

South Carolina  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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[www.scdhhs.gov](http://www.scdhhs.gov)

January 15, 2009

*Physicians  
MCO  
Medical Clinics*

# MEDICAID BULLETIN

**TO: Medicaid Adolescent Pregnancy Services (MAPPS) Providers**

**SUBJECT: Changes in Medicaid Policy Effective February 15, 2009**

Effective with the date of service **February 15, 2009**, the South Carolina Department of Health and Human Services (DHHS) will implement policy changes for the provision of Medicaid Adolescent Pregnancy Services (MAPPS). Changes to the policies are as listed:

**1. Risk Factors**

Participant must have one or more of the following risk factors:

- Participant is a teen parent.
- Participant is sexually active.
- Participant has a history of sexual abuse.
- Peer pressure to engage in sexual activity is identified as a problem by the adolescent. Peer pressure is identified **by the participant and documented in the record. Peer pressure must be defined in the record as:**
  - a. The participant is in a relationship with a partner who is sexually aggressive or is trying to persuade the participant to engage in sex
  - or**
  - b. The participant has friends who are sexually active and are urging the participant to engage in sexual activity with which he or she is uncomfortable.

Participants enrolled in MAPPS, regardless of risk factor(s), who were receiving services before **February 15, 2009** may continue until their next assessment or 12-month case plan update.

**2. Assessment and Case Plan**

The assessment and case planning will be limited to **1 hour per state fiscal year**. Each completed Assessment and Case Plan must include the beneficiary's primary medical care provider and managed care organization, if applicable. Assessments and case plans must also use the revised risk factors. The basic screening assessment must include all information contained in the Screening Form and Case Plan Form along with a description of services to be rendered. A copy of the Case Plan may be forwarded to the primary medical care provider so that these medical needs of the beneficiary are documented. The assessment and the case plan must be completed by a licensed or certified health care professional and must be updated at least annually or when additional risk factors are identified.

**3. Progress Report**

Services must be documented in a Progress Report that is filed in the clinical record and a copy sent to the beneficiary's Primary Care Physician at the end of the assessment/12-month case plan period or when the beneficiary is discharged. The Report must summarize the services provided, the beneficiary's response to goals, and give the reason for continuation of services or discharge. The Report must include all the information in the Service Summary Report, must be completed by a licensed or certified health care professional and must be updated at least annually. A Service Summary Report may be prepared and forwarded to the primary medical care provider when the beneficiary begins services.

**4. Group Session**

Participants who **are not** sexually active will be allowed **16 hours** of group session **per lifetime**. Participants who are not currently sexually active but are enrolled in MAPPS before **February 15, 2009** may continue until their next assessment or 12-month case plan update.

Participants who **are** currently sexually active will be allowed **16 hours** of group session **per year**.

**5. Diagnosis Codes**

Providers should use pregnancy prevention or other ICD-9 diagnosis codes that represent need for MAPPS services.

Please note the following continued requirements for MAPPS:

- Individual sessions continue to be limited to **16 hours (64 units) per participant per state fiscal year**.
- Providers must use **approved** evidence-based curricula. Verification source for acceptability of curricula is the SC Campaign to Prevent Teen Pregnancy.
- Revised forms are attached and are also located in the Medicaid Enhanced Services Manual, Forms Section, located on the agency's website at [www.scdhhs.gov](http://www.scdhhs.gov).

Questions regarding this bulletin should be directed to the Department of Medical Support Services at (803) 898-4614.

/S/

Emma Forkner  
Director

EF/mhp

Enclosures

**Note:** To receive Medicaid bulletins by email, please register at <http://bulletin.scdhhs.gov/>. To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer (EFT) for instructions.



Medicaid Adolescent Pregnancy Prevention Services

CASE PLAN

Treatment Protocol (T1023-FP)

Participant's Name \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Needs Statement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan of Care: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Goals and Objectives	Frequency	Completion Date

This ICP will be reviewed on (6 months from ICP date): \_\_\_\_\_

Date Reviewed: \_\_\_\_\_ (Review case plan during Individual Session)

Progress Report prepared by: \_\_\_\_\_ Date: \_\_\_\_\_

Mailed to: \_\_\_\_\_ Date: \_\_\_\_\_  
(Primary Care Physician)

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Provider of Service)  
Licensed/Certified Signature and Title: \_\_\_\_\_  
Date: \_\_\_\_\_

Units: \_\_\_\_\_

**SCREENING FORM**

1. Name of Participant: (First, Middle Initial, Last) \_\_\_\_\_
2. Age of Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female
3. Social Security #: \_\_\_\_\_ Medicaid # \_\_\_\_\_ Patient Account: \_\_\_\_\_
4. Eligibility:  Medicaid  Foster Care  Child Protective Services
5. Date of Assessment: (Month, Date, Year) \_\_\_\_\_
6. Racial or Ethnic Background of Participant: (Check one)  
 White or Anglo, Not of Hispanic Origin  Black, Not of Hispanic Origin  Hispanic  
 American Indian  Asian or Pacific Islander  Other: \_\_\_\_\_
7. Special needs of the participant (Check All That Apply)  
 None  Attention Deficit Disorder (ADD)  Learning Disability  Emotionally Handicapped  
 Other: (Specify) \_\_\_\_\_
8. Does the participant have a primary medical care provider? If so, name and address:  
 \_\_\_\_\_ Managed  
 Care Plan \_\_\_\_\_
9. Parent/Guardian: \_\_\_\_\_ SSN: \_\_\_\_\_
10. Employment Status of the Mother/Guardian:  Full-Time  Part-Time  Not Employed  Other: \_\_\_\_\_
11. Employment Status of the Father/Guardian:  Full-Time  Part-Time  Not Employed  Other: \_\_\_\_\_
12. Martial Status of Parent (s):  Married  Single  Separated  Widowed  Other: \_\_\_\_\_  
 \_\_\_\_\_

**Environmental**

13. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	<input type="checkbox"/> No Telephone

14. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members


15. Access to Transportation: (Check One)  Yes  No Comment \_\_\_\_\_

**Referral/ Health Risk Factors**

16. What was the referral source for MAPPs? (Check One)  
 DSS  Teacher  Counselor  Relative  Friend  Other: (Specify) \_\_\_\_\_

17. Referral Risk Factor (s): (Explain in Narrative)  
 Participant is a Teen Parent  Participant is Sexually Active  Participant has a history of Sexual Abuse  
 Peer Pressure to engage in sexual activity is identified as a problem by the adolescent (give details)

18. Is the participant currently sexually active?  Yes  No  
 If no, has the participant ever been sexually active?  Yes  No

19. Has the participant ever been an expecting parent (abortion/fetal death)?  Yes  No

20. Has the participant ever used a birth control method?  Yes  No

Method Used: (Check All That Apply)

Birth Control Pills  Condom  Depo-Provera Shot  Diaphragm  IUD  Rhythm

Other: \_\_\_\_\_

21. Does the participant understand or know the health risks associated with having sex?  Yes  No

22. Has the participant ever had a STD?  Yes  No If yes, specify: \_\_\_\_\_

23. Has the participant ever experimented with alcohol, tobacco, and/or other drugs?  Yes  No  
 If yes, what kind? \_\_\_\_\_

**Activities**

24. Does the participant engage in extracurricular activities?  Yes  No  
 If yes, list activities: \_\_\_\_\_

25. How does the participant spend his/her free time?  
 After School: \_\_\_\_\_  
 Weekends: \_\_\_\_\_

26. Do household rules cause any conflict between the parent/guardian and the participant?  Yes  No  
 If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
 -  
 What are the parent/guardian's and the participant's feelings about the household rules? \_\_\_\_\_  
 \_\_\_\_\_

27. Does participant have friends?       Yes     No

If yes, gender and age? \_\_\_\_\_

-

When they spend time together, what do they do? \_\_\_\_\_

How does the participant get along with friends? \_\_\_\_\_

-

28. How does the participant get along with adults? (Including teachers) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

