

KEEPING CURRENT

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How to Survive an Insurance Audit: Seven Practical Considerations

By Lad Kucis

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

Once an insurance audit has been initiated, a health provider's actions, including potential missteps, can significantly affect the outcome. Audits conducted by extended health benefits insurers frequently expand beyond routine claim verification and may lead to repayment demands, de-listings or complaints to regulatory colleges.

In this second part of my two part series on insurance audits, I outline seven key steps that health providers can take to protect themselves in the event an audit has been commenced.

1. Communicate In Writing

Health providers should exercise caution when insurers request telephone discussions or in-person meetings during an audit. Insurers routinely record telephone calls and statements made during conversations can be relied upon in audit findings or repayment demands.

As a general rule, health providers should communicate with insurers in writing as much as possible.

Written communication allows health providers to manage accuracy, consistency and tone, while maintaining a clear record of what has been disclosed.

This guidance also applies to any communications between insurers and staff members who may be asked questions as part of an audit.

2. Be Careful When Completing Claims Verification and Other Audit Questionnaires

Claims verification and other audit questionnaires are not neutral information-gathering tools. They often ask health providers to confirm treatments dates, times, services provided, protocols and billing practices.

In preparing questionnaire responses, health providers should:

- Ensure that all questions are answered (double check to verify completeness and accuracy)
- Avoid providing any information that is not being requested, as this can inadvertently broaden the scope of the audit

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- Ensure that the information provided can be supported by the patient record (i.e. appointment log, clinical notes, receipts, etc.)

Beyond the patient record, the questionnaire response is the primary document insurers rely on when deciding whether to take action against a health provider.

3. Review Patient Records Before Submitting Them

Before producing patient records to an insurer, health providers should review them to ensure that they are providing the complete record being requested.

In addition, patient records should be reviewed carefully to assess how they may be interpreted by an insurer. This process can help identify missing documentation, inconsistencies, or ambiguities that may become focal points during an audit.

While deficiencies cannot be retroactively corrected, awareness of the content of patient records is essential when completing questionnaires or responding to insurer concerns.

4. Do Not Alter Clinic Policies or Patient Records

Clinic policies and patient records cannot be altered once an audit has commenced. Even well-intentioned changes can result in serious credibility issues and may expose a health provider to allegations of fraud or misrepresentation. This can result in significant issues with the insurer and a potential regulatory college complaint.

5. Do Not Coach Staff Members

It is critical that health providers are not seen as attempting to influence or coach staff members during an audit, especially in advance of interviews or other communications with insurers. Conduct of this nature can significantly undermine the provider's credibility and escalate the audit.

As a matter of course, insurers often ask staff members (typically at the outset of an interview) what information the health provider has shared with them regarding the audit. In some cases, insurers may also request copies of email communications between the provider and staff to verify the accuracy of those exchanges.

6. Approach Repayment Demands Strategically

If an insurer issues a repayment demand, health providers should not assume the amount claimed is accurate or final. Repayment demands are often based on sampling or extrapolation methodologies and providers need to carefully review both the rationale for the demand and the manner of calculation.

Furthermore, health providers need to be aware that insurers are typically open to some level of negotiation in respect of a repayment demand. However, it is imperative to recognize that providing repayment will not necessarily mean that the matter is otherwise resolved. In fact, I have seen many cases where health providers have provided repayment only to be subject to a de-listing and a regulatory college complaint shortly thereafter. As such, health providers should seek to clarify whether the insurer intends to pursue any further adverse actions if repayment is made.

7. Seek Legal Advice Early When an Audit Escalates

If an audit progresses beyond routine verifications, such as requests for interviews, allegations of irregular billing or formal repayment demands, it is often prudent to seek legal advice. Early legal guidance can help clarify issues of concern; justify billing practices; explore the possibility of practice changes; and negotiate favorable resolutions.

Final Thoughts

Insurance audits conducted by extended health



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benefits insurers can be disruptive, time-consuming, and carry significant business and professional risk. While some audits begin as routine verification exercises, they can escalate quickly if not handled carefully.

By approaching the audit process in an informed and strategic manner, health providers can mitigate risk and best protect their interests. When combined with the proactive audit prevention strategies outlined in Part 1 of this series, health providers can minimize the chances of insurer scrutiny.

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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