Where do I enter information and data in DrChrono in order to report it with Healthmonix MIPSpro?

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With Healthmonix MIPSpro, you can easily document your measures in DrChrono. It is a best practice to regularly enter your data so that this data will sync with Healthmonix.

In this article, we will look at the main areas where you will enter your discrete data in DrChrono for:

- Appointment code data
- Patient Data

Appointment Billing Details

Entering ICD-10, CPT, and HCPCS codes is the primary way Healthmonix MIPSpro gathers data for reporting. There are a few places DrChrono you can access the billing details for an appointment.

From the schedule, open an appointment and navigate to the **Billing** tab. Here you can enter

- ICD-10 Codes ex. E10.10
- CPT Codes ex. 99213, 3046F - Modifiers (if needed)
- HCPCS codes ex. G0438

You can also access a similar screen in the clinical note by navigating to the **Billing** section under the **H&P** or **SOAP** tabs.

In the Live Claims Feed (**Billing** > **Live Claims Feed**), you can also enter codes associated with the appointment.

1. Click on the **Date of Service** for the appointment.

2. Scroll down to the **Line Items Transactions** section. Enter the desired codes. CPT and HCPCS codes are entered in the same area. Click **+Add Line Item** and **Verify & Save** when finished.

Note: You can make the process of adding codes easier by building and applying billing profiles or adding codes to clinical note fields.

Documenting Patient Data

1. Demographics and patient information can be recorded in the chart under the **Important** and **Demographics** tabs. You can also document **Smoking Status** under the appropriate tab.

Note: After entering data, please scroll down to the bottom of the page and click **Save Demographics.**

2. One area where ICD-10 codes can be entered is the **Problem List**. Codes documented during the visit will automatically be added to this list. You can also enter ICD-10 codes by clicking **+New Problem**.

ICD-10 codes can also be entered in the billing areas described above or in the clinical note by navigating to the **Assessment** section under the **H&P** or **SOAP** tabs. From here you can enter codes under the **Billing ICD-10** or **Problems** tabs.

3. Medications are added to the chart when prescribed, but they can also be added to the chart by going to the **Medication List** and selecting **+Add Medication**.

4. One area where allergies can be entered is in the chart under **Allergy List** in the chart. To add an allergy select **+New Allergy**.

Medications and allergies can also be entered in the clinical note by navigating to the **Medications & Allergies** section under the **H&P** or **SOAP** tabs. You can enter data under the **Medication** or **Allergy** tabs by clicking on the (

+

) icon.

5. Under the **CQMs** section you can see a summary of some of the patient data and add any **Intervention**, **Risk Category/Assessment**, **Physical Exam**, or **Communication** by clicking the **+New button.**

6. Lab results information can be added or viewed under the **Lab Orders** section.