

Mojave Crest Assurance Company

Appeals & Grievances Coordinator Desk Manual

Vista Access PPO: Small Group Commercial

Document Version 2.1

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Member Services, Appeals & Grievances Unit

Approved By: Tamra Reyes, Director, Appeals & Grievances

1. Introduction & Purpose

1.1 About This Manual

This manual is the primary reference document for Appeals & Grievances Coordinators on the Member Services team at Mojave Crest Assurance Company (MCA). It is written to be used in your day to day, as you work through a queue of incoming member and provider appeals under the Vista Access PPO small group commercial product. It consolidates the plan's internal appeals policies, relevant benefit provisions from the Vista Access Evidence of Coverage, and operational procedures you are expected to follow.

If you encounter a situation that is not addressed in this manual, or if anything in a case feels unclear, reach out to your Appeals Supervisor before taking action.

This manual is updated twice a year. The version and effective date are printed on the footer of every page. If you are reading a printed copy, check for the current version before relying on any specific timeline.

1.2 About Mojave Crest Assurance Company

Mojave Crest Assurance Company is a regional health insurer headquartered in Las Vegas, Nevada. MCA writes fully insured commercial health, dental, and vision products in Nevada and is licensed and regulated by the Nevada Division of Insurance. The Vista Access PPO, is a fully insured small group plan sold to Nevada employers of around 2 to 50 eligible employees. The Vista Access PPO integrates medical, behavioral health, and prescription drug benefits under a single product, as we do not outsource behavioral health to a separate vendor.

As a Nevada-domiciled fully insured carrier, MCA is subject to Nevada Revised Statutes Chapter 689A (health insurance), Chapter 689B (group and blanket health insurance), and Chapter 695G (managed care), as well as the Nevada Mental Health Parity requirements and federal mental health parity and addiction equity laws. The internal timeline rules, review structures, and authority thresholds described in this manual are MCA's internal policies. They are designed to meet or exceed all applicable state and federal requirements. When in doubt about whether a rule in this manual is driven by law or by MCA internal policy, please escalate and a Medical Director or Compliance will answer the question.

1.3 Your Role as an Appeals & Grievances Coordinator

As an Appeals & Grievances Coordinator, you are the first point of contact for every appeal or grievance that reaches MCA. Your job is to receive requests, classify them correctly, route them to the right reviewer, keep the regulatory clock accurate, draft correspondence from approved templates, and make sure nothing is dropped. A single mistake at intake, such as a misclassified grievance, a miscalculated clock, or a missed parity flag can cascade into a regulatory complaint weeks later. Take intake seriously.

You are responsible for:

- Receiving incoming appeals and grievances from all intake channels (secure email, fax-to-email, mailed correspondence, and referrals from Member Services)
- Verifying that the requestor has standing to file (member, authorized representative, or provider on the member's behalf)

- Classifying each request correctly: appeal vs. grievance, standard vs. expedited, pre-service vs. post-service vs. concurrent care, medical vs. behavioral health vs. pharmacy
- Opening the case file, entering the case into the Appeals Log, and setting the regulatory clock based on the date of receipt at MCA
- Sending the acknowledgment letter within the required window
- Requesting any missing information from the member or provider using the approved template
- Routing the case to the correct clinical reviewer (RN Reviewer, Medical Director, Pharmacy Director, or Behavioral Health Reviewer)
- Drafting determination letters from approved templates once a decision has been made
- Maintaining the case file including every document received, every outbound communication, and every clock event must be logged
- Identifying and escalating cases that meet any mandatory escalation trigger (see Section 9)
- Forwarding cases to the External Review Organization when internal appeals are or deemed exhausted

1.4 What You Handle

- New appeal request
- Provider appeal letter
- Authorized Representative (AOR) form
- Clinical records
- Original denial letter
- Evidence of Coverage (EOC) for the member's plan year
- Medical policy in effect on the date of service
- Prior authorization history for the member
- Claims payment history for the member
- Internal compliance alerts (e.g., DOI complaint filed)

2. Your Team & Key Contacts

2.1 Appeals & Grievances Unit Structure

The Appeals & Grievances Unit is within Member Services and reports up through the Director of Appeals. You work closely with clinical reviewers from Utilization Management and with the Parity Review Committee. The table below lists the people you will contact most often.

Role	Name		Slack Handle
Director, Appeals & Grievances	Tamra Reyes	t.reyes@mojavecrest.com	@treyes
Appeals Supervisor	Darnell Whitfield	d.whitfield@mojavecrest.com	@dwhitfield
Senior Appeals Coordinator	Priya Annadurai	p.annadurai@mojavecrest.com	@pannadurai
Appeals Coordinator (You)	—	—	—
Medical Director (Medical/Surgical)	Dr. Helena Bergstrom, MD	h.bergstrom@mojavecrest.com	@hbergstrom
Medical Director (Behavioral Health)	Dr. Ayla Ontario, MD	a.ontario@mojavecrest.com	@aontario
Lead RN Reviewer	Marisol Alvarado, RN	m.alvarado@mojavecrest.com	@malvarado
Pharmacy Director	Dr. Jules Henning, PharmD	j.henning@mojavecrest.com	@jhenning
Compliance Officer	Kendel Dufree	k.dufree@mojavecrest.com	@kdufree
Parity Review Committee Chair	Dr. Ayla Ontario, MD	parity@mojavecrest.com	@parity-committee

2.2 Clinical Reviewer Routing

You do not pick which clinical reviewer sees a case based on personal preference. Route according to the type of service in dispute:

Service Type	Routes To
Medical / surgical services (inpatient, outpatient, diagnostic, DME)	RN Reviewer team first; Medical Director if RN upholds
Physical, occupational, and speech therapy	RN Reviewer team first; Medical Director if RN upholds
Mental health services (outpatient therapy, IOP, PHP, inpatient psych)	Behavioral Health RN Reviewer first; Dr. Ontario if upheld
Substance use disorder services (residential, MAT, detox)	Behavioral Health RN Reviewer first; Dr. Ontario if upheld
Pharmacy / formulary exception (medical benefit drug)	Dr. Henning (Pharmacy Director) no RN tier
Pharmacy / formulary exception (Rx benefit drug)	Dr. Henning (Pharmacy Director) no RN tier

Service Type	Routes To
Any case flagged for potential parity concern	Dr. Ontario AND Parity Review Committee
Any case with a total dispute value exceeding \$75,000	Direct to Medical Director, skip RN tier

The \$75,000 threshold is calculated on the total dispute value, not the out-of-pocket amount to the member. For example, if an inpatient stay was denied and the total billed charges are \$180,000, this routes directly to the Medical Director even if the member's in-network out-of-pocket maximum would cap their exposure at \$8,500.

2.3 External Review Organization

MCA contracts with a single independent review organization for all Vista Access PPO external reviews. Do not attempt to contact any other ERO, even if a member names one in their request.

Organization	Canyon Ridge Review Services
Purpose	Independent external review of final adverse determinations
Intake email	intake@canyonridgereview.com
Urgent intake email	urgent-intake@canyonridgereview.com
Turnaround, standard	Canyon Ridge has 45 calendar days to render a decision once we forward
Turnaround, expedited	Canyon Ridge has 72 hours to render a decision once we forward
Point of contact at MCA	Kendel Dufree, Compliance Officer

2.4 Slack Channels

Channel	Purpose
#appeals-intake	New case logging, general unit announcements, routing questions
#appeals-clinical-queue	Routing cases to RN Reviewer and Medical Director teams
#appeals-urgent	Expedited cases, deadline-at-risk alerts, CAT-level compliance events
#appeals-parity	General parity discussion; B-3 flag notifications are sent via DM to @parity-committee, not posted here.
#appeals-compliance	Regulatory complaint intake, DOI notifications, audit requests
#appeals-general	General questions, kudos, non-case discussion

Never post member protected health information (PHI) in any public Slack channel. Use the member's internal Case ID (format CASE-YYYY-NNNNN) when referring to cases in channel. If you need to discuss PHI, use a direct message to the specific reviewer.

Case ID Assignment: When you create a new row in the Appeals Log, assign the next sequential Case ID in the format CASE-YYYY-NNNNN, where YYYY is the calendar year of receipt and NNNNN is a zero-padded sequential counter (e.g., CASE-2026-00413 follows CASE-2026-00412). The counter resets to 00001 on January 1 of each year. Do not manually edit or reformat Case IDs after assignment.

3. The Vista Access PPO — Plan Overview

3.1 Product Structure

The Vista Access PPO is Mojave Crest's fully insured small group (2–50 eligible employees) commercial health plan. It is a preferred provider organization, meaning members have access to both in-network and out-of-network benefits, with richer cost sharing in-network. The plan year runs on a calendar year basis for most groups, but individual employer groups may renew on other dates. Always confirm the plan year the claim falls under before looking up benefit details, because benefit structures can change year over year.

Vista Access integrates medical, behavioral health, and prescription drug coverage. There is no behavioral health carve out as MCA is the payer for all three. This is important for parity analysis (see Section 8) because it means Vista Access is subject to the full parity comparison between medical/surgical and mental health/substance use disorder benefits, with no separate vendor to point at.

3.2 Benefit Categories

For parity classification purposes, Vista Access benefits fall into six federal classifications. You do not need to memorize every benefit, just know the classification of the service in dispute so you can confirm the parity comparisons.

Classification	Examples (Medical/Surgical)	Examples (Mental Health / SUD)
Inpatient, in-network	Hospital admission, surgical stay	Inpatient psych, residential SUD
Inpatient, out-of-network	OON hospital admission	OON inpatient psych
Outpatient, in-network	Office visits, outpatient surgery, PT/OT/ST	Therapy, IOP, PHP, outpatient MAT
Outpatient, out-of-network	OON office visits, OON outpatient procedures	OON therapy, OON IOP
Emergency care	ER visits, ambulance	Psychiatric ER evaluation
Prescription drugs	Tier 1 - 4 medical drugs	SSRIs, buprenorphine, naltrexone

When you are reviewing an appeal, identify which classification the disputed service sits in. If the member's complaint involves a restriction that appears to apply only to the mental health or

SUD side of a classification (for example, a visit limit on outpatient therapy that does not apply to outpatient PT), flag it as a potential parity issue. See Section 8 for the parity flag procedure.

3.3 Evidence of Coverage (EOC)

Every Vista Access group has an Evidence of Coverage document for each plan year. The EOC is the contractual benefit document and is the source for what is and is not covered, what cost sharing applies, and what the member's appeal rights are. You must reference the EOC in effect on the date of service in dispute and not the current EOC. If a member received care in March 2024 and filed an appeal in February 2026, you look at the 2024 plan year EOC for that group.

EOCs are stored in the MCA document repository, organized by group ID and plan year. The filename convention is EOC_[GroupID]_[PlanYear].pdf. If you cannot locate an EOC for a specific group and plan year, do not proceed and contact the Compliance Officer.

3.4 Medical Policies

MCA publishes internal medical policies that define medical necessity criteria for specific services. These are the criteria a clinical reviewer will apply when deciding whether a denied service was medically necessary. Like the EOC, the medical policy you apply is the one in effect on the date of service, not the current version. Medical policies are versioned by effective date in the format MP_[###]v[#.#]_[YYYYMMDD].pdf.

Medical policies are maintained in the MCA Medical Policy Library. To determine which version was in effect on the date of service, check the Effective Date and Superseded Date fields in each policy's header block. If multiple versions could apply to a date range, or if you cannot locate the correct version, contact your Appeals Supervisor before proceeding.

Your job as a Coordinator is not to apply the medical policy, that is the clinical reviewer's job. Your job is to pull the correct version of the policy and attach it to the case file, so the reviewer is looking at the right criteria. A reviewer applying a newer or older version of a medical policy than the one in effect on the date of service is a serious quality issue and can void a determination.

4. Member Rights & Types of Appeals

4.1 Who Can File

The following parties have standing to file an appeal or grievance under Vista Access:

- The member themselves, whether they are the subscriber or a covered dependent age 18 or older
- A parent or legal guardian, on behalf of a covered dependent under age 18
- A legal guardian or conservator, on behalf of an adult member who has been legally adjudicated as lacking capacity (court documentation required)
- An Authorized Representative (AOR) designated in writing by the member on MCA's AOR form or an equivalent signed writing that identifies the member, identifies the AOR, and states the scope of authorization.

A common error is assuming that because a provider's office staff is communicating with MCA, the provider has standing to appeal on behalf of their patient. They do not have standing, unless the member has signed an AOR form. A letter on provider letterhead saying "my office is appealing on behalf of our patient" is not an AOR.

4.2 Appeal vs. Grievance

Appeals and grievances are different processes with different timelines and outcomes. .

An appeal is a formal request to overturn an adverse benefit determination. An adverse benefit determination is any denial, reduction, or termination of a benefit. For example, a denied prior authorization, a denied claim, a reduction in authorized units for physical therapy, or termination of ongoing authorized care. An appeal is asking MCA to change a decision. Appeals follow strict regulatory timelines and result in a formal determination letter with external review rights.

A grievance is a complaint about the quality of service, the behavior of MCA staff, the accessibility of the provider network, the clarity of plan documents, or any other dissatisfaction that does not involve a request to overturn a benefit decision. Grievances do not have the same regulatory clock as appeals and do not result in a determination letter with external review rights. Grievances are logged, investigated, acknowledged, and responded to, but they do not change a benefit decision.

Here is the test you should apply at intake: does the member want MCA to approve, pay for, or authorize something that was previously denied, reduced, or terminated? If so, it is an appeal. If not, it is a grievance.

Mixed requests. A single letter from a member can contain both an appeal and a grievance. For example, a member may write "my claim was denied and your customer service representative was rude to me when I called to ask about it." The denial portion is an appeal, while the rudeness complaint is a grievance. When this happens, open two separate cases, one appeal, and one grievance, with two distinct Case IDs. Each has its own clock and its own response process. Do not try to handle both in a single case file.

Cross-referencing mixed cases. When you open the two cases, you must cross-reference them in two specific locations so that downstream reviewers, auditors, and quality staff can find the related case. First, in the Appeals Log (Appendix C), enter the related Case ID in the "Related Case ID" column for both rows. Second, in each Case Determination Memo (Appendix D), note the related Case ID in the Case Identification section under a "Related Cases" line. Do not cross-reference in any other location, and do not create a single combined folder.

4.3 Types of Appeals

Vista Access recognizes five types of appeals. Each has its own timeline rule and procedural requirements. Classify the appeal correctly at intake as a classification error almost always produces a timeline error.

4.3.1 Pre-Service Standard Appeal

A pre-service appeal is an appeal of a denied request for authorization of care that has not yet been received. The classic example is a denied prior authorization for an upcoming surgery, imaging study, or course of outpatient therapy. The service has not happened yet, and the member is disputing the denial before receiving care. Pre-service appeals are handled on the standard timeline unless the member or provider requests expedited review and criteria are met (see 4.3.2).

4.3.2 Pre-Service Expedited Appeal

An expedited pre-service appeal is a pre-service appeal where applying the standard timeline could seriously jeopardize the member's life, health, or ability to regain maximum function, OR in the opinion of the treating physician, would subject the member to severe pain that cannot be

adequately managed without the care in dispute. Expedited status is triggered either automatically (when the treating physician certifies that expedited review is medically necessary) or by request (from the member, AOR, or provider) followed by MCA confirmation that expedited criteria are met.

When a treating physician certifies in writing that expedited review is medically necessary, MCA must honor the request and proceed on the expedited timeline. You cannot override a treating physician's expedited certification. When a member or AOR requests expedited review without a physician's certification, the RN Reviewer evaluates whether expedited criteria are met. If they are not, the case converts to standard, and the member is notified by phone within 24 hours and by written notice within 2 calendar days.

4.3.3 Concurrent Care Appeal

A concurrent care appeal is an appeal of a reduction or termination of previously approved ongoing care, while the member is still receiving that care. The classic example is a member who has been approved for 20 inpatient rehab days and receives notice on day 12 that MCA is terminating coverage effective day 14. Concurrent care appeals are always treated as expedited if the reduction or termination would end coverage before the appeal can be decided on within the standard timeline.

The decision deadline for concurrent care appeals is the earlier of: (a) 72 hours from the date of receipt, or (b) the date the reduction or termination takes effect, whichever gives the member less time. Coverage must continue through the appeal decision.

Concurrent care appeals have a special timeline rule: the decision must be rendered before the reduction or termination takes effect, whenever possible.

4.3.4 Post-Service Appeal

A post-service appeal is an appeal of a denied or reduced claim for care that has already been received. The service has happened, the provider has billed, the claim has been denied or paid at a lower amount than expected, and the member (or AOR, or provider with AOR) is disputing the denial or reduced payment. Post-service appeals always follow the post-service standard timeline. They cannot be expedited, because the care has already been delivered and there is no medical urgency.

4.3.5 Prescription Drug Exception Request

Prescription drug exception requests are a special category. They include requests for coverage of non-formulary drugs, requests for exceptions to step therapy, quantity limit exceptions, and tier exceptions. These follow the pharmacy timeline rules (see Section 5) and are routed to the Pharmacy Director rather than the RN Reviewer team. A pharmacy exception is treated as an appeal only if it arises after a denial of a prior authorization or an initial exception request; an initial exception request is not itself an appeal.

Initial Pharmacy Exception Requests: When an initial exception request (non-formulary, step therapy, quantity limit, or tier exception) arrives at Appeals, route it directly to Dr. Henning (Pharmacy Director) without opening an appeals case file and without sending an acknowledgment letter. **Appeals of Pharmacy Exception Denials:** If Pharmacy denies the initial request and the member or provider appeals that denial, treat the appeal as a formal appeals case. Open the case in the Appeals Log and send Template A-1 acknowledgment within 24 hours.

5. Timeline Rules & the Regulatory Clock

5.1 The Clock Starts at Receipt

Every appeal has a regulatory clock. The clock starts on the date the appeal is first received at any MCA intake address, and not before. "Received" means the document is time-stamped into the MCA appeals queue by the intake system, or, for mailed correspondence, is date-stamped by the mail room. Only the date MCA actually received it counts, while the postmark date on the envelope, the date the member wrote on their letter, or the date the provider's office printed the letter is irrelevant.

A member's letter is dated January 3, postmarked January 5, and arrives in the MCA mail room on January 8 — where it is scanned and uploaded to the appeals queue on January 9. The clock starts January 9. Do not use any of the earlier dates. When you open a case, the "date of receipt" you enter into the Appeals Log must be the queue timestamp, not any date printed on the document itself.

5.2 Standard Timelines

The following are MCA's internal timeline rules for Vista Access appeals. These are measured from the date of receipt (defined in 5.1) to the date the determination letter is issued (not to the date a decision is made internally — the clock runs until the member is notified).

Appeal Type	Acknowledgment	Decision Deadline
Pre-service standard	5 business days from receipt	30 calendar days from receipt
Pre-service expedited	Verbal within 24 hours; written within 24 hours	72 hours from receipt
Concurrent care (reduction/termination)	Verbal within 24 hours	Before the reduction/termination takes effect, or 72 hours, whichever is shorter
Post-service standard	5 business days from receipt	60 calendar days from receipt
Pharmacy exception, standard	24 hours from receipt (verbal or written)	72 hours from receipt
Pharmacy exception, expedited	24 hours from receipt (verbal)	24 hours from receipt
Grievance	5 business days from receipt	30 calendar days from receipt
External review forwarding, standard	N/A (internal forwarding)	5 business days from member's external review request
External review forwarding, expedited	N/A (internal forwarding)	24 hours from member's external review request

Appeal Type	Acknowledgment	Decision Deadline
External review decision (Canyon Ridge), standard	N/A (external)	45 calendar days from Canyon Ridge receipt
External review decision (Canyon Ridge), expedited	N/A (external)	72 hours from Canyon Ridge receipt

5.3 Business Days vs. Calendar Days

Pay attention to whether a timeline is stated in business days or calendar days. The two are not interchangeable and the rules in this manual use both.

- **Business days** exclude weekends and MCA's observed holidays. If an acknowledgment is due within 5 business days and the appeal is received on a Wednesday, the acknowledgment is due the following Wednesday, not the Monday. MCA-observed holidays are listed in the annual holiday schedule posted in #appeals-general each December.

MCA observes the following federal holidays for business day calculations: New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. The Director may designate additional holidays. When a deadline falls on an observed holiday, the deadline extends to the next business day.

- **Calendar days** include every day, including weekends and holidays. If a pre-service standard decision is due within 30 calendar days and the appeal is received on the 1st of the month, the decision is due on the 30th or 31st of that same month regardless of what days of the week those fall on.
- **Hours** (as in "72 hours" or "24 hours") run continuously and they do not pause for weekends or holidays. A 72-hour expedited appeal received at 3:00 PM on a Friday is due by 3:00 PM the following Monday. If you realize the deadline will fall on a weekend and you will not be available, escalate the case to the on-call coordinator before you leave.

5.4 Tolling for Missing Information

If you determine that you need additional information from the member, the AOR, or the provider in order to adjudicate the appeal, you may toll (pause) the regulatory clock one time per case. The tolling rule has three parts, and they must all be followed:

1. You must send the Missing Information Request (Template A-2) to the member (or AOR or provider, as applicable). The clock stops on the date you send the request.
2. You give the recipient 15 calendar days to respond. The clock remains stopped during this period.
3. The clock restarts on the earlier of (a) the date the requested information is received, or (b) the expiration of the 15-day window. If information is not received by the 15-day deadline, the clock restarts on the 16th day and you proceed with whatever information you have.

Tolling is one time only. You may request missing information more than once, but only the first request tolls the clock. A second or third request does not extend the deadline. If you realize through a case that you need additional information you should have asked for at intake,

you are usually stuck on the original clock and must work faster to make the deadline. Do not attempt to re-toll as it is not allowed and will result in an untimely decision.

Tolling is not available for expedited appeals. If you need information on an expedited case, you may request it but the clock does not stop. This is because the entire point of expedited review is that the member's medical situation cannot wait.

5.5 Missed Deadlines: "Deemed Exhausted"

If MCA fails to render a decision within the applicable timeline (including any tolling), the internal appeal is "deemed exhausted" under federal rules.

If you realize a deadline is at risk of being missed, escalate immediately to your Appeals Supervisor using Slack Format B-2 and tag the message URGENT. Do not wait to see if the reviewer will finish in time. The Appeals Supervisor will work with the clinical reviewer to either expedite the decision or begin preparing the deemed exhausted forwarding packet to Canyon Ridge Review Services.

If a deadline has already been missed, stop and notify the Appeals Supervisor and the Compliance Officer (Kendel Dufree) in #appeals-compliance using Slack Format B-4 (Deemed Exhausted Notification). A missed deadline is a compliance event and must be logged. Do not attempt to backdate the determination letter or otherwise obscure the miss as doing so is grounds for termination.

6. Intake, Classification & Case Setup

6.1 Intake Workflow

When a new document arrives in the intake queue, work through the following steps in order. The entire intake process should take no more than 30 minutes per case.

1. Read the entire incoming document. Do not classify based on the subject line or the first paragraph.
2. Confirm the member's identity by searching for a member record on file using the name, date of birth, and member ID. If any of these three do not match, stop and escalate as you may be looking at a member mix-up. Confirm that the member has an active MCA plan.
3. Identify the requestor. Is it the member, a parent, guardian, AOR or provider? If the requestor is anyone other than the member, you must confirm standing before opening the case on the regulatory clock. Confirm standing per Section 4.1. If standing is clear, proceed using the intake queue timestamp as the Date of Receipt per Section 5.1. If standing is not clearly established, send the Missing Information Request (Template A-2) asking for AOR documentation to both the requestor and the member. Do not send the acknowledgment letter or open the case until standing is established. The 5-business-day acknowledgment window begins when valid standing documentation is received, not when the original request arrived.
4. Classify the request. If it's an appeal, identify which of the five types and proceed with the steps below. (See Section 4.3.)
5. Identify the original denial. For an appeal, locate the original denial letter or EOB in the claims system. You will need the denial date, the denial reason, the medical policy cited (if any), and the EOC year.

6. Pull supporting documents, the correct plan year EOC, the correct medical policy version (if applicable), the prior authorization history for the service, and any claims payment history. Attach all of these to the case file.
7. Set the regulatory clock. Enter the date of receipt into the Appeals Log (Appendix C). The Log will automatically calculate the decision deadline based on the appeal type you selected.
8. Send the acknowledgment letter (Template A-1) to the requestor within the acknowledgment timeline (Section 5.2). Use the correct letter template for the appeal type.
9. Route the case. For medical necessity cases, route to the appropriate clinical reviewer per Section 2.2. For cases with parity concerns, route to Dr. Ontario and the Parity Review Committee (Section 8).
10. Log the case in the Appeals Log with Case ID, member ID, appeal type, date of receipt, decision deadline, and current status (Intake, With Reviewer, Draft Letter, Sent, Closed).

6.2 Classification Checklist

Use this checklist at intake for every case. It is printed on a laminated card at every Coordinator's desk. Answer all seven before opening the case.

1. Is this an appeal or a grievance? (If you cannot answer this in one sentence, please read Section 4.2.)
2. If it is an appeal, identify the type (Pre-service standard, pre-service expedited, concurrent care, post-service, or pharmacy exception.)
3. Who is the requestor and do they have standing? (Member, parent/guardian, AOR with current form on file, or provider for pre-service only.)
4. What is the date of receipt? (Per Section 5.1, the MCA queue timestamp, not any date on the document itself.)
5. What is the plan year of the disputed service? (Determines which EOC and which medical policy version to use.)
6. Does this case present a potential parity issue? (If the member's complaint mentions disparate treatment between medical and behavioral health, or if the disputed service is a behavioral health service with a restriction that may not apply to medical/surgical then flag per Section 8.)
7. Does this case meet any mandatory escalation trigger? (See Section 9.2.)

If the answer to question 6 or question 7 is yes, you must follow the corresponding escalation procedure before finishing intake.

6.3 Case File Contents

Every case file must contain the following documents, organized in the case folder in the shared Appeals repository:

- The original appeal or grievance letter (PDF), as received
- Any attachments provided by the requestor (clinical records, receipts, correspondence)
- The AOR form, if applicable
- The original denial letter or EOB being appealed

- The EOC for the member's plan in the applicable plan year
- The relevant medical policy version(s) in effect on the date of service
- Prior authorization history for the disputed service (XLSX export)
- Claims payment history for the disputed service (XLSX export)
- The acknowledgment letter you sent (Template A-1)
- Any correspondence with the requestor during the case
- The clinical review worksheet completed by the RN or Medical Director
- The final determination letter (Template A-5, A-6, or A-7)
- The Case Determination Memo (Appendix D)

Case files are subject to audit by the Nevada Division of Insurance, by the federal Department of Labor, and by internal Quality Review. A case file that is missing any of the above items will fail audit even if the substantive decision was correct.

7. Clinical Review & Medical Necessity

7.1 Your Role in Clinical Review

Your job is to make sure the right clinical reviewer looks at the right materials under the correct criteria. The clinical reviewer will apply their professional judgment using the applicable medical policy. Never write "the service is medically necessary" or "the service is not medically necessary" in a letter unless you are directly quoting a clinical reviewer's worksheet.

7.2 Standards of Review

Not every denied service is denied for medical necessity reasons. The reason for the original denial determines which standard of review applies, and applying the wrong standard is one of the most consequential errors at intake. The five standards are:

Standard	When It Applies	Who Reviews
Medical necessity	The original denial said the service was "not medically necessary" or did not meet medical policy criteria	RN Reviewer → Medical Director
Experimental / investigational	The original denial said the service is experimental, investigational, or not supported by generally accepted medical evidence	Medical Director directly; RN Reviewer cannot uphold an E/I denial
Benefit exclusion	The original denial said the service is a specific exclusion under the EOC (e.g., cosmetic surgery, custodial care)	Coordinator with Supervisor co-signature; no clinical reviewer signature required (see Section 9.1.3)
Administrative	The original denial was for administrative reasons (missing prior auth, out-of-network, claim filed late, eligibility at date of service)	Coordinator with Supervisor co-signature; no clinical reviewer signature required

Standard	When It Applies	Who Reviews
Pharmacy exception	The original denial was of a prescription drug exception request (non-formulary, step therapy, quantity limit, or tier exception)	Pharmacy Director (Dr. Henning) directly; no RN tier

The standard of review must match the original denial reason. If the original denial was administrative (for example, "prior authorization was not obtained"), you cannot reclassify the appeal as a medical necessity appeal just because the provider's letter argues the service was medically necessary. The question on an administrative denial is whether the administrative requirement was satisfied, not whether the care was medically warranted. Route the case under the standard that matches the original denial. If the appeal letter raises a new argument, note it in the case file but do not change the standard of review without Supervisor approval.

7.2.1 Adjudicating Administrative Denials

Administrative denials do not require clinical review because the question is procedural, not medical. You adjudicate these yourself with Supervisor's co-signature. Use the following logic depending on the denial reason:

- **Missing prior authorization:** Check the prior authorization history XLSX export for the member. If a valid authorization existed for the service and date of service, overturn. If no authorization existed, uphold.
- **Out-of-network:** Check the network status of the billing provider on the date of service using the provider directory export. If the provider was in-network, overturn. If out-of-network, check the EOC for any emergency or continuity of care exceptions that might apply, and if none apply, uphold.
- **Claim filed late:** Check the date of service against the date the claim was received. If the claim was received within the timely filing window stated in the EOC, overturn. If outside the window, check for a provider good-cause exception, and if none, uphold.
- **Eligibility at date of service:** Check the eligibility history for the member. If the member was eligible on the date of service, overturn. If not eligible, uphold.

All four adjudication patterns require Supervisor co-signature on the determination letter, you cannot issue an administrative determination without Supervisor review, even though no clinical reviewer is involved. If the facts are not clear, escalate to Supervisor with a recommendation.

7.2.2 Adjudicating Benefit Exclusions

Benefit exclusion denials are also adjudicated by the Coordinator with Supervisor co-signature, with no clinical reviewer signature required. The question is whether the service falls within a specific exclusion in the EOC. Locate the relevant exclusion language in the EOC in effect for the date of service, confirm that the service as described is within that exclusion, and prepare the determination letter citing the specific exclusion provision. If the member argues that the service is medically necessary and therefore should not be excluded, the argument does not defeat the exclusion and benefit exclusions apply regardless of medical necessity. However, if the member's appeal alleges that the service is not actually within the exclusion (for example, that a procedure the carrier classified as cosmetic is actually reconstructive), the case may need clinical review to determine which classification applies. In that situation, route to the appropriate clinical reviewer even though the original denial was administrative in form.

7.3 Routing to Clinical Reviewers

Once you have classified the appeal and identified the correct standard of review, route clinical cases using the Clinical Routing Slack format (Format B-1) in the #appeals-clinical-queue channel. The routing message must include:

- Case ID in the format CASE-YYYY-NNNNN (no member name, no PHI)
- Appeal type (pre-service standard, pre-service expedited, concurrent care, post-service, pharmacy)
- Service classification (medical/surgical, behavioral health, SUD, pharmacy)
- Standard of review (medical necessity, experimental/investigational, benefit exclusion, administrative)
- Decision deadline (date and time, which is critical for expedited cases)
- Link to the case folder in the shared Appeals repository
- Any parity flag status (see Section 8)

For expedited cases, also send a direct Slack message to the specific reviewer on call AND tag @dwhitfield in #appeals-urgent. Do not rely on the reviewer seeing the queue message for an expedited case. When the deadline is measured in hours, minutes matter.

7.4 What a Clinical Reviewer Will Need

A well-prepared case file includes a one page Case Summary (top of the file folder) identifying:

- The disputed service, in plain terms (e.g., "inpatient psychiatric admission, 7 days, February 12–19, 2025")
- The CPT or HCPCS codes billed, and the place-of-service code
- The billing provider's name and NPI
- The date of the original denial and the specific denial reason
- The medical policy cited in the original denial (by policy number and version)
- The applicable EOC plan year and any relevant benefit language
- Any new clinical information submitted with the appeal
- The decision deadline

Do not editorialize in the Case Summary. Do not argue the member's position for them, and do not argue against it. Describe the dispute factually and let the reviewer apply their judgment.

8. Mental Health & SUD Parity Review

8.1 Why Parity Matters

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) and Nevada's parity requirements require that MCA apply no more restrictive standards to mental health and substance use disorder (MH/SUD) benefits than it applies to comparable medical and surgical (M/S) benefits within the same classification. "No more restrictive" applies to both quantitative treatment limits (QTLs), such as visit limits, day limits, dollar limits, and non-quantitative treatment limits (NQTLs), including prior authorization requirements, step therapy, network composition, medical necessity criteria, and reimbursement methodology.

A parity violation is a serious compliance matter. If a member complains about a restriction on MH/SUD care that does not appear to apply to M/S care in the same classification, the case must be flagged for Parity Review Committee review in addition to the normal clinical review. Parity flags cannot be waived, overlooked, or deferred. If in doubt, flag.

8.2 Parity Flag Indicators

Flag the case for Parity Review Committee review if any of the following are present:

- The member's letter mentions disparate treatment between medical/surgical and behavioral health services (for example, "my physical therapy had no visit limit, but my therapy was capped at 20 visits")
- The member's letter mentions parity directly, by any of these terms: "parity," "MHPAEA," "Mental Health Parity," "discrimination against mental health," or "different rules for mental health"
- The disputed service is a behavioral health service AND the member's letter or the denial reasoning raises the possibility that a medical necessity criterion, visit limit, day limit, or prior authorization requirement is being applied more restrictively to MH/SUD than to comparable M/S services
- The denial cites an internal medical policy applicable only to MH/SUD care with no parallel M/S policy mentioned in the denial
- The member is appealing a denial of inpatient SUD residential treatment, and the denial reasoning relies on criteria more restrictive than those used for comparable M/S inpatient rehabilitation
- The member or their provider asserts that a prior authorization requirement applied to the behavioral health service does not apply to comparable M/S services in the same classification (you do not need to independently verify this assertion since the assertion itself is a flag)

You are not being asked to decide whether a parity violation occurred. You are being asked to flag cases where one might have occurred, so that a clinician and the Parity Review Committee can make that determination. The standard for flagging is broad. A case that is flagged but turns out to be compliant, is not a problem, and case that is not flagged but turns out to have a parity issue is a serious quality failure.

8.3 Parity Flag Procedure

When a parity flag is raised, the parity review replaces the standard clinical. The reason is that a parity analysis requires comparing MH/SUD benefit design to M/S benefit design, which is not a standard RN Reviewer competency, and having two reviewers working the same case creates coordination problems and duplicate determinations. Route a parity-flagged case only to Dr. Ontario and the Parity Review Committee, even if the case would otherwise have gone to a medical/surgical reviewer.

Parity-flagged cases are routed exclusively to Dr. Ontario and the Parity Review Committee. The service-type-based clinical routing (e.g., RN Reviewer tier) does not apply to parity-flagged cases. Dr. Ontario's review encompasses both the clinical assessment and the parity analysis. Do not route a parity-flagged case through the standard RN tier first.

1. Within the Case Determination Memo, check the "Parity Flag: YES" box in the Parity Analysis section (Appendix D).

2. Send a Parity Flag Notification using Slack Format B-3 as a direct message to @parity-committee. Do not post this message in #appeals-parity, that channel is for general discussion and announcements only.
3. Route the case to Dr. Ayla Ontario (behavioral health Medical Director) rather than the standard clinical reviewer the case would otherwise have gone to. Dr. Ontario is the Parity Review Committee chair and coordinates both the clinical review and the parity analysis for flagged cases.
4. Do not issue a determination letter on a parity flagged case without the Parity Review Committee's concurrence (see 8.3.1 for how the concurrence is communicated back to you). If a deadline is at risk while waiting for Parity Review, escalate to the Appeals Supervisor immediately.
5. In the determination letter, if the appeal was partially or fully overturned as a result of the parity review, the letter must state this plainly.

8.3.1 Parity Review Committee: Closed-Loop Communication

When the Parity Review Committee completes its review, the Committee communicates its decision back to you in a direct Slack message from @parity-committee (or from Dr. Ontario) using the Parity Committee Concurrence format below. Do not act on verbal concurrence, email, or informal chat.

Parity Committee Concurrence Slack format (inbound, from @parity-committee to you):

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PARITY CONCURRENCE
Case #: [CASE ID]
Committee Decision: [CONCUR WITH UPHOLD / CONCUR WITH OVERTURN /
                    PARTIAL OVERTURN ON PARITY GROUNDS]
Rationale: [1-3 sentences from the Committee]
Clinical Review Notes: [Dr. Ontario's clinical review worksheet
                       file name in the case folder]
Safe to Issue Letter: YES / NO

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When you receive a Parity Committee Concurrence message, save the Slack message text to the case folder as a file named parity_concurrence.txt. This is the record that the Committee signed off on the determination. Do not draft the determination letter until this file exists in the case folder.

If the Parity Committee Concurrence indicates "Safe to Issue Letter: NO" or recommends a decision outcome that differs from the clinical review outcome, stop immediately. Do not draft the determination letter. Contact Dr. Ontario via Slack DM to clarify the Committee's position. The Parity Review Committee's recommendation is binding on the final appeal determination. Proceed with drafting only after the Committee confirms "Safe to Issue Letter: YES."

If you have not received a Parity Committee Concurrence within 7 calendar days of sending the Parity Flag Notification (Format B-3), follow up with Dr. Ontario via DM and, if the case deadline is approaching, escalate to the Appeals Supervisor using Slack Format B-2 with trigger "Parity Review Delay."

8.4 Common Parity Classification Errors

This happens because parity complaints and medical necessity appeals can look almost identical on the surface. Both involve a denied behavioral health service, both involve a member

who disagrees with the denial, and both can involve clinical arguments about the care that was requested.

If the member's argument is "my care meets the criteria in your medical policy and you applied the policy incorrectly," that is a medical necessity appeal. If the member's argument is "your medical policy itself is more restrictive for mental health than it is for medical, and that is a parity violation," that is a parity case. You can have both in the same letter. When in doubt, flag for parity.

9. Authority Levels & Escalation

9.1 Coordinator Authority

As an Appeals & Grievances Coordinator, your independent authority is narrow. MCA structures authority by tier, based on role and the total dispute value of the case. Your tier determines which cases you can work to closure without your Supervisor's co-signature and which cases must be escalated regardless of the decision.

9.1.1 Authority Tiers by Role

The following tiers define the maximum total dispute value a role may adjudicate without additional approval. "Total dispute value" means the total billed charges at issue in the appeal, not the member's out-of-pocket exposure. A case with \$240,000 in billed charges exceeds the Coordinator tier even if the member's out-of-pocket maximum would cap them at \$8,500.

Role	Authority Limit (Total Dispute Value)
Appeals & Grievances Coordinator (you)	Up to \$25,000 per case
Senior Appeals Coordinator	Up to \$75,000 per case
Appeals Supervisor	Up to \$150,000 per case
Director, Appeals & Grievances	Up to \$500,000 per case
Above \$500,000	Requires Chief Medical Officer approval

If a case exceeds your tier, you remain the Coordinator of record and continue to work the case, but the final determination letter must be co-signed by someone at the appropriate tier. Escalate via Slack Format B-2 with trigger "Exceeds Coordinator Authority" as soon as you identify the dispute value and do not wait until you are drafting the letter.

The tier table applies to the substantive authority to approve or deny. Regardless of tier, the mandatory escalation triggers in Section 9.2 still apply. For example, a \$3,000 post-service appeal with a parity flag must be escalated even though \$3,000 is within the Coordinator tier.

9.1.2 What You Can Do Independently

Within your tier and absent any mandatory escalation trigger, you can:

- Open and classify cases
- Send acknowledgment letters (Template A-1) and missing information requests (Template A-2) without review
- Dismiss cases for clear lack of standing or clear untimeliness, when the facts are clear, with Supervisor review of the dismissal letter before sending

- Draft determination letters from approved templates, based on the clinical reviewer's written decision
- Close cases in the Appeals Log after the determination letter has been sent

9.1.3 What You Cannot Do

Under no circumstances may a Coordinator at any tier:

- Issue a determination letter without a clinical reviewer's signed determination (except for administrative denials and benefit exclusion denials, both of which are adjudicated by the Coordinator with Supervisor's co-signature under Sections 7.2.1 and 7.2.2)
- Change a clinical reviewer's decision or "adjust" the reasoning in a determination letter
- Contact defense counsel, the Nevada Division of Insurance, or any regulatory agency directly
- Settle a case by offering payment, benefit, or any other consideration to the member
- Commit MCA to any future benefit coverage beyond what the determination letter states
- Access or pull clinical records for members other than those assigned to your cases

9.2 Mandatory Escalation Triggers

Escalate to your Appeals Supervisor (Darnell Whitfield) via Slack Format B-2 whenever any of the following is present, regardless of case value or type:

1. The member, AOR, or provider has threatened legal action or has been identified as being represented by an attorney in the appeals correspondence
2. A lawsuit or arbitration demand has been initiated against MCA, OR the member has filed an external review request directly with the Nevada Division of Insurance or a federal agency rather than through MCA's standard internal external-review forwarding process (note: a routine member request for external review of a final MCA determination is handled under Section 10.6 and is NOT itself a mandatory escalation trigger. Only adversarial or out-of-process external review filings escalate)
3. A complaint has been filed with the Nevada Division of Insurance, the U.S. Department of Labor, or any federal or state consumer protection agency
4. The case has attracted or is likely to attract media attention (a reporter has contacted MCA, the member has a significant social media following and has posted publicly about the case, etc.)
5. The case involves a fatal outcome, imminent serious bodily harm, or alleged harm resulting from a prior MCA decision
6. The case involves a Vista Access employer group that is also an MCA commercial client (cross-functional conflict of interest)
7. The case involves an MCA employee, board member, or family member of either, as the member or as a treating provider
8. A parity flag has been raised (see Section 8)
9. The total dispute value exceeds the Appeals Supervisor tier of \$150,000, or would establish coverage for services over \$25,000 per month on an ongoing basis
10. You are uncertain about any of the classification decisions at intake, and when in doubt, escalate

11. A deadline is at risk of being missed (see Section 5.5)
12. The case involves a concurrent care termination where the member is currently receiving care that would end in the next 72 hours
13. The total dispute value exceeds the Coordinator's \$25,000 authority tier (see Section 9.1.1).

9.3 Escalation Procedure

1. Send a direct Slack message to @dwhitfield using Slack Format B-2 (Escalation to Appeals Supervisor). Do not post escalations in public channels. Use DM.
2. Include: Case ID, appeal type, decision deadline, specific escalation trigger (from the list in 9.2), a 2 to 3 sentence summary of the situation, your recommended next action, and what you need from the Supervisor (approval, guidance, direct takeover).
3. Do not take the action that requires escalation approval until you receive a response. If the matter is time sensitive and the Supervisor has not responded within 2 business hours, escalate further by posting in #appeals-urgent and tagging @dwhitfield and @treys.
4. Log the escalation in the case file with the date, time, channel, Supervisor response, and any action taken.

An escalation is not a handoff. When you escalate a case, you remain the Coordinator of record and continue to be responsible for the case file, the clock, and correspondence unless the Supervisor explicitly reassigns it. Escalation means you are requesting guidance or approval, not that you have transferred the case.

9.4 Compliance Events

A compliance event is any event that may trigger a regulatory reporting obligation, a corrective action plan, or an audit finding. Compliance events include:

- A missed decision deadline (deemed exhausted) see Section 5.5
- A Nevada Division of Insurance complaint notification
- A federal Department of Labor inquiry
- A discovered miscategorization of a case that affected the timeline (e.g., realizing a case that was treated as post-service was actually concurrent care)
- A HIPAA reportable event (PHI disclosure to the wrong party, missing member, or combining two members' records)
- A Parity Review Committee finding that a prior determination should be overturned on parity grounds

Compliance events must be reported to both your Appeals Supervisor and the Compliance Officer (Kendel Dufree) within 4 business hours of discovery. Use Slack Format B-4 (Compliance Event Notification) in #appeals-compliance. Do not discuss the specifics of a compliance event in any other channel and do not discuss it in any outbound correspondence with the member or provider until Compliance has approved the response.

10. Specific Appeal Type Procedures

10.1 Pre-Service Standard Appeals

For a pre-service standard appeal, work the case through these steps:

1. Acknowledge within 5 business days using Template A-1.
2. Verify standing and complete intake classification (Section 6).
3. Route to RN Reviewer via Slack Format B-1 in #appeals-clinical-queue.
4. Monitor the case. Check the reviewer's status by day 15 and again by day 22. If the reviewer indicates they need more time, escalate to the Supervisor.
5. Draft the determination letter (Template A-5 for adverse, A-6 for favorable) based on the clinical reviewer's written decision. The letter must include specific benefit being appealed, specific denial reason from the original denial, the reviewer's finding, the specific policy or EOC provision cited, and the required external review notice.
6. Have the Supervisor review any adverse determination letter before sending.
7. Send the letter no later than 30 calendar days from the date of receipt.
8. Complete the Case Determination Memo (Appendix D) and close the case in the Appeals Log.

10.2 Pre-Service Expedited Appeals

Expedited appeals run on a 72 hour clock measured in continuous hours. The operational rhythm is completely different from standard appeals and there is very little margin for error. Work these cases in priority order and an expedited case takes precedence over any standard case in your queue.

1. Confirm expedited criteria immediately on receipt (Section 4.3.2). If a treating physician has certified the need for expedited review in writing, proceed on the expedited clock without question. If the member or AOR has requested expedited review without a physician certification, route to an RN Reviewer within 1 hour for an expedited eligibility determination.
2. If expedited criteria are NOT met, convert to standard and notify the requestor by phone within 24 hours and by written notice (Template A-9, Expedited Denied: Converted to Standard) within 2 calendar days.
3. If expedited criteria ARE met, send the expedited acknowledgment (Template A-1 with expedited header) within 24 hours.
4. Route immediately in #appeals-urgent and DM the on-call reviewer directly. Tag @dwhitfield. Do not rely on the queue.
5. Set a calendar block for yourself at the 48-hour mark to check on reviewer progress.
6. Draft the determination letter using Template A-7 (Expedited Determination). Supervisor review is required but should take no more than 30 minutes and flag the Supervisor in Slack the moment the draft is ready.
7. Send the letter no later than 72 hours from the date of receipt. The clock does not pause for weekends, holidays, or the Coordinator's work schedule.
8. If the deadline is at risk for any reason, such as reviewer unavailability, clinical complexity, missing records, then escalate IMMEDIATELY.

10.3 Concurrent Care Appeals

Concurrent care appeals have the tightest effective timelines of any appeal type because the decision must be made before the member loses coverage. When a concurrent care case

comes in, your first action is to determine the effective date of the reduction or termination date, that is your real deadline, even if it is sooner than the 72-hour expedited window.

1. Identify the effective date of termination from the original termination notice. If the effective date is within 72 hours of the appeal receipt, this is your deadline.
2. If the effective date is more than 72 hours out, use the 72 hour expedited deadline.
3. Coverage must continue through the appeal decision and do not notify the provider that authorization will lapse while the appeal is pending. Continuation-of-coverage pending appeal is a federal requirement for concurrent care.
4. Route immediately to the appropriate clinical reviewer (RN Reviewer team for M/S, Dr. Ontario for BH/SUD) and flag that this is a concurrent care case in Slack Format B-1.
5. Draft the determination letter using Template A-7 (Expedited Determination) with the concurrent care header block.
6. If the appeal is favorable (overturn), the authorization must be reinstated in the claims system, and the provider notified the same day. Do not wait until the determination letter is sent to notify the provider, call or email the provider directly.

10.4 Post-Service Appeals

They involve care that has already been delivered and a claim that has already been adjudicated. The regulatory clock is 60 calendar days.

1. Acknowledge within 5 business days using Template A-1.
2. Verify the original claim in the claims system. Pull the full claim history and not just the denied line because related claims may affect the analysis.
3. Identify the specific denial reason code and confirm which standard of review applies (Section 7.2).
4. If there is any dispute about whether a service was actually delivered (for example, the member claims they received care the provider did not bill for, or the provider is billing for care the member says did not occur), do not attempt to resolve the factual dispute yourself. Flag the case using Slack Format B-6 (Suspected Claim Fraud) as a DM to the Compliance Officer (@kdufree). Continue handling the appeal on the regular clock while the fraud review is in progress. Do not pause the case waiting for the fraud review outcome.

Fraud Review Outcome: If the fraud review concludes before the appeal determination, the Compliance Officer will provide written direction on how the finding affects the case. If the finding is substantiated, Compliance may direct a specific disposition or require additional documentation before determination. If the finding is unsubstantiated, proceed with the appeal as normal. If the appeal determination deadline arrives before the fraud review concludes, issue the determination based on the clinical and contractual merits of the appeal as if no fraud flag existed. Do not reference the fraud review in the determination letter. Document the fraud review status in the case notes with a reference to the Compliance case number.

5. Route to clinical review if medical necessity is in dispute; otherwise handle as an administrative or benefit-exclusion review per Section 7.2.
6. Draft and send the determination letter within 60 calendar days of receipt. If the letter is favorable, you must include the corrected payment amount and the expected payment date. Do not calculate either yourself. To obtain them, after the clinical reviewer's favorable determination is finalized, open a Claim Reprocessing Request in the claims

system, attach the reviewer's determination, and mark it "Appeals Overturn." Within 2 business days, the Claims Adjustment team will return a Reprocessing Worksheet to you in Slack DM with three fields: (a) the corrected allowed amount, (b) the corrected payment amount payable to the provider or member, and (c) the expected payment date. Copy these three values verbatim into the determination letter. Do not modify the amounts. If the Reprocessing Worksheet has not been returned within 2 business days, escalate to Appeals Supervisor. The claim reprocessing must be initiated within 5 business days of the favorable determination.

10.5 Pharmacy Exception Requests

Pharmacy appeals are handled differently from medical appeals. They are routed to Dr. Henning (Pharmacy Director) rather than through the RN tier, and the timelines are shorter. Read the pharmacy timeline row in the Section 5.2 table carefully as the standard pharmacy exception has a 72 hour decision deadline, not 30 days.

1. Identify whether the request is for (a) a non-formulary drug, (b) a step therapy exception, (c) a quantity limit exception, or (d) a tier exception. The reviewer will need to know which.
2. Determine urgency. If the treating prescriber has indicated the member's condition is urgent, this is an expedited pharmacy exception and must be decided within 24 hours.
3. Confirm whether this is an initial exception request or an appeal of a prior exception denial. Only the latter is subject to the formal appeal process; initial exception requests are handled by Pharmacy directly and are only subject to Intake Workflow steps 1-3 (6.1).
4. Send the acknowledgment letter (Template A-1, with the Pharmacy Header Block prepended) within 24 hours of receipt. The pharmacy acknowledgment timeline is 24 hours, not 5 business days. Do not default to the standard appeal acknowledgment window.
5. Route to Dr. Henning via DM. Do not post pharmacy cases in #appeals-clinical-queue.
6. Draft the determination letter based on Dr. Henning's decision using Template A-5 (adverse) or A-6 (favorable) with the pharmacy header block. The letter must specify the drug name, strength, and the specific exception criterion the reviewer applied.

10.6 External Review Forwarding

When MCA has issued a final adverse determination on an internal appeal, or when a case is deemed exhausted, the member has the right to request external review by Canyon Ridge Review Services. External review forwarding is your job, and it is time sensitive.

1. A request for external review must be received from the member within 120 days of the final adverse internal determination. Verify this date before forwarding. If the request is late, issue a dismissal (Template A-3, Dismissal: Untimely) unless the Supervisor authorizes a good-cause exception.
2. Compile the external review packet: (a) the original appeal, (b) all clinical records considered by MCA, (c) the original denial and any subsequent internal determination letters, (d) the applicable medical policy versions, (e) the applicable EOC, (f) the Case Determination Memo, and (g) a cover sheet identifying the member, case ID, and contact information for MCA.

3. Forward to Canyon Ridge within 5 business days of receipt of the member's external review request. For expedited external review (when the case meets expedited criteria under Section 4.3.2), forward within 24 hours to urgent-intake@canyonridgereview.com.
4. Use Template A-8 (External Review Forwarding) for the forwarding email. The email must contain the Case ID, the member's initials only (full names are PHI and must not appear in the email body, Template A-8 enforces this), the date of MCA's final internal determination, and a clear statement that this is a standard or expedited external review.
5. Copy the Compliance Officer (Kendel Dufree) on all external review forwarding emails. The Compliance Officer is the MCA point of contact for Canyon Ridge, not you.
6. Log the external review in the Appeals Log. The case remains open until Canyon Ridge returns a decision.

Canyon Ridge's decision is binding on MCA. If Canyon Ridge overturns MCA's internal decision, MCA must implement the overturn within 5 business days. This includes reinstating authorization, reprocessing claims, or issuing payment. Do not attempt to re-litigate a Canyon Ridge decision through further internal review. The external review decision is final.

10.7 Grievance Workflow

Grievances follow a separate workflow from appeals. They are not adjudicated by clinical reviewers, they do not produce a determination letter, and they do not generate external review rights. They are investigated, responded to, and closed. The Grievance workflow is intentionally lighter than the Appeal workflow because the Coordinator handles most of it directly.

Use this workflow for any case classified as a grievance at intake (Section 4.2) or for the grievance half of a mixed appeal-plus-grievance filing. The grievance clock is 30 calendar days from date of receipt to date of grievance resolution letter, with a 5 business day acknowledgment window.

1. Acknowledge within 5 business days using Template A-1 with the subject line modified to read "Mojave Crest Grievance Case #[CASE ID] - Acknowledgment of Your Grievance" and the body adapted to refer to a grievance rather than an appeal.
2. Open the grievance case in the Appeals Log with Appeal Type = "Grievance" and the 30 calendar day clock.
3. Identify the type of grievance from the member's complaint. Common categories: (a) staff conduct, (b) provider network access or accuracy, (c) plan document clarity, (d) administrative process complaint, (e) facility or telephonic accessibility, (f) cultural or language access. Note the category in the case file as this drives where you route the investigation.
4. Route the investigation to the appropriate owner: staff conduct grievances go to the Appeals Supervisor (DM @dwhitfield); network grievances go to Provider Relations via email at provider.relations@mojavecrest.com; document clarity grievances go to the Compliance Officer; accessibility grievances go to the Member Services Director. Use Slack Format B-2 to notify the Appeals Supervisor of the routing even when the investigation owner is outside the Appeals unit, so the Supervisor can track grievance volumes.
5. Maintain ownership of the case in the Appeals Log even when the investigation is being conducted by another team. You remain the Coordinator of record. Follow up with the investigation owner if you have not received their findings by day 20 of the 30 day clock.

6. When the investigation owner returns their findings, summarize the findings and the action taken (if any) in the Case Determination Memo. Grievances do not have an "Outcome" of upheld or overturned in the appeals sense. Use "Resolved with Action" (the investigation owner took corrective action), "Resolved without Action" (the complaint was investigated and no action was warranted), or "Referred Out" (the complaint required external referral, e.g., to a state licensing board).
7. Draft the Grievance Resolution Letter using Template A-10. The letter must summarize the grievance, describe the investigation conducted, state the resolution, and inform the member of their right to file a complaint with the Nevada Division of Insurance if they remain dissatisfied. Grievance resolution letters do NOT include external review rights. External review is only available for adverse benefit determinations on appeals.
8. Send the Grievance Resolution Letter no later than 30 calendar days from the date of receipt. Supervisor review is required for grievance resolution letters that involve staff conduct findings or that include any corrective action described in writing.
9. Close the grievance in the Appeals Log. Grievance cases are not routed to the Parity Review Committee even if they touch on behavioral health. The parity flag procedure (Section 8.3) applies only to appeals of adverse benefit determinations. A pure complaint about behavioral health network access is a network grievance, not a parity case.

Common grievance handling errors: (a) treating a grievance as an appeal and routing it to clinical review; (b) using an appeal determination template (A-5, A-6, A-7) instead of the Grievance Resolution Letter (A-10); (c) including external review language in a grievance resolution letter; (d) missing the 30-day clock because no clinical reviewer is involved and the case feels less urgent. The grievance clock runs the same way as the standard appeal clock and missed grievance deadlines are also reportable to the Nevada Division of Insurance.

11. Red Flags, Dismissals & Quality Review

11.1 Appeal Marketing Mill Indicators

In the past several years, a small number of third-party appeal marketing firms (appeal mills) have begun filing high volumes of appeals on behalf of members using templated language and aggressive recruitment tactics. These firms are not AORs. They recruit members, solicit signatures on boilerplate AOR forms, and then file identical appeal letters across many members. Identifying these filings is important because the boilerplate appeal often does not match the specific facts of the individual member's case.

Appeal Mill Follow-Up: When the Senior Coordinator confirms an appeal mill pattern, the case continues on its normal regulatory clock. The appeal mill designation does not pause, extend, or alter any timeline. The Senior Coordinator will document the finding in the case notes and may direct additional scrutiny on the clinical record, but the Coordinator must not delay or prejudice the appeal based on the source. If the Senior Coordinator determines the appeal was filed without the member's informed consent, escalate to Compliance via Slack Format B-5. The appeal still proceeds to determination — a member's rights are not diminished by the actions of a third party.

Flag a case for possible appeal mill review if two or more of the following are present:

- The appeal letter contains language that is word-for-word identical to another recent appeal from a different member (the Senior Coordinator maintains a reference file of known mill templates)

- The AOR form is from a third-party entity rather than an attorney, family member, or provider
- The appeal letter references medical criteria or facts that do not match the member's actual claim or denial
- The same AOR entity has filed 5 or more appeals for different members in the past 90 days
- The AOR form is dated within 7 days of the appeal filing (suggesting the AOR was obtained specifically for the appeal)
- The member has no documented relationship with the AOR outside of the appeals process

If you identify a potential mill filing, flag the case in Slack Format B-5 (Appeal Mill Flag) as a DM to the Senior Coordinator (Priya Annadurai). Continue handling the case normally while the flag is under review. A mill flag does not by itself invalidate an appeal, and the case must still receive a timely decision.

11.2 Dismissals

Some appeals are not eligible to be heard on the merits and must be dismissed. Dismissal is different from a denial as a dismissal means MCA did not substantively review the appeal, usually for a procedural reason. Dismissals are appealable on their own, so the dismissal letter must be clear about what happened and why.

The grounds for dismissal are:

- **Untimely filing:** the appeal was received more than 180 calendar days after the original denial date, or more than 120 calendar days after a final internal determination for external review. Both windows are measured in calendar days, not business days. Use Template A-3. Before dismissing for untimeliness, check whether the member has asserted good cause for the delay (serious illness, natural disaster, denial letter delivery failure). Good cause exceptions require Supervisor approval.
- **No adverse determination:** the member's complaint does not actually involve a denial, reduction, or termination. This usually means the case should be handled as a grievance instead. Use Template A-12 (Dismissal for No Adverse Determination). If the matter is properly a grievance, open a parallel grievance case under a new Case ID and note the new ID in the Template A-12 letter so the member knows the grievance is being handled.
- **Duplicate filing:** the same appeal has already been decided by MCA (not a reconsideration of new information, but a re-submission of the same request). Use Template A-11 (Dismissal for Duplicate Filing). The second filing is dismissed with reference to the original Case ID, and the dismissal letter explicitly invites the member to submit new information if any exists or to pursue external review of the original case if they have not yet exercised that right.

Supervisor review is required for all dismissal letters before sending. When you draft a dismissal letter, Slack the draft to @dwhitfield for review before sending, even if the facts seem completely clear.

11.3 Quality Review

MCA's Quality Review team audits a random 5% sample of closed appeals each month, plus 100% of any case that received a regulatory complaint or that was overturned on external review. A Quality Review finding that identifies a material error in your handling of a case may

result in a corrective action, typically additional training, sometimes a formal counseling, and in repeated cases, disciplinary action. Quality Review findings are not a punishment, they are how the unit learns. Respond to quality findings honestly and promptly. Argue with the finding if you disagree as a well-reasoned disagreement is respected, but do not defend a clear error.

Case elements reviewed by Quality include, standing verification at intake, timeliness of acknowledgment, accuracy of classification, correct clock calculation, correct routing to clinical review, letter template selection and content, parity flag assessment, and overall case file completeness. A case that was substantively correct but procedurally sloppy can still produce a Quality finding.

12. Communication Standards

12.1 Contact Timelines

Communication	Timeline
Initial acknowledgment - standard appeal	Within 5 business days of receipt
Initial acknowledgment - expedited appeal	Within 24 hours of receipt (verbal or written)
Response to any inbound member/provider inquiry about an open case	Within 1 business day
Status update to member (if there is no other activity for 14+ days)	Every 14 calendar days
Status Update Procedure: If a case has had no outbound communication to the member for 14 or more calendar days, send a status update email to the member. The update must include the Case ID, a brief statement of the current case status (e.g., "under clinical review," "awaiting additional information from your provider," "pending determination"), and the applicable decision deadline. Do not include clinical details, internal reviewer names, or preliminary findings. Log the status update in the Appeals Log. If the 14-day mark falls on a weekend or holiday, send the update on the next business day. Determination letter	Per the applicable deadline in Section 5.2
Claim reprocessing after favorable post-service determination	Within 5 business days of determination
External review forwarding	Within 5 business days of receipt of external review request (24 hours expedited)

12.2 Tone and Language

Members who are writing to the appeals unit are often frustrated, worried about their health, and dealing with a denial that may feel unfair. Your correspondence should be professional and matter of fact. Do not editorialize, do not apologize for the original denial, and do not speculate about what Canyon Ridge or a court might decide. Answer the question the member asked, in plain language.

- Use plain language as health insurance is already confusing.
- When denying an appeal, always cite the specific EOC provision, medical policy criterion, or administrative requirement that supports the denial. "The service is not covered" is not enough, be sure to state why.
- Never say "your appeal is denied" without explaining why. Always follow with the specific basis.
- Never make promises about payment amounts, timelines, or outcomes you cannot guarantee.
- Never speculate about coverage in correspondence. If you are unsure, say you are reviewing the matter and will follow up but do not guess.
- Always sign correspondence with your full name, title, Case ID, and the Appeals Unit phone number: (702) 555-0148.

12.3 Mail and Email Protocols

- All letters to members or providers must be sent via physical mail to the address on file unless the recipient has signed a Paperless Enrollment form. If the individual has enrolled in Paperless Enrollment, all letters sent to them must be emailed to the email address listed on the Paperless Enrollment form (not the email address listed on their Member Profile).
- All letters sent by mail must include the date, full name of the addressee, and mailing address at the top of the letter and must be saved as a PDF. The filename convention is [YYYYMMDD]_[Member ID]_Correspondence.pdf.
- If the patient has an AOR, all letters must be sent to both the patient and the AOR with "CC: [Patient's Full Name or AOR Full Name]" written at the bottom of each letter.
- Use the templates in Appendix A. You may customize the body text where the template indicates with square brackets, but the required Case ID, member ID, specific policy or EOC citations, and external review rights notice must always be included.
- All outbound emails to members or providers must include the Case ID in the subject line, formatted: "Mojave Crest Appeals Case #CASE-YYYY-NNNNN — [Brief Description]"
- All outbound emails must be sent from your @mojavecrest.com address, never from a personal email. PHI should never leave the MCA email environment.
- Do not combine a coverage decision and a request for more information in the same email.
- Do not include the reviewer's name in correspondence to the member. Use "the reviewing clinician" or "our Medical Director" as clinical reviewer names are confidential to protect against targeted pressure on individual reviewers.

12.4 Slack Protocols

- Never post PHI (member name, date of birth, member ID, diagnosis, treatment details) in any public Slack channel
- Use the Case ID (CASE-YYYY-NNNNN format) in any public channel reference
- Use DM for escalations, parity flags, and any discussion that would require PHI
- Use the Slack formats in Appendix B
- Slack is for internal communication only. Never add or @-mention external parties (members, providers, attorneys)
- Do not discuss compliance events, regulatory complaints, or litigated cases outside of #appeals-compliance and direct messages to the Compliance Officer

12.5 Prohibited Actions

The following actions are prohibited and are grounds for disciplinary action up to and including termination:

- Backdating any document, correspondence, or log entry
- Modifying a clinical reviewer's written decision before pasting it into a determination letter
- Issuing a determination letter without the required clinical review
- Sharing PHI outside of MCA's secure email environment
- Discussing open appeals with the press, on social media, or with anyone outside of MCA
- Accepting gifts, favors, or payments of any kind from members, providers, or any other party involved in an appeal
- Contacting the Nevada Division of Insurance directly without explicit authorization from the Compliance Officer
- Issuing a benefit authorization, payment, or other coverage commitment outside of what a clinical reviewer has authorized

13. Glossary of Terms

Adverse Benefit Determination	Any denial, reduction, or termination of a benefit, including a denied prior authorization, a denied claim, a reduced payment, a reduction in authorized units or days, or a termination of ongoing authorized care.
AOR (Authorized Representative)	A person designated in writing by a member to act on the member's behalf in appeals and grievances.
Appeals Log	The shared Excel workbook (see Appendix C) used to track all open and closed appeals and grievances. The source of truth for case status and deadlines.
Case Determination Memo	The internal Word document (see Appendix D) that summarizes the analysis and decision for each case. Required for every case file.
Case ID	The unique identifier assigned to each appeal or grievance case, formatted CASE-YYYY-NNNNN (e.g., CASE-2026-00412).

Concurrent Care	Ongoing previously authorized care that the member is currently receiving at the time of the appeal.
Date of Receipt	The date MCA first received the appeal document, which is the intake queue timestamp, not the postmark or letter date. See Section 5.1.
Deemed Exhausted	A status applied to an appeal when MCA has failed to meet the regulatory decision deadline, allowing the member to proceed directly to external review.
Evidence of Coverage (EOC)	The contractual benefit document that describes what is covered under a specific plan for a specific plan year. The authoritative source for coverage determinations.
Expedited Review	An accelerated review process used when standard timelines could seriously jeopardize the member's health. See Section 4.3.2.
External Review	Independent review of a final adverse internal determination by Canyon Ridge Review Services (MCA's contracted ERO).
Grievance	A complaint about service quality, access, staff behavior, or any other dissatisfaction that does not involve a request to overturn a benefit determination. See Section 4.2.
MHPAEA	The federal Mental Health Parity and Addiction Equity Act. Requires that MH/SUD benefits be no more restrictive than comparable M/S benefits within the same classification.
NQTL (Non-Quantitative Treatment Limit)	A non-numeric limitation on benefits such as prior authorization requirements, step therapy, network composition, and medical necessity criteria. Subject to parity analysis.
Parity Review Committee	The MCA cross-functional committee chaired by Dr. Ayla Ontario, that reviews cases flagged for potential parity concerns.
PHI (Protected Health Information)	Individually identifiable health information. Subject to HIPAA rules and never post in public Slack channels, never share outside MCA's secure environment.
QTL (Quantitative Treatment Limit)	A numeric limitation on benefits such as visit limits, day limits, or dollar limits. Subject to parity analysis.
Standard of Review	The legal and procedural framework applied to review a denial, medical necessity, experimental/investigational, benefit exclusion, or administrative. See Section 7.2.
Tolling	Pausing the regulatory clock to wait for requested missing information. One-time-only per case. See Section 5.4.

Vista Access PPO	MCA's fully-insured small group commercial PPO product, integrating medical, behavioral health, and prescription drug coverage.
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Appendix A - Letter Templates

These are the approved letter templates for all outbound correspondence to members, AORs, and providers. You may customize the bracketed fields and the [BODY] sections, but the required elements — subject line format, Case ID, header block, closing block, and any boilerplate notices marked "required verbatim" — must appear in every outbound letter. Do not remove or modify required verbatim text.

Template A-1 - Acknowledgment Letter

Subject line: Mojave Crest Appeals Case #[CASE ID] - Acknowledgment of Your Appeal

Body:

Dear [MEMBER OR AOR FULL NAME],

This letter confirms that Mojave Crest Assurance Company has received your appeal regarding [BRIEF DESCRIPTION OF DISPUTED SERVICE].

Your case details:

Case Number: [CASE ID]

Member Name: [MEMBER NAME]

Member ID: [MEMBER ID]

Date Received: [DATE OF RECEIPT]

Appeal Type: [APPEAL TYPE]

Decision Due By: [DEADLINE DATE]

I will be your Appeals Coordinator throughout this case. I may contact you if additional information is needed to complete the review. You or your Authorized Representative may submit additional information in support of your appeal at any time before the decision date.

If you have questions about your case, please reply to this email or call the Appeals Unit at (702) 555-0148, referencing your Case Number above.

Sincerely,

[YOUR FULL NAME]

Appeals & Grievances Coordinator

Mojave Crest Assurance Company

Case #: [CASE ID]

Template A-2 - Missing Information Request

Subject line: Mojave Crest Request [MEMBER ID] - Information Needed

Body:

Dear [FULL NAME],

In order to complete our review of your request, I need the following additional information:

[LIST OF SPECIFIC DOCUMENTS OR INFORMATION NEEDED]

Please provide the requested information within 15 calendar days of the date of this letter. Your request will remain on hold until we receive the required documentation. The review period will begin once valid authorization documentation is received.

You may respond by email with attachments, by mail, or by submitting documents through the secure member portal at portal.mojavecrest.com.

If the requested information is not received within 15 days, your request will be dismissed.

Sincerely,

[YOUR FULL NAME]

Appeals & Grievances Coordinator

Mojave Crest Assurance Company

Phone: (702) 555-0148

Template A-3 - Dismissal for Untimely Filing

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Dismissed

Supervisor review required before sending.

Body:

Dear [MEMBER OR AOR FULL NAME],

I am writing regarding the appeal you submitted on [DATE RECEIVED] concerning [BRIEF DESCRIPTION]. Mojave Crest Assurance Company has determined that this appeal must be dismissed because it was not filed within the required time period.

Under your Vista Access PPO Evidence of Coverage, an appeal of an adverse benefit determination must be filed within 180 days of the date of the original denial. The original denial in your case was dated [ORIGINAL DENIAL DATE], and your appeal was received on [DATE RECEIVED], which is [NUMBER] days later.

If you believe you have good cause for the delay in filing – for example, serious illness, natural disaster, or failure of the original denial letter to reach you – you may submit a good cause statement for consideration. Please provide any good cause information within 15 days of the date of this letter.

You also have the right to file a complaint with the Nevada Division of Insurance, Consumer Services Section, 1818 E. College Parkway, Suite 103, Carson City, NV 89706, phone (775) 687-0700, website doi.nv.gov.

Sincerely,
[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Case #: [CASE ID]

Template A-4 - No longer in use

Template A-5 - Adverse Determination

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Decision

Supervisor review required before sending.

Body:

Dear [MEMBER OR AOR FULL NAME],

Mojave Crest Assurance Company has completed the review of your appeal, Case #[CASE ID], regarding [BRIEF DESCRIPTION]. This letter explains our decision.

Decision: Your appeal is [DENIED / PARTIALLY APPROVED].

Reason for the decision:

[SPECIFIC REASON FROM THE REVIEWING CLINICIAN, INCLUDING THE SPECIFIC EOC PROVISION, MEDICAL POLICY CRITERION, OR ADMINISTRATIVE REQUIREMENT CITED. THE MEDICAL POLICY NUMBER AND VERSION MUST BE CITED IF APPLICABLE.]

Your right to external review (REQUIRED VERBATIM BELOW):

You have the right to request an independent external review of this decision by an independent review organization. You must request external review within 120 days of the date of this letter. The external review is free of charge to you. To request external review, submit your request in writing to appeals@mojavecrest.com or by mail to Mojave Crest Assurance Company, Appeals Unit, referencing Case #[CASE ID]. Your request will be forwarded to an independent review organization and you will receive a decision from that organization within 45 calendar days of their receipt of the case file.

You also have the right to file a complaint with the Nevada Division of Insurance, Consumer Services Section, 1818 E. College Parkway, Suite 103, Carson City, NV 89706, phone (775) 687-0700, website doi.nv.gov.

If you have any questions about this decision, please contact me at the number below.

Sincerely,

[YOUR FULL NAME]

Appeals & Grievances Coordinator

Mojave Crest Assurance Company

Phone: (702) 555-0148

Case #: [CASE ID]

Template A-6 - Favorable Determination

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Decision

Body:

Dear [MEMBER OR AOR FULL NAME],

Mojave Crest Assurance Company has completed the review of your appeal, Case #[CASE ID], regarding [BRIEF DESCRIPTION]. I am pleased to inform you that your appeal has been APPROVED.

Decision: [DESCRIBE WHAT IS BEING AUTHORIZED OR REPROCESSED, INCLUDING SPECIFIC SERVICE, DATE RANGE, AND — FOR POST-SERVICE APPEALS — THE

CORRECTED PAYMENT AMOUNT AND EXPECTED PAYMENT DATE.]

Reason for the decision:

[SPECIFIC REASONING FROM THE REVIEWING CLINICIAN OR – FOR PARITY OVERTURNS – A PLAIN STATEMENT THAT THE DECISION WAS BASED ON PARITY REVIEW.]

For pre-service approvals: this authorization is valid for [VALIDITY PERIOD] from the date of this letter. Please share this letter with your treating provider.

For post-service approvals: the corrected claim will be reprocessed and payment issued within 5 business days. You will receive a corrected Explanation of Benefits shortly after.

If you have any questions about this decision, please contact me at the number below.

Sincerely,

[YOUR FULL NAME]

Appeals & Grievances Coordinator

Mojave Crest Assurance Company

Phone: (702) 555-0148

Case #: [CASE ID]

Template A-7 - Expedited Determination

Subject line: URGENT - Mojave Crest Appeals Case #[CASE ID] - Expedited Decision

Body:

Dear [MEMBER OR AOR FULL NAME],

This is an expedited decision on your appeal, Case #[CASE ID]. Because this case was reviewed on an expedited timeline, we are notifying you immediately in writing. You may also be contacted by phone.

Decision: Your appeal is [APPROVED / DENIED / PARTIALLY APPROVED].

[IF CONCURRENT CARE:] This decision [DOES / DOES NOT] continue your current authorization for [SERVICE]. [IF OVERTURN, STATE REINSTATEMENT DETAILS. IF UPHOLD, STATE EFFECTIVE DATE OF TERMINATION.]

Reason for the decision:

[SPECIFIC REASONING]

Your right to external review (REQUIRED VERBATIM BELOW):

If this is an adverse decision, you have the right to request an expedited external review by an independent review organization. Expedited external review is available when the standard timeline would seriously jeopardize your life or health. To request expedited external review, contact the Appeals Unit at (702) 555-0148 or email appeals@mojavecrest.com with "URGENT EXTERNAL REVIEW" in the subject line. Expedited external reviews are decided within 72 hours of the independent review organization's receipt of the case file.

Sincerely,

[YOUR FULL NAME]

Appeals & Grievances Coordinator

Mojave Crest Assurance Company

Phone: (702) 555-0148

Case #: [CASE ID]

Template A-8 - External Review Forwarding

To: intake@canyonridgereview.com (or urgent-intake@canyonridgereview.com for expedited)

CC: Kendel Dufree (k.Dufree@mojavecrest.com)

Subject line: External Review Request - Case #[CASE ID] - [STANDARD / EXPEDITED]

Body:

Canyon Ridge Review Services Intake Team,

Mojave Crest Assurance Company is forwarding the following case for independent external review:

Case Number: [CASE ID]

Member Initials: [INITIALS ONLY – NO FULL NAME IN EMAIL BODY]

Member ID: [MEMBER ID]

Plan: Vista Access PPO

Review Type: [STANDARD / EXPEDITED]

Date of Final Internal Determination: [DATE]

Date of External Review Request from Member: [DATE]

Disputed Service: [BRIEF DESCRIPTION]

MCA Decision: [DENIED / PARTIALLY APPROVED / DEEMED EXHAUSTED]

The complete case file, including clinical records, internal

determination letters, applicable medical policies, and the Evidence of Coverage, has been uploaded to the secure file transfer link provided separately.

The MCA point of contact for this case is Kendel Dufree, Compliance Officer, copied on this email.

[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Phone: (702) 555-0148

Template A-9 - Expedited Denied, Converted to Standard

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Review Update

Body:

Dear [MEMBER OR AOR FULL NAME],

I am writing to let you know that the expedited review request for your appeal, Case #[CASE ID], has been evaluated. Our clinical review team has determined that your case does not meet the criteria for expedited review. Expedited review is available only when applying the standard timeline could seriously jeopardize your life, health, or ability to regain maximum function.

Your appeal has been moved to our standard review process. The standard timeline is 30 calendar days for pre-service appeals from the date we received your appeal, which was [DATE OF RECEIPT]. We will issue a decision no later than [STANDARD DEADLINE].

If your medical circumstances change and you believe expedited review should apply, please have your treating physician send a written certification to appeals@mojavecrest.com indicating that expedited review is medically necessary, referencing Case #[CASE ID].

Sincerely,
[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Phone: (702) 555-0148
Case #: [CASE ID]

Template A-10 - Grievance Resolution Letter

Subject line: Mojave Crest Grievance Case #[CASE ID] - Resolution

Supervisor review required if the grievance involves a finding of staff conduct or any corrective action described in writing.

Body:

Dear [MEMBER OR AOR FULL NAME],

Mojave Crest Assurance Company has completed the investigation of your grievance, Case #[CASE ID], regarding [BRIEF DESCRIPTION OF GRIEVANCE]. This letter explains the outcome.

Grievance Category: [Staff Conduct / Provider Network Access /
Plan Document Clarity / Administrative Process /
Accessibility / Cultural or Language Access]

Investigation Summary:

[2-4 SENTENCES DESCRIBING WHAT WAS REVIEWED, WHO WAS CONSULTED, AND WHAT FINDINGS WERE MADE. WRITE IN PLAIN LANGUAGE. DO NOT NAME INDIVIDUAL MCA EMPLOYEES; REFER TO "OUR STAFF" OR "OUR PROVIDER RELATIONS TEAM" INSTEAD.]

Resolution: [Resolved with Action / Resolved without Action /
Referred Out]

[IF RESOLVED WITH ACTION:] As a result of this investigation, MCA has taken the following action: [DESCRIBE THE CORRECTIVE ACTION IN GENERAL TERMS — DO NOT DISCLOSE INTERNAL DISCIPLINARY DETAILS.]

[IF RESOLVED WITHOUT ACTION:] After investigating your concern, we determined that no corrective action is warranted. [BRIEF EXPLANATION]

[IF REFERRED OUT:] We have referred this matter to [EXTERNAL ENTITY, e.g., the Nevada State Board of Medical Examiners] for their review.

Please note: a grievance is a complaint about service or process, not an appeal of a benefit decision. This grievance resolution does not change any prior coverage determination on your benefits and does not create a right to external review. If you have a separate concern about a denied claim or service, you may file an appeal under the appeals process described in your Evidence of Coverage.

If you remain dissatisfied with the outcome of this grievance, you have the right to file a complaint with the Nevada Division of Insurance, Consumer Services Section, 1818 E. College Parkway, Suite 103, Carson City, NV 89706, phone (775) 687-0700, website doi.nv.gov.

If you have any questions about this resolution, please contact me at the number below.

Sincerely,
[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Phone: (702) 555-0148
Case #: [CASE ID]

Template A-11 - Dismissal for Duplicate Filing

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Dismissed (Duplicate)

Supervisor review required before sending.

Body:

Dear [MEMBER OR AOR FULL NAME],

I am writing regarding the appeal you submitted on [DATE RECEIVED] concerning [BRIEF DESCRIPTION]. Mojave Crest Assurance Company has determined that this appeal must be dismissed because the same matter has already been decided by MCA in a prior appeal.

Original Case Number: [PRIOR CASE ID]

Original Decision Date: [DATE OF PRIOR DETERMINATION]

Original Decision: [UPHELD / OVERTURNED / PARTIALLY APPROVED]

MCA does not re-decide an appeal that has already been adjudicated unless you are submitting new information that was not available at the time of the original decision. If you are submitting new clinical records, new test results, or other new evidence that materially differs from what was considered in the original case, please reply to this email and identify specifically what is new. We will then evaluate whether the new information warrants reopening the case.

If the original case was a final adverse determination and you have not yet exercised your right to external review, you may still request

external review by an independent review organization within 120 days of the original determination date shown above. To request external review, contact the Appeals Unit at (702) 555-0148 or email appeals@mojavecrest.com referencing the original Case Number.

You also have the right to file a complaint with the Nevada Division of Insurance, Consumer Services Section, 1818 E. College Parkway, Suite 103, Carson City, NV 89706, phone (775) 687-0700, website doi.nv.gov.

Sincerely,
[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Case #: [CASE ID]

Template A-12 - Dismissal for No Adverse Determination

Subject line: Mojave Crest Appeals Case #[CASE ID] - Appeal Dismissed

Supervisor review required before sending.

Body:

Dear [MEMBER OR AOR FULL NAME],

I am writing regarding the appeal you submitted on [DATE RECEIVED] concerning [BRIEF DESCRIPTION]. Mojave Crest Assurance Company has determined that this appeal must be dismissed because there is no adverse benefit determination to appeal.

An appeal under your Vista Access PPO Evidence of Coverage is a request to overturn a denial, reduction, or termination of a benefit. After reviewing your case, we determined that:

[CHECK ONE:]

- ☐ No prior denial, reduction, or termination of benefits has occurred for the service you described.
- ☐ The matter you described is a complaint about [SERVICE QUALITY / PROVIDER ACCESS / PLAN DOCUMENTS / OTHER], not an appeal of a benefit decision.
- ☐ The service you described was approved or paid in full and there is no decision to overturn.

[IF THE MATTER IS A GRIEVANCE:] Because your concern is a complaint about [CATEGORY] rather than a benefit decision, we have opened a

grievance case under Case Number [GRIEVANCE CASE ID]. You will receive a separate acknowledgment for that case and a resolution within 30 calendar days. The grievance case will follow the grievance process rather than the appeals process.

[IF THE BENEFIT WAS APPROVED OR PAID IN FULL:] Our records show that the service in question was [APPROVED on DATE / PAID in full on DATE]. If you believe our records are incorrect, please reply to this email with the specific date of service and any documentation you have, and we will review.

If you believe this dismissal is in error and there is in fact a denial, reduction, or termination of benefits that we should be reviewing, please reply to this email with the date of the denial, the denial letter or Explanation of Benefits, and a description of the disputed service. We will reopen the case if a qualifying adverse determination is identified.

You also have the right to file a complaint with the Nevada Division of Insurance, Consumer Services Section, 1818 E. College Parkway, Suite 103, Carson City, NV 89706, phone (775) 687-0700, website doi.nv.gov.

Sincerely,
[YOUR FULL NAME]
Appeals & Grievances Coordinator
Mojave Crest Assurance Company
Case #: [CASE ID]

Header Block Variants

Certain appeal types require a specific header block inserted at the top of the letter body, immediately after the salutation ("Dear [NAME],") and before the main body text. The header block is verbatim, do not modify the field labels or reorder them. Use the correct header block for the appeal type. If the appeal type does not appear below, no header block is required.

Concurrent Care Header Block

Insert at the top of Template A-7 (Expedited Determination) when the case is a concurrent care appeal. This header makes the reduction/termination status and effective date unambiguous to the member.

--- CONCURRENT CARE APPEAL ---
Authorization Currently in Effect: [AUTH NUMBER]
Service Under Review: [SERVICE NAME]
Original Termination Effective Date: [DATE]

Coverage Status During Appeal: CONTINUED THROUGH DECISION DATE

Pharmacy Header Block

Insert at the top of Template A-1 (Acknowledgement Letter), A-5 (Adverse Determination), or Template A-6 (Favorable Determination) when the case is a pharmacy exception request. This header identifies the specific drug and exception type so the member can share the letter with their pharmacy without confusion.

--- PHARMACY EXCEPTION REQUEST ---

Drug Name: [DRUG NAME, STRENGTH, DOSAGE FORM]

Prescribing Provider: [PROVIDER NAME] ([NPI])

Exception Type: [Non-Formulary / Step Therapy / Quantity Limit / Tier Exception]

Review Type: [Standard 72-hour / Expedited 24-hour]

Expedited Acknowledgment Header Block

Insert at the top of Template A-1 (Acknowledgment Letter) when the case is any expedited appeal. This header alerts the member that the case is on an accelerated clock.

--- EXPEDITED REVIEW ---

Expedited Basis: [Treating Physician Certification /

Member Request Confirmed by MCA Clinical Review]

Decision Due By: [DATE and TIME]

Appendix B - Slack Message Formats

These are the approved Slack formats for internal communication within the Appeals unit and across teams. Use the exact field layout. Never post PHI in a public channel — use the Case ID and role descriptors, not member names. When a format specifies a channel or a DM target, post to that location and no other.

Format B-1 - Clinical Routing

Post to: #appeals-clinical-queue (for standard cases)

For expedited cases: DM the on-call reviewer AND post in #appeals-urgent tagging @dwhitfield

Format:

```
CLINICAL ROUTING
Case #: [CASE ID]
Type: [Pre-Service Standard / Pre-Service Expedited / Concurrent Care /
      Post-Service / Pharmacy]
Service Classification: [Medical/Surgical / Behavioral Health / SUD /
                        Pharmacy]
Standard of Review: [Medical Necessity / Experimental-Investigational /
                     Benefit Exclusion / Administrative]
Deadline: [DATE and TIME for expedited]
Parity Flag: [YES / NO]
Case Folder: [LINK]
```

Format B-2 - Escalation to Appeals Supervisor

Post to: DM to @dwhitfield

For URGENT time-sensitive matters: Also post in #appeals-urgent tagging @dwhitfield

Format:

```
ESCALATION
Case #: [CASE ID]
Type: [Pre-Service / Post-Service / Concurrent / Pharmacy / Grievance]
Deadline: [DATE and TIME]
Trigger: [Specific trigger from Section 9.2]
Summary: [2-3 sentence description of the situation]
My Recommendation: [What I think should happen]
Requested Action: [Approval / Guidance / Direct Supervisor Takeover]
```

Format B-3 - Parity Flag Notification

Post to: DM to @parity-committee

DO NOT POST IN #appeals-parity - the channel is for general discussion only.

Format:

PARITY FLAG

Case #: [CASE ID]

Service Classification: [Outpatient BH / Inpatient BH / Outpatient SUD /
Inpatient SUD / Pharmacy BH-SUD]

Comparable M/S Classification: [WHICH M/S CLASSIFICATION THE MH/SUD
SERVICE WOULD BE COMPARED AGAINST]

Flag Indicator: [Specific indicator from Section 8.2]

Case Folder: [LINK]

Decision Deadline: [DATE]

Format B-4 - Compliance Event / Deemed Exhausted Notification

Post to: #appeals-compliance AND DM to @kDufree

Format:

COMPLIANCE EVENT

Case #: [CASE ID]

Event Type: [Missed Deadline / DOI Complaint / DOL Inquiry /
HIPAA Event / Miscategorization / Other]

Date of Event: [DATE]

Discovered: [DATE and TIME]

Summary: [Factual description – no speculation, no assignment of blame]

Immediate Actions Taken: [What has been done so far]

Case Folder: [LINK]

Format B-5 - Appeal Mill Flag

Post to: DM to @pannadurai (Senior Coordinator)

Format:

APPEAL MILL FLAG

Case #: [CASE ID]

Indicators Observed: [List specific indicators from Section 11.1,
minimum 2 required for flag]

AOR Entity: [Name of the AOR entity, if applicable]

Similar Cases: [Case IDs of any other appeals with matching templated
language from the same AOR entity, if known]

Case Folder: [LINK]

Format B-6 - Suspected Claim Fraud

Post to: DM to @kDufree (Compliance Officer)

DO NOT POST IN #appeals-compliance - the channel is for compliance events involving MCA handling, not suspected external fraud. Use DM.

Format:

SUSPECTED CLAIM FRAUD

Case #: [CASE ID]

Provider NPI: [NPI]

Provider Name: [BILLING PROVIDER NAME]

Dates of Service in Dispute: [DATE RANGE]

Fraud Type: [Service Not Delivered / Billing Discrepancy /
Upcoding Concern / Duplicate Billing / Other]

Basis for Suspicion: [2-4 sentences describing the factual conflict
between the member's statement and the provider's
billing – factual only, no speculation about motive]

Appeal Status: [Will continue on regular clock]

Case Folder: [LINK]

Do not mention the fraud flag in any correspondence to the member, the provider, or the AOR. Do not delay the appeal decision waiting for the fraud review as the two workflows run in parallel. If the Compliance Officer determines the fraud concern affects the appeal outcome (for example, if Compliance determines that billed services were not delivered), the Compliance Officer will contact you directly to coordinate the appeal decision.

Appendix C - Appeals Log

The Appeals Log is the master Excel workbook used by the Appeals & Grievances Unit to track every open and closed case. It is stored on the shared Appeals repository as `appeals_log_master.xlsx`. Every case must be entered into the log at intake and updated at each status change. The log has the following required columns. Do not add, remove, rename, or reorder columns without the Director's approval:

Column Name	Description	Example
Case ID	Unique identifier, format CASE-YYYY-NNNNN	CASE-2026-00412
Member ID	Unique identifier, format ABCXXXXXXXXXX	DGJ457998451
Group ID	Employer group ID, listed on EOC	195893
Plan Year	Year the disputed service falls in	2025
Appeal Type	One of the 5 types in Section 4.3, or Grievance	Pre-Service Standard
Service Classification	From Section 3.2 classifications	Outpatient, in-network (BH)
Standard of Review	From Section 7.2	Medical Necessity
Date of Receipt	MCA queue timestamp, Section 5.1 rule	2026-02-16 09:32 (Mon)
Acknowledgment Due	Calculated by formula (5 business days)	2026-02-23 (Mon)
Acknowledgment Sent	Actual date sent	2026-02-18 (Wed)
Tolled (Y/N)	Whether clock has been tolled one-time	N
Toll Start	Date tolling began	
Toll End	Date tolling ended (receipt or day 16)	
Decision Due	Calculated deadline (30 calendar days, after tolling)	2026-03-18 (Wed)
Reviewer Assigned	Reviewer name or team	Dr. Ontario (parity routing)
Parity Flag	Y / N	Y
Compliance Escalation	Y / N and reason	N
Related Case ID	Linked appeal or grievance from a mixed-request filing, if any	
Decision Date	When determination letter was sent	2026-03-12 (Thu)

Column Name	Description	Example
Outcome	Upheld / Overturned / Partial / Dismissed	Overturned
External Review Requested	Y / N, date if Y	N
Case Status	Intake / With Reviewer / Draft Letter / Sent / Closed	Closed
Coordinator	Your name	[YOUR FULL NAME]

The log contains formulas that calculate Acknowledgment Due and Decision Due automatically based on the Appeal Type and Date of Receipt. Acknowledgment Due uses business days (excluding weekends and MCA-observed holidays). Decision Due uses calendar days for standard appeals or continuous hours for expedited and pharmacy cases. Do not overwrite the formulas. If a deadline looks wrong, escalate to the Supervisor and do not adjust the formula yourself. Note also that the example row above corresponds to a Pre-Service Standard appeal; for Pre-Service Expedited appeals the Decision Due column will display a date and time (e.g., "2026-02-19 09:32") because the deadline is measured in continuous hours, not days.

The log is sorted by Decision Due, ascending, so the cases closest to deadline appear at the top. Work your queue from the top down unless you have an expedited case, which always takes priority regardless of where it falls in the sort order.

Appendix D - Case Determination Memo Template

Every case, appeal or grievance, upheld or overturned, dismissed or decided, must have a Case Determination Memo filed in the case folder. The memo is a Word document (.docx) saved with the filename CASE-YYYY-NNNNN_Determination_Memo.docx in the case folder. It documents the analysis and rationale for the decision and serves as the authoritative internal record of the case. The memo must contain the following sections with these exact headings, in this exact order.

Required Memo Sections

The memo must contain the following section headings, in this order, with the described content under each:

Case Identification

- Case Number (CASE-YYYY-NNNNN)
- Member ID and Plan Year
- Group ID
- Appeal Type (from Section 4.3)
- Date of Receipt
- Decision Deadline
- Coordinator Name

Requestor and Standing

- Requestor (Member / Parent / AOR Name / Provider)
- Standing Confirmed: YES / NO
- AOR on File: YES / NO (if applicable)

Disputed Service

- Specific service in dispute (plain description)
- CPT/HCPCS codes and place of service
- Billing provider name and NPI
- Date(s) of service (or proposed dates for pre-service)
- Billed amount (if applicable)

Original Denial

- Date of original denial
- Denial reason code and narrative
- Medical policy cited (number and version)
- EOC provision cited

Standard of Review Applied

- Medical Necessity / Experimental-Investigational / Benefit Exclusion / Administrative

- Rationale for selecting this standard

Clinical Review Summary

- Reviewer name (internal only and not released to member)
- Reviewer type (RN / Medical Director / Pharmacy Director)
- Date of clinical review
- Summary of the reviewer's finding (paraphrase and the verbatim reviewer worksheet is attached separately)

Parity Analysis

- Parity Flag Raised at Intake: YES / NO
- Parity Review Committee Consulted: YES / NO
- If YES, summary of the parity finding

Fraud and Mill Indicators

- Appeal Mill Flag: YES / NO
- If YES, number of indicators observed (from Section 11.1)
- Senior Coordinator reviewed: YES / NO

Timeline Log

- Date received
- Acknowledgment sent
- Tolling (if any): start date, end date, reason
- Clinical review received
- Determination letter sent
- Case closed

Decision and Rationale

- Decision: Upheld / Overturned / Partial / Dismissed
- Rationale (2-5 sentences summarizing the decision basis)
- Specific EOC provision, medical policy citation, or administrative requirement applied

Authority

- Total dispute value (for authority threshold check)
- Coordinator Authority Limit: \$25,000 (from Section 9.1.1)
- Within Coordinator Authority: YES / NO
- Supervisor Approval Required: YES / NO
- Supervisor Approval Obtained: Date and Name (or N/A)

External Review Status

- Case Forwarded to Canyon Ridge: YES / NO
- Forwarding Date (if applicable)

- Canyon Ridge Case Reference (if applicable)

End of Mojave Crest Assurance Company Appeals & Grievances Coordinator Desk Manual,
Version 2.1

For questions about this manual, contact Darnell Whitfield, Appeals Supervisor, at
d.whitfield@mojavecrest.com.