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: (i) timely independent medical examinations; (ii) medical bill reviews, including but not limited to a determination of usual and customary charges, with or without the use of medical fee databases: (iii) use of preferred provider organizations, managed care programs, and/or expert medical systems; and (iv) other 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. 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.

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 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.

F. Claim Payment

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

    e. The deductible applied if applicable.

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

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

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

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

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

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

    l. 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.