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**State/Territory Name: Louisiana**

**State Plan Amendment (SPA) #: 13-34**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Dallas Regional Office  
1301 Young Street, Suite 833  
Dallas, Texas 75202



**DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI**

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November 13, 2013

Our Reference: SPA LA 13-34

Ms. Ruth Kennedy, State Medicaid Director  
Department of Health and Hospitals  
Bienville Building  
628 North 4<sup>th</sup> Street  
Post Office Box 91030  
Baton Rouge, LA 70821-9030

Attn: Darlene Adams  
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 13-34. The state plan amendment reduces the reimbursement rates for adult denture services 1.5 percent.

Transmittal Number 13-34 is approved with an effective date of August 1, 2013 as requested. A copy of the HCFA-179, Transmittal No. 13-34 dated September 6, 2013 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at [ford.blunt@cms.hhs.gov](mailto:ford.blunt@cms.hhs.gov) or by phone at (214) 767-6381.

Sincerely,

A solid black rectangular box used to redact the signature of Bill Brooks.

Bill Brooks  
Associate Regional Administrator

Enclosures

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

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

<b>TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES</b>		1. TRANSMITTAL NUMBER: <b>13-34</b>	2. STATE <b>Louisiana</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE <b>August 1, 2013</b>	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 447, Subpart F</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>2013</b> <b>(\$5.19)</b> b. FFY <b>2014</b> <b>(\$4.62)</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B, Item 12b, Page 1</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Same (TN 12-44)</b>	
10. SUBJECT OF AMENDMENT: <b>The SPA proposes to revise the reimbursement methodology for adult denture services to reduce reimbursement rates by 1.5 percent of the fee amounts on file as of July 31, 2013.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>The Governor does not review state plan material.</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>J. Ruth Kennedy, Medicaid Director State of Louisiana Department of Health and Hospitals 628 N. 4<sup>th</sup> Street PO Box 91030 Baton Rouge, LA 70821-9030</b>	
13. TYPED NAME: <b>Kathy H. Kliebert</b>			
14. TITLE: <b>Secretary</b>			
15. DATE SUBMITTED: <b>September 4, 2013</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>6 September, 2013</b>		18. DATE APPROVED: <b>13 November, 2013</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1 August, 2013</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Bill Brooks</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid &amp; Children's Health</b>	
23. REMARKS:			

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:

CITATION  
42 CFR 447

Medical and  
Remedial Care and  
Services  
Item 12b

Dentures

State: Louisiana  
Date Received: 6 September, 2013  
Date Approved: 13 November, 2013  
Date Effective: 1 August, 2013  
Transmittal Number: LA 13-34

I. Methods of Payment

Adult denture services are reimbursed the lower of the dentist's billed charges or the state established schedule of fees. This fee schedule is reviewed annually.

Effective for dates of service on or after July 1, 2012, the reimbursement fees on file for the following adult denture services shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report 70<sup>th</sup> percentile, unless otherwise stated:

1. 65 percent for the comprehensive evaluation exam; and
2. 56 percent for full mouth x-ray.

Removable prosthodontics shall be excluded from the July 1, 2012 reimbursement rate reduction.

Effective for dates of service on or after August 1, 2013, the reimbursement for adult denture services shall be reduced by 1.5 percent of the fee amounts on file as of July 31, 2013.

Removable prosthodontics shall be excluded from the August 1, 2013 reimbursement rate reduction.

II. Standards for Payment

Only the services of dentists who are licensed by the State Board of Dental Examiners are reimbursed.