COMMONWEALTH AUTOMOBILE REINSURERS
101 Arch Street, Suite 400 Boston, Massachusetts 02110
www.commauto.com 617-338-4000
NATALIE A. HUBLEY
PRESIDENT

ADDITIONAL INFORMATION

TO MEMBERS OF THE CLAIMS SUBCOMMITTEE

FOR THE MEETING OF:

Tuesday, May 22, 2018 at 10:00 a.m.

CLMS
18.04 Claims Performance Standards

Attached are draft revisions to the Private Passenger and Commercial Claims Performance Standards for the Subcommittee's consideration. The current Performance Standards can be located on CAR's website. (Docket #CLMS18.04, Exhibit #1)

PETER BERTONI
Compliance Auditor

Attachment

Boston, Massachusetts
May 16, 2018

Private Passenger and Commercial Claims Performance Standards – May 22, 2018

General Modifications

The Performance Standards and Appendices for the handling and payment of claims are reviewed every two years in accordance with Massachusetts G.L. c. 175 sec. 113H. In 2016, significant modifications were made and approved by Division of Insurance (DOI) effective May 31, 2016.

For the purpose of this review, 'redlined' formatting is used to identify only proposed substantive modifications. However, some minor changes were made that either added or modified existing language but were not included in the 'redlined' material because it does not alter meaning or intent.

Private Passenger Specific Modifications:

Table of Contents
- The DOI Bulletin referenced in Appendix N has been updated.
- The most recent communication titled Bulletin 2017-06 (November 22, 2017) is now referenced.

Standard III No-Fault Personal Injury Protection Benefits Handling
- Language is added in the section pertaining to Fraud Handling to include Special Investigations. The suggested language is consistent with Standard II Bodily Injury & Uninsured/Underinsured Motorist.

Measurements & Penalties
- Compliance Audit Committee is changed to Compliance and Operations Committee.

Appendix A – CAR SIU Standards
- Language is adjusted to reflect the updated process for all ARCs to provide CAR the SIU Quarterly Activity Log.

Appendix I – CAR Compliance Audit Claim Review Process
- Compliance Audit Committee is changed to Compliance and Operations Committee.

Appendix J – CAR SIU File Review Process – MAIP Policies
- Clarifying language is suggested regarding the SIU components of the Hybrid Audit.

Appendix N – Division of Insurance, Bulletin 2008-12
- As noted in the Table of Contents, the DOI issued an updated Bulletin 2017-06 clarifying the coordination of benefits.
- The updated Bulletin issued on November 22, 2017 is inserted as an exhibit replacing the prior.

Commercial Specific Modifications:

Table of Contents
- The DOI Bulletin referenced in Appendix N has been updated.
- The most recent communication titled Bulletin 2017-06 (November 22, 2017) is now referenced.

Standard III No-Fault Personal Injury Protection Benefits Handling
- Language is added in the section pertaining to Fraud Handling to include Special Investigations. The suggested language is consistent with Standard II Bodily Injury & Uninsured/Underinsured Motorist.

Measurements & Penalties

- The Expense Best Practice is moved from Voluntary/Ceded Claim Handling Differential section into the Performance Standards section.
- Compliance Audit Committee is changed to Compliance and Operations Committee.

Appendix A – CAR SIU Standards

- Language is adjusted to reflect the updated process for all SC's to provide CAR the SIU Quarterly Activity Log.

Appendix I – CAR Compliance Audit Claim Review Process

- Compliance Audit Committee is changed to Compliance and Operations Committee.

Appendix J – CAR SIU File Review Process – MAIP Policies

- Language is added to referencing CAR Rule 10.C. (companion rule to private passenger Rule 32.C.) that requires the SIU to verify underwriting policy components and conduct an audit of a representative sample of policies.
- Clarifying language is suggested regarding the SIU components of the Commercial Claims Performance Standards Report and SIU Evaluation.

Appendix K – Compliance Audit Claim Questionnaire

- Note that the private passenger and commercial questionnaire are consistent. However, language has been added to the Commercial questionnaire specific to the validation of a risk's principal place of business, in accordance with the recent update to Rule 2.

Appendix N – Division of Insurance, Bulletin 2008-12

- As noted in the Table of Contents, the DOI issued an updated Bulletin clarifying the coordination of benefits.
- The updated Bulletin issued on November 22, 2017 was inserted as an exhibit replacing the prior.

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Performance Standards

Appendices

A. Screening Reports and Initial Investigation

1. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

2. Initial investigation shall confirm that coverage is appropriate:

   a. Date of loss within policy period and all policy coverage is in order.

   b. Injured persons are eligible for no-fault benefits.

   c. Private health insurance availability shall be verified and documented.

   d. Injuries arise from use of a motor vehicle.

   e. Massachusetts statute applies.

   f. No exclusions apply, such as drunk driving, stolen car, or workers compensation.

3. The setting of initial and subsequent reserves shall be timely, reasonable, and follow documented company policy.

B. Contacts

1. Injured persons or their legal representative making a claim shall be contacted within 2 business days of the receipt of notice of injury for purposes of investigation and verification.

2. The named insured, if not an injured party, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

3. The insured operator, if not identified in B.1. or B.2., shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Necessary forms shall be mailed or, if preferred by the injured party, electronically sent to the address specified within 5 business days after notice of injury.

C. Medical Management

1. ARCs must establish a plan to maintain a continuing awareness of the disability claimed, the medical treatment, and whether the treatment and medical expense are reasonable, necessary, and related to the motor vehicle accident.

2. Any plan shall include historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches.

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

   If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or indications of potential fraud exist (such as accident of unusual circumstances, severity of accident, unusual number of injured passengers, prior index history, recognition of a pattern related to prior cases of fraud), the case shall be referred for special investigation with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with consideration given to referring the claim to IFB, NICB or appropriate law enforcement agency for prosecution.

   b. The CAR SIU Standards for investigation of suspicious claims must be consulted and considered as part of the special investigation process.

   c. ARCs shall have a plan designed to deal with claims involving exaggerated damages or injuries, such as inflated doctors' bills or wage statements, and such plan shall provide a strategy for concluding those cases at a reasonable amount, as well as reporting the same to the Detail Claim Database (DCD) at the AIB. Savings realized from this process shall be documented on the SIU Quarterly Log.

d. Legal expenses incurred shall be itemized, monitored, and related to the claim being paid.

E. Subrogation/Recovery

1. The initial contact and investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier against which subrogation may be directed. If applicable, a preliminary notice of subrogation shall be sent to the other carrier.

2. In cases of injury serious enough to exceed the tort threshold, the no-fault carrier shall alert the tort carrier immediately.

F. Claim Payment

1. No payment shall be made until the reported loss has been verified and:

a. The deductible applied if applicable.

b. Benefits coordinated in conjunction with existing health carrier and wage continuation plans.

c. Medical bills verified prior to payment and reviewed for reasonableness, medical necessity, and relationship to the accident.

d. Wage rate/working hours verified with employer, using wage/salary verification forms.

e. Lost wages confirmed by employer's statement as to time missed and by physician's statement verifying disability for that period of time.

f. Investigations promptly conducted. Upon agreement to pay, checks are issued within 10 business days.

g. A litigation management program is designed to bring cases to the earliest conclusion at a reasonable value.

h. Legal expenses incurred are itemized, monitored, and related to the claim being paid.

2. In the normal course of claim handling, a file shall be referred for special investigation when discrepancies exist that are unresolved. Refer to Appendix A for a list of indicators.

3. Evaluation and Settlement

   After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

A. Measurements

The key claim requirements of G.L.c.175, §113H that will be measured by the Compliance Audit Plan are:

- That claims handling is consistent for voluntary and residual market claims.
- That each ARC maintains a SIU which provides effective fraud control procedures.

Voluntary and residual market claims will be reviewed for compliance with policy provisions and applicable statutes, rules and regulations for the following Best Practices:

- Coverage
- Investigation
- Special Investigation
- Medical Management
- Litigation Management
- Evaluation and Settlement

The benchmark for compliance with these Best Practices is 93% in accordance with the NAIC error tolerance of 7% for standards involving claim resolution. The aggregate score for these Best Practices will be calculated. If the score is less than 93% the ARC will be required to address the reasons in its response and submit a remedial action plan.

Chi square testing will be conducted on each Best Practice Voluntary and MAIP score to determine if any statistical difference in handling exists. If the difference is statistically significant, the ARC will be required to address the reasons in its response and submit a remedial action plan when requested.

B. Non-Compliance Penalties

In the case of non-compliance, the ARC will be required to submit a remedial action plan to CAR. The Governing Committee will determine if further action including penalties is warranted based on the recommendation of the Compliance and Operations~~Audit~~ Committee.

The reduction of insurance fraud, by monitoring and coordinating the investigation of suspicious claims, is an important goal of CAR. It seeks the achievement of three beneficial results:

- Successful resistance to the payment of fraudulent claims
- The establishment of a deterrent to fraud
- The reduction of losses, with the consequent improvement in insurance rates

In order to achieve these results, ARCs must pursue the investigation of fraud by establishing a commitment to support and encourage the activities of its SIU.

A. CAR SIU

The CAR SIU, as part of the Compliance Audit Department exists under the authority of Article III of the Plan of Operation. It is charged with monitoring the efforts of Servicing Carriers to control fraud. In addition, it will assist Members and ARCs on request. CAR will perform a triennial audit of the SIU of each ARC as part of the HAP audit to evaluate its effectiveness.

Assistance of the CAR SIU is intended to provide expert investigation beyond the capabilities of the average ARC's investigator. The basic investigation of a suspicious claim is the responsibility of the ARC. CAR SIU will also assist with the coordination of an investigation involving several ARCs.

B. CAR Standards for ARC SIU

CAR evaluations of an ARC's SIU will be based on its performance in accordance with the following guidelines:

1. Each Servicing Carrier is required by Article IV of the Plan of Operation to maintain a SIU to investigate suspicious claims for the purpose of eliminating fraud. A SIU shall be staffed by experienced salaried employees who are adequately trained in the recognition and investigation of insurance fraud. A SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. The work of a SIU may be supplemented by closely supervised independent adjusters or investigators.

2. Each ARC shall ensure that all motor vehicle insurance claims, where there is a suspicion of fraud, are referred promptly to its SIU.

3. Each ARC SIU shall maintain a SIU Quarterly Activity Log of cases referred to it containing at least the following information:

   - Date of referral
   - Date of loss
   - Claim number
   - Policyholder
   - Type of claim
   - Amount of claim
   - Amount paid
   - Date completed

   ~~Copies of active pages of the log shall either be mailed or submitted electronically at the end of each calendar quarter to:~~

   ~~Commonwealth Automobile Reinsurers~~
   ~~101 Arch Street – Suite 400~~
   ~~Boston, MA 02110~~
   ~~ATTN: Special Investigative Unit~~

   The log shall be uploaded by each ARC to a secure SIU application located on CAR's website in the format prescribed by CAR. The log file shall be transmitted at the end of each quarter and no later than the 15th of the following month.

4. Regulation 211 CMR 75.00 establishes the NICB as the central organization engaged in motor vehicle loss prevention as required by G.L.c.175, §113O. It also requires certain actions by insurers with respect to theft claims. An insurer must, among other things:

   - Report all thefts to NICB
   - Obtain NICB's acknowledgement before paying claims
   - Report disposition of salvage
   - Investigate and report evidence of fraud
   - Defer payment in certain circumstances

5. The NICB has been established as the central organization to whom insurance companies report cases of bodily injury fraud for possible further action with law enforcement agencies and criminal prosecuting authorities.

   In all cases where careful further investigation has established the strong possibility of bodily injury fraud, the ARC should forward a

complete photocopy of the claim file to NICB for further consideration and action.

If an ARC is not a member of NICB, the ARC may refer such case directly to the appropriate local law enforcement agency for consideration of criminal prosecution.

6. The Motor Vehicle Fraud Profile described in Section D. identifies circumstances in which a motor vehicle theft or fire claim should be considered suspicious. Such claims warrant careful investigation into the possibility of fraud.

7. Both law and equity dictate that a prompt and thorough investigation precede any decision with respect to payment or denial of a claim. The provisions of G.L. c.93A and c.176D must be borne in mind at all times. Penalties incurred by members for violations of these laws are subject to reimbursement by CAR and may not be reported as loss or allocated expense.

8. The quality of investigation performed by a SIU is an important criterion of its effectiveness. It will be given careful consideration by CAR during an audit. It is not possible to outline every avenue of the investigation of a suspicious claim; it is limited only by the experience and imagination of the investigator. There are, however, certain elements which are common to the investigation of suspicious fire or theft claims that should be covered in every such case referred to a SIU, or the file should reflect the reasons why it was not. Refer to Sections C. and D. for these guidelines.

C. CAR Standards for Investigation of Collision and Comprehensive Losses

1. Interviews of Owner, Custodian, Companions, Witnesses, etc.

A recorded statement should be obtained from the owner of the motor vehicle, exploring in depth and in detail the areas described below. Statements of others with knowledge of some or all of the circumstances are also important.

- The individual interviewed
- Name, address, date of birth, occupation, employer
- The motor vehicle

  Year, make, model, VIN; when purchased, from whom, amount paid, motor vehicle traded in, amount allowed; if used, condition, odometer reading, improvements by

insured; amount borrowed, from whom, term of loan; where kept when not in use, who uses the motor vehicle, purpose; service, inspection, repair; problems.

2. Insurance

   How long insured by this company; if short time, former carrier; any other insurance; recent changes of coverage; history of claims.

3. The Loss

   Date, time, and place; description of event; when and how the motor vehicle got to that location; purpose of its presence there; identity of witnesses; was car locked; who had keys; activities between leaving motor vehicle and discovery of loss; time, place, and method of report to police; identity of those responsible.

4. Police

   The owner or custodian of a motor vehicle which is stolen or substantially damaged must report in writing to the police. An insurer may not pay a theft claim until it has confirmed the existence of such a report. Its file should contain a copy of the report or an explanation of its absence. Police reports of the recovery of a motor vehicle and any investigation should be obtained. Interviews of police officers are useful in selected cases. The possibility of investigation by other governmental agencies should be considered if the claim appears to be part of an organized pattern of activity.

5. Claim History

   A record of the policyholder's prior losses should be obtained. The record is not necessarily evidence of impropriety. However, an extensive record warrants a study of the claim files to identify patterns of activity or other information of interest. This is a fruitful source of leads.

6. Insurance File

   A study of the underwriting file should be undertaken. A recent application and/or changes of motor vehicle or coverage may suggest premeditation.

7. Mortgagee

   Inquire via telephone about the timeliness of installment payments and the amount of the loan outstanding. A history of late payments and/or a delinquency of several months suggest financial difficulty which might motivate one to destroy his/her motor vehicle.

8. Ownership and Value

   Copies of the Bill of Sale, the Application for Title and/or Registration, and the Title should be obtained. These establish ownership, identify the prior owner, and establish the value at the time of purchase. Inconsistencies of purchase price suggest dishonesty. Seek verification by the seller of the price and condition at the time of sale. Be alert to prior use as a public or private livery motor vehicle.

9. Betterment

   It is often claimed that the value of a motor vehicle has been enhanced by the addition of special equipment or by cosmetic improvements. Receipts for such things should be requested, and if received, verified.

10. Service and Repair

    The interview with the policyholder and the examination of the motor vehicle should cover the service and repair history of the motor vehicle. The inspection sticker and stickers recording oil changes and lubrication will provide leads, as may the contents of the glove compartment. Investigate recent service and repair activity to identify problems which might provide a motive for destroying the motor vehicle.

11. The Motor Vehicle Examination

    A careful, thorough, and early examination of the motor vehicle when it is available is important.

    a. Start with the plate bearing the VIN. Look for evidence of tampering, either of the plate itself or of the rivets that hold it in place. Record the complete number by placing a paper over it and rubbing it with a pencil. Report whether the number is consistent with the type and model of the motor vehicle and consistent with the policy.

b. Obtain abundant clear photographs of the engine, passenger, and trunk compartments and all areas of the exterior, including wheels and tires. The engine, the ignition lock, and the registration plate particularly are important. Don't mark the face of a photograph; it may destroy its value as evidence.

c. Determine the odometer reading. Report whether it is consistent with the age and condition of the motor vehicle and with the mileage reported by the owner.

d. Examine the ignition lock. Report whether there is evidence of damage and whether it contained a key.

e. Report whether the glove or trunk compartments contain the usual articles. Take possession of bills related to service, repair, or improvements. A thief has no interest in the usual contents; their absence may suggest removal by the owner in anticipation of a loss.

f. Examine the inspection sticker. Report when and where it was inspected, whether it is current, or whether there is a rejection sticker.

g. Examine the registration plate. Report the date of expiration.

h. Record date on service or oil change stickers.

i. Try to distinguish old damage from new. The presence or absence of dirt and/or rust should be considered. Report evidence of recent changes of wheels or tires.

j. Consider or give consideration to wear and tear, mechanical and electrical failures, and missing parts and equipment.

k. Determine the level and condition of crankcase and transmission oil, brake fluid, and radiator coolant.

l. In selected cases, a professional analysis of the ignition, the engine, or the transmission may be warranted.

D. Motor Vehicle Fraud Profile

The following items should serve as indicators in determining whether an investigation, beyond normal claim handling, is justified in the processing of all motor vehicle claims. None of these indicators is necessarily incriminating. Perfectly appropriate claims can often bear these characteristics. These items are present only to provoke further

thought on the part of the adjusters when one or more of the indicia are present. A common sense approach to potential fraud investigation is recommended; therefore, any factor that suggests that a fraudulent claim is being made is worth discussing with SIU.

Collision & Comprehensive Fraud Indicators

Motor Vehicle

- Late model motor vehicle with unusually high mileage
- Completely burned
- High value extras on inexpensive motor vehicle
- Allegedly numerous repairs prior to theft
- Extensive collision damage, especially if no collision coverage
- Inspection sticker expired, altered, or otherwise defective
- Ignition or steering lock intact
- Excessive mileage on leased motor vehicles
- Previous total loss
- Missing parts surgically removed
- Registered other than in the state of residence
- Grey market foreign car or American diesel
- NICB difficulty in matching the VIN to the motor vehicle
- Purchase price exceptionally low

Loss

- Loss near inception of policy
- Fire late at night in remote area
- Loss prior to titling and registration
- Loss reported unusually late
- Loss near date of cancellation

Insured

- Occupation does not justify expensive motor vehicle
- Insured avoids use of mail
- Loan payments late
- Insured is suspiciously knowledgeable of insurance terminology and the claim process
- Insured exceptionally anxious to settle
- Insured uses a PO Box, hotel, or motel as his/her address
- Insured in obvious financial difficulty
- Insured is unemployed and without visible means of support
- Insured or friend locates the stolen motor vehicle
- No report to police
- Bad loss record
- Insured is evasive as to identity of prior owner of motor vehicle
- Insured wants to retain total loss
- Insured recently purchased stated value policy
- Insured has no phone and cannot be contacted at work

Coverage

- Coverage increased just prior to loss
- No lienholder on new model, or lienholder is an individual rather than lending institution

Purchase

- Title is a duplicate or none available
- Previous owner cannot be located

Bodily Injury, Including No-Fault

The Accident

- No witness
- Police report fails to verify accident, or presence of claimants fails to verify any injury on the part of any claimant
- Other motor vehicle in accident denies involvement
- Too many claimants for described accident
- Any allegation of intentional involvement
- Description of accident does not support injuries claimed
- Claimant or insured is difficult to find; claims to be self-employed or employed by another family member
- Injuries appear to be excessive in light of details of the accident or appear unrelated to the accident

Injuries and Damages

- Treatment appears excessive for the type of injury, indicative of build-up to exceed tort threshold
- Injuries are limited to soft tissue, and recovery appears to be unusually prolonged
- Index history shows a history of claims
- The attorney and physician involved have appeared on a number of questionable cases
- Medical bills received are reproductions of originals or bear evidence of alterations
- Wage loss not verified or wage verification form not signed, bears questionable signature or is suspicious

The Motor Vehicle

- No verification that described motor vehicle involved
- Damage seems too minor for injuries alleged
- Extent and location of damage do not match allegations

The Hybrid Audit Plan includes the Premium and Claims Statistical audits, Claims Performance Standards reviews, and SIU reviews. One of the primary objectives of the Hybrid Audit Plan is to verify adherence to statutory requirements. With the inclusion of the Claims Performance Standards and the SIU review in the Plan, an ARC's compliance with the key statutory requirements of G.L. c.175, §113H are evaluated:

- Claims handling is consistent for voluntary and residual market claims, and
- The ARC maintains a SIU which provides effective fraud control procedures.

A. Performance Standards

1. Cycle and Sample

   Every actively reporting Member and ARC will be audited on a three-year cycle. The cycle will be continually evaluated as new Members enter the Massachusetts private passenger motor vehicle insurance market. The ARC Compliance Audit Claim Questionnaire (Appendix K) and internal documentation including, but not limited to, claim manuals, reserving and claim settlement procedures, and internal audits will be reviewed at the onset of the examination.

   Under the Hybrid Audit Plan, all of an individual Member's or ARC's compliance audits will be conducted concurrently using a consistent sample selection. The sample size will be 270 policies with at least one claim. Data for the audit is verified at a 90% confidence level with a standard error rate of +/- 5% through stratified random sample audits for all functions.

2. Measurements and Penalties

   Voluntary and residual market claims will be reviewed for compliance with policy provisions and applicable statutes, rules, and regulations for the following Best Practices:

   - Coverage
   - Investigation
   - Special investigation
   - Medical management
   - Litigation management
   - Evaluation and settlement

The benchmark for compliance with these Best Practices is 93% in accordance with the NAIC error tolerance of 7% for standards involving claim resolution. Compliance will be measured as yes, no or not applicable. If no, a comment will be entered into the worksheet with an explanation. Chi square testing will be conducted on each Best Practice voluntary and MAIP score to determine if there is any statistical difference in handling. If the aggregate score is less than 93% or the difference is statistically significant the Member or ARC will be required to address the reasons in its response and submit a remedial action plan. The Governing Committee will determine if a penalty should be assessed based on the recommendation of the Compliance and Operations ~~Audit~~ Committee.

B. Private Passenger Ceded Pool Run-off

As the volume of claims in the Private Passenger Ceded Pool diminishes the remaining ceded claims will be reviewed with a twofold approach described below.

1. Ad Hoc Reviews – Large Loss/Indemnity/Reserve Review

   As part of the current Large Loss review procedures ceded claims will be selected quarterly from the Loss Limitations Report. Criteria for selection include large reserve and indemnity payments, litigation files, payments over a certain threshold, and allocated expenses. CAR will request a summary of the claim file including large loss reports, settlement reports, and adjuster notes. CAR will reserve the right to review the entire file if necessary. Additionally, a number of files requested by the Loss Reserving Committee are reviewed each quarter.

2. Bodily Injury Claim Reviews

   A random sample of ceded bodily injury claims will be reviewed during the course of the triennial audit. Files selected will have claim activity including indemnity and/or expense payments and reserves within the 12 month audit period. The sample would be on approximately 5 to 10 percent of the claims having activity. Results of this review will be included in the Audit Summary Report. The Compliance and Operations ~~Audit~~ Committee will review the volume of ceded claims and these run-off review procedures annually.

C. Definitions

1. Contact

   Under the PIP and BI Standards, Contact must be either in person or by phone. If the injured party cannot be reached on this initial contact a letter or email may be sent as a follow-up.

2. Independent Medical Examination

   A physical examination of the injured party to document the injury and provide an opinion on whether the treatment is reasonable, necessary and appropriate for the injury sustained. Cut off dates may be established.

3. Medical Audit

   Peer reviews of some or all of a claimant's medical bills and/or records by doctors, nurses, or other medical professionals.

4. Medical Bill Review

   A review of medical bills using a computerized/expert system, PPO, or provider of the same medical discipline as the provider bills being reviewed. Bills are checked for reasonableness of cost and modality. Duplication of treatments or unnecessary modalities are eliminated and not paid.

A. ARCs are required by G.L. c.175, §113H and Rule 30 to maintain a SIU to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud. The SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. ARCs are required to report SIU activity - assignments, denials, compromises, and savings to CAR using the standardized SIU Quarterly Activity Log.

During the triennial Hybrid Audit, a sample of 25 voluntary and/or MAIP claims or underwriting cases selected from the SIU log will be reviewed to determine the effectiveness of the ARC's fraud screening and quality of the SIU investigations. The cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings.

B. Rule 32. C. requires that the ARC's SIU investigate suspicious claims on all policies whether issued through the MAIP or issued voluntarily. Also, the SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues. Additionally, Rule 32.C. requires the ARC to conduct an audit of voluntary and MAIP policies to verify garaging and policy facts. ~~The results of these audits will be reviewed during the Hybrid Audit.~~ The SIU relevant components are included in the Hybrid Audit report and considered by the Compliance and Operations Committee upon completion.

1. Definitions

Special Investigations may be performed by SIU personnel or other personnel trained to handle suspicious claims using activity checks, surveillance, accident reconstruction, statements or examinations under oath. Special investigations also include third party expert analysis of documents associated with suspicious claims. Liability investigations are not considered to be special investigations.

To: Automobile Insurers, Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations

From: Gary D. Anderson, Commissioner of Insurance

Date: November 22, 2017

Re: Clarification of Coordination of Benefits under 211 CMR 38.00 for Medical Claims Associated with Motor Vehicle Accidents

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On October 7, 2016, the Massachusetts Division of Insurance ("Division") adopted new rules and amendments to its Coordination of Benefits ("COB") regulation, 211 CMR 38.00. In light of the update to 211 CMR 38.00, the Division issues this Bulletin to address the coordination of benefits for accident-related medical claims between fully-insured health policies and the Personal Injury Protection ("PIP") and Medical Payments ("MedPay") benefits of motor vehicle liability policies. This Bulletin and the current version of the COB regulation replace and supersede any prior guidance regarding coordination of benefits, including B-1990-2 and Bulletin 2008-12.

Applicability of Coordination of Benefit Rules to Insured Health Plans

The provisions of 211 CMR 38.00 apply to insured health plans issued or renewed in Massachusetts. Carriers should refer to the definition of "Plan" in 211 CMR 38.02, which specifies that a Plan does not include the following:

1. Hospital Indemnity Benefits coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received;
5. Medicare Supplement policies;
6. School accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
7. Benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
8. A state plan under Medicaid; or
9. A governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Self-funded employment-sponsored health plans are not subject to state insurance rules and, therefore, are not bound by the provisions of 211 CMR 38.00[1]. However, many self-funded employment-sponsored health plan administrators may elect to adopt the rules established within 211 CMR 38.00 to ease the administration of payments for motor vehicle accident-related medical claims.

Medical Expense Benefits within Motor Vehicle Liability Policies

PIP is a compulsory coverage included in all Massachusetts motor vehicle liability insurance policies. It can pay up to $8,000 for a claimant's medical expenses, replacement services, lost wages, and funeral expenses. M.G.L. c. 90, §§34A and 34M define PIP benefits under a standard Massachusetts motor vehicle liability insurance policy and §34A provides for the coordination of benefits between health insurance carriers and automobile insurers.

MedPay is coverage offered as part of a motor vehicle liability insurance policy. MedPay can pay for reasonable medical and funeral expenses incurred as a result of a motor vehicle accident, as noted in M.G.L. c. 175, §111C. Although automobile insurers are required to offer MedPay coverage of "at least five thousand dollars" under M.G.L. c. 175, §113C, coverage is optional.

Coordination of Health and Automobile Insurance Benefits

The first $2,000 in medical and funeral expenses incurred as a result of a motor vehicle accident must be submitted to the automobile insurer to be paid under PIP[2]. Coordination of benefits becomes necessary after the first $2,000 in medical and funeral expenses is paid under PIP.

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[1] Since self-funded employee benefit plans are exempt from state insurance laws, a self-funded plan may contain language deferring primary coverage to the automobile insurer, but is not required to do so. If the self-funded plan does contain such deferral language, then the PIP insurer will not be able to rely on the coordination provisions in 211 CMR 38.00. PIP must cover up to $8,000 in medical expenses, replacement services, funeral expenses and lost wages, and when PIP is exhausted, the Medical Payments coverage, if any, will apply.

[2] "[P]ersonal injury protection provisions shall not provide for payment of more than two thousand dollars of expenses incurred within two years from the date of accident for medical, surgical, X-ray and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services if, and to the extent that, such expenses have been or will be compensated, paid or indemnified pursuant to any policy of health, sickness or disability insurance or any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services." *Creswell v. Medical West Community Health Plan, Inc.*, 419 Mass. 327, 332 (1995).

The remaining amount in PIP coverage is coordinated between the claimant's health and motor vehicle insurance plans. Once the first $2,000 of PIP has been exhausted, any medical-related claims must be submitted to the health insurance carrier for coverage determination, if health coverage exists. The health insurance carrier cannot deny payment for medical expenses on the basis of the existence of PIP coverage. If there is a MedPay benefit within the motor vehicle policy, MedPay coverage is always secondary to and in excess of the benefits of the health coverage and the PIP benefit up to the limits of the MedPay benefit. *See* 211 CMR 38.05(1)(b).

PIP is not required to cover claims denied by a health insurance provider when the claimant has failed to comply with the requirements of the health coverage policy, e.g., by seeking out-of-network care that could have been obtained through one's health maintenance organization health insurance policy. *Dominguez v. Liberty Mut. Ins. Co.*, 429 Mass. 112, 112-113 (1999). However, if MedPay benefits are available, such denied claims would be payable under the MedPay coverage. *Mejia v. American Cas. Co.*, 55 Mass.App.Ct. 461, 466 (2002).

Coordination of benefits between health coverage, PIP and MedPay under 211 CMR 38.00[3]:

1. **Claimant does not have health coverage or MedPay.**
   PIP will pay up to $8,000 in medical expenses, replacement services, lost wages, and funeral expenses incurred as a result of an automobile accident.

2. **Claimant has health coverage and does not have MedPay.**
   The first $2,000 in medical and funeral expenses is covered by PIP and any medical expenses in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. If the health insurance carrier denies payment for a claim, the claimant may resubmit the claim to the motor vehicle insurer for consideration of coverage under PIP. PIP would not be required to cover a claim that was denied by the health insurance carrier for the claimant's failure to comply with the requirements of the health coverage policy, but PIP must pay for reasonable expenses not covered under the claimant's health coverage policy (*e.g.*, copayments; deductibles; and treatment that is not covered by health insurance, such as acupuncture).

3. **Claimant has MedPay and does not have health coverage.**
   The first $8,000 in medical expenses, replacement services, lost wages, and funeral expenses is covered by PIP. Once PIP has been exhausted, medical and funeral expenses are submitted to MedPay for coverage up to the limits of the coverage purchased.

4. **Claimant has health coverage and MedPay.**
   The first $2,000 in medical and funeral expenses are covered by PIP and any medical bills in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. The health insurance carrier is responsible for payment of claims in excess of the $2,000 PIP threshold, except where the health insurance carrier denies coverage for a legitimate reason (*e.g.*, claim for non-covered service). After payment is made by the health insurance carrier, the outstanding balance on the claim is then resubmitted to the motor vehicle insurer for consideration under PIP and, where PIP is unavailable or not required to pay for a claim denied by the health insurance carrier (for example, because of the claimant's failure to comply with the terms of the health policy), the claim must be covered by MedPay up to the limits of the MedPay coverage purchased.

   Generally, the MedPay benefit of a motor vehicle liability policy pays for:
   - applicable patient copayments, coinsurance or deductibles under the health coverage;
   - health care services that are not covered services under the claimant's health coverage; or
   - health care services from providers that are not part of the health coverage's network or were provided without prior authorization under the health coverage.

[3] Please note that these are general coordination of benefit rules between a fully-insured health plan and the PIP and MedPay coverages of a motor vehicle policy. Under certain circumstances, the PIP and MedPay benefits of a motor vehicle policy may be unavailable, reduced, or eliminated. *See* M.G.L. c. 90, §§34A and 34M; standard Massachusetts automobile insurance policy.

Restrictions on Billing Automobile Carriers for Amounts Beyond Health Carrier Payments

Where the PIP and MedPay coverages of a motor vehicle liability policy are secondary to coverage under a health plan, the coordination of benefits rules may not be used by a provider to increase the amount of payment to the provider for a service beyond the amount that the provider agreed to accept from the health insurance carrier as payment for the services. Thus, the provider may not bill the motor vehicle liability policy or the insured the difference between the provider's negotiated payment with the health insurance carrier and the provider's charge. Unless otherwise permitted under 211 CMR 38.00, the coordination of benefits rules may not be used to circumvent contractual agreements between providers and health plans by increasing the provider payment or decreasing the amount the provider has negotiated to accept in payment for services, less any required deductibles, coinsurance or copayments. Health plans should include provisions in their provider contracts to account for payments under coordination of benefits.

Limitations to Coordination of Benefits within Insured Health Plan Documents

Fully-insured health benefit plans *may not* include a "coordination of benefits" provision in their contracts making their coverage secondary to other coverage for health care services, including MedPay. Automobile insurers may continue to determine whether PIP or MedPay pays first based on the reason for the health insurance carrier's denial or based upon an exclusion under M.G.L. c. 90, §34A (e.g., felonious conduct) or under the terms of the automobile insurance policy. The Division expects all health carriers to submit amendments to existing policy form materials that remove coordination of benefits provisions that are impermissible under 211 CMR 38.00 (*i.e.*, deferral to MedPay).

Effective Date of Amended Coordination of Benefits Rules

The Division expects all health and automobile insurance carriers to establish systems by no later than January 1, 2018 that comply with the provisions of 211 CMR 38.00 when responding to medical claims associated with automobile accidents that occur on and after that date.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner, Health Care Access Bureau, at 617-521-7323 or kevin.beagan@state.ma.us.

Performance Standards

Appendices

A. Screening Reports and Initial Investigation

1. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

2. Initial investigation shall confirm that coverage is appropriate:

   a) Date of loss within policy period and all policy coverage is in order.

   b) Injured persons are eligible for no-fault benefits.

   c) Private health insurance availability shall be verified and documented.

   d) Injuries arise from use of a motor vehicle.

   e) Massachusetts statute applies.

   f) No exclusions apply, such as drunk driving, stolen car, or workers compensation.

3. The setting of initial and subsequent reserves shall be timely, reasonable, and follow documented company policy.

B. Contacts

1. Injured persons or their legal representative making a claim shall be contacted within 2 business days of the receipt of notice of injury for purposes of investigation and verification.

2. The named insured, if not an injured party, shall be contacted within 3 business days of the receipt of notice of injury for purposes of investigation and verification.

3. The insured operator, if not identified in B.1. or B.2., shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Necessary forms shall be mailed or, if preferred by the injured party, electronically sent to the address specified within 5 business days after notice of injury.

C. Medical Management

1. SCs must establish a plan to maintain a continuing awareness of the disability claimed, the medical treatment, and whether the treatment and medical expenses are reasonable, necessary, and related to the motor vehicle accident.

2. Any plan shall include historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches.

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or indications of potential fraud exist (such as accident of unusual circumstances, severity of accident, unusual number of injured passengers, prior index history, recognition of a pattern related to prior cases of fraud), the case shall be referred for special investigation with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. Refer to Appendix A for other indicators.

2. Special Investigation

a) Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with consideration given to referring the claim to IFB, NICB or appropriate law enforcement agency for prosecution.

b) The CAR SIU Standards for investigation of suspicious claims must be consulted and considered as part of the special investigation process.

c) SCs shall have a plan designed to deal with claims involving exaggerated damages or injuries, such as inflated doctors' bills or wage statements, and such plan shall provide a strategy for concluding those cases at a reasonable amount, as well as reporting the same to the Detail Claim Database (DCD) at the Automobile Insurers Bureau (AIB). Savings realized from this process shall be documented on the SIU Quarterly Log.

d) Legal expenses incurred shall be itemized, monitored, and related to the claim being paid.

B. Subrogation/Recovery

1. The initial contact and investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the SC against which subrogation may be directed. If applicable, a preliminary notice of subrogation shall be sent to the other SC.

2. In cases of injury serious enough to exceed the tort threshold, the no-fault carrier shall alert the tort carrier immediately.

C. Claim Payment

1. No payment shall be made until the reported loss has been verified and:

a) The deductible applied if applicable.

b) Benefits coordinated in conjunction with existing health carrier and wage continuation plans.

c) Medical bills verified prior to payment and reviewed for reasonableness, medical necessity, and relationship to the accident.

d) Wage rate/working hours verified with employer, using wage/salary verification forms.

e) Lost wages confirmed by employer's statement as to time missed and by physician's statement verifying disability for that period of time.

f) Investigations promptly conducted. Upon agreement to pay, checks are issued within 10 business days.

g) A litigation management program is designed to bring cases to the earliest conclusion at a reasonable value.

h) Legal expenses incurred are itemized, monitored, and related to the claim being paid.

2. In the normal course of claim handling, a file shall be referred for special investigation when discrepancies exist that are unresolved. Refer to Appendix A for a list of indicators.

3. Evaluation and Settlement

   After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

A. Measurements

G.L. c.175, §113H requires that CAR propose rules to govern the application of penalties for, among other things, the failure to meet the Performance Standards for the Handling and Payment of Claims by SCs.

The following Performance Standards, approved by the Commissioner of Insurance apply to the Commercial SC Program.

1. Measurements of performance and compliance with the standards are conducted through examinations of claims enhanced by relevant Statistical Plan data and procedures established by CAR. The completion of a questionnaire by the SCs prior to the biennial review provides background information on the claim handling programs established by the SC to comply with the Standards. This will be supplemented at the time of the examination by a review of company internal documentation including but not limited to claim manuals, reserving and claim settlement procedures, and internal audits. In addition to the Statistical Plan data, SCs are required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

2. SCs are evaluated on the effectiveness of their claim handling in meeting industry best practices as well as for their compliance with the Performance Standards and the NAIC Standards. SCs are measured against the benchmarks listed and industry averages as well as their own prior performance. Both quantitative and qualitative aspects of the claims process are evaluated. The most readily quantifiable standards are the ones that involve specific timeframes, averages, and counts. Other standards are qualitative such as reserving, medical management, evaluation, and settlement. The benchmark for compliance with the best practices and standards is 80%. The measurements for glass, re-inspections, and ICPIP are set at MA statutory levels.

3. If it is determined that a SC is not in compliance with the Performance Standards on ceded files the CAR Compliance Audit Department will then determine the degree to which the non-compliance exists in the following areas addressed by the Standards. Specifically, the areas are:

Standard I – Motor Vehicle Physical Damage & Property Damage Liability Claims
Standard II – Bodily Injury & Uninsured/Underinsured Motorist
Standard III – No-Fault Personal Injury Protection Benefits
Standard V – Expenses

4. For Standard IV-Voluntary/Ceded Claim Handling Differential, CAR will evaluate and compare the individual company performance on the handling of ceded and voluntary claims. Statistical testing will be performed to determine if there is any statistically significant difference in the handling of voluntary and ceded claims by the SC. If CAR determines that the company is in non-compliance with the Voluntary/Ceded Claims Handling Differential Standard a penalty will be assessed.

B. Non Compliance Penalties

1. Minor non-compliance indicates that a SC is not in compliance with the Standards in one or more areas but the quality of claim handling is unaffected and no overpayments result from this situation.

2. Major non-compliance indicates that a SC has failed the Standards in one or more areas. Claim handling is affected and overpayments may be occurring as a result. The SC will be notified of the extent and areas in which non-compliance exists and will be warned that the subsequent review of the SC must reflect compliance in all of the cited areas to avoid penalty.

3. If in the review subsequent to being warned of major non-compliance a SC remains in non-compliance but has improved its claim handling practices significantly, a Type I penalty will be assessed for the area in which this non-compliance exists.

4. If in the review subsequent to being warned of major non-compliance a SC fails to improve its claim handling practices, a Type II penalty will be assessed for the area in which this non-compliance exists.

5. One penalty will be assessed in each of the following sections of the Standards in which major non-compliance is found:

Standard I – Motor Vehicle Physical Damage & Property Damage Liability Claims
Standard II – Bodily Injury & Uninsured/Underinsured Motorist
Standard III – No-Fault Personal Injury Protection Benefits

Standard IV – Voluntary/Ceded Claim Handling Differential
Standard V – Expenses

6. The amount of the penalty will be determined by the type of penalty using the following Schedule of Penalties.

Schedule of Penalties			
Type I Penalty by Year			
1st Year	2nd Year	3rd Year	4th Year
Warning	$6,000	$30,000	Governing Committee
Type II Penalty by Year			
1st Year	2nd Year	3rd Year	4th Year
Warning	$20,000	$100,000	Governing Committee

7. In the event that non-compliance continues beyond two years, the penalties will increase for the third year according to the Schedule of Penalties. In the fourth year of non-compliance the SC would be referred to the Governing Committee for possible termination.

8. Should a SC achieve compliance after being penalized for non-compliance with the Standards, it must maintain compliance for two years before it is returned to pre-warning status.

9. Should a SC disagree with the findings of the CAR Compliance Audit Department, it will notify the Governing Committee and a meeting will be held to discuss the findings. If agreement cannot be reached, the SC may appeal the decision to the Commissioner of Insurance in accordance with Rule 20.

10. The compliance status of the Commercial SC's will be reported to the Compliance and Operations ~~Audit~~ Committee, the Governing Committee, and the Division of Insurance.

11. The following benchmarks and measurements are used to compare the SCs performance to the Industry on commercial claims handling. Except where noted, the benchmark compliance is 80%.

Best Practices	NAIC Standard	Measurement	Benchmark
Physical Damage/Property Damage			
Assignment/Contact	NAIC 1	• Appropriate assignment and contact to establish loss fact	
Coverage	NAIC 3, 7	• Coverage verified, garaging and operator issues resolved if applicable	
Appraisal	NAIC 6	• Appraisal assignment within 2 business days • Transmittal of appraisal within 2 business days • Quality of appraisal - Aftermarket/LKQ, betterment, screening for fraud, photos, recognition of fraud, and cause and origin.	
Reserving	NAIC 10	• Timely, reasonable, follow documented company policy	
Screening and Investigation	NAIC 2, 3, 6	• Screening for fraud, recognition of fraud indicators • Timely investigation • Liability apportioned correctly	
Settlement	NAIC 3, 6	• Depreciation and ACV calculations appropriate • Salvage disposal proper • On property damage, comparative negligence recognized • Payment within 5 days under Direct Payment Plan; 7 days CWCF	
Subrogation/Recovery	NAIC 8	• Subrogation recognized and pursued • Reimbursement of deductible is timely and accurate when and where appropriate	

Best Practices	NAIC Standard	Measurement	Benchmark
Reinspections	NAIC 6, 9	• Compliance with Regulation 212 CMR 2.04	75%>$4,000; 25%<$4,000
Glass	NAIC 6	• Program for repair of glass in place • Carrier tracks percent of repair	100%
Litigation Management	NAIC 13	• Bring cases to the earliest conclusion at a reasonable value	
No Fault Personal Injury Protection Claims			
Contact	NAIC 1, 9	• Injured party - 2 days • Uninjured party - 3 days • PIP form mailing - 5 days	Contact
Reserving	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	
Medical Management	NAIC 4, 5, 6, 11	• Claims warranting IME referral vs. claims referred for IME • Appropriate utilization of IME results to cut off claim, reduce bills • Appropriate utilization of Medical Bill Review program	
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation	
Subrogation/Recovery	NAIC 8	• Subrogation recognized and pursued • Reimbursement of deductible is timely and accurate when and where appropriate	
Bodily Injury/Uninsured Motorist Claims			
Contact	NAIC 1	• Injured party - 2 days • Uninjured party - 3 days	
Reserves	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	

Best Practices	NAIC Standard	Measurement	Benchmark
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation	
Litigation Management	NAIC 7, 13	• Reservation of Rights and Excess letters used when and where appropriate	
Settlement	NAIC 3, 5, 6	• Evaluation range documented and appropriate • Settlement within range or documented why exceeded	
Subrogation/Recovery	NAIC 3	• Recovery potential recognized and pursued • Contribution from joint tortfeasor obtained	
Expenses	NAIC 14	• Reported properly as defined in the Statistical Plan	
Voluntary/Ceded Claim Handling Differential			
Claim Handling	NAIC 6	• A comparison of the compliance results for each of the resolution standards in the Ceded and Voluntary claims will be calculated • Statistical testing will be performed on the aggregate results of each of the three applicable sections: Physical Damage/Property Damage, PIP, and BI • If the difference is statistically significant, the carrier will be required to address the reasons in response • Following the response, CAR will make a determination on whether the Voluntary/Ceded Standard was in compliance	
~~Expenses~~	~~NAIC 14~~	• ~~Reported properly as defined in the Statistical Plan~~	

The reduction of insurance fraud, by monitoring and coordinating the investigation of suspicious claims, is an important goal of CAR. It seeks the achievement of three beneficial results:

- Successful resistance to the payment of fraudulent claims
- The establishment of a deterrent to fraud
- The reduction of losses, with the consequent improvement in insurance rates

In order to achieve these results, SCs must pursue the investigation of fraud by establishing a commitment to support and encourage the activities of its SIU.

A. CAR SIU

The CAR SIU, as part of the Compliance Audit Department exists under the authority of Article III of the Plan of Operation. It is charged with monitoring the efforts of SCs to control fraud. In addition, it will assist Members and SCs on request. CAR will perform a biennial audit of the SIU of each SC as part of the commercial audit to evaluate its effectiveness.

Assistance of the CAR SIU is intended to provide expert investigation beyond the capabilities of the average SC's investigator. The basic investigation of a suspicious claim is the responsibility of the SC. CAR SIU will also assist with the coordination of an investigation involving several SCs.

B. CAR Standards for SC SIU

CAR evaluations of a SC's SIU will be based on its performance in accordance with the following guidelines:

1. Each SC is required by Article IV of the Plan of Operation to maintain a SIU to investigate suspicious claims for the purpose of eliminating fraud. A SIU shall be staffed by experienced salaried employees who are adequately trained in the recognition and investigation of insurance fraud. A SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. The work of a SIU may be supplemented by closely supervised independent adjusters or investigators.

2. Each SC shall ensure that all motor vehicle insurance claims, where there is a suspicion of fraud, are referred promptly to its SIU.

3. Each SC SIU shall maintain a SIU Quarterly Activity Log of cases referred to it containing at least the following information:

   - Date of referral
   - Date of loss
   - Claim number
   - Policyholder
   - Type of claim
   - Amount of claim
   - Amount paid
   - Date completed

   ~~Copies of active pages of the log shall either be mailed or submitted electronically at the end of each calendar quarter to:~~

   ~~Commonwealth Automobile Reinsurers~~
   ~~101 Arch Street – Suite 400~~
   ~~Boston, MA 02110~~
   ~~ATTN: Special Investigative Unit~~

   The log shall be uploaded by each SC to a secure SIU application located on CAR's website in the format prescribed by CAR. The log file shall be transmitted at the end of each quarter and no later than the 15th of the following month.

4. Regulation 211 CMR 75.00 establishes the NICB as the central organization engaged in motor vehicle loss prevention as required by G.L. c.175, §113O. It also requires certain actions by insurers with respect to theft claims. An insurer must, among other things:

   - Report all thefts to NICB
   - Obtain NICB's acknowledgement before paying claims
   - Report disposition of salvage
   - Investigate and report evidence of fraud
   - Defer payment in certain circumstances

5. The NICB has been established as the central organization to whom insurance companies report cases of bodily injury fraud for possible further action with law enforcement agencies and criminal prosecuting authorities.

   In all cases where careful further investigation has established the strong possibility of bodily injury fraud, the SC should forward a complete photocopy of the claim file to NICB for further consideration and action.

If a SC is not a member of NICB, the SC may refer such case directly to the appropriate local law enforcement agency for consideration of criminal prosecution.

6. The Motor Vehicle Fraud Profile described in Section D identifies circumstances in which a motor vehicle theft or fire claim should be considered suspicious. Such claims warrant careful investigation into the possibility of fraud.

7. Both law and equity dictate that a prompt and thorough investigation precede any decision with respect to payment or denial of a claim. The provisions of G.L. c.93A and c.176D must be borne in mind at all times. Penalties incurred by members for violations of these laws are subject to reimbursement by CAR and may not be reported as loss or allocated expense.

8. The quality of investigation performed by a SIU is an important criterion of its effectiveness. It will be given careful consideration by CAR during an audit. It is not possible to outline every avenue of the investigation of a suspicious claim; it is limited only by the experience and imagination of the investigator. There are, however, certain elements which are common to the investigation of suspicious fire or theft claims that should be covered in every such case referred to a SIU, or the file should reflect the reasons why it was not. Refer to Section C. for these guidelines.

C. CAR Standards for Investigation of Collision and Comprehensive Losses

1. Interviews of Owner, Custodian, Companions, Witnesses, etc.

   A recorded statement should be obtained from the owner of the motor vehicle, exploring in depth and in detail the areas described below. Statements of others with knowledge of some or all of the circumstances are also important.

   - The individual interviewed
   - Name, address, date of birth, occupation, employer
   - The motor vehicle

     Year, make, model, VIN; when purchased, from whom, amount paid, motor vehicle traded in, amount allowed; if used, condition, odometer reading, improvements by insured; amount borrowed, from whom, term of loan; where

kept when not in use, who uses the motor vehicle, purpose; service, inspection, repair; problems.

2. Insurance

   How long insured by this company; if short time, former carrier; any other insurance; recent changes of coverage; history of claims.

3. The Loss

   Date, time, and place; description of event; when and how the motor vehicle got to that location; purpose of its presence there; identity of witnesses; was car locked; who had keys; activities between leaving motor vehicle and discovery of loss; time, place, and method of report to police; identity of those responsible.

4. Police

   The owner or custodian of a motor vehicle which is stolen or substantially damaged must report in writing to the police. An insurer may not pay a theft claim until it has confirmed the existence of such a report. Its file should contain a copy of the report or an explanation of its absence. Police reports of the recovery of a motor vehicle and any investigation should be obtained. Interviews of police officers are useful in selected cases. The possibility of investigation by other governmental agencies should be considered if the claim appears to be part of an organized pattern of activity.

5. Claim History

   A record of the policyholder's prior losses should be obtained. The record is not necessarily evidence of impropriety. However, an extensive record warrants a study of the claim files to identify patterns of activity or other information of interest. This is fruitful source of leads.

6. Insurance File

   A study of the underwriting file should be undertaken. A recent application and/or changes of motor vehicle or coverage may suggest premeditation.

7. Mortgagee

   Inquire via telephone about the timeliness of installment payments and the amount of the loan outstanding. A history of late payments and/or a delinquency of several months suggest financial difficulty which might motivate one to destroy his/her motor vehicle.

8. Ownership and Value

   Copies of the Bill of Sale, the Application for Title and/or Registration, and the Title should be obtained. These establish ownership, identify the prior owner, and establish the value at the time of purchase. Inconsistencies of purchase price suggest dishonesty. Seek verification by the seller of the price and condition at the time of sale. Be alert to prior use as a public or private livery motor vehicle.

9. Betterment

   It is often claimed that the value of an motor vehicle has been enhanced by the addition of special equipment or by cosmetic improvements. Receipts for such things should be requested, and if received, verified.

10. Service and Repair

    The interview with the policyholder and the examination of the motor vehicle should cover the service and repair history of the motor vehicle. The inspection sticker and stickers recording oil changes and lubrication will provide leads, as may the contents of the glove compartment. Investigate recent service and repair activity to identify problems which might provide a motive for destroying the motor vehicle.

11. The Motor Vehicle Examination

    A careful, thorough, and early examination of the motor vehicle when it is available is important.

    a. Start with the plate bearing the VIN. Look for evidence of tampering, either of the plate itself or of the rivets that hold it in place. Record the complete number by placing a paper over it and rubbing it with a pencil. Report whether the number is consistent with the type and model of the motor vehicle and consistent with the policy.

b. Obtain abundant clear photographs of the engine, passenger, and trunk compartments and all areas of the exterior, including wheels and tires. The engine, the ignition lock, and the registration plate particularly are important. Don't mark the face of a photograph; it may destroy its value as evidence.

c. Determine the odometer reading. Report whether it is consistent with the age and condition of the motor vehicle and with the mileage reported by the owner.

d. Examine the ignition lock. Report whether there is evidence of damage and whether it contained a key.

e. Report whether the glove or trunk compartments contain the usual articles. Take possession of bills related to service, repair, or improvements. A thief has no interest in the usual contents; their absence may suggest removal by the owner in anticipation of a loss.

f. Examine the inspection sticker. Report when and where it was inspected, whether it is current, or whether there is a rejection sticker.

g. Examine the registration plate. Report the date of expiration.

h. Record date on service or oil change stickers.

i. Try to distinguish old damage from new. The presence or absence of dirt and/or rust should be considered. Report evidence of recent changes of wheels or tires.

j. Consider or give consideration to wear and tear, mechanical and electrical failures, and missing parts and equipment.

k. Determine the level and condition of crankcase and transmission oil, brake fluid, and radiator coolant.

l. In selected cases, a professional analysis of the ignition, the engine, or the transmission may be warranted.

D. Motor Vehicle Fraud Profile

The following items should serve as indicators in determining whether an investigation, beyond normal claim handling, is justified in the processing of all motor vehicle claims. None of these indicators is necessarily incriminating. Perfectly appropriate claims can often bear these characteristics. These items are present only to provoke further

thought on the part of the adjusters when one or more of the indicia are present. A common sense approach to potential fraud investigation is recommended; therefore, any factor that suggests that a fraudulent claim is being made is worth discussing with SIU.

Collision & Comprehensive Fraud Indicators

Motor Vehicle

- Late model motor vehicle with unusually high mileage
- Completely burned
- High value extras on inexpensive motor vehicle
- Allegedly numerous repairs prior to theft
- Extensive collision damage, especially if no collision coverage
- Inspection sticker expired, altered, or otherwise defective
- Ignition or steering lock intact
- Excessive mileage on leased motor vehicles
- Previous total loss
- Missing parts surgically removed
- Registered other than in the state of residence
- Grey market foreign car or American diesel
- NICB difficulty in matching the VIN to the motor vehicle
- Purchase price exceptionally low

Loss

- Loss near inception of policy
- Fire late at night in remote area
- Loss prior to titling and registration
- Loss reported unusually late
- Loss near date of cancellation

Insured

- Occupation does not justify expensive motor vehicle
- Insured avoids use of mail
- Loan payments late
- Insured is suspiciously knowledgeable of insurance terminology and the claim process
- Insured exceptionally anxious to settle
- Insured uses a PO Box, hotel, or motel as his/her address
- Insured in obvious financial difficulty
- Insured is unemployed and without visible means of support
- Insured or friend locates the stolen motor vehicle
- No report to police
- Bad loss record
- Insured is evasive as to identity of prior owner of motor vehicle
- Insured wants to retain total loss
- Insured recently purchased stated value policy
- Insured has no phone and cannot be contacted at work

Coverage

- Coverage increased just prior to loss
- No lienholder on new model, or lienholder is an individual rather than lending institution

Purchase

- Title is a duplicate or none available
- Previous owner cannot be located

Bodily Injury, Including No-Fault

The Accident

- No witness
- Police report fails to verify accident, or presence of claimants fails to verify any injury on the part of any claimant
- Other motor vehicle in accident denies involvement
- Too many claimants for described accident
- Any allegation of intentional involvement
- Description of accident does not support injuries claimed
- Claimant or insured is difficult to find; claims to be self-employed or employed by another family member
- Injuries appear to be excessive in light of details of the accident or appear unrelated to the accident

Injuries and Damages

- Treatment appears excessive for the type of injury, indicative of build-up to exceed tort threshold
- Injuries are limited to soft tissue, and recovery appears to be unusually prolonged
- Index history shows a history of claims
- The attorney and physician involved have appeared on a number of questionable cases
- Medical bills received are reproductions of originals or bear evidence of alterations
- Wage loss not verified or wage verification form not signed, bears questionable signature or is suspicious

The Motor Vehicle

- No verification that described motor vehicle involved
- Damage seems too minor for injuries alleged
- Extent and location of damage do not match allegations

This section incorporates the selection of the sample, review procedures, and criteria to conduct these examinations following the guidelines in Chapter VIII G. Claims of the NAIC Market Conduct Examiners Handbook.

A. Introduction

Rule 10.C of the CAR Rules of Operation requires CAR to conduct periodic audits of SCs claims including policies ceded to CAR and voluntarily written as specified in G.L. c.175 §113H. To satisfy this rule CAR conducts claim examinations to evaluate the effectiveness of claim handling in meeting Industry Best Practices as well as compliance with the Performance Standards and NAIC Standards. Procedures for the examination are based on Chapter VIII G. of the NAIC Market Conduct Examiners Handbook and are further defined in the Manual of Administrative Procedures Chapter IV - Claims. The Compliance Audit Claim Questionnaire and internal documentation including, but not limited to, claim manuals, reserving and claim settlement procedures, and internal audits will be reviewed at the onset of the examination. The reviews are conducted using a systems application that has been built specifically for the purpose of evaluating claim handling practices and compliance with the Performance Standards.

B. Scope and Sample

1. The SCs will be audited biennially. The scope of the audit includes the review of a randomly selected sample of records for the account year being evaluated from the CAR loss statistical data base.

2. The sample consists of 220 claims (55 for each coverage type: Physical Damage, Property Damage, PIP and Bodily Injury) selected based on company reporting from each commercial class type. The audit provides for the inclusion of all types of transactions from all classifications of business. It allows for the extrapolation of data, provides a standard for measuring the performance of an audited company, and the comparison of one audited company to another.

3. The audited company is required to supply the claim file and any other pertinent documentation supporting the company's handling of the loss. Ceded and voluntary claims are selected randomly in proportion to the total claim population. Statistical testing is

completed to determine if any significant difference exists in the handling of voluntary and ceded claims. Each audited company is assigned an overall compliance value and a ceded compliance value. A penalty is assessed when the audited company does not attain an 80 percent compliance rate for the handling of ceded claims.

4. At the conclusion of each audit, a preliminary report is issued. In any instance that the audited company does not agree with an audit finding and appropriate documentation can be supplied, the necessary adjustments are included in the final report. The company is asked to submit a written response to the audit findings to be included in the final report. The report and response letter is distributed to the Compliance and Operations ~~Audit~~ Committee and the Massachusetts Division of Insurance.

5. The Division of Insurance Summary of Commercial Audits – Annual Report will be submitted biennially to the Compliance and Operations ~~Audit~~ Committee, Governing Committee, and the Division of Insurance.

C. Commercial Ceded Pool Run-Off

1. Run-off Claim Reviews

   A sample of ceded claims will be reviewed biennially from those companies that are no longer SCs. Files selected will have ceded claim activity including indemnity and/or expense payments and reserves within the accounting year being evaluated. The sample will be approximately 5 to 10 percent of the claims having activity. A Summary of Review will be prepared for the carrier.

2. Ad Hoc Reviews - Large Loss/Indemnity/Reserve Review

   As part of the current Large Loss review procedures, ceded claims are selected quarterly from the Loss Limitations Report. Criteria for selection include a large dollar reserve or indemnity payments, litigation files, payments over a certain threshold, and allocated expenses. CAR will request a summary of the claim file which shall include large loss reports, settlement reports, and adjuster notes. CAR will reserve the right to review the entire file if necessary. Additionally each quarter, a number of files requested by the Loss Reserving Committee are reviewed.

D. Definitions

1. Contact:
   Under the PIP and BI Standards contact must be either in person or by telephone call. If the injured party cannot be reached on this initial contact a letter or email may be sent as a follow-up.

2. Independent Medical Examination (IME):
   A physical examination of the injured party to document the injury and provide an opinion on whether the treatment is reasonable, necessary, and appropriate for the injury sustained. Cut off dates may be established.

3. Major Non-Compliance:
   A carrier is not in compliance with the Standards in one or more areas and claim handling is affected and overpayments may be occurring as a result.

4. Medical Audit:
   Peer reviews of some or all of a claimant's medical bills or records by doctors, nurses, or other medical professionals.

5. Minor Non-Compliance:
   A carrier is not in compliance with the Standards in one or more areas but the quality of claim handling is unaffected and no overpayments result from this situation. Neither a warning nor penalty will result from a finding of minor non-compliance.

6. Medical Bill Review (MBR):
   A review of medical bills using a computerized expert system, PPO, or provider of the same medical discipline as the provider bills being reviewed. Bills are checked for reasonableness of cost and modality. Duplication of treatments or unnecessary modalities are eliminated and not paid.

7. SIU:
   Special investigations may be performed by SIU personnel or other personnel trained to handle suspicious claims using activity checks, surveillance, accident reconstruction, statements or examinations under oath. Special investigations also include third party expert analysis of documents associated with suspicious

claims. Liability investigations are not considered to be special investigations.

8. Type 1 Penalty:
   A Type 1 penalty is assessed when a carrier remains in non-compliance in the review subsequent to being warned but has improved its claim handling practices significantly.

9. Type 2 Penalty:
   A Type 2 penalty is assessed when a carrier fails to improve its claim handling practices in the review subsequent to being warned for non-compliance.

A. The CAR SIU is charged with monitoring the efforts of the SCs to control fraud. A biennial evaluation of each SC's SIU is conducted to examine the overall SIU operation and quality of investigations.

File Selection and Review

B. A random sample of approximately 25 voluntary and ceded referrals from the SIU Quarterly Activity Log pertaining to claims or underwriting is selected. Files are reviewed to determine the ability of the staff to recognize potentially fraudulent claims and the quality of the SIU investigations. In addition, CAR reviews the accuracy of the savings reported to CAR. An examination of the effectiveness of the carriers' fraud screening and the SIU referral process has been incorporated into the biennial Claims Reviews. Cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings. ~~The findings of the SIU review will be considered during the Commercial Audit.~~

C. Rule 10.C. requires that the SC's SIU investigate suspicious circumstances surrounding underwriting, rating and premium issues. Also that a claim shall not be investigated by the SIU solely on the basis that the claim arises from a ceded policy. Additionally, Rule 10 requires the SC to conduct an audit of a representative sample of policies to verify garaging and policy facts. The SIU relevant components are included in the Commercial Claims Performance Standards Report and SIU Evaluation. This report is considered by the Compliance and Operations Committee upon completion.

CAR	**Commercial Claims Performance Standards**
Appendix K	**Compliance Audit Claim Questionnaire**
Revision Date	**2018.05.22**
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Pursuant to G.L. c.175, §113H, CAR is required to establish Performance Standards designed to contain costs, ensure prompt customer service and the payment of legitimate claims, and resist inflated, fraudulent, and unwarranted claims. These Performance Standards require that all SCs establish plans and programs to meet these objectives. Often this only requires that the SC formalize or enhance its current practices and procedures. In other instances, SCs may need to develop new practices and procedures to become compliant with these Performance Standards.

This Compliance Audit Claim Questionnaire included below is distributed to every SC prior to the Commercial Audit scheduled start date. The purpose of the questionnaire is to gather information from the SC relative to plans and programs it maintains. The SC is required to provide detailed responses to the questions included in the questionnaire, and return by the date established by CAR staff. The Claim Questionnaire shall be signed by a SC staff member with appropriate authority to provide this information to CAR on behalf of the SC.

Commonwealth Automobile Reinsurers
Compliance Audit Claim Questionnaire
Claims Performance Standards

Certification of Authority

Printed Name:	
Title:	
Company Name:	
Signature:	

1. Does the company offer a Direct Payment Plan for physical damage and property damage losses as referenced in Performance Standard I. A. 2. a.?

   Click here to enter text.

2. How does the company determine actual cash value for total loss payments? Is there an evaluation process in place to determine that the actual cash value is comparable to other vehicles?

   Click here to enter text.

3. What procedures are used during the initial screening of a loss to identify warning signs requiring special investigation? What specific information is sought during the screening process? Do these procedures and the information sought vary depending on the type and level of coverage? Are these procedures and resulting information considered in the assignment of the claim to staff with sufficient experience and training?

   Click here to enter text.

4. What method is used to ensure that the losses processed and paid are consistent with the associated policy, including listed operators, coverage, and garaging information provided? What procedures are used to resolve coverage issues? What triggers notification to underwriting? For Commercial losses, how is the Principal Place of Business verified?

   Click here to enter text.

5. What methods are used to establish initial reserves and what procedure is used to update reserves throughout the duration of the claim? Are different methods used for losses involving injuries?

   Click here to enter text.

6. What components comprise the SIU, including staffing? How many and what types of cases are handled? Describe the SIU screening and referral procedures. What type of fraud awareness training is provided to the claim staff and SIU on a yearly basis?

   Click here to enter text.

7. What is the percentage of glass claims repaired to total paid glass claims as referenced in Performance Standard I. D. 1.?

   Click here to enter text.

8. What diary systems are used for bodily injury claims as referenced in Performance Standard II A. 5. d.?

   Click here to enter text.

9. How are payment authority levels established for the handling of bodily injury claims? Does this process change when policy limits will be exhausted?

   Click here to enter text.

10. What procedure does the company use to evaluate BI and UM claims? Is a third party evaluation tool used in this process?

    Click here to enter text.

11. Describe the company's litigation management program used to bring cases to conclusion during a reasonable time frame and at a reasonable cost on all types of losses?

    Click here to enter text.

12. What process is used to refer suspicious BI claims for SIU? Does this process occur at the screening process or initial investigation level?

    Click here to enter text.

13. How are SIU claims resolved and settled? What is the screening and referral process for losses that require special investigation?

    Click here to enter text.

14. What methods are used to determine whether medical treatment and expenses are reasonable, necessary and related to the automobile accident? Does the company maintain staff with medical training as consultants to assist or contribute to claim handling, evaluation of reasonable and necessary treatment, causality, etc? If yes, describe this process.

    Click here to enter text.

15. What role does an Independent Medical Examination, Medical Audit or Medical Bill Reviews have in the medical management process? After any of these are concluded, what process is in place to determine if payments should then be issued?

    Click here to enter text.

16. What controls ensure that residual market claims are processed with the same degree of diligence as voluntary claims?

    Click here to enter text.

17. How are legal defense costs including legal bills controlled? What type of Alternative Dispute Resolution program is in place?

    Click here to enter text.

18. How does the company ensure that allocated expenses are properly reported and unallocated expenses are not reported as defined in the Statistical Plan?

    Click here to enter text.

To: Automobile Insurers, Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations

From: Gary D. Anderson, Commissioner of Insurance

Date: November 22, 2017

Re: Clarification of Coordination of Benefits under 211 CMR 38.00 for Medical Claims Associated with Motor Vehicle Accidents

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On October 7, 2016, the Massachusetts Division of Insurance ("Division") adopted new rules and amendments to its Coordination of Benefits ("COB") regulation, 211 CMR 38.00. In light of the update to 211 CMR 38.00, the Division issues this Bulletin to address the coordination of benefits for accident-related medical claims between fully-insured health policies and the Personal Injury Protection ("PIP") and Medical Payments ("MedPay") benefits of motor vehicle liability policies. This Bulletin and the current version of the COB regulation replace and supersede any prior guidance regarding coordination of benefits, including B-1990-2 and Bulletin 2008-12.

Applicability of Coordination of Benefit Rules to Insured Health Plans

The provisions of 211 CMR 38.00 apply to insured health plans issued or renewed in Massachusetts. Carriers should refer to the definition of "Plan" in 211 CMR 38.02, which specifies that a Plan does not include the following:

1. Hospital Indemnity Benefits coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received;
5. Medicare Supplement policies;
6. School accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
7. Benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
8. A state plan under Medicaid; or
9. A governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Self-funded employment-sponsored health plans are not subject to state insurance rules and, therefore, are not bound by the provisions of 211 CMR 38.00[1]. However, many self-funded employment-sponsored health plan administrators may elect to adopt the rules established within 211 CMR 38.00 to ease the administration of payments for motor vehicle accident-related medical claims.

Medical Expense Benefits within Motor Vehicle Liability Policies

PIP is a compulsory coverage included in all Massachusetts motor vehicle liability insurance policies. It can pay up to $8,000 for a claimant's medical expenses, replacement services, lost wages, and funeral expenses. M.G.L. c. 90, §§34A and 34M define PIP benefits under a standard Massachusetts motor vehicle liability insurance policy and §34A provides for the coordination of benefits between health insurance carriers and automobile insurers.

MedPay is coverage offered as part of a motor vehicle liability insurance policy. MedPay can pay for reasonable medical and funeral expenses incurred as a result of a motor vehicle accident, as noted in M.G.L. c. 175, §111C. Although automobile insurers are required to offer MedPay coverage of "at least five thousand dollars" under M.G.L. c. 175, §113C, coverage is optional.

Coordination of Health and Automobile Insurance Benefits

The first $2,000 in medical and funeral expenses incurred as a result of a motor vehicle accident must be submitted to the automobile insurer to be paid under PIP[2]. Coordination of benefits becomes necessary after the first $2,000 in medical and funeral expenses is paid under PIP.

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[1] Since self-funded employee benefit plans are exempt from state insurance laws, a self-funded plan may contain language deferring primary coverage to the automobile insurer, but is not required to do so. If the self-funded plan does contain such deferral language, then the PIP insurer will not be able to rely on the coordination provisions in 211 CMR 38.00. PIP must cover up to $8,000 in medical expenses, replacement services, funeral expenses and lost wages, and when PIP is exhausted, the Medical Payments coverage, if any, will apply.

[2] "[P]ersonal injury protection provisions shall not provide for payment of more than two thousand dollars of expenses incurred within two years from the date of accident for medical, surgical, X-ray and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services if, and to the extent that, such expenses have been or will be compensated, paid or indemnified pursuant to any policy of health, sickness or disability insurance or any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services." *Creswell v. Medical West Community Health Plan, Inc.*, 419 Mass. 327, 332 (1995).

The remaining amount in PIP coverage is coordinated between the claimant's health and motor vehicle insurance plans. Once the first $2,000 of PIP has been exhausted, any medical-related claims must be submitted to the health insurance carrier for coverage determination, if health coverage exists. The health insurance carrier cannot deny payment for medical expenses on the basis of the existence of PIP coverage. If there is a MedPay benefit within the motor vehicle policy, MedPay coverage is always secondary to and in excess of the benefits of the health coverage and the PIP benefit up to the limits of the MedPay benefit. *See* 211 CMR 38.05(1)(b).

PIP is not required to cover claims denied by a health insurance provider when the claimant has failed to comply with the requirements of the health coverage policy, e.g., by seeking out-of-network care that could have been obtained through one's health maintenance organization health insurance policy. *Dominguez v. Liberty Mut. Ins. Co.*, 429 Mass. 112, 112-113 (1999). However, if MedPay benefits are available, such denied claims would be payable under the MedPay coverage. *Mejia v. American Cas. Co.*, 55 Mass.App.Ct. 461, 466 (2002).

Coordination of benefits between health coverage, PIP and MedPay under 211 CMR 38.00[3]:

1. **Claimant does not have health coverage or MedPay.**
   PIP will pay up to $8,000 in medical expenses, replacement services, lost wages, and funeral expenses incurred as a result of an automobile accident.

2. **Claimant has health coverage and does not have MedPay.**
   The first $2,000 in medical and funeral expenses is covered by PIP and any medical expenses in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. If the health insurance carrier denies payment for a claim, the claimant may resubmit the claim to the motor vehicle insurer for consideration of coverage under PIP. PIP would not be required to cover a claim that was denied by the health insurance carrier for the claimant's failure to comply with the requirements of the health coverage policy, but PIP must pay for reasonable expenses not covered under the claimant's health coverage policy (*e.g.*, copayments; deductibles; and treatment that is not covered by health insurance, such as acupuncture).

3. **Claimant has MedPay and does not have health coverage.**
   The first $8,000 in medical expenses, replacement services, lost wages, and funeral expenses is covered by PIP. Once PIP has been exhausted, medical and funeral expenses are submitted to MedPay for coverage up to the limits of the coverage purchased.

4. **Claimant has health coverage and MedPay.**
   The first $2,000 in medical and funeral expenses are covered by PIP and any medical bills in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. The health insurance carrier is responsible for payment of claims in excess of the $2,000 PIP threshold, except where the health insurance carrier denies coverage for a legitimate reason (*e.g.*, claim for non-covered service). After payment is made by the health insurance carrier, the outstanding balance on the claim is then resubmitted to the motor vehicle insurer for consideration under PIP and, where PIP is unavailable or not required to pay for a claim denied by the health insurance carrier (for example, because of the claimant's failure to comply with the terms of the health policy), the claim must be covered by MedPay up to the limits of the MedPay coverage purchased.

   Generally, the MedPay benefit of a motor vehicle liability policy pays for:
   - applicable patient copayments, coinsurance or deductibles under the health coverage;
   - health care services that are not covered services under the claimant's health coverage; or
   - health care services from providers that are not part of the health coverage's network or were provided without prior authorization under the health coverage.

[3] Please note that these are general coordination of benefit rules between a fully-insured health plan and the PIP and MedPay coverages of a motor vehicle policy. Under certain circumstances, the PIP and MedPay benefits of a motor vehicle policy may be unavailable, reduced, or eliminated. *See* M.G.L. c. 90, §§34A and 34M; standard Massachusetts automobile insurance policy.

Restrictions on Billing Automobile Carriers for Amounts Beyond Health Carrier Payments

Where the PIP and MedPay coverages of a motor vehicle liability policy are secondary to coverage under a health plan, the coordination of benefits rules may not be used by a provider to increase the amount of payment to the provider for a service beyond the amount that the provider agreed to accept from the health insurance carrier as payment for the services. Thus, the provider may not bill the motor vehicle liability policy or the insured the difference between the provider's negotiated payment with the health insurance carrier and the provider's charge. Unless otherwise permitted under 211 CMR 38.00, the coordination of benefits rules may not be used to circumvent contractual agreements between providers and health plans by increasing the provider payment or decreasing the amount the provider has negotiated to accept in payment for services, less any required deductibles, coinsurance or copayments. Health plans should include provisions in their provider contracts to account for payments under coordination of benefits.

Limitations to Coordination of Benefits within Insured Health Plan Documents

Fully-insured health benefit plans *may not* include a "coordination of benefits" provision in their contracts making their coverage secondary to other coverage for health care services, including MedPay. Automobile insurers may continue to determine whether PIP or MedPay pays first based on the reason for the health insurance carrier's denial or based upon an exclusion under M.G.L. c. 90, §34A (e.g., felonious conduct) or under the terms of the automobile insurance policy. The Division expects all health carriers to submit amendments to existing policy form materials that remove coordination of benefits provisions that are impermissible under 211 CMR 38.00 (*i.e.*, deferral to MedPay).

Effective Date of Amended Coordination of Benefits Rules

The Division expects all health and automobile insurance carriers to establish systems by no later than January 1, 2018 that comply with the provisions of 211 CMR 38.00 when responding to medical claims associated with automobile accidents that occur on and after that date.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner, Health Care Access Bureau, at 617-521-7323 or kevin.beagan@state.ma.us.