

Program HH (HIV/AIDS) Services

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Overview

The Ryan White HIV/AIDS Treatment Extension Act of 2009 codifies a variety of core medical and support services provided to eligible people with HIV. The Minnesota Department of Human Services (DHS) directly administers Ryan White program services for eligible people living with HIV under Program HH.

Program HH provides access to crucial medications and care services for people with HIV in Minnesota. It includes Minnesota AIDS Drug Assistance Program (ADAP), insurance program, dental program, mental health program, supplemental nutrition program and limited medication therapy management services.

Eligible Members

An applicant must be a person living with HIV to be eligible for Program HH. An eligible applicant must submit an application and provide documentation proving they meet the following requirements:

- Have a physician certification of an HIV infection
- Reside in Minnesota
- Have a household income not exceeding 400 percent of the federal poverty guidelines
- Are uninsured or underinsured

Refer to the [Apply for HIV programs and services](#) webpage for more information and application forms.

People may be eligible for Program HH only, or in conjunction with other Minnesota Health Care Programs (MHCP), such as Medical Assistance (MA); as well as other private insurance including qualified health plans, off-exchange (or off-MNSure) private plans and employer sponsored insurance plans.

People eligible for Program HH can have one of two benefit levels as indicated in the following table:

Benefit and eligibility type	Dental	Mental Health	Nutrition	Drug	Medication Therapy Management Services
Basic dental and nutrition (DN)	X	X	X		X
Basic dental and nutrition with drug and health insurance assistance (HI)	X	X	X	X	X

Basic Benefit set (DN)

- For Program HH members on other Minnesota Health Care Programs, such as MA and Minnesota Care.
- The Program HH DN Benefit set includes coverage for dental, mental health, nutrition supplements and medication therapy management services (MTMS).

Health Insurance Assistance Benefit set (HI)

- For Program HH members who are uninsured, or have private insurance, such as MNsure qualified health plans, off MNsure/exchange private plans and employer sponsored insurance plans.
- The Program HH HI benefits set includes all the benefits in the DN benefits set as well as assistance with [medication costs and copays](#) and [help paying for insurance premiums](#).

Dental Benefit

- Program HH is a payer of last resort. This means, if there is another public or private insurer for the same covered service, providers must bill that payer first for the service.
- Review the [Billing Policy Overview](#) under [Medicare and Other Insurance](#) in the [MHCP Provider Manual – Provider Basics](#). The Program HH dental benefit includes all services in the [Children and Pregnant Women](#) benefit set and additional services.

Dental Benefit Eligible Members

All members eligible for the Program HH under the Basic Benefit set (DN) and Health Insurance Assistance Benefit set (HI) are eligible for the Program HH Dental Benefit.

Dental Benefit Covered Services

The Program HH dental benefit covers the services listed in the dental benefit for [Children and Pregnant Women](#) independent of the Program HH member's age or pregnancy status. The Program HH dental benefit includes additional dental services specific to Program HH. These additional services are listed in the following table.

Diagnostic

CDT Code	Description	Service Limits
D0150	Comprehensive exam	Once every three years instead of once per five years
D0210	Full mouth series	Once every four years

Diagnostic Imaging

CDT Code	Description	Service Limits
D0801	3D dental surface scans	One per date service
D0802	3D dental scan indirect	One per date service
D0803	3D Facial Scan Direct	One per date service
D0804	3D Facial Scan Indirect	One per date service

Prevention

CDT Code(s)	Description	Service Limits
D1310	Nutritional Counselling	One per date service
D1320	Tobacco Counselling	One per date service
D1321	Substance Abuse Counselling	One per date service
D1330	Oral Hygiene Instruction	One per date service

Restorative

CDT Code	Description	Service Limits
D2740	Crown-Porcelain/Ceramic	Once every seven years per tooth number. Authorization Required
D2750	Crown-Procelain fused to high noble metal	Once every seven years per tooth number. Authorization Required
D2751	Crown-Porcelian fused to predominantly base metal	Once every seven years per tooth number. Authorization Required
D2752	Crown-Procelain fused to nobel metal	Once every seven years per tooth number. Authorization Required
D2753	Crown-Procelain fused to titanium alloys	Once every seven years per tooth number. Authorization Required
D2780	Crown-3/4 cast high noble metal	Once every seven years per tooth number. Authorization Required
D2781	Crown-3/4 cast predominantly base metal	Once every seven years per tooth number. Authorization Required
D2782	Crown-3/4 cast noble metal	Once every seven years per tooth number. Authorization Required
D2783	Crown-3/4 porcelain/ceramic	Once every seven years per tooth number. Authorization Required
D2790	Crown-full cast high noble metal	Once every seven years per tooth number. Authorization Required
D2791	Crown-full cast predominantly base metal	Once every seven years per tooth number. Authorization Required
D2792	Crown-full cast noble metal	Once every seven years per tooth number. Authorization Required
D2794	Crown-titanium and titanium alloys	Once every seven years per tooth number. Authorization Required

Periodontics

CDT Code	Description	Service Limits
D4921	Gingival irrigation per quadrant	One per date service

Removable Prosthodontics

CDT Code	Description	Service Limits
D5991	Vesiculobullous disease medicament carrier	One per date service
D5999	Unspecified Maxillofacial prosthesis	One per date service. Authorization Required.

Adjunctive General Services

CDT Code	Description	Service Limits
D9310	Consultation	One per date service
D9311	Consultation with a medical health care professional	One per date service

Dental Benefit Authorization Requirements

If a person is eligible for another MHCP benefit program and Program HH, follow [MHCP authorization requirements](#) and submit the authorization to the medical review agent. The medical review agent must receive all required documentation to complete its review. Refer to MHCP fee-for-service (FFS) Dental Authorization chart for procedure-specific documentation requirements for [Children and Pregnant Women Authorization Chart](#).

If the Program HH enrollee is not dual-enrolled in Medicaid, refer to the [Program HH Dental Authorization Requirement Chart](#) for instructions about submission of prior authorization requests to the medical review agent.

Dental Benefit Billing

Providers are responsible for [coordination of services](#). Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Refer to [Billing](#) under Dental Services in the MHCP Provider Manual for complete billing information.

Refer to the services listed above in this section and those that require authorization in the [Program HH Dental Authorization Requirement Chart](#) for specific coverage details.

Denied benefit claim questions

If a provider has denied dental benefit claims that you believe are covered by Program HH, the provider must contact Program HH Customer Care either by calling 651-431-2398 or emailing dhs.programhh@state.mn.us to have denied claims reviewed for reimbursement. Providers should have the following information about the Program HH members: member's full name (as noted on their MHCP ID card), member's MHCP subscriber number, member's date of birth, date(s) of service, provider name and NPI number for the denied claims in question. **Providers should leave a separate voicemail for each member.**

Mental Health Benefit

Program HH is a payer of last resort. This means, if there is another public or private insurer for the same covered service, providers must bill that payer first for the service. Review the [Billing Policy Overview](#) on [Medicare and Other Insurance](#) from the [MHCP Provider Manual – Provider Basics](#).

Mental Health Benefit Eligible Members

All members eligible for the Program HH under the Basic Benefit set (DN) and Health Insurance Assistance Benefit set (HI) are eligible for the Mental Health Benefit.

Mental Benefit Health Covered Services

Program HH members have access to limited mental health services. The Program HH mental health benefit covers the following limited outpatient services:

- [Diagnostic Assessment](#) (Program HH covers only 90791)
- [Psychotherapy](#) (Program HH does not cover 90875 and 90876)

The Program HH mental health benefit does not cover medications, but several mental health medications are included on the Program HH limited drug formulary. Search the [Program HH drug formulary](#) for covered medications (choose "HH" on the Major Program dropdown).

Mental Health Benefit Billing

Providers are responsible for [coordination of services](#). Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Refer to the billing guidelines in the MHCP [Diagnostic Assessment](#) and [Psychotherapy](#) for complete billing information. Review denied claims for members with Program HH because MHCP may reimburse services differently under Program HH than with other MHCPs.

Refer to [Denied benefit claims questions](#) if a provider has denied claims that you believe are covered by Program HH.

Nutrition Benefit

Program HH is a payer of last resort. This means, if there is another public or private insurer for the same covered service, providers must bill that payer first for the service. Review the [Billing Policy Overview on Medicare and Other Insurance](#) from the [MHCP Provider Manual – Provider Basics](#).

Nutrition Benefit Eligible Members

All members eligible for the Program HH under the DN Benefit or HI Benefit set are eligible for the nutrition benefit.

Nutrition Benefit Covered Services

Program HH covers enteral nutritional products when recommended by a registered dietitian for up to \$100 per calendar month for members approved for the nutrition benefit.

Members must first meet with an MHCP-enrolled registered dietitian to determine the medical necessity for nutritional supplements to receive the Program HH nutrition benefit.

Nutrition Benefit Authorization Requirements

Registered Dietitian Responsibilities

An MHCP-enrolled registered dietitian must identify and document the medical necessity for nutritional supplements using the [Nutritional Supplemental Authorization Request \(DHS-5849\) \(PDF\)](#). The dietitian completes the member and dietitian information sections every six months and faxes the form to the dispensing provider. The member may also take the form to give to the dispensing provider.

If the member is eligible for MA in addition to the Program HH benefit coverage, the provider must submit claims for dietitian services to MHCP according to licensed dietitians and licensed nutritionists billing guidelines. Refer to [Medical Nutritional Therapy \(MNT\)](#) under Physician and Professional Services in the MHCP Provider Manual for billing guidelines.

If the member is eligible for only Program HH and not any of the other MHCPs, the member or the member's private insurance (if any) may be responsible for the dietitian services. The member can [get help to find a dietitian](#), if Medicaid, Medicare or other insurance do not cover the dietitian service.

Dispensing Provider Responsibilities

An MHCP-enrolled medical supplier or pharmacy must request authorization for the Program HH nutritional products from the Program HH Customer Care Specialist. The medical supplier or pharmacy completes the dispensing provider information section of the [Nutritional Supplemental Authorization Request \(DHS-5849\) \(PDF\)](#) and faxes it to 651-431-7414. Do not submit these requests to the medical review agent.

Program HH will fax the approved or denied authorization request to the medical supplier or pharmacy. MHCP will issue a follow-up letter to the dispensing provider in the MN-ITS mailbox and send a letter to the member.

Nutrition Benefit Billing

Providers are responsible for the [coordination of services](#). Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

To receive Program HH payment for the nutritional products, the dispensing provider must submit the claim(s) as follows:

- Bill using the [MN-ITS 837P](#).
- Enter the approved authorization number (from the approval notice from the customer care specialist).
- Enter the registered dietitian's NPI as the ordering provider.
- Enter the appropriate diagnosis code(s) that matches the authorization form.

Drug Benefit

Program HH is a payer of last resort. This means, if there is another public or private insurer for the same covered service, providers must bill that payer first for the service. Review the [Billing Policy Overview on Medicare and Other Insurance](#) from the [MHCP Provider Manual – Provider Basics](#).

Drug Benefit Eligible Members

Only members eligible for the Program HH under the HI Benefit set are eligible for the Drug Benefit.

Drug Benefit Covered Services

The Program HH [AIDS Drug Assistance Program \(ADAP\)](#) Drug Benefit has an open drug formulary that mirrors the Minnesota Department of Human Services Fee For Services Drug Formulary, with the exception of controlled substances. Program HH covers the copay for drugs from the [Program HH Medication Program \(ADAP\) Formulary](#) for eligible members with insurance coverage, and may cover the full cost for the uninsured eligible member.

Providers can search the Program HH formulary [NDC Search](#) for medications they are prescribing or dispensing to the Program HH member. When on the [NDC Search](#) page, providers have a variety of options while searching the drug formulary (choose "HH" in the Major Program dropdown).

If a drug prescribed to a Program HH member is currently not on the Program HH drug benefit formulary, providers or members can request to have it added to the Program HH/ADAP formulary. To add the drug to the Program HH/ADAP formulary, submit a formulary addition request to the Program HH Customer Care by emailing dhs.programhh@state.mn.us or calling 651-431-2398. With each formulary addition request, providers should include the drug name, dosage and modality. If Program HH determines the medication is appropriate to add to the Program HH/ADAP formulary, staff will add the medication to the formulary, coverage is effective the month after the addition.

Drug Benefit Authorization Requirements

Follow MHCP [pharmacy services authorization requirements](#) and submit the authorization to the medical review agent. The medical review agent must receive all required documentation to complete its review.

Drug Benefit Billing

Providers are responsible for [coordination of services](#). Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Complete billing as outlined in [Billing](#) under Pharmacy Services in the MHCP Provider Manual. Contact the [MHCP Provider Resource Center](#) with drug benefit billing questions (choose option 2).

Change to Coverage for Injectable ART Drug Coverage for Cabenuva (cabotegravir/rilpivirine), Trogarzo (ibalizumab-uiyk), and Sunlenca (lenacapavir sodium)

This change (effective Jan. 1, 2022) to Program HH coverage for Drug benefits is in line with Drug Benefits Authorization Requirements and Drug Billing sections above as well [MHCPs covers Outpatient Physician-Administered Drugs](#), Program HH now covers both Cabenuva (cabotegravir/rilpivirine), Trogarzo (ibalizumab-uiyk), and Sunlenca (lenacapavir sodium) as a:

- Pharmacy benefit ONLY when a Program HH enrollee has third party liability insurance that covers it as a pharmacy benefit.
- Effective date Jan. 1, 2022, Program HH covers Cabenuva (cabotegravir/rilpivirine), Trogarzo (ibalizumab-uiyk), and Sunlenca (lenacapavir sodium) as a [MN-ITS 837P](#) Professional Claim if Program HH is the only payor or as secondary payor to non-MHCP third-party liability/primary insurance that requires the drug to be covered as a Professional Claim. The patient must have Program HH's "Basic dental and nutrition with drug and health insurance assistance (HI)" on the date of service.

Program HH also pays for the cost of office visits or injection j-code ONLY if drugs approved for injectable ART [currently Cabenuva (cabotegravir/rilpivirine), Trogarzo (ibalizumab-uiyk), and Sunlenca (lenacapavir sodium)] have been billed in unison on the same claim. The drugs must be in PAID or TO BE PAID status.

- If the drugs are not on PAID or TO BE Paid status, the claim will deny the office visit.
- If the drug is not billed at the same time as office visit or injection code, the claim will deny.

The following are billed on a [MN-ITS 837P](#) Professional claim with HCPCS (begin with J) and NDC (11 digits). These are the following codes allowed:

J-Code	NDC	Description
J0741	49702025315	Cabenuva (cabotegravir/rilpivirine) 400mg-600/2
J0741	49702024015	Cabenuva (cabotegravir/rilpivirine) 600mg-900/3
J1746	62064012201	Trogarzo (ibalizumab-uiyk) 200mg/1.33
J1746	62064012202	Trogarzo (ibalizumab-uiyk) 200mg/1.33
J1961	61958300201	Sunlenca (lenacapavir sodium) 463.5/1.5
J1961	61958300401	Sunlenca (lenacapavir sodium) 463.5/1.5

The following CPT office visit codes are allowed for both Cabenuva (cabotegravir/rilpivirine), Trogarzo (ibalizumab-uiyk), and Sunlenca (lenacapavir sodium):

CPT Code	Description
99202	Office/outpatient visit, new patient, single focused, 15-29 min
99203	Office/outpatient visit new patient, low complexity 30-44 min
99204	Office/outpatient visit new patient, mod complexity 45-59 min
99205	Office/outpatient visit new patient, high complexity 60-74 min
99211	Office/outpatient visit established patient, may x req phy/qhp
99212	Office/outpatient visit established patient, single focused 10-19 min
99213	Office/outpatient visit established patient, low complexity 20-29 min
99214	Office/outpatient visit established patient, moderate complexity 30-39 min
99215	Office/outpatient visit established patient, high complexity 40-54 min
96372	Injection of drug or substance under skin or into muscle, if billed with a 25 modifier and the office visit is billed the same date of service.

Medication Therapy Management Services (MTMS)

Program HH is a payer of last resort. This means, if there is another public or private insurer for the same covered service, providers must bill that payer first for the service. Review the [Billing Policy Overview](#) on [Medicare and Other Insurance](#) under the [MHCP Provider Manual - Provider Basics](#).

Program HH reimburses providers who help members understand the importance of their drug regimen, issues with compliance, possible side effects; and offer ongoing support for medication adherence. Eligible Program HH members may receive MTMS if they are currently taking or have a prescription for medication but have not yet started it.

Program HH also covers the services listed in this section in addition to MTMS included under [MTMS](#) in the MHCP Provider Manual.

MTMS Eligible Members

All members eligible for the Program HH under the Basic Benefit set (DN) and Health Insurance Assistance Benefit set (HI) are eligible for MTMS.

MTMS Covered Services

In addition to the covered services included under [MTMS](#) in the MHCP Provider Manual, Program HH also covers services provided by telephone. Providers should follow the MHCP [Telehealth Services](#) policy.

Program HH members may receive up to 12 MTMS encounters per year without authorization. Providers may request authorization for additional encounters from Program HH.

MTMS Authorization Requirements

If a member requires more than the annual 12 MTMS encounters, complete the [MTMS Authorization Request \(DHS-6246\) \(PDF\)](#) and fax it to the Program HH Customer Care at 651-431-7414. Do not fax to state medical review agent.

MTMS Billing

Providers are responsible for [coordination of services](#). Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Complete [billing](#) as outlined under [MTMS](#) in the MHCP Provider Manual. Billing limits are as follows:

MTMS codes

Code	Description	Unit	Benefit Limit
99605	A first encounter performed face-to-face	15 min	1 per 365 days
99606	Subsequent follow-up with same member	15 min	Up to 11 per 365 days
99607	Additional increments for 99605 or 99606	15 min	Up to 4 per date of service

Additional Resources

- [HIV Resources](#)
- [DHS HIV Webpage](#)
- [Program HH Policy Manual](#)

Legal References

- [Ryan White HIV/AIDS Treatment Extension Act of 2009](#) (Public Law 111-87, October 30, 2009)
- [Minnesota Statutes, 256.9365](#) (Purchase of Health Care Coverage for People Living with HIV)
- [Minnesota Statutes, 256.01](#), subdivisions 18, 19, 20 (State authority for HIV/AIDS)