RESPONDING TO INSURANCE AUDITS:
A GUIDE FOR PHYSIOTHERAPISTS

A. INTRODUCTION

Physiotherapy services are commonly included in private extended health benefit plans that are designed to supplement provincial hospital and medical insurance coverage. Insurance providers administer extended health benefit plans, which include physiotherapy services. To maintain the sustainability of their plans, these insurers implement control measures. These measures aim to confirm that the claims submitted under their benefit plans adhere to their policies and that the services rendered by the physiotherapists are valid and appropriate. This process may involve a request for information from the service provider, commonly referred to as an "audit".

If an insurance audit identifies that the services claimed are not eligible for reimbursement, or that the documentation supporting a claim is incomplete, insufficient, or non-existent, the claim will likely be disallowed, and the insurer may reserve the right to recover any amounts already paid under the claim. For this reason, it is important to be prepared to respond to an insurance audit and to adhere to best practices to ensure submitted claims are well-documented and valid. This guide provides a brief overview on how to navigate the insurance audit process as well as tips to proactively manage your practice to ensure you are prepared to respond.

For more information on extended health insurance plans, the Canadian Physiotherapy Association, in collaboration with Canadian Life and Health Insurance Association (CLHIA) has prepared a guide entitled *Supplementary Health Insurance Explained*, dated November 2019 to help patients and providers understand the private health insurance environment.

B. THE INSURANCE AUDIT PROCESS

The Purpose of an Audit

The CLHIA defines the purpose of an insurance audit as follows[1]:

> Audits are typically routine rather than in response to a known or suspected problem and are intended to refine guidance on submitting claims. The objective of audit is to establish that the services were provided to the patient and that the claim is eligible according to the terms of the contract.

Accordingly, notice of an audit does not necessarily imply the insurer is suspicious of services rendered by the provider. For instance, audits may be initiated if concerns are identified with specific claims made by a claimant. In cases where claimant-related concerns arise, providers may be requested to verify the services provided to a specific patient and the corresponding dates. This may involve providing details from patient records confirming the necessity of treatment and the respective dates of provision. Insurers may select providers for audit based on random selection, payment analytics and comparison of claims data, as well as tips received through whistleblower hotlines or complaints[2].

Notice of an Audit

Audits may take the form of a written request for information or a telephone request for clarification (often referred to as "desk audit") or an on-site inspection of information where the auditor(s) from the insurer attend the provider's location.

Where documents are requested, insurers typically provide notification of an audit by means of formal letter. This letter sets out the information requested and a specified time frame to respond. A typical time

frame is between 2 to 4 weeks, subject to reasonable extensions granted by the insurer.

Clinics usually receive advance notice of on-site inspections, with some flexibility provided as to the date. In rare circumstances, insurers may make unannounced visits, if they have reason to believe the provider would not cooperate with the auditors if given such notice[3].

It is important not to ignore these notices. If the time period has passed to produce the requested records, some insurers may make an adverse inference and conclude that no records exist to support a claim, or the documentation supporting a claim is incomplete or insufficient.

Patient Consent to Disclose Information

In order to process claim submissions efficiently, insurers typically require plan members to authorize the release and exchange of information between a healthcare provider and the insurer. This authorization is normally included in the terms of claim reimbursement forms, which are either acknowledged on electronic submission forms or signed-off on paper claim forms. Providers should request appropriate evidence of authorization to release the patient's personal health information, if requested by the insurer. Absent authorization, the provider may be required to confirm the consent of the patient to release the requested information, or release the record to the patient directly (who in turn may release it to the insurer). To avoid issues relating to consent and authorization, it is best practice to obtain authorization during your intake process.

Your informed consent form can include language authorizing you to provide information to insurance companies when requested. You should advise patients that by using their extended health benefits to pay for services, you may be required to provide access to information in their records to support their claim or otherwise respond to reasonable insurer requests. Failure to comply with insurance company audit requests may result in the patient and/or provider having the claim denied, future reimbursement being denied, and demands for repayment of claims already paid by the insurer.

Result Letter

Following the completion of an audit, the insurer commonly issues a formal letter to communicate the outcome. This letter states whether no further action will be taken or if there is a need for a reimbursement of funds. In instances requiring recovery, the report specifies the amount to be recovered and outlines the reasons the insurer deems the claims as improper.

Some insurers provide detailed audit findings, while others provide high-level summaries. If a provider intends to challenge the audit findings, they should request particulars so they can understand what the insurer finds objectionable about each claim where a recovery is sought.

It is common practice for insurers to allow the provider with an opportunity to respond to the results letter. This is an opportunity to clarify the provider's practice and procedures, and identify any information, documents or materials that may have been overlooked.

Complaints to Professional Colleges

There are some practices that may prompt the insurer to issue a complaint to a provider's regulatory college. Common areas of concern include poor record keeping, improper billing records and the unauthorized use of unregulated providers in treatment, particularly as they relate to supervised exercise programs.

Where a risk of professional misconduct is identified, it is not uncommon for insurers to engage in covert investigations, where an auditor assumes the role of a patient and intentionally requests services that are clearly ineligible. The purpose of such investigations is to assess whether the clinic or healthcare provider allows and/or facilitates practices that fall outside the standards of professional conduct or the boundaries defined by their insurance policies.

C. HOW TO PREPARE FOR AN AUDIT

To ensure you are ready for an insurance audit, it is important to keep detailed, accurate, and up to date records that substantiate the need for the services rendered. It is also valuable to stay informed with respect to the billing procedures of your patient's insurer, and ensure compliance with your College billing standards. Finally, physiotherapists should confirm that delegation of certain tasks to unregulated providers, such as physiotherapy assistants, are in keeping with College standards, and ensure patients have an opportunity to confirm that such services meet the coverage criteria established by their insurers. Below are some tips with respect to record keeping and providing eligible services.

Record Keeping Practices

Keep patient health records in compliance with your College Standard on Record Keeping including:

- unique identifiers for the patient and for all providers involved in that patient's care
- ongoing discussions with the patient to obtain consent to assessment, treatment, and involvement of other care providers
- the date of every patient encounter, including missed appointments
- details about analysis, diagnosis, patient goals, treatment plan, and treatments performed
- progress notes, outcomes, reassessments, and resulting changes to the treatment plan
- discharge summaries including reassessment findings, reason for discharge and other recommendations.

In short, clinical records should substantiate physiotherapists' reasoning for the care they deliver. These records must incorporate objective data, evidence, and relevant outcome measures whenever possible and appropriate.

Billing Record Practices

It is also important to maintain accurate, up to date billing records in compliance with your College Standard including:

- the name of the patient and the name of the physiotherapist, physiotherapist assistant, and others who provided care under the physiotherapist's supervision;
- date of service;
- description of the care, service, or product provided;
- amount of the fee for the care, service or product; and
- any payment received.

In addition to applicable College standards, the CLHIA has issued a public document entitled '*Service and Supply Provider Receipts Best Practices for Group Benefit Reimbursement*', in order to assist providers in ensuring the necessary information required to consider a claim for payment is present on billing records.

With respect to receipts, it is recommended to avoid leaving blank fields on invoices to prevent potential tampering. Instead, mark these fields with zeros or use "N/A" as appropriate.

Eligible Providers and Services

The practice of delegation and supervision of care is within the scope of practice of physiotherapy, and recognized within the standards of practice of regulatory Colleges, for example in British Columbia[1] and Ontario[2]. While insurers understand that the scope of practice allows this, some plans require that the services or supplies be delivered directly by the physiotherapist in order for the associated expense to be eligible for coverage.

With respect to non-regulated heath providers, the CLHIA notes the following[6]:

> If the insurer/benefit administrator decides that the membership requirements of a particular association do not meet the coverage criteria they have established within their company, claims for services or supplies delivered by members of that association will be declined.

Where patients seek reimbursement from their insurer, it is their responsibility to ensure that the services rendered are eligible for coverage. However, physiotherapists are encouraged to ask the insurer directly or request clarification from the patient before expenses are incurred.

D. CASE STUDY: SUPERVISED PHYSIO-EXERCISE PROGRAMS

Some insurers have recently issued notices to physiotherapists in British Columbia setting out eligibility criteria for reimbursement. In particular, these insurers define physiotherapy as “one-on-one treatment between the registered physical therapist and the patient”. Pursuant to this definition, any “services rendered by other practitioners, such as a physical therapist support worker (PTSW), kinesiologist, personal trainer, or yoga or pilates instructors during the visit, are not considered eligible expenses for reimbursement, even if conducted under the direction or supervision of a registered physical therapist”. While this decision remains in effect, physiotherapists that wish to continue the use of physical therapy assistants must bill patients directly for these services, and advise that these services will not be reimbursed by their insurers.

Similarly, insurers in other provinces have initiated regulatory complaints relating to improper billing practices whereby supervised exercise programs solely administered by physiotherapy assistants, are subsequently billed by a physiotherapists as physiotherapy. The College of Physiotherapists of Ontario (CPO) has referred some of these complaints to the Discipline Committee resulting in suspensions. In these cases the College takes the position that that exercise programs under the supervision of a physiotherapist only qualify as physiotherapy if certain conditions are met.
These conditions include:

> a. An initial assessment that identifies a health problem, illness, deficit within the scope of physiotherapy. This includes dysfunctions in the neuromuscular, musculoskeletal, and cardiorespiratory systems;
>
> b. The exercises program must specifically address the identified condition or deficit, consistent with the patient's stage of recovery;
>
> c.The program includes specific exercises that target identified deficits;
>
> d. The physiotherapist is responsible for not only prescribing the exercises but also determining the appropriate frequency and intensity of the treatment, providing clear direction to the assistant. Any modification of the treatment plan must be made by the physiotherapist, not the assistant; and
>
> e. The exercise program must be supported by objective and quantifiable measures recorded in the initial assessment and clinical notes, to demonstrate progress and determine whether the treatment goals are being met.

E. CONCLUSION

An insurance audit can be stressful and disruptive. However, you can prepare for these audits by maintaining accurate and detailed records validating the services rendered. Stay informed about insurer coverage criteria, bearing in mind thateven if insurers allow reimbursement for services by unregulated providers, you must ensure compliance with College standards on delegation and that the services properly constitute physiotherapy. If you are a clinic owner, partner, or sole practitioner, it is prudent to

require regular audits within your practice to ensure compliance with College standards on billing and record keeping.

WHERE TO GET HELP

Pro Bono Hotline

By participating in your association's (PLI) Program, you also have access to **pro bono legal advice from Gowling WLG, one of Canada's largest national legal firms** CPA members have access to the dedicated helpline to receive legal advice for questions involving professional practice issues

Toll Free: 1-888-943-0953

HOW DOES THE CPA PROFESSIONAL LIABILITY INSURANCE PROTECT ME?

The CPA Professional Liability insurance (PLI) protects insured members against liability or allegations of liability for injury or damages that have resulted from a negligent act, error, omission, or malpractice that has arisen out of their professional capacity as a physiotherapist.

The CPA PLI also includes coverage for complaints made against members to their provincial physiotherapy regulatory College. The PLI automatically includes a $160,000 per claim/aggregate in Regulatory Legal Expense coverage for legal costs associated with having to appear at a disciplinary hearing with a Provincial Regulatory organization or agency. In the event of a complaint or investigation, members are provided with superior legal representation and defense protection.

Can I/should I increase my insurance coverage?

The CPA PLI automatically includes a $160,000 per claim/aggregate limit for Regulatory Legal Expenses. As a CPA member you have the option to increase your Regulatory Legal Expense Coverage to $200,000 per claim/aggregate. Taking into account the specific risks associated with your practice and assessing changes in the legal and economic environment is best practice in making the decisiono increase your insurance coverage.

Please contact a BMS broker at 1-855-318-6136 or cpa.insurance@bmsgroup.com to discuss your unique practice circumstances.

How do I report a claim under my CPA Professional Liability Insurance?

Timeliness of reporting a claim under your PLI policy is critical and could make the difference between coverage for a claim being accepted or declined. As soon as you become aware of a claim or potential claim, please report this immediately to Crawford & Company (Canada) Inc. at 1-877-805-9168 or by email at BMSclaims@crawco.ca. Please ensure to formally document the incident, including details of those involved.

When reporting, you will be asked to provide:

- Your certificate of insurance;
- Statement of claim, Declaration, Motion, College complaint letter, or other legal process, as appropriate;
- Other relevant documentation.

Once you have contacted Crawford & Company, they will acknowledge receipt of the claim and assign a claims adjuster to your case. The adjuster will be responsible for investigating the claim and determining the appropriate course of action, including connecting you with legal counsel. You will work with your legal counsel to draft your initial response to the College. Your response should reflect what happened, your interactions and your rationale behind your care or conduct.

KEY CONTACT INFORMATION

For more information about your insurance policy or to speak with a BMS broker, please at contact 1-855-318-6136 or cpa.insurance@bmsgroup.com.

To access Gowlings WLG pro bono legal advice please call 1-888-943-0953.

To report a professional liability insurance claim please contact Crawford & Company (Canada) Inc. at 1-877-805-9168 or by email at BMSclaims@crawco.ca.

This article was prepared and written by Aweis Osman, Gowling WLG in partnership with BMS Canada Risk Services.

This article is for general information purposes and should not be interpreted as the provision of legal or broker advice. If you require specific advice with respect to responding to insurance audits, we recommend you seek out legal advice from a qualified lawyer in your jurisdiction or contact the Gowling WLG pro bono hotline offered through the Canadian Physiotherapy Association. If you have specific questions related to your professional liability insurance policy, please contact BMS to speak with an insurance professional.

CITATIONS

[1] CLHIA. *Supplementary Health Insurance Explained: For Healthcare Providers*, November 2019, Section 6, p. 15

[2] See for example, *Pacific Blue Cross, Health Reference Guide*, September 2022, Provider Guidelines, p. 37

[3] Supra note 2, p. 37

[4] See College of Physical Therapists of British Columbia (CPTBC) *Practice Resource: Working with Physical Therapist Support Workers*;

[5] See College of Physiotherapists of Ontario (CPO) Working with Physiotherapist Assistants Standard, updated June 29, 2016

[6] CLHIA. Supplementary Health Insurance Explained: For Healthcare Providers, November 2019, section 5, p. 13