Well Child Documentation Tips

Be sure your documentation meets all EPSDT well child requirements. Thorough EPSDT well child documentation may help improve your P4P and HEDIS scores.

**Health History**
*Should be documented at every EPSDT and well child visit.*

**EXAMPLES:**
- “Medical history, surgical history, allergy list, medical list was reviewed and updated. No illnesses since last visit.”
- “39.4 weeks gestation, vaginal delivery, mom GBS +ve, Hep B Imm at birth, birth weight 7.6 oz.”
- “Here for 6yo well visit. Historian: foster mother. Pt’s problem list, medical history, surgical history, and medication list were reviewed. Sleeping >8 hours. No enuresis. Saw allergist yesterday, awaiting lab results.”

**Psychosocial/Family History**
*Should be documented at every EPSDT and well child visit*

**EXAMPLES:**
- “PSH/PFM reviewed and updated.”
- “Parent adjustment to child: adjusting well; sibling adjustment to child: adjusting well; childcare: in-home daycare 3xweek; living at home with mom, dad, sisters (x2), and 2 cats. Smoking: dad smokes outside only.”
- “Family history reviewed– unremarkable; interacts well with peers; involved in school activities; parents involved with homework and know child’s social circle. No signs of domestic violence or child maltreatment.”

**Structured Developmental Screening**
*Development screening at 9 mo, 18 mo, and 30 mo. Autism screening at 18 mo and 24 mo. Name of screening tool used AND result should be documented at each EPSDT visit (as indicated by age).*

**EXAMPLES:**
- “PSC completed. WNL.”
- “Development normal for age– see Ages and Stages Questionnaire in chart.”
- “M-CHAT completed-results reviewed with pt’s grandmother. First Steps referral.”

**Ongoing Developmental Surveillance**
*Developmental milestones should be documented at each EPSDT and well child visit. A complete listing of developmental milestones or a statement similar to, “all areas of development normal for age,” meet both mental and physical developmental surveillance.*

**EXAMPLES:**
- **Mental**
  - “Behavioral NL. Has friends. +eye contact. Future plans of trade school. Involved in community.”
  - “Alert. Turns and calms to parent’s voice.”
  - “Names 3-4 colors. Clear speech. Sings songs.”
- **Physical**
  - “Wt 60% Ht 20% BMI%72. Vision acuity 20/20 OU. Normal gait. LMP 2/22/2015. Not sexually active.”
  - “Strong root reflex. Follows face to midline.”
  - “Balances on 1 foot. Hops, skips. Mature pencil grasp.”
  - “Dresses self. Copies a circle/cross. Walks up stairs.”

**Depression Screening/ Risk Assessment**
*All children annually ages 11-21 yr. Depression screening using the PHQ-2, PHQ-9 or other tool. Tobacco and risk assessments using CRAFFT, HEEADSSS or a similar screening tool should be document at each EPSDT visit (beginning at 11 yr). Maternal Depression Screening: To be completed on the mother of members 1, 2, 4 and 6 mo.*

**EXAMPLES:**
- “CRAFFT screening completed– negative. PHQ-9 completed-positive. Refer to behavioral health.”
- “HEEADSSS completed. PHQ-2 negative. No behavioral concerns identified. No suicidal ideation or depression symptoms identified.”
- “SBIRT completed– no concerns identified. PHQ-9 negative. Will re-screen in 3 months.”
**Nutritional and Physical Activity Assessment**

*Nutritional assessments should be documented at all EPSDT and well child visits, and a physical assessment beginning at age 3 years and older.

**EXAMPLES:**
- “Nutrition hx reviewed. Exercise includes softball and volleyball. Positive body image.”
- “Reviewed nutritional habits, no concerns. 60 mins outdoor play time: yes. Outdoor activities as a family: yes.”
- “Enjoy physical activity and a variety of fruits and vegetables every day.”

**Physical Examination**

*A head to toe exam should be documented at all EPSDT and well child visits. “PE: WNL” is NOT sufficient. EPSDT requires an external eye exam and an oral inspection at each EPSDT visit.

**EXAMPLES:**

Documentation examples of external eye inspection:
- “PEERL, lids NL, conjunctivae/sclera clear.”
- “EOMI, pupils equal and round, no eye redness or drainage noted.”

Documentation examples of oral inspection:
- “Mouth/gums: palate intact, no thrush, no dental ridges, no bleeding or inflammation of gums.”
- “Oral cavity: MMM, tongue/frenulum: NL, gums NL, dentition NL, no staining, no lesions.”

**Vision and Hearing Screenings**

*Screenings should be implemented and documented according to the Bright Futures periodicity schedule for all EPSDT visits.

- **Hearing**: NB to 3 mo, 4-6 yr, 8-10 yr, 11-14 yr, 15-17 yr and 18-21 yr (While annual check-ups are optimal, documentation should occur not less than one time within each noted age period.)
- **Vision**: 3, 4, 5, 6, 8, 10, 12 and 15 yr

**EXAMPLES:**
- “Vision acuity: 20/40 OU. Pt has appt with optho next month. Hearing screening done at school earlier this year, was normal per mother.”
- “Vision acuity tested, 20/15 OU. Referred to audiologist for hearing screening.”
- “Unable to perform vision acuity or hearing testing d/t child unable to cooperate. Will retest in 6 months.”

**Dental Screening**

*Assess for a Dental Home (12 mo, 18 mo-16 yr. If no dental home at these ages, complete a dental risk assessment and give Dental referral. Fluoride Supplementation Risk Assessment (6, 9, 12, mo and 18 mo-16 yr. Fluoride Varnish may be completed every 3-6 mo by either PCP or Dental Provider (6 mo-5 yr).

**EXAMPLES:**
- “Reviewed importance of dental hygiene. Has never been to a dentist. Referral given for dental clinic.”
- “Dental home: yes. Dental visit within past 6 months: yes. Recent dental emergencies: no.”
- “Flushes teeth 2x day, flosses, annual dental visits. Discussed importance of routine dental care.”

**Anticipatory Guidance/ Health Education**

*Should be documented at every EPSDT and well child exam

**EXAMPLES:**
- “Bright Futures handout given.”
- “AG discussed.”
- “Preventive health reviewed: nutrition, exercise, safety, dental, development, & behavior.”

**Immunizations**

*Should be documented at all EPSDT and well child visits

**EXAMPLES:**
- “IMMS UTD. See IMM record.”
- “Checked CHIRP. Due for Dtap and Hep A. Referred to Health Dept. Health Dept. to fax UTD IMM record.”
- “Needs HPV #1. To RTC in 1 mos. for HPV #2.”
NEWBORN BLOOD SCREENING
- Newborn Blood Screening: Confirm completed, follow-up as indicated
- For detailed information please visit the HRSA (Health Resources & Services Administration) website at: https://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf
- Newborn: 1 mo, 2 mo
- Newborn Congenital Heart Defect Screening, completed by Pulse Oximetry: Confirm completed, follow-up as indicated
- Newborn Bilirubin: Confirm completed, follow-up as indicated

ANEMIA SCREENING
- Administer at 12 mo
- Anemia Risk Assessment: 4 mo, 15 mo, annually through 21 yr

DISLIPIDEMIA SCREENING
- Once between 9-11 yr, once between 17-21 yr
- Dyslipidemia Risk Assessment: 24 mo, 4 yr, 6 yr, 8 yr, 12-16 yr

HIV SCREENING
- Once between 15-18 yr

BLOOD LEAD SCREENING
1In accordance with IC-12-15-12-20, the Office of Medicaid Policy & Procedure (OMPP) requires Medicaid providers to screen children for lead poisoning.
- Once between 9-12 mo, re-test prior to child’s second birthday
- If child has not been tested previously, administer test up to 6 yr
- If positive for blood lead poisoning, entire family should be tested and treated.
- For more information, please review FSSA’s Provider Reference Module for EPSDT/Healthwatch