Health Insurance Disputes

Hospitals, doctors, ambulatory surgical centers, behavioral health practitioners – the panoply of health care providers -- can face an uphill battle when fighting for their rights against insurance companies

Health insurers can benefit from the reality that providers are busy providing life-saving medical care and do not have the time, resources, or expertise necessary to challenge improper claim denials, underpayments, repayment demands, offsets, discriminatory limits on coverage, and other questionable practices which require navigating often convoluted claims processes. To complicate matters, health insurance claims are governed by a complex web of state and federal laws.

Zuckerman Spaeder has developed one of the country's preeminent legal practices dedicated to redressing this problem. By leveraging a sophisticated understanding of often-overlooked legal rights, we have developed a collection of strategies to combat insurer misconduct. These strategies are designed to avoid litigation to the extent possible. However, if litigation becomes necessary, our trial attorneys have a track record of winning cases that expand provider rights, delivering unprecedented monetary wins, and forcing insurers to reform their practices.

Our attorneys have not only been trailblazers in developing the legal concepts that are central to this fight, they have cultivated extensive and meaningful relationships with key federal and state regulators along the way.

Leadership and Innovation

Our success is the result of a groundbreaking legal approach developed by partners Brian Hufford and Jason Cowart, and further advanced by partners Caroline Reynolds and Andrew Goldfarb.

In the two decades since this team began challenging health insurer practices—primarily through the Employee Retirement Income Security Act of 1974 (ERISA), the federal statute that governs employer-sponsored benefit plans—they have been at the vanguard of an entirely new health insurance recovery legal practice, securing numerous precedent—setting decisions.

The practice and partners Brian Hufford and Jason Cowart are consistently recognized by leading legal ranking publication, including by *Chambers USA,* which has repeatedly named them as the top practitioners in this practice area. And *Law360* has also repeatedly listed Zuckerman Spaeder, Brian Hufford, and Caroline Reynolds among its Health Care and Benefits "Practice Groups" and "MVPs" of the year.

"second to none and spectacular"

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ZUCKERMAN SPAEDER

MORE THAN $600M recovered from insurers

We are here to help you grasp and challenge the vast array of complicated and questionable insurer practices.

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 is consistent with generally recognized medical standards.

Mental Health and Addiction 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, there is a high likelihood that the discrepancies in coverage violate plan terms as well as the Mental Health Parity Act and Addiction Equity Act.

Insurer Misrepresentations During Pre-Authorization

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, there is a well-documented historical trend of insurers providing wrong information or information inconsistent with the insurer's ultimate benefit decision, causing undue hardship for providers and patients.

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-insurance, 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.

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.

Licensing Requirements

Insurers increasingly 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.