TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
Send to the Division Field Office
Handling the Claim

CLAIM # _____

CARRIER'S CLAIM #_____

REQUEST FOR EXTENSION OF MAXIMUM MEDICAL IMPROVEMENT FOR SPINAL SURGERY

Pursuant to Texas Labor Code, Section 408.104 and Rule 126.11, application is hereby made to extend the statutory maximum medical improvement (MMI) date.

1. Employee's Name	2. Employee's Social Security Number
3. Mailing Address (Street or P.O. Box)	4. Date of Injury
City State ZIP	5. Employee's Telephone Number
6. Employer	7. Insurance Carrier's Name

8. Date Spinal Surgery was approved: _____ (month/day/year).

9. Date Spinal Surgery is scheduled to be performed:_____ (month/day/year).

10. I have sent a copy of this form to the ☐ insurance carrier ☐ injured employee ☐ injured employee rep. on _____ (month/day/year), the same day I sent this to DWC. I have complied with Workers' Compensation Rule 126.11(c) and (f) as specified in the instructions on the back of this form.
NOTE: Copies required per Workers' Compensation Rule 126.11(d).

Requestor's Signature_____ Telephone Number (_____)_____
(Employee or Carrier)
Printed Name/Title _____ Date _____

DIVISION ORDER

☐ **APPROVED** - Pursuant to Section 408.104 and Workers' Compensation Rule 126.11 and based on a benefit accrual date of_____, the Division has extended the statutory date of maximum medical improvement an additional _____ weeks. Based on the extension, statutory maximum medical improvement will be reached on: _____.

☐ **DENIED** - For the following reason(s):

- ☐ Date of Injury is prior to January 1, 1998.
- ☐ Request was received prior to 12 weeks before statutory MMI.
- ☐ Request received was more than 110 weeks from date income benefits begin to accrue.
- ☐ The request was not provided to the treating doctor or surgeon prior to submission.
- ☐ Request received date is less than 15 days from date provided to treating doctor/surgeon.
- ☐ Spinal Surgery was not performed or approved between 92-104 weeks from date benefits began to accrue.
- ☐ One extension beyond 104 weeks already approved.
- ☐ MMI in dispute.
- ☐ Injured employee has been certified at MMI.
- ☐ Other _____

Authorized DWC Employee's Signature _____ Telephone (_____)_____

Printed Name and Title _____ Date _____

The injured employee, his/her representative or insurance carrier may dispute the approval, denial or length of the extension by requesting a Benefit Review Conference no later than 10 days after the date this order is received.

INSTRUCTIONS FOR DWC FORM - 57
(Request for Extension of Maximum Medical Improvement for Spinal Surgery)

When an injured employee, injured employee's representative or carrier requests an extension of statutory maximum medical improvement for spinal surgery, he/she should complete DWC FORM-57, Request for Extension of Maximum Medical Improvement for Spinal Surgery, and submit it to the Division Field Office handling the claim.

Requirements of Rule 126.11(c)and (f):

Prior to submission the requestor must request from the treating doctor or surgeon the following information:

(1) typical recovery times for the specific spinal surgery procedure
(2) the projected date and information regarding when the condition will be medically stable
(3) case specific information regarding any extenuating circumstances that may have resulted in variances from conservative treatment protocols and time frames or that may impact recovery times
(4) information from any source regarding intentional or non-intentional delays in securing the surgery or medical treatment
(5) any pending or unresolved disputes regarding the date of maximum medical improvement
(6) information provided by the insurance carrier, injured employee or injured employee's representative (if any) regarding the extension being requested

The request must also be sent to the injured employee, the injured employee's representative and the insurance carrier by first class mail on the same day it is submitted to the treating doctor or surgeon.

The Division will, after reviewing the documentation, approve or deny the request. If approved, the order will state the number of weeks that MMI has been extended and the end date of the extension. If denied, the order will state the reason(s). A copy of the order will be sent to the carrier, the injured employee and the employee's representative, if any.

If the insurance carrier or the employee disagrees with the order, either party may request a Benefit Review Conference. The insurance carrier and the employee's representative, if any, are required to use DWC FORM-45, Request for a Benefit Review Conference. An unrepresented employee may request a conference by contacting the Division in any manner.