FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 839	**COMPANION BILL:** None
TITLE: Insurance Overpayment Claims Submitted to Psychologists	**LINKED BILLS:** None
SPONSOR(S): Booth	**RELATED BILLS:** CS/SB 944 (Davis)

Committee References

Insurance & Banking
17 Y, 0 N, As CS
➤ Health Care Facilities & Systems
➤ Commerce

SUMMARY

Effect of the Bill:

By default, under Florida law, health insurers and health maintenance organizations (HMOs) have 30 months after rendering payment to a provider to submit a claim for overpayment. The bill reduces the 30-month period to 12 months for overpayment claims submitted to licensed psychologists provided on or after January 1, 2026.

The bill adds licensed psychologists to a list of providers that already enjoy the shortened overpayment claim window under Florida law. Existing law applies the 12-month period for overpayment claims to several licensed providers (chiropractors, podiatrists, osteopaths, certain physicians and dental surgeons).

Fiscal or Economic Impact:

Insurers and HMOs may recover less from overpaid claims to psychologists due to the reduced overpayment claim period. The effect on premiums is indeterminate.

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ANALYSIS

EFFECT OF THE BILL:

The bill adds psychiatrists licensed under ch. 490, F.S., to a list of licensed providers that enjoy a reduced time period for insurers and health maintenance organizations (HMOs) to submit claims for overpayment. Under the reduced time period, claims for overpayment must be submitted to the provider within 12 months, rather than the standard 30-month period.

The changes in the bill apply to claims for services provided on or after January 1, 2026.

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

Insurers may recover less from overpaid claims to psychologists due to the reduced overpayment claim period. The effect on premiums is indeterminate.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Insurer Review of Claims Overpayment

Subsections s. 627.6131(6), F.S., and 641.3155(5), F.S., contain the process by which a health insurer may make a claim for overpayment against a provider to whom it rendered payment. The insurer must send a written or electronic statement specifying the basis for the retroactive denial or payment adjustment to the provider of the

specific provider claim(s) for which the overpayment is submitted. Often, overpayment claims are the result of a retroactive review or audit of coverage decisions and payment levels.

If the overpayment is not related to fraud, the health insurer must submit its claim for overpayment within 30 months after the insurer paid the claim. After receiving the claim for overpayment, the provider has 40 days in which to pay, deny, or contest the claim. A contested claim for overpayment must be paid or denied by the provider within 120 days after receipt. If, after 140 days, the provider has not paid or denied the overpayment claim, an uncontestable obligation is placed on the provider to pay the insurer's claim. A provider that chooses to deny or contest an insurer's claim must notify the insurer in writing of the provider's decision within 35 days after the provider received the claim for overpayment. If the claim is contested, the provider must request additional information, which the insurer has 35 days to give the provider after receiving the request. After receiving the additional information, the provider has 45 days to pay or deny the claim.

Subsections s. 627.6131(18), F.S., and s. 641.3155(16), F.S., provide an exception. Claims for overpayment must be submitted within 12 months, rather than the usual 30-month period, to certain providers. Specifically, the exception applies to overpayment claims submitted to physicians licensed under ch. 458, F.S., osteopaths licensed under ch. 459, F.S., chiropractors licensed under ch. 460, F.S., podiatrists licensed under ch. 461, F.S., and (for oral surgery only) dental surgeons licensed under ch. 466, F.S.

Health Maintenance Organizations (HMOs)

Pursuant to Part 1 of Ch. 641, F.S., a health maintenance organization (HMO) is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee	17 Y, 0 N, As CS		Lloyd	Schenk
THE CHANGES ADOPTED BY THE COMMITTEE:	The amendment applied the same change to health maintenance organizations (HMOs) as the original bill provided for health insurers.			
Health Care Facilities & Systems Subcommittee				
Commerce Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
