Frequently Asked Questions
Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Q: What are the 3 covered Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations?

A: Treatment Services for Children with Cognitive Impairments & Functional Limitations; Specialized Services for Children with Cognitive Impairments & Functional Limitations; and Assessments.¹

Q: What are Treatment Services for Children with Cognitive Impairments & Functional Limitations?

A: Medically necessary treatment services for children under age 21 that are designed to retain or improve functional abilities which have been negatively impacted by the effects of cognitive or functional impairment and are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills. Services include:

- problem solving activities in order to help the child develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs,
- learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults,
- learning the skills that will improve a child’s self-awareness, environmental awareness, social appropriateness and support social integration, and
- learning awareness of and appropriate use of community services and resources.²

Q: What are Specialized Services for Children with Cognitive Impairments & Functional Limitations?

A: Medically necessary, evidence based treatment services for children under age 21 that utilize behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree. Services include:

- problem solving activities in order to help the child develop and maintain skills and abilities necessary to manage his or her behavioral health treatment needs,
- learning the social skills and behaviors necessary to live with and interact with other community members and independently, and to build or maintain satisfactory relationships with peers or adults,
- learning the skills that will improve a child’s self-awareness, environmental awareness, social appropriateness and support social integration, and
- learning awareness of and appropriate use of community services and resources.³

¹ §28.04-1, §28.04-2, §28.04
² §28.04-1
³ §28.04-2
In order to be “Specialized Services,” the services must also utilize the process of systematically applying interventions based upon empirically derived principles of behavior to improve socially significant behaviors to a measurable degree, and to demonstrate that interventions employed are responsible for improvements in behavior. Assessment includes systematic information gathering regarding factors that influence occurrence of a behavior including interview, direct observation and experimental analysis.\(^4\) While the term “evidenced based” is not defined in the regulations, DHHS has stated: “Generally, evidenced-based practice is the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preference. (APA Presidential Task Force on Evidence-Based Practice, 2006)\(^5\) If Specialized Services are being requested, the child must meet the criteria for Specialized Services (a diagnosis of Autism or PDD-NOS) and the school district must be authorized as a Specialized Services provider under MaineCare.\(^6\)

**Q:** What are Assessment Services?

**A:** For “Specialized Services,” the Assessment includes systematic information gathering regarding factors that influence occurrence of a behavior including interview, direct observation and experimental analysis.\(^7\) In addition, Assessment Services are Comprehensive Assessments and treatment planning. It is DHHS’ intent to authorize up to 10 hours for completion of the assessment and ITP reimbursable under the appropriate procedure code as authorized by DHHS.\(^8\)

**Q:** What does “medically necessary” mean?

**A:** Reasonably necessary and remedial services that are provided in an appropriate setting; recognized as standard medical care based on national standards for best practices and safe, effective, quality care; required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being; are MaineCare covered services; performed by enrolled providers within their scope of licensure and/or certification and are provided within the regulations of the Maine Care Benefits Manual.\(^9\)

**Q:** What is a “Comprehensive Assessment?”

**A:** An Assessment used to identify strengths and needs of the child and family and develop an Individual Treatment Plan. The comprehensive assessment process determines the intensity and frequency of medically necessary services and includes utilization of instruments as may be approved or required by DHHS.\(^10\)

\(^4\) §28.01-14
\(^6\) While this statement is not found in the Section 28 regulations, it is found on the Enrollment Form for School Provided Section 28 Checklist, issued by DHHS.
\(^7\) §28.01-14
\(^9\) §1.02-4.E.
\(^10\) §28.01-4
Q: What are the elements of a Comprehensive Assessment?

A:

- A supervisor or staff with qualifications comparable to a supervisor must complete a comprehensive assessment within thirty (30) days of initiation of services and must be included in the child’s record. The comprehensive assessment process must include a direct encounter with the child, if appropriate, and parents or guardians. The comprehensive assessment must be updated as needed, annually at a minimum.  

- The comprehensive assessment must contain documentation of the following:
  - the child's identifying information, including the reason for referral,
  - family history relevant to family functioning including, but not limited to, concerns regarding mental health, developmental disabilities, substance abuse, domestic violence and trauma,
  - the child's developmental history, if known, educational history and current status, and transition planning if age appropriate, and
  - identification of the child’s strengths and needs regarding functioning in the areas of behavior, social skills, activities of daily living, communication, cultural issues and need for accommodation, and
  - for children fourteen years of age or older, independent living skills.

- The assessment must be summarized, signed, credentialed with licensure or certification, if applicable, and dated by the staff conducting the assessment, the parent or guardian and the child, if appropriate, and include the source and date of the diagnosis.

- The assessment must contain documentation if information is missing and the reason the information cannot be obtained.

Q: Must a school use a DHHS-developed standardized comprehensive assessment?

A: While guidance from DHHS in response to Section 28 rulemaking indicated that a standardized comprehensive assessment is required, the Maine Department of Education has indicated in its guidance that schools will not be required to use this standardized format. The DOE does indicate, however that “…schools should review the assessment form on the web site to assure that they are appropriately assessing children for the service.” We do not believe it prudent to rely on DOE guidance in this regard where DHHS comments to official rulemaking indicated that the standardized format is required. See the standardized form, as well as other forms at http://www.maine.gov/dhhs/ocfs/cbhs/provider/forms/section-28.html (as of 6/9/10)

Q: What is an “Individual Treatment Plan” (ITP)?

11 §28.05-2.A., DHHS response to comments during section 28 rulemaking, comment 24, p. 8.
12 §28.05-2.B.
13 §28.05-2.C.
14 §28.05-2.D.
15 DHHS response to comments during section 28 rulemaking, comment 4, p. 1; comment 52, p. 14.
16 http://www.maine.gov/education/medicaid/qa.html, Section 28, Question 2 (as of 4/29/11)
A: The plan of care developed by the treatment team (which includes the child, if appropriate, the parent or guardian, the provider and natural supports\textsuperscript{17}) which is based on a comprehensive assessment and a diagnostic evaluation of the child. The Individual Treatment Plan shall include a Crisis/Safety Plan and a Discharge Plan, along with other elements of the plan of care. The Individual Treatment Plan describes the medically necessary treatment the child will receive.\textsuperscript{18}

Q: What are the elements of an ITP?

A:

- Developed by the treatment team within thirty (30) days of initiation of services; based on the comprehensive assessment; and is appropriate to the developmental level of the child.\textsuperscript{19}
- The ITP must contain the following\textsuperscript{20}:
  - The child’s diagnosis\textsuperscript{21} and reason for receiving the service.
  - Specific medically necessary treatment services to be provided with methods, frequency and duration of services and designation of who will provide the service.
  - Objectives with target dates that allow for measurement of progress toward meeting identified developmentally appropriate goals.
  - Measurable long term goals with target dates.
  - Measurable short term goals with target dates.\textsuperscript{22}
  - Special accommodations needed to address barriers to provide the service.
  - The signature of the parent or guardian and the child, if applicable, and the date the ITP is signed.
  - Documentation of review of the ITP every ninety (90) days by the treatment team.
  - Documentation of how the child’s needs may be reassessed and the ITP revised.
  - Provision of a copy of the initial and reviewed ITP within ten (10) days of signing to the child by the provider.
  - A discharge plan that must contain:
    - identification of discharge criteria that are related to the goals and objectives described in the ITP; and
    - identification of the individuals responsible for implementing the plan; and
    - identification of natural and other supports necessary for the child and family to maintain the safety and well-being of the child, as well as sustain progress made during the course of treatment; and
    - documentation that the discharge plan has been reviewed by the treatment team every ninety (90) days.
  - A Crisis/Safety Plan, as applicable that:
    - Identifies the potential triggers which may result in a crisis;

\textsuperscript{17} §28.01-15
\textsuperscript{18} §28.01-9.
\textsuperscript{19} §28.05-3.A.
\textsuperscript{20} §28.05-3.B.
\textsuperscript{21} “Documentation of diagnosis is required for eligibility for the service and reimbursement under MaineCare.” DHHS response to comments during section 28 rulemaking, comment 61, p. 16. \url{http://www.maine.gov/dhhs/oms/rules/adopted.shtml#id92879} as of 6/9/10.
\textsuperscript{22} The School Based Audit Checklist for Section 28, published by DHHS in October 2013, indicates measurable long term goals and short term goals with target dates are required in the ITP.
- Identifies the strategies and techniques that may be utilized to assist the child who is experiencing a crisis and stabilize the situation;
- Identifies the individuals responsible for the implementation of the plan including any individuals identified by the child (or parents or guardian, as appropriate) as significant to the child’s stability and well-being.

Q: Does a Comprehensive Assessment need to be conducted to develop all ITPs?
A: Yes.\(^{23}\)

Q: Does a “Diagnostic Evaluation” need to be conducted in addition to a Comprehensive Assessment to develop all ITPs?
A: Yes.\(^{24}\)

Q: What is a “Diagnostic Evaluation?”
A: The term is not defined in section 28 or in DHHS’ response to comments under section 28 rulemaking.

Q: Do all Section 28 covered services provided by a school have to be ordered in an ITP?
A: Yes.\(^{25}\)

Q: How often does a Comprehensive Assessment need to be updated?
A: As needed and at a minimum, annually.\(^{26}\)

Q: How often does an ITP need to be reviewed by the treatment team?
A: Every 90 days.\(^{27}\)

Q: What are the eligibility requirements in making a determination as to whether or not a child “qualifies” for the delivery of section 28 covered services?
A:
- Under age 21
- MaineCare eligible
- Services are medically necessary
- The child must have a completed multi-axial evaluation with an Axis I or Axis II behavioral health diagnosis using the most recent Diagnostic and Statistical Manual of Mental Health Disorder or an Axis I diagnosis from the most recent Diagnostic Classification of Mental Health or Developmental Disorders of Infancy and Early Childhood Manual (DC 0-3); AND

\(^{23}\)§28.05-1.B.
\(^{25}\)§28.05-1.C.
\(^{26}\)§28.05-2.A.
\(^{27}\)§28.05-3.B.6.
• Have a functional assessment administered within one (1) year prior to the date of the referral documenting functional impairment measured as two (2) standard deviations below the mean on the composite score or have one point five (1.5) standard deviations below the mean on the composite score and two standard deviations below the mean in the communication or social domain sub score of the most current version of the Vineland Adaptive Behavior
http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=Vineland-II, or the Adaptive Behavioral Assessment Scales
http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8004-507&Mode=summary, or Battelle Developmental Inventory
http://www.riverpub.com/products/bdi2/index.html, or Bayley Scales of Infant and Toddler Development http://www.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8027-264 or other functionally equivalent tools approved by DHHS28 and other clinical assessment information obtained from the child and family; OR for a child age birth through 5 years, have a diagnosis from a physician (including psychiatrist) of a specific congenital or acquired condition, and a written assessment by a physician (including psychiatrist) that there is a high probability that because of that condition, the child will meet the functional impairment criteria of above later in life if medically necessary services and supports are not provided to the child29; AND

• Family Participation is required in treatment services to the greatest degree possible given the individual needs as well as family circumstances30 “Family Participation” may include being a member of the treatment team, participation in the assessment process, and helping to develop the Individual Treatment Plan (ITP). Family participation may also mean participating in treatment, modeling, and reinforcing skills learned in the course of treatment.31 “Families are expected to participate according to the language in the rule, and providers should facilitate such participation. Providers simply must document their efforts to engage families, but lack of family participation in that circumstance would not exclude a child from services.”32

Q: Do all Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations need to be “prior authorized” by DHHS?

A: Yes.33

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28 The ABAS is also considered an equivalent tool approved by DHHS- Enrollment Form for School Provided Section 28 Checklist
29 §28.02.C.2
30 §28.02.C.3.
31 §28.01-8
33 §28.01-12, §28.06-3, §28.08-1.B.
Q: Are all Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations subject to “Central Enrollment” requirements?

A: Yes.  

Q: What is “Central Enrollment?”

A: The process of determining eligibility for treatment services. The goals of central enrollment are to determine a child’s eligibility for treatment; facilitate referrals to appropriate service providers; expedite delivery of service to children in need of treatment; reliably track the service status of children enrolled in the system; and gather data that will inform DHHS of resource development needs. DHHS administers the central enrollment process. “Central enrollment in terms of wait list management and assignment of clients to providers is not required for schools.”

Q: Who is qualified to deliver Treatment Services for Children with Cognitive Impairments & Functional Limitations?

A: Properly supervised Direct Care Staff:

- At least 18 years of age
- Possess a high school diploma or equivalent
- Obtains a Behavioral Health Professional certification (BHP) within one year of date of hire

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34 §28.06-1
35 §28.01-2
38 §28.08-2.A.1.
Q: **What are the requirements for supervision of Direct Care Staff?**

A: Provider agencies must identify qualified professional supervisors for each direct care position. Direct care staff employed full time must be supervised a minimum of four hours per month. Direct care staff employed part time must receive a prorated amount of supervision, with a minimum requirement of one hour per month.\(^{39}\)

Q: **What are the qualification requirements for supervisors of Direct Care Staff?**

A:

- Bachelor’s degree in a human services or related field and at least (two) 2 years related experience; or
- Master’s degree in a human services or related field and at least (one) 1 year of related experience; or
- Licensed social worker (LSW) with at least (one) 1 year of related experience; or
- Licensed social worker (LSW) who has attained a related Master’s degree; or
- Licensed professional counselor (LPC), licensed clinical professional counselor (LCPC), licensed clinical professional counselor conditional clinical (LCPC-CC), licensed clinical social worker (LCSW), Licensed Masters Social Worker conditional (LMSW-C), a Board Certified Behavior Analyst (BCBA), psychologist, physician, or advanced practice registered nurse; or
- Registered professional nurse with 3 years related experience.\(^{40}\)

Q: **Who is qualified to deliver Specialized Services for Children with Cognitive Impairments & Functional Limitations?**

A: A Behavioral Health Professional providing Specialized Services who meets all of the certification requirements as stated for the Certification as Behavioral Health Professional or equivalent as determined by the Department and is:

- Under the Supervision of a Licensed Psychologist, Board Certified Behavior Analyst or equivalent as determined by the Department, and
- Is able to demonstrate specific competencies required to provide Specialized Services including but not limited to the basic principles of behavior\(^{41}\); and
- Is able to apply, under the direction of the supervisor, an array of procedures specific to Specialized Services.\(^{42}\)

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\(^{39}\) §28.08-2.A.A.

\(^{40}\) §28.08-2.B.

\(^{41}\) The "basic principles of behavior" include that scientifically validated behavioral analytic procedures are used to analyze challenging behavior and that resulting interventions are developed, employed and repeatedly reviewed using the scientific method. Scientifically validated analytic procedures may include, but are not limited to, task analysis, modeling, discrete trial instruction and activity-embedded instruction. Providers are expected to present documentation to the Department as to the training requirements for staff to provide Specialized Services for the Department’s approval. The provider must then document the training that staff have been trained and have met the required competencies. DHHS response to comments during section 28 rulemaking, comment 97, p. 24. [http://www.maine.gov/dhhs/oms/rules/adopted.shtml#id92879](http://www.maine.gov/dhhs/oms/rules/adopted.shtml#id92879) as of 6/9/10.

\(^{42}\) §28.08-2.C.
Q: **What are the supervision requirements for Behavioral Health Professionals with a Specialized Services Endorsement** for the delivery of Specialized Services for Children with Cognitive Impairments & Functional Limitations?

A: Behavioral Health Professionals with Specialized Services Endorsement employed full time must be supervised a minimum of four hours per month. Behavioral Health Professionals with Specialized Services employed part time must receive a prorated amount of supervision, with a minimum requirement of one hour per month. Supervisors must be able to minimally:

- Plan, direct and monitor the interventions;
- Develop, approve and/or review behavior plans;
- Collect and analyze data;
- Analyze individual and aggregate outcome measurement(s);
- Supervise/directly observe on site for at least one hour monthly as determined by the needs of the child, family, and/or direct treatment staff; and
- Attend and participate in monthly team meetings.

Q: **What are the qualification requirements for supervisors of Behavioral Health Professionals with a Specialized Services Endorsement for the delivery of Specialized Services for Children with Cognitive Impairments & Functional Limitations?**

A: Licensed as a Psychologist or Board Certified Behavior Analyst or equivalent as determined by the Department with at least one full calendar year in providing Specialized Services directly to children.

Q: **Is supervision time reimbursable?**

A: No.

Q: **Does supervision have to be “face to face”?**

A: Observation of staff providing service is one component of supervision. Face-to-face supervision is preferred. Telephone supervision is allowable in exceptional circumstances such as scheduling conflicts during a particular week.

Q: **What records need to be retained to support MaineCare reimbursement for Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations?**

A: Child’s name, address, birth date, and MaineCare ID number;

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43 “The provider will submit documentation of the education and training of the staff to the Department and assurance that supervision requirements under Section 28.08(C) (2), (4) and (5) [sic] are met.” DHHS response to comments during section 28 rulemaking, comment 99, p. 24. [http://www.maine.gov/dhhs/oms/rules/adopted.shtml#id92879](http://www.maine.gov/dhhs/oms/rules/adopted.shtml#id92879) as of 6/9/10.

44 §28.08-2.C.3.a

45 §28.08-2.C.4.b.

46 §28.08-2.C.4.a.


48 Id., comment 112, p. 27
• A written copy of the child’s comprehensive assessment;
• ITP, including the strengths and needs identified in the planning process;
• Written, signed, credentialed with licensure or certification, if applicable, and dated progress notes, kept in the child’s records;
• DHHS, or its authorized agent, must approve changes regarding intensity and duration of treatment services provided. The Provider must document the approval of the changes in the ITP and in the child’s record.

Q: What information must be documented in progress notes?

A:

• Providers must maintain written progress notes for all treatment services, in chronological order.
• All entries must include a description of the treatment service provided, the provider’s signature, the date on which the service was provided, the duration of the service, and the progress the child is making toward attaining the goals or outcomes identified in the ITP.
• For in-home services, the provider must ask the child, or an adult responsible for the child, to sign off on the progress note documenting the date, time of arrival, and time of departure of the provider.

49 §28.05-1
50 §28.05-4. In addition, the FAQs for the Sections 65 and 28 Audit Checklist published by DHHS in October of 2013, indicates the service provider must address every requirement in the record even if these items are not applicable.