

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-44	2. STATE Louisiana
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE August 1, 2010	

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT
 COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart B

7. FEDERAL BUDGET IMPACT:
 a. FFY 2010 (\$15.80) ~~(\$15.66)~~
 b. FFY 2011 (\$87.82) ~~(\$74.55)~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Item 20b, Page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Same (TN 10-14)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement rates for dental services provided to Medicaid eligible pregnant women in order to avoid a budget deficit.**

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED **The Governor does not review state plan material.**
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[Signature]

13. TYPED NAME:
Bruce Greenstein

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 28, 2010

16. RETURN TO:
**State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **28 September, 2010**

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 August, 2010

21. TYPED NAME:
BILL BROOKS

18. DATE APPROVED:
2 December, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[Signature]

22. TITLE: **Associate Regional Administrator
Division of Medicaid & Children's Health**

23. REMARKS:
Pen and Ink change made in block 7 per State's e-mail dated 16 November, 2010

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

- Removal of impacted tooth, soft tissue; and
- Removal of impacted tooth, partially bony.

Effective for dates of service on or after August 1, 2010, the reimbursement fees for dental services provided to Medicaid eligible pregnant women shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise stated:

- 69 percent for the comprehensive periodontal evaluation exam;
- 65 percent for the following diagnostic services:
Intraoral-periapical first film;
Intraoral-periapical, each additional film; and
Panoramic film and prophylaxis, adult; and
- 58 percent for the remaining diagnostic services and all periodontic procedures, restorative and oral and maxillofacial surgery procedures which includes the following dental services:

- Intraoral, occlusal film;
- Bitewings, two films;
- Amalgam (one, two or three surfaces) primary or permanent;
- Amalgam (four or more surfaces);
- Resin-based composite (one, two or three surfaces), anterior;
- Resin-based composite (four or more surfaces) or involving incisal angle, anterior;
- Resin-based composite crown, anterior;
- Resin-based composite (one, two, three, four or more surfaces), posterior;
- Prefabricated stainless steel crown, primary or permanent tooth;
- Prefabricated resin crown;
- Periodontal scaling and root planing (four or more teeth per quadrant);
- Full mouth debridement to enable comprehensive evaluation and diagnosis;
- Extraction, coronal remnants-deciduous tooth;
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal);
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
- Removal of impacted tooth, soft tissue; and
- Removal of impacted tooth, partially bony.

A	
STATE	LOUISIANA
DATE REC'D.	9-28-10
DATE APPL'D	12-2-10
DATE EFF.	8-1-10
HCFA 179	10-17

Fee schedules are published on the Medicaid provider website at www.lamedicaid.com. Public and private providers are paid the same rate for the same type of service.

TN # 10-17 Approval Date 12-2-10 Effective Date 8-1-10

Supersedes

TN # 10-17

SUPERSEDES: TN- 10-17