

# KEEPING CURRENT

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## How to Avoid an Audit from an Extended Health Benefits Insurer: The Top Seven Triggers

By Lad Kucis

*Part 1 of 2 in a practice advisory series on insurance audits*

An audit by an extended health benefits insurer can be an extremely invasive and stressful process for a health provider. These audits also carry significant potential consequences, including demands for repayment, being de-listed by the insurer and complaints to regulatory colleges.

In this first of a two part series, I will outline the **top seven triggers** that commonly lead insurers to initiate an audit of a health provider.

### 1. Statistically Abnormal Billing Volume

Insurers routinely use sophisticated software programs to compare a provider's billing patterns against those of similarly situated peers in the same profession.

Common red flags include:

- Exceptionally high daily patient volumes
- Large annual billings to a single insurer
- Consistently billing more than 8–10 hours per day

While none of these factors necessarily indicate wrongdoing, they often prompt further scrutiny and can result in an audit being initiated.

### 2. Other Unusual Billing Patterns

In addition to overall volume, insurer algorithms are designed to detect anomalies in billing patterns, such as:

- Identical billing amounts at every visit
- Repeated use of the same combination of services
- Very frequent treatment over extended periods (i.e. three to four visits per week for several months)
- A high percentage of claims reaching policy maximums, whether for services or devices
- Billing from multiple clinics on the same day

As artificial intelligence tools continue to evolve, insurers' ability to analyze billing behaviour in greater depth will only increase.

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### 3. Inappropriate Claims Submitted by Staff

One of the fastest ways to trigger an audit is through the submission of claims that are inappropriate or incomplete. Common examples include:

- Forms that are not properly signed by the provider (i.e. OCF Forms)
- Claims submitted outside coverage limitations
- Missing or inadequate referral documentation where referrals are required

For this reason, it is critical that clinic staff receive thorough and ongoing training regarding compliant billing practices. Ultimately, the provider remains responsible for what is submitted under their name, whether they are the owner/operator of the clinic or simply work there as an employee or independent contractor.

### 4. Patient Complaints

A complaint from a patient is often an almost certain pathway to an insurance audit. Common complaints include allegations that:

- A service was billed but not provided
- Billing was excessive or inappropriate
- The clinic engaged in questionable business or marketing practices, including inducements or re characterizing services once annual maximums have been reached

Even a single credible complaint can prompt an insurance audit.

### 5. Poor Recordkeeping Practices

Insurers have been known to initiate audits upon discovering that a provider's recordkeeping practices may be deficient. Examples include:

- Failing to consistently prepare clinical notes

- Missing patient histories, assessments or re-assessments
- Utilization of templated chart notes rather than individualized notes

Inadequate records can also significantly undermine a provider's ability to defend their billings during an audit.

### 6. Association With Previously Flagged Clinics

Health professionals are at a substantially higher risk of audit if they are associated with a clinic that has previously been flagged by an insurer.

If inappropriate practices are occurring at the clinic, it can be exceptionally difficult for an individual provider to convince an insurer that they were unaware. Providers should carefully vet their business associations, including reviewing regulatory college public registers, the FSRA website and lists of de-listed providers maintained by insurers.

### 7. Prior Disciplinary History with a Regulatory College

Increasingly, insurers are initiating audits solely because a health professional has a prior disciplinary finding related to billing matters with their regulatory college.

In some cases, I have seen health professionals de-listed based on that history alone, without a formal audit having taken place.

As such, I encourage health professionals to take every regulatory college matter very seriously and ensure that all potential steps are taken to avoid a referral to a discipline proceeding.

### Final Thoughts

I hope this article has provided health providers with practical insight into the most common triggers for insurance audits and assists in



reducing the risk of insurer scrutiny.

In Part 2 of this practice advisory series, I will outline the top seven strategies for surviving an insurance audit, if commenced.

#### **About the Author**

Lad Kucis is certified by the Law Society of Ontario as a specialist in health law and provides advice and representation to regulated health professionals in respect of all types of regulatory matters, including complaint and disciplinary matters before their regulatory colleges, and complaint reviews before the Health Professions Appeal and Review Board.

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