

16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 48.

16.1 Enrollment

Medicaid's Fiscal Agent enrolls FQHC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for FQHC-related claims.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment. The 10-digit NPI is required when filing a claim.

FQHC facilities are assigned a provider type of 56 (FQHC) and the valid specialty is 080 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering NPI (Block 24J) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual NPIs that are linked to the FQHC number. Each of these providers is assigned a provider type of 56 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to Chapter 28 Physician)
- 070 (LPC- Licensed Professional Counselor)
- 072 (LMFT- Licensed Marriage and Family Therapist)
- 074 (LICSW- Licensed Independent Clinical Social Worker)
- 095 (Certified Nurse Midwife)
- 093 (Certified Registered Nurse Practitioner)
- 100 (Physician Assistant)

Enrollment Policy for FQHC Providers

To participate in the Alabama Medicaid Program, FQHC providers must meet the following requirements:

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites
- Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, Physician Assistants, Psychologists, and Licensed Independent Clinical Social Workers associated with the clinic must also complete enrollment applications.
- For Behavioral Health/Mental Health Providers, an unannounced site visit may be required as part of the enrollment process. Site visits are unscheduled, unannounced visits conducted by Gainwell Technologies Provider Representatives. If you are selected for a visit, please take a few moments to answer the questions and provide the additional documentation needed. For additional enrollment requirements, please refer to section 34.1 of Chapter 34 of the Provider Billing Manual.

Provider contracts are valid for the time of the grant award period and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will

be 60 days beyond the end date of the budget period on the Grant Award Notice.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

Mobile Dental Clinic

- Complete guidelines for mobile dental clinics are in Provider Manual Chapter 13 Dental.

FQHCs are required to notify Medicaid's fiscal agent in writing within five state working days of any of the following changes:

- Losing FQHC status
- Any changes in dates in the FQHC grant budget period
- Opening(s) and/or closing(s) of any satellite center(s)
- Additions or terminations of providers

Alabama Coordinated Health Network (ACHN) Requirements for Federally Qualified Health Centers (FQHC)

- Refer to Chapter 40 for details and requirements about the ACHN Program.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency.

School Campus Facility

NOTE:

Only FQHC satellite center(s) may enroll using the specialty type 082 School Campus Facility/FQHC.

FQHC facilities are required to enroll each satellite clinic providing school-based services (SBS) with Medicaid. This will serve for informational purposes only. Satellite Clinics that provide SBS will be assigned the specialty type of 082 School Campus Facility/FQHC.

16.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/Medically Necessary Care. Refer to Chapter 28, Physician, for additional information for FQHC physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants.

Mental Health

- Psychologists and Licensed Independent Clinical Social Workers may provide services to EPSDT/QMB referred recipients. Please refer to Provider Manual Chapter 34 Behavioral Health for additional information.
- Effective January 1, 2024, Licensed Marriage and Family Therapists (LMFT) and Licensed Professional Counselors (LPC) may enroll with the Alabama Medicaid Agency (Medicaid) and provide Behavioral Health services in Federally Qualified Health Centers (FQHCs). The CPT codes for billing are 90832, 90834, 90837, 90791 and 90785. These codes are inclusive of the PPS rate for the FQHC facilities. Appropriate documentation must be documented in the medical record. Documentation requirements can be found in Chapter 34 of the Provider Billing Manual.

16.2.1 Benefits

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health. Home Health services are excluded as an FQHC service because home health services are available on a state wide basis.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

16.2.2 Limitations

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 6, for details.

16.2.3 Reimbursement

As described in Section 1902(aa) of the Social Security Act, FQHCs will be paid under a prospective payment system rate (PPS rate) effective January 1, 2001. The rate setting period is from October 1 through September 30th. Each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care

services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.

If a service has been eliminated, the Health Center must notify Medicaid that they have discontinued a given service. Medicaid must be notified in writing within ninety (90) calendar days of any termination of service(s). The notification of discontinued service must include the 12-month cost report for the discontinued service leading up to the termination of the service. The Agency may request additional documentation. An elimination of a service or services will not result in a rate adjustment unless the elimination has a cost impact of 3%. Failure to notify Medicaid of a termination of service may result in recoupment of paid claims.

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Reimbursement for all new FQHC providers or providers who have a Medicaid approved change in scope will be subject to the ceiling provided under rule 560-X-56.04(3)

Change in Scope (CIS)

An FQHC may request that their PPS rate be adjusted to take into account a change (either increase or decrease) in the scope of services furnished by the FQHC. A change in scope of services is defined as a change in the type, intensity, duration, and/or amount of services provided during a FQHC visit. Change in Scope requests must meet regulatory compliance as required by state and federal law as it relates to the operation of FQHC services provided under the Alabama Medicaid ("Medicaid") Program.

A change in scope request must be sent to the Managed Care Operations Division for review. The request must specifically state what FQHC service was changed, and specifically detail how the type, intensity, duration, or amount of that service has changed. Medicaid will not review the CIS request until a complete submission is received. A complete submission includes the documentation listed below. The CIS request must be submitted to the Agency no later than 180 days (six months) after the Health Clinic's fiscal year end. The request shall include, at a minimum, the following clearly labeled and identified documentation:

1. Narrative of the Qualifying Event or Events including a description of the Event or Events and other relevant information such as the locations affected, the date new services began, time period over which the changes took place or how patients are impacted; any relevant supporting documentation should also be provided. The Health Clinic must specify their fiscal year period in the narrative that will be submitted with the CIS request. Failure to disclose the fiscal year in the narrative will result in an incomplete submission.
2. A current copy of Form 5A, 5B, and 5C, if applicable.
3. A current copy of HRSA's Notice of Award (NOA), if applicable.
4. A CIS Medicaid cost report with at least 12-months of actual expenses associated with the requested change in scope.
 - ☐ The Medicaid cost report must reflect ALL clinic visits.

Also, initial supporting documentation must include the following:

- General Ledger Detail (in excel format) for the period under audit
 - Trial Balance (in excel format)
 - Crosswalk of Trial Balance accounts to Medicaid cost report line item
 - Medicare Cost Report for period(s) consistent with the Medicaid Cost Report
5. The FQHC's proposed PPS rate with detailed documentation of how the proposed PPS rate was derived or calculated.
 6. A listing of deleted services not reported to Medicaid, if applicable. Listing must include the deleted service and the date the service was deleted.
 7. The current HRSA UDS Report (detailed) that contains the change in scope qualifying events.

The Medicaid Agency may request more documentation or clarification of the documentation provided. If the FQHC fails or refuses to provide the documentation requested by the Medicaid Agency, the change in scope request may be denied. FQHCs may submit one CIS request within 12-months of the last submitted CIS request.

NOTE:

A deletion in service(s) does not count towards the 12-month CIS submission limitation.

The Agency will notify the Health Clinic within seven days of receipt of a CIS request. If the Health Clinic does not receive a response within seven days, it is the Health Clinic's responsibility to reach out to the Agency regarding receipt of the CIS request. The Agency will review the CIS request to determine if the CIS request is complete. The Agency will notify the Health Clinic within 30 days regarding the completion status of the CIS request. The Agency will notify the Health Clinic within 60 days from CIS submission completion date of the qualifying events that do or do not meet the definition of a change in the scope of services as defined by Medicaid.

A change in the scope of service occurs if the FQHC has added or discontinued any service that meets the definition of FQHC services as provided in Section 1905(a) (2) (B) and (C) of the Act, and the service is included as a covered Medicaid service under the Alabama Medicaid State Plan. A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of services compared to the services offered at the time of the last change of scope rate adjustment.

Type- the FQHC/RHC has added or dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a) (2) (B) and (C) of the Social Security Act or if the service is included as a covered Medicaid service in the State Plan.

Intensity- a change in the characteristics of services offered in an average visit such that the average patient receives a different array of services.

Amount- an increase or decrease in the quantity of services that an average patient receives in an average visit.

Duration- a change in the average length of time it takes medical providers to complete an average patient visit due to changing circumstances.

A change in scope review will not take increased costs or inflation into account. Further, Patient-Centered Medical Home (PCMH) certification will not qualify for a rate adjustment. When the cost of the changed service has been determined, the incremental/decremental rate adjustment to the individual service will be combined into the overall PPS rate thereby calculating a revised encounter rate. Only the services that changed will be included in the PPS rate calculation during the change in scope request review. If the new PPS rate results in an overall increase or decrease of at least 3 percent of the PPS rate at the time Medicaid receives the change in scope request, then the PPS rate will be adjusted. The effective date of the new PPS rate will be the first day of the month that the Medicaid Agency receives a completed CIS request. The Agency will notify the health clinic within 30 days if the CIS request is complete or not. A complete submission includes the documentation listed above.

NOTE:

For example: if a CIS request is received on March 31, but does not contain all required information, it will be returned. On May 15th, the Agency receives the resubmitted CIS request with all required documentation, therefore the effective date will be May 1st.

The FQHC must demonstrate the following:

- a cost impact per qualifying event or a combination of more than one qualifying event and
- the incremental cost impact per visit to the change in scope of service.

Any costs supporting the rate adjustment must be allowable for FQHCs under the Administrative Code Chapter 56- Federally Qualified Health Center Reimbursement. The calculated incremental cost per visit of the change in scope will be applied to the PPS rate currently in effect.

A Change in Scope request may take more than a period of one year to process; however, the Agency anticipates processing change in scope requests within 6 months. For additional information, please contact the Managed Care Operations Division.

NOTE:

New PPS rates due to an approved change in scope will be based on the incremental and/or decremental costs of the qualifying event(s) that meet the definition of a change in scope of service.

Costs Reimbursed by Other Than FQHC Encounter Rate

Costs reimbursed by other Medicaid programs are not reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

- Maternity care
- Prescription drugs by enrolled pharmacy providers
- Surgical procedures performed in place of service 21 (inpatient) or 22 (outpatient) will be reimbursed fee-for-service

Family Planning

- Family planning services are services provided to prevent or delay pregnancy.
- The Plan First visit will be reimbursed at the encounter rate when billed.
- Complete guidelines for family planning are in the Provider Billing Manual, Appendix C.

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services. A patient may have one physical health encounter and one behavioral health (psychologist or clinical social worker) encounter on the same day. If the patient later suffers an illness or injury requiring additional diagnosis or treatment on the same date of service, a separate encounter may be billed.

Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter in addition to one physical health and/or behavioral health encounter on the same day.

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to Medicaid's fiscal agent for payment through the proper filing of claims forms. Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to Medicaid's fiscal agent for payment.

16.3 Prior Authorization and Referral Requirements

FQHC procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the ACHN program, refer to Chapter 40 to determine whether your services require a referral from the Primary Care Physician (PCP).

16.4 Cost Sharing (Copayment)

The copayment amount is **\$3.90** per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an “active user letter” issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible recipient because of the recipient’s inability to pay the cost-sharing (copayment) amount imposed.

16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

16.6 Completing a Claim

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

- Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own NPI on Block 24J of the CMS-1500 claim form. Enter the clinic’s number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

16.6.1 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of services on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

16.6.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Nurse Practitioners/Physician Assistants

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Chapter 21, CRNP and PA Services

Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number. Reimbursable services provided by an RN in an FQHC are restricted to the following:

<i>Procedure Codes</i>	<i>Description</i>
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99381-EP	Periodic EPSDT, normal, under 1 year of age
99382-EP	Periodic EPSDT, normal, 1-4 years of age
99383-EP	Periodic EPSDT, normal, 5-11 years of age
99384-EP	Periodic EPSDT, normal, 12-17 years of age
99385-EP	Periodic EPSDT, normal, 18-20 years of age
99381-EP	Periodic EPSDT, abnormal, under 1 year of age
99382-EP	Periodic EPSDT, abnormal, 1-4 years of age
99383-EP	Periodic EPSDT, abnormal, 5-11 years of age
99384-EP	Periodic EPSDT, abnormal, 12-17 years of age
99385-EP	Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

* Must be approved by the Alabama Medicaid Agency to provide these services.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for additional information.

Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List.

16.6.3 Place of Service Codes

The following place of service codes apply when filing claims for FQHC services:

POS	Description
11	Office
12	Home
15	Mobile Dental Clinic
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities

NOTE:

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

16.6.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials
- When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

16.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N