Shifting the Balance of Power

Health Care Provider Insurance Practice
Hospitals, doctors, ambulatory surgical centers (ASC), and other health care providers, can face an uphill battle when fighting for their rights against insurance companies.

Insurers often take advantage of the fact that hospital and ASC administrators and providers are busy and simply do not have the time, resources, or experience to challenge improper claim denials, underpayments, repayment demands, offsets, discriminatory limits on mental health and substance use coverage, and other questionable practices.

Zuckerman Spaeder has helped shift the balance of power between health care providers and commercial insurers. By leveraging client data and our deep understanding of often-overlooked legal rights, we develop strategies that increase insurer reimbursements. These strategies are designed to avoid litigation. However, if litigation becomes necessary, our attorneys have a track record of winning cases that expand provider rights, delivering unprecedented monetary wins for our clients, and forcing insurers to reform their practices.

Taking on the world’s largest insurers demands a sophisticated approach and mastery of the interrelationship between a complex web of state and federal laws.

Our attorneys not only developed the legal concepts that are central to this fight, they have spent years refining their strategy and building strong relationships with the U.S. Department of Labor.

LEADERSHIP AND INNOVATION
Our success is the result of a groundbreaking legal approach developed by partners D. Brian Hufford and Jason Cowart.

In the two decades since they first began challenging health insurer practices—primarily through ERISA, the federal statute that governs employer-sponsored benefit plans—they have been at the vanguard of an entirely new insurance recovery legal practice.

In 2017, Law360 named Zuckerman Spaeder’s health care practice its “Health Care Practice Group of the Year” and Mr. Hufford was designated as a “Health MVP” for the third year in a row. Bill Schultz, former General Counsel of Health and Human Services, also returned to the firm.

A terrific litigation boutique.”
Wrongful denial of claims
Insurers often deny claims based on criteria that are more restrictive than those found in the terms of patient health insurance plans. For example, most plans cover services that are consistent with generally accepted standards of care, yet insurers routinely deny claims for lack of medical necessity or based on an “experimental or investigational” exclusion, even when the treatment at issue was consistent with generally recognized medical standards.

Insurer misrepresentations
Providers often contact insurance companies—before providing medical services to a patient—to confirm that the patient is covered by an insurance plan and obtain information about the scope of coverage. Patients and providers rely on this information to determine whether to go forward with the treatment. Unfortunately, the information provided by insurers is often wrong or inconsistent with the insurer’s ultimate benefit decision, causing hardship for providers and patients.

Recoupments and offsets
A common—and highly lucrative—insurer practice is to demand money back from providers, asserting that a prior claim was overpaid. If the provider doesn’t immediately pay up, insurers often refuse to pay any new and unrelated claims, giving the provider no meaningful opportunity to challenge the take-back.

Mental health and addiction coverage limits
Insurers frequently seek ways to limit coverage for behavioral care, and often develop more restrictive internal coverage guidelines for mental health and substance abuse claims than those applied to medical or surgical care. In doing so, they almost certainly violate plan terms as well as the Mental Health Parity Act and Addiction Equity Act.

Attacks on out-of-network services
Insurers have increasingly taken steps to discourage out-of-network care. They do so by unilaterally reducing out-of-network reimbursement rates, even when those reductions are inconsistent with the terms of a particular patient’s insurance plan. Another insurer tactic is to accuse a provider of failing to collect patient co-pays or co-insurances, and then use that accusation as the basis for refusing to pay the provider’s new claims, seeking repayment of previously paid claims, and even bringing charges of fraud against the provider.

Licensing requirements
Insurers often demand that medical facilities obtain specific accreditation or licensing before they are eligible to receive certain types of fees, even though no such requirement exists in the relevant health insurance plan or in state law.

WE’RE IN YOUR CORNER
We can help you challenge these questionable insurer practices, among others:

*Attorney advertising. Prior results do not guarantee a similar outcome.*

$600+ MILLION
recovered from health insurers
About Zuckerman Spaeder LLP

Zuckerman Spaeder is consistently recognized as a leading litigation boutique—and for good reason. For 40 years, the firm has attracted extraordinarily talented and experienced attorneys—who never shy away from the most complex and high-stakes cases and who consistently deliver positive results for clients.

With an approach that is both aggressive and savvy, Zuckerman Spaeder seeks to resolve matters before they get to trial—often saving clients from considerable expense and unwanted attention. And when needed, the firm’s focused trial teams know how to go toe-to-toe with government regulators, leading businesses, and the largest law firms.