DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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.

FORM HCFA-179 (07-92)

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 Louisiana
DATE RECD. 12-20-10
DATE APPV'D 2-28-11
DATE EFF 1-1-11
HCFA 179 10-71

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