COLORADO
Department of
Labor and Employment

Filing an Admission of Liability

Welcome!

We are the Colorado DOWC Claims Management Unit

Claims Management – 303-318-8041

Customer Service – 303-318-8700

Claim Timelines

1. Employee reports injury to employer within 4 days.
2. Employer reports the injury to the carrier within 10 days.
3. Carrier / TPA submits a First Report of Injury to DOWC via EDI.
4. Carrier / TPA admits or denies liability within 20 days after submitting the FROI.

Position Statement

"A legal document that states the carrier's position on liability for workers' compensation benefits defined by statute."

- Notice of Contest (NOC)
- General Admission of Liability (GAL)
- Final Admission of Liability (FAL)

All forms can be found at https://cdle.colorado.gov/resources/forms

Emergency Rules due to COVID-19

Eff 3.11.2020, Updated 6.15.2020

Sec 4, (1)

All information submitted to the Division of Workers' Compensation must be submitted via electronic mail.

Only ONE document per email message (i.e. one FA or one GA). Multiple attachments will not be accepted.

cdle_dowc_filings@state.co.us

Emergency Rules due to COVID-19

Eff 3.11.2020, Updated 6.15.2020

Sec 4, (1) (l)

The email subject line must include (in this order):

WC#, Claimant's first name, Claimant's last name, Type of document (FA or GA).

The document must also be named in the same format as the subject line.

cdle_dowc_filings@state.co.us

Filing a

Notice of Contest

Form WC74 Rev 04/08

- **Must be submitted via EDI (Electronic Data Interface)**
- **NOC cannot be mailed, emailed, or faxed**

Filing a

General Admission

Form WC2 Rev 07/14

- **All forms can be found at https://cdle.colorado.gov/resources/forms**
- **Must be submitted via email cdle_dowc_filings@state.co.us**

1 - Average Weekly Wage (AWW)

2 –Benefit History for Indemnity: TTD, TPD

3 - Adjuster Contact Information

4 - Certificate of Service Date and Signature

5 – Carrier Block #, Adjuster Code

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

GENERAL ADMISSION OF LIABILITY

WC # ______
Carrier # ______
Soc. Sec. # ______
Employer ______
Date of Injury ______
Average Weekly Wage ______ ← 1
Date first payment paid TTD ______
Date first payment PPD ______
Date of MMI ______

TO: ______ Claimant's Name
______ Claimant's Address
______
and
DIVISION OF WORKERS' COMPENSATION

YOU ARE HEREBY NOTIFIED that the insurance carrier or self-insured employer (named below) admits that the injury or occupational disease reported herein is compensable. YOU ARE ALSO NOTIFIED that if a child-support obligation is owed, compensation benefits may be attached and payment of the child-support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

Liability is admitted for the following benefits:

See Reverse Side for Codes

Safety Rule Violation ☐
Offset ☐ Attach Calculation
Amount of Interest Paid $ ______
Amount of Penalties Paid $ ______

☐ medical benefits
☐ temporary total disability
☐ temporary partial disability
☐ rehabilitation maintenance benefits
☐ disfigurement
☐ permanent partial disability

☐ Working unit ______ % Disability ______ Age
1. ☐ Schedule Injury ______ % ______ (part of body)
2. ☐ Schedule Injury ______ % ______ (part of body)

Complete the following if admitting for disability

2

Type of Benefit	Time Periods					Rate per Week	Totals
		thru		=	wks	$	$
		thru		=	wks	$	$
		thru		=	wks	$	$
		thru		=	wks	$	$
		thru		=	wks	$	$
		thru		=	wks	$	$
		thru		=	wks	$	$

The above time periods represent inclusive dates.

Remarks: ______

NOTICE TO CLAIMANT: IF YOU DISAGREE WITH THE AMOUNT OR TYPE OF BENEFITS WHICH THE CARRIER HAS AGREED TO PAY, YOU MAY WRITE A LETTER TO THE DIVISION OF WORKERS' COMPENSATION, 633 17th ST., SUITE 400, DENVER, CO 80202-3626, STATING THAT YOU OBJECT TO THIS ADMISSION OF LIABILITY.

3

______ Carrier or Self-Insured
______ Address
______
______ Telephone No.
By: ______ Adjuster or Claims Representative

4

Copies of this admission were mailed this ______ day of ______, ______ to:
☐ Claimant's Attorney ☐ Employer ☐ Division of Workers' Compensation ☐ Respondent's Attorney ☐ Claimant

5

Block #	Adj. Code

WC2 Rev 07/14 PLEASE READ REVERSE SIDE

1.GA

AVERAGE WEEKLY WAGE (AWW)

- The first time you admit for TTD benefits, if an AWW is different/lower from what is listed on the Employer's First Report of Injury (FROI) and/or the Workers' Claim for Compensation, you must **include wages and your computation to support the admitted AWW.**
    - Use the AWW calculation worksheet.

2. GA

BENEFIT HISTORY

Double check all TTD dates and totals to confirm accuracy.

Document termination of temporary benefits (TTD or TPD) pursuant to Rule 6-1(A).

- ❖ If terminating an open period of TTD, all documents supporting termination be included with the admission.
- ✓ *If applying an offset,* the documentation for the offset *and the calculation* must be included with the admission.
- ❖ Once admitted, **DO NOT** omit or reduce the TTD rate without an approved Petition per Rule 6 or documentation supporting the change.
- ❖ Verify that the admitted benefit period corresponds with the lost time dates listed on the Supplemental Report of Return to Work form and that the date of RTW is not estimated for a future date.

Send written documentation of the TPD calculation consistent with the admitted benefit period.

- ❖ Use a TPD worksheet to document the TPD benefits admitted and paid.

3
ADJUSTER INFORMATION

The name, address, telephone number and e-mail address of the administrator(s) responsible for the claims adjusting.

If you sign your name, please also **print** your name near the signature.

4
CERTIFICATE OF SERVICE

Must be the *current* date of filing (even when filing a corrected admission).

5
CARRIER BLOCK #, ADJUSTERS CODE

Cross reference for reports.

“Once you have admitted liability, you cannot file a Notice of Contest (NOC) without an Order.

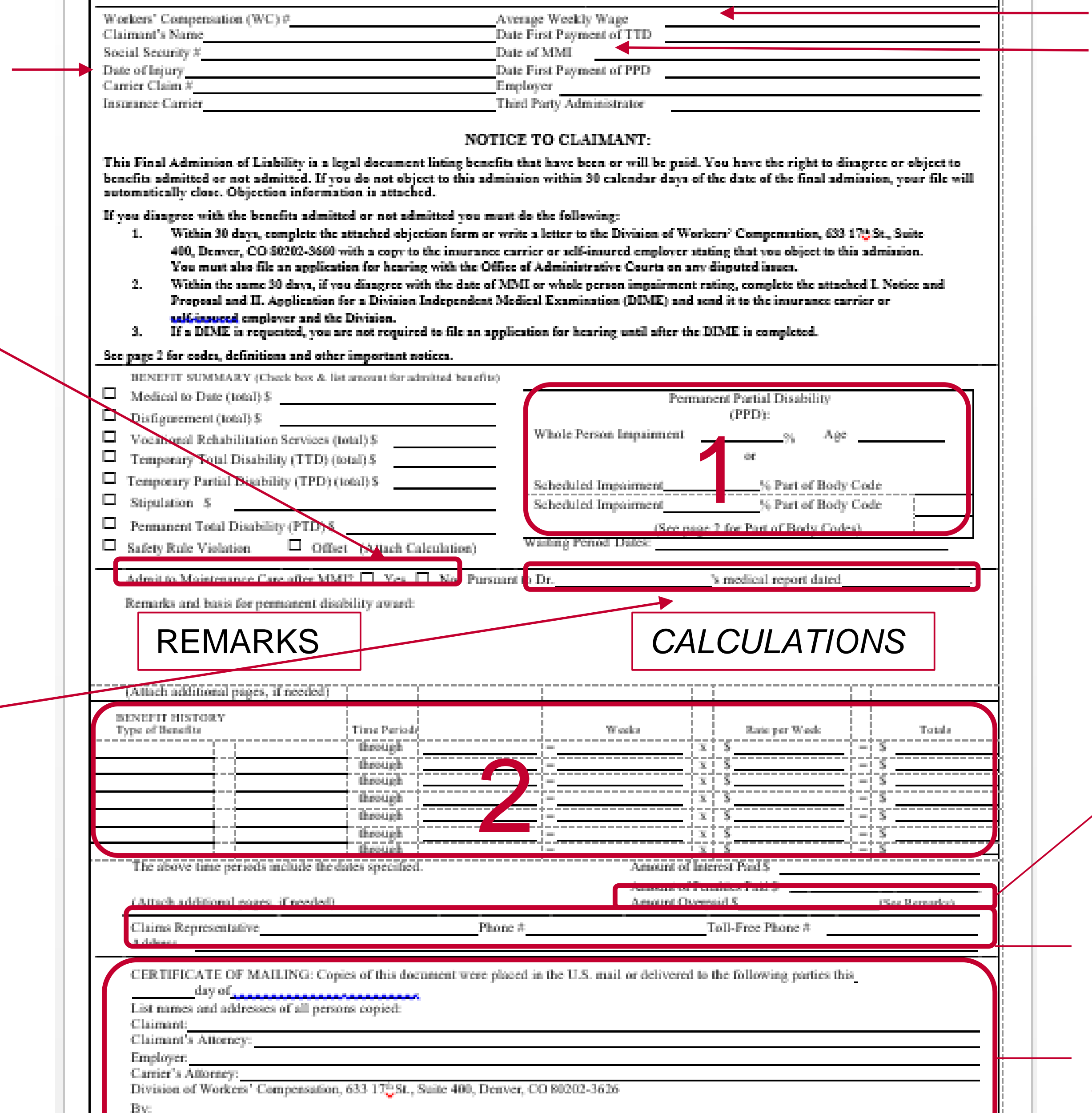
Filing a Final Admission

Form WC4 Rev 03/19

- All forms can be found at https://cdle.colorado.gov/resources/forms
- Must be submitted via email cdle_dowc_filings@state.co.us

The admission shall state the insurer's position on the provision of medical benefits after maximum medical improvement.

The admission shall make specific reference to the medical report by listing the physician's name and the date of the report in the remarks section of the admission.



FINAL ADMISSION OF LIABILITY

Workers' Compensation (WC) # ____ Average Weekly Wage ____
Claimant's Name ____ Date First Payment of TTD ____
Social Security # ____ Date of MMI ____
Date of Injury ____ Date First Payment of PPD ____
Carrier Claim # ____ Employer ____
Insurance Carrier ____ Third Party Administrator ____

NOTICE TO CLAIMANT:

This Final Admission of Liability is a legal document listing benefits that have been or will be paid. You have the right to disagree or object to benefits admitted or not admitted. If you do not object to this admission within 30 calendar days of the date of the final admission, your file will automatically close. Objection information is attached.

If you disagree with the benefits admitted or not admitted you must do the following:

1. **Within 30 days, complete the attached objection form or write a letter to the Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3660 with a copy to the insurance carrier or self-insured employer stating that you object to this admission. You must also file an application for hearing with the Office of Administrative Courts on any disputed issues.**
2. **Within the same 30 days, if you disagree with the date of MMI or whole person impairment rating, complete the attached I. Notice and Proposal and II. Application for a Division Independent Medical Examination (DIME) and send it to the insurance carrier or self-insured employer and the Division.**
3. **If a DIME is requested, you are not required to file an application for hearing until after the DIME is completed.**

See page 2 for codes, definitions and other important notices.

BENEFIT SUMMARY (Check box & list amount for admitted benefits)

☐ Medical to Date (total) $ ____
☐ Disfigurement (total) $ ____
☐ Vocational Rehabilitation Services (total) $ ____
☐ Temporary Total Disability (TTD) (total) $ ____
☐ Temporary Partial Disability (TPD) (total) $ ____
☐ Stipulation $ ____
☐ Permanent Total Disability (PTD) $ ____
☐ Safety Rule Violation ☐ Offset (Attach Calculation)

Permanent Partial Disability (PPD):
Whole Person Impairment ____% Age ____
or
Scheduled Impairment ____% Part of Body Code ____
Scheduled Impairment ____% Part of Body Code ____
(See page 2 for Part of Body Codes)
Waiting Period Dates: ____

Admit to Maintenance Care after MMI? ☐ Yes ☐ No Pursuant to Dr. ____'s medical report dated ____.

Remarks and basis for permanent disability award:

(Attach additional pages, if needed)

BENEFIT HISTORY Type of Benefits	Time Periods		Weeks		Rate per Week		Totals
	through	=		x	$	=	$
	through	=		x	$	=	$
	through	=		x	$	=	$
	through	=		x	$	=	$
	through	=		x	$	=	$
	through	=		x	$	=	$
	through	=		x	$	=	$

The above time periods include the dates specified. Amount of Interest Paid $ ____
Amount of Penalties Paid $ ____
(Attach additional pages, if needed) Amount Overpaid $ ____ (See Remarks)

Claims Representative ____ Phone # ____ Toll-Free Phone # ____
Address ____

CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this ____ day of ____
List names and addresses of all persons copied:
Claimant: ____
Claimant's Attorney: ____
Employer: ____
Carrier's Attorney: ____
Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3626
By: ____
Signature

WC4 Rev 01/17/18 Page 1 of 2 See page 2 for important notices and codes Block # Adj. Code

Rule 5-5 When the Final Admission is predicated upon medical reports; the following shall accompany the admission:

1. The ATP's completed Physician's Report of Workers' Compensation Injury form WC164,
2. The ATP's narrative report and
3. The appropriate worksheets

WC164

1. Date of MMI
2. Post MMI Care
3. Permanent Medical Impairment
4. Authorized treating Physician (ATP) signature or countersignature
5. Date of the Report

NARRATIVE

IMPAIRMENT RATING WORKSHEETS

Clear Form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Physician's Report of Workers' Compensation Injury

A copy of this report must be sent to the injured worker and the insurer.

1. REPORT TYPE ☐ Initial ☐ Progress ☐ Closing EXAM DATE ____________
2. CASE INFORMATION
   Date of Injury____________ Insurer Claim # ____________
   Injured Worker____________ Insurer Name/TPA _ Social Security # Date of Birth
   ____________ Insurer Phone/Fax
   ____________ Employer Name ____________
3. INITIAL VISIT (only)
   a. Injured worker's description of accident/injury
   b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? ☐ Yes ☐ No
4. CURRENT WORK STATUS ☐ Working ☐ Not Working
5. WORK-RELATED MEDICAL DIAGNOSIS(ES) ____________
6. PLAN OF CARE
   a. TREATMENT PLAN
   ☐ Diagnostic tools/tests ____________
   ☐ Procedures ____________
   ☐ Therapy ____________
   ☐ Medications ____________
   ☐ Supplies ____________
   ☐ Other ____________
   b. WORK STATUS
   ☐ Able to return to full duty on ____________
   ☐ Able to return to modified duty from____________ to ____________
   ☐ Unable to work from ____________ to ____________
   ☐ Able to return to part time work on____________ for____________ hours per day
   c. LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions
   ☐ Lifting (maximum weight in pounds)________ lbs. ☐ Walking________ hours per day
   ☐ Repetitive lifting ________ lbs. ☐ Standing________ hours per day
   ☐ Carrying ________ lbs. ☐ Sitting ________ hours per day
   ☐ Pushing / Pulling ________ lbs. ☐ Crawling________ hours per day
   ☐ Pinching / Gripping____________ ☐ Kneeling________ hours per day
   ☐ Reaching over head ☐ Squatting________ hours per day
   ☐ Reaching away from body ☐ Climbing________ hours per day
   ☐ Repetitive Motion Restrictions ____________
   ☐ Other ____________
7. FOLLOW UP CARE AND REFERRALS - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)
   a. ☐ Return Appointment Date ____________
   b. ☐ Referral for ☐ Treatment (specify)____________ ☐ Evaluation (specify) ____________
   ☐ Impairment Rating ____________ ☐ Other (specify) ____________
   Referred Provider's Name____________ Phone # ____________
   c. ☐ Discharged for Non-Compliance* ☐ Discharged from Care for Nonmedical Reasons*
8. MAXIMUM MEDICAL IMPROVEMENT (MMI)
   ☐ Injured Worker has reached MMI Date of MMI ____________ 1
   ☐ Injured Worker is not at MMI, but is anticipated to be at MMI on ____________
   ☐ MMI date unknown at this time because ____________
9. MAINTENANCE CARE AFTER MMI ☐ Yes ☐ No 2
   If yes, specify care:
10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED) 3
    ☐ No permanent impairment ☐ Permanent Impairment (attached required worksheets and narrative)
    ☐ Anticipate permanent impairment ☐ Needs referral to Level II physician for impairment rating (see 7b above)
11. PHYSICIAN'S SIGNATURE____________ Date of Report ____________
    Print Name____________ License #____________ Phone # ____________

4 5

Workers' Compensation Rules of Procedure

https://cdle.colorado.gov/workers-compensation-rules-of-procedure

- The Division carefully reviews every admission for *completeness, accuracy, and supporting documentation*.
- If the information on the admission doesn’t match the FROI, the admission may be rejected.
- If an admission is deficient or fails to follow the rules of procedure, an Error Letter will be issued with a request to refile.

Subsequent Admissions

All subsequent admissions must reflect the same benefit history as the previous admission.

Only benefits that are statutorily owed should be listed in the Benefit History section of the admission.

Every new admission supersedes / replaces the previous and stands on its own.

If you are responding to an error letter, particularly Final Admissions, you should attach all required supporting documents *again*.

All admissions must

Be legible

If admission is illegible or any of its attachments are illegible, it may be rejected or an error letter may be issued.

Include the WC#

If the claim information is not accurate, the Document Entry Unit cannot enter it into our system as a valid admission and it will be returned.

Contain Block #'s and TPA Codes

This information is vital to assure the admission references the correct Insurance Carrier and/or TPA.

Stay Safe

Stay Healthy

We appreciate all of your hard work!

Thank You!

Stephanie Nichols, Claims Manager
(303) 318-8604
stephanie.nichols@state.co.us

Taylor Duran, Claims Manager
(303) 318-8014
taylor.duran@state.co.us

Bert Sandoval, Workers' Compensation Supervisor
(303) 318-8768
bert.sandoval@state.co.us

Workers' Compensation Customer Service 303-318-8700 or 888-390-7936

Visit our website https://cdle.colorado.gov/dwc