A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

   a. 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 to a person with sufficient experience and training.

   b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

   c. The initial screening shall include checking policy information and accident history, and reporting to the Central Index Bureau (CIB) to evaluate for possible warning signs.

   d. The fraud indicators of CAR SIU Standards and Fraud Profile shall also be considered for possible warning signs. Refer to Appendix A.

   e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

   The initial investigation shall include:

   a. Reviewing policy information to verify coverage and resolve any coverage issues. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

   b. Contacting involved parties and securing sufficient documentation of facts involving the accident circumstances to verify occurrence and to establish degree of fault.

   c. Securing documentation to verify that all alleged injured parties were actually involved in the accident.

   d. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

   e. Timely setting of reasonable initial reserves and following the documented company policy.

3. Contacts

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

    b. 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.

    c. The insured operator, if not one of the above, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Loss Management

    Loss management, assessment, and verification tools shall be used when appropriate to identify the disability claimed, the medical treatment and whether the treatment and medical expenses are reasonable, necessary, and related to the motor vehicle accident.

5. Follow-Up and Continuing Investigation

    The continuing investigation shall include:

    a. Verifying and evaluating the type and extent of injury substantiated by available reports and/or independent examinations.

    b. Confirming and documenting that treatment and expenses are reasonable, necessary, and related to the accident.

    c. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

    d. Employing proper diary systems and ensuring ARC reporting and authority levels are followed.

    e. Timely and reasonable changes to the reserves that follow the documented company policy.

6. Settlement Negotiations or Denial

    a. ARCs shall have a settlement evaluation plan to obtain reasonable negotiated settlements of warranted claims. Settlements shall be within the approved range or the reason clearly documented if exceeded.

b. Settlements shall be evaluated and pursued when the injury and expense end result can be established.

c. Mitigating factors that may reduce settlement value, such as comparative negligence or joint tortfeasor situations shall be evaluated.

d. Unwarranted or fraudulent claims shall be resisted and denied.

e. In the normal course of claim handling, a file shall be referred for a special investigation or expert analysis when discrepancies exist that are unresolved.

f. Underinsured motorist claims shall be documented when no other party is identified as liable.

7. Cases in Suit

a. ARCs shall have a litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

b. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

c. Suit referral shall be timely and assigned to appropriate counsel.

d. Evaluation, case strategy, and legal action plan shall be documented.

e. Legal bills shall be reviewed for accuracy and reasonableness.

f. ARCs shall have an Alternative Dispute Resolution Program.

8. DOR Requirements

Prior to making any payment equal to or in excess of $500 to a third-party claimant, the ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, G.L. c.175, §24D. NOTE: Failure to comply with G.L. c.175, §24D will subject the ARC to penalties proscribed by the DOR. These penalties will be in lieu of those penalties imposed for noncompliance with the Performance Standards. Refer to Appendix H.

9. Subrogation/Recovery

   The investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier or party against whom subrogation will be directed, if applicable.

B. 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 (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.

3. Evaluation and Settlement

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

C. Fraud Training

1. ARCs must have a plan that provides for ongoing training of fraud awareness and how to identify suspicious claims.

2. ARCs must have a plan to provide training for special investigation and handling of suspicious and suspected fraudulent claims.

3. ARCs must have a plan to provide training on claim reporting and fraud recognition to producers and their customer service representatives.