[*Upon request of the Enrollee, their representative, or My Ombudsman MMPs must send a list of coverage documents that it reviewed against for coverage in making its decision on the Enrollee’s request, including but not limited to the Annual Plan Benefit Package for the current Year, Medicare coverage criteria, MassHealth Provider Regulations, MassHealth Bulletins, Enrollee’s Assessment and Care Plan, case notes, and Member Handbook.*]

[*By sending this notice, MMPs are certifying that all relevant coverage information has been reviewed in making the decision, including relevant Medicare and Medicaid coverage criteria, OneCare three-way contract requirements, member’s Care Plan and other care coordination information, and any other relevant sources of coverage information.*]

<Plan Name> Notice of Denial or Change

Denial of Level 1 Appeal

**IMPORTANT:** For help with this notice, contact:

**<Plan Name>** at <Plan customer service phone/relay numbers>**, OR**

***My Ombudsman* at (phone)** [855-781-9898](tel:+18557819898)**, (video phone)** [339-224-6831](tel:3392246831)**, or (email)** [info@myombudsman.org](mailto:info@myombudsman.org)

**Date: Member number:**

**Name:**

**Service:**

# [*Insert as applicable*: Authorization *or* Payment] requested:

On [*insert date of appeal*] [*insert as appropriate:* you *or* your care coordinator] asked us to reconsider our decision to [*Insert as applicable*: **authorize,** *or* **pay for you to get** *or* **pay for the following:**]

[*Description of appeal:* *describe the services/items, Part B drug, Medicaid drug and amount, duration, and scope, of what the member requested e.g. Physical therapy visits 2 times per week for 1 year.*]. In other words, you asked for a Level 1 Appeal.

# The Level 1 Appeal was denied

We’ve [*insert as applicable*: denied *or* partially denied] the Level 1 Appeal for the [*insert as applicable*: payment of] services/items listed above. Our decision is [*plain language, specific description of the decision, e.g. we will not cover physical therapy visits for you; we will only cover physical therapy visits 3 times per week for three months, not for a year as you requested*]:

# Why did we deny your Level 1 Appeal?

We [*insert as applicable*: denied *or* partially denied]the Level 1 Appeal above because [*Plain language explanation of the decision here should include:* *(1) relevant context for the decision (e.g. if this was something that was approved for the member in the past the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now, such that it is no longer being approved); (2) coverage information considered including but not limited to Medicare and Medicaid coverage benefits, OneCare three-way contract requirements, and the amount allowable under the plan’s benefit package; and (3) if applicable, information on how or why the requested service or item is not supported by the member’s needs (e.g. your medical records do not show that past Acupuncture visits have helped you improve in the past). Plans must also provide citation of State or Federal regulation or law and, for services with broader OneCare three-way contract coverage, cite Contract requirement. Plans may also include Evidence of Coverage/Member Handbook provisions to support decision.*]:

You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

# You have the right to appeal our decision

You have the right to ask for a review of our decision by asking for a Level 2 Appeal (sometimes called an external appeal). A Level 2 Appeal is done by an independent organization that is not connected to the plan. MassHealth’s Level 2 Appeal organization is called the MassHealth Board of Hearings. You can ask to look at the medical records and other documents used to make our Level 1 Appeal decision any time before or during the Level 2 Appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**You can ask the MassHealth Board of Hearings to review our decision to deny your Level 1 Appeal.** You must make your request within **120 calendar days** of the date at the top of this notice.

If you are appealing because we planned to reduce or stop a service you currently get, you have the right to keep getting the service during the review by the Board of Hearings. **If you want the service to continue, you must ask for a Level 2 Appeal from the Board of Hearings within 10 days of the date at the top of this notice.**

# If you want someone else to request a Level 2 Appeal for you

You can name a relative, friend, attorney, health care provider, or someone else to make an appeal for you. You must tell us who you want to make the appeal for you on the Fair Hearing Request form attached to this notice.

# There are two kinds of Level 2 Appeals

**Standard Appeal –** The Board of Hearings must give you a written decision on a standard appeal within **30 calendar days** after it gets your appeal. If the Board of Hearings needs to gather more information that may help you, it can take up to 14 more calendar days.

**Fast (Expedited) Appeal** – The Board of Hearings must give you an answer within **72 hours** of when it gets your appeal. If the Board of Hearings needs to gather more information, it can take up to 14 more calendar days. If you had a fast appeal at Level 1, you will automatically get a fast appeal at Level 2. You can also ask for a fast appeal if you or your health care provider believe your health, life, or ability to regain maximum function may be put at risk by waiting up to 30 calendar days for a decision. If you don’t qualify for a fast appeal, the Board of Hearings will give you a decision within 30 calendar days.

# How to make a Level 2 Appeal to the MassHealth Board of Hearings

You, or your authorized representative, including your health care provider acting on your behalf, must ask for a Level 2 Appeal within **120 calendar days** of the date at the top of this notice.

**Step 1:** Complete the Fair Hearing Request Form that is attached to this notice. You can also get the form:

* Online in English or Spanish at: [www.mass.gov/service-details/masshealth-member-forms](https://www.mass.gov/service-details/masshealth-member-forms).
* By calling MassHealth Customer Service at 1-800-841-2900, TTY 711 (for people who are deaf, hard of hearing, or speech disabled).

**Step 2:** Make a copy of this notice.

**Step 3:** Send the completed Fair Hearing Request Form and the copy of this notice to the MassHealth Board of Hearings. You can:

* Mail to: Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or
* Fax to: 617-847-1204.

# What happens next?

The Board of Hearings will schedule a hearing. When the hearing is completed, the Board of Hearings will send a written decision on your Level 2 Appeal.

* If the Board of Hearings says “yes” to part or all of what you asked for, we must approve the service for you, per that decision, within 72 hours.
* If the Board of Hearings says “no” to what you asked for, it means they agree with the Level 1 Appeal decision. The letter you get will tell you that you can appeal to the Commonwealth of Massachusetts Superior Court.

# Get help & more information

* <**Plan name**>: If you need any help or additional information about our decision and the appeal process, call <Member Services> at: <phone number> (TTY: <TTY number>), <hours of operation>. You can also visit our website at <plan website>.
* **My Ombudsman**: If you need more help or information, you can also contact My Ombudsman. My Ombudsman is an independent program. My Ombudsman staff can talk with you about how to make an appeal and what to expect during the appeal process. My Ombudsman services are free. Here are the ways to get help from My Ombudsman:
  + Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898. People who are deaf or hard of hearing may use Videophone (VP) at 339-224-6831.
  + Email [info@myombudsman.org](mailto:info@myombudsman.org)
  + Write to or visit the My Ombudsman office at 25 Kingston Street, 4th floor, Boston, MA 02111.
* Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
  + Visit My Ombudsman online at [www.myombudsman.org](http://www.myombudsman.org).
* **Medicare**: 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048)
* **Medicare Rights Center**: 1-800-333-4114
* **MassHealth Customer Service**: 1-800-841-2900 (TTY: 711)
* [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Plan must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Member Services toll-free phone and TTY numbers, and days and hours of operation*]. The call is free.