AAO
Private Insurance Delistings Guide

Alberta Association of Optometrists

Overview

Delisting by a private insurance company refers to an insurer's decision to remove, suspend, or otherwise restrict the provider, clinic, or organization from its approved provider registry, direct billing platform, or claims adjudication system. As a result, the provider may no longer be recognized by the insurer as eligible to submit claims, receive direct payment, or deliver products or services under the insurer's plans.

Patients may still choose to receive services from the delisted provider, however direct billing privileges may be suspended, and reimbursement may be restricted or require the patient to self-submit claims manually.

Delisting can arise for a range of reasons, often following audits or investigations relating to claims patterns, billing discrepancies, or suspected irregularities. In some cases, insurers may use covert verification activities, including secret shopper investigations.

Insurers have also invested in fraud detection, claims analytics, and investigation capabilities. Many insurers maintain dedicated anti-fraud or special investigations units that may include individuals with backgrounds in law enforcement, forensic accounting, or claims investigations. These teams often leverage data analytics, cross-insurer information sharing, and other investigative tools to identify unusual billing patterns, potential benefits abuse, or suspected fraud.

Examples of clinic processes or practices that may trigger a review or investigation include unusual or statistically atypical patterns, such as:

- Above-average dispensing of low-prescription eyewear, including sunglasses
- Above-average dispensing of high-prescription eyewear to youths
- Inappropriate dispensing of company gift cards
- Above-average purchases of uncut lenses
- Excessive number of patient order cancellations
- Above-average patient returns
- Above-average order re-dos
- Price matching and discounting
- Billing that does not precisely match services rendered or products dispensed
- Inconsistencies between clinical records, invoices, and claims submissions

The consequences of delisting can be significant and may extend well beyond the loss of direct billing privileges. Depending on the circumstances, a delisting may result in:

- **Loss of patients and revenue:** Patients may choose to seek care from providers that remain eligible for direct billing, particularly where reimbursement is unavailable or becomes more burdensome.
- **Recruitment and retention challenges:** Delisted clinics may experience difficulties attracting and retaining practitioners and staff, as concerns regarding reputation, patient volumes, and financial stability may influence employment decisions.
- **Broader insurer action:** Delisting by one insurer may prompt scrutiny by other insurers, creating a risk of further audits, restrictions, or delisting decisions across multiple insurance networks.
- **Reputational harm:** Delisting may negatively affect the reputation of both the clinic and its providers among patients, referral sources, insurers, and other stakeholders.

In some cases, the cumulative effect of these consequences can pose a significant operational and financial challenge to the continued viability of a clinic or practice.

According to the Canadian Life and Health Insurance Association (CLHIA), examples of administrative or billing practices that may trigger insurer scrutiny include:

- Billing for health services that were never received
- Submitting the same claim to multiple insurers to double benefits
- Allowing non-plan members to use benefits
- Plan members or their dependents use all annual maximums annually when services are not medically necessary
- Providers mixing marketing practices with patient treatment (i.e., use of incentives)
- Encouraging plan members to utilize all their benefits before the end of the year, driving up plan utilization
- Providing unnecessary treatments to maximize billings

See **https://fraudisfraud.ca** for more information on health benefits fraud and benefits abuse.

Not all delistings involve allegations of fraud. In many cases, concerns arise from administrative errors, inadequate oversight, non-compliant billing practices, or misunderstandings regarding insurer requirements.

Additionally, insurers may monitor disciplinary decisions issued by regulatory colleges and may elect to delist a provider based on the findings or outcomes of those proceedings. Patient complaints may also trigger investigations by insurers, which can ultimately result in delisting.

Typically, providers will receive written notification of a delisting, sent by registered mail or courier, which may or may not be preceded by an audit request. In many cases, delisting notices are brief and provide only limited information regarding the basis for the insurer's decision. Providers should not expect the insurer to disclose its evidence, investigative findings, or a detailed explanation of the concerns giving rise to the delisting.

In addition, insurers may provide little or no opportunity for a provider to respond before a delisting decision is implemented. Accordingly, the delisting notice itself may be the first indication that a provider is under investigation or that concerns have been identified by an insurer. In some cases, where insurers conduct coordinated or parallel investigations, a provider may be delisted by multiple insurers arising from the same underlying concerns.

Given the potentially significant consequences of delisting, providers should take any audit, investigation, or delisting notice seriously and respond promptly. Early efforts to understand the insurer's concerns, preserve relevant records, assess internal practices, and implement corrective measures may improve the provider's ability to address the issues identified and, where appropriate, seek reinstatement.

This guide provides an overview of key aspects of the delisting process and practical steps that providers may consider when responding to a delisting decision. This guidance is provided for informational purposes only and is not intended to substitute for legal advice. Members are encouraged to consult qualified legal counsel for advice specific to their circumstances.

Resources for Healthcare Providers

Visit the CLHIA website for resources:
www.clhia.ca/en-ca/industry/resources-for-healthcare-providers

Delisting Notices

Providers are typically issued a written notice of a delisting. The contents and terms of such notices must be closely reviewed by the provider, and timely action should be taken to comply with the terms of the notice.

Providers should immediately preserve all potentially relevant paper and electronic records, including claims records, lab orders, communications, audit correspondence, electronic medical records, software logs, and other documents that may be relevant to the insurer's concerns or any subsequent review process. This includes refraining from deleting, modifying, overwriting, destroying, or otherwise altering such records.

Key details to take note of include:

- The scope of the delisting (i.e., who the delisting applies to). In some cases, a delisting may extend beyond the individual provider to include the clinic, clinic owner, or affiliated clinics.
- The effective date of the delisting
- The basis for the delisting; e.g., misrepresentations in claims submitted, improper or unacceptable billing or administrative practices
- Requirement to notify patients of the delisting
- Whether the notice provides any appeal or reconsideration process
- Any deadlines for a response to the delisting

Important

Preserve all records immediately.

Do not delete, modify or overwrite electronic records after receiving a notice.

Delisting Journey

Audit

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Investigation

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Delisting Notice

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Internal Review

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Corrective Measures

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Appeal

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Possible Reinstatement

Internal Audit and Investigations

On receipt of a delisting notice, providers should act quickly to conduct a comprehensive internal audit and investigation. Where significant financial exposure, allegations of fraud, regulatory implications, or reputational risks are present, providers should consider engaging legal counsel at an early stage so that investigative steps may be undertaken with appropriate consideration of legal privilege and strategic risk management.

The internal investigation is a critical step in identifying the underlying practices, errors, or concerns that may have contributed to the insurer's decision to delist the provider.

Investigation Process

Receive Notice
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Preserve Records
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Conduct Audit
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Interview Staff
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Identify Issues
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Implement Changes

Investigative steps may include:

- Review of relevant CLHIA guidelines, e.g., Service and Supply Provider Receipt Best Practices for Group Benefit Reimbursement
- Review of last audit request received from the insurer and the audit response provided
- Audit of claims submissions over an appropriate retrospective period, e.g., two years or longer depending on the circumstances
- Audit of lab orders, prescriptions, receipts
- Review of relevant clinic policies, procedures and training
- Interviews with relevant owners, practitioners, and administrative staff, conducted as early as possible following receipt of the delisting notice to preserve recollection of relevant events and reduce risks associated with staff turnover, unavailable witnesses, or fading memory
- Reconciliation of accounts and detailed calculations of any billing discrepancies (e.g., claims submitted for full retail price where products were discounted, claims submitted as prescription eyewear when item dispensed was non-prescription, claims submitted under the wrong plan member).

See the **Internal Audit Checklist** to assist with a systematic and thorough audit.

Providers should also ensure careful management of internal and external communications regarding the delisting, including communications with staff, patients, suppliers, insurers, and regulators, to avoid inaccuracies and preserve the integrity of the investigation.

Corrective and Preventative Measures

Prompt corrective and preventative measures are critical to demonstrating accountability, mitigating ongoing risk, and rebuilding insurer confidence. The nature and extent of the remedial measures should be proportionate to the issues identified and supported by appropriate documentation.

While corrective measures directly rectify the issues underlying the delisting, preventative measures are introduced as administrative safeguards to prevent future instances of the subject practices.

The appropriate measures will vary depending on the circumstances and should correspond to the specific investigation findings. These may include:

- Personnel management measures, where warranted, including additional training, supervision, or disciplinary action
- Amending clinic policies and procedures
- Training in administrative and billing practices or fraud prevention
- Updating or changing software systems or vendors
- Designating an internal compliance lead or responsible manager
- Implementing periodic compliance audits or spot-check reviews
- Periodic review of insurer billing reports
- Documenting owner, director, or governance oversight of remediation efforts
- Formal notices to patients regarding updated administrative and billing practices
- Reimbursement of amounts associated with improperly processed claims, where appropriate, to affected insurers

Notably, providers should not assume that reimbursing the insurer will result in relisting, as repayment alone may not address the insurer's underlying concerns regarding billing or administrative practices, compliance, trust, or professional conduct.

Delisting Appeal

Once the delisted provider has completed their internal audit and investigation and implemented appropriate corrective and preventative measures to rectify any problematic findings of its investigation, the provider may prepare a written appeal of the delisting and formally seek reinstatement. The contents of the appeal materials should include:

- Summary of procedural background of the delisting (e.g., preceding audit request, notification of delisting, related correspondence with the insurer)
- Detailed summary of internal audit and investigation steps taken
- Summary of investigation findings
- Explanation of the issues identified during the investigation, including contributing factors and context where appropriate
- Summary of corrective and preventative measures implemented
- Calculation of value of billing discrepancies and offer of reimbursement, as applicable
- Inclusion of key documents in support of the appeal, with appropriate redactions and safeguards to comply with applicable privacy and health information legislation.

The objective of the appeal process is not only to address the issues giving rise to the delisting, but also to re-establish a relationship of trust and confidence between the insurer and the provider. The appeal should demonstrate not only what occurred, but why the provider has confidence that the identified issues will not recur. Full and candid disclosure of all relevant information is therefore essential. Providers should assume that the insurer's primary concern is whether it can have confidence that the issues giving rise to the delisting have been fully identified, appropriately addressed, and are unlikely to recur.

Conclusion

A delisting by a private insurer can present significant operational, financial, and reputational challenges for providers and clinics. A prompt, organized, and well-documented response is critical. Early preservation of records and gathering evidence, a thorough internal audit and investigation, implementation of appropriate corrective and preventative measures, and a carefully prepared appeal and request for reinstatement may improve a provider's ability to address insurer concerns and seek reinstatement.

Where allegations involve billing irregularities, fraud concerns, regulatory implications, or significant financial exposure, providers should consider obtaining independent legal advice from qualified counsel at an early stage.

Each delisting will turn on its own facts. Providers are encouraged to seek advice tailored to their specific circumstances.

Members are encouraged to regularly monitor resources published by the AAO, including informational resources, bulletins, webinars, and member communications, for updates and additional guidance relating to private insurance billing practices, audits, investigations, and delistings.

Actions if you have been Delisted

1. Review the terms of the delisting notice
2. Promptly initiate internal audit and investigation
3. Report the delisting to the AAO
4. Contact Tory Hibbitt at Embury & West LLP for advice and support

Resources

Alberta Association of Optometrists (AAO)

The AAO provides members with resources, education, and support relating to insurance billing practices, fraud prevention, insurer investigations, and insurance delisting matters.

Members are encouraged to report delisting activity and insurer concerns to the AAO so that trends can be monitored and appropriate supports can be developed for the profession.

Canadian Association of Optometrists (CAO)

The CAO maintains resources relating to insurance billing, fraud prevention, insurer investigations, and professional practice matters affecting optometrists across Canada.

Members can access guidance documents, educational materials, and updates regarding insurer expectations and industry developments.

Canadian Life & Health Insurance Association (CLHIA)

The CLHIA represents Canada's life and health insurance industry and periodically publishes resources for healthcare providers relating to claims administration, fraud prevention, billing practices, and insurer expectations.

Healthcare providers are encouraged to familiarize themselves with CLHIA guidance materials and best practices.

Legal Support for Insurance Delisting Matters

Embury & West LLP – Support for Optometrists Facing Insurance Delistings
Embury & West LLP advises healthcare clinics, regulated professionals, and practice owners on insurance delistings, insurer investigations, billing compliance, professional regulatory matters, privacy issues, and risk management.

The firm assists clients with:

- insurance delisting and reinstatement matters
- insurer audits, investigations, and information requests
- billing, claims submission, and reimbursement compliance
- fraud prevention and compliance programs
- clinic governance and operational risk management
- professional regulatory and College-related matters
- privacy, recordkeeping, and documentation issues, and
- corrective action plans and appeals processes

Insurer investigations often create legal, regulatory, operational, financial, and reputational risks simultaneously. Embury & West LLP provides integrated advice that addresses these interconnected issues through a coordinated strategy tailored to each client's circumstances.

Lead Counsel – Tory Hibbitt
Tory Hibbitt leads Embury & West LLP's Health and Privacy Law Group and its Insurance Delisting and Professional Risk Management Practice. She is recognized for her work assisting healthcare clinics and regulated professionals across Canada with insurer audits, investigations, delisting matters, compliance reviews, and reinstatement efforts. Her practice combines expertise in healthcare regulation, professional liability, privacy, and risk management.

She has extensive experience supporting clinics and professionals across a range of regulated health sectors and provincial jurisdictions. This cross-profession experience provides valuable insight into insurer investigations, audit trends, billing practices, and compliance expectations across the healthcare landscape.

Tory works closely with clients to assess risk, respond to insurer concerns, implement corrective measures, and pursue reinstatement where appropriate. Her approach is focused on protecting the long-term interests of clinics and practitioners while strengthening compliance and reducing future risk.

When Should Optometrists Seek Legal Advice?
Optometrists are encouraged to seek advice as early as possible when concerns arise that may have insurance implications, including:

- receipt of a delisting notice
- insurer audits, investigations, or requests for records
- concerns relating to undercover investigations or insurer reviews
- allegations involving billing, claims submission, discounts, or promotions
- situations where insurer concerns may also trigger College, privacy, employment, or regulatory issues
- structuring internal investigations, preparation of responses, corrective action plans, appeals, or reinstatement requests, and
- proactive reviews of clinic policies, procedures, and compliance practices

Early intervention often provides the greatest opportunity to address insurer concerns, mitigate risk, preserve insurer relationships, and improve the likelihood of a successful outcome.

Preferred Rates for AAO Members
Embury & West LLP is pleased to offer preferred legal service rates to AAO members.

AAO members may access preferred pricing for legal services relating to insurer audits, investigations, delisting matters, compliance reviews, appeals, reinstatement efforts, and risk management initiatives.

Members seeking assistance are encouraged to contact Tory Hibbitt directly at 403.776.3911 to discuss their circumstances and determine the most appropriate course of action.

Alberta Association of Optometrists

Thank you for being a member of the Alberta Association of Optometrists

Alberta Association of Optometrists

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