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Please note that two additional steps have been incorporated to this version of the instructions.
They are marked by an orange star, on pages 2 and 5.
Agency Setup
The first step is to make sure that you have the other payor set up. You can choose an Invoice or a CMS-1500 as the Billing Form. For the purposes of this outline, we will be working with Kaiser as the non-Medi-Cal payor plan.

Don’t forget to complete the Agency and Facility Profile for this payor plan, in particular the Payor Name, the Payor ID#, the Agency Primary Provider #, and the Primary Provider # Type.
You will then need to make sure that you have rates set up for this non-Medi-Cal payor plan. In this case, rates that are Plan-Specific or Agency Plan-Specific, where the plan is not Kaiser, would not work for releasing an encounter to Kaiser. You should either have Agency-Standard rates, or Plan-Specific rates for Kaiser set up.
You will then need to set up the Plan Payment for the Primary Payor(s).

This payment record should have a $0 balance, because the assumption is that the Primary Payor denied the claim in full. You will use this same payment record to process all Primary Payor denials for this Payor.
Client Setup

Enroll the client in the primary payor group. Be sure to fill out the Subscriber # field, even though it is not dark yellow.
Billing the Primary Payor
Create an encounter the way you would in your typical process.

Release to the Primary Payor.
Medi-Cal as Secondary Payor

V.3

Note the error message about the rate for the selected service. This is what happens when there is no rate established for the date/payor/service, as described in the Agency Setup section.

On the claim item list, you will see the claim item you just created.

Create the Batch for the Primary Payor.
Select “Profile” from the Batch List Actions column to continue processing the batch.

If the batch looks fine, Release it.
Then Bill it.

In this case, I have the Kaiser plan set up to create in Invoice. You can save the file, mail it out, or close it and forget about it. WITS will not know the difference. It assumes you have actually billed the Primary
Medi-Cal as Secondary Payor

Payor at this point.

The “Billed” status is shown on the Claim Batch list.
Recording the Denial

From the Payment List, search for the $0 payment you set up earlier for the Primary Payor plan. Select “Apply Payment”.
The next screen is the Payment Application screen. The Plan is automatically selected for you, and claim items eligible to be paid by this plan are listed.

Select the claim items that should be denied, select a Denial Reason from the dropdown, and then select “Denied in Full”.

Note that if you come back at a later date and try to process a denial for this same claim item, you will receive a message letting you know that this claim has already been processed:
Having selected “Denied in Full” on an eligible claim, you will be brought to the Bill Another Payor screen.

Select the Initial Status that you want the new claim item to be in when you select Finish.
Selecting “Finish” on the Bill Another Payor screen creates the following EOB transactions:

You will not see this information unless you go to the EOB Transaction list to look it up, but it is there.

Creating the New Claim Item

Selecting “Finish” on the Bill Another Payor screen also creates a new claim item for Medi-Cal, which will be in the status you specified.

At this point, you can edit the claim item if you need to add an override code, etc., by selecting the “Profile” Action link.

You can proceed to bill Medi-Cal as you normally would at this point. The 837 file will reflect the primary payor denial.