



Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH



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By allwell.™



May 18, 2026

Provider Education: Behavioral Health Providers Billing Reminders

This notice provides reminders about billing requirements for behavioral health services for Home State Health (HSH) and Show Me Healthy Kids (SMHK) members. Submitting clean claims **ensures** timely processing and supports compliance with program requirements.

Medical records **must** support the services billed by documenting what was provided, when it was provided, and why it was medically necessary. Complete, timely documentation **ensures** claims include required information and reflect the care delivered.

Medical record documentation for behavioral health services **must** be individualized and reflect the unique needs of each patient. Providers **must ensure** records contain detailed information specific to the patient’s diagnosis, treatment plan, and progress. Documentation **must** meet established behavioral health standards, including thorough descriptions of interventions, outcomes, and any changes in care, so it accurately supports the clinical necessity and appropriateness of billed services.

Place of Service (POS) Guidance

Providers **must** bill services using the POS code that reflects where the service was rendered, not the billing or administrative location. Services billed outside of these POS codes are not payable.

POS reporting must align with provider type, facility licensure, and service definitions.

Professional claims related to inpatient services: 21 – Inpatient hospital or 51- Inpatient psychiatric facility

- Professional claims billed with any POS **other than** inpatient during an approved inpatient stay are subject to denial or recoupment.
- Professional services billed for days denied as not medically necessary are subject to denial or recoupment.

H0019 – Residential Behavioral Health Services (RTC): 33 – Custodial Care Facility

H2020 – Treatment Foster Care Services (TFC): 12 - Home

HomeStateHealth.com

Home State: 1-855-694-4663 / TTY: 711

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Show Me Healthy Kids: 1-877-236-1020 / TTY: 711

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Ambetter: 1-855-650-3789 / TTY: 711

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Wellcare By Allwell: MAPD 1-800-977-7522 / D-SNP: 1-844-796-6811 / TTY:711

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H2022 – Aftercare and Transition Treatment Foster Care Services (TFC): 12 – Home or 99 – Other Place of Service

H2013 – Psychiatric Residential Treatment Facility (PRTF): 56 – Psychiatric Residential Treatment Center

- Services are only authorized when provided in a state-approved PRTF location.
- PRTF per diems include both facility and professional services; no separate professional claim payments will be made.

Maximum Units Guidance

- HSH and SMHK **apply** state limits on outpatient services consistent with the MO HealthNet BH provider manual. Visits exceeding these limits **require** prior authorization.
- SMHK **pays only** for one Comprehensive Community Support (CCS) per diem service per day (H0019, H2020, or H2022).
- HSH and SMHK **limit** outpatient per-day payments for behavioral health services consistent with the MO HealthNet fee schedule guidance.

Other Billing Reminders

- Medical record documentation must be available upon request for audit/medical review.
- First-time claims **must be submitted within 180 days**.
- Submitting an incorrect POS may result in claim denial or recoupment.
- Certain services **must include** one or more modifiers for payment.
- When submitting corrected claims, **follow** the guidance in the HSH Provider Manual (link below).
- When billing for CCS care:
 - To reduce claim processing time, bill one service line (or one claim) for each date of service. Each line (or single-service claim) should include both the start date and end date of service.
 - **Aftercare services (H2022)** are limited to **six (6) months post-residential discharge**. Services rendered beyond this timeframe require an auth. Claims submitted without prior authorization will be **denied as non-payable**.
 - SMHK pays for one CCS per diem code (H0019, H2020, H2022) per day across providers.
- Coordination of Benefits (COB) claims **must be** submitted within 365 days from the primary carrier’s Explanation of Payment (EOP).
 - Providers **must verify all applicable** member insurance coverage prior to claim submission. If Other Insurance Coverage (OIC) is termed for the date of service, normal timely filing guidelines outlined in the Provider Manual apply, **even if EOP is present**.

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Providers **should submit claims electronically** using one of the following options:

- Using an 837 transaction via a clearinghouse
- Via secure provider portal: Availity (preferred) or Home State Health

References:

[MHD Provider Manuals](#)

[HSH Provider Manual](#)

Questions? For additional information or support, please contact Provider Service at 1-855-694-4663.

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