COMMONWEALTH AUTOMOBILE REINSURERS
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NATALIE A. HUBLEY
PRESIDENT

NOTICE OF MEETING

CLAIMS SUBCOMMITTEE

A meeting of the Claims Subcommittee will be held at the Automobile Insurers Bureau Conference Center at 101 Arch Street, 7th Floor, Boston, on

WEDNESDAY, JULY 25, 2018 AT 10:00 A.M.

MEMBERS OF THE SUBCOMMITTEE

Mr. David DeLuca – Chair
Vermont Mutual Insurance Company

Ms. Kathleen Devericks	Bender Hatch Insurance, Inc.
Mr. Gregory Favreau	Electric Insurance Company
Mr. Robert Hallinan	Plymouth Rock Assurance Corporation
Ms. Elizabeth Kim	Arbella Insurance Group
Mr. Steven McNaney	Amica Mutual Insurance Company
Mr. Paul Narciso	Safety Insurance Company
Mr. Steven Shiner	MAPFRE U.S.A. Corporation
Ms. Marie-Armel Theodat	R. Theodat Insurance Agency, Inc.

AGENDA

CLMS
18.01 Records of Previous Meeting

The Records of the Claims Subcommittee meeting of May 22, 2018 should be read and approved.

CLMS
18.03 CAR Conflict of Interest Policy

The Chair will read a statement relative to CAR's Conflict of Interest Policy.

CLMS
18.04 Claims Performance Standards

The Subcommittee will continue its biennial review of the Private Passenger and Commercial Claims Performance Standards pursuant to G.L. c. 175, §113H. CAR staff redrafted Standard III, No-Fault Personal Injury Protection Benefits Handling to include the adjusted language requested by the Subcommittee. (Docket #CLMS18.04, Exhibit #2)

Additionally, staff has developed an overview of the history and timeline of the 2015 Performance Standards review concerning FAIR Health and medical fee databases language pertaining to Standard III, No-Fault Personal Injury Protection Benefits Handling. (Docket #CLMS18.04, Exhibit #3)

Other Business

To transact any other business that may properly come before this Subcommittee.

Executive Session

The Claims Subcommittee may convene in Executive Session in accordance with the provisions of G.L. c. 30A, § 21.

PETER BERTONI
Compliance Auditor

Attachments

Boston, Massachusetts
July 12, 2018

CAR	**Private Passenger Claims Performance Standards**
Standard III	**No-Fault Personal Injury Protection Benefits Handling**
Revision Date	**2018.07.25**
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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. 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.

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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.

Memorandum – Medical Fee Databases

To: Claims Subcommittee
Date: July 12, 2018

Overview:

Per the enabling statute (G.L.c.175, §113H), CAR is required to biennially review the Claims Performance Standards (CPS) and recommend modifications. All suggested changes are provided to the Division of Insurance (DOI) for consideration. The DOI then schedules a public hearing, reviews any testimony provided by interested parties and subsequently issues a decision to accept, reject or modify the recommended changes.

The Claims Subcommittee met on May 22, 2018 in adherence of the statute to review the CAR suggested CPS changes and consider any other modifications. The Subcommittee conceptually approved the recommended changes with some modifications prior to beginning a discussion regarding the use of medical fee databases as a medical management tool utilized to adjust PIP claims.

The recommendation for the use of medical fee databases had previously been included in the CPS approved by CAR's Governing Committee in November 2015 and provided to the DOI for consideration. While accepting all other recommended changes to the CPS, the DOI rejected the use of medical fee databases in its May 2016 decision stating that the current Performance Standards already provide adequate tools for investigating usual and customary charges for the purpose of negotiating PIP claims.

The following summarizes the considerations and outcome of the medical fee databases issue during the 2015 CPS review.

Claims Performance Standards Subcommittee:

The process began with the Subcommittee meeting of August 2015 to consider recommended changes to the Performance Standards. Recommendations were made by the Alliance of Automotive Service Providers (AASP), the Subcommittee chair, and CAR staff. The Subcommittee rejected all recommendations other than CAR's biennial modifications and the chair's recommended addition to the medical management section of Standard III, No-Fault Personal Injury Protection Benefits Handling. The following underlined wording was inserted in C.2. and recommended by the Subcommittee:

> *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.* ***In determining usual and customary charges, an ARC may utilize the FAIR Health national medical fee database for determination of usual and customary medical charges*****.**

FAIR Health is a national independent and not-for-profit corporation established specifically to develop a transparent data source to determine appropriate cost of care within geographical areas for the use of both consumers and insurers. The Subcommittee determined that this would be a useful tool in the determination of usual and customary charges in relation to overbilling by medical providers that exhaust the PIP benefit available to the consumer and considered this to be a reasonable and measured solution to an existing issue.

This change was then forwarded to the Compliance Audit Committee for consideration.

Compliance Audit Committee:

The recommended changes to the CPS were included on the agenda of the Committee's September 2015 meeting. Some Committee members were initially skeptical to the inclusion of the FAIR Health medical fee database recommendation and questioned why the proposed additional language was necessary. A claims professional on the Committee suggested that the language in the current standards was already flexible enough to allow for medical management tools such as medical fee databases. Other comments included concern with endorsing a specific source that could potentially present future problems if other similar organizations also seek to be included. The Committee settled on the elimination of the specific reference to FAIR Health and simplified the recommendation to read:

> *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,* ***medical fee databases,*** *and/or expert medical systems, as well as innovative approaches.*

Governing Committee:

At its November 2015 meeting, the Governing Committee voted unanimously to accept the recommended changes and forward the CPS to the DOI.

DOI Public Hearing:

A hearing was held at the DOI in January 2016 to consider all recommended changes to the CPS including the wording specific to the use of medical fee databases. The DOI presiding officer focused on the inclusion of the medical fee databases asking several specific questions including the following:

- Why did the Committee choose to add this to the existing language?
- Why was more specific language included?
- Was any attempt made to survey CAR members with respect to disputes that have arisen in connection with the use of such databases?
- Was there discussion about how the use of such databases would assist companies in meeting the statutory standards for determining when a claim is reasonable?
- Does CAR audit procedures include whether or not the audited company actually uses these databases or question a company's choice of medical fee databases?
- Did the Committee study the extent to which the use of fee databases has been challenged in court in connection with any claims? Or challenged by the injured party?
- Does the industry utilize medical fee databases on a global scale or simply in connection with an individual case?
- Are member companies already looking at these databases?
- How many medical databases are companies using?
- In terms of payment billing to the injured party, what happens if the company using a database determines the fee payment is not reasonable?

Decision and Order:

The DOI concluded that the current CPS provides adequate tools necessary for the investigation of usual and customary charges while negotiating PIP payments. Therefore, the Commissioner pursuant to the authority under G.L.c.175, §113H deleted the reference to medical fee databases from the CPS leaving the language unchanged in Standard III, C.2.