PA Federation of Injured Workers

Utilization Review Organization/URO

& Peer Review Organization/PRO

An Injury To One, Is An Injury To ALL

SUBCHAPTER C. MEDICAL TREATMENT REVIEW
UR -- GENERAL REQUIREMENTS

§ 127.401. Purpose/review of medical treatment

(a) Section 306(f.1)(6) of the act (77 P. S. § 531(6)) provides a UR process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.

(b) UR of medical treatment shall be conducted only by those organizations authorized as UROs by the Secretary, under the process in §§ 127.651 -- 127.670 (relating to authorization of UROs and PROs).

(c) UR may be requested by or on behalf of the employer, insurer or employee.

(d) A party, including a health care provider, aggrieved by the UR determination, may file a petition for review of UR, to be heard and decided by a workers' compensation judge.

§ 127.402. Treatment subject to review

Treatment for work-related injuries rendered on and after August 31, 1993, may be subject to review.

§ 127.403. Assignment of cases to UROs by the Bureau

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with this subchapter.

§ 127.404. Prospective, concurrent and retrospective review

(a) UR of treatment may be prospective, concurrent or retrospective, and may be requested by any party eligible to request UR under § 127.401(c) (relating to purpose/review of medical treatment).

(b) If an insurer or employer seeks retrospective review of treatment, the request for UR shall be filed within 30 days of the receipt of the bill and medical report for the treatment at issue. Failure to comply with the 30-day time period shall result in a waiver of retrospective review. If the insurer is contesting liability for the underlying claim, the 30 days in which to request retrospective UR is tolled pending an acceptance or determination of liability.

(c) If an employee files a request for UR of treatment, the Bureau will confirm whether the insurer is liable for the underlying alleged work injury. The Bureau will process the UR request only when workers' compensation liability for the underlying injury has been accepted or determined.

(d) If an employee files a request for UR of prospective treatment which satisfies the requirements of subsection (c), the Bureau will determine whether the insurer is denying payment for the treatment.

(1) The Bureau will send a copy of the employee's request for UR to the insurer, together with a written notice asking the insurer whether it will accept payment for the treatment or is denying payment for the treatment. The insurer shall respond in writing to the Bureau's written notice within 7 days of receipt of the notice.

(2) If the insurer responds that it is willing to accept payment for the treatment, the Bureau will not process the employee's request for UR. After the treatment at issue has been provided, the insurer may not request, and the Bureau will not process, a retrospective UR on the same treatment. The insurer shall pay for the treatment as if there had been an uncontested UR determination finding the treatment to be reasonable or necessary.

(3) If the insurer is denying payment for the treatment, the insurer shall state the reasons for the denial in its written response. If no reasons are stated for the denial, or if the insurer's written response to the Bureau notice is untimely, the insurer shall pay for the cost of the UR and pay for treatment found to be reasonable or necessary by an uncontested UR determination.

(4) If the insurer responds in writing to the Bureau's notice by denying a causal relationship between the work-related injury and the treatment, the Bureau will not process the employee's UR request until the underlying liability is either accepted by the insurer or determined by a Workers' Compensation judge.

§ 127.405. UR of medical treatment in medical only cases

(a) In medical only cases, when an insurer is paying for an injured worker's medical treatment but has not either filed documents with the Bureau admitting liability for a work-related injury nor has there been a determination to the effect, the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for UR.
(b) If the insurer files a request for UR in a medical only case, the insurer is responsible for paying for the costs of the UR.
(c) If the insurer files a request for UR in a medical only case, then the insurer shall be liable to pay for treatment found to be reasonable or necessary by an uncontested UR determination.

§ 127.406. Scope of review of UROs
(a) UROs shall decide only the reasonableness or necessity of the treatment under review.
(b) UROs may not decide any of the following issues:
(1) The causal relationship between the treatment under review and the employe's work-related injury.
(2) Whether the employe is still disabled.
(3) Whether "maximum medical improvement" has been obtained.
(4) Whether the provider performed the treatment under review as a result of an unlawful self referral.
(5) The reasonableness of the fees charged by the provider.
(6) The appropriateness of the diagnostic or procedural codes used by the provider for billing purposes.
(7) Other issues which do not directly relate to the reasonableness or necessity of the treatment under review.

§ 127.407. Extent of review of medical records
(a) In order to determine the reasonableness or necessity of the treatment under review, UROs shall obtain for review all available records of all treatment rendered by all providers to the employee for the work-related injury. However, the UR determination shall be limited to the treatment that is subject to review by the request.
(b) UROs may not obtain or review medical records of treatment which are not related to the work injury.

UR -- INITIAL REQUEST

§ 127.451. Requests for UR -- who may file
Requests for UR may be filed by an employee, employer or insurer. Health care providers may not file requests for UR.

§ 127.452. Requests for UR -- filing and service
(a) A party seeking UR of treatment rendered under the act shall file the original and 8 copies of a form prescribed by the Bureau as a request for UR. All information required by the form shall be provided. If available, the filing party shall attach authorizations to release medical records of the providers listed on the request.
(b) The request for UR shall be served on all parties and their counsel, if known, and the proof of service on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.
(c) Requests for UR shall be sent to the Bureau at the address listed on the form.
(d) The request for UR shall identify the provider under review. Except as specified in subsection (e), the provider under review shall be the provider who rendered the treatment or service which is the subject of the UR request.
(e) When the treatment or service requested to be reviewed is anesthesia, incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the request for UR shall identify the provider who made the referral, ordered or prescribed the treatment or service as the provider under review.

§ 127.453. Requests for UR -- assignment by the Bureau
(a) The Bureau will randomly assign a properly filed request for UR to an authorized URO.
(b) The Bureau will send a notice of assignment of the request for UR to the URO; the employee; the employer or insurer; the health care provider under review; and the attorneys for the parties, if known.

§ 127.454. Requests for UR – reassignment
(a) If a URO is unable, for any reason, to perform a request for UR assigned to it by the Bureau, the URO shall, within 5 days of receipt of the assignment, return the request for UR to the Bureau for reassignment.
(b) A URO may not directly reassign a request for UR to another URO.
(c) A URO shall return a request for UR assigned to it by the Bureau if the URO has a conflict of interest with the request, as set out in § 127.455 (relating to requests for UR -- conflicts of interest).

§ 127.455. Requests for UR -- conflicts of interest
(a) A URO shall be deemed to have a conflict of interest and shall return a request for UR to the Bureau for reassignment

if one or more of the following exist:
(1) The URO has a previous involvement with the patient or with the provider under review, regarding the same underlying claim.
(2) The URO has performed precertification functions in the same matter.
(3) The URO has provided case management services in the same matter.
(4) The URO has provided vocational rehabilitation services in the same matter.
(5) The URO is owned by or has a contractual arrangement with any party subject to the review.
(b) A URO shall inform the reviewer assigned to perform UR of the reviewer's obligation to notify the URO of any potential or realized conflicts arising under § 127.468 (relating to duties of reviewers -- conflict of interest).

§ 127.456. Requests for UR – withdrawal
(a) A party who wishes to withdraw a request for UR shall notify the Bureau of the withdrawal in writing. The withdrawal notice may not be sent directly to the URO.
(b) The Bureau will promptly notify the URO of the withdrawal.
(c) The insurer or employer shall pay the costs incurred by the URO prior to the withdrawal.
(d) A withdrawal of a request for UR shall be with prejudice.

§ 127.457. Time for requesting medical records
A URO shall request records from the treating providers listed on the request for UR within 5 days from receipt of the Bureau's notice of assignment.

§ 127.458. Obtaining authorization to release medical records
If a request for UR does not have the necessary authorizations to release records attached to it, the URO may contact the providers or insurer to obtain the necessary authorizations.

§ 127.459. Obtaining medical records -- provider under review
(a) A URO shall request records from the provider under review in writing. The written request for records shall be by certified mail, return receipt requested. In addition, the URO may request the records from the provider under review by telephone.
(b) The medical records of the provider under review may not be requested from, or supplied by, any source other than the provider under review.
(c) The provider under review, or his agent, shall sign a verification that, to the best of his knowledge, the medical records provided constitute the true and complete medical chart as it relates to the employee's work-injury.

§ 127.460. Obtaining medical records -- other treating providers
(a) A URO shall request records from other treating providers in writing. In addition, the URO may request records from other treating providers by telephone.
(b) A provider, or his agent, who supplies medical records to a URO pursuant to this section shall sign a verification that, to the best of his knowledge, the medical records constitute the true and complete medical chart as it relates to the employee's work injury.
(c) If a URO is not able to obtain records directly from the other treating providers, it may obtain these records from the insurer, the employer or the employee.
(d) If an insurer, employer or employee supplies medical records to a URO under subsection (c), it shall sign a verification that, to the best of its knowledge, the records supplied are the complete set of records as received from the provider that relate to the work-injury and that the records have not been altered in any manner.

§ 127.461. Obtaining medical records -- independent medical exams
UROs may not request, and the parties may not supply, reports of independent medical examinations performed at the request of an insurer, employer, employee or attorney. Only the records of actual treating health care providers shall be requested by, or supplied to, a URO.

§ 127.462. Obtaining medical records -- duration of treatment
UROs shall attempt to obtain records from all providers for the entire course of treatment rendered to the employee for the work-related injury which is the subject of the UR request, regardless of the period of treatment under review.

§ 127.463. Obtaining medical records -- reimbursement of costs of provider

(a) The URO shall, within 30 days of receiving medical records, reimburse the provider for record copying costs at the rate specified by Medicare and for actual postage costs. The Bureau will publish the Medicare rate in the Pennsylvania Bulletin as a notice when the rate changes.

(b) Reproduction of radiologic films shall be reimbursed at the usual and customary charge. The cost of reproducing such films shall be itemized separately when the URO bills for performing the UR.

§ 127.464. Effect of failure of provider under review to supply records

(a) If the provider under review fails to mail records to the URO within 30 days of the date of request of the records, the URO shall render a determination that the treatment under review was not reasonable or necessary, if the conditions set forth in subsection (b) have been met.

(b) Before rendering the determination against the provider, a URO shall do the following:

(1) Determine whether the records were mailed in a timely manner.

(2) Indicate on the determination that the records were requested but not provided.

(3) Adequately document the attempt to obtain records from the provider under review, including a copy of the certified mail return receipt from the request for records.

(c) If the URO renders a determination against the provider under subsection (a), it may not assign the request to a reviewer.

§ 127.465. Requests for UR -- deadline for URO determination

(a) A request for UR shall be deemed complete upon receipt of the medical records or 35 days from the date of the notice of assignment, whichever is earlier.

(b) A URO shall complete its review, and render its determination, within 30 days of a completed request for UR.

§ 127.466. Assignment of UR request to reviewer by URO

Upon receipt of the medical records, the URO shall forward the records, the request for UR, the notice of assignment and a Bureau-prescribed instruction sheet to a reviewer licensed by the Commonwealth in the same profession and having the same specialty as the provider under review.

§ 127.467. Duties of reviewers – generally

Reviewers shall apply generally accepted treatment protocols as appropriate to the individual case before them.

§ 127.468. Duties of reviewers – conflict of interest

A reviewer shall return a review to the URO for assignment to another reviewer if one or more of the following exist:

(1) The reviewer has a previous involvement with the patient, or with the provider under review, regarding the same matter.

(2) The reviewer has performed precertification functions in the same matter.

(3) The reviewer has provided case management services in the same matter.

(4) The reviewer has provided vocational rehabilitation services in the same matter.

(5) The reviewer has a contractual relationship with any party in the matter.

§ 127.469. Duties of reviewers -- consultation with provider under review

The URO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussion with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.470. Duties of reviewers -- issues reviewed

(a) Reviewers shall decide only the issue of whether the treatment under review is reasonable or necessary for the medical condition of the employee.

(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employee's work-related injury. Reviewers may not consider or decide issues such as whether the employee is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

§ 127.471. Duties of reviewers -- finality of decisions

(a) Reviewers shall make a definite determination as to whether the treatment under review is reasonable or necessary.

Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is reasonable or necessary, reviewers may consider whether other courses of treatment exist. However, reviewers may not determine that the treatment under review is unreasonable or unnecessary solely on the basis that other courses of treatment exist.
(b) If the reviewer is unable to determine whether the treatment under review is reasonable or necessary, the reviewer shall resolve the issue in favor of the provider under review.

§ 127.472. Duties of reviewers – content of reports
The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

§ 127.473. Duties of reviewers -- signature and verification
(a) Reviewers shall sign their reports. Signature stamps may not be used.
(b) Reviewers shall sign a verification pursuant to 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

§ 127.474. Duties of reviewers -- forwarding report and records to URO
Reviewers shall forward their reports and all records reviewed to the URO upon completion of the report.

§ 127.475. Duties of UROs -- review of report
(a) UROs shall check the reviewer's report to ensure that the reviewer has complied with formal requirements (such as signature and verification).
(b) UROs shall ensure that all records have been returned by the reviewer.
(c) A URO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

§ 127.476. Duties of UROs -- form and service of determinations
(a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.
(b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in these cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.
(c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employee, the insurer or employer, the provider under review, the attorneys for the parties, if known, and the Bureau.
(d) The URO shall also serve a copy of a petition for review of a UR determination on all parties and their attorneys, if known.
(e) Service shall be made by certified mail, return receipt requested and shall be made on the same date as is entered on the appropriate line of the face sheet.

§ 127.477. Payment for request for UR
The insurer or the employer shall pay the reasonable and customary charge of the URO for the UR determination, regardless of who the requesting party is. Payment shall be made within 30 days of the date the UR determination was received. The URO shall send its itemized bill to the insurer responsible for payment and a copy of the itemized bill to the Bureau.

§ 127.478. Record retention requirements for UROs
(a) UROs shall retain records relating to URs for 1 year from the date that a determination was rendered. These records shall include, but are not limited to, the notice of assignment, all correspondence, all certified mail return receipts and documents, all medical records reviewed, the face sheet and the reviewer's report.
(b) The URO's files will be subject to inspection and audit by the Bureau without notice.

§ 127.479. Determination against insurer -- payment of medical bills
If the UR determination finds that the treatment reviewed was reasonable or necessary, the insurer shall pay the bills sub-

mitted for the treatment in accordance with § 127.208 (relating to time for payment of medical bills).

§§ 127.501. – 127.515. [Reserved]

UR -- PETITION FOR REVIEW

§ 127.551. Petition for review by Bureau of UR determination

If the provider under review, the employee, the employer or the insurer disagrees with the determination rendered by the URO, a request for review by the Bureau may be filed on a form prescribed by the Bureau as a petition for review of a UR determination.

§ 127.552. Petition for review by Bureau -- time for filing

The original and eight copies of the petition for review shall be filed with the Bureau within 30 days of receipt of the URO's determination.

§ 127.553. Petition for review by Bureau -- notice of assignment and service by Bureau

(a) The Bureau will assign the petition for review to a workers' compensation judge. The Bureau will serve the notice of assignment and the petition for review upon the URO, the employee, the employer or insurer, the health care provider under review, and the attorneys for the parties, if known.
(b) When a petition for review is filed in a case already in litigation before a workers' compensation judge, the Bureau will assign the petition for review to the workers' compensation judge who is hearing the case-in-chief.
(c) Before assigning a petition for review, the Bureau will review the petition to ensure that a UR has been filed and a determination has been rendered.

§ 127.554. Petition for Review by Bureau -- no answer allowed

No answer to the petition for review may be filed.

§ 127.555. Petition for review by Bureau -- transmission of URO records to workers' compensation judge

(a) Upon the workers' compensation judge's own motion, or motion of any party to the proceeding, the workers' compensation judge may order the URO to forward all medical records obtained for its review to the workers' compensation judge. The URO shall forward all records within 10 days of the date of the workers' compensation judge's order.
(b) When a petition for review has been filed, the Bureau will forward the URO report to the workers' compensation judge assigned to the case.
(c) An authorized agent of the URO shall sign a verification stating that, to the best of his knowledge, the complete set of unaltered records obtained by the URO is being transmitted to the workers' compensation judge.
(d) When records are provided under subsection (a), the URO shall transmit its itemized bill for record copying costs to the manager of the Medical Treatment Review Section, together with a copy of the workers' compensation judge's order directing the URO to provide the records. The URO shall be reimbursed by the Bureau for its record copying costs at the rate specified by Medicare, and for actual postage costs. Reproduction of radiologic films shall be reimbursed at a reasonable cost.

§ 127.556. Petition for Review by Bureau -- de novo hearing

The hearing before the workers' compensation judge shall be a de novo proceeding. The URO report shall be part of the record before the workers' compensation judge and the workers' compensation judge shall consider the report as evidence. The workers' compensation judge will not be bound by the URO report.

PEER REVIEW

§ 127.601. Peer review – availability

(a) A Workers' Compensation judge may obtain an opinion from an authorized PRO concerning the necessity or frequency of treatment rendered under the act when one of the following exist:
(1) A petition for review of a UR determination has been filed.
(2) It is necessary or appropriate in other litigation proceedings before the Worker's Compensation judge. Peer review shall be deemed not to be necessary or appropriate if there is a pending UR of the same treatment.
(b) Nothing in subsection (a) requires a Workers' Compensation judge to grant a party's motion for peer review.

§ 127.602. Peer review -- procedure upon motion of party

(a) A party may not make a motion for peer review if the same course of treatment has been submitted for UR.

(b) After making a motion for peer review, neither party may file a request for UR while the motion is pending. If the motion is not specifically ruled on within 10 days, then it shall be deemed denied.
(c) If the Workers' Compensation judge has not ruled on the motion within 10 days, or if the motion is denied, the parties shall be free to file requests for UR.
(d) If the motion is granted, the Workers' Compensation judge will proceed in accordance with § 127.604 (relating to peer review -- forwarding a request to the Bureau).

§ 127.603. Peer review -- interlocutory ruling
The ruling on a motion for peer review shall be deemed interlocutory.

§ 127.604. Peer review -- forwarding of request to Bureau
(a) If the Workers' Compensation judge decides that peer review is necessary or appropriate, the Judge will forward a request for peer review to the Bureau on a form prescribed by the Bureau. The Workers' Compensation judge will notify counsel, or the parties, if unrepresented, by serving a copy of the request for peer review upon them.
(b) In cases other than petitions for review of a UR determination, the Worker's Compensation judge will attach subpoenas to the request for peer review which the assigned PRO shall use to obtain medical records.

§ 127.605. Peer review -- assignment by the Bureau
(a) The Bureau will randomly assign a properly filed request for peer review to an authorized PRO.
(b) The Bureau will send a notice of assignment of the request for peer review to the PRO, the Workers' Compensation judge, counsel for the parties, or the parties, if unrepresented, and the health care provider under review.

§ 127.606. Peer review – reassignment
(a) If a PRO is unable, for any reason, to perform a peer review assigned to it by the Bureau, the PRO shall, within 5 days of receipt of the assignment, return the request for peer review to the Bureau for reassignment.
(b) A PRO may not, under any circumstances, reassign a request for peer review to another PRO.
(c) A PRO shall return requests for peer review assigned to it by the Bureau if the PRO has a conflict of interest in the request assigned to it.

§ 127.607. Peer review -- conflicts of interest
(a) A PRO shall return a request for peer review to the Bureau for reassignment if the following apply:
(1) The PRO has a previous involvement with the patient or provider under review in the same matter.
(2) The PRO has performed precertification functions in the same matter.
(3) The PRO has provided case management services in the same matter.
(4) The PRO has provided vocational rehabilitation services in the same matter.
(5) The PRO is owned by or has a contractual relationship with any party subject to the review.
(b) A PRO shall inform the reviewer assigned to perform peer review of the reviewer's obligation to notify the PRO of any potential or realized conflicts arising under § 127.615 (relating to duties of reviewers -- conflict of interest).

§ 127.608. Peer review – withdrawal
(a) A request for peer review shall be withdrawn only at the direction of the Workers' Compensation judge. The Workers' Compensation judge will notify the Bureau of the withdrawal in writing.
(b) The Bureau will promptly notify the PRO of the withdrawal. The Bureau will pay the costs incurred by the PRO prior to the withdrawal out of the Workmen's Compensation Administration Fund.
(c) If a previously withdrawn peer review request is resubmitted to the Bureau, the Bureau will assign the matter to the PRO which handled it prior to the withdrawal.

§ 127.609. Obtaining medical records
(a) In cases where peer review has been requested on a petition for review of a UR determination, the Workers' Compensation judge may order the URO to forward all the records received and reviewed for the purposes of the UR to the PRO assigned to perform the peer review by the Bureau.
(b) In other cases, the PRO shall have 10 days from the date of the notice of assignment to subpoena records from treating providers.

§ 127.610. Obtaining medical records -- independent medical exams
PROs may not subpoena, request or be supplied with records of independent medical examinations performed at the re-

quest of an insurer, employer, employee or attorney. Only the records of actual treating health care providers may be subpoenaed by or supplied to a PRO.

§ 127.611. Obtaining medical records -- duration of treatment
PROs shall attempt to obtain records from all providers for the entire course of treatment rendered to the employee for the work-related injury which is the subject of the peer review request, regardless of the period of treatment under review.

§ 127.612. Effect of failure of provider under review to supply records
(a) If the provider under review fails to mail records to the PRO within 30 days of the date of service of the subpoena for the records, the PRO shall report the provider's noncompliance with the subpoena to the Workers' Compensation judge.
(b) If the provider fails to supply records, the PRO may not assign the matter to a reviewer, and may not make a determination concerning the necessity or frequency of treatment.

§ 127.613. Assignment of peer review request to reviewer by PRO
Upon receipt of the medical records, the PRO shall forward the records, the request for peer review and the notice of assignment to a reviewer licensed by the Commonwealth in the same profession and Board certified in the specialty or sub-specialty as the provider under review. Board-certification shall be by an accredited specialty board.

§ 127.614. Duties of reviewers – generally
Reviewers shall apply generally accepted treatment protocols, as appropriate, to the individual case before them.

§ 127.615. Duties of reviewers -- conflict of interest
A reviewer shall return a review to the PRO for assignment to another reviewer if one or more of the following exist:
(1) The reviewer has a previous involvement with the patient or provider under review regarding the same matter.
(2) The reviewer has performed precertification functions in the same matter.
(3) The reviewer has provided case management services in the same matter.
(4) The reviewer has provided vocational rehabilitation services in the same matter.
(5) The reviewer has a contractual relationship with any party in the matter.

§ 127.616. Duties of reviewers -- consultation with provider under review
The PRO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussions with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

§ 127.617. Duties of reviewers -- issues reviewed
(a) Reviewers shall decide only issues concerning the necessity and frequency of the treatment under review.
(b) Reviewers shall assume the existence of a causal relationship between the treatment under review and the employee's work-related injury. The reviewer may not consider or decide issues such as whether the employee is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees.

§ 127.618. Duties of reviewers -- finality of decisions
(a) Reviewers shall make a definite determination as to the necessity and frequency of the treatment under review. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is necessary, reviewers may consider whether other coursers of treatment exist. However, reviewers may not render advisory opinions as to whether other courses of treatment are preferable.
(b) If the reviewer is unable to determine whether the treatment under review is necessary or of appropriate frequency, then the reviewer shall resolve the issue in favor of the provider under review.

§ 127.619. Duties of reviewers -- content of reports
The written reports of reviewers shall contain, at a minimum, the following elements: a listing of the records reviewed; documentation of any actual or attempted contacts with the provider under review; findings and conclusions; and a detailed explanation of the reasons for the conclusions reached by the reviewer, citing generally accepted treatment protocols and medical literature as appropriate.

§ 127.620. Duties of reviewers -- signature and verification

(a) Reviewers shall sign their reports. Signature stamps may not be used.

(b) Reviewers shall sign a verification under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) that the reviewer personally reviewed the records and that the report reflects the medical opinions of the reviewer.

§ 127.621. Duties of reviewers -- forwarding report and records to PRO

Reviewers shall forward their reports and all records reviewed to the PRO upon completion of the report.

§ 127.622. Duties of PRO -- review of report

(a) PROs shall check the reviewer's report to ensure that formal requirements, such as signature and verification, have been complied with by the reviewer.

(b) PROs shall ensure that all records have been returned by the reviewer.

(c) A PRO may not contact a reviewer and attempt to persuade the reviewer to change the medical opinions expressed in a report.

§ 127.623. Peer review -- deadline for PRO determination

A PRO shall complete its review and render its determination within 30 days of receipt of the medical records.

§ 127.624. PRO reports -- filing with judge and service

The PRO shall file its report directly with the Workers' Compensation judge and mail copies to all the parties listed on the notice of assignment by certified mail, return receipt requested.

§ 127.625. Record retention requirements for PROs

PROs shall comply with all the record retention requirements specified in § 127.478 (relating to record retention requirements). Their files shall be subject to inspection and audit by the Bureau without notice.

§ 127.626. PRO reports – evidence

The PRO report shall be a part of the record of the pending case. The Workers' Compensation judge will consider it as evidence but will not be bound by it.

§ 127.627. PRO reports – payment

The PRO shall submit its itemized bill to the Workers' Compensation judge for approval. The judge will forward the bill to the Bureau with an order for payment. Payment will be made from the Workmen's Compensation Administration Fund.

SUPREME COURT OF THE UNITED STATES

AMERICAN MANUFACTURERS MUTUAL INSURANCE
CO. ET AL. *v.* SULLIVAN ET AL.
CERTIORARI TO THE UNITD STATES COURT OF APPEALS FOR
THE THIRD CIRCUIT

No. 97–2000. Argued January 19, 1999— Decided March 3, 1999 Under Pennsylvania's Workers' Compensation Act, once an employer becomes liable for an employee's work-related injury because liability either is not contested or is no longer at issue the employer or its insurer must pay for all "reasonable" and "necessary" medical treatment. To assure that only medical expenses meeting these criteria are paid, and in an attempt to control costs, Pennsylvania has amended its workers' compensation system to provide that a self-insured employer or private insurer (collectively insurer) may withhold payment for disputed treatment pending an independent "utilization review," as to which, among other things, the insurer files a one-page request for review with the State Workers' Compensation Bureau (Bureau), the Bureau forwards the request to a "utilization review organization" (URO) of private health care providers, and the URO determines whether the treatment is reasonable or necessary.
Respondents, employees and employee representatives, filed this suit under 42 U. S. C. §1983 against various Pennsylvania officials, a self-insured public school district, and a number of private workers' compensation insurers, alleging, *inter alia,* that in withholding benefits without predeprivation notice and an opportunity to be heard, the state and private defendants, acting "under color of state law," deprived respondents of property in violation of due process. The District Court dismissed the private insurers from the suit on the ground that they are not "state actors," and later dismissed the state officials and school district on the ground that the Act does not violate due process. The Third Circuit disagreed on both issues, holding, among other rulings, that a private insurer's decision to suspend payment under the Act constitutes state action. The court also noted the parties' assumption that employees have a protected property interest in workers' compensation medical benefits, and held that due process requires that payment of medical bills not be withheld until employees have had an opportunity to submit their view in writing to the URO as to the reasonableness and necessity of the disputed treatment.
Held:
1. A private insurer's decision to withhold payment and seek utilization review of the reasonableness and necessity of particular medical treatments is not fairly attributable to the State so as to subject the insurer to the Fourteenth Amendment's constraints. State action requires *both* an alleged constitutional deprivation caused by acts taken pursuant to state law *and* that the allegedly unconstitutional conduct be fairly attributable to the State. *E.g., Lugar*, v. *Edmondson Oil Co.,* 457 U. S. 922, 937. Here, while it may fairly be said that the first requirement is satisfied, respondents have failed to satisfy the second. The mere fact that a private business is subject to extensive state regulation does not by itself convert its action into that of the State. See, *e.g., Blum* v. *Yaretsky*, 457 U. S. 991, 1004. The private insurers cannot be held to constitutional standards unless there is a sufficiently close nexus between the State and the challenged action so that the latter may be fairly treated as that of the State itself. *Ibid.* Whether such a nexus exists, depends on, among other things, whether the State has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State. *E.g., ibid.* That the statutory scheme previously prohibited insurers from withholding payment for disputed medical services and no longer does so merely shows that the State, in administering a many-faceted remedial system, has shifted one facet from favoring the employees to favoring the employer. This sort of decision occurs regularly in the legislative process and cannot be said to "encourage" or "authorize" the insurer's actions. Also rejected is respondents' assertion that the challenged decisions are state action because insurers must obtain "authorization" or "permission" from the Bureau before withholding payment. The Bureau's participation is limited to requiring submission of a form and related functions, which cannot render it responsible for the insurers' actions. See *id.,* at 1007. Respondents' twofold argument that state action is present because the State has delegated to insurers powers traditionally reserved to itself also lacks merit. First, the contention as to delegation of the provision of state-mandated "public benefits" fails because nothing in Pennsylvania's constitution or statutory scheme obligates the State to provide either medical treatment or workers' compensation benefits to injured workers. Second, their argument as to delegation of the governmental decision to suspend payment for disputed medical treatment is supported by neither historical practice nor the state statutory scheme. That Pennsylvania originally recognized an insurer's traditionally private prerogative to withhold payment, then restricted it, and now (in one limited respect) has restored it, cannot constitute the delegation of an exclusive public function. Finally, respondents misplace their reliance on a "joint participation" theory of state action. Privately owned enterprises providing services that the State would not necessarily provide, even though they are extensively regulated, do not fall within the ambit of that theory. 2. The Pennsylvania regime does not deprive disabled employees of "property" within the meaning of the Due Process Clause of the Fourteenth Amendment. Only after finding deprivation of a protected property interest does this Court look to see if the State's procedures comport with due process. *Mathews* v. *Eldridge*, 424 U. S. 319, 332. Here, respondents contend that state law confers upon them such a protected interest in workers' compensation medical benefits. However, under Pennsylvania law, an employee is not entitled to payment for *all* medical treatment once the employer's initial liability is established, as respondents' argument assumes. Instead, the law expressly limits an employee's entitlement to "reasonable" and "necessary" medical treatment, and requires that disputes over the reasonableness and necessity of particular treatment be resolved *before* an employer's obligation to pay— and an employee's entitlement to benefits— arise. Thus, for an employee's property interest in the payment of medical benefits to attach under state law, the employee must clear two hurdles: He must prove (1) that an employer is liable for a work-related injury, and (2) that the particular medical treatment at issue is reasonable and necessary. While respondents have cleared the first hurdle, they have yet to satisfy the second. Consequently, they do not have the property interest they claim.