

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
10-71

2. STATE
Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
* ~~December 1, 2010~~ January 1, 2011

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

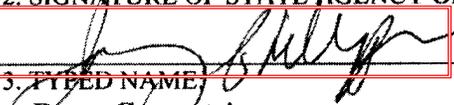
7. FEDERAL BUDGET IMPACT:
* a. FFY 2011 (\$23.19) ~~(\$44.46)~~
b. FFY 2012 ~~(\$47.41)~~

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (If Applicable):
None (New Page)

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
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bruce Greenstein
14. TITLE:
Secretary
15. DATE SUBMITTED:
December 10, 2010

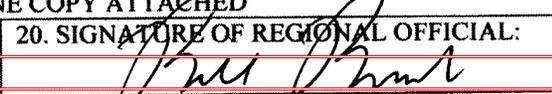
16. RETURN TO:
**State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 20 December, 2010 18. DATE APPROVED: 28 February, 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
~~1 December, 2010~~ 1 January, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME:
Bill Brooks

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

23. REMARKS: * Pen and Ink change made per State's E-mail dated 1-18-2011, changing the Fiscal Impact for 2011 and the Effective Date of the SPA.

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:

Effective for dates of service on or after January 1, 2011, 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:

1. 67.5 percent for the comprehensive periodontal evaluation exam;
2. 63.5 percent for the following diagnostic services:
 Intraoral-periapical first film;
 Intraoral-periapical, each additional film; and
 Panoramic film and prophylaxis, adult; and
3. 57 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 planning (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.

STATE <u>Louisiana</u>	A
DATE REC'D. <u>12-20-10</u>	
DATE APPV'D. <u>2-28-11</u>	
DATE EFF. <u>1-1-11</u>	
HC.FA 179 <u>10-71</u>	

TN # 10-71 Approval Date 2-28-11 Effective Date 1-11

Supersedes _____
 TN # _____ SUPERSEDES: NONE - NEW PAGE