Tables 1-3 below describe discipline and place of service that must accompany each claim and modifiers that will be present on most claims.

Table 1-Disciplines

Rendering providers/practitioners may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description. The following table describes the abbreviations that are used in code tables. The column labeled Abbreviations gives the abbreviation used in code tables and the column labeled Discipline states what the discipline is. Providers allowed to perform each procedure are specified in code tables.

Abbreviations	Discipline
MD	Medical Doctor
DO	Doctor of Osteopathy
Pharm	General Pharmacist or Advanced Practice Pharmacist
CNS	Clinical Nurse Specialist
NP	Nurse Practitioner
RN	Registered Nurse
LCSW	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse
OT	Occupational Therapist
PCC	Professional Clinical Counselor
MFT	Marriage and Family Therapist
MHRS	Mental Health Rehabilitation Specialist
PhD	Doctor of Philosophy, Clinical Psychologist
PsyD	Doctor of Psychology, Clinical Psychologist
PA	Physician Assistant
Peer	Certified Peer Specialist
PT	Psychiatric Technician
Other	Other Qualified Provider

Table 2-Place of Service Codes for Professional Claim

Many codes have specified place of service codes describing where they can be performed. As a result, allowable places of service must accompany appropriate CPT and HCPCS codes for SDMC to process the claim. Below are the allowable places of service that are associated with codes listed in the code tables. The column titled Place of Service Code lists the place of service code associated with the name of that place of service. The column titled Place of Service Description describes the place of service. Allowable places of service for each code are listed in the code tables. As the Centers for Medicare and Medicaid Services (CMS) develops and maintains place of service codes and descriptions, DHCS will not be changing or in any way altering them until they are modified by CMS. Please note that if a service is provided via telehealth (audio only or audio/video) place of service code 02 or 10 **must** be used unless the service is mobile crisis. Please note that service code 10 is used when telehealth is provided in the patient's home.

Place of Service Code	Place of Service Name	Place of Service Description
01	Pharmacy	A facility where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home	The location where service and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters)
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

Place of Service Code	Place of Service Name	Place of Service Description
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care and which is not identified by any other Place of Service code.
17	Walk-in Retail Health Clinic	A walk-in retail clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other Place of Service code, owned and operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus—Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Place of Service Code	Place of Service Name	Place of Service Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On-Campus Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

Place of Service Code	Place of Service Name	Place of Service Description
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility—Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia or influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

Place of Service Code	Place of Service Name	Place of Service Description
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Table 3-Modifiers

Modifiers provide a way to report or indicate that a service or procedure that has been performed has been modified by some specific circumstance but not changed in its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. For example, a service code with an HL/GC modifier (service provided by a pre-licensed professional or resident) should be billed directly to SD/MC; a service billed with an HW modifier indicates that the county provided the service as a result of a state mandate and that the state will pay the non-federal share of that service pursuant to Proposition 30. If a modifier is used to override a lockout (for example modifier XP can be used to indicate that two CPT codes that could not otherwise be billed together can be billed together in this case) the modifier must be used with the "target" code or the code that would otherwise not be able to be billed with the primary service. Please note that HCPCS (alpha) modifiers can be used with CPT and HCPCS codes but CPT (numeric) modifiers can only be used with CPT codes.

The column labeled Modifier provides the modifier number or alpha-numeric character. The column labeled Definition provides the definition of the modifier from the CPT Manual or HCPCS list, as appropriate. The column labeled "When to Use" explains the only times when that modifier should be used. Modifiers not listed in this table are not used in the SDMC claiming system.

For a transaction to be HIPAA-compliant, a procedure code cannot use more than four modifiers. DHCS recommends that, in the rare situations that MHPs exceed four modifiers per procedure code in a given transaction, they not use telehealth modifiers.

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
27	**Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date**: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level of outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden have ** next to them in the code tables . This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
59	**Distinct Procedural Service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. This modifier is also to be used by any appropriate professional to override a 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider. This does not mean that if a provider performs an outpatient service while a patient is in a crisis stabilization unit, they can submit a separate claim for that service. Doing so would cause the service to be denied. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will be used with: • CPT codes that are part of an over-ridable lockout combination • S9484
76	**Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.	Use this modifier to override 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider.	This modifier will be used with: • CPT codes that are part of an over-ridable lockout combination • S9484

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
77	**Repeat Procedure by Another Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an evaluation and management service.	Use this modifier to override 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention or any other outpatient service. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider. This does not mean that if a provider performs an outpatient service while a patient is in a crisis stabilization unit, they can submit a separate claim for that service. Doing so would cause the service to be denied.	This modifier will be used with S9484
93	**Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunication System:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified professional. The totality of the communication of information exchanged between the physician or other qualified health care professional during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telephone. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service and via telephone.
95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunication System.** Synchronous telemedicine service is defined as a **real-time** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet	Use this modifier when a health care professional is providing services and benefits via telehealth. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service.

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
	the key components and/or requirements of the same service when rendered via a face-to-face interaction.		
SC	Valid for codes when the service was provided via telephone or audio-only systems.	Modifier SC is used only with HCPCs codes and to indicate that the service was provided via telephone or audio-only. If using the SC modifier, the place of service must be 02 or 10, unless the service is mobile crisis. With HCPCS codes, if the service is in POS 02 or 10 but does not have the SC modifier, the telehealth service is video/audio.	This modifier only applies only to HCPCS codes when telephone services are being provided.
GT	Via telehealth in 24-hour or day facilities or as part of mobile crisis.	Use this modifier on day, 24-hour or mobile crisis, transportation mileage or transportation staff time claims when the service was provided via telehealth.	This modifier only applies to HCPCS codes H2011, POS 15, A0140, and T2007
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use this modifier when the service was performed by a physician resident. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising physician's NPI would be reported with modifier GC after the service to indicate that the service was performed by a resident. If the service was performed by a pre-licensed professional who is not a resident, use modifier HL.	
HA	Child/adolescent program	Use this modifier when billing for Children's Crisis Residential Program (CCRP) services or psychiatric inpatient: administrative day under 21.	
HB	Adult program, non-geriatric	Use this modifier when billing for crisis residential treatment services provided to adults from 21 through 64 years of age.	
HC	Adult program, geriatric	Use this modifier when billing for crisis residential treatment services provided to adults 65 years of age.	
HE	Mental health program	Use this modifier when billing for 24-hour and day services. For additional information about when this modifier is required refer to the code tables. Do not use this modifier when claiming for outpatient services.	

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
HK	Specialized mental health programs for high-risk populations. *County EHR has hard coded "HK" for PWB/IS co-horts for ICC/IHBS codes	Use this modifier to indicate that a Katie A, IHBS or ICC service was provided.	
HL	Intern	Use this modifier when the service was performed by a registrants and interns who are working in clinical settings under supervision to obtain licensure. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising clinician's NPI would be reported with modifier HL after the service to indicate that the service was performed by a pre-licensed professional. If the service was performed by a resident, use modifier GC.	Services provided by individuals who are currently registered with the applicable Board.
HQ	Group setting	Use this modifier to indicate that a therapy service was provided in a group setting. We will use for rehab services also per DHCS outpatient rate spreadsheet	This modifier should be used with add-on code ~~G2212~~ when that code adds time to 90849 (multiple family group psychotherapy) or 90853 (group psychotherapy other than a multiple-family group)
HV	The State covers 50 percent of the nonfederal share, as the service was determined to be covered under Proposition 30. Please note that this definition does not correspond to the national description reference; the definition reflects state policy.	Use this modifier to identify services that the county provided as a result of a **federal** mandate that are subject to Proposition 30. Currently, services provided by the Qualified Individual (QI) as a result of the federal requirements contained in the Family First Prevention Services Act (FFPSA), such as intensive care coordination services, should use the modifier HV. Likewise, aftercare services (for six months after discharge from an STRTP) are a new requirement of the FFPSA, and specialty	

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
		mental health services provided as part of a High-Fidelity Wraparound program should also use the modifier HV.	
HW	The State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30.	Use this modifier to identify services that the county provided as a result of a **state** mandate that are subject to Proposition 30. Currently continuum of care services provided as a result of AB 403 and mobile crisis services should use the HW modifier.	
TG	Complex/high tech level of care	Use this modifier when billing for day treatment intensive and crisis stabilization. For additional information about when this modifier is required refer to 24 hr & Day Service table. Do not use this modifier when claiming for outpatient services.	
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	
XP	Separate practitioner, a service that is distinct because it was performed by a separate practitioner.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's	

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
		history. If two service codes cannot be billed together, whichever code is processed second will be denied.	
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	