Director's Interpretations of Issues Impacting the Colorado Workers' Compensation System

In an effort to provide guidance on the practical applications of the Colorado Workers' Compensation Act, we are publishing Director's interpretations of statutes and other factors affecting the system, in the form of *Interpretive Bulletins*. The purpose is to provide greater levels of consistency and predictability as to how the Colorado system is intended to operate. While the opinions do not have the force and effect of rule, they are offered as navigational tools to clarify and simplify processes, create efficiencies and to reduce litigation.

If you have questions regarding this information or issues you would like to see addressed in future bulletins, please direct your inquiries to Paul Tauriello, Director of the Division of Workers' Compensation, at 633 17th St., Suite 400, Denver, CO 80202-3660, fax 303.318.8632, or e-mail at paul.tauriello@state.co.us.

Colorado Workers' Compensation Fee Schedule Implementation Data (CWCFSID) Rule 18 Medical Fee Schedule, Effective January 1, 2014.

Release Date: 09/16/2013
Revision Date: 08/27/2013

For medical services rendered after January 1, 2014, Rule 18 makes a number of references to medical procedures. This interpretive bulletin identifies *Current Procedural Terminology* (CPT®) codes for many of those procedures and identifies the citations within Rule 18 where these CPT® codes logically fit into that language. There are a few instances of *Relative Values for Physicians* (RVP©*)* with no assigned relative value units (RVU) where the Division believes it would be appropriate to provide reasonable values. These codes are referenced in the paragraphs below under their respective sections of the RVP©*.* The full text of Rule 18 can be found on the Division's webpage under "Rules of Procedure."

The five character codes included in the CWCFSID are obtained from CPT®, copyright 2012 by the American Medical Association (AMA). CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

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Rule 16, effective January 1, 2014

To receive an NPI number, providers can go to https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart (accessed September 20, 2013).

Rule 18, effective January 1, 2014

In some instances of high frequency services, the 2013 RVP© has not established RVUs. In other cases, RVP© RVUs have not been adopted. The Division considers the following RVU values to be appropriate:

Table 1

CPT® / Code	DOWC Revised Relative Value Unit	Identifier
62273	1.9	Epidural of blood or clot patch injection
62310	2.0	Epidural or subarachnoid injection of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), NOT neurolytic substances, including needle or catheter placement and contrast for localization when performed, cervical or thoracic level
62311	1.65	Epidural or subarachnoid injection of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), NOT neurolytic substances, including needle or catheter placement and contrast for localization when performed, Lumbar or sacral (caudal)
62318	1.85	Injection, including indwelling catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast for either localization of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, other solution); epidural or subarachnoid cervical or thoracic
62319	1.77	Injection, including indwelling catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, other solution); epidural or subarachnoid lumbar or sacral caudal)
64405	1.5	Somatic nerve injections, greater occipital nerve
64412	1.5	Somatic nerve injections, spinal accessory
64416	1.0	Injection brachial plexus, continuous infusion by catheter (including catheter placement)
64421	1.7	Injection intercostal nerve) multiple regional block
64446	1.3	Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter (including catheter placement)
64447	1.5	Injection anesthetic agent, femoral nerve, single

CPT® / Code	DOWC Revised Relative Value Unit	Identifier
64448	1.2	Injection, femoral nerve, continuous infusion by catheter (including catheter placement)
64449	2.0	Injection, anesthetic agent; lumbar plexus posterior approach, continuous infusion by catheter (including catheter placement)
64450	1.25	Injection, anesthetic agent, other peripheral nerve or branches
64490	2.0	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	1.25	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure) an add-on code
64492	1.10	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any addition level(s) (List separately in addition to code for primary procedure) an add-on code
64493	1.75	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	1.0	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure) an add-on code
64495	1.0	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any addition level(s) (List separately in addition to code for primary procedure) an add-on code
64517	1.3	Injection, anesthetic agent, superior hypogastric plexus
64520	2.0	Injection, anesthetic agent, lumbar or thoracic (paravertebral sympathetic)
64605	5.5	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital., mental or inferior alveolar branch
64620	3.0	Destruction by neurolytic agent, intercostal nerve
64630	3.0	Destruction by neurolytic agent; pudendal nerve
64633	4.4	Destruction by neurolytic agent, paravertebral facet joint nerve(s), w imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet
64634	2.0	Destruction by neurolytic agent, paravertebral facet joint nerve(s), w imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List in addition to code for primary procedure)
64635	4.2	Destruction by neurolytic agent, paravertebral facet joint nerve(s), w imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet
64636	1.8	Destruction by neurolytic agent, paravertebral facet joint nerve(s), w imaging guidance (fluoroscopy or CT); lumbar or sacral, each

CPT® / Code	DOWC Revised Relative Value Unit	Identifier
		additional facet joint (List separately in addition to code for primary procedure)
64640	1.6	Destruction by neurolytic agent; other peripheral nerve or branch
64680	2.9	Destruction by neurolytic agent, celiac plexus, with or without imaging
97113	5.0	Aquatic therapy with therapeutic exercise
99053	4	Medicine: Service between 10:00 PM and 8:00 AM, 24-hr facility
99100	1	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines, cf. Rule 18-5(D)(1)(b)
99116	5	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines, cf. Rule 18-5(D)(1)(b)
99135	5	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines, cf. Rule 18-5(D)(1)(b)
99140	2	Anesthesia Qualifying Circumstance, cf. RVP© Anesthesia Guidelines, cf. Rule 18-5(D)(1)(b)
99183	24	Medicine: Hyperbaric Oxygen Therapy Services
99455	0	For Impairment rating max fee by authorized treating Level II physician. Do not use 99455. Use DoWC Z0759
99456	0	For Impairment rating max fee by authorized treating Level II physician. Do not use 99456. Use DoWC Z0760

Table 2

HCPCS Level II Codes

Ground Ambulance	Urban Medicare*250%	Rural Medicare*250%	Super Rural Medicare*250%	Description
A0425	$17.72	$17.90	No change	Ground mileage, per statue mile
A0426	$663.40	669.90	$821.30	ALS 1-Non-Emergency
A0427	$1,050.38	$1060.68	$1,300.38	ALS 1-Emergency
A0428	$552.83	$558.25	$684.40	BLS
A0429	$884.53	$893.20	$1,095.05	BLS-Emergency
A0432	$967.45	$976.93	No change	PI, Paramedic intercept
A0433	$1,520.23	$1,535.18	$1,882.13	ALS2
A0434	$1796.70	$1,814.30	$2,224.35	SCT
Code		DoWC Recommended Value		Identifier
G0289		RVP© value 11.8 RVUs		Arthroscopy multiple add on
G0378		$45.00/hr observation		Observation Room
G0431		$136.09		Drug screen, qualitative, multiple drug classes by high complexity test method
G0434		$27.22		Drug screen, other than chromatographic any number of drug

			classes
S9088		$75.00	Urgent Care Facility Fee
S9364	$160.00/day	Parenteral Nutrition	<1 Liter
S9365	$174.00/day	Parenteral Nutrition	1 Liter
S9366	$200.00/day	Parenteral Nutrition	1.1-2.0 Liter
S9367	$227.00/day	Parenteral Nutrition	2.1-3.0 Liter
S9368	$254.00/day	Parenteral Nutrition	>3 Liter
S9494	$158.00/day	Antibiotic Therapy	
S9497	$152.00/day	Antibiotic Therapy	once every 3 hours
S9500	$97.00/day	Antibiotic Therapy	every 24 hours
S9501	$110.00/day	Antibiotic Therapy	once every 12 hours
S9502	$122.00/day	Antibiotic Therapy	once every 8 hours
S9503	$134.00/day	Antibiotic Therapy	once every 6 hours
S9504	$146.00/day	Antibiotic Therapy	once every 4 hours
S9329	$0.00/day	Chemotherapy	Administrative Services
S9330	$91.00/day	Chemotherapy	Continuous (24 hrs or more) chemotherapy
S9331	$103.00/day	Chemotherapy	Intermittent (less than 24 hours)
S9341	$44.09/day	Enteral nutrition	Via Gravity
S9342	$24.23/day	Enteral nutrition	Via Pump
S9343	$24.23/day	Enteral nutrition	Via Bolus
S9326	$79.00/day	Pain Management	Continuous (24 hrs. or more) chemotherapy
S9327	$103.00/day	Pain Management	Intermittent (less than 24 hours)
S9328	$116.00/day	Pain Management	Implanted pump
S9373	$61.00/day	Fluid Replacement	<1 Liter
S9374	$85.00/day	Fluid Replacement	1 Liter per day
S9375	$85.00/day	Fluid Replacement	>1 but <2 Liters per day
S9376	$85.00/day	Fluid Replacement	>2 but <3 Liters
S9377	$85.00/day	Fluid Replacement	>3 Liters
S9123	$111.00/hr	Skilled Nursing	RN
S9124	$89.00/hr	Skilled Nursing	LPN
S9122	$25.00/hr	Certified N Asst.	CAN

Rule 18-4

The conversion factors (CF) found in Rule 18-4 are listed here with their applicable code ranges for your convenience. Maximum reimbursement is calculated by multiplying the respective CF by the RVU from the RVP©.

Table 3

RVP©	Code Range	CONVERSION FACTOR
Anesthesia	(CPT® 00100 –01999 and 99100-99140)	$53.20 /RVU
Surgery	(CPT® 10021-69990)	$98.96/RVU

Radiology	(CPT® 70010-79999)	$18.23/RVU
Pathology	(CPT® 80047-89398)	$13.58/RVU
Medicine	(CPT® 90281 - 96999 and 98925 – 99199 and 99500-99607)	$ 7.91/RVU
Physical Medicine	(CPT® 97001-97814)	$ 6.17/RVU
Evaluation & Management	(CPT® 99201 – 99499)	$10.06/RVU

Rule 18-5(D)(1)

Anesthesia add-on codes 99100-99140 found in both the Medicine section and the Anesthesia Guidelines of the RVP©, are reimbursed using the anesthesia CF and the unit values found in the RVP©, Anesthesia Guidelines XII, "Qualifying Circumstances".

Rule 18-5(G)

The Medicine section of the RVP©:

- Home therapy codes 99500-99602 are not adopted.
- Biofeedback training codes are 90901 and 90911.
- Speech therapy codes are 92506, evaluation, 92507-92508, treatment, and 96105-96111 CNS and aphasia evaluation.
- Electro-diagnostic study codes are 95860-959437.
- Osteopathic manipulation codes are 98925-98929.
- Chiropractic manipulation codes are 98940-98943.
- Add-on code for psychiatric procedures with interactive complexity is 90785. CPT© specifies what is required to report this code.
- Psychological diagnostic evaluation procedures are 90791-90792.
- Psychotherapy services are 90832-90838, 90845-90853, and 90875-90876, 90882.
    - NOTE: 90882 is environmental intervention for medical management on a psychiatric patient's behalf with agencies, employers or institutions.
- Crisis psychotherapy procedures are 90839-90840.
- Hyperbaric oxygen therapy service code is 99183.
- Qualified non-physician, healthcare provider telephone services are 98966-98968.

- Qualified non-physician, healthcare provider on-line service is 98969.
- CNS assessments and test procedures are 96101-96125.

Rule 18-5(H)

Physical Medicine and Rehabilitation:

- Medical nutrition therapy codes are 97802-97804 (prior authorization required).
- Procedure codes are 97110-97533 and 97542.
- Unattended, non-timed modality codes are 97010-97028.
- Attended, timed modality codes are 97032-97039.
- Physical therapist evaluation code is 97001 and 97002 is re-evaluation.
- Occupational therapist evaluation code is 97003 and 97004 is re-evaluation.
- Athletic training evaluation code is 97005 and 97006 is re-evaluation.
- Interdisciplinary rehabilitation programs use DoWC Z0500.
- Special Tests
  - Job site evaluation is 97537.
  - Functional capacity evaluation is 97750
  - Computer enhanced evaluation code is DoWC Z0503
  - Work tolerance screening code is DoWC Z0504
  - Assistive technology assessment code is 97755.
- Work conditioning, work hardening, and work simulation codes are 97545 and 97546.
- Orthotic management and training code is 97760.
- Prosthetic training code is 97761.
- Checkout of orthotic/prosthetic devices code is 97762.
- Telephone assessment services are Medicine codes 98966, 98967, 98968
- Non-physician on-line medical evaluation code is Medicine code 98969

Rule 18-5(I)

Evaluation and Management (E&M):

- Office or other outpatient visit codes are 99201-99350.
- Medical team conference physician codes are:
  - With a minimum of three qualified healthcare professionals from different specialties or disciplines that includes the patient/family, bill code 99366.
  - With a minimum of three qualified healthcare professionals from different specialties or disciplines that does not include the patient/family, bill code 99367
- Non-face-to-face telephone or on-line E&M service by a physician, PA or NP to an injured worker or family member is coded under 99441-99444. Criteria for medical/record documentation and CPT© criteria need to be me.
- Face-to-face or telephonic meeting by a treating physician with an employer, claims representative or any attorney to provide a medical opinion on a specific worker's compensation case, with a written report is billed under Rule 18-6(A) and DoWC code Z0701.
- Non-treating physician telephone or on-line service with employer, claims representative or any attorney to provide a medical opinion on a specific worker's compensation case
  - Without a report is coded: Z0601 $65.00/15 minutes;
  - With a report is coded: Z0758 (Special Report) $325.00/hr.

Rule 18-6(F)

Permanent impairment ratings are billed using codes Z0759 (treating physician) and Z0760 (non-treating physician).

Rule 18-6(J) Hospital Out-Patient Facility Fees

All professional services billed by hospitals, such as PT/OT, MD, etc., regardless of the type of hospital (VA, Children's, etc.), are payable according to the applicable section(s) of Rule 18. All maximum hospital outpatient facility fees are determined by Rule 18-6(J).

Most outpatient hospital facility fees, except facilities listed under Rule 18-6(J)(3)(a)&(b), are based upon Medicare's Ambulatory Payment Classification (APC) system as listed in Exhibit #4. To assist in the determination of the appropriate APC Grouper under Rule 18-6(J)(3), a list of CPT® codes and their respective APC Grouper is given in the "Exhibit for Outpatient Surgery Facility Codes and Fees" to this interpretive bulletin. Medicare's Status Indicators (SI) are applicable according to Rule 18-6(J)(5) directives. Only surgical implants are separately payable at the facilities cost, please refer to Rule 18-6(J)(4) for directives on what is "packaged" and not separately payable.

Grouper code 210, found in that exhibit, was created by DOWC to reimburse CPT® spinal fusion codes not listed in Medicare's Addendum B. For CPT® codes not contained in that Exhibit, refer to Medicare's Revised Addendum B (July) 2013. Addendum B can be found on Medicare's Hospital Outpatient Prospective Pay Systems (PPS) website. The address as of September 20, 2013 was:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2013-July-Addendum-B.html?DLPage=1&DLSort=2&DLSortDir=descending

Status indicators S and T with listed values are paid in accordance with Rule 18-6(J)(6)(a).

The link to the APC offset file for implants and biologicals, as of September 20, 2013, was: Link to "Related Links" 2013 OPPS APC Offset File

Rule 18-6(K) Freestanding (Not Affiliated with a Hospital) Outpatient Diagnostic Testing or Treatment Facilities

The types of facilities and their fees include:

- ASC –- 5th column of Exhibit #4 (plus cost of implants only, + observation fees + pre-operative testing) in and applied per hospital Rules under Rule 18-6(J).
- Physician's Offices –- 100% of appropriately modified RVP x the applicable conversion factor
- Freestanding Radiology Imaging and Cardiovascular Testing and procedure Centers (includes arteriograms and arthrography) –- 90% of RVP x applicable conversion factors –- maximum of 4 CPT codes the highest allowed at 100% of maximum fees and 50% the subsequent 3 additional codes.
- Urgent Care –- non hospital $75.00 facility fee if criteria is met in this Rule 18-6(K)
- The maximum fees for all clinical laboratory testing shall be reimbursed according to the fees as outlined under the Pathology section in 18-5(F).

Dyes, contrast and supplies are included and not separately payable for Freestanding Urgent Care, Radiology or Cardiovascular facilities.

All observation services must be prior approved by the payer if time is greater than 3 hours at an Urgent Care Facility or 6 hours if at an ASC -- G0378 at $45.00/hour

Rule 18-6(M)(8)(b)

Pharmacy fees for pharmaceuticals that have no NDC code are appropriately billed as a supply using the *RVP*© supply code 99070 and the documented invoice.

Rule 18-6(O)

Acupuncture service codes are the physical medicine codes 97810-97814.

Rule 18-6(Q)

Ambulance Fee Schedule

Table 4: Division Established Zxxxx Codes and Values

Click here for a link to Excel® spreadsheet of Division established codes and values (Z codes)

Table 4: Division Established Zxxxx Codes (See: Rule 18 for full descriptions)

Cite Rule18	Code	New Rate	RVUs	Time	Description
18-5(E)(2)(d)	Z0200	$865.37			Upper body w/Autonomic Stress Testing
18-5(E)(2)(d)	Z0201	$865.37			Lower Body w/autonomic Stress Testing
18-5(G)(9)	Z0401	$1,007.00			QSART
18-5(H)(4)	Z0500	per diem			Interdisciplinary Team
18-5(H)(6)	Z0501	$33.32	5.4		Single or multiple muscles - dry needling
18-5(H)(6)	Z0502	$35.79	5.8		Three or more muscles - dry needling
18-5(H)(8)	Z0503	$58.62	9.5	per 15 min	Computer Enhanced Evaluation
18-5(H)(8)	Z0504	$58.62	9.5	per 15 min	Work Tolerance Screening
18-6(H)(10)	Z0505	$9.26	1.5	per day	Unattended Treatment fixed fee per day
18-5(I)(6)	Z0601	$65.00		per 15 min	Face-to-face or telephonic meeting
18-6(A)	Z0701	$75.00		per 15 min	Face-to-face or telephone meeting by a treating physician with employer, claims representative or any attorney with a written report
18-6(B)	Z0720	$150 or 1/2 fee			Cancellation fee for injured worker missed appointments that were carrier scheduled is 1/2 usual fee or rate whichever is less
18-6(C)	Z0721	see cite			Copying Fee
18-6(P)	Z0722	negotiated			Interpreter
18-6(E)	Z0723	$0.53			Injured worker maximum mileage rate
18-6(E)	Z0724	See cite			Injured worker – other travel expenses
18-6(D)(2)	Z0730	$325.00		hr.	Prep Time Deposition and Testimony
18-6(D)(3)	Z0731	see cite		hr.	Deposition cancellation 7+
18-6(D)(3)	Z0732	see cite		hr.	Deposition cancellation >5 but <7
18-6(D)(3)	Z0733	see cite		hr.	Deposition cancellation <5
18-6(D)(3)	Z0734	see cite		hr.	Deposition fee per hr
18-6(D)(4)	Z0735	see cite		hr.	Testimony cancellation 7+
18-6(D)(4)	Z0736	see cite 0		hr.	Testimony cancellation >5 but <7
18-6(D)(4)	Z0737	see cite		hr.	Testimony cancellation <5
18-6(D)(4)	Z0738	$450.00		hr.	Testimony Fee $450.00/hr
18-6(G)(2)(e)	Z0750	$42.00			Initial WC 164
18-6(G)(2)(e)	Z0751	$42.00			Progress Report
18-6(G)(2)(e)	Z0752	$42.00			Closing Report
18-6(G)(2)(e)	Z0753	$42.00			Initial and Closing on same report
18-6(G)(3)	Z0754	$42.00			Completion addt'l forms
18-6(G)(4)	Z0755	$325.00		hr.	Special Report - Written Report only
18-6(G)(4)	Z0756	$325.00		hr.	Special Report - IME/Report W Patient Exam
18-6(G)(4)	Z0757	$325.00		hr.	Special Report - Lengthy Form Completion
18-6(G)(4)	Z0758	$325.00		hr.	18-5(I)(7) Meeting & Report with Non-treating Physician
18-6(F)(4)(b)(1)	Z0759	$355.00			Impairment Rating Treating Physician

Cite Rule18	Code	New Rate	RVUs	Time	Description
18-6(F)(4)(b)(2)	Z0760	$575.00			Impairment Rating Referral
18-6(G)(4)	Z0761	see cite		hr.	Special Report - cancellation not requiring patient exam
18-6(G)(4)	Z0762	see cite		hr.	Special Report - IME/Report W Patient Exam Cancellation +7 days
18-6(G)(4)	Z0763	see cite		hr.	Special Report - IME/Report W Patient Exam Cancellation >5 but <7 days
18-6(G)(4)	Z0764	see cite		hr.	Special Report - IME/Report W Patient Exam Cancellation <5 days
18-6(G)(5)(b)	Z0765	$75.00		per 15 min	Opioid Management
18-6(G)(4)	Z0766	$30.00		per exam	CRS 8-43-404 IME Audio Recording
	Z0767	$20.00		per copy	CRS 8-43-404 IME Audio Copying Fee
Rule 11	Z0768	$675.00			DIME Division Independent Medical Exam
Rule 11	Z0769	$100.00			DIME Late Payment adjustment
18-6(L)(4)	Z0772	$0.53		mile	Home Therapy Travel max Mileage rate
18-6(L)(5)	Z0773	$30.00		Hr.	Home therapy maximum travel time rate when time is >1 hr, requires prior agreement
18-6(M)(4)	Z0790	$75.00		Per 30 day supply	Compounded Drugs -- Category I
18-6(M)(4)	Z0791	$150.00		Per 30 day supply	Compounded Drugs -- Category II
18-6(M)(4)	Z0792	$250.00		Per 30 day supply	Compounded Drugs -- Category III
18-6(M)(4)	Z0793	$350.00		Per 30 day supply	Compounded Drugs -- Category IV
18-6(R)(3)(b)(2)	Z0800	$98.72			LAc new patient
18-6(R)(3)(b)(2)	Z0801	$66.64			LAc established patient

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Click here for link the APC crosswalk of Rule 18, Exhibit 4

Colorado Division of Workers' Compensation
Rule 18 Interpretive Bulletin: Exhibit for Outpatient Surgery Facility Codes & Fees
For CPT® codes not contained in this Exhibit, refer to Rule 18-6(J)(3)(c)
Effective January 1, 2014