Assessment of Public Comment

During the public comment period, the Board received approximately 83 comments, including several copies of a form letter and several repeated (or substantially the same) comments from the same individual(s).

At the outset, the Board notes that it plans to update the fee schedules more regularly going forward and will take a more comprehensive look at reimbursement rates in the next editions of the fee schedule as well. It should be noted that this fee schedule update represents the first phase of a multi-phase process that intends to methodically update our fee schedule(s), with expanding areas of focus as we move through all of our fee schedules, until all are appropriately benchmarked and regularly updated.

Acupuncture Fee Schedule

One comment requested that acupuncture services be exempt from the 12-RVU daily limit in the proposal. This limit currently exists in the fee schedule and was not changed with this proposal, so no change has been made in response to this comment.

One commenter stated that they disagreed with the requirement that acupuncture treatment "must now" be pursuant to a referral by a physician. This requirement already exists in the current fee schedule, and the proposal did not add it – it is not new. Therefore, no change has been made in response to this comment.

A handful of comments requested that the medical fee schedules not restrict access to acupuncture modalities, including infrared therapies in combination with acupuncture and adding cupping therapy as an approved treatment. The Medical Treatment Guidelines (MTGs) are quite specific with respect to what acupuncture modalities are recommended and what are not for any given condition – any updates to clinical modalities would need to be raised when an update is made to the MTGs, not the fee schedules, so no change has been made in response to these comments. It should also be reiterated that inclusion of any modality in any of our fee schedules does not inherently imply medical necessity, it simply lists reimbursement rates for those clinical interventions that are included.

One comment suggested removing the RVU direction from the MTGs and adding a General Ground Rule into the Acupuncture Fee Schedule. The Board considered this suggested formatting change but believes it is unnecessary and has not made a change in response to this comment.

Behavioral Health Fee Schedule

Several comments generally disagreed with the detailed documentation requirements for such considerations as medical necessity, comprehensive opinions on causal relationship and other such required communications. Because this proposal is just updating the fee schedule to match

the current practice (with the transition to the CMS-1500 in 2022), and because it reflects best clinical practice, no change has been made in response to these comments.

The Board received several comments disagreeing with the proposed fee structure for psychological, neurological, and neuropsychological testing service and cognitive rehabilitation, stating it would be a reduction of approximately 30-40% in compensation. The Board followed the American Psychological Association's guidance and the RVUs were evaluated using national benchmark data. Some of the comments also expressed the same concern about the behavioral health fee schedule in general. Some of these commenters submitted a letter to the Board's Medical Director's Office (MDO), providing examples purporting to demonstrate this decrease. However, when the MDO reviewed these examples, there was insufficient detail provided to permit an actual analysis. When making reasonable assumptions to fill the information gaps in the examples provided in the comments, it appeared that the examples used an application of the old fee schedule when billing for services that was actually inappropriate and included overbilling – and when reviewing the submitted examples of shortfalls in the proposed updates, these also seemed to be underbilling. The MDO independently investigated some of the codes in question, and while there was a decrease in some of the codes as noted, this decrease is reflective of normative national decreases in the valuation of these services, which was coupled with an increased detail and specificity in reporting as the new national standard with adoption of these new codes. Finally, it should be noted that these codes represent only a small number of codes in the Behavioral Health Fee Schedule, have relatively narrow indications in the Medical Treatment Guidelines, and represent an exceedingly small percentage of all behavioral health billing. For example, in an assessment of nine months of recently collected billing data, one code, 96118, represented only 0.13% of all bills received, and another code, 96101, represented only 0.21% of all bills received. That said, the Board is cognizant of the issue that has been raised, and will continue to research these issues in greater detail as we move to future phases of the fee schedule updates. In the meantime, in response to the comments received, and to avoid any inadvertent reductions to the fee schedule, the Board now proposes that the CPT code set for Behavioral Health (BH) will remain the same as the currently published 2020 Behavioral Health Fee Schedule, using 2018 CPT code sets. However, the BH fee schedule has been refreshed to reflect current WCB regulations, and also to provide clarifications of existing ground rules.

As addressed generally at the outset of this assessment, the Board does intend for this proposal to be the first in a series of updates to the fee schedules, and plans to look at the Behavioral Health Fee Schedule (and all the fee schedules) for updates.

One of the above commenters also disagreed with the removal of a 20% enhancement for psychological services fees. The 20% enhancement was not removed from non-physician providers and never applied to neuropsychological testing. Another comment questioned the 20% enhanced reimbursement limited to specific codes with Modifier 1B and requested clarification of the codes to which the modifier applies. Another similar comment requested clarification about this as well. This change is just updating the fee schedule to reflect current guidance and practice, so no change has been made in response to this comment, but the Board

will issue additional guidance, including a list of codes to which Modifier 1B can be applied, in order to provide greater clarity.

One comment expressed concern about the "proposed 11-hour cap on neuropsychological testing services." This cap is not new and was not changed in this proposal, so no change has been made in response to this comment.

The Board received some comments requesting changes to the conversion factors and general fees due to inflation with several specific recommendations. The fees are benchmarked against national workers' compensation data and statewide private health insurance data, and the fees match those benchmarks, so no change has been made in response to this comment, but the Board also notes that this is the first of several intended updates to the fee schedule and plans to address other areas of the fee schedule in future proposals where fees are lagging behind and looking holistically at the fee structures.

One comment expressed concern about Ground Rule language requiring some cognitive testing to be done face to face and opining that this was inconsistent with the telehealth regulation. The testing codes are not included in the telehealth regulation, so this is not an accurate understanding of the proposal and/or telehealth regulation, and therefore no change has been made in response to this comment.

One comment opined that neuropsychological assessment is cost-effective and limited reimbursement may reduce availability of these evaluations. The Board notes that nothing in the MTGs or fee schedules is designed to dissuade neuropsychological testing, but the fee schedules are meant to provide a framework for getting an accurate picture of the actual clinical intervention provided so it can be billed accordingly, so no change has been made in response to this comment.

Two comments disagreed with language about cognitive testing, opining that it was too restrictive. The updates to the fee schedule reflect the current MTGs, including the Traumatic Brain Injury MTGs, but because the Board has retained the 2018 code sets existing in the current version of the Behavioral Health Fee Schedule for this edition, the cognitive testing rules have been reverted back to the existing 2020 fee schedule.

One comment disagreed with this proposal not changing psychotherapy compensation generally. As discussed in this assessment of public comment, the Board does plan to do a more holistic update to the fee schedules in the near term as well as more regular updates going forward. The Board invites detailed feedback and suggestions as well. For this proposal, immediate concerns are addressed and no change has been made in response to this comment.

The Board received a handful of comments expressing concern about CPT codes 97129 and 97130, indicating that the fee amount is too low. Please see our prior response about the Board's decision to keep the Behavioral Health codes static while we research these issues in greater detail.

<u>Chiropractic Fee Schedule</u>

Several comments requested that a "cost of living adjustment" be added to the conversion factors, many of the comments citing inflation starting with the COVID-19 pandemic as a reason. The Board looked at national and state data in arriving at this proposal, but as stated throughout this assessment, the Board plans to have more frequent updates and notes that updates to RVU and conversion factor methodologies are an avenue that will be explored for future versions once the most immediate needs are addressed with this proposal. Therefore, no change has been made to this proposal in response to these comments.

The Board received a handful of comments disagreeing with the "proposed change" to the definition of new versus established patients. This rule was not changed with this proposal and uses standard language that has been in place for years, so no change has been made in response to this comment.

One comment requested an increase in maximum RVUs for E/M that include treatment. The workers' compensation fee schedules are already more lenient than private insurance (where you would not be able to bill for the office visit), and this would be a departure from the industry standard, so no change has been made in response to this comment.

One comment requested that the fee schedule change "0" for reimbursement for miscellaneous, unlisted, unspecified, or not otherwise specified codes to "BR" for by report. The Board intentionally listed these as zero because it better reflects the application of these services in practice. Moreover, the BR code would infuse unnecessary uncertainty in the billing process. No specific data to drive such changes was provided in the comments. No change has been made in response to this comment.

This comment also requested modification of Ground Rule 10 of the Chiropractic Fee Schedule to allow use of CPT codes approved via the prior authorization request (PAR) process. Ground Rule 10 indicates that chiropractors can only bill using the Chiropractic Fee Schedule. This is intentional. Chiropractors, as with any discipline, must treat within their scope of practice, which is generally reflected in the respective fee schedules. No change has been made in response to this comment.

One comment requested the incorporation of CPT codes 99213 and 99214 into the Chiropractic Fee Schedule. These codes are for longer visits and the Board believes changes of this nature would be better addressed in updates to the relevant MTGs, and no supporting data was provided to advocate for this change over the current proposal, so no change has been made in response to this comment. The Board will consider this in future editions of the fee schedule, especially if supporting data is provided.

One comment had specific suggestions for adoption of proposed E/M conversion factors at a 25% discount consistent with the difference in professional practice expense (Region I and II: 11.95; Regions III and IV: 12.05). The Board has not made a change to this proposal in response to this comment because additional data and benchmarking is needed. The Board notes that it does plan to do a more comprehensive and holistic update to the fee schedule in the near future.

Two comments requested that the Board consider adding code S9090 (non-surgical spinal decompression). The medical fee schedules do not use S codes, so no change has been made in response to this comment. The comment also requested the addition of codes 97037 and 76499, but these codes are included in the medical fee schedule and not the chiropractic fee schedule and that is intentional, so no change has been made in response to this comment. The comment also requested the addition of code 0101T (extracorporeal shockwave therapy), but the Board did not address this code at this time, as there are presently no recommendations for this service in the MTGs that fall under conditions typically treated by chiropractors, and moreover, codes ending in T are experimental and generally not included in the fee schedules. These modalities may be looked at in greater detail with updates to the medical treatment guidelines, but no change has been made in this proposal in response to these comments.

Two comments pointed out that code 95999 was changed from 0 RVU to BR. This was a typographical error in the proposal – the Board did not intend to change this and has changed this code back to 0 as it exists in the current fee schedule.

A couple of comments echoed the comments on the behavioral health fee schedule that generally disagreed with the requirements for detailed documentation about such items as medical necessity and comprehensive opinions on causal relationship, to name just a few. As explained with those comments, this proposal is just updating the fee schedule to reflect current practice. No change has been made in response to this comment.

One comment requested that the wording requiring chiropractors to bill using only their own fee schedule be added to all the sections like it appears in Ground Rule 10. Every fee schedule already contains ground rules noting that providers may only use CPT codes contained in their own fee schedule, but the Board has added clarifying language to specifically refer to the fee schedule in those ground rules.

One comment requested that language be added indicating that the codes/services are specific for workers' compensation patients only (and the Board received a general fee schedule comment about this as well in reference to E&M codes 99455 and 99456). Because, by definition, the codes are for workers' compensation patients and this proposal is updating the workers' compensation medical fee schedules, no change has been made in response to this comment.

One comment disagreed with the removal of Manipulation Under Anesthesia from the chiropractic fee schedule while leaving it in the medical fee schedule. This is not recommended by the Medical Treatment Guidelines (and the Board did not change this with this proposal, i.e. this is not new to the fee schedule) so no change has been made in response to this comment.

<u>General or Unspecified</u>

The Board received a comment expressing strong support for the fee schedule updates in general.

Several comments, like the ones on the chiropractic fee schedule, requested that a "cost of living adjustment" be added to the conversion factors, many of the comments citing inflation starting

with the COVID-19 pandemic as a reason. The Board looked at national and state data in arriving at this proposal and is proposing not to make any such changes at this time, but as stated throughout this assessment, the Board plans to have more frequent updates and notes that updates to RVU and conversion factor methodologies are an avenue that will be explored for future versions once the most immediate needs are addressed with this proposal. Therefore, no change has been made to this proposal in response to these comments.

One comment requested an increase of three percent to the reimbursement rate for physical therapists. For the same reasons above, no change has been made in response to this comment.

The Board received a handful of comments, like the ones on the chiropractic fee schedule, disagreeing with the "proposed change" to the definition of new versus established patients. One comment specified that they believed initial evaluations should be reimbursed as code 97161. This rule was not changed with this proposal and uses standard language that has been in place for years, so no change has been made in response to these comments.

The Board received comments from two individuals (including several from the same individual) disagreeing with the proposal limiting the ability to perform Osteopathic Manipulative Treatment (OMT) exclusively to licensed osteopathic physicians (DOs). The rule in the existing fee schedule was vague, and the Board updated the language to make this limitation clear. The Board would consider changing this in future editions of the Medical Fee Schedules if presented with additional information about scope of practice and data to support this change, but has made no change at this time.

The Board received several comments from one individual on billing for facility bills for ambulatory surgery centers vs. doctors providing care in their office. While the Board appreciates this analysis and believes it raises some points that should be considered as a whole, these comments are more systemic changes and not directly related to the fee schedule, so no change has been made to this proposal in response to these comments.

One comment expressed concern about the inclusion of CPT code 76942, stating it is no longer active. This proposal would adopt the 2024 AMA code sets (not 2026) which contains the code, so no change has been made in response to this comment.

One comment requested the Board increase the RVU cap from 12 to 16 and one other comment requested an increase generally, disagreeing with the existing (and unchanged) shared cap. The Board changed the RVU cap in the last update to the fee schedules. The Board considered this suggestion, but determined that no such increase is clinically necessary at this time, and therefore did not change this cap at this time. The Board can reconsider this issue in future phases of fee schedule updates.

One comment requested the Board consider amending its requirement for physicians to complete MG-2 forms. This is a PAR question and unrelated to the fee schedule, so no change has been made in response to this comment.

One comment from an association expressed concern over the proposed changes because they opine that the proposed increases will increase costs in the No-Fault auto industry due to No-Fault utilizing the workers' compensation fee schedule. The Board does not have jurisdiction over No-Fault and therefore may not make statements as to the applicability of any of its rules to the No-Fault system. Any questions about the fee schedules' applicability to the No-Fault system should be directed to the NYS Department of Financial Services, and no change has been made in response to this comment.

One comment expressed concern about the rules around electronic billing allowing providers to offset the cost of using an electronic submission partner up to one dollar and requested amendments to the rule for clarity. The Board believes that CPT code 99080 and the rule is clear as written and issued a GovDelivery laying out guidance about this several months ago, which can be seen here: https://content.govdelivery.com/accounts/NYWCB/bulletins/3e71236 Therefore, no change has been made in response to this comment.

One comment opined that CPT code 95941 should not be a BR code. The Board plans to propose regulations addressing this topic, but no change has been made to this proposal in response to this comment, as it requires change to other regulations.

One comment requested an increase to reimbursement to address future inflation, opining that it will likely be several years before the next update. The Board plans to update the fee schedules more regularly and does plan to take a broader look at reimbursement rates and methodologies, etc. as detailed elsewhere in this assessment once immediate concerns are addressed with this proposal, so no change has been made in response to this comment with this proposal.

One comment requested that the Board publish the fee schedule on their website. The Board plans to continue to explore updating contracts and publishing formats for the fee schedules in the future, but has made no change in response to this comment for this proposal.

One comment requested that physical therapists be involved in the process of requesting approval for visits and the appropriate frequency of treatment. Because this suggestion is not solely within the scope of the fee schedule and implicates other regulations and the PAR process, no change has been made at this time in response to this comment.

Several comments requested that the Board reconsider the proposed conversion-factor methodology as applied to 0101T (shockwave therapy) and establish a reimbursement rate that preserves patient access to this "effective non-surgical treatment" per the commenters. Non-surgical treatment is not assigned a surgery conversion factor – there are other codes for when this is done surgically with anesthesia - but non-surgical treatment is given a medicine conversion factor that can be billed. The use of that modality and code are also addressed in the MTGs, and the Board believes the reimbursement rate is appropriate, so no change has been made in response to these comments.

One comment highlighted that several new CPT codes have been recently introduced by AMA that are not present in this proposed update to the medical fee schedule. Because this version of the fee schedule is being updated to the 2024 code sets and these cited codes were 2025 CPT

codes, no change has been made in response to this comment for this proposal, but the Board notes that it plans regular updates going forward and plans to continue updating the code sets as it does so.

One comment opined that NYS has the second lowest fee schedule in the United States and requested a holistic update to the fee schedules. The Board believes that this assertion is not accurate, as national benchmarking data was used in arriving at this proposal. The Board has not made a change in response to this comment, but does also note that it plans to regularly update the fee schedules going forward.

One comment requested clarification about why the Board did not include CPT code 99439 in this proposal. This was a new code since the last update to the fee schedule and there were 39 codes of this type the Board did not incorporate because they refer to extra staff time – but the Board did incorporate the one of this type reflecting additional time for physicians, as they are an authorized provider type who would be billing using the fee schedule. No change has been made in response to this comment.

The Board received a general comment requesting clarification about whether providers could bill outside their fee schedule. Because this has always been a rule (that providers must bill within their own fee schedule) and this proposal did not change that requirement, no change has been made in response to this comment.

One comment requested clarification about surgery modifier codes in chapter 4 of the medical fee schedule and addition of language about pricing for these modifiers specifically, and another comment had similar concerns. Because many of these codes and modifiers are extremely context-dependent and variable, it does not make sense to include static amounts – for example, a provider may be planning to do one procedure, but circumstances required a lesser procedure be done instead. Therefore, flexibility and non-fixed pricing were intentional to ensure accurate billing, so no change was made in response to these comments.

The same commenter requested that CPT code 99024 be changed from BR to 0 for reimbursement because normal postoperative care is included with all services assigned follow-up days. While it is true that providers may not bill for a follow-up visit within certain prescribed days following some procedures, there are some circumstances that could warrant being paid for a visit. Therefore, leaving this code as BR allows for those narrow circumstances to be paid and no change has been made in response to this comment.

One comment requested clarification about the effective date of the medical fee schedules because the draft has a January 1, 2026, date in some places. The January 1, 2026, date was just a placeholder and the proposal will be updated with the actual effective date.

One comment opined that the Board should continue to follow Medicare's RBRVS approach "as it did in 2019." Because the Board did not adopt Medicare's RBRVS approach in 2019, no change has been made in response to this comment but the Board notes that it is planning more regular updates and more holistic updates in the future and will continue to look at that model and national benchmarking data, etc. in future editions of the fee schedules.

The Board received two comments requesting clarification about what the appropriate action is when a valid CPT code is billed that does not appear in the medical fee schedule. The billing guidance has always been to bill the correct CPT code, and if it does not appear in the medical fee schedule it does not get reimbursed, and an HP-1 containing an incorrect billing code would be rejected. No change has been made in response to these comments.

One comment requested the Board to accept national modifier AS (non-physician assistant at surgery). This was not a change with this proposal. Modifiers 83 and 84 have specific guidelines per NYS WCB regulations and do not follow CPT definitions for modifier AS, so no change has been made in response to this comment.

The same comment requested clarification about pricing rules for QX/QK/QY scenarios. The Board added modifiers in this proposal to use for clarification for billing CRNA services and added specific language about 80% of the anesthesiologist rate for clarification, so no change has been made in response to this comment.

The comment also requested clarification about whether narrative reporting is a global expectation, and another comment opined that the proposed changes would "substantially alter how claims are submitted and reviewed." Because this proposal is just updating the fee schedule to match the current practice (with the transition to the CMS-1500 in 2022), no change has been made in response to these comments.

The comment also requested inclusion of the Modifier number for co-surgeons in 12D. Because the actual definition of co-surgery is two different surgeons (who would not be sharing codes in this scenario), there would be no modifier to use. The Ground Rules are detailed and contain examples, so no change has been made in response to this comment.

One comment requested clarification and guidance about the use of modifiers under CPT 2024. Because the Board adopted the actual CPT language into the proposal (and the codes have definitions, etc.) the Board has not made a change in response to this comment.

One comment requested clarification about reimbursement for codes not in that provider's fee schedule. Because the requirement has always been that providers use codes only in their fee schedule(s), no change has been made in response to this comment – this proposal did not change that requirement.

One comment expressed strong support for the proposal with regard to CPT codes 99202-99215.

One comment opined that the proposed changes to the fee schedule would "dramatically increase costs well beyond the 2-3 percent system-wide impact originally projected" and specified several CPT codes of concern, including 99202, 99203, 99004, 99205, 99211, 99213, 99214, and 99215. The Board used national benchmarking data to arrive at the numbers in the proposal and the codes listed represent only a fraction of the codes used for overall billing for healthcare services. The Board also notes that billing for healthcare services is also a fraction of costs to the workers'

compensation system overall, so believes the estimate originally projected is accurate. These specific codes were also a top priority of the Board to increase because they were lagging far behind and needed immediate attention. No change has been made in response to this comment.

The same comment asserted that the Board should formalize telehealth in the fee schedule rather than through website guidance and disagreed with this approach. The Board notes that there is in fact a regulation regarding telehealth and that the rules are codified in that regulation, (12 NYCRR 3256-1.26), not solely via website guidance, and that regulation (which was adopted in 2023) is not part of this proposal, so no change has been made in response to this comment.

This comment also requested that the Board revise guidance about CPT 99358 because no-fault decisions are less consistent than workers' compensation decisions and it is an issue in the no-fault system. The Board does not have jurisdiction over No-Fault and therefore will not make statements as to the applicability of any of its rules to the No-Fault system. Any questions about the fee schedules' applicability to the No-Fault system should be directed to the NYS Department of Financial Services, and no change has been made in response to this comment.

One comment requested clarification about whether an anesthesiologist and a CRNA may both bill for the same anesthesia service. Because CRNAs cannot bill independently and their services must be billed through the supervising anesthesiologist, no change has been made in response to this comment.

The comment also disagreed with the expansion of services designated as BR, citing uncertainty in how the procedures will be billed and reimbursed, including CPT codes 97037, 0552T, and 0770T, as well as CPT code 95940. Codes 0552T and 0770T are experimental and not typically used. The Board also notes that "BR" codes would go through the PAR process which would mitigate much of the uncertainty about reimbursement. Code 95940 deals with remote intraoperative monitoring, and the Board plans to issue a separate regulatory proposal specific to this topic. No change has been made in response to this comment.

The Board received one comment from an otolaryngologist who sees patients with noise induced hearing loss who highlighted that their fee has not increased for many years. The Board notes that these codes changed in 2026, but this proposal only updates to the 2024 code sets. When the Board updates the code sets reimbursement for this treatment will increase. The Board will also make note to specifically look at these codes in the planned updates going forward as well, but no change has been made with this version because it updates to 2024.

One comment requested clarification about how Ground Rule 3 affects the billing of HCPCS codes that do not appear in the fee schedule. The Board notes that Ground Rule 19 explains which provider types can use which fee schedules and therefore no change has been made in response to this comment.

One comment requested the addition of language stating that the RVU total is per patient per day from all providers combined in Ground Rule 11. The Board notes that this language already exists and is consistent in all applicable fee schedule sections in a note that states: "When a patient receives physical medicine procedures, acupuncture, and/or chiropractic modalities from

more than one provider, the patient may not receive more than 12.0 RVUs per day per case number from all providers combined… .” Therefore, no change has been made in response to this comment.

One comment disagreed with the inclusion of Ground Rule 7 regarding radiology, stating it is too restrictive and should be deleted. This language was not new and was not changed with this proposal. It refers to a radiologist consult and the express language states that “they shall evaluate the patient’s problem” and does not explicitly require an in-person examination, so no change has been made in response to this comment.

One comment requested at least six months from the publication of this proposal’s adoption to making the updates effective. The Board anticipates, barring any further revisions based on public comment received, to adopt this proposal sometime before the end of the year with an effective date of July 2027. The Board believes this will allow sufficient time for stakeholders to make any required changes based on the amendments to the fee schedules and alleviate concerns about preparing for the updates.

One comment requested clarification about why “Current” CPT/AMA codes and references use a 2023 date if these updates correspond to the 2024 CPT code set. The copyright date for CPT codes is always the year prior to the effective year, as the codes are published in the fall of the year preceding when they take effect (so, for example 2023 means the 2024 codes), so no change has been made in response to this comment.

The fee schedules contain language about the procedures and fee structure for deposition testimony. Because the fees and procedures for deposition testimony are contained elsewhere in the regulations, and to avoid conflict with those regulations, the Board has removed the text about depositions and instead kept only the reference to the relevant regulation to ensure that the fee schedules do not become out of sync with the regulations about depositions.

Changes made:

- Edited text to reflect revised proposal date
- Change CPT code 95999 from “BR” back to “0” as this was not an intended change (see page 25 of the Chiropractic Fee Schedule)
- Clarifying language added to ground rules specifying provider types throughout the fee schedules
- Updating effective date throughout the fee schedules (placeholder of “TBD” for now) –
- Deposition language throughout fee schedules changed to become evergreen (referencing the regulation where deposition fees and processes are contained) – (see page 9 of the Chiropractic Fee Schedule, page 10 of the Podiatry Fee Schedule, page 9 of the Behavioral Health Fee Schedule, page 12 of the Medical Fee Schedule)
- Reverting the Behavioral Health fee schedule to the current existing fee schedule (removing proposed changes from the first proposal), see pages 7-10, 12, 14-16, 17-18