

Early Intensive Developmental and Behavioral Intervention (EIDBI) Clinical Supervision Training Q&A, Sept 17th, 2025

Training questions

Q: Will the presentation and recording be recorded?

A: Yes, they will be posted on the DSD Training Handouts Archive under Miscellaneous.

Policy and procedure

Q: Does the compliance officer need any specific credentialing?

A: Please ask [licensing](#).

Q: Can a center owner provide services directly to clients at their own facility?

A: Yes, if it is not a conflict of interest, they avoid dual roles and meet the provider qualifications.

Q: What is the provider shortage law that was referred to earlier?

A: Read about [building EIDBI provider capacity](#).

Q: Can a center owner who is in the process of beginning supervised fieldwork for BCBA certification allowed to complete these hours at his/her therapy center?

A: Yes, if the supervisor is qualified and there is not a conflict of interest or dual role occurring. Follow the BACB supervision requirements.

Q: When we are reviewing BT notes, is that billable?

A: No, that is nonbillable time.

Q: Will there be a compliance or self-audit list like there is for 245D programs?

A: Please ask [licensing](#).

Q: Does the QSP have to be certified in ABA if that is the treatment modality of the center?

A: Not if you have another advanced certification provider on staff.

Q: Does the QSP have to sign off on each session note?

A: No

Q: Would reviewing session notes as a part of file review and ensuring quality services for the child count toward supervision of the case? Does this not count as H0032?

A: No, it not included in treatment plan review. Reviewing session notes is not a billable service.

Q: Starting January 1, 2026, will providers be required to have a center to apply for a provisional license?

A: No.

Q: Do home-based providers qualify for a provisional license?

A: Yes, all EIDBI agencies must apply for the provisional license.

Q: When will the licensing start so we can be ready for Jan 1st, 2026?

A: Licensing applications will be posted by January 1, 2026, and current providers have until the end of May 2026 to apply. Follow MHCP provider news updates for more information.

Q: If I've just earned my BCBA, do I immediately qualify to be a QSP, or is one year of BCBA experience required first?

A: There isn't a specific time frame of how long you must be a licensed behavior analyst before you apply to be a QSP. You must review the QSP roles and responsibilities and ensure that your education, experience and training has prepared you to work within your scope of practice as a QSP. It is your clinical responsibility to ensure you have and continue to receive the proper training, supervision and experience to fill the role you are attesting to in law.

Q: Can a QABA credential be used in place of a BCBA in Minnesota under the statute added in 2024?

A: QABA credentialed individuals may enroll as level 1 EIDBI providers.

Q: What is the process for a QABA professional to become affiliated, and if not, what changed in the 2024 statute that affects approval?

A: Nothing changed in the 2025 legislation related to QABA professionals. They do not qualify to be licensed behavior analysts in the state of MN. They can still enroll and affiliate as a level 1 provider. The Board of Psychology makes these decisions.

Q: Is writing a case note billable time?

A: No.

Treatment plan

Q: With the recent changes to QSP requirements, could you please clarify the appropriate process for updating a QSP for a client in the middle of a 3- or 6-month treatment plan?

A: The QSP would add their info to the ITP and review with the family and add an addendum signature page for the dates they are taking over.

Q: Is a new signature page required reflecting the updated QSP and effective date?

A: Yes.

Q: Should Section B of the treatment plan, where the QSP is listed, also be updated?

A: Yes.

Q: Do any of these updated documents need to be submitted to the medical review agent for authorization or documentation purposes?

A: Not unless it is impacting the approved service authorization/ agreement.

Q: I assumed BCBA responsibilities for a BCBA that left. I have been following her treatment plan as the ITP as not due for updating. Can I change the way the treatment is implemented?

A: Yes, you need to update the ITP and review again with the family for their agreement.

Q: Can you define what "progress monitoring" means as a billable service under H0032 ITP treatment review.

A: Covered services for progress monitoring are outlined in policy: [EIDBI - ITP development and progress monitoring](#)

Q: How does a QSP ensure progress in treatment without review session notes and data collected?

A: Session notes is not a billable service or clinical supervision. Data review and collection typically occurs outside of the session notes and is an expectation of clinical supervision regardless.

Q: On one of your slides, it said Treatment Planning was under 97151 - can you please provide examples for this.

A: Treatment planning is only provided under H0032. 97151 is the CMDE.

Qualified supervising professional

Q: Can a BCBA fall into the role of the QSP as well?

A: Reference the QSP [EIDBI - QSP qualifications, roles and responsibilities](#) Licensed behavior analysts may meet the criteria to enroll as a QSP.

Q: Is a BCBA considered a QSP? or agency needs to hire them both?

A: A licensed Behavior Analyst may enroll as a QSP but if they are not the QSP, then the agency must have a licensed mental health professional in the QSP role and someone who has advanced certification in the modality the agency provides.

Q: If a client has 24 units of O&D, that's 6 hours a day. Does that mean 6 hours can be completed, or does that vary, and does that it has to be completed every day?

A: Just because the 6 hours is allowed per day, does not mean that you must provide that many units. All services must be based on medical necessity and based on the clinical needs of the child.

Clinical supervision:

Q: Does high intensity behavior support count towards the 1:16 supervision requirements?

A: No, that is part of their direct supervision time.

Q: How do you document in case notes for staff supervision if that is not billable service?

A: Reference the policy manual documents: [EIDBI - Observation and direction requirements](#), [EIDBI - Clinical supervision requirements](#) and the [EIDBI - Health service records](#).

Q: If 2 QSPs sign the treatment plan, do they both need to meet 1:16 or do they need to work together to make sure the 1:16 is met?

A: The requirement is per 16 hours of treatment for the participant. Two could meet the requirement collectively and are both responsible for the treatment of the participant.

Q: For a 40-hour client, would it be acceptable for the QSP to complete 1 hour of observation and direction (O&D) per week, along with 2 hours of treatment review (reviewing session notes, analyzing data, and providing treatment updates under the H-code)?

A: Session notes review is not a billable service. Observation and direction and client specific treatment review billed under H0032 may meet the criteria for clinical supervision, yes. Covered and non-covered services for H0032 are listed here: [EIDBI - ITP development and progress monitoring](#)

Q: If H0032 ITP session is scheduled for 1 hour but only 30 minutes are completed, should it still be billed as 1 hour, or should it only count as 30 minutes toward the required 2–3 hours per week?

A: Services need to be recorded as actual clock time. Case notes require actual start and stop time. Including for encounter codes. 30 minutes equal 30 minutes of supervision time.

Q: What are the requirements for the passive observation? would that still fall under the 1-16 requirement or are providers able to provide more of those observation hours under the 97155 code?

A: Passive observation is not billable, and it most likely does not meet clinical supervision requirements. If needed, reach out to our team directly to discuss what specific activities do and do not fall under observation and direction.

Q: How long will it take to get the approval (or not) for the supervision exception requests?

A: Approval follows the current medical review agent timelines.

Q: If an ITP was sent in with "The supervision schedule meets the 1:16 ratio" but as the treatment period progresses and the QSP is not able to meet that requirement can an addendum be sent in to add the alternative supervision plan?

A: Agencies are required to plan for the 1:16 ratio to be in place by January 1, 2026. Exceptions to the ratio must be based on client necessity, not scheduling. If clinically appropriate, a treatment plan may request an alternative ratio.

Q: Can it only be 1 additional QSP or could there be more?

A: There can be up to 2 QSPs monitoring a person's treatment plan.

Q: Is it okay if the QSP is over the 1:16 ratio if it is not identified in the ITP?

A: Yes.

Q: What if a BCBA is taking the lead on goal modifications and progress monitoring but they are not a QSP would they count towards the supervision? What role does the BCBA have in supervision and client care?

A: No, the 1:16 ratio is required by the QSP. Others could add additional supervision, but the QSP must meet that minimum.

Q: For clarity, do all these requirements apply to clients that are on PMAP plans?

A: Yes, all EIDBI recipients regardless of health plan.

Q: If we fall short on meeting the supervision due to oversight on scheduling or by QSP, what should we do?

A: If this is occurring regularly, we would recommend scheduling a meeting with us to help support the agency in complying.

Q: Recommended Guidelines and for clinical supervision has a focus on the supervisee. Will the policy guidance be updated to reflect supervision standards or are we still supposed to have supervision plans based on the staff need as well?

A: The clinical supervision requirements are based on the clients. Refer to the policy manual page [EIDBI - Clinical supervision](#) for additional guidance. New licensing requirements with additional criteria for the supervision plans is coming soon. Watch the [Early Intensive Developmental and Behavioral Intervention \(EIDBI\) Licensing / Minnesota Department of Human Services](#) page for updates.

Q: The updated policy states that Observation & Direction (O&D) must occur at least once per month per client, with no more than two consecutive months conducted via telehealth. Could you please confirm whether this requirement applies universally across all provider levels (QSP, Level I, and Level II), or if there are distinctions in responsibility by provider type?

A: The observation and direction requirements are tied to the client, not the staff.

Q: How does this requirement apply to out-of-state QSPs who are supervising Minnesota clients? For example, are there specific restrictions?

A: They must fulfill the requirements like any other QSP.

Q: Can you provide example of how to keep track of 1:16hr supervision hours per staff that is acceptable per DHS rules?

A: We don't recommend specific software or ways to track the hours. Consult with other agencies for ideas. You can schedule a meeting with us to see if your current tracking method meets the needs.

Q: In an instance of a QSP being out for a week on vacation would it be appropriate to make up that weekly time the next week or would it be better to have a secondary QSP for when this occurs?

A: Either way may be appropriate. Base your decision on clinical needs of the client.

Q: A Level I or Level II staff can provide up to 3 hours per day of O&D and once the total reaches 16 hours, the QSP must provide 1 hour of supervision — is that correct?

A: No, overall, the QSP must provide 1:16 ratio of clinical supervision. They are solely responsible for the 1:16 ratio of supervision hours per client. That is a minimum standard that must be completed by the QSP that signed off on the child's treatment plan. Beyond that 1:16 minimum, other providers may supplement additional supervision time as clinically necessary.

Q: If two QSPs attend a client-specific meeting that lasts one hour, the supervision time is not doubled just because two QSPs are present. In that case, does only one QSP bill for the hour?

A: Both QSPs may bill for their time. It doesn't count as double the amount of supervision for the client.

Q: If a client has 35 hours of direct treatment, the QSP would need to do at least 2.25 hours of supervision each week? Indirect time or parent training isn't considered with the 1:16 ratio?

A: Parent training is not included in the definition of clinical supervision. Some indirect activities may be covered if they are client specific and fall under the definition of clinical supervision that included treatment planning, progress monitoring, review and staff supervision.

Q: Regarding H0032 what aspects of it can be counted towards Clinical supervision under the 1:16 ratio.

A: Any activity that falls under a covered treatment plan service could be counted towards the clinical supervision requirements.

Q: To confirm, the 1:16 in person ratio is for QSPs, not BCBAs?

A: It is for the QSP to complete per client. Licensed behavior analysts can enroll as QSPs if they meet the qualifications.

Observation and direction

Q: For staff who are on variances and require to one-time weekly supervision would O/D cover that supervision?

A: It is required that they receive observation and direction if they have not met the required amount of supervision hours. There are no longer variances.

Q: We talk about the QSP not doing three consecutive months of observation and direction sessions via telehealth. Can the 3rd supervision be done by a level 1 or does the QSP need to do it?

A: The QSP is always encouraged to conduct services in person with the client. The minimum requirement is at least every 3 months, and it may be done by the QSP, level 1 or 2 staff as clinically appropriate.

Q: Observation and direction cannot be provided via telehealth for more than two consecutive months per person. If two QSPs are assigned, does each QSP need to provide in-person visits, or can one QSP handle the in-person requirement while the other remains remote?

A: The requirement is per child, not provider. As long as the child has an in-person observation and direction session at least once every 3 months conducted by the QSP, level 1 or 2 provider, the requirement will be met.

Q: I conduct O&D weekly per child, is that too much?

A: It depends on the client. All EIDBI services must be based on clinical necessity and the justified rationale for each service must be documented in the case note.

Telehealth

Q: The DHS website lists Store-and-Forward technology as part of telehealth services. Can you provide guidance on how EIDBI providers could use Store-and-Forward?

A: Store-and-forward telehealth means health information is collected at one point in time (video recordings, photos, data, or documentation) and then sent to a provider later for review. It does not happen in real-time like video or phone sessions.

For EIDBI services, store-and-forward generally does not apply because:

1. EIDBI treatment services (like intervention, O&D, treatment plan updates) require direct, interactive engagement with the client and/or caregiver.
2. Billing codes used for EIDBI are designed for real-time services, not asynchronous review.
3. Documentation review, data analysis, and treatment planning are included in existing EIDBI covered services (like O&D or treatment plan development), but they are not separately billed as store-and-forward telehealth.

EIDBI providers wouldn't use store-and-forward as a telehealth modality.

Q: Are there specific services or CPT codes where this is or isn't allowed?

A: Not currently.

Q: Would Store-and-Forward apply to Observation and Direction?

A: No.

Advisory group

Q: Is there a way to learn names of those on advisory committees and other study groups that you have.

A: Yes, contact us at ASD.DHS@state.mn.us