Q&A: Early Intensive Developmental and Behavioral Intervention (EIDBI) Clinical Supervision Training, Aug. 20, 2025

Training questions

Q: Will this presentation be sent out after the training?

A: The slides will be posted to the Training page, and we will let participants know once they are posted.

Q: Will there be a certificate provided after completion?

A: Certificates of completion can be requested by emailing ASD.DHS@state.mn.us Keep in mind the training was not approved for CEUs by any licensure boards and may not be approved for licensure renewal.

Q: Will the training recording be available?

A: Yes, it will be shared on the Training page after the session.

Q: How do we enroll in the September 17th training?

A: Registration link is here: DSD eList: New EIDBI clinical supervision requirements

Policy and procedure

Q: Can you share the link for the EIDBI Policy and Procedure FAQ?

A: EIDBI Policy and Procedures FAQ

Q: Can a sibling to the client provide services for the client?

A: No, family members cannot be paid to provide services to their family member. This poses a conflict of interest. This is outlined under EIDBI - Services in the Non-covered services section.

Q: Where can we find the duties listed for the compliance officer?

A: Beginning January 1, 2026, all EIDBI agencies must choose someone to be their compliance officer. This person is responsible for making sure the agency follows Medical Assistance (MA) laws and rules. Main duties include:

- Creating clear policies and procedures
- Training all staff, billers, and subcontractors
- Looking into any concerns
- Following Laws and checking regularly
- Reporting any known violations
- Proper Billing and Overpayment.

Q: For the compliance officer role, can a Level 1 or Level 2 staff who are providing services to clients also serve as the compliance officer? Or does the compliance officer need to only provide compliance services? Or must it be an external person to the agency?

A: Contact the licensing division at Licensing.EIDBI.DHS@state.mn.us for these requirements.

Q: Is an independent contractor considered an employee?

A: No, they are not considered employees.

Advisory group and other EIDBI meetings

Q: Are you still accepting new members to the advisory group?

A: Applications open in October on the Secretary of State website. Other groups will also be formed to give input on the development of the comprehensive licensure standards.

Q: How does an agency or provider make an in-person appointment with DHS, as suggested during the training?

A: Agencies or providers interested in scheduling an in-person appointment should contact DHS directly via email at ASD.DHS@state.mn.us. The team will provide guidance on available times and the process for arranging a meeting.

Q: I'm considering starting a monthly, agency-led discussion group to review DHS EIDBI updates and share implementation strategies. Would something like this fall under the groups that DHS will be forming, or would it be separate from those efforts?

A: This would be separate from the formal stakeholder groups that DHS will be forming. DHS-led groups are structured to gather broad stakeholder input, guide policy development, and provide official updates. An agency-led discussion group, on the other hand, can be a great complementary effort — giving your staff a space to digest updates, problem-solve implementation challenges, and share strategies with one another. While not part of DHS's formal engagement structure, these internal or agency-led groups can strengthen fidelity and consistency in practice across your team.

Clinical supervision and observation and direction

Q: Is there a definition of "supervision"?

A: Yes, definitions are on slide 25 and in the EIDBI Glossary.

Q: Can you explain the difference between clinical supervision and O&D?

A: Observation and direction (97155) is a billable service involving real-time clinical supervision and protocol modification by a QSP or another qualified provider (i.e., level I or II provider). It includes modeling, data collection, and protocol modification.

While staff supervision is one component of clinical supervision, clinical supervision also includes broader responsibilities like treatment planning and progress monitoring, which may or may not involve direct observation or be billable.

Q: We do case consultation in our group supervision, and it is focused on clients. Can we count that?

A: We would need more specifics about what activities are included in case consultation to answer this question. We recommend you reference back to the definition of clinical supervision in the EIDBI Glossary and reference the billable activities that coincide with those services. If you have other questions, reach out to ASD.DHS@state.mn.us

Q: Should QSP keep separate documentation to show that the ratios are being met, with billable and non-billable services?

A: Yes

Q: Can a center have more than one QSP with separate caseloads, or is only a single QSP's license used for billing purposes?

A: EIDBI agencies can have multiple QSPs that are responsible for clinical oversight, billing for services and carry separate caseloads.

Q: Can you clarify what it means when the policy says other providers may deliver clinical supervision under the direction of the QSP? Specifically, does this mean the QSP can delegate supervision tasks to certain providers, or that other providers can take on parts of clinical supervision as long as the QSP is ultimately responsible?

A: The policy means that while certain tasks of clinical supervision can be carried out by other qualified providers, the QSP remains ultimately responsible for all clinical oversight. Other providers may assist or perform delegated supervision activities under the direction and guidance of the QSP, but the QSP retains accountability for ensuring supervision is consistent, compliant, and meets the standards required by EIDBI. Specially the QSP is required to implement a minimum of 1:16 hours of clinical supervision per client. Other providers may supplement beyond that minimum requirement.

Q: If we need to change the supervising QSP and they sign the ITP, does the ITP need to be resubmitted to the medical review agent (Acentra Health/Atrezzo) for review and approval if that is the only change? And if so, are we only making changes to the signature page and Section B of the ITP in the QSP section?

A: Not necessarily. The only time it's required to resubmit an ITP before the next progress monitoring update is if you are requesting a change to the approved service agreement. In this case, you would update the QSP information in Section B of the ITP and the signature page to reflect the new supervising QSP, review with the family and document it in the child's file.

Q: Will DHS be providing examples of covered O&D services that are less specific to ABA and can be generalized to the other modalities?

A: The same principles apply across modalities. The case note must contain observable and measurable data.

Progress notes should:

- Describe specific observations (skills, behaviors, responses)
- Identify adjustments made and why
- Link decisions to treatment goals
- Reflect individualized intervention, not a generic template

- Show how the session benefited the child's progress.

If you would like additional examples or would like the EIDBI team to review your current documentation for observation and direction, reach out to the EIDBI team at ASD.DHS@state.mn.us

Q: Where do modality specialists fit into this supervision guidance when the QSP does not have certification and/or experience in the Agencies registered modality? While modality specialists are Level 1 providers, they hold a higher authority than a standard Level 1 provider who does not have required certification in the modality and is not enrolled as the agencies required modality specialist.

A: The role of advanced certification provider or "modality specialists" is not fundamentally changing under the new EIDBI supervision guidelines. The function of the clinical supervision and observation and direction requirements is to establish a minimum standard of care across EIDBI agencies. The primary update affects the supervision structure of Qualified Supervising Professionals (QSPs), rather than modality-specific roles.

The supervision requirements are based on the EIDBI provider type that staff are enrolled in within the program; this is how it is defined in law, and our policy and guidance reflect that to help ensure providers meet the statutory requirements. Modality specialists were not explicitly referenced because their roles are already recognized within the broader team structure.

Q: Will the Department issue clearer guidance on what time period will be used for calculating compliance with the 1-to-16 requirement? The example on slide 45 (child who receives 20 hours/week) could be confusing if the provider argues they calculate based on weekly hours (1 hour/week or 4 hours/month) but the Department calculates based on monthly hours (5 hours/month). How can we ensure all stakeholders are using the same period?

A: The providers plan should be clearly documented in the treatment plan for auditing and documentation purposes. Aligning on a consistent weekly and monthly-based approach is generally recommended, as this ensures the total supervision requirement matches the child's billed hours over time rather than fluctuating daily. Any fluctuations should also be clearly documented to account for variability in the event of a state or federal audit.

Q: Other qualified EIDBI providers may supplement clinical supervision services as clinically appropriate." Who are considered other qualified EIDBI providers?

A: Those providers that are outlined on the EIDBI billing as being allowed to bill for those specific EIDBI services and meet the requirements outlined in the policy manual to fulfill the roles and responsibilities for the delivery of that covered service.

Q: If providing FCTC-only services, what rationale would we give on the ITP since I'm assuming we wouldn't select the 1:16 ratio?

A: Correct—the 1:16 clinical supervision ratio does not apply when only Family/Caregiver Training and Counseling (FCTC) services are being provided, since no direct intervention hours are delivered. On the ITP, the rationale should clarify that:

- The service plan is limited to FCTC-only.
- No direct intervention services are being delivered; therefore, the 1:16 supervision ratio is not applicable.
- Clinical oversight will still occur as appropriate to support the family/caregiver in implementing strategies.

This ensures the ITP reflects compliance while explaining why the supervision ratio is not applied.

Q: If A BCBA is licensed (i.e., Licensed Behavior Analyst) and they are enrolled as a QSP, can their clinical supervision time count towards the 1:16 requirement?

A: Yes

Q: Can two QSPs bill for their time to go over the client's progress?

A: Yes, two QSPs can meet to coordinate a client's plan or hold a coordinated care conference and each bill separately for their time. The training example clarifies that when calculating the client's required clinical supervision hours, overlapping time is counted only once. For example, if both providers work from 10:00–11:00, they can each be reimbursed for that hour, but for supervision tracking, the overlapping time counts as one hour total toward the client's clinical supervision requirement.

Q: Can one QSP provide supervision, and another provide the in-person portion?
A: Starting Jan. 1, 2026:

- O&D must occur at least monthly by the QSP, level 1 or 2 provider.
- No more than two consecutive months of O&D can be done via telehealth by the QSP, level 1 or 2 provider.

- The QSP(s) must complete at least 1:16 ratio of clinical supervision.

Q: Does the 1:16 ratio apply to staff hours or client hours?

A: It applies to client supervision, not staff hours.

Q: If multiple QSPs are assigned, who is responsible?

A: Any QSP who signs the treatment plan is responsible for the client's clinical supervision hours.

Q: Does group supervision count toward the 1:16 ratio?

A: No, it must be individualized to the client.

Q: What activities count as clinical supervision?

A: Treatment planning, staff supervision, ITP progress monitoring, and treatment review.

Q: Where can I find requirements for staff supervision? Does the variance process stay the same or is staff supervision now counted within what is required for the client unless they are a TRBT and require BCBA supervision?

A: Staff supervision requirements remain outlined in the EIDBI policy manual and provider qualifications. Staff supervision requirements remain as they did before. Clinical supervision tied to the client's treatment (the 1:16 requirement).

Q: Who can complete in-person supervision every 3 months?

A: A QSP, Level 1, or Level 2 provider may complete this.

Q: If two QSPs are present, does supervision time double?

A: No. Supervision is measured by clock time, not multiplied by providers.

Q: Can QSPs work at multiple agencies?

A: Yes, but by Jan. 1, 2026, they must be employees to all agencies they are affiliated/ enrolled with. They remain responsible for all clients whose ITPs they sign.

Q: Does creating client-specific materials count toward clinical supervision?

A: No, that is considered administrative time and is not a billable activity.

Q: If the total minutes of clinical supervision provided by the QSP for a week happened to be 51 minutes, can that be rounded up to count for an hour for the week?

A: No, supervision must be documented in actual clock time. It cannot be rounded up.

Q: If there are two QSPs working with the same client, can only one of them complete the in-person supervision requirement within the 1:16 ratio after January 2026?

A: The in-person Observation and Direction requirement (at least once every 3 months) may be completed by a QSP, Level 1 provider, or Level 2 provider.

Q: Is there a comprehensive list of what all counts towards the 1:16 clinical supervision?

A: See EIDBI - Clinical supervision for a comprehensive explanation of the new requirements.

Q: Can the clinical supervision that is part of the 1:16 requirement for a client also count as the employee supervision required by their variance?

A: Yes, the same supervision activity may meet both requirements, if it is clearly documented that the supervision addressed both the client's clinical needs and the staff's variance requirements.

Q: If a QSP is on maternity leave for three months, does another QSP need to be hired, or is that an acceptable gap?

A: No, a gap of three months is not acceptable.

- Any gap in QSP coverage longer than 31 days is not allowed, even for planned maternity leave.
- Therefore, if the QSP is out for three months (≈90 days), the agency must assign another QSP to cover their caseload during that time.
- You could either temporarily hire a QSP or reassign clients to an existing QSP to ensure no gap exceeds the 31-day limit.

Q: Can the hours taken to write a CMDE be counted for the client's 1:16?

A: No.

Q: Can QSPs work for multiple agencies (i.e. five agencies)?

A: While QSPs may work for multiple agencies, as of January 1, 2026, they must be employees of all agencies they are enrolled/ affiliated with and must be able to manage appropriate caseloads to fulfill the 1:16 ratio of supervision requirements for all clients on their caseload.

Q: CASP guidelines support a tiered service delivery model as the gold standard. Why is DHS requiring a primary clinical supervisor? Isn't that going against the tiered model? Do you have research backing the benefits of a primary clinical supervisor versus a tiered approach?

A: DHS is not going against a tiered model approach. We recognize, and support, that a tiered model — where multiple trained professionals provide intervention under the direction of a supervising clinician — is an evidence-based and nationally accepted practice.

What DHS does require, however, is that there be a designated primary supervising professional who assumes overall responsibility for the client's treatment plan, and they are responsible for the 1:16 minimum supervision requirements. This is consistent with both federal and state requirements for minimum standards of care. The licensed professional who signs the plan is ultimately accountable for ensuring that:

- The treatment plan is clinically appropriate and individualized.
- Other staff delivering services are trained, supported, and implementing programs with fidelity.
- The client's health, safety, and progress are monitored at the minimum standard of care.

This does not exclude a tiered model. Rather, it ensures there is clear accountability while still allowing a team of trained professionals to deliver services consistent with CASP and other best-practice guidelines.

In short:

- DHS supports a tiered approach.
- The requirement of a primary supervisor is about accountability and compliance, not about limiting team-based care.
- Both can coexist: the primary supervising professional holds responsibility for the plan, and trained team members carry out intervention and other tasks as part of the tiered model.

Q: Does the 1:16 provider-to-client ratio begin for each client starting January 1, 2026, or at their next ITP authorization/report in 2026?

A: The 1:16 ratio requirement applies starting January 1, 2026, regardless of the client's individual ITP authorization or reporting schedule. Agencies should plan to meet this standard across all clients as of that date.

Q: Slide 32 lists three categories of activities that count toward the clinical supervision requirement. The statute definition of clinical supervision includes four activities: (1) individual treatment planning, (2) staff supervision, (3) individual treatment plan progress

monitoring, and (4) treatment review for each person. Can you confirm that all four of these activities are reflected on your list on Slide 32?

A: Yes. All four of the statutory activities are represented within the three categories shown on Slide 32. The slide groups related and billable services together for clarity, but each statutory requirement — individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review — is fully captured within those categories.

Q: With the implementation of these requirements, is DHS doing anything to address the QSP and BCBA shortage?

A: For clarification, the legislature established the EIDBI clinical supervision requirements, with input from various stakeholders, including DHS. These requirements were not specifically a DHS proposal; our role was to provide technical assistance and guidance during the process. If stakeholders have input or recommendations for future changes, they should reach out to their local representative. Going forward, DHS can continue to provide EIDBI agencies with technical assistance to help meet the requirements and achieve compliance.

While some may perceive these standards as increasing staffing demands, EIDBI agencies were always expected to operate within professional and ethical guidelines, managing appropriate caseloads to ensure quality care. These updated clinical supervision and observation and direction standards primarily establish a minimum standard of care, ensuring consistency across agencies and supporting program integrity for children and families.

DHS has also taken steps to support agencies in meeting these standards:

- Expanding QSP Roles for LBAs: Licensed Behavior Analysts (LBAs) can now enroll as QSPs, increasing the pool of qualified supervisors available to agencies.
- Provider Shortage Variances Made Official Law: Previous provider shortage variance standards have now been incorporated into official law, reinforcing flexible options for providers to enroll and receive supervision while maintaining program quality.
- DHS has organized and hosted multiple career fairs, workforce shortage work groups, think tanks and recruiting events over the years, specifically for EIDBI agencies
- Training and Workforce Development: DHS offers trainings to enhance staff skills, support professional development, and improve retention. The EIDBI team provides 1:1 technical assistance and consolation to provider agencies related to recruitment and retention efforts.
- The EIDBI is currently managing grants for rural EIDBI providers to expand and retain services in greater MN.
- EIDBI policy has retained COVID-19 exceptions that allow for increased telehealth use and family-caregiver training services only. These policies allow for increase health equity for

families and providers from culturally and linguistically diverse populations, rural areas, and lower socioeconomic backgrounds. As well as increased care coordination and decreased cancellation of sessions.

- Individual EIDBI providers were also included in recent retention and recruitment bonus payments. The legislature appropriated money to allow EIDBI providers to give incentives to current and future employees including:
    - Tuition reimbursement
    - Childcare
    - Recruitment bonuses
    - Retention bonuses

These measures reinforce high-quality, ethically delivered EIDBI services while ensuring agencies can meet consistent standards of care for children and families.

Q: Since we can no longer provide observation and direction (OD) for groups, is it still necessary to provide OD when fading a client toward a less restrictive environment—to determine next steps, assess readiness, and guide staff on supporting independence? Will this topic be addressed in future guidance?

A: It would still be critical to provider support to the staff and clients when transitioning or fading services. OD for groups is no longer billable, but the same supervision and guidance can still occur during 1:1 direct O&D sessions where the provider observes the client, assesses readiness, and directs staff to support independence. Similar activities can also happen outside of O&D, such as informal coaching or team consultation, but those times are not billable under EIDBI.

Q: What hours are BCBAs responsible for per client per week outside of QSP hours?

A: The clinical supervision requirements pertain to the QSP. There are no additional specific requirements pertaining to BCBAs/ LBAs.

Q: Our agencies LBA is not affiliated as a QSP. Does that mean the supervision she provides is not considered part of the 1:16 ratio?

A: Yes, that is correct. Supervision provided by an LBA who is not affiliated as a QSP does not count toward the 1:16 supervision ratio requirement. Only supervision provided by a designated QSP is included in that ratio.

Q: Can a BCBA and QSP do observation and direction at the same time?

A: Multiple providers could potentially provide simultaneous observation and direction but they both need their own case note and clinical justification why two providers need to be observing at the same time. The service must not be duplicative. For more information, see EIDBI - Observation and direction

Q: For providers providing in home services, sometimes space within the home is limited. Will there any exceptions for providers doing in home services regarding in person supervision for QSP?

A: No, there will be no exceptions made to the in-person observation requirements.

Q: Can you talk about therapists who are getting clinical hours for their BCBA certification? Is it the BCBA or QSP that will provide the clinical supervision hours, or can both do it? Who can provide restricted and unrestricted hours?

A: Supervision for BCBA certification hours must follow the Behavior Analyst Certification Board (BACB) requirements. Only a qualified BCBA (or BCBA-D) who meets the BACB's supervisor requirements can provide supervision for fieldwork hours. A QSP who is not a BCBA cannot independently supervise hours toward BCBA certification, though they may play a role in modeling or training within their scope.

In short, only a BCBA can provide supervision that counts toward BACB certification hours. A QSP may support training and clinical supervision within an EIDBI agency, but unless they are also a BCBA and meet BACB supervisor requirements, they cannot sign off on those required supervision hours for certification and licensure.

Q: If one of our QSPs is out of state and one is in state, but both sign off on ITPs, does the out-of-state QSP need to conduct the in-person supervision at the 3rd month as well? Or can the in-state QSP take care of the in-person supervisions?

A: The observation and direction in person requirement can be fulfilled by the QSP, level 1 or 2 provider on the child's team.

Q: Does behavior support count as direct service hours in the 1:16 ratio?

A: Clinical supervision is defined as the overall responsibility for the control and direction of EIDBI service delivery, including:

- Individual treatment plan (ITP) development and progress monitoring.
- Staff supervision.

- Treatment review for each person who receives services.

It may be appropriate to write a behavior intervention plan as part of the treatment plan development and monitoring, but actual behavior support is more likely to be provided during 1:1 intervention services.

Q: If a Level 1 or Level 2 provider conducts an Observation and Direction (O&D), does that count as clinical supervision?

A: Observation and Direction (O&D) provided by a Level 1 or Level 2 does not count towards the 1:16 ratio of clinical supervision that is required by the Qualified Supervising Professional (QSP). They may supplement additional time beyond the minimum required by the QSP.

Q: If a client requests an early discharge (e.g., mid-month) and clinical supervision was planned for later that month, does this failure to provide the required clinical supervision for the final month need to be documented?

A: Yes. If a client discharges before the scheduled supervision occurs, the provider should document the reason supervision was not completed as planned. This ensures the record reflects that the missed supervision was due to the client's early discharge rather than provider non-adherence to the requirements. Clear documentation protects both the provider and the integrity of the client's record.

Q: If a client is receiving high intensity services with those hours count towards the direct service hour ration or 1:16?

A: No, those are direct intervention hours and do not count as clinical supervision hours.

Q: Is the 1:16 ratio per QSP or combined between the primary and secondary QSP?

A: The 1:16 ratio is per child, not per QSP or provider. Each child must receive at least one hour of clinical supervision for every 16 hours of direct EIDBI intervention services delivered. If multiple QSPs are assigned (e.g., a primary and secondary QSP), they may share responsibilities, but the required supervision ratio is still measured based on the child's total direct intervention hours.

Q: Can a BCBA complete the 1:16 hour clinical supervision requirement?

A: Yes—if the BCBA is enrolled with MHCP as a Qualified Supervising Professional (QSP). The 1:16 clinical supervision requirement must be completed by a QSP. A BCBA who is not enrolled as a QSP cannot independently meet this requirement.

Q: For QSP changes, do caregivers also have to re-sign any ITPs?

A: Yes. When a supervising QSP changes, the ITP must be updated with the family. The ITP is a plan of care that requires both provider and caregiver agreement, caregivers are also required to sign the updated ITP reflecting the new QSP. This ensures that the family is aware of and consents to the updated clinical supervision arrangement.

Treatment plan

Q: What if the QSP who signed the ITP leaves?

A: Another QSP must be reassigned immediately, with a new signature page completed to avoid any gaps in treatment coverage.

Q: Can more than one QSP sign off on a treatment plan?

A: Yes, up to two QSPs may sign and share responsibility. More than two is not recommended.

Q: What if a new QSP signs off on an ITP?

A: They must sign a new signature page, review with the family and document in the client's file.

Q: When conducting a client-focused meeting, will both QSPs and attendees be able to bill for their time?

A: It depends. Staff may not bill under ITP development and progress monitoring (i.e., billing code H0032) when they attend a meeting only to listen, learn or receive general information. This is staff training or administrative activity, which is not a billable EIDBI service.

To bill for ITP development and progress monitoring (i.e., billing code H0032), the provider must actively contribute to the person's treatment planning or progress monitoring. To actively contribute, the provider:

- Meaningfully discusses the person's progress.
- Provides input on goals.
- Reviews and analyzes data.
- Helps update the ITP based on the person's needs.

Q: Can you bill ITP development and progress monitoring (i.e., H0032) for writing goal procedures or programs?

A: For H0032, the key is that it covers developing, reviewing, and revising the individual treatment plan. Updating or writing the child's programs when they are part of the overall treatment plan goals, objectives, or strategies may be included as H0032. That means any new or updated programs should be reflected in the child's ITP document if billed as H0032. It would be best practice to document in the progress note that you revised the ITP and specify which goals/programs were added or changed.

- If you're modifying how staff run an existing program during a session, that would likely be more appropriate to be billed as 97155 observation and direction.
- Here is a decision tool to help determine which service to bill for or if the activity is non-billable.

Programming Decision Flow

Step 1: Am I creating or changing something that belongs in the ITP itself?

Yes → Bill H0032 (ITP Development/Revision):

- Writing/revising treatment goals or objectives
- Developing new skill acquisition programs aligned to goals
- Adding/changing mastery criteria or discharge criteria in the plan
- Documenting new behavior interventions tied to assessed needs.

Step 2: Am I making clinical decisions about how staff run existing programs?

Yes → Bill Observation and direction 97155

- Adjusting prompts, reinforcement, or teaching sequences
- Rotating mastered and novel targets
- Modeling correction procedures for staff
- Reviewing data and making mid-session adjustments.

Step 3: Am I just formatting, copying, or preparing materials?

Yes → Administrative (Not billable)

- Typing up or editing program instructions that were already developed
- Adding additional targets or exemplars that don't warrant an update to the child's treatment plan.
- Making or printing data sheets/visuals/ token boards, etc.
- Entering program content into the electronic health record

- Organizing binders or creating new program materials.

Enrollment

Q: Does the new moratorium mean enrollment is closed?

A: The pause for enrolling new EIDBI agencies will go into effect upon federal approval. If/ when this occurs, there will be additional communications sent out.

Q: Does a QSP have to be a BCBA?

A: No. QSP requirements are outlined in EIDBI - QSP qualifications, roles and responsibilities policy manual page.

Q: Can a center have more than one Qualified Supervising Professional (QSP)?

A: Yes. A center may employ more than one QSP, if each QSP meets the qualifications outlined in statute and rule.

Q: If there are multiple QSPs, do they all have to be listed as management through DHS provider assurance paperwork?

A: Yes. All QSPs must be listed as managing employees for enrollment purposes.

Background study requirements

Q: What about background studies for staff or billing companies?

A: Background studies are required for anyone that has direct contact with clients or their families. Additional requirements also pertain to owners and board members. For a complete list of background study requirements, see EIDBI / Minnesota Department of Human Services

Q: Does the current owner need to have a background check?

A: Yes. For a complete list of requirements, see EIDBI / Minnesota Department of Human Services

Q: NET Study indicated they cannot determine which individuals require background studies. Should we contact the DHS ASD team for guidance?

A: The law determines who is required to have a background study. For a complete list of requirements, see EIDBI / Minnesota Department of Human Services

Q: Regarding the MHCP email sent on 8/7/25 about EIDBI provider changes, it states that individual EIDBI providers affiliated with an agency require a new BGS and that the BGS ID or application ID from the NS2 system should be included in the notes section of the affiliation request in MPSE. For providers who are already enrolled and affiliated with an agency, do we need to submit a new request in MPSE to indicate the BGS ID from NS2, or does the Net Study system communicate directly with MPSE?

A: For providers who are already enrolled and affiliated with an agency, a new request in the MPSE portal is not required to update the affiliation with the BGS ID from the NS2 system. Currently, the Net Study system does not automatically communicate BGS information to MPSE. The provider news message should have clarified this was regarding providers affiliating to a new EIDBI agency. Going forward, new affiliations or enrollments will require the BGS number on the application and this must be manually entered. A clarification to the original message will be issued soon.

Speech and OT coordination

Q: How would we know what Speech or OT billed for, to make sure we are not making duplicative billing?

A: Each provider is responsible for accurate billing and documentation. Agencies should coordinate with Speech or OT providers, review documentation, and ensure billing codes align with the services delivered to avoid duplication.

- Providers should check on conflicting Centers for Medicare and Medicaid Services (CMS) billing requirements that do not allow for concurrent or simultaneous billing of certain codes. It is the providers responsibility to ensure that there are no conflicts. Review the CMS National Correct Coding Initiative in Medicaid and click on National Correct Coding Initiative Edits:
    - Procedure to procedure edits
    - Procedure to procedure and medically unlikely edits.
- Time is only billable if the service directly reflects goals from the child's treatment plan and was being provided for more than half the unit (e.g., 8 minutes our of a 15-minute unit) otherwise it would not be billable.
- It is the providers responsibility to ensure that the person meets eligibility and medical necessity for all services being billed.
- Goals and objectives during each session are documented in the corresponding treatment plan(s)
- Authorization may be required for the services you are providing.

- Providers are responsible to document and provide rationale for services billed and ensure they meet the requirements. Failure to do so may result in payment takeback or withholding payments. Services must not be duplicative.
- Although it's not explicitly prohibited from an EIDBI standpoint, any simultaneous service delivery should be done with caution and consideration and must follow all applicable MHCP and Medicaid laws.

Q: Can direct services still occur when the SLP/OT is conducting their services?

A: Each provider agency is responsible for accurate billing and documentation. Agencies should coordinate with Speech or OT providers, review documentation, and ensure billing codes align with the services delivered to avoid duplication. For more information on coordination of services, see EIDBI - Services.

Q: If a Behavior Therapist (BT) accompanies a client to a speech or OT appointment and actively assists the client, and the documentation reflects that the client was receiving OT or speech services, can the agency still bill for that time?

A: Each provider agency is responsible for accurate billing and documentation. Agencies should coordinate with Speech or OT providers, review documentation, and ensure billing codes align with the services delivered to avoid duplication. For more information on coordination of services, see EIDBI - Services.

Coordinating care

Q: If meeting with a provider (e.g., OT, SLP, School, Psychiatrist), does the parent have to be present to do a T1024 (care coordinated conference)?

A: To bill a coordinated care conference, T1024, yes, either the person or their legal guardian must be present. Coordinating care with those providers can certainly occur without the person or family present, it just would not be a billable EIDBI service.