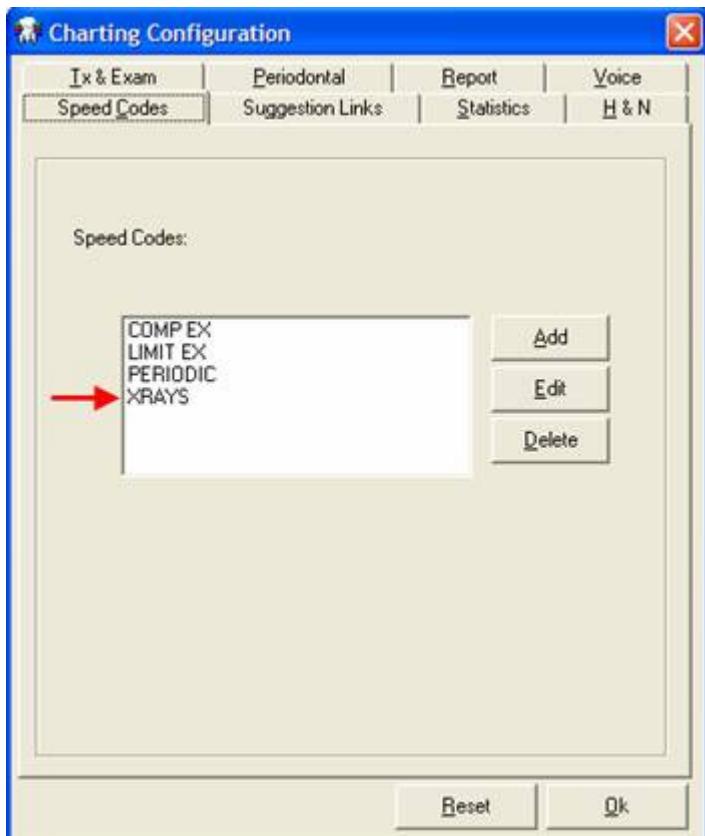


Figure 169: Newly Created Speed Code

To Edit or Delete the XRAYS Speed Codes grouping, highlight the name and click the Edit or Delete buttons. Provide appropriate entry in the subsequent screens; otherwise click Ok to complete this part of the process.

To complete the Speed Code process, move to the Completed Care view of the Treatment & Exam screen and click on one of the undesignated icons squares. Click on the drop-down arrow and highlight desired Speed Code and click. Click the Ok button and the Speed Code will be loaded on that icon.

The following screen will be displayed:

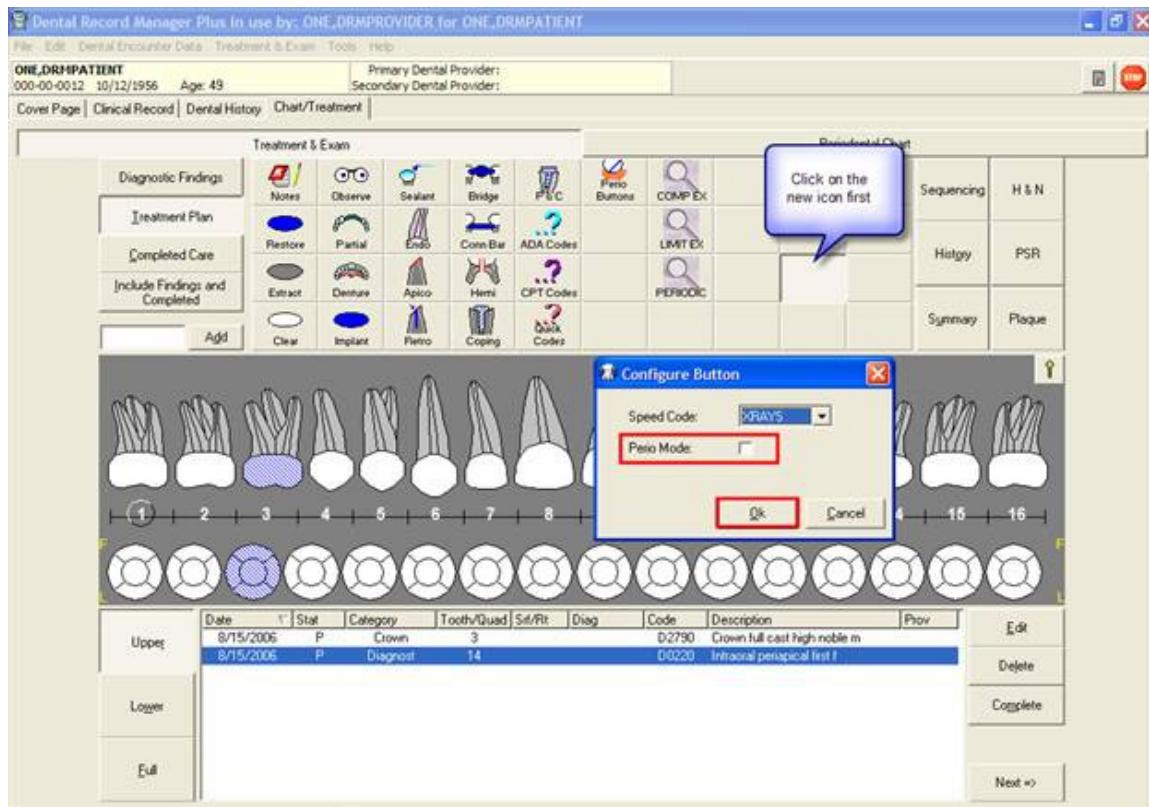


Figure 170: Configure Speed Code in non-Perio Mode

The Perio Mode checkbox 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 on the Perio Buttons will display any Speed Code icons that have been designated in the Perio Mode (checkbox clicked) while hiding any non-Perio Mode Speed Code icons from the display. Clicking the Perio Buttons again reverses the display. This option allows for a total of 38 Speed Code icons to be created. The non-Perio mode Speed Codes are the default Speed Code icons when you initially open up DRM Plus.

Click OK to complete naming the new icon. The new icon name will appear (highlighted) in the Treatment Plan and Completed Care screen views as displayed on the following screen:

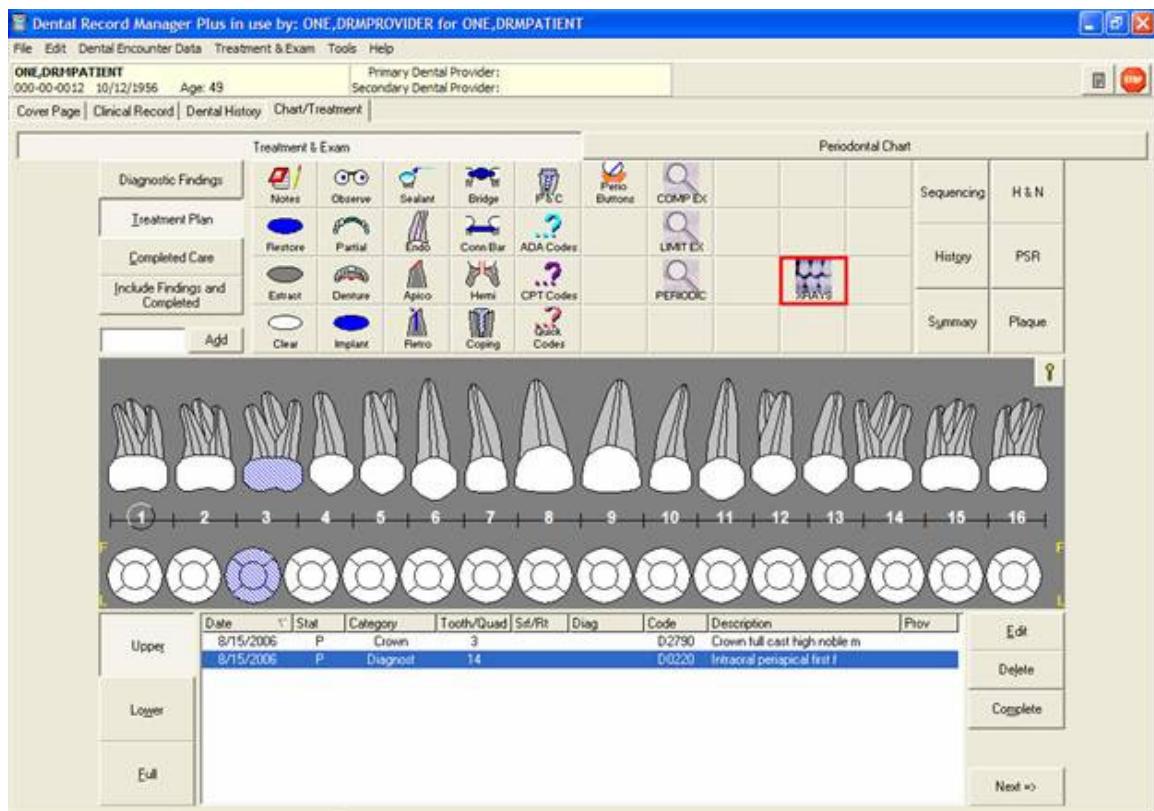


Figure 171: Speed Code Icon in Completed Care Screen

When entering Treatment Plan or Completed Care procedures, the Speed Code icon may be accessed via a click. The following screen will be displayed if any of the codes require modifier entry. Check marks in the available check boxes indicate which codes will be included in the Treatment Plan or Completed Care entry. D0240 will require a tooth entry.

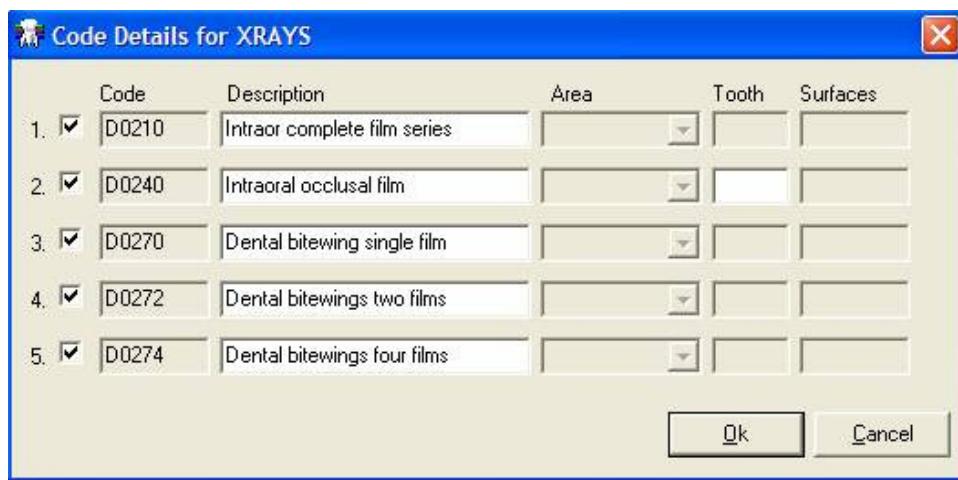


Figure 172: Speed Code Details for XRAYS

Click OK to complete the process.

If none of the codes designated in the Speed Code setup require modifier entries, the following screen will appear in succession for each code when using the Completed Care screen.

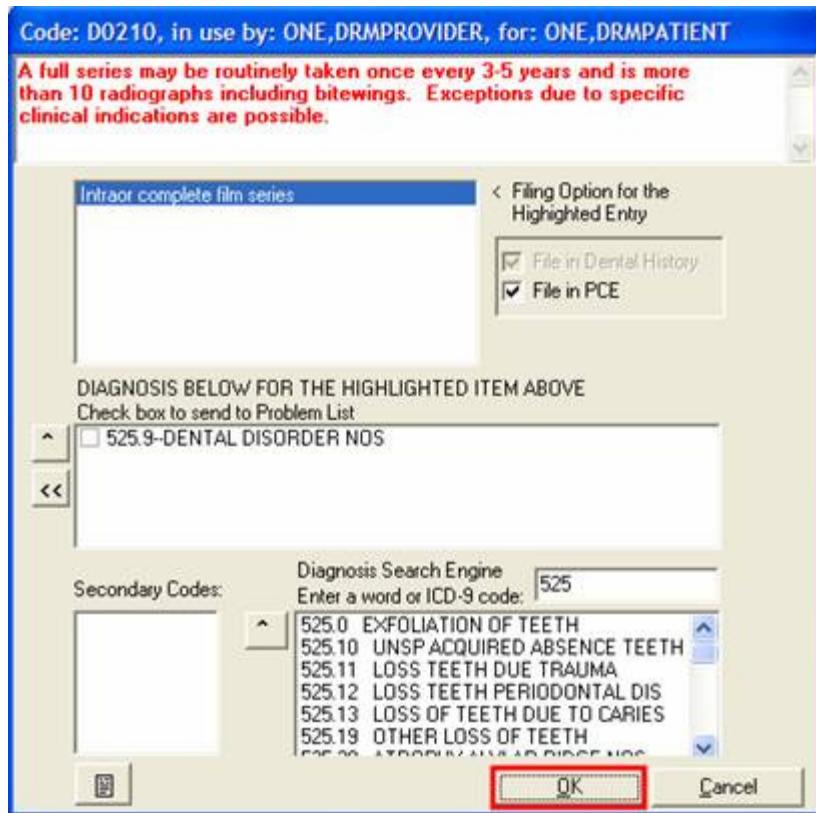


Figure 173: No Codes Designated Require Modifier Entries

Clicking OK includes the code in Completed Care. Clicking Cancel excludes the entry in Completed Care. When this decision is made, the Filing Option/Diagnosis screen for the next code is automatically displayed.

Suggestion Links tab – Clicking on this tab initiates a process that allows users to "link" two or more ADA codes. For example: the Exam code D0140, may be linked with the Bitewings code, D0274. When entering Completed Care entries and code D0140 is selected, DRM Plus will ask the user if they would also like to enter code D0274. When the Suggestion Links tab is clicked, the following screen is displayed:

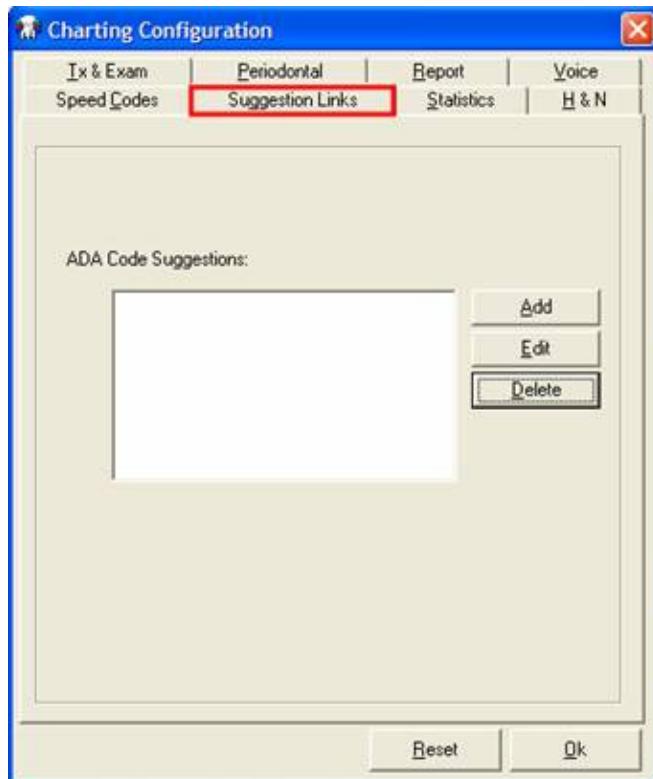


Figure 174: Charting Configuration Suggestion Links Tab

Click the Add button. The following screen is displayed:

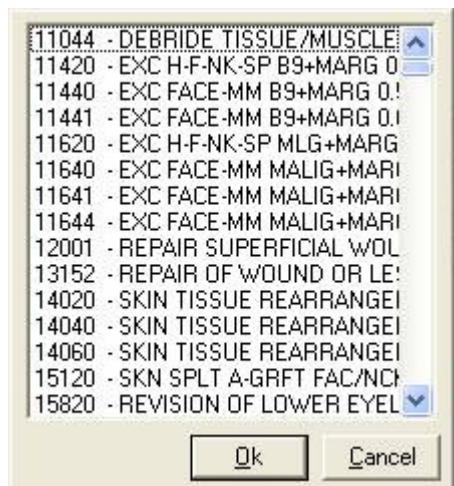


Figure 175: Select Primary ADA Code

Highlight the first of the codes that will be linked with another code and click OK.

The following screen is displayed:

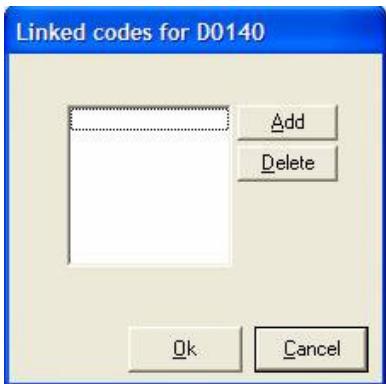


Figure 176: Linked Codes for D0140

Click the Add button to initiate designating the second code to be linked. The following screen is displayed:

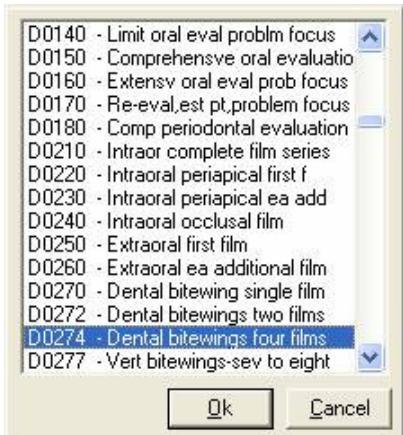


Figure 177: Select Second Code to Be Linked

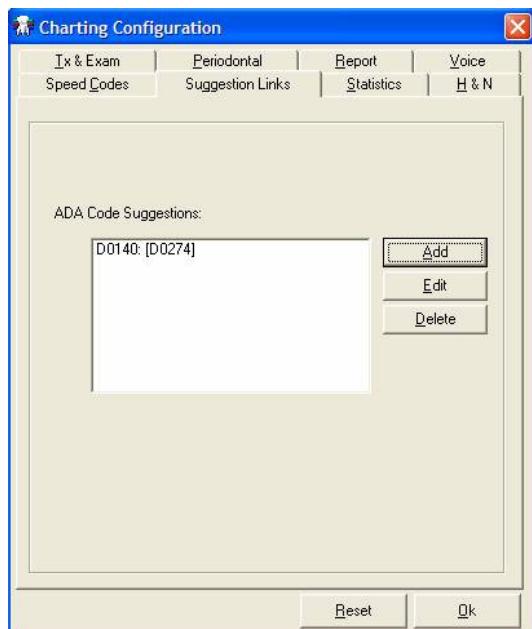
Highlight the second code to be linked and click OK.

The following screen is displayed:



Figure 178: D0274 is Linked to D0140

Additional codes may be added by repeating the process of clicking the Add button. When all desired codes have been linked, click OK. The following screen is displayed as illustrated on the following screen:



Note: Suggestion Link codes work when using the icons, ADA codes icon list, CPT codes icon list, and/or Quick Codes icon list; however, Suggestion Links are not functional with Speed Codes.

Figure 179: ADA Code Suggestions

Click OK to complete the process. The Edit and the Delete buttons may be used to adjust the linked codes. When entering Treatment Plan or Completed Care procedures, the user will be given the option to choose the linked code from a pop-up box after the Primary ADA code was selected.

Statistics tab – Clicking on the Statistics tab displays the following screen:

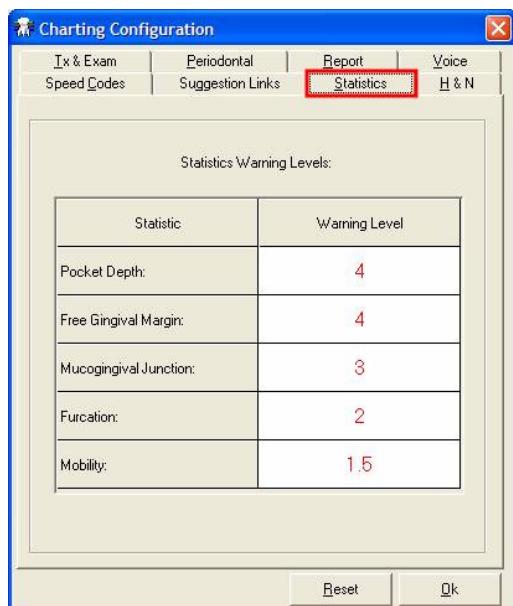


Figure 180: Charting Configuration Statistics Tab

Double click in a Warning Level box to change the warning value. The following box is displayed:

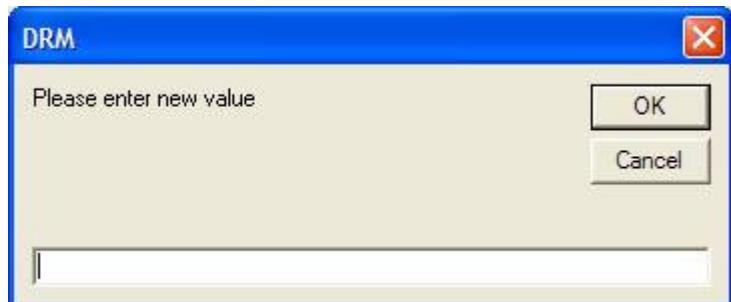


Figure 181: Warning Levels

Enter a value and click OK.

Repeat this process for each Statistic as desired. Clicking on OK completes the process.

Note: Warning levels can be changed and then displayed. The Pocket Depth warning level in the Statistics tab must be the same as the Pocket Depth Warning in the Periodontal tab. (See the section called “Using the DRM Plus Menu Bar”).

Head & Neck (H & N) tab - Clicking on the H & N tab displays the following screen:

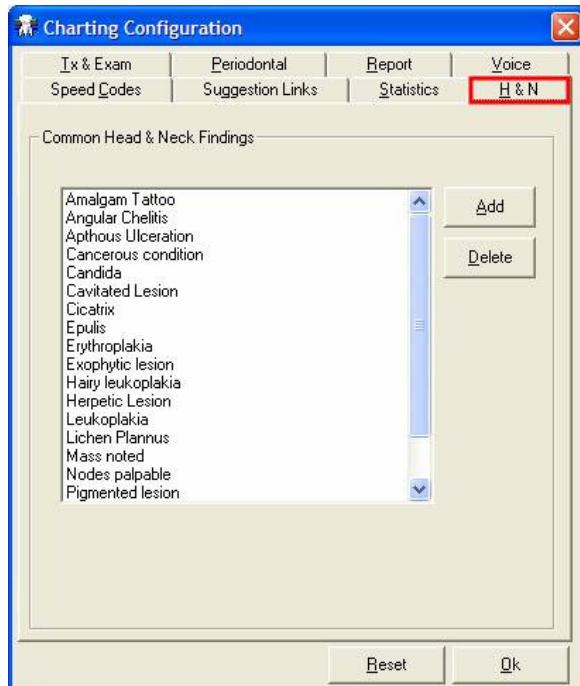


Figure 182: Charting Configuration H&N Tab

A DRM Plus administrator may permanently add Common Head & Neck Findings here for later use when describing lesions found during a Head & Neck examination. The regular user may enter new Head & Neck Findings that will be stored for 24 hours. The Delete button may be used to remove a Finding Description.

Clicking the Add button displays the following box:

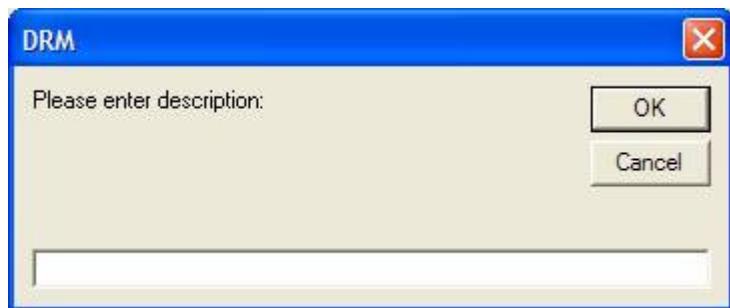


Figure 183: Enter Desired H&N Findings

Enter the desired H&N Findings and click OK. Repeat the process as desired. The new common finding will be added to the list of existing common findings.

Add/Edit Personal Quicklist – This option allows users to create, add to, edit, and delete codes associated with the Quick Codes icon displayed on the Treatment Plan and Completed Care views of the Treatment & Exam screen.

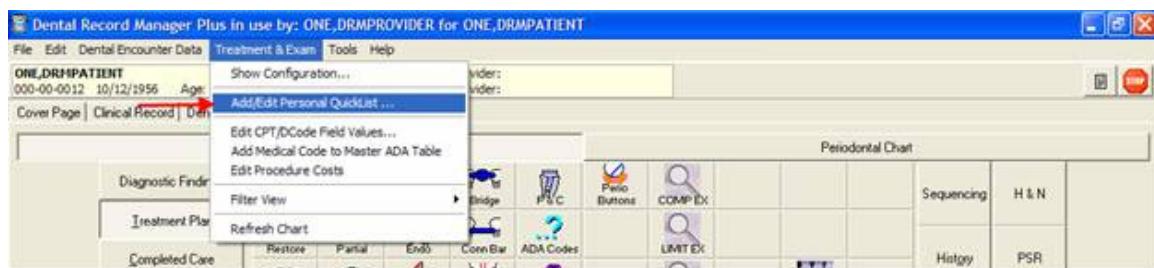


Figure 184: Add/Edit Personal Quick List

Clicking on this option displays the following screen:

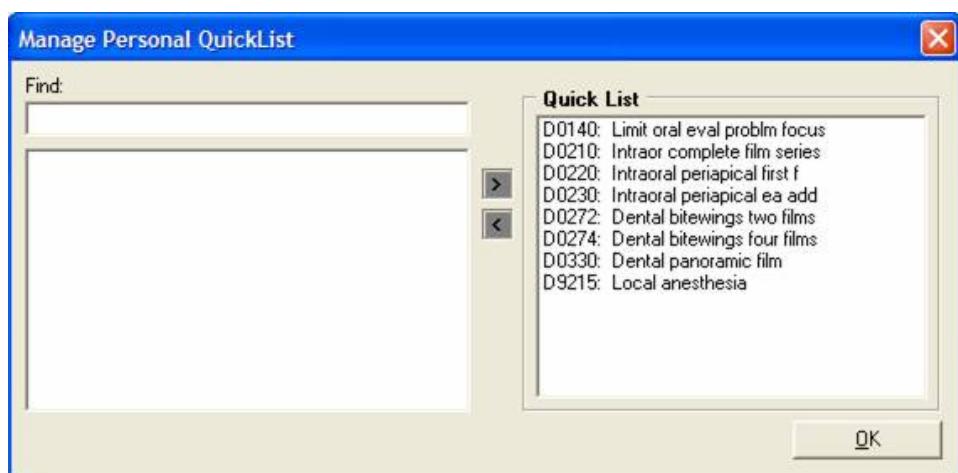


Figure 185: Manage Personal Quick List

Enter ADA codes search criteria in the Find box and press Enter. The following screen is displayed:

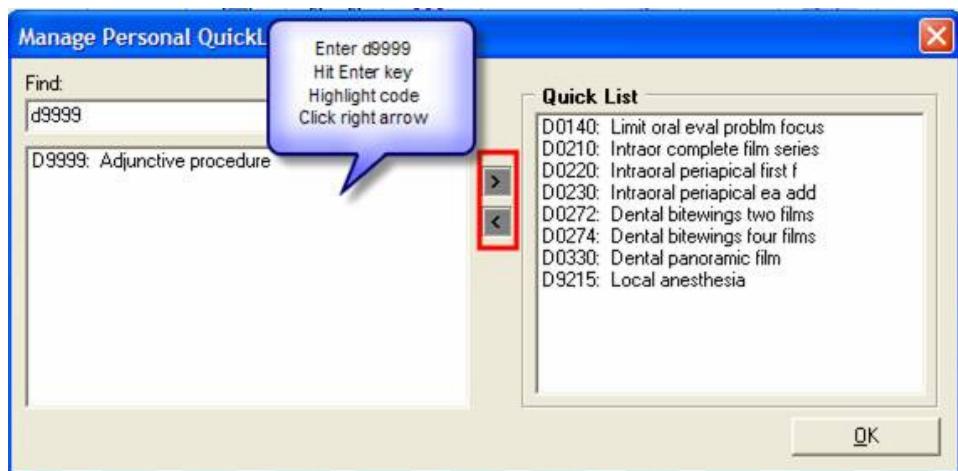


Figure 186: Add Selected Codes to Quicklist

Use the directional arrows to add the selected code to the Quicklist. The directional arrows may also be used to delete codes from the Quicklist. Clicking OK completes the process. The user may select from a complete category of the ADA Codes by entering [d0, d1, d2, etc...].

Edit CPT Code Field Values – Discussed in the Administrative Manual.

Add Medical Code to Master ADA Table – Discussed in the Administrative Manual.

Edit Procedure Costs – Discussed in the Administrative Manual.

Filter View – Allows users to set episode of care and date range views. The following options are displayed:

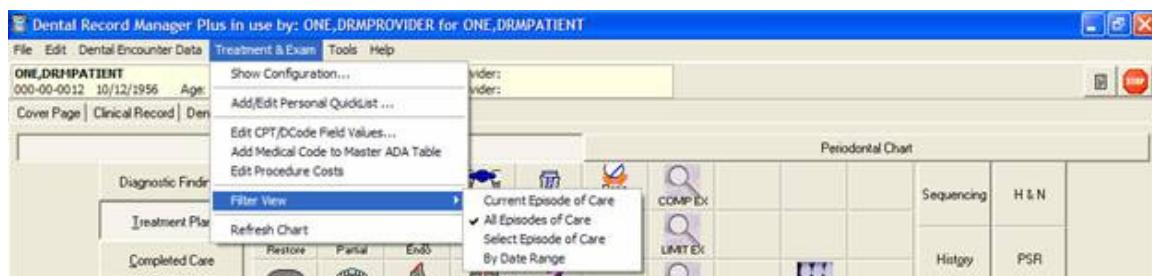


Figure 187: Filter View

Select the desired option. The Treatment & Exam screen view will show entries entered during the selected period. If Select Episode of Care is selected, a pop-up screen appears allowing designation of the desired episode of care. If By Date Range is selected, screens allowing the designation of the start and end dates will be displayed.

The following procedures, even if completed prior to the start date will still be reflected in the screen view: Missing, Extract, Retained Roots, Implants, Impacted, and Hemi Section. If these same procedures have been entered subsequent to the end date, a message box will be displayed notifying the user of the subsequent entry.

Tools Menu Options

Clicking on the Tools drop-down menu displays the following options:



Figure 188: Tools Menu

Window Calculator – Use this calculator to do simple calculations, or in scientific view to do advanced scientific and statistical calculations.

Windows Explorer – GUI interface that is used to navigate to other parts of the PC or LAN. This facilitates a series of Windows-related tasks such as changing passwords, folder operations, customizing/changing Start menu, etc.

Windows Notepad - A text editor that is used for creating simple documents or for creating Web pages.

User Inquiry – This function can be used as a phone directory or locator for co-workers. It may also be used to edit the users VistA information. Clicking on the User Inquiry option displays the following screen:

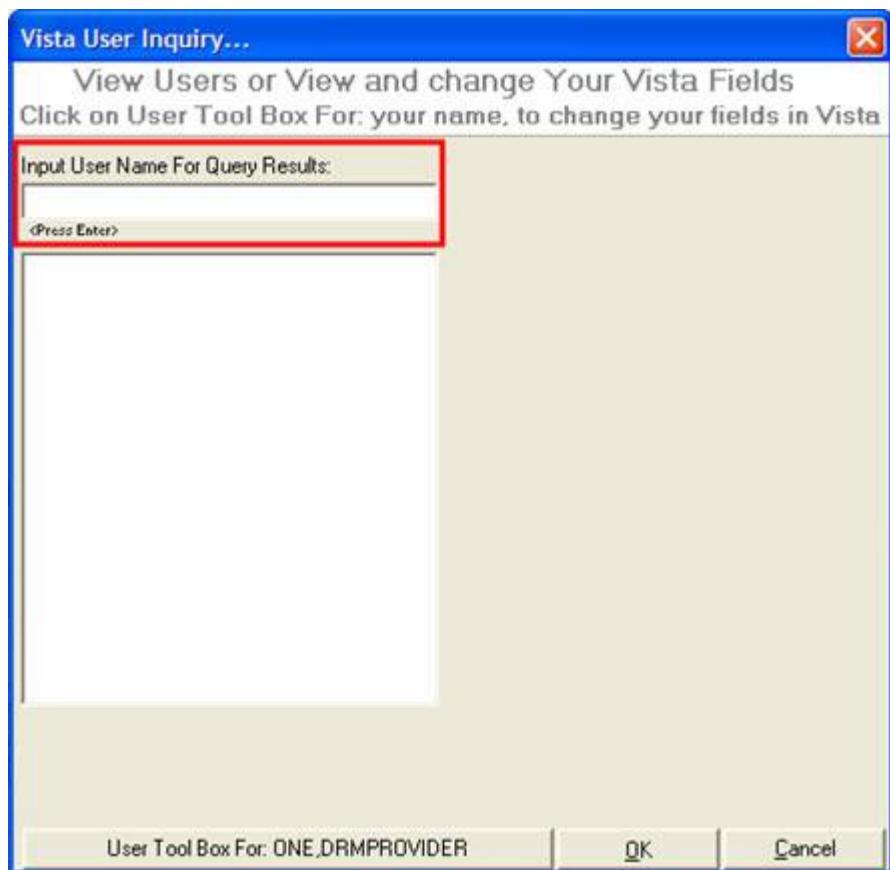


Figure 189: VistA User Inquiry

Enter search criteria in the Input User Name box and press Enter to display the selection choices. Click on the desired match to display the VistA information. If making changes is permitted by IRM, they may be initiated from this screen by clicking on the User Tool Box.

User Options – If the appropriate permissions have been granted to the user, this option allows the current user to set certain DRM Plus parameters.

General tab – The **Date Range Defaults** button allows users to customize the number of days DRM Plus looks back for numerous options such as Visits/Admissions, Progress Notes, Lab Results, and Tooth History. The following screen is displayed:

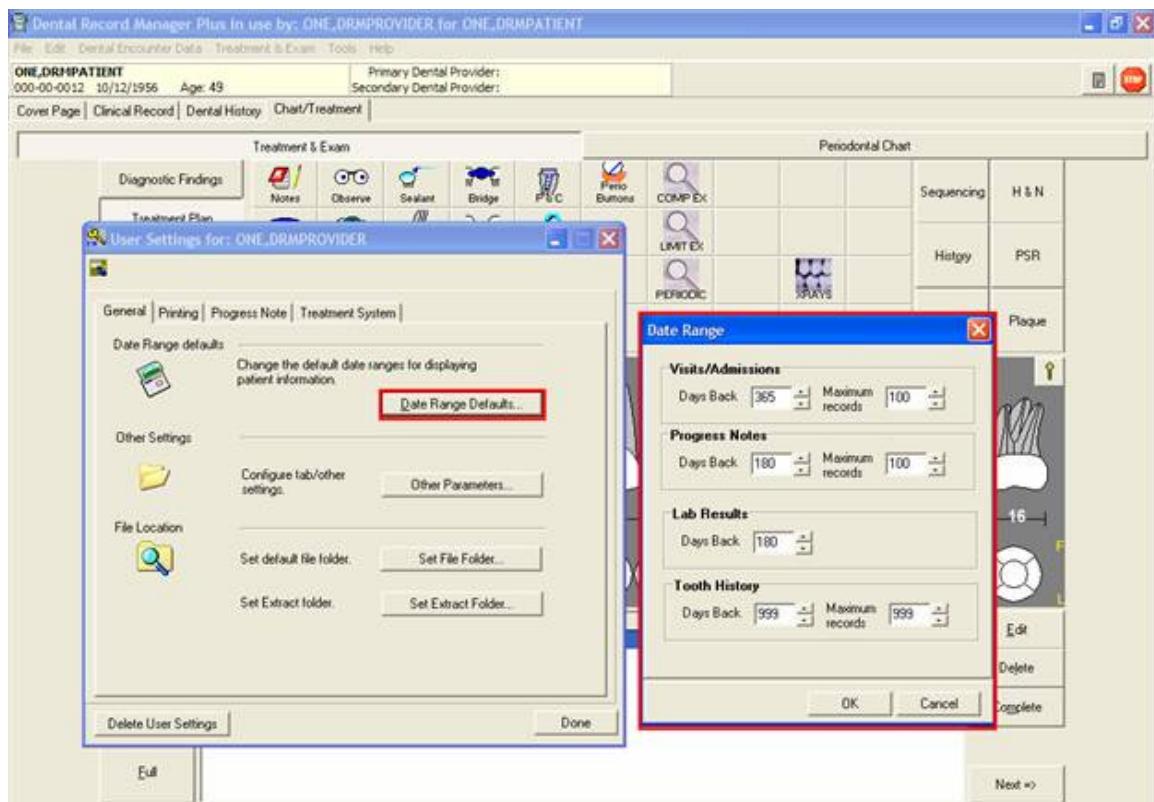


Figure 190: Date Range Defaults

Set the new values by clicking in the appropriate boxes and typing the desired values or by using the arrows. Click OK to complete the process.

Note: The Date Range defaults should not be changed unless you check with local IRM support. Increasing these values can degrade overall network/systems performance.

The **Other Parameters** button allows users to set the screen tab settings order of preference. The following screen is displayed:

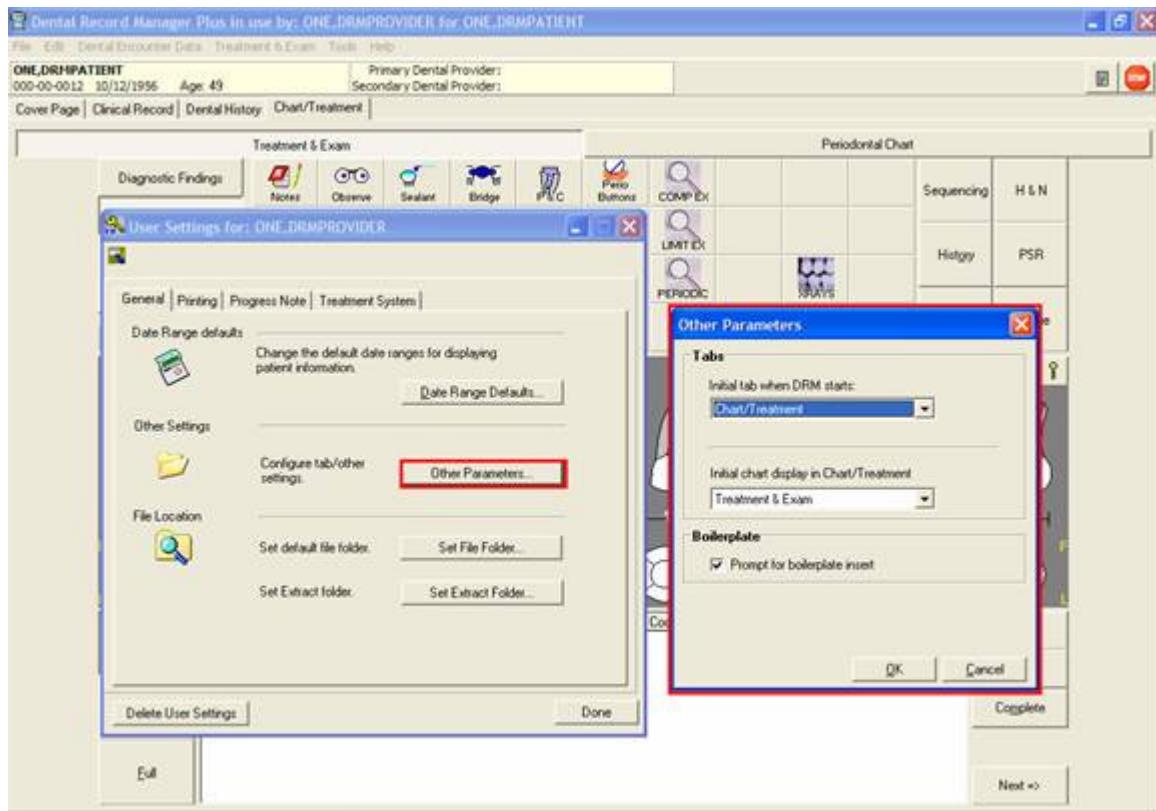


Figure 191: Other Parameters

Use the pull-down arrow to select the desired initial tab to be displayed when DRM Plus is opened. At the bottom of the Other Parameters screen is a checkbox option that allows boilerplate inserts to be prompted or not. These boilerplates are residing in CPRS and are usually tied to a Progress Note title.

The user will have a choice to select “Initial tab when DRM starts” using the drop-down arrow shown in the following screen.

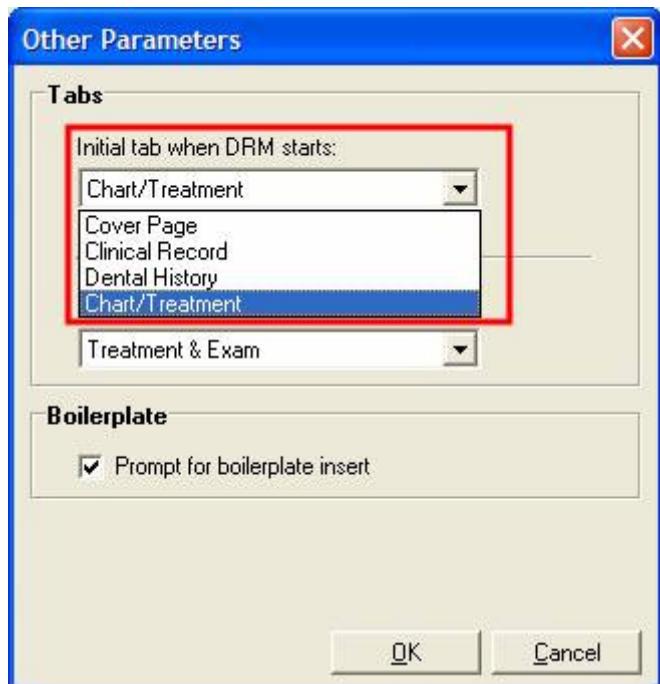


Figure 192: Initial tab when DRM Plus starts

The user also has the choice to select “Initial chart display in Chart/Treatment” using the drop down arrow shown in the following screen.

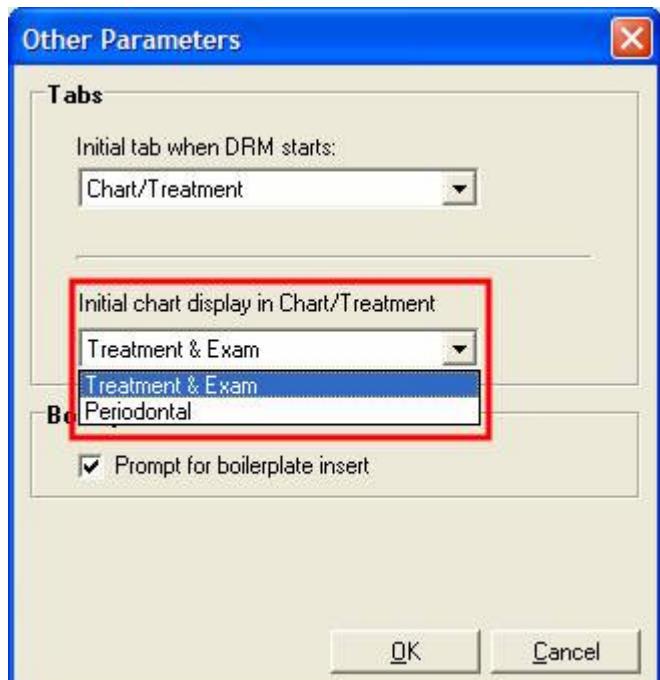


Figure 193: Initial chart display in Chart/Treatment

The **Set File Folder** button allows users to set the directory/file location where the text files are located for importing into a patient Progress Note. The following screen is displayed:

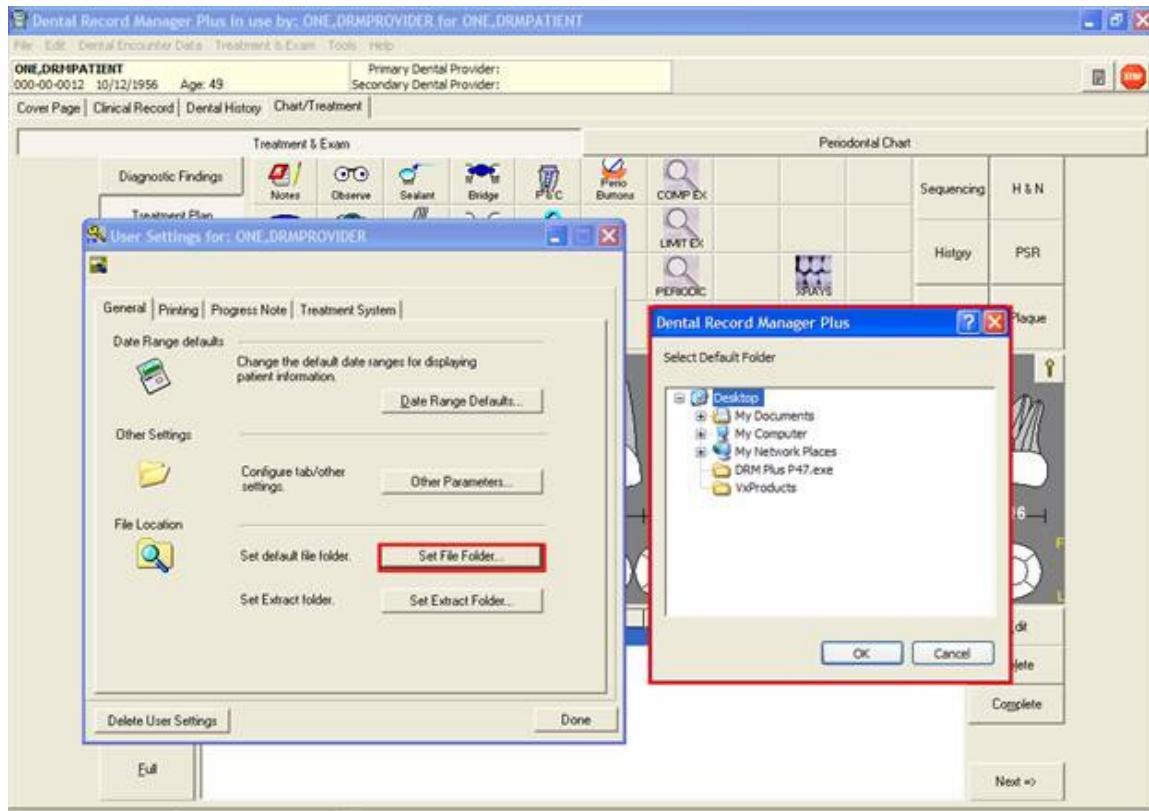


Figure 194: Set File Folder

Highlight the area or folder that will be used to import the text files. Click OK to complete the process.

The **Set Extract Folder** button allows users (with Administrative privileges) to set the directory/file location where the extraction of the Dental History file will be stored. The following screen is displayed:

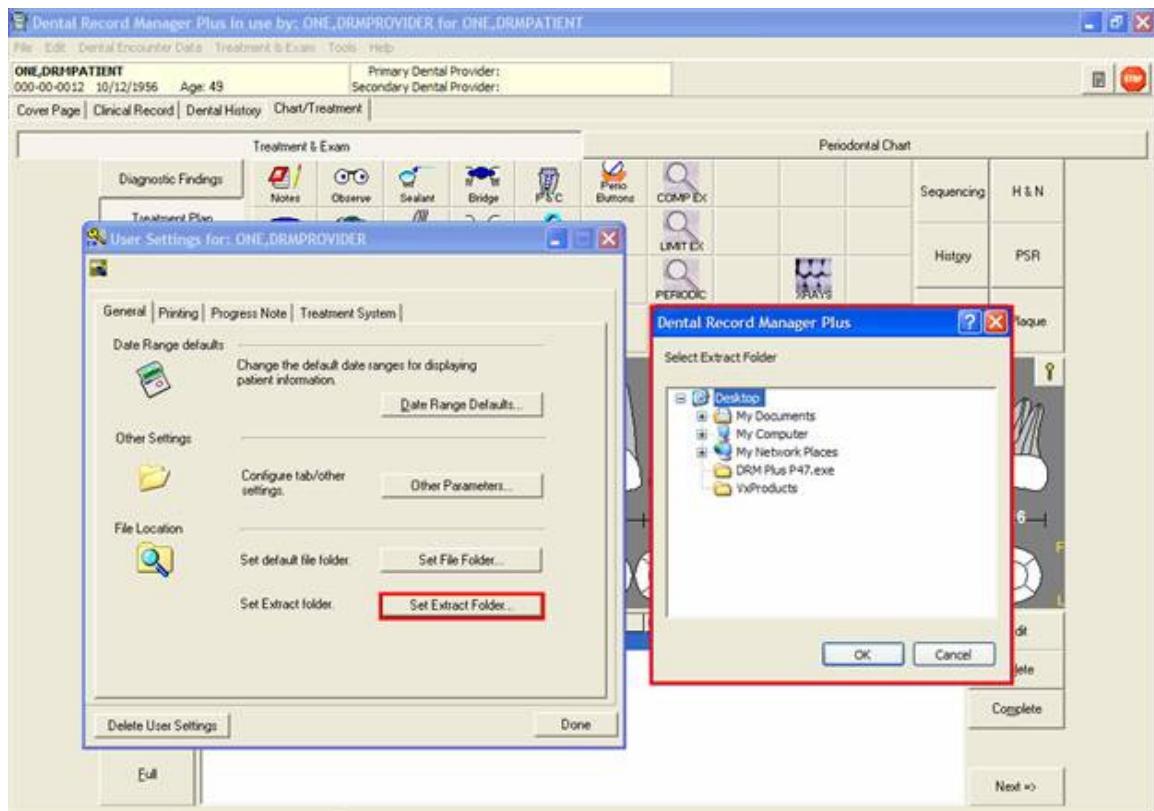


Figure 195: Set Extract Folder

Note: Set Extract Folder is only present if the user is allowed to do History Extracts or is a DRM Plus Administrator.

Clicking on the **Printing** tab and then on the **Page Setup** button displays the following screen:

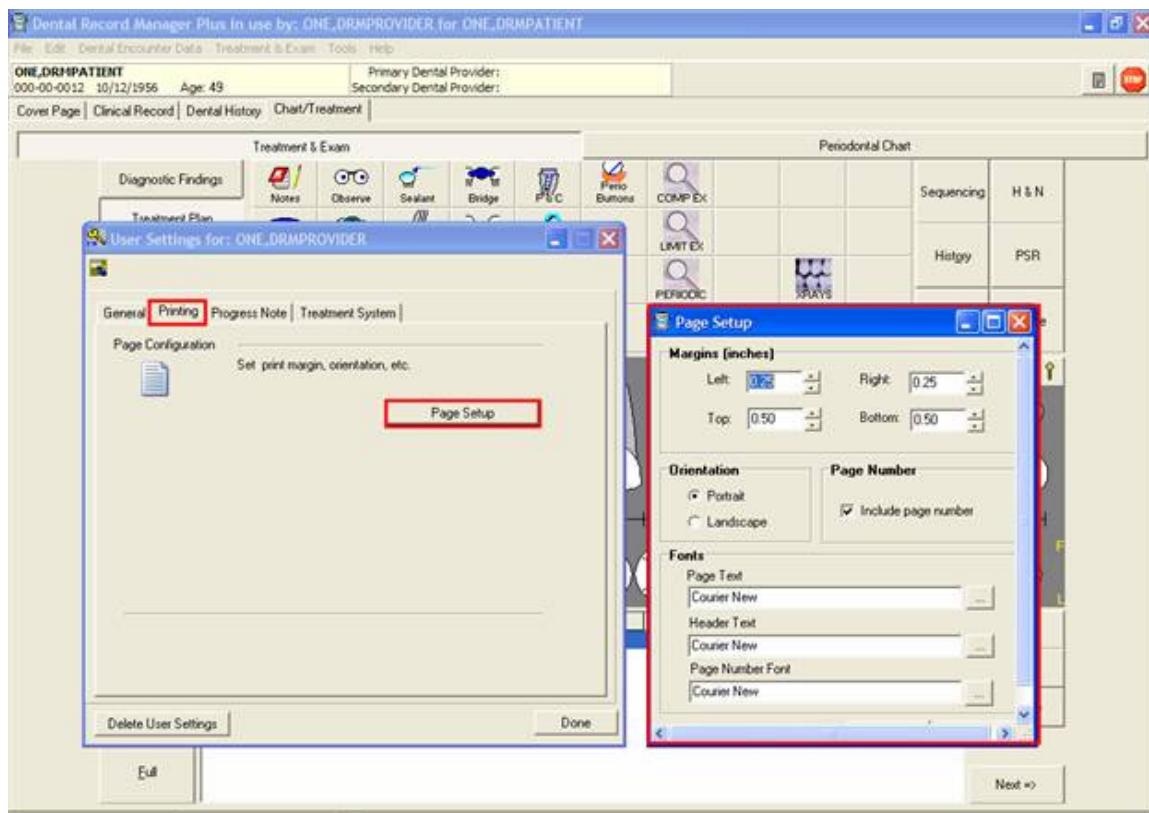


Figure 196: Page Setup

The Page Setup window may be used to format the following:

- Margins for the Progress Notes printed.
- Type of fonts will be used.
- Page setup to be used – portrait or landscape.
- Page number counter.

Use the drop down arrows, radio buttons and browse buttons to make the desired settings. Click OK to complete the process and save the settings.

Clicking on the **Progress Note** tab and then on the **Progress Note Data** button allows users to modify the default settings for Note objects. The following screen is displayed:

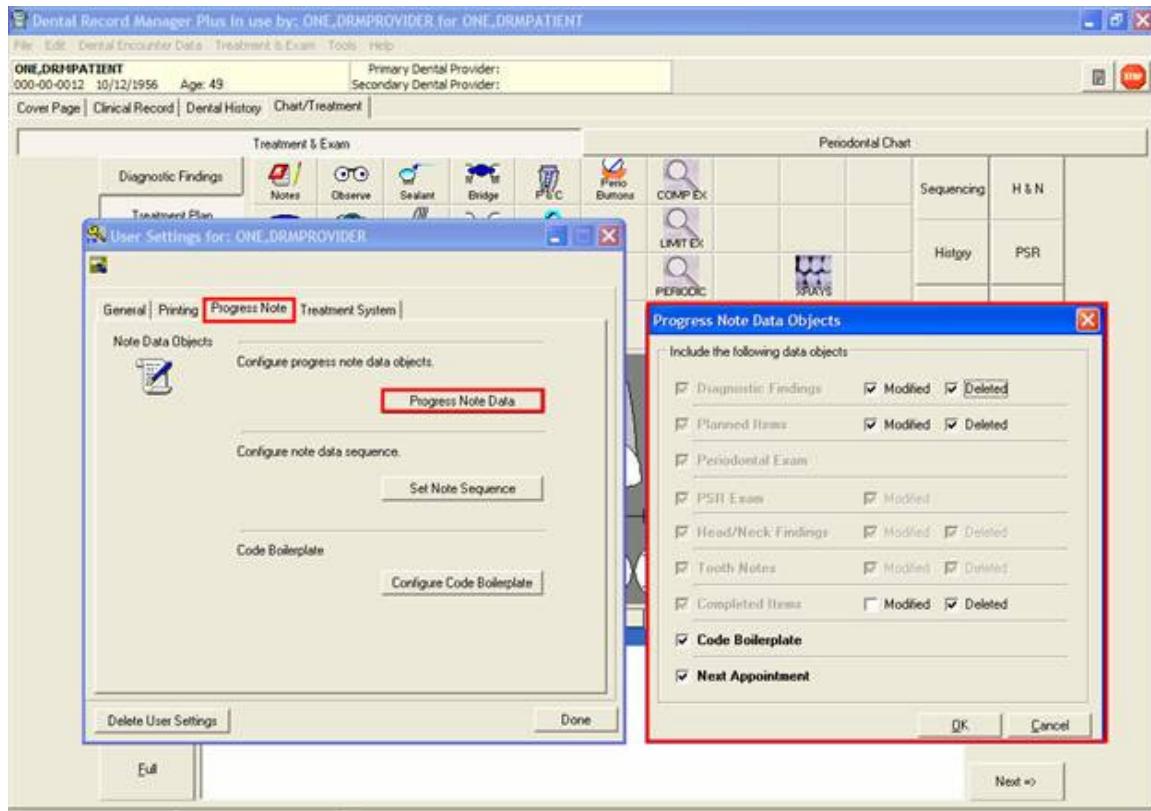


Figure 197: Progress Note Data Options

The Progress Note data selections have been preset and are shown “grayed out” above. Items that do not appear “grayed out” may be selected in addition to the pre-selected items.

Note: This Code Boilerplate checkbox activates the importing into the Progress Note of any boilerplate created in DRM Plus.

The Set Note Sequence button displays the following screen:

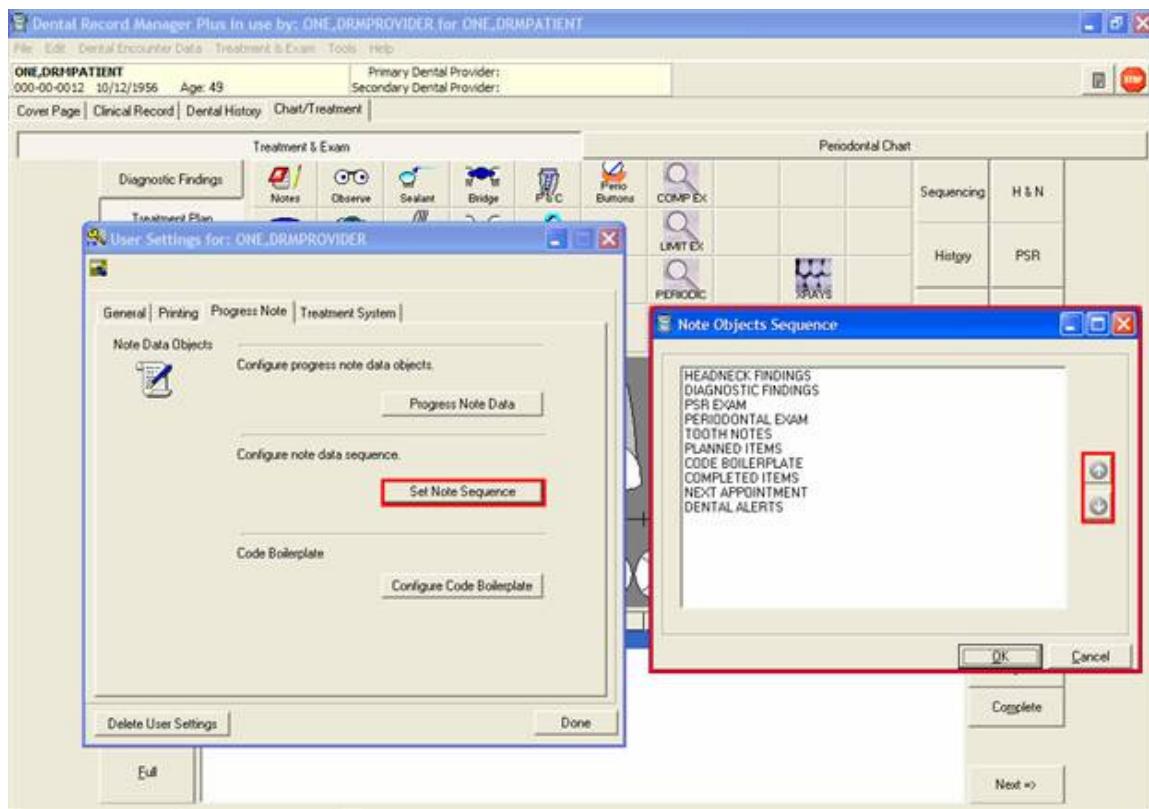


Figure 198: Note Objects Sequence

The Note Objects Sequence window may be used to sequence items that will be included in patient Progress Notes. Highlighting items listed in this screen and moving them up/down with the arrow buttons on the right side of the screen determines the sequence. The top item listed will be the first item sequenced.

The **Configure Code Boilerplate** button displays the following screen:

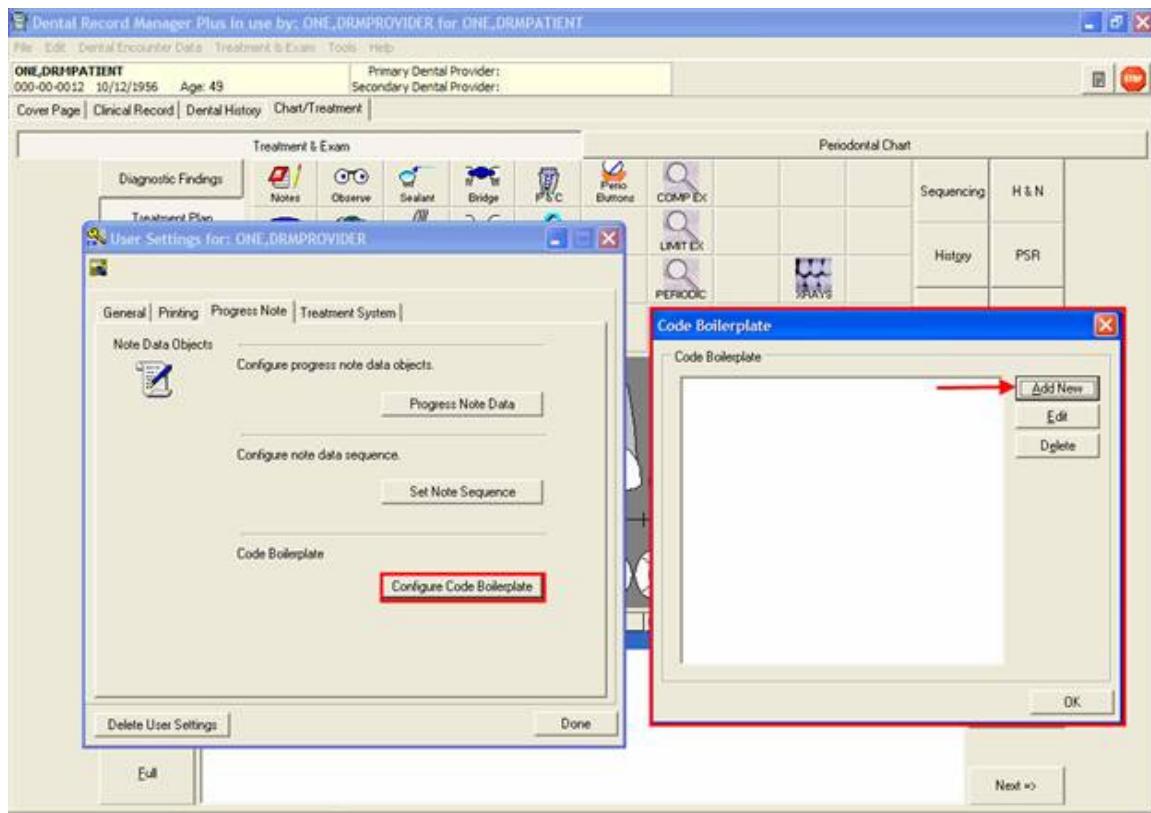


Figure 199: New Code Boilerplate

The Code Boilerplate function allows users to develop code-specific boilerplates. When the Code Boilerplate checkbox is checked in the Progress Note data screen, DRM Plus will automatically include these boilerplates in the Progress Note whenever the related D-Code is selected as a Completed Care item.

Clicking the Add New button displays the following dialogue box:



Figure 200: New Boilerplate Name

Each boilerplate must be named. In this example, the name chosen is “Prophy”. Entering “Prophy” in the name box and clicking on OK displays the following screen:

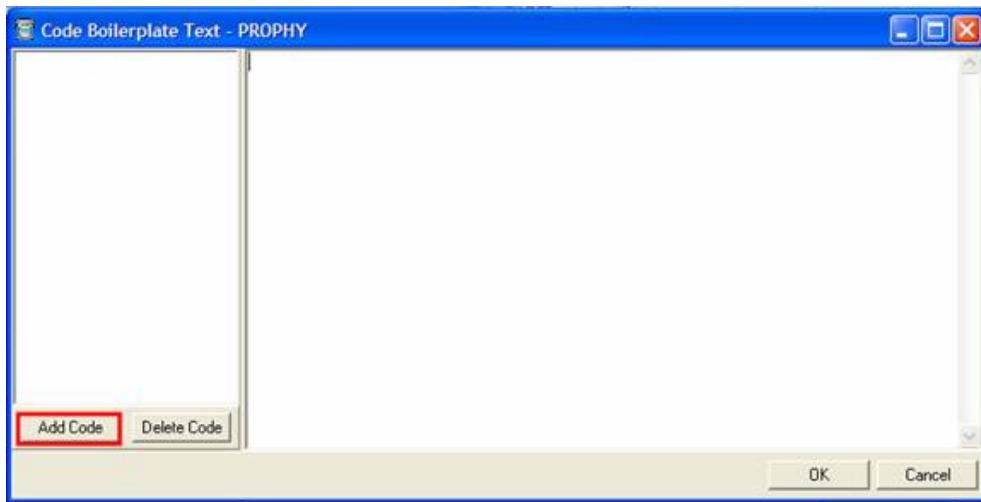


Figure 201: Code Boilerplate Text – PROPHY

Clicking the Add Code button displays the following screen:

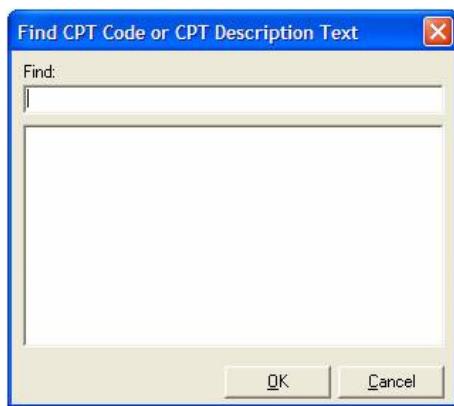


Figure 202: Find CPT Code

Typing the appropriate code in the Find box and pressing Enter displays the following:

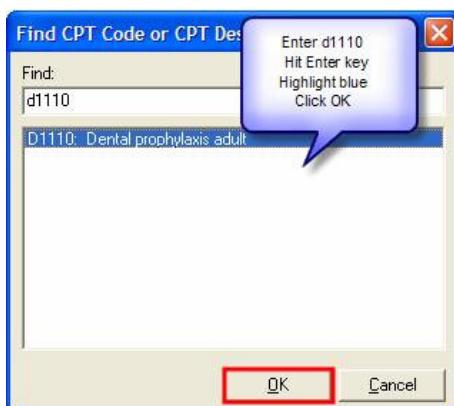


Figure 203: Find CPT Code, Enter ADA Code

Highlighting the desired code and clicking OK displays the following screen:



Figure 204: Code Boilerplate Text – PROPHY with ADA Code

The next step in the process requires placing the cursor in the right-hand box and typing in the desired boilerplate text. The next screen shows the text added.

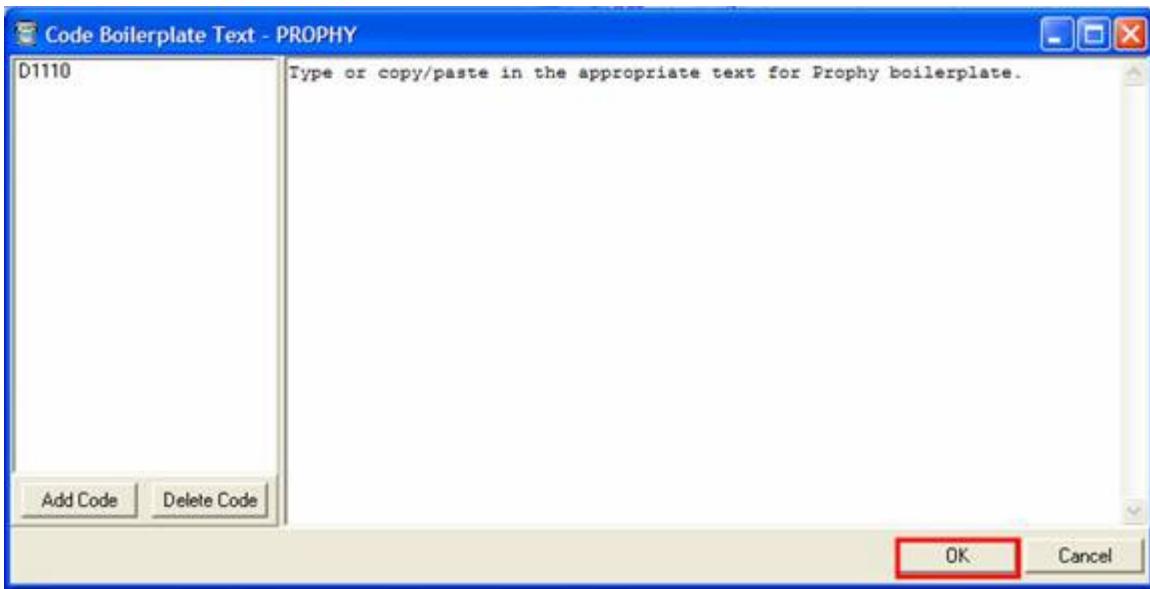


Figure 205: Code Boilerplate Text – PROPHY with text

Clicking OK displays a confirmation box. Clicking OK on the confirmation box displays the following screen:



Figure 206: Code Boilerplate

Code Boilerplates may be edited or deleted by highlighting the appropriate code and clicking on the Edit or Delete button. Clicking OK completes the Code Boilerplate entry process.

Note: Multiple boilerplates may be added for a single code or multiple codes may be associated to the same boilerplate. As many boilerplates and related codes as desired may be established.

Clicking on the **Treatment System** tab displays the following screen:

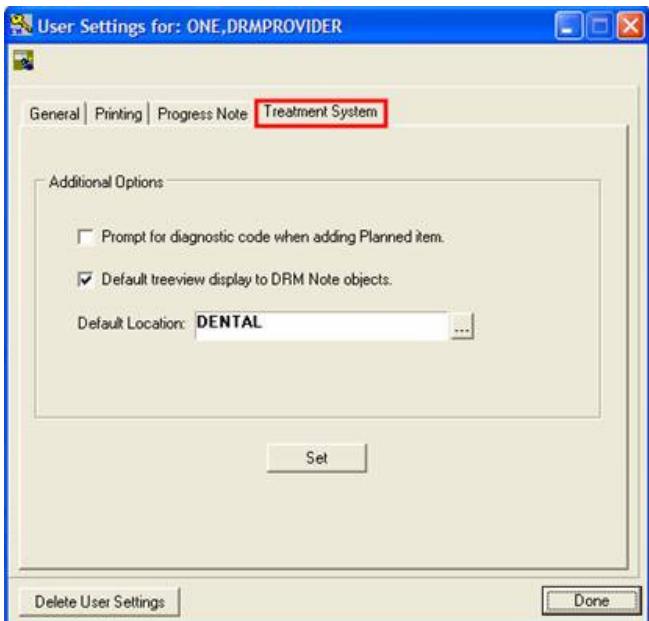


Figure 207: Treatment Plan tab

The first checkbox allows Treatment Plan procedures to be associated with related diagnoses. This function is discussed in the section entitled “Entering Treatment Plan Procedures with a Related Diagnosis”.

The second checkbox defaults the DRM Note Objects to display on the Progress Notes screen. Removing the checkmark will display CPRS templates on the Progress Notes screen.

To select a default location, click on the ellipse button located to the right of the text area. The user can then type in the appropriate location that corresponds with new appointments when a visit has not been scheduled through the appointment management package.

Administrative Toolbox – Used by Administrators; discussed in the Administrative Manual.

Provider Add/Edit – Allows changing from four digit provider code to eight digit provider code (necessary for creating DES reports). Discussed in the Administrative Manual.

Ancillary Section – Clicking on any option in this section of the Tools menu will launch the specific ancillary. Ancillary examples are MiPACS, iMedConsent, etc. If the site has purchased this imaging system, the MiPACS application can be launched from within DRM Plus.

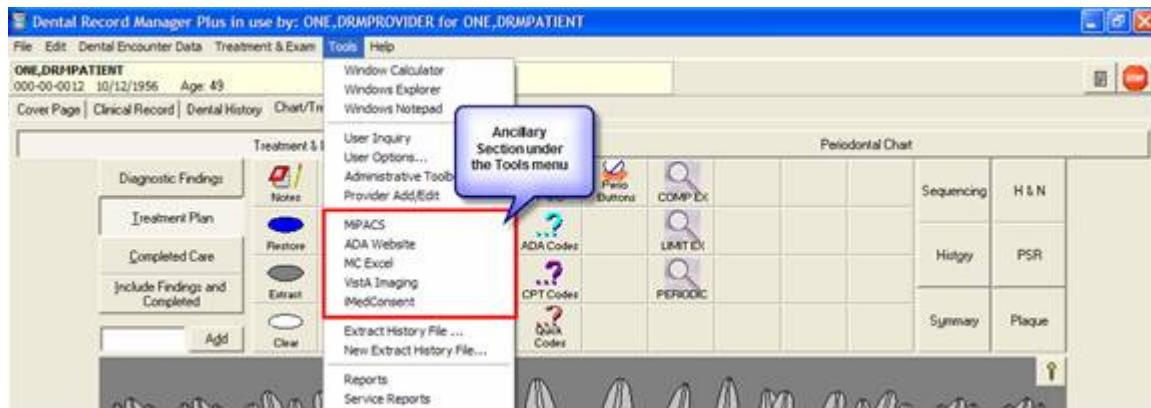


Figure 208: Tools Menu Ancillary Section

Select the desired ancillary menu option on the Tools drop-down menu to launch the ancillary system from within DRM Plus.

Ancillary menu options on the Tools drop-down menu will be enabled after configured by a DRM Plus administrator. Settings for these options must be configured in the Administrative Toolbox option. The location of these application executables may require IRM assistance.

Note: The dental administrator may customize up to 10 ancillary applications or websites to launch from the DRM Plus Tools menu option. This replaces the "hard-coded" launch for Vista Imaging and iMedConsent and allows additional applications, including Microsoft Excel for example, to be launched depending on the needs of the site.

Extract History File – Discussed in the Administrative Manual.

New Extract History – Discussed in the Administrative Manual.

Reports – Created from the old DAS reports and some new DES reports as discussed in the Administrative Manual.

Service Reports – KLF-style Reports retrieving data using DAS or DES type categories; discussed in the Administrative Manual.

Help Menu Options

Clicking on the Help drop-down menu displays the following options:

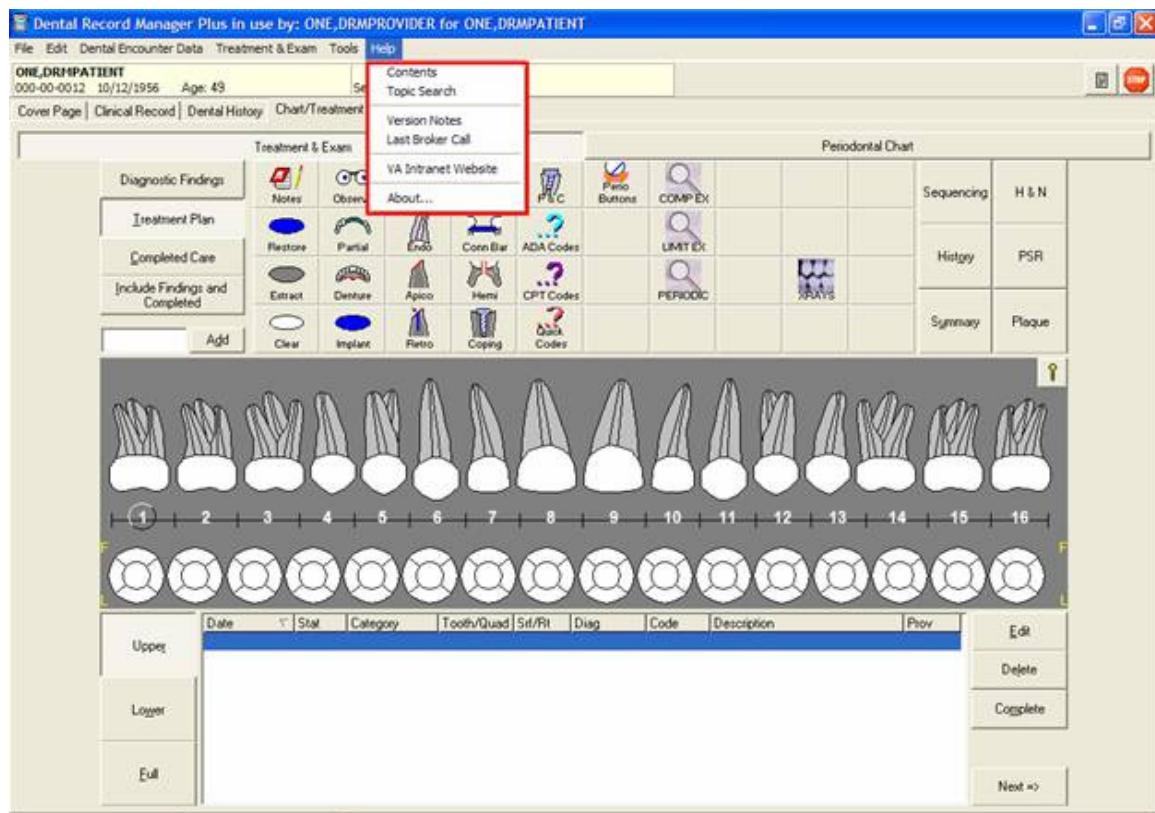


Figure 209: Help Menu

Contents – Displays the outline of subjects in DRM Plus. The following screen is displayed:

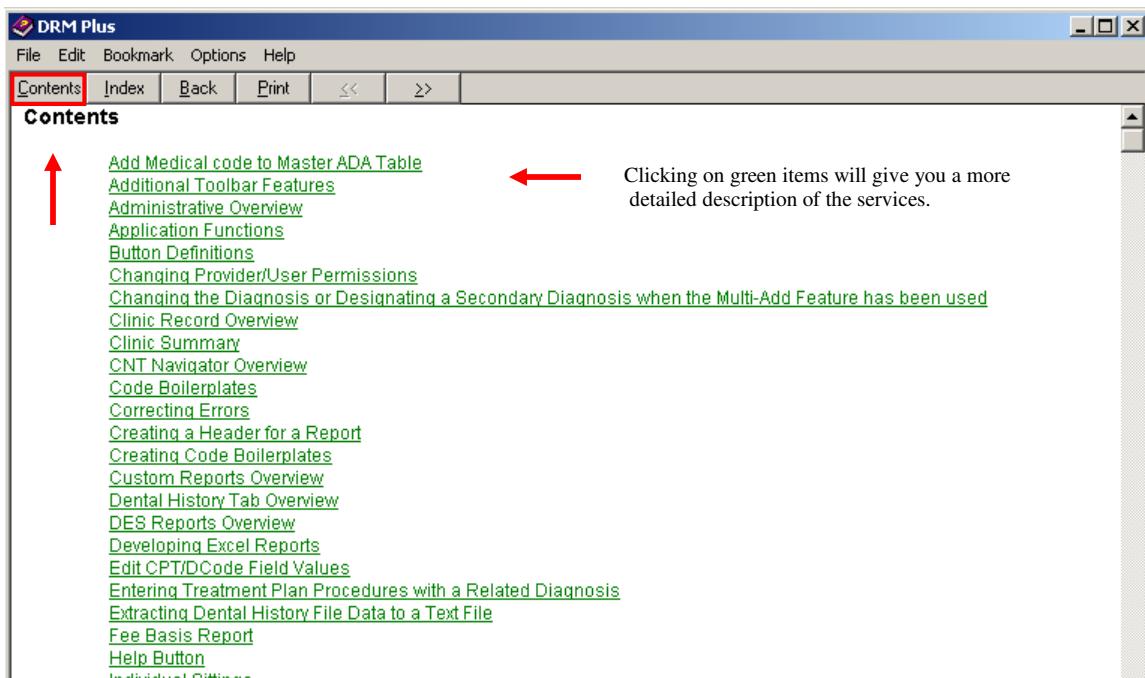


Figure 210: Help Contents Button

Contents button – Clicking on this button will provide a new window with enhanced Help functionality such as **Contents**, **Index**, and **Find** tabs. The following screen is displayed:

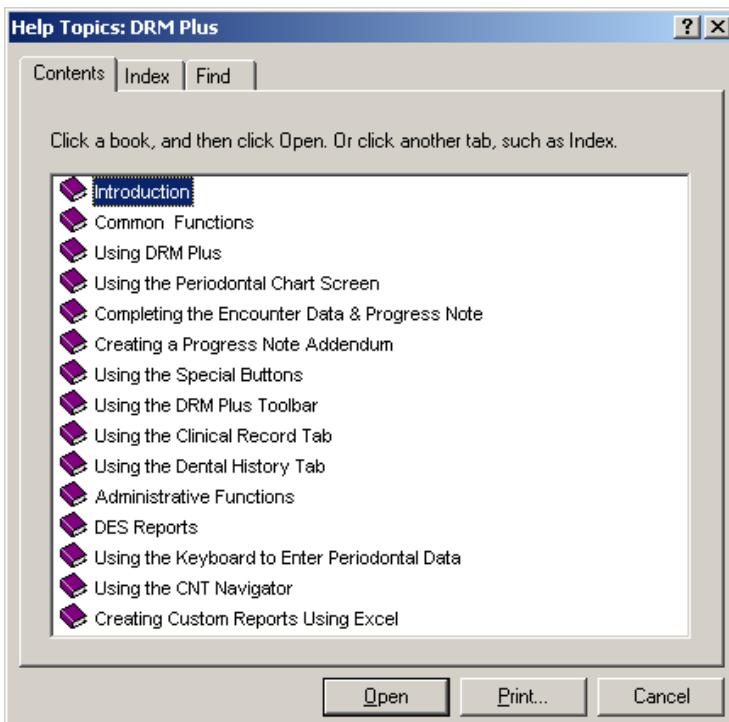


Figure 211: Enhanced Help Items: Content, Index, Find

The **Contents** tab displays a series of “books” that provide specific sets of information regarding each title. By clicking on a desired book of reference, it will open all of the available chapters for that book as illustrated below:

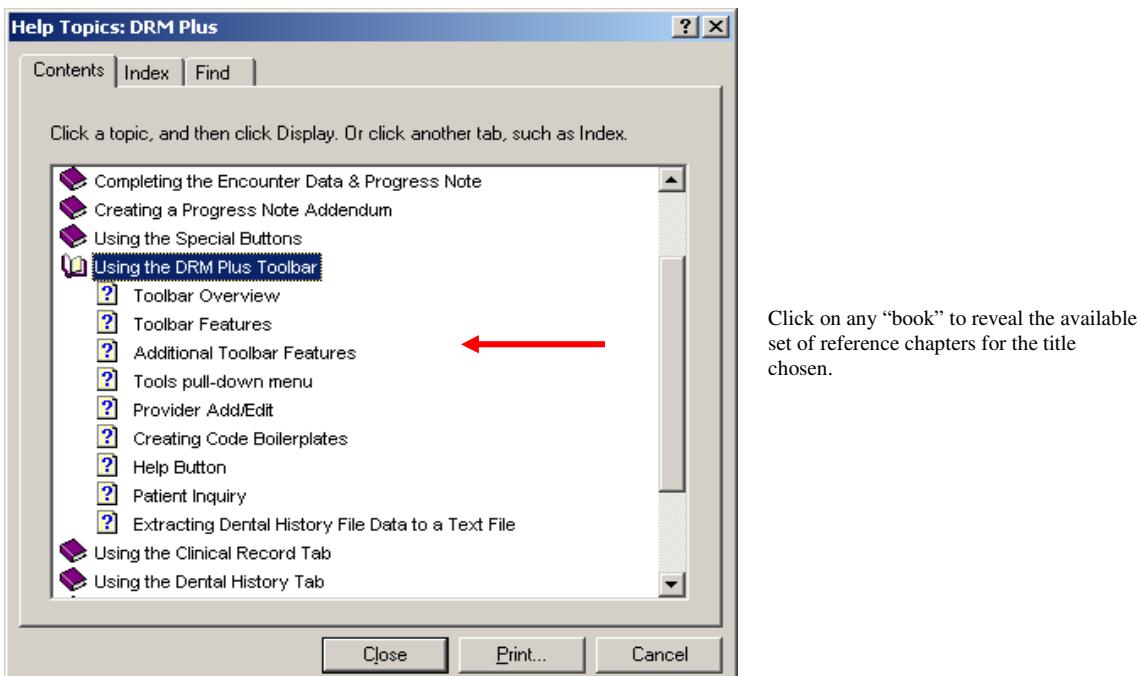


Figure 212: Help Book Sub-topics

Each sub-topic is represented by a “?” symbol. Click on the desired sub-topic to reveal the help information. For example, the “**Tools pull-down menu**” sub-topic has been selected as illustrated below:

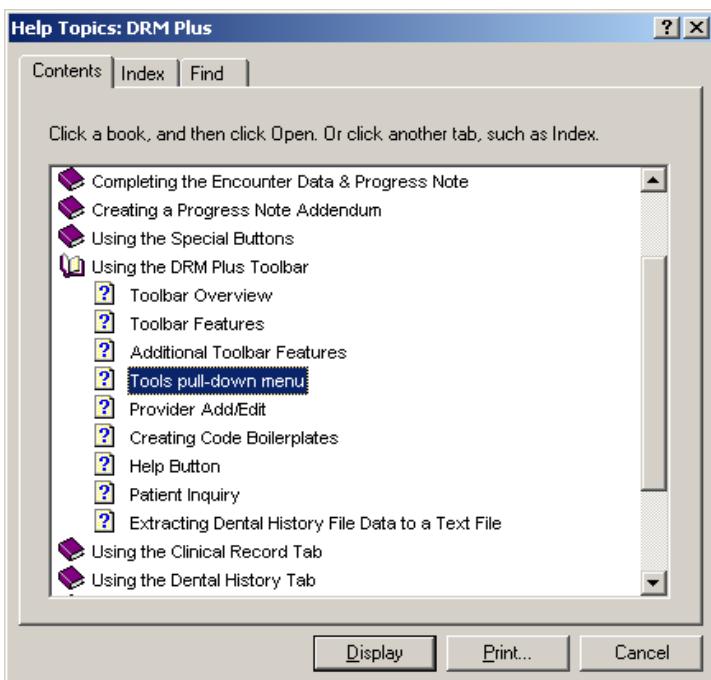


Figure 213: Select Book Sub-topic

Users can either double-click on the sub-topic or click the Display button to reveal the desired help information. To click a hard copy of the sub-topic, click on the **Print** button located at the top of the screen.

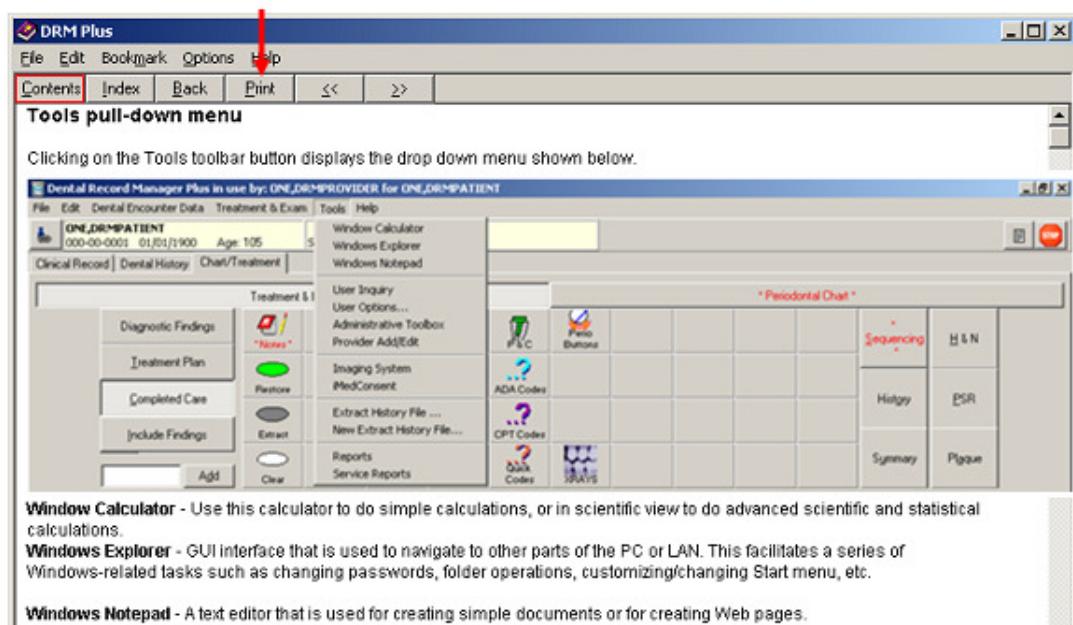


Figure 214: Print Help Sub-Topic Information

To return back to the main help contents screen, click on the **Contents** tab located at the upper right side of the screen.

Topic Search - The second tab, **Index**, is used to create a quick search for all of the available topics in the Help file. By typing in the name of the topic desired in the text box, a list of all of the available topics will appear. In order to access the information, simply double-click on the desired topic or click on the Display button.

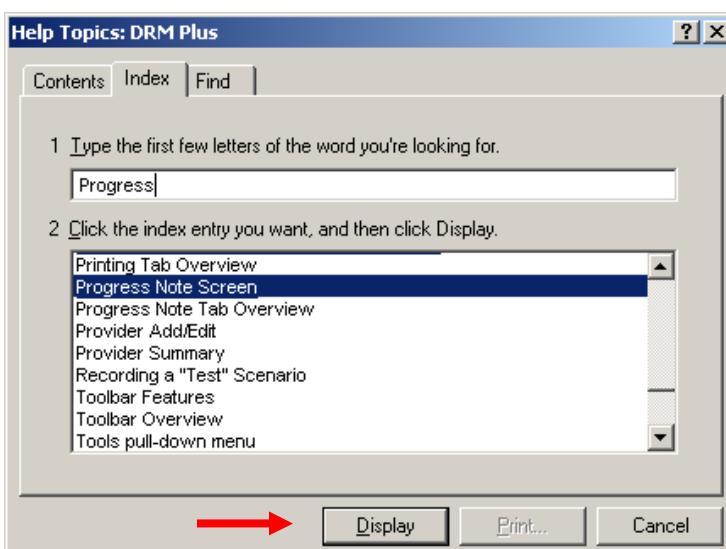


Figure 215: Help Topic Search

Version Notes – Version information.

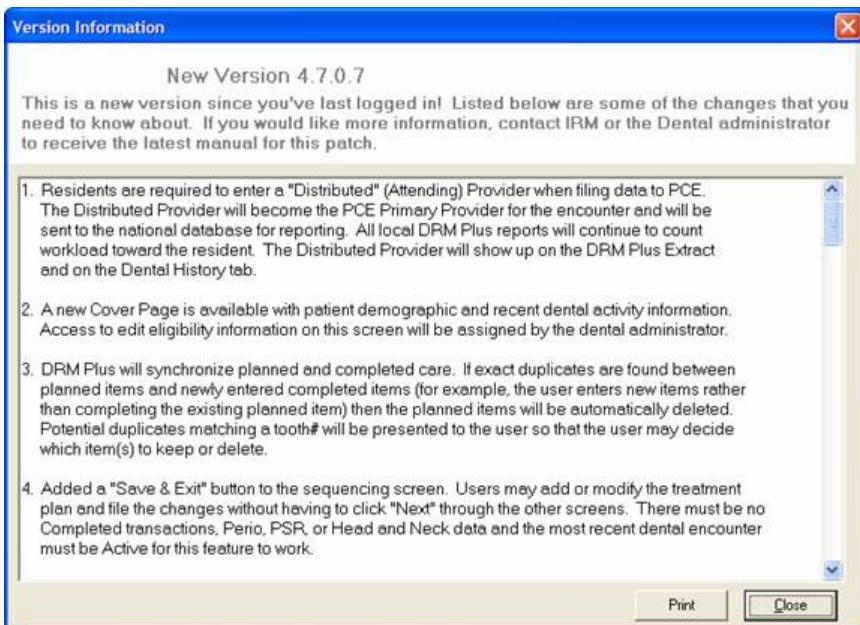


Figure 216: Version Notes

Last Broker Call – Allows users to display a list of broker calls. The Maximum Calls feature is used to determine the number of broker calls displayed at one time.

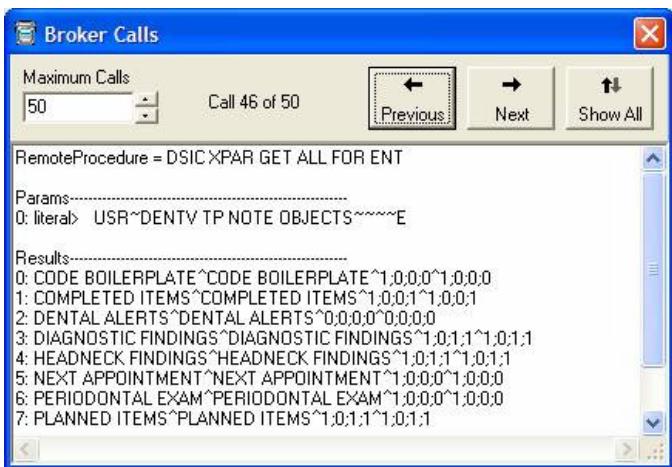


Figure 217: Broker Calls

The Previous or Next buttons can be used to display the broker call information as needed. The Show All button will generate all of the broker calls on the screen.

Note: The Last Broker Call option is used by IRM and providers to document problems. It is not normally used by providers.

VA Intranet Website – Clicking this option connects the user with the VA Intranet website where additional dental related information can be obtained.

About – Displays a version of DRM Plus and the DSS web page address.

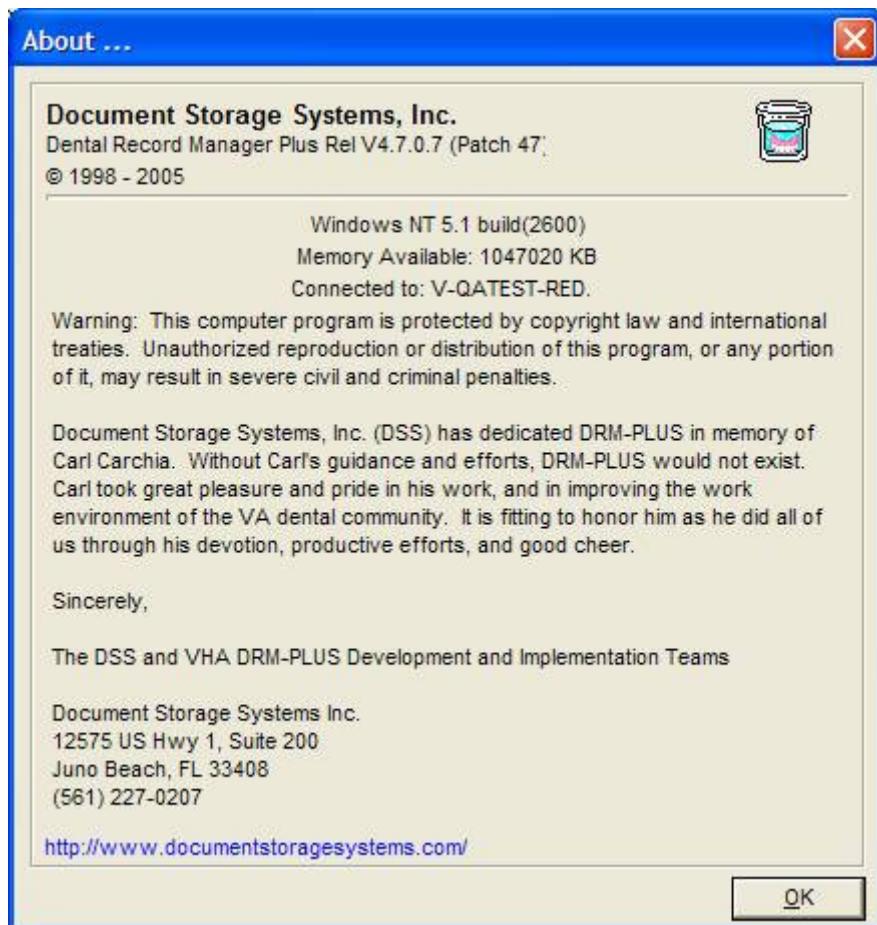


Figure 218: About

Patient Inquiry

A patient inquiry is a useful tool for reviewing patient information contained in VistA. To perform a patient inquiry click on the patient's name from any screen within DRM Plus. The patient's name is located in the upper left hand corner of the screen just under the drop-down menu items. The following screen is displayed:

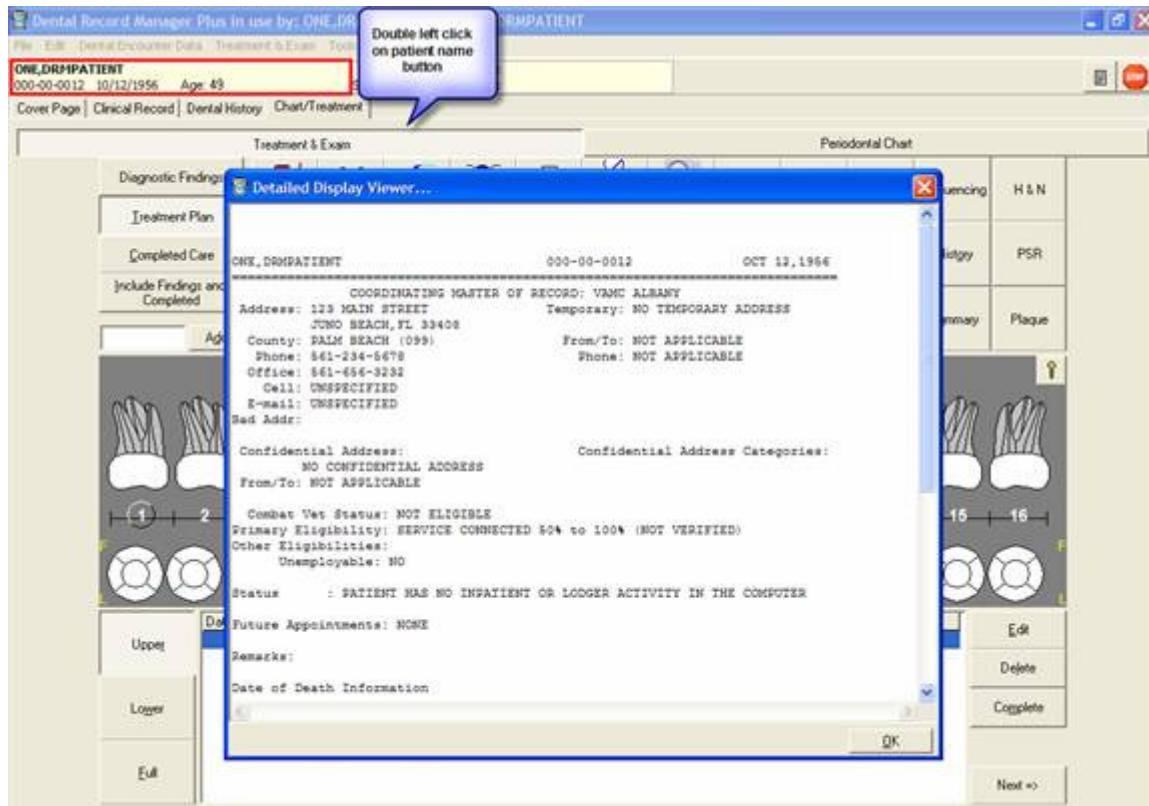


Figure 219: Patient Inquiry

A detailed display viewer will appear. Information about Service Connected/Dated Disabilities and other useful information may be found in the patient Inquiry.

Using the Cover Page Tab

Overview

Clicking the Cover Page tab displays the Cover Page screen shown below. This is a new tab which contains demographic, historical and planned dental activity. The Cover Page was created to help users make administrative and/or care decisions for patients.

Dental Record Manager Plus in use by: ONE_DRMProvider for ONE_DRMPatient

File Edit Dental Encounter Data Treatment & Exam Tools Help

ONE_DRMPATIENT
000-00-0012 10/12/1956 Age 49 Primary Dental Provider:
Secondary Dental Provider:

Cover Page Clinical Record | Dental History | Chart/Treatment

Dental Eligibility

Dental Class: 17-CLASS VI

Eligibility Expiration Date: []

Service Connected Teeth: []

Adjunctive Medical Condition(s): [Add/Edit]

Diabetic cataract

Anticipated Rehab Date: []

Save

Case Management

Status: Active Inactive Maintenance

Suggested Recare Date: []

Save

Notes: Patient is living with daughter, DRMdaughter.

Recent Dental Activity

Last Comprehensive Exam: []

Last Brief Exam: Aug 16, 2006

Last Periodontal Exam: []

Last Panorex Image: []

Last Full Mouth Image: Aug 16, 2006

Last Bitewing Image: Aug 16, 2006

Last Prophylaxis: []

Last Visit: Aug 16, 2006

Last Provider: ONE_DRMProvider

Planned Care

Treatment Plan:

Phase 1: (D7140) Extraction erupted tooth/dec. 1 (Next Appl)
(D7140) Extraction erupted tooth/dec. 32 (Next Appl)

Phase 2: (D7140) Extraction erupted tooth/dec. 16
(D7140) Extraction erupted tooth/dec. 17

Phase 3: (D3320) Root canal therapy 2 canals: 28(l)
(D3421) Root survey bicuspid: 20(l)
(D3430) Retrograde filling: 28(l)

Phase 4: (D2952) Post and core cast + crown: 28(l)
(D2790) Crown porcelain w/ h noble met: 24
(D2790) Crown full cast high noble met: 2

Phase 5: (D2790) Crown 3/4 cast h noble met: 25
(D2790) Crown 3/4 cast h noble met: 24
(D2790) Crown full cast high noble met: 2

Phase 6: (D2160) Amalgam three surfaces pema: 3(D08)
(D2160) Amalgam three surfaces pema: 14(D08)
(D2160) Amalgam three surfaces pema: 18(D08)
(D2160) Amalgam three surfaces pema: 31(D08)

Dental Alerts

Antibiotic Premed

Figure 220: Cover Page tab

The screen is split up into different sections:

- **Dental Eligibility** data can be edited only by users who have been set up by the administrator to allow eligibility edits. The Dental Class is the class for the patient, which will default to the encounter, but can be changed for the encounter (on the 1st Completing the Encounter screen). Class IIA patients require an entry in Service Connected Teeth, Class III or Class VI patients require an entry in the Adjunctive Medical Condition field. The Anticipated Rehab date is only editable for Class V patients, but it is not required for those patient types. Clicking the Add/Edit button for Adjunctive Medical Conditions brings up the following screen allowing selection from the patient's Problem list, or a code lookup.

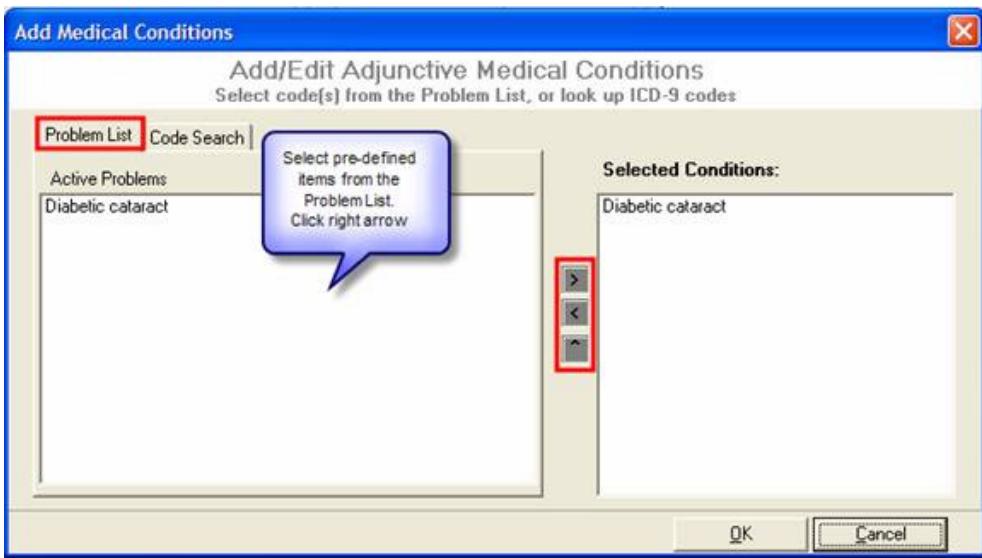


Figure 221: Add Medical Conditions Problem List tab

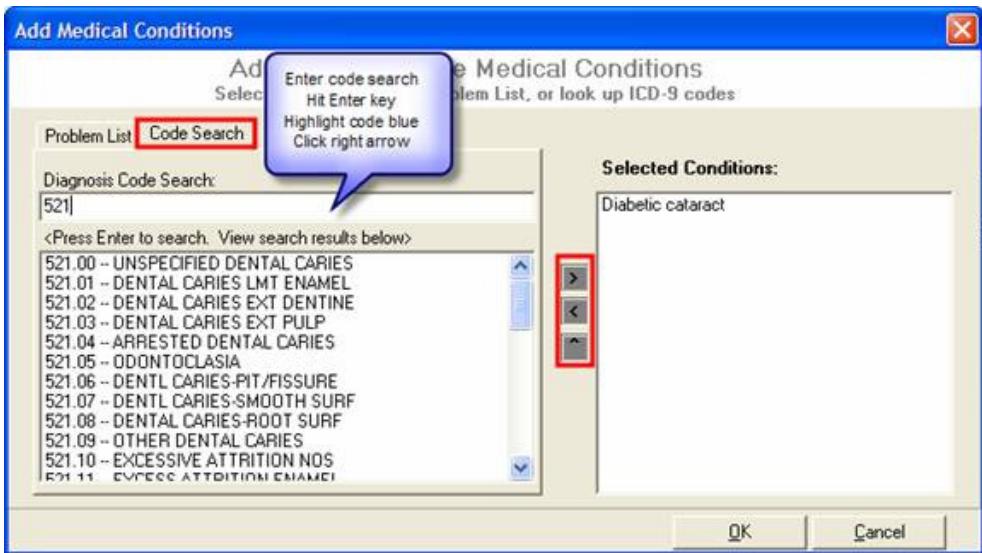


Figure 222: Add Medical Conditions Code Search Tab

- **Case Management** allows the user to edit the patient status which will update the status for the last encounter. There is a new status entry called Maintenance. This field will default for the encounter. There is a Suggested Recare Date that may be entered for the patient. Refer to Appendix G for further detailed description on Case Management.
- **Notes** of a general nature may be entered for the patient.
- **Demographics** data is retrieved from VistA for the patient and displayed if available.

- **Recent Dental Activity** displays the most recent date for selected types of procedures.
Note: hovering the mouse pointer over the heading will display all the CDP codes making up the data for that heading.
 - Last Comprehensive Exam = D0150 or D0160.
 - Last Brief Exam = D0120, D0140 or D0170.
 - Last Periodontal Exam = D0180.
 - Last Panorex Image = D0330.
 - Last Full Mouth Image = D0210.
 - Last Bitewing Image = D0270, D0272, D0274, or D0277.
 - Last Prophylaxis = D1110 or D1205.
 - Last Visit displays the last dental visit date for the patient.
 - Last Provider displays the provider for the last visit.
- **Dental Alerts** displays the same alert data available from the Alerts button without having to hover or click on the button.
- **Planned Care** displays the sequencing screen information.

Note: After entering data in the Dental Eligibility, Case Management or Notes sections requires the user to click Save to update the field. Clicking on another tab will cause the following screen to appear if data was entered and not saved.



Figure 223: Save Cover Page data

The Cover page may be selected as the default tab for the user by editing the User Options on the DRM Plus Tools menu:

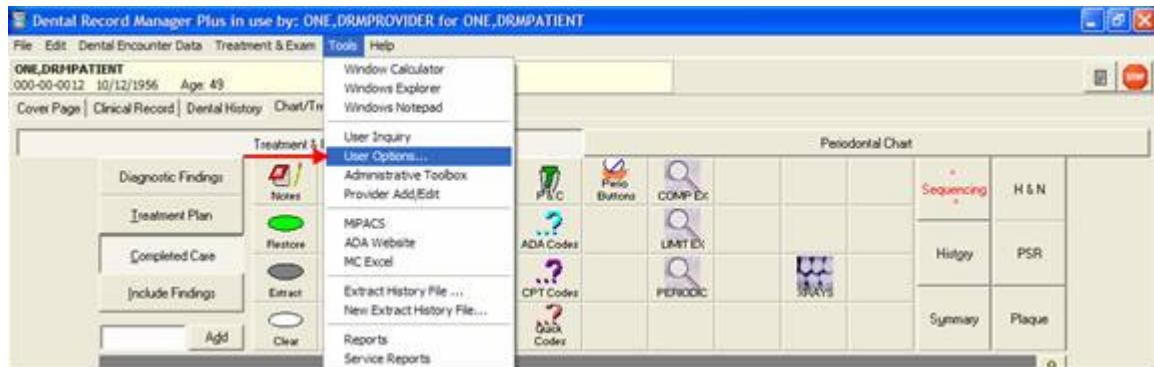


Figure 224: Editing User Options

Click on Other Parameters button and select the Parameter tab option after clicking on the drop-down menu arrow to select your default tab when entering DRM Plus.

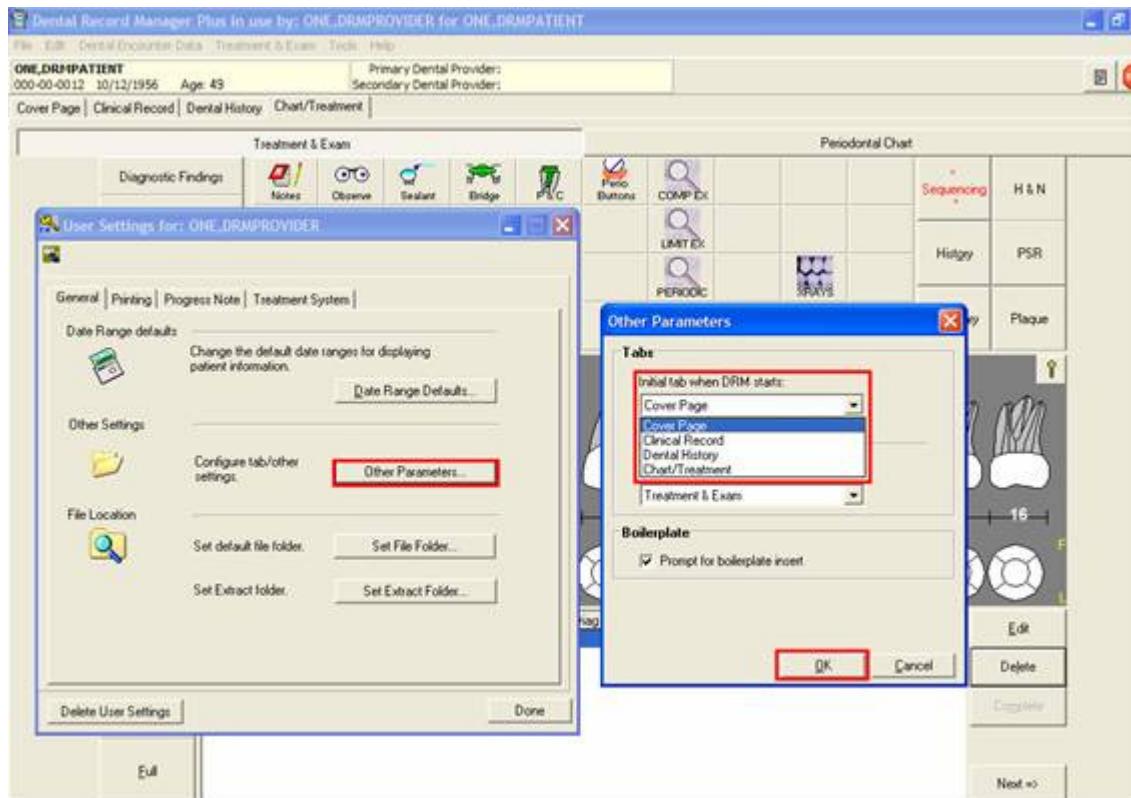


Figure 225: Other Parameters default tab when DRM starts

Using the Clinical Record Tab

Overview

Clicking the Clinical Record tab displays the Clinical Record screen shown below. This screen allows viewing of certain CPRS stored data for the selected patient. The Problems radio button is the default button. Selecting other radio buttons allows viewing of the selected CPRS data. Additional certain functions can be performed from this screen as explained below.

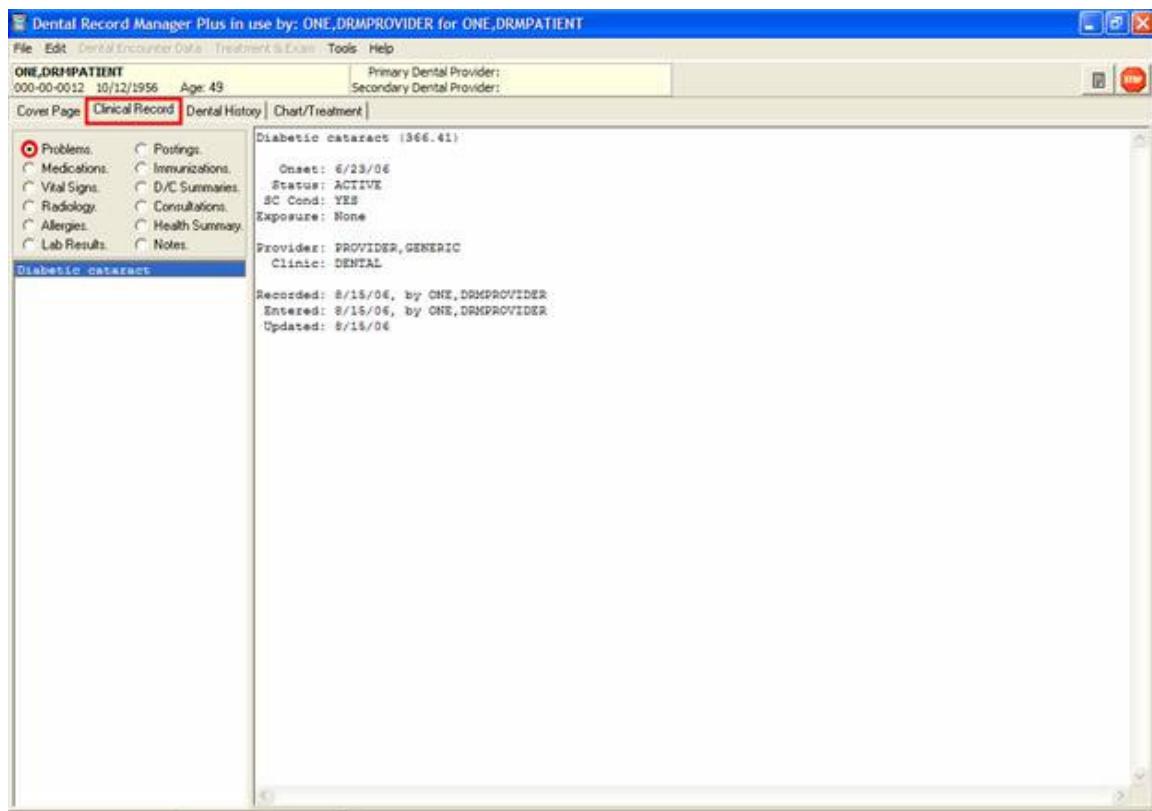


Figure 226: Clinic Record Tab

Note: All data resides in CPRS.

The radio buttons work like CPRS tabs. Clicking on a button displays a list in the left box. Clicking on an item in the list displays the items detail in the right box. The Vital Signs button is the only button that works differently. Clicking the Vital Signs button displays the most recent recorded vital signs. There is no function to select other recorded vitals.

Problems – A listing of active problems previously entered into CPRS is displayed. Once a problem is selected, a right mouse click provides the option to inactivate the problem as shown in the screen below.

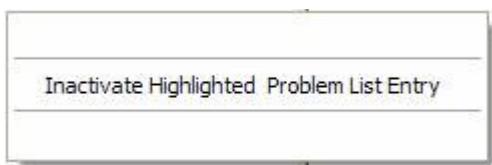


Figure 227: Active Problems Displayed

Click on the dialogue box to initiate the process to inactivate the problem.

Medications – A listing of current medications displayed.

Vital Signs – The most recent recorded vital signs will be displayed.

Radiology – A listing of radiology reports is displayed.

Allergies – A listing of allergies is displayed.

Lab Results – A listing of lab reports is displayed.

Postings – A listing of any clinical warnings, advanced directives (CWAD) is displayed.

Immunizations – A record of immunizations is displayed.

D/C Summary – A listing of discharge summaries is displayed.

Consultations – A listing of consults is displayed.

Health Summary – A listing of Health Summaries is displayed.

Notes – A listing of All completed notes (the default listing) is displayed. Right-clicking in the note box to the left of the screen displays the dialogue box shown below.

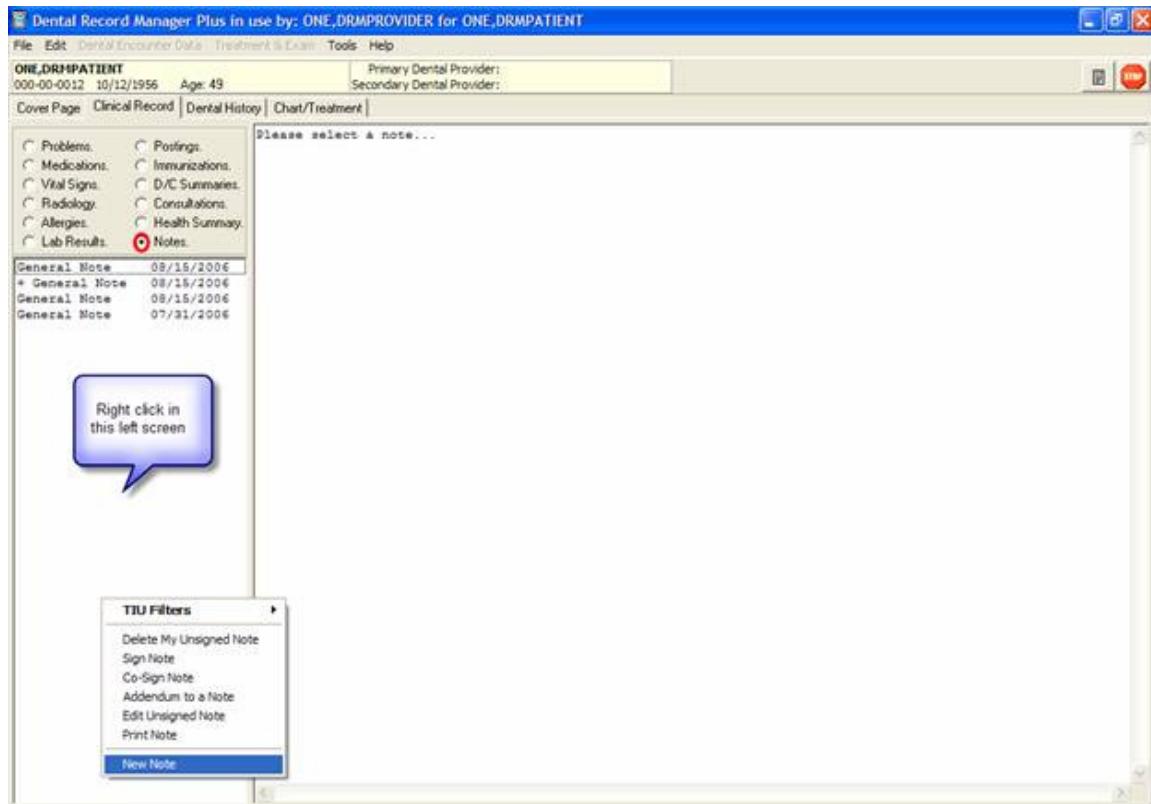


Figure 228: All Completed Notes Displayed

Clicking on New Note option and selecting a Note title from the pop-up screen allows the following screen to be displayed:

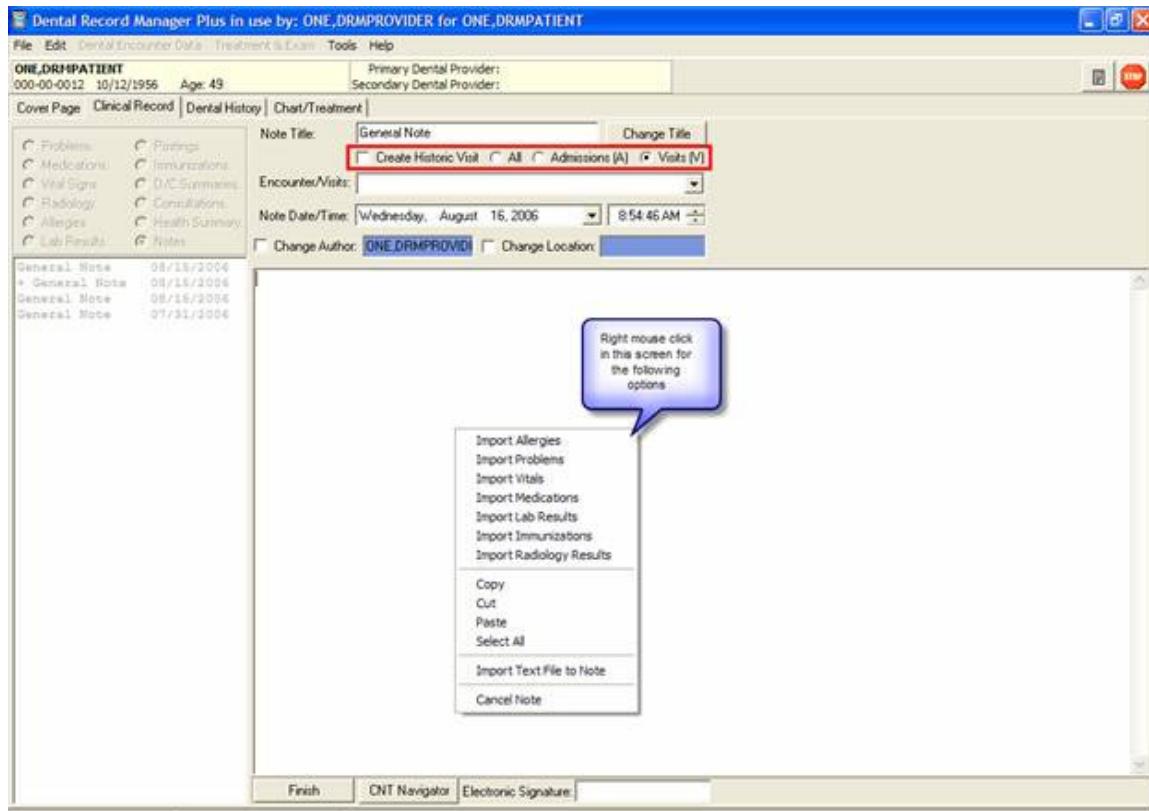


Figure 229: New Note

This New Note screen works the same as in the Notes tab of CPRS. Historical notes may be entered using this option.

Selecting the TIU Filter option allows the list of Notes to be filtered to facilitate finding the desired note.

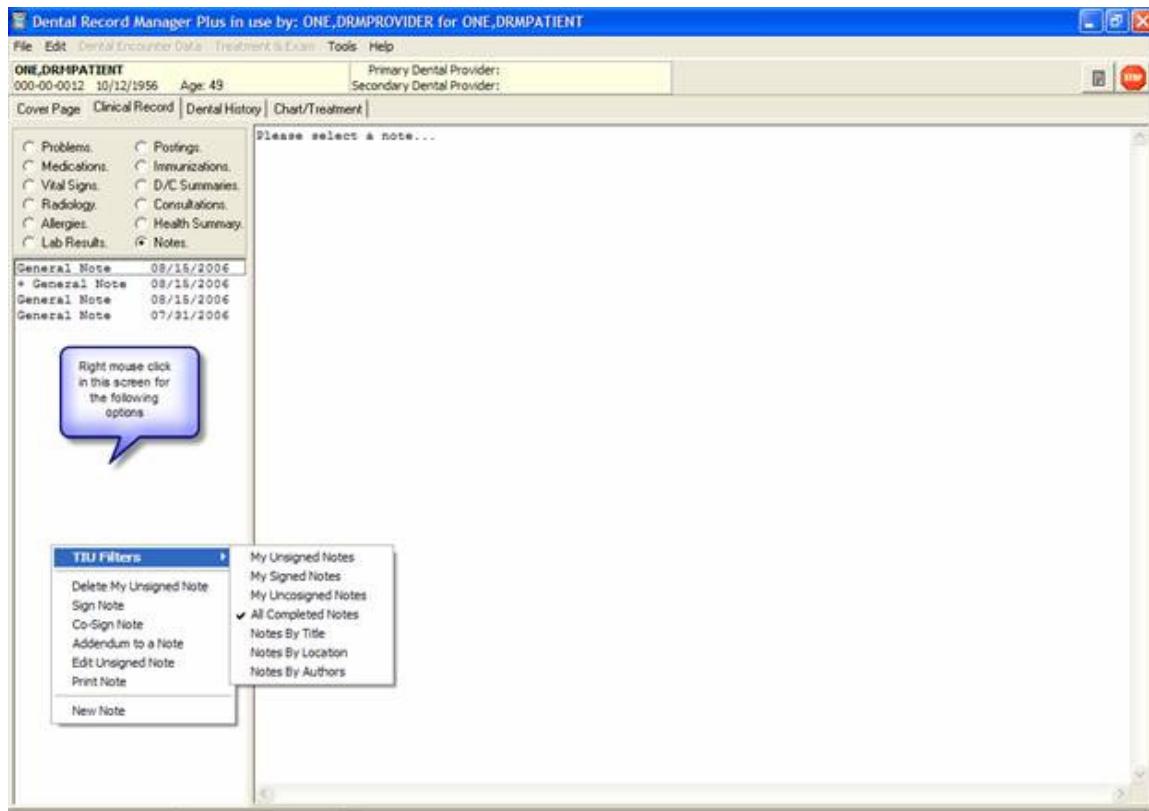


Figure 230: TIU Filter

Once the desired note is found and opened, a right click in the Notes box to the left of the screen displays the functions available for the selected note. The functions available coincide with the Action menu options as seen on the Notes tab in CPRS and work the same. The function is selected by a left click.

To exit the Clinical Record tab, click one of the other tabs.

Using the Dental History Tab

Overview

Clicking the Dental History Tab displays the Dental History screen shown below. The Dental History screen presents graphic and text box presentations of all dental procedures entered through DRM Plus or DRM since installation of the software. Users can designate the view of the screen through the use of the buttons and check boxes discussed below.

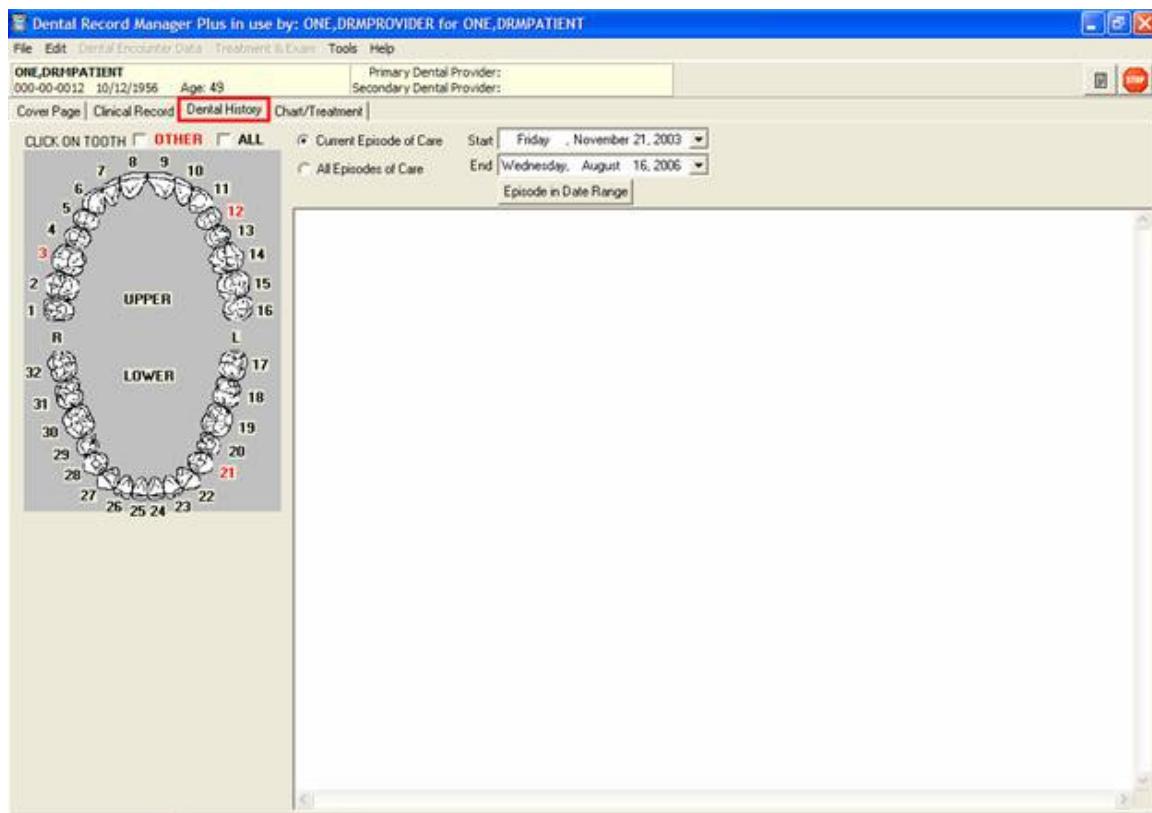


Figure 231: Dental History Tab

The options for choosing the Dental History display are discussed below. The tab defaults to the Current Episode of Care radio button.

History of a Specific Tooth - A tooth number displayed in red indicates that the tooth has a tooth specific history. Clicking directly on the desired tooth in the graphic displays the history in the text box; more than one tooth may be selected.

Checkboxes:

Other – Clicking this box displays all non-tooth specific procedures performed within the episode of care selection.

All – Clicking this box displays all procedures performed within the Episode of Care selection. Clicking on All a second time clears the display window.

Radio Buttons:

Current Episode of Care (default) – Click this button to display only those procedures done during the present active (in progress) Episode of Care, Treatment Plan or in-progress visits. This episode does not show any history before the last inactive (completed or terminated) entry date.

All Episodes of Care – Displays the entire dental history.

Episodes in Date Range – Select a start and an end date by using the down arrows, and then click the Episode in Date Range button to display the dental history within that date range.

Clicking all teeth shown in red displays the tooth-specific procedure history. The following screen is displayed:

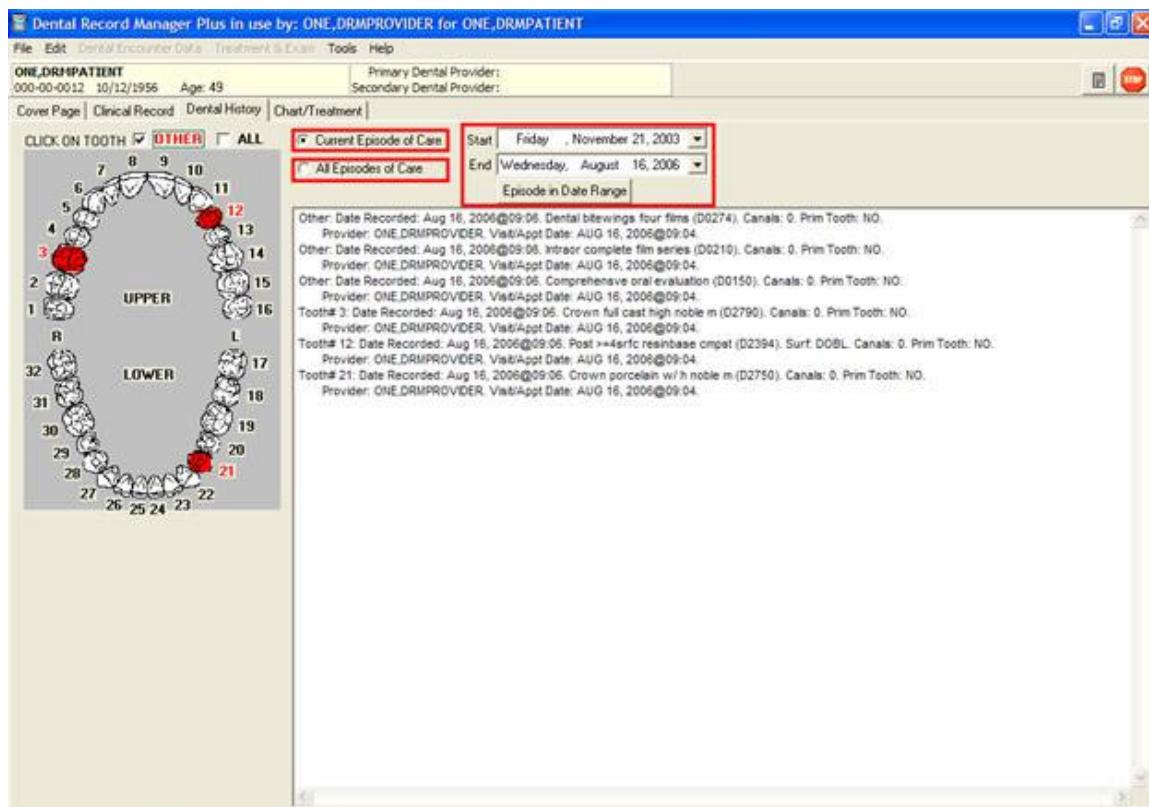


Figure 232: Tooth-Specific Procedure History

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 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 who is authorized to provide patient care.
CNT	Clinical Note Template (Used to format TIU Notes)
CPR	Cardiopulmonary Resuscitation
CPRS	Computerized Patient Record System
CPT	Common Procedure Terminology
CQI	Continuous Quality Improvement
DAS	Dental Activity System (also called AMIS)
DES	Dental Encounter System (also called DES)
DHCP	Decentralized Hospital Computer Program see VistA
DNR	Do Not Resuscitate
DOD	Department of Defense

DRG	Diagnostic Related Group
DSS	Decision Support System
DSS	Document Storage Systems, Inc.
DVA	Department of 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 can 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	Functional 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 many kinds of data from VistA and displays it in a standard format
HR IGA	Human Resources Office of Intergovernmental Affairs
INPATIENT VISIT	Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient
IOM	Institute of Medicine
ISDA	Intensity Severity Admission Discharge (criteria)
IT	Information Technology
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LAN	Local Area Network

M V V	Mission Vision Values
MAC	Management Assistance Council
MCCR	Medical Care Cost Recovery
MDS	Minimum Data Set
NHCU	Nursing Home Care Unit
OE RR	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 Instrument
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 Veterans 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 – Data Security

As a VA computer user, one of the most important things you can do to contribute to good computer security is to know your data, its level of sensitivity, that it is free of viruses, what would happen if it wasn't available, how long could it be done without, and the effect of someone changing it without approval.

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

Confidentiality - information must be kept private as its owner instructs.

Integrity - information must not be inappropriately changed or destroyed.

Availability - the information must be ready for use when 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 (e.g., contracting or economic forecast information, which is sensitive until its publication or release date, after which it is publicly available). Up-to-date information is generally more valuable than older information.

Show me **what I can do to protect my data.**

All employees and contractors have a responsibility to:

- Be familiar with VA security policies, procedures, rules, and regulations (know what to do, how to do it, and why).
- Ask your supervisor or your ISO, if you have any questions about your security responsibilities.

You are responsible for:

- **Reporting known or suspected incidents immediately** to your 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 your logon or account password with anyone (including the Help Desk).
- **Complying with safeguards, policies, and procedures** to prevent unauthorized access to VA computer systems.
- **Recognizing the accountability assigned to your UserID and password.** Each user must have a unique ID to access 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 your data is backed up, tested, and stored safely.**

- **Not generating or sending offensive** or inappropriate e-mail messages, graphical images, or sound files. Limit distribution of e-mail to only those who need to receive it. **Realize** that you are identified as a user of VA's computer systems when you are logged onto the Internet.
- **Using authorized virus scanning software** on your workstation or PC and your home computer. Know the source before using diskettes 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).
- Knowing your data and properly **classifying** and **protecting** all data, inputs, and outputs according to their sensitivity and value. **Label sensitive media**, use a screen saver with a password, logoff when you leave your work area, and secure that sensitive information is removed from hard disks that are sent out for maintenance. Do not send sensitive information over the internet unless it has been encrypted.
- **Learning** as much as you can about information security to help your ISO. Numbers alone make users the most important security asset we have. Compared to one ISO for a system, users offer the chance for many eyes and ears to be alert to dangers to our information systems.

Appendix C – 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 (F -10) button (highlighted below) initiates using the keyboard to navigate and enter data on this screen.

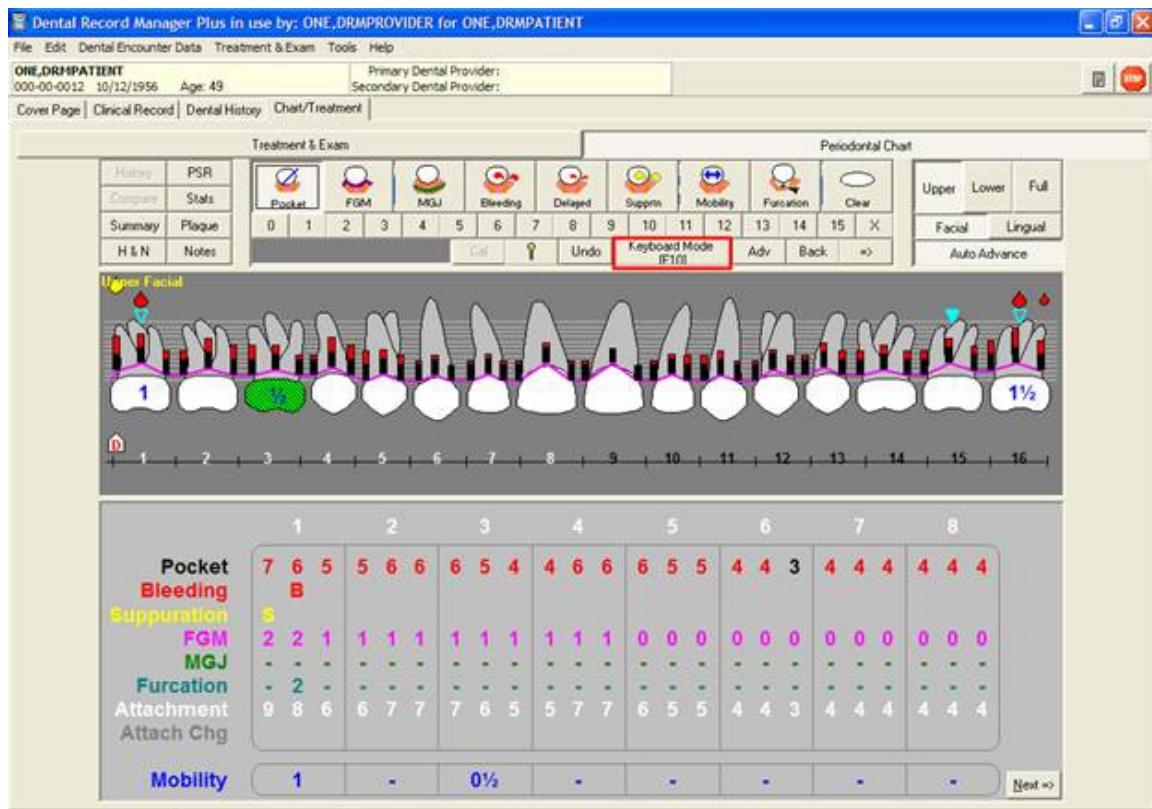


Figure 233: Using the Keyboard to Enter Periodontal Data

When this button is clicked, all of the icons are “grayed out” and the keyboard is activated. The keyboard functions are described in this section.

The screen appears as shown on the following page:

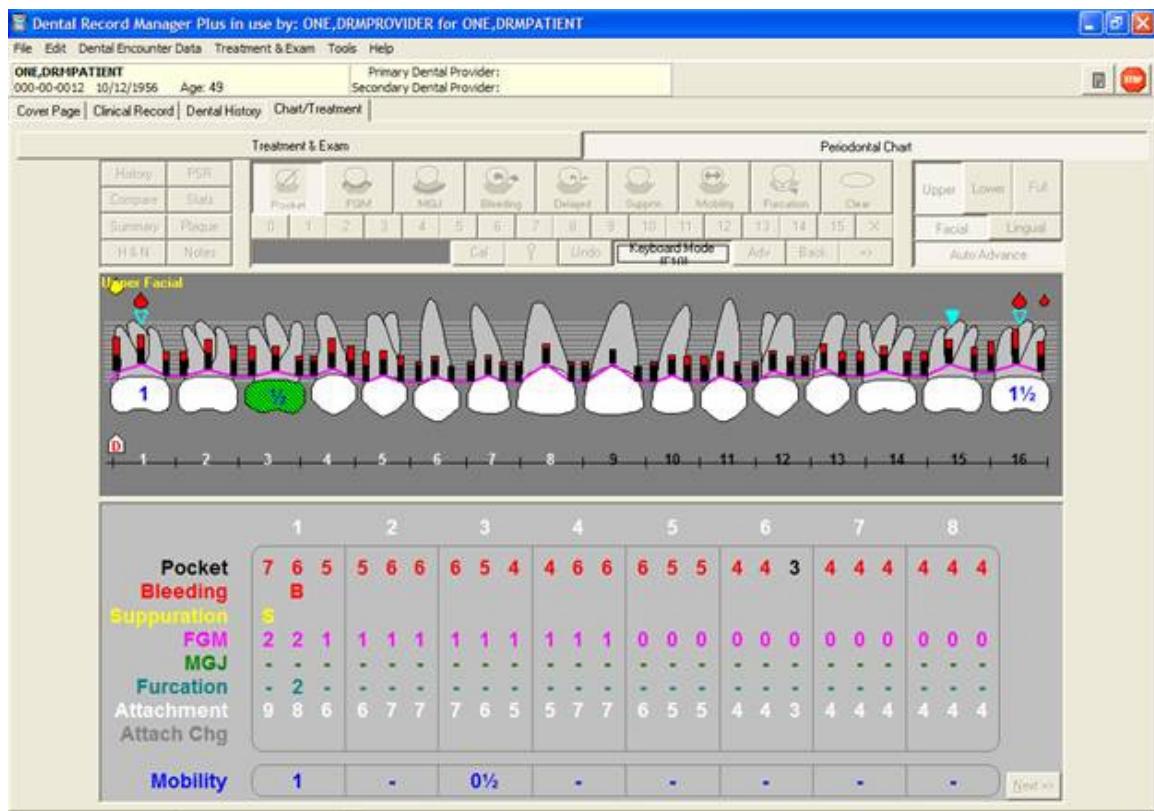


Figure 234: Navigating the Periodontal Screen

Navigating the Periodontal screen – Use the following key strokes to change the screen views.

Arch views – The screen moves from the existing view 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 - Tooth/Surface Selection – Four options exist for moving the cursor to select a Tooth/Surface.

Enter – Moves the cursor one surface in the direction of the higher number tooth.

Backspace – Moves the cursor one surface in the direction of the lower number tooth.

> – with or without the Shift key – moves the cursor one surface in the direction of the higher number tooth.

< – with or without the Shift key – moves the cursor one surface in the direction of the lower number tooth.

Click on the “A” key to toggle on/off the Auto Advance function.

Entering Data – Entering data from the keyboard requires the cursor be placed on the desired Tooth/Surface, selecting the desired condition and entering the data values in the proper manner.

Note: All numeric values must be entered with two digits (1=01, 2=02, 10=10). Entering FGM and Mobility require the values have a prefix (See below).

K = Pocket – Press the “K” key and with the cursor in the correct position enter a two digit value. Progress the cursor to the next surface.

G = FGM – Press the “G” key and with the cursor in the correct position enter +and a two digit value or just a two digit value. Progress 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. Progress the cursor to the next surface.

B = Bleeding – With the cursor in the correct position depress the “B” key.

D = Delayed Bleeding - With the cursor in the correct position depress the “D” key.

S = Supporation - With the cursor in the correct position depress the “D” key.

O = Mobility – Press the “O” key and with the cursor in the correct position enter a two digit value. For a value of 1 ½ , 2 ½ etc. enter the two digit value preceded by a +.

I = Furcation – Press the “T” key and with the cursor in the correct position enter a two digit value. Progress the cursor to the next surface.

R = Reset – Resets all values to zero (Use this function very carefully).

Ctrl z = Undo.

Special Buttons – Initiating the viewing of the Special Button screens requires the 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. Mouse clicks are required to navigate these screens.

Other Functions:

Z = Cal
X = Lock

For your convenience, a tear-out of the following Periodontal Keyboard shortcut chart is available on page 182.

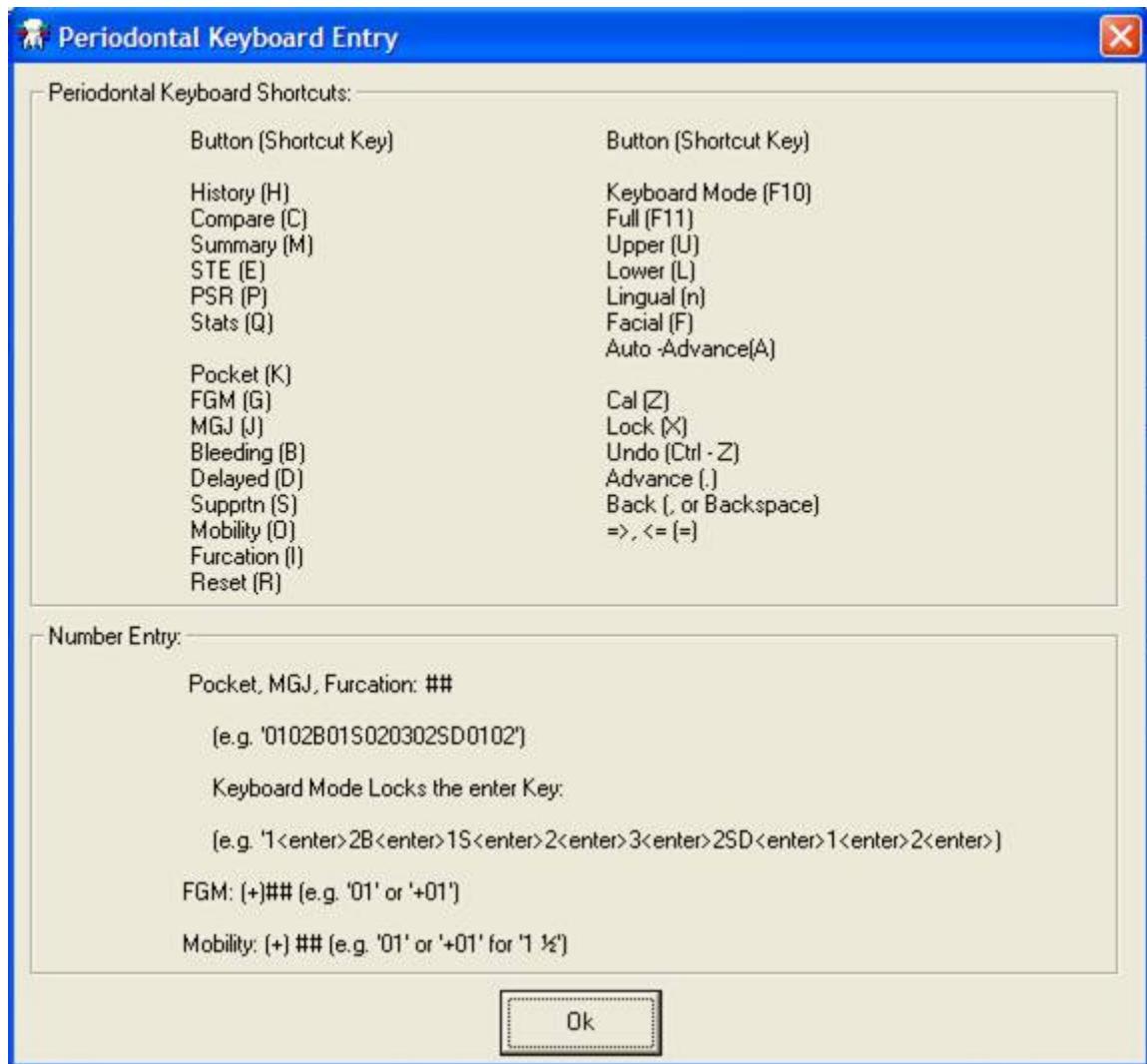


Figure 235: Periodontal Keyboard Entry

Appendix D – Using the CNT Navigator

Clicking on CNT Navigator will bring up a directory of clinical note templates that are used, as a tool, to assist you in writing your note or adding additional information into the note.

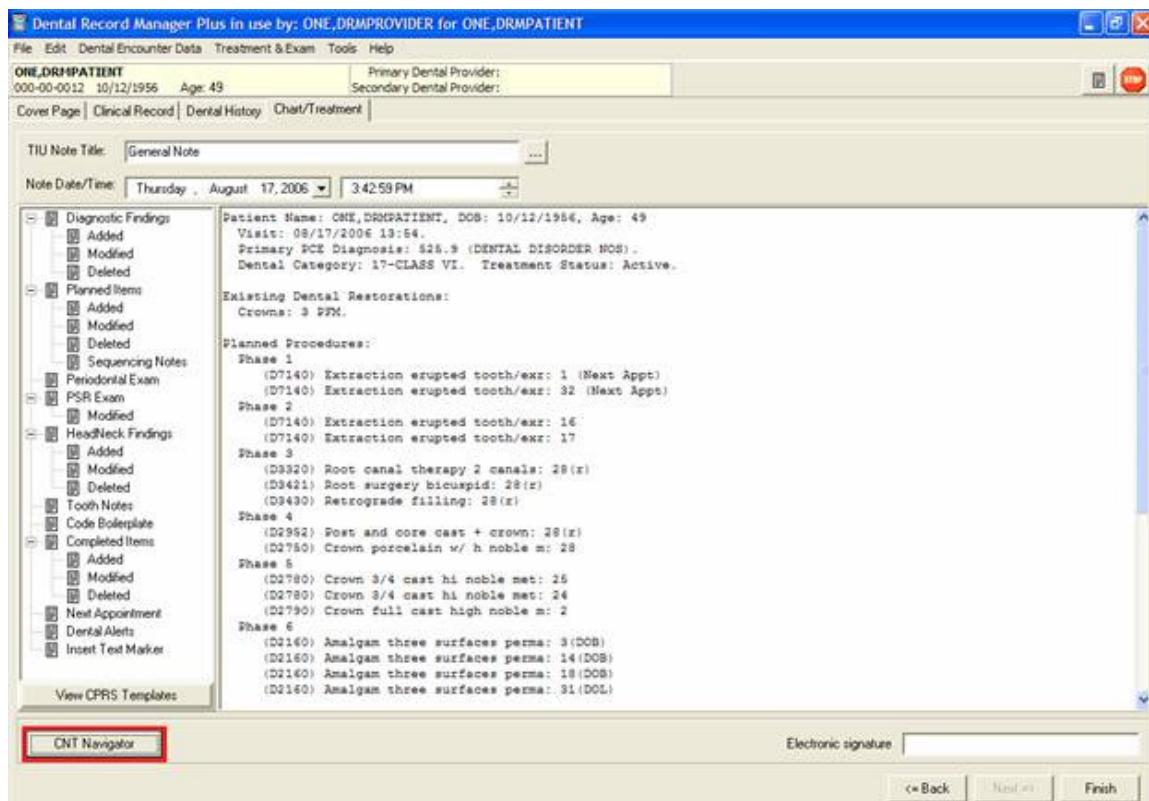


Figure 236: CNT Navigator

CNT Navigator is designed for you to point and click with a mouse to select pre-canned text in the development of your note. You can also free text type within the Clinical Note Template if the pre-canned text or statements do not contain the verbiage you wish to use.

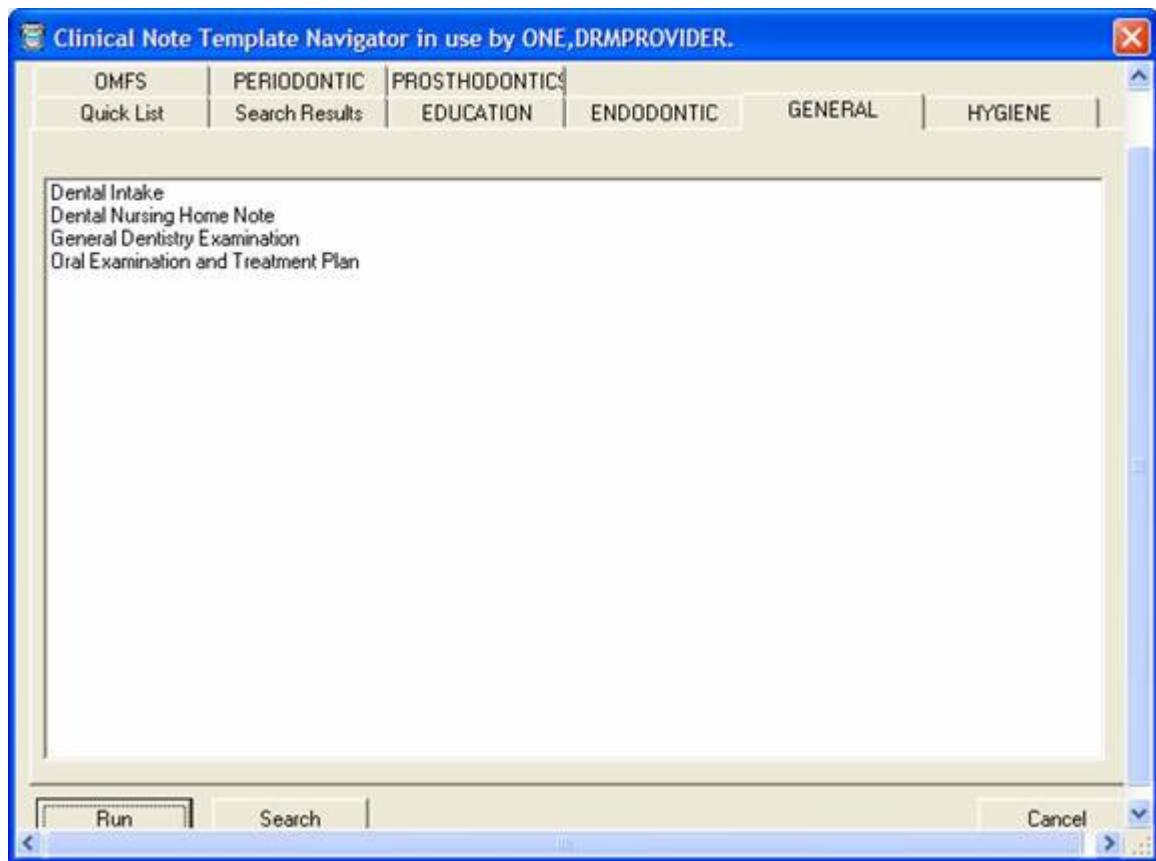


Figure 237: Using the CNT Navigator

To Access CNT you would:

Click on any of the tabs. A listing of CNT's specific to the tab you selected appears. Either single click on the template you wish to use and click on RUN or double click.

Navigating within CNT's

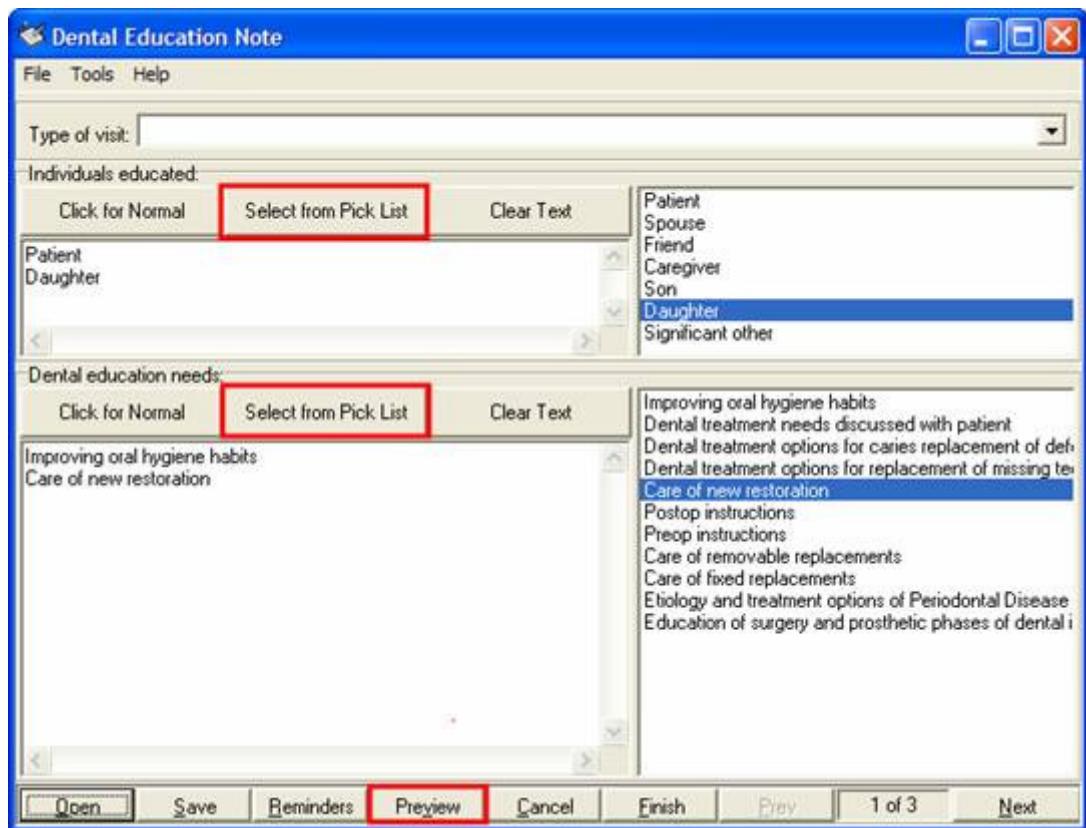


Figure 238: Navigating Within CNT

To navigate within CNT you:

- Point and click within windows, tabs, drop down arrows, check boxes and radio buttons. Each navigational method provides you with a different way of entering or selecting information.
- Preview the note you are writing by clicking on PREVIEW.
- Simply click on REVIEW To Form to continue writing your note.

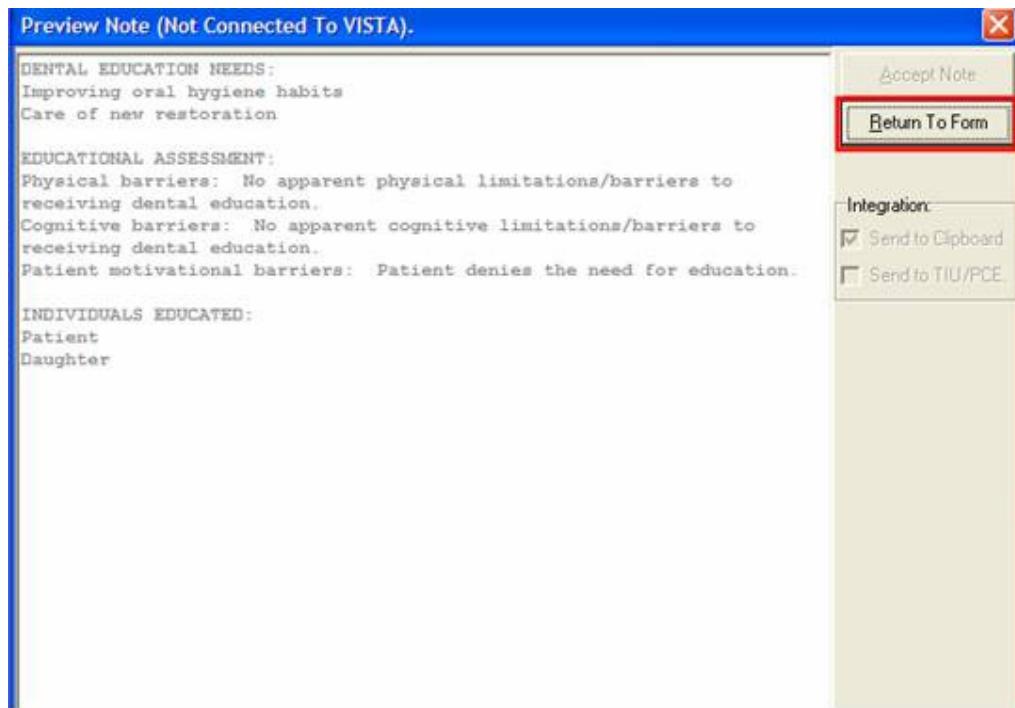


Figure 239: Preview Note

When you have completed your note, click on **Finish**. Then click on **Accept Note**.

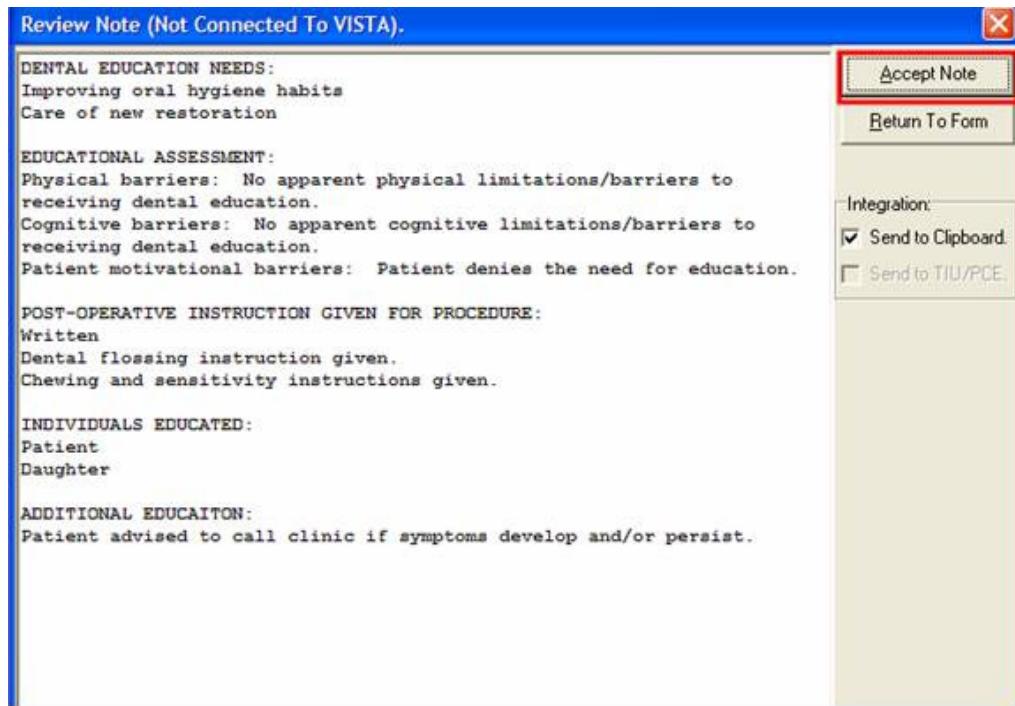


Figure 240: Finish and Accept Note When Completed

The note will be automatically added to the end of TIU note DRM has created for you.

Appendix E – Range Codes

Using the graphic icons on the Treatment Plan and Completed Care screens is not only straightforward, but it minimizes the possibility of errors. Certain codes, designated as Range 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.

Range Codes:

Removable	Fixed Prosthodontics, cont.
5130	6253
5140	6545
5211	6448
5212	6600
5213	6601
5214	6602
5281	6603
5820	6604
5821	6605
5860	6606
5861	6607
Implant Services	6608
6054	6609
6055	6610
6068	6611
6069	6612
6070	6613
6071	6614
6072	6615
6073	6720
6074	6721
6075	6722
6076	6740
6077	6750
6078	6751
6079	6752
Fixed Prosthodontics	6780
6210	6781
6211	6782
6212	6783
6240	6790
6241	6791
6242	6792
6245	6793
6250	
6251	
6252	6920

Appendix F – Business Use of the DRM Plus Software

As important it is to know how to use the DRM Plus software, it is equally essential to be aware of how to enter codes, fees and other similar DRM 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 national and local level, clarify current and future funding issues, and ascertain how to provide even better care to our patients.

Please review this information carefully. If you have any questions, about the use of the software or the accompanying business policies, please contact the local DRM Plus Subject Matter Expert at your site. If that person cannot answer your question, s/he will know whom to contact to find the correct solution.

Local policy and practice

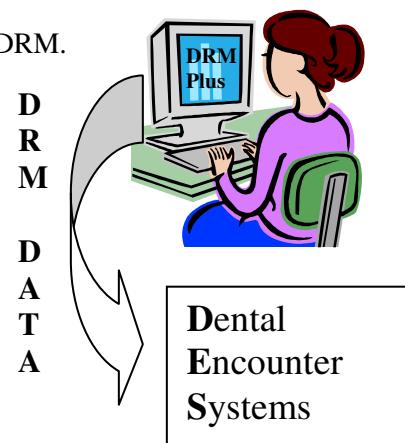
The workflow processes addressing the provider's data entries for the following

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

National policy and practice-Coding Guidelines

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

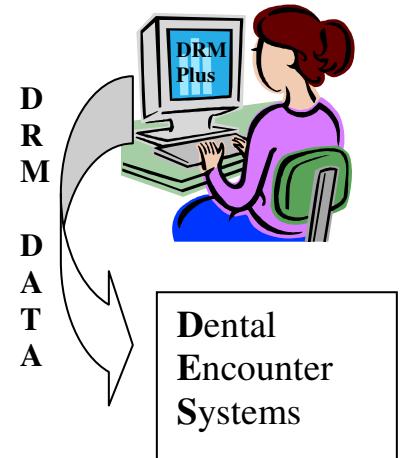
- procedures by staff
- fee-basis onsite
- sharing onsite
- contract onsite
- residents
- without compensation
- students
- hygienists



- For example, if a surgeon goes to the OR and enters the procedure into PCE (Patient Care Encounter) through the surgery package or through an encounter, that procedure must be entered into DES through DRM
- Coding guidelines should be followed in an attempt to calibrate providers so when the same encounters are observed at two separate clinics, this will ensure the encounters are coded the same.

National Business Practices – Fee Basis

- Fee basis patient data must be entered through Dental Record Manager (DRM).
- DRM Fee Basis Report should be completed in DRM when each 2570-D is authorized for payment by the signature of the authorizing dentist (or through the equivalent delegated authority).
- This DRM Fee Basis Report will automatically be sent to the Dental Encounter System (DES) database in Austin. Please note that the DRM Fee Basis Report is entered at the time the 2570-D is authorized for payment, not at the time of obligation of funds.
- The data must be entered by someone who has access to the DRM Fee Basis Report screen and to CPRS.



Appendix G – Active-Inactive-Maintenance Control

With the introduction of DRM Plus, the direct entry of [Completed] or [Terminated] cases was removed from the program and instead the concept of Patient Disposition was introduced. The provider could choose between an [Active] or [Inactive] status for the patient. If the provider changed the patient from an [Active] to [Inactive] status, and there were no planned items remaining, the case was recorded as [Completed]. If the provider changed the patient from an [Active] to [Inactive] status, and there were planned items remaining, the case was recorded as [Terminated]. The Current Episode of Care was defined as that interval from when the patient was last changed from an [Inactive] status to [Active] and then back to [Inactive].

It has been recognized that there is the need to account for patients who may not be actively 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, Dental Record Manager Plus will now allow the provider to choose the status of [Active], [Inactive] or [Maintenance] for their patient.



Figure 241: 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 will end. If the provider changes the patient's status from [Active] to [Maintenance], and there are planned items remaining, the case will remain ongoing with no changes to the episode of care. No matter what the patient's previous status, a patient's status will be 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 will provide a date flag for reporting and re-evaluation purposes. (As we move forward with CPRS reengineering, this flag will eventually be used for setting a clinical reminder in CPRS).

Upon loading of Patch 47, the install routine will traverse 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 will be set to [Inactive]. Then, on a monthly basis, a maintenance routine will 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.

1. A newly enrolled veteran is eligible for dental care and the patient is new to the Dental Clinic. Their case will be automatically set to [Active] without user intervention upon the first time opening the patient in DRMPplus.
2. A Class II patient has had their post-discharge dental care episode finished. Upon completion of care, their status is changed to [Inactive].
3. 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.
4. A Class III/VI patient has had their adjunctive care completed. Upon completion of the adjunctive care, their status is changed to inactive. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation.
5. A Class V patient has had their necessary dental care completed. Upon completion of care, their status is changed to [Inactive]. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation.
6. 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 DRMPplus and thus by opening the patient in DRMPplus 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 will have a significant wait for care, it is suggested the Recommended Recare Date be set to the approximate date the patient's dental care will be initiated to avoid automatic inactivation of the patient after 24 months.
7. A Class I/IIC/IV patient has failed to keep appointments and not followed through with their care. The provider will make a progress note of the patient's failure to adhere to medical recommendations and change the patient's status to [Inactive]. The provider can choose whether or not to recommend and enter a recare date; there is no statutory requirement for the VA to meet that recommendation. The patient's status is changed to [Active] upon a new application for care.
8. 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].

Periodontal Keyboard Shortcuts: Tear-Out

