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Owner Braden Thompson:
Revenue Cycle Director
Area Business Office

Bad Debt & Collections Policy

Purpose:

To establish clear, consistent, and enforceable guidelines and compliant approach for billing, collection, bad debt, and charity care practices while ensuring patients are treated fairly, respectfully, and in accordance with applicable Minnesota statutes.

Scope:

This policy applies to all self-pay patient accounts including balances remaining after insurance processing, services, departments, and staff involved in patient billing, collections, financial assistance, and revenue cycle operations.

General Principals:

- Patients are responsible for timely payment of balances owed.
- Payment plans are a temporary accommodation, not a long-term financing option.
- Consistent communication and documentation are required at all stages.
- Financial Assistance and Medical Assistance options must be offered when inability to pay is expressed.
- Failure to communicate or comply with payment or application requirements will result in escalation to collections.

Billing Process:

- Patient statements are generated and mailed monthly
- All patient and third-party payer communications must be documented in the patient account.

- Patients are encouraged to utilize MyChart Bill Pay when available
- The self-pay collection timeline begins after the initial patient statement is issued.

Insurance Information Request Letter

- Insurance Information Request Letters are sent when additional information is required to process insurance claims.
- Failure to respond may result in the balance becoming patient responsibility.

Payment Expectations

- Patients are always asked for payment in full prior to offering payment plan options.
- Acceptable payment sources include:
 - Credit Card
 - Check
 - Payroll deduction (employees)
 - Approved electronic payment methods (HRA secure bill pay)

Payment Plans

- Standard payment plans shall not exceed 24 months
- Payment plans must be established in the MHS EMR (Epic)
- Patients must make consistent monthly payments.
- Payment plans exceeding 24 months require Leadership and/or Revenue Cycle Director approval and must have documented financial hardship.
- Minimum monthly payment is the greater of:
 - 10% of the outstanding balance, OR
 - \$50 per month

Outstanding Balance	Maximum Number of Payments
\$50.01 – \$500.00	6 payments
\$500.01 – \$1,500.00	10 payments
\$1,500.01 – \$3,000.00	12 payments
\$3,000.01 – \$5,000.00	18 payments
\$5,000.01 – \$7,000.00	24 payments

*Balances exceeding \$7,000 or payment plans exceeding 24 months require leadership approval in EPIC.

Self-Pay Reminder & Notice Letters

- A reminder (warning) letter is sent 45 days after the initial statement if no payment has been received.
- The reminder letter advises the patient of the outstanding balance and invites them to:

- Submit payment in full
- Establish a payment plan
- Request a Financial Assistance (Charity Care) application

Final Notice Letter

- If no payment or patient contact occurs with 30 days of the reminder letter, a Final Notice Letter is issued.
- The final notice letter informs the patient that failure to respond within 30 days may result in referral to collections or legal action.
- Failure to respond includes lack of payment and lack of communication.
- The Final Notice Letter again provides the opportunity to request a payment plan or charity care application.

Payment Plan Default

- A payment plan is considered in default if: One payment is missed without prior communication, or Two payments are missed within a 12-month period.
- Payment Default Letter
 - To notify patient that payment or updated debit or credit card information is needed from them to keep their account current.
- Default Escalation Process:
 - Warning letter is sent to patient
 - A documented phone call is made within 10 days of the warning letter if no payment has been received.
 - Final Notice Letter is issued if unresolved
 - A final phone call is made and documented.
 - Failure to resolve includes missed payments, lack of payment, or lack of communication. If no resolution occurs within 30 days of the final note, the account is referred to collections.

Required Phone Contact & Documentation

- All phone attempts must be documented and include:
 - Date
 - Time
 - Outcome (contact made, voice mail, no answer)
- Phone calls are required at key escalation points, including:
 - After missed payments
 - Prior to final notice
 - Prior to referral to collections.

Payment & Refund Letters

1. Overpayment and Refund Letter
 - i. Credit will be applied to outstanding balances in other accounts at Madison Healthcare Services first.
 - ii. If all accounts are paid in full, refund will be sent with explanatory letter.
 - iii. If payment causes partial credit, apply to account and issue refund.
 - iv. Apply all insurance payments to identified account regardless if it causes a credit balance.

Financial Assistance & Medical Assistance:

Patients who express inability to pay must be offered:

- Medical Assistance application (with assistance if needed) and/or
- Financial Assistance (Charity Care) application. All applications must be returned within 30 days.

MHS will accept one Financial Assistance application per calendar year; updated financial information is required with each submission. Failure to submit an application or communicate status within 30 days will result in escalation to collections.

Collections Referral

Account may be referred to collections if:

- Payment plan defaults are not resolved, or
- Required applications are not submitted, or
- The patient fails to communicate with MHS

Prior to referral, MHS will ensure compliance with Minnesota Statute 144.588 including:

- Verification of patient responsibility
- Billing of all known third-party payers
- Offering reasonable payment plans
- Providing opportunity to apply for charity care

Bankruptcies

Upon receipt of bankruptcy notification:

- Clinic accounts are placed in bankruptcy status
- Hospital accounts are placed on hold
- Statements cease immediately

Deceased Patients & Probate Process:

To establish a standardized process for resolving outstanding balances for deceased patients in a manner consistent with:

- CMS Medicare Cost Report requirements
- IRS §501(r) Financial Assistance requirements (if applicable)
- State probate procedures
- Organizational billing and collection policies

Probate Verification Process

- Probate status shall be verified through Minnesota court records in the county where the decedent resided at the time of death.
- Verification must be documented in the patient account record.
- If an estate is open:
 - File a written statement of claim within required statutory timeframes.
 - Claims should be filed after third-party payments have processed unless filing deadlines require earlier action.
- If no estate is open:
 - File a Demand for Notice when appropriate.
- A minimum of forty-five (45) days must pass from the date of death before final account determination.
- All third-party payments must be processed prior to final classification.
- Log in to <http://pa.courts.state.mn.us.default.aspx#MainContent> to see if there is an estate file open in Probate division of the court Administrator's Office in the county where the decedent resided at the time of death.

Payer-Based Account Classification

- After completion of probate verification, third-party billing, and standard collection efforts, accounts shall be classified as follows:
- Traditional Fee-for-Service Medicare
- The balance shall be adjusted as:
 - **Medicare Bad Debt Write-Off**

Such balances shall be reported in accordance with CMS Medicare Cost Report requirements. Medicare Bad Debt amounts shall not be classified as Charity Care.

- If the patient was covered under Traditional (Fee-for-Service) Medicare:
 - Remaining deductible and/or coinsurance amounts
 - Reasonable collection efforts completed
 - Account deemed uncollectible
 - No estate or no recovery from estate
 - The balance shall be adjusted as:
 - **Medicare Bad Debt Write-Off**

Such balances shall be reported in accordance with CMS Medicare Cost Report requirements. Medicare Bad Debt amounts shall not be classified as Charity Care.
- Medicare Advantage
 - Remaining patient responsibility balances under Medicare Advantage plans shall not be treated as Medicare Bad Debt. These balances shall:
 - Be screened under the organization's Financial Assistance Policy (FAP), including presumptive eligibility criteria if applicable.
 - If the patient qualifies under the FAP → Adjust as **Charity Care**.
 - If the patient does not qualify under the FAP → Adjust as **Bad Debt – Deceased/No Estate**.
- Commercial Insurance
 - Remaining patient responsibility balances shall:
 - Be screened under the Financial Assistance Policy.
 - If eligible → Adjust as **Charity Care**.
 - If not eligible → Adjust as **Bad Debt – Deceased/No Estate**.
- Medicaid and PMAP
 - Balances under Medicaid or PMAP shall be adjusted in accordance with payer contractual obligations.
 - Non-covered or denied amounts required by contract shall be recorded as **Contractual Adjustments**.
 - Any allowable patient responsibility shall be screened under the Financial Assistance Policy prior to final classification.

Financial Assistance Screening

- For all non-Traditional Medicare balances:

- Accounts shall be screened for Financial Assistance eligibility prior to classification as Charity Care.
 - Screening results must be documented in the account record.
 - Charity Care determinations must comply with the organization's written Financial Assistance Policy.
- Charity Care classification shall not be based solely on non-collectability.

Documentation Requirements

- The following must be documented prior to final write-off:
 - Date of death
 - Probate court verification
 - Estate claim filing (if applicable)
 - Third-party billing completion
 - Collection efforts performed
 - Financial Assistance screening results
 - Final classification determination
- An account may not be classified as both Medicare Bad Debt and Charity Care.
- Charity Care determinations must be consistent with the Financial Assistance Policy.
- All write-offs must be properly coded in the general ledger to ensure accurate Cost Report and Schedule H reporting.

Hospital Screening Requirements for Public Health Care Eligibility and Charity Care

- Per MN Statute 144.588 Certification of Expert Review, Madison Healthcare must serve the defendant (patient) with an affidavit stating the following, if pursuing collections actions.
 - Unless patient declines to participate, hospital complied with the requirements in the law.
 - Reasonable basis to believe patient owes the debt.
 - All known third party payors have been billed and any remaining debt is the responsibility of the patient.
 - Patient was given reasonable opportunity to apply for charity care.
 - If patient indicated the inability to pay in one payment, they were offered a reasonable payment plan.

Approval Signatures

Step Description	Approver	Date
Leadership	Carol Borgerson: CFO	02/2026
	Braden Thompson: Revenue Cycle Director	02/2026

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