# Office of Medicaid
# BOARD OF HEARINGS

**Appellant Name and Address:**

[redacted]

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| **Appeal Decision:** | Denied | **Appeal Number:** | 2509970 |
| **Decision Date:** | 9/30/2025 | **Hearing Date:** | 08/08/2025 |
| **Hearing Officer:** | Christine Therrien | | |

**Appearance for Appellant:**
Pro se

**Appearances for MassHealth:**
Eileen Cynamon, DES; Tyrome Witherspoon, Springfield MEC

*The Commonwealth of Massachusetts*
*Executive Office of Health and Human Services*
*Office of Medicaid*
*Board of Hearings*
*100 Hancock Street, Quincy, Massachusetts 02171*

# APPEAL DECISION

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| **Appeal Decision:** | Denied | **Issue:** | Disability Requirements |
| **Decision Date:** | 9/30/2025 | **Hearing Date:** | 08/08/2025 |
| **MassHealth's Reps.:** | Eileen Cynamon, DES; Tyrome Witherspoon | **Appellant's Rep.:** | Pro se |
| **Hearing Location:** | Springfield MassHealth Enrollment Center Telephonic | | |

## Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

## Jurisdiction

Through a notice dated 5/15/25, MassHealth informed the appellant that she was not disabled because MassHealth determined that the appellant did not meet MassHealth's disability requirements. (130 CMR 505.002(E) and Exhibit 1). The appellant filed this appeal in a timely manner on 7/2/25. (130 CMR 610.015(B) and Exhibit 3). Denial of assistance is valid grounds for appeal. (130 CMR 610.032).

## Action Taken by MassHealth

MassHealth notified the appellant that she does not meet MassHealth's disability requirements.

## Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 505.002(E), in determining that the appellant is not permanently and totally disabled.

## Summary of Evidence

The Disability Evaluation Services (DES) representative testified that DES's role is to determine, for MassHealth, if an applicant meets the Social Security Administration (SSA) level of disability from a clinical standpoint. The DES representative testified that DES uses a 5-step process, as described by SSA regulations at Title 20 Code of Federal Regulations (CFR) Ch. III part 416.920 to determine initial disability status. The process is driven by the applicant's medical records and disability supplement. SSA 20 CFR §416.905 states the definition of disability is the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months (Exhibit 5, page 8). To meet this definition, one must have a severe impairment(s) that makes him or her unable to do their past relevant work or any other substantial gainful work that exists in the regional economy. Per 20 CFR 416.989, adult MassHealth applicants who have been previously declared disabled will periodically undergo a Continuous Disability Review (CDR) to determine if an applicant remains clinically eligible for disability (Exhibit 5, page 39). A CDR is initiated by DES at the request of MassHealth. The CDR is an 8-step evaluation process as described within 20 CFR 416.994 (Exhibit 5, pages 46-60).

The DES representative testified that per SSA 20 CFR 416.994, if an applicant is entitled to disability benefits as a disabled person aged eighteen or over (adult), there are a few factors DES considers in deciding whether the applicant's disability continues. DES must determine if there has been any medical improvement in the applicant's impairment(s) and, if so, whether this medical improvement is related to the applicant's ability to work. Even where medical improvement related to the applicant's ability to work has occurred, DES must also show that the applicant is currently able to engage in substantial gainful activity (SGA) before DES can find that the applicant is no longer disabled.

The DES representative testified that to ensure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, DES follows specific steps in reviewing the question of whether your disability continues. The CDR may cease, and benefits may be continued at any point if it is determined there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The 8-step sequential review process is listed within 20 CFR 416.994(b)(5) (Exhibit 5, pages 57-58).

The DES representative testified that the appellant was initially determined clinically disabled in 2002, status-post (s/p) a motorcycle accident on [redacted] 2002, in which he sustained multi-trauma injuries that required a prolonged hospitalization, multiple surgeries, and outpatient

rehabilitation. The appellant's injuries included: left tibia-fibula fracture s/p open reduction internal fixation (ORIF) surgery, left upper extremity degloving injury, right wrist distal radius fractures (triquetral and intra-articular radial styloid) s/p ORIF, left scapular fracture, aortic rupture s/p interposition graft repair, intraparenchymal frontal lobe hemorrhage, recurrent pericardial effusion, as well as lacerations, contusions and other trauma associated complications (Exhibit 5, pages 267-272). The clinical documentation supported his disability through the 5-step process, equaling SSI listing 1.11 – Fracture of the Femur, Tibia, Tarsal Bone or Pelvis (Exhibit 5, page 255), considering the combination of impairments. A next recommended disability review date of September 11, 2003, was recorded (Exhibit 5, page 248). This 2002 initial disability review (IDR) episode will be referred to as the Comparison Point Determination (CPD) episode (Exhibit 5, pages 246-414).

The DES representative testified that the appellant is a [redacted] who submitted a complete MassHealth Adult Disability Supplement to DES on March 10, 2025. DES initiated a Continuous Disability Review (CDR) episode. The appellant reported current and continued complaints of migraines/headaches, neck and back pain, cyclic vomiting syndrome (CVS), vitamin D deficiency, difficulty with lifting/using arms overhead, lightheadedness, pain in legs with long walks (left leg hardware), and shortness of breath with exertional activity (Exhibit 5, pages 77-78).

DES requested and obtained medical documentation using the medical releases the appellant provided (Exhibit 5, pages 62-69). Information was received from the client's reported providers: [redacted] and [redacted] all of [redacted] (Exhibit 5, pages 121-129), [redacted] - [redacted] (Exhibit 5, pages 132-174), and [redacted] (Exhibit 5, pages 181-245). The DES representative testified that while the RFI response received from [redacted] included the returned [redacted] letters for both [redacted] and [redacted] no documented visits with [redacted] were included in the records provided by the facility.

The DES representative testified that prior to initiating the 8-step process, the question of sufficient information received/available to make a determination must be evaluated (A). The review considers both the appellant's current and prior (CPD) impairments/ complaints (Exhibit 5, page 82), review of current medical documentation and historic (CPD) documentation, confirming sufficient information to complete the CDR process has been obtained. For this review (A) was marked, "Yes" on (Exhibit 5, page 84).

Then, the 8-step CDR process was started (page 85).
**Step 1** asks if the claimant is engaging in substantial gainful activity (SGA). While federal SSA regulations would stop if the claimant is engaging in SGA, MassHealth waives this step and continues with the review. Step 1 was marked, "Yes" (Exhibit 5, page 85). This step is a SSA

consideration having to do with earnings and has no bearing on whether someone is found disabled or not disabled.

**Step 2** asks does any impairment(s) meet or equal a listing in the current Listing of Impairments? (Exhibit 5, page 85). When a specific impairment or diagnosis does not have its own listing under the SSI criteria, the evaluation will consider the listing that most closely matches the impairment or the findings related to the impairment(s) to confirm they are at least of equal medical significance to those of a listed impairment. The CDR reviewer answered, "No," citing SSI listings considered: 1.15 – Disorders of the Skeletal Spine resulting in Compromise of a Nerve Root(s), 1.18 – Abnormality of Major Joint(s) in any Extremity, 5.06 – Inflammatory Bowel Disease (Cyclic Vomiting Syndrome), 11.02 Epilepsy (Migraines/ Headaches) (Exhibit 5, pages 93-99). Additionally, this appeal reviewer also considered SSI listings: 1.22 - Non-Healing or Complex Fracture of the Femur, Tibia, Pelvis or one or more of the talocrural bones, 1.23 - Non-Healing or Complex Fracture of an Upper Extremity, 3.03- Asthma (complaints of shortness of breath with activity), 5.08- Weight Loss due to Any Digestive Disorder (CVS) (Exhibit 5, pages 100-104).

**Step 3** asks if there is Medical Improvement (MI) (Decreased Severity)? (Exhibit 5, page 85). The CDR reviewer answered "Yes," indicating the appellant has had a significant decrease in medical severity in at least one of the impairments present at the time of CPD, resulting in MI; the reviewer completed the MI Comparison documentation (Exhibit 5, page 86).

CPD: [redacted] inpatient hospitalization records spanning ED/In-patient Admission [redacted] (Exhibit 5, pages 266-414):

- Discharge Summary [redacted] Addendum to Discharge Summary [redacted] (Exhibit 5, pages 266-271) – discharge to home with outpatient referral to physical therapy and rehabilitation, he is non-weightbearing on his left lower extremity until at least [redacted] 2002 (3 months) and non-weightbearing on his right upper extremity; follow up appointments with multiple specialists such as plastic surgery, otorhinolaryngology, trauma service, orthopedics, ophthalmology.
- [redacted] 2002 PT progress note (Exhibit 5, page 349),
- [redacted] 2002 Nursing progress note (Exhibit 5, page 351-352),
- [redacted] 2002 Occupational Therapy Evaluation (Exhibit 5, page 359),
- [redacted] 2002 Physical Therapy Evaluation (Exhibit 5, page 368-367).

Current Evidence: [redacted] (Exhibit 5, pages 181-245).

[redacted] 2025 Telehealth OBAT (Office Based Addiction Treatment) – see HPI, exam and assessment/plan (Exhibit 5, page 184) - feels "excellent", sleep "good", denies pain, stress/ anxiety level 1/10, oriented to time, place, person, thought content normal.

[redacted] 2025 Telehealth OBAT – see HPI, exam and assessment/plan (Exhibit 5, pages 189-190) – reports nothing new, had another episode in the ER, has been going every month, was trying to come off all meds and maybe that worsened his sxs, plans to see endocrinology, gastro put him back on Inderal and nortriptyline- he liked being off his meds

and now is going back on them and losing his gains from before, feels his "homeostasis" is off balance. Pt doesn't think this is related to his heavy MJ use- daily user… daily dosing, denies cravings/slip ups, misses a dose or few when he gets cyclic vomiting… (this week) feeling okay now. Denies fatigue, constipation, rash, headache. Alert, normal affect, pupil equal, EOMI, normal sclerae, normal gaze, normal gait and coordination, oriented, normal thought process. A/P- Migraine: no Sumatriptan use x 1 year, on TCA for tx cyclic vomiting working to come down off these meds with specialists, Chronic back pain- upper and lower treated with Suboxone, NSAID, Tylenol, has had pain clinic tx. Feels adequately treated now. Weight loss discussed eating natural foods, encouraged protein intake. Cyclical vomiting syndrome- has had some vomiting. Feels worried about his overall health. In the past has been on Inderal, TCA, Ativan. Might need to go back on Inderal. Has f/u with GI.

- [redacted] 2025 Telehealth OBAT- (Exhibit 5, page 194)
- [redacted] 2024 Telehealth OBAT (Exhibit 5, page 198)
- [redacted] 2024 Office OBAT (Exhibit 5, pages 200-204) – [redacted] BMI [redacted] BP 123/77, HR 78, RR, 18, O2 sat 98% RA, see HPI, exam.
- [redacted] 2024 Office OBAT (Exhibit 5, page 206-210) - [redacted] BMI [redacted] BP 121/77, HR 74, O2 sat 98% RA, see HPI, exam.
- [redacted] 2024 Office OBAT (Exhibit 5, page 222-226) – [redacted] BMI [redacted], BP 102/70, HR 88, see HPI, exam.
- [redacted] 2024 labs results (pages 231-235) – no evidence of celiac disease, IgA normal, tTG-IgA not detected (normal), HbA1c normal, Mg normal, CMP all normal, CBCD all normal.

Current Evidence: [redacted] (Exhibit 5, pages 132-174)

- [redacted] 2025 ER (Exhibit 5, pages 133-140) - arrival time [redacted] admit time [redacted] Emergency, Walk-in/self-referral, discharge time [redacted] stable condition to home or self-care. Triage note- complaining of cyclic vomiting that started 2 days ago. Take Zofran at home with no effect. BP 153/87, HR 97, RR 18, O2 sat 96% (no weight reported). On exam, he appears underweight, ill-appearing, mucous membranes moist, no scleral icterus, neck with normal ROM. no focal neuro deficits, motor function intact, EOMI, conjunctiva normal, normal heart rate/rhythm, normal heart sounds, pulmonary effort normal, no respiratory distress, normal breath sounds, abdomen with increased bowel sounds, no distension, soft to palpation without tenderness, musculoskeletal ROM normal, no tenderness, skin warm/dry, pale without jaundice, CSM nl, neuro no focal deficits, GCS 15, CNs intact, sensation. Motor function and coordination are all intact, thought content normal. Lab work – CMP within normal limits, urinalysis + ketones, CBCD wnl. MDM: Vomiting resolved, nausea persists, comfortable with discharge.
- [redacted] 2024 ER (Exhibit 5, pages 159-165) – arrival time [redacted] admit time [redacted] Emergency, Walk-in/ self-referral, discharge time [redacted] stable condition to home or self-care. Exam and lab work obtained-MDM likely exacerbation of cyclic vomiting which is what he thinks it is also. Typical symptoms of his cyclic vomiting. No abdominal ttp. Improved with Haldol/Benadryl and Zofran which is what has had in

the past. I think stable for dc home. [redacted] noted. Ivf with k given. Will replete po for a few days also. Pt feeling better. Feels comfortable with discharge home. Decision regarding hospitalization addressed. Given improvement I think safe for discharge home.

Current Evidence: [redacted] and [redacted] all of [redacted] (Exhibit 5, pages 121-129).

- [redacted]24 Telehealth video visit in follow-up for cyclic vomiting (Exhibit 5, pages 121-124)
  -
    - Diagnosed in 2002, initially followed by [redacted] Stable with [redacted] as of 5/7/19; experienced 1-2 CVS flares per year managed in the ER
    - Ativan tapered off in [redacted] 2019; symptoms recurred, then reinstated
    - [redacted] 2020: No acute symptoms, no flares since starting current regimen (Ativan TID, nortriptyline 125 mg daily, propranolol 60 mg daily)
    - [redacted] 2022: No ED visits in 3-4 years, continued daily medications, attending weekly psychology sessions
    - [redacted] 2023: Symptom-free, wanted to taper medications; nortriptyline reduced to 75 mg daily
    - [redacted] 2023: Nortriptyline decreased to 50 mg daily
    - [redacted] 2023: No rebound symptoms, nortriptyline decreased to 25 mg daily
    - [redacted] 2024: COVID-related episode in December, resolved; nortriptyline decreased to 10 mg QHS; pain-free and no nausea or vomiting currently; nortriptyline eventually d/c'ed
    - [redacted] 2024: Doing well. Tapering down propranolol

  Today, [appellant] is doing well. He unfortunately contracted COVID-19 in August, which resulted in CVS (cyclical vomiting syndrome) relapse requiring ED treatment with Haldol and Zofran. He also experienced a setback with pneumonia two weeks later, resulting in a weight loss of [redacted] pounds (from [redacted] to [redacted]). Fortunately, he has now returned to his baseline…. he continues to take daily Motrin for back pain and uses a PRN PPI. He has stopped taking propranolol and plans to begin tapering off lorazepam soon.

  In summary, [the appellant] is a [redacted] with CVS on Ativan TID, propranolol 60 mg daily for prophylaxis with good effect. Impression and Plan:

  Cyclic vomiting syndrome, well-controlled. Continue Ativan 1 mg TID. Start tapering to 1mg BID as able. Off propranolol. Patient taking Zofran PRN. Abortive therapy for severe vomiting in ED - Combination of Benadryl + Thorazine/Haldol + Zofran

  H/o NSAID-induced esophagitis. - He continues on daily NSAIDs for his chronic pain. He will continue omeprazole indefinitely while he remains on NSAIDs… recommended continue taking a PPI daily. Continue omeprazole daily.

For the duration of the review Residual Functional Capacity (RFCs) assessments are necessary. An RFC is a clinical assessment that describes what a person can still do despite his or her

impairments. Current RFCs are used at Step 4b in conjunction with the CPD RFCs and are also needed for Steps 7 & 8.

A CDR All- Impairments Physical RFC evaluation (considering all impairments supported by current data as of 5/14/2025) was completed by [redacted] on [redacted] 2025. The RFC indicated that the client is capable of performing the full range of Medium work activity; consideration of occasional climbing (ladders, scaffolding, etc.) and crawling and limiting overhead reaching to frequently related to chronic neck and back pain, and limiting environmental hazards (machinery, heights, etc.) related to prescribed Ativan and reported daily marijuana use (Exhibit 5, pages 105-107).

1. [redacted] (Exhibit 5, page 106) [redacted] with a history of MVA in 2002 resulting in ORIF of wrist and ankle fracture, chronic neck and low back pain, opioid addiction, and migraine headaches.

   He developed cyclical vomiting syndrome (CVS). Progress notes from GI in [redacted] of 2024 state he was having 1-2 episodes of prolonged nausea and vomiting once or twice per year in 2019. Over the next few years, he did well on a regimen of Ativan, nortriptyline, and propranolol. He did not have any episodes of CVS for 3-4 years. He began a slow weaning of his medications directed by his gastroenterologist. He did well until contracting COVID in August of 2024 which triggered a severe bout of CVS.

   Progress notes from August of 2024 to January of 2025 document nearly monthly flares of his CVS associated with not returning to his previously successful three drug treatment.

   ER notes from [redacted] of 2025 state his MSK and neurological examination were unremarkable. ER notes from [redacted] stated "coming off all medication" had caused worsening CVS. He was still using marijuana daily. Gastroenterology had put him back on Inderal and nortriptyline.

   Progress notes from [redacted] of 2025, state his pain was well controlled, he was exercising regularly, migraines were not intractable, and he had not had a flare of CVS since restarting medications.

   The records do not indicate any significant limitations related to his migraines, vitamin D deficiency, left leg pain or shortness of breath. His chronic pain remained controlled with suboxone daily use.

**Step 4** asks if there is Medical Improvement (MI) related to ability to work? (Exhibit 5, page 88). The 2002 CPD determination was based on the impairment(s) meeting or equaling a listing; it did not, and therefore the current review proceeds to Step 4a.

**Step 4a** asks if the prior listing(s) currently met or equaled (as that listing appeared at CPD))? See SSI listing 1.11 as it appeared in 2002 (Exhibit 5, page 255). The CDR reviewer marked “No,” indicating that the medical improvement relates to the ability to work. Continue to STEP 6.

**Step 6** asks is there a current impairment(s) or a combination of impairments that is severe? (Exhibit 5, page 90). The CDR reviewer selected, “Yes” and the review proceeded to Step 7.

**Step 7** asks does the claimant retain the capacity to perform Past Relevant Work (PRW)? (Exhibit 5, page 91). The appellant is [redacted] English communicating and literate, with an associate degree in [redacted] Per his supplement, he indicates he is currently employed (since April 2019) as a [redacted] working 32 hours/week at a rate of $19.00/hour (this is approx. $2,632.00/month), which is considered SGA. The appellant indicates he uses a computer, office machines, phone, cash register, drives a car or truck, and performs filing to perform his work. He indicates he typically walks/stands one hour/workday, sits 3 hours/workday, and reaches 2 hours/workday, lifts and carries less than 10 lbs. most often, and may need to lift 10 lbs. (Exhibit 5, pages 79-80). While [the appellant] is describing his work as light activity, a survey of similar jobs using the Dictionary of Occupational Titles (DOT) more consistently describes this work as Medium work activity (DOT 299.477-010, 906.683-010, 292.353-010) (Exhibit 5, pages 111-113). Both the light description given by the appellant and the medium description found in the DOT fall within the Physical RFC guidance provided by [redacted] of Medium work activity. The CDR reviewer selected "Yes" indicating the client is capable of performing his current/past relevant work activity, and the determination of "Not Disabled" using decision code 230; the CDR ceases at this step. The CDR disability process concluded with a final review and endorsement of the disability decision by Medical Physician Advisor (PA) [redacted] on [redacted] 2025, (Exhibit 5, pages 82, 115). A UMass Chan DES Disability Determination denial letter for the client was created on May 15, 2025 (Exhibit 5, page 116), and DES transmitted the decision to MassHealth on May 21, 2025 (Exhibit 5, page 72).

In summary, the appellant does not meet or equal the Adult SSI listings either individually or considering the combination of complaints. Additionally, the appellant has had a significant decrease in medical severity in at least one of his impairments present at the time of the 2002 CPD, resulting in Medical Improvement, which is related to his ability to work. The appellant's RFC indicates he is capable of performing medium work activity in the competitive labor market. Finally, his current/past work as a Delivery Driver is within his current capabilities. The appeals review concludes the appellant was correctly determined 'Not Disabled' for Title XVI benefits under the 8-step CDR process.

The appellant testified that it took him years to learn to walk and talk again. The appellant testified that any kind of sickness can cause cyclical vomiting, so he has to be very cautious about his health. The appellant testified that he can work, but cannot work fulltime because sometimes he gets sick.

# Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. DES's role is to determine, for MassHealth, if an applicant meets the SSA level of disability from a clinical standpoint.

2. DES uses a 5-step process, as described by SSA regulations at Title 20 Code of Federal Regulations (CFR) Ch. III part 416.920 to determine initial disability status. The process is driven by an applicant's medical records and disability supplement.

3. SSA 20 CFR §416.905 states the definition of disability is the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months (Exhibit 5, page 8).

4. To meet this definition, one must have a severe impairment(s) that makes them unable to do their past relevant work or any other substantial gainful work that exists in the regional economy.

5. Per 20 CFR 416.989, adult MassHealth applicants who have been previously declared disabled will periodically undergo a CDR to determine if an applicant remains clinically eligible for disability (Exhibit 5, page 39). A CDR is initiated by DES at the request of MassHealth. The CDR is an 8-step evaluation process as described within CFR 416.994 (Exhibit 5, pages 46-60).

6. Per SSA 20 CFR 416.994, if an applicant is entitled to disability benefits as a disabled person aged eighteen or over (adult), there are a few factors DES considers in deciding whether the applicant's disability continues. DES must determine if there has been any medical improvement in the applicant's impairment(s) and, if so, whether this medical improvement is related to the applicant's ability to work. Even where medical improvement related to the applicant's ability to work has occurred, DES must also show that the applicant is currently able to engage in substantial gainful activity (SGA) before DES can find that the applicant is no longer disabled.

7. To ensure that disability reviews are carried out in a uniform manner, that a decision of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally, and are fully documented, DES follows specific steps in reviewing the question of whether your disability continues.

8. The CDR may cease, and benefits may be continued at any point if it is determined there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The 8-step sequential review process is listed within 20 CFR 416.994(b)(5) (Exhibit 5, pages 57-58).

9. The appellant was initially determined clinically disabled in 2002, status-post (s/p) a motorcycle accident on [redacted] 2002, in which he sustained multi-trauma injuries that required a prolonged hospitalization, multiple surgeries, and outpatient rehabilitation.

10. The appellant's injuries included: left tibia-fibula fracture s/p open reduction internal fixation (ORIF) surgery, left upper extremity degloving injury, right wrist distal radius fractures (triquetral and intra-articular radial styloid) s/p ORIF, left scapular fracture, aortic rupture s/p interposition graft repair, intraparenchymal frontal lobe hemorrhage, recurrent pericardial effusion, as well as lacerations, contusions and other trauma associated complications (Exhibit 5, pages 267-272).

11. The clinical documentation supported his disability through the 5-step process, equaling SSI listing 1.11 – Fracture of the Femur, Tibia, Tarsal Bone or Pelvis (Exhibit 5, page 255), considering the combination of impairments and a next recommended disability review date of September 11, 2003, was recorded (Exhibit 5, page 248).

12. This 2002 IDR episode will be referred to as the CPD episode (Exhibit 5, pages 246-414).

13. The appellant is a [redacted] who submitted a complete MassHealth Adult Disability Supplement to DES on March 10, 2025.

14. DES initiated a CDR episode on March 10, 2025.

15. The appellant reported current and continued complaints of migraines/ headaches, neck and back pain, CVS, vitamin D deficiency, difficulty with lifting/ using arms overhead, lightheadedness, pain in legs with long walks (left leg hardware), and shortness of breath with exertional activity (Exhibit 5, pages 77-78).

16. DES requested and obtained medical documentation using the medical releases the appellant provided (Exhibit 5, pages 62-69).

17. Information was received from the client's reported providers: [redacted] Clinic (Exhibit 5, pages 121-129), [redacted] Center (GLFHC), (Exhibit 5, pages 181-245).

[redacted] no visits with [redacted] were included in the records provided by the facility.

19. Prior to initiating the 8-step process, the question of sufficient information received/ available to make a determination must be evaluated (A). The review considers both the appellant's current and prior (CPD) impairments/ complaints (Exhibit 5, page 82), review of current medical documentation and historic (CPD) documentation, confirming sufficient information to complete the CDR process has been obtained. For this review (A) was marked, "Yes" on (Exhibit 5, page 84).

20. Then, the 8-step CDR process was started (page 85).

21. **Step 1** asks if the claimant is engaging in SGA. While federal SSA regulations would stop if the claimant is engaging in SGA, MassHealth waives this step and continues with the review. Step 1 was marked, "Yes" (Exhibit 5, page 85). This step is a SSA consideration having to do with earnings and has no bearing on whether someone is found disabled or not disabled.

22. **Step 2** asks does any impairment(s) meet or equal a listing in the current Listing of Impairments? (Exhibit 5, page 85). When a specific impairment or diagnosis does not have its own listing under the SSI criteria, the evaluation will consider the listing that most closely matches the impairment or the findings related to the impairment(s) will be evaluated to confirm they are at least of equal medical significance to those of a listed impairment. The CDR reviewer answered, "No," citing SSI listings considered: 1.15 – Disorders of the Skeletal Spine resulting in Compromise of a Nerve Root(s), 1.18 – Abnormality of Major Joint(s) in any Extremity, 5.06 – Inflammatory Bowel Disease (Cyclic Vomiting Syndrome), 11.02 Epilepsy (Migraines/ Headaches) (Exhibit 5, pages 93-99). The following SSI listings were also considered: 1.22 - Non-Healing or Complex Fracture of the Femur, Tibia, Pelvis or one or more of the talocrural bones, 1.23 - Non-Healing or Complex Fracture of an Upper Extremity, 3.03- Asthma (complaints of shortness of breath with activity), 5.08- Weight Loss due to Any Digestive Disorder (CVS) (Exhibit 5, pages 100-104).

23. **Step 3** asks if there is MI (Decreased Severity)? (Exhibit 5, page 85). The CDR reviewer answered "Yes" indicating the appellant has had a significant decrease in medical severity in at least one of the impairments present at the time of CPD, resulting in MI; the reviewer completed the MI Comparison documentation (Exhibit 5, page 86).

24. The following medical record information was used.

CPD: [redacted] inpatient hospitalization records spanning ED/ In-patient Admission [redacted] (Exhibit 5, pages 266-414):

- Discharge Summary [redacted] 2002, Addendum to Discharge Summary [redacted] 2002 (Exhibit 5, pages 266-271) – discharge to home with outpatient referral to physical therapy and rehabilitation, he is non-weightbearing on his left lower extremity until at least November 2002 (3 months) and non-weightbearing on his right upper extremity; follow up appointments with multiple specialists such as plastic surgery, otorhinolaryngology, trauma service, orthopedics, ophthalmology.
- [redacted] 2002 PT progress note (Exhibit 5, page 349),
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- [redacted] 2002 Occupational Therapy Evaluation (Exhibit 5, page 359),
- [redacted] 2002 Physical Therapy Evaluation (Exhibit 5, page 368-367).

25. Current Medical Evidence: [redacted] Smith *et al*. of [redacted] (Exhibit 5, pages 181-245).

[redacted] 2025 Telehealth OBAT (Office Based Addiction Treatment) – see HPI, exam and assessment/plan (Exhibit 5, page 184) - feels "excellent", sleep "good", denies pain, stress/anxiety level 1/10, oriented to time, place, person, thought content normal.

[redacted] 2025 Telehealth OBAT – see HPI, exam and assessment/plan (Exhibit 5, pages 189-190) – reports nothing new, had another episode in the ER, has been going every month, was trying to come off all meds and maybe that worsened his sxs, plans to see endocrinology, gastro put him back on Inderal and nortriptyline- he liked being off his meds and now is going back on them and losing his gains from before, feels his "homeostasis" is off balance. Pt doesn't think this is related to his heavy MJ use- daily user… daily dosing, denies cravings/ slip ups, misses a dose or few when he gets cyclic vomiting… (this week) feeling okay now. Denies fatigue, constipation, rash, headache. Alert, normal affect, pupil equal, EOMI, normal sclerae, normal gaze, normal gait and coordination, oriented, normal thought process. A/P- Migraine: no Sumatriptan use x 1 year, on TCA for tx cyclic vomiting working to come down off these meds with specialists, Chronic back pain- upper and lower treated with Suboxone, NSAID, Tylenol, has had pain clinic tx. Feels adequately treated now. Weight loss discussed eating natural foods, encouraged protein intake. Cyclical vomiting syndrome- has had some vomiting. Feels worried about his overall health. In the past has been on Inderal, TCA, Ativan. Might need to go back on Inderal. Has f/u with GI.

- [redacted] 2025 Telehealth OBAT- (Exhibit 5, page 194)
- [redacted] 2024 Telehealth OBAT (Exhibit 5, page 198)
- [redacted] 2024 Office OBAT (Exhibit 5, pages 200-204) – [redacted] lbs., BMI [redacted] BP 123/77, HR 78, RR, 18, O2 sat 98% RA, see HPI, exam.
- [redacted] 2024 Office OBAT (Exhibit 5, page 206-210) - [redacted] BMI [redacted], BP 121/77, HR 74, O2 sat 98% RA, see HPI, exam.
- [redacted] 2024 Office OBAT (Exhibit 5, page 222-226) – [redacted] BMI [redacted], BP 102/70, HR 88, see HPI, exam.

- [redacted] 2024 labs results (pages 231-235) – no evidence of celiac disease, IgA normal, tTG-IgA not detected (normal), HbA1c normal, Mg normal, CMP all normal, CBCD all normal.

Current Medical Evidence: [redacted] (Exhibit 5, pages 132-174)

- [redacted] 2025 ER (Exhibit 5, pages 133-140) - arrival time [redacted] admit time [redacted] Emergency, Walk-in/ self-referral, discharge time [redacted] stable condition to home or self-care. Triage note- complaining of cyclic vomiting that started 2 days ago. Take Zofran at home with no effect. BP 153/87, HR 97, RR 18, O2 sat 96% (no weight reported). On exam, he appears underweight, ill-appearing, mucous membranes moist, no scleral icterus, neck with normal ROM. no focal neuro deficits, motor function intact, EOMI, conjunctiva normal, normal heart rate/rhythm, normal heart sounds, pulmonary effort normal, no respiratory distress, normal breath sounds, abdomen with increased bowel sounds, no distension, soft to palpation without tenderness, musculoskeletal ROM normal, no tenderness, skin warm/dry, pale without jaundice, CSM nl, neuro no focal deficits, GCS 15, CNs intact, sensation. Motor function and coordination are all intact, thought content normal. Lab work – CMP within normal limits, urinalysis + ketones, CBCD wnl. MDM: Vomiting resolved, nausea persists, comfortable with discharge.
- [redacted] 2024 ER (Exhibit 5, pages 159-165) – arrival time [redacted] admit time [redacted] Emergency, Walk-in/ self-referral, discharge time [redacted] stable condition to home or self-care. Exam and lab work obtained-MDM likely exacerbation of cyclic vomiting which is what he thinks it is also. Typical symptoms of his cyclic vomiting. No abdominal ttp. Improved with Haldol/Benadryl and Zofran which is what has had in the past. I think stable for dc home. Hypok noted. Ivf with k given. Will replete po for a few days also. Pt feeling better. Feels comfortable with discharge home. Decision regarding hospitalization addressed. Given improvement I think safe for discharge home.

Current Medical Evidence: [redacted] Exhibit 5, pages 121-129).

- [redacted] 24 Teleheatlh video visit in follow-up for cyclic vomiting (Exhibit 5, pages 121-124) -
  - Diagnosed in 2002, initially followed by [redacted] with [redacted] as of [redacted] 19; experienced 1-2 CVS flares per year managed in the ER
  - Ativan tapered off in [redacted] 2019; symptoms recurred, then reinstated
  - [redacted] 2020: No acute symptoms, no flares since starting current regimen (Ativan TID, nortriptyline 125 mg daily, propranolol 60 mg daily)
  - [redacted] 2022: No ED visits in 3-4 years, continued daily medications, attending weekly psychology sessions
  - [redacted] 2023: Symptom-free, wanted to taper medications; nortriptyline reduced to 75 mg daily

- [redacted] 2023: Nortriptyline decreased to 50 mg daily
- [redacted] 2023: No rebound symptoms, nortriptyline decreased to 25 mg daily
- [redacted] 2024: COVID-related episode in December, resolved; nortriptyline decreased to 10 mg QHS; pain-free and no nausea or vomiting currently; nortriptyline eventually d/c'ed
- [redacted] 2024: Doing well. Tapering down propranolol

Today, [appellant] is doing well. He unfortunately contracted COVID-19 in August, which resulted in cyclical vomiting syndrome relapse requiring ED treatment with Haldol and Zofran. He also experienced a setback with pneumonia two weeks later, resulting in a weight loss of [redacted] pounds (from [redacted] to [redacted]). Fortunately, he has now returned to his baseline…. he continues to take daily Motrin for back pain and uses a PRN PPI. He has stopped taking propranolol and plans to begin tapering off lorazepam soon.

In summary, [the appellant] is a [redacted] male with CVS on Ativan TID, propranolol 60mg daily for prophylaxis with good effect. Impression and Plan:

Cyclic vomiting syndrome, well-controlled. Continue Ativan 1 mg TID. Start tapering to 1mg BID as able. Off propranolol. Patient taking Zofran PRN. Abortive therapy for severe vomiting in ED - Combination of Benadryl + Thorazine/Haldol + Zofran

H/o NSAID-induced esophagitis. - He continues on daily NSAIDs for his chronic pain. He will continue omeprazole indefinitely while he remains on NSAIDs… recommended continue taking a PPI daily. Continue omeprazole daily.

26. For the duration of the review RFCs assessments are necessary. An RFC is a clinical assessment that describes what a person can still do despite their impairments. Current RFCs are used at Step 4b in conjunction with the CPD RFCs and are also needed for Steps 7 & 8.

27. A CDR All- Impairments Physical RFC evaluation (considering all impairments supported by current data as of 5/14/2025) was completed by [redacted] on [redacted] 2025. The RFC indicated that the client is capable of performing the full range of Medium work activity; consideration of occasional climbing (ladders, scaffolding, etc.) and crawling and limiting overhead reaching to frequently related to chronic neck and back pain, and limiting environmental hazards (machinery, heights, etc.) related to prescribed Ativan and reported daily marijuana use (Exhibit 5, pages 105-107).

28. [redacted]: (Exhibit 5, page 106) [redacted] with a history of MVA in 2002 resulting in ORIF of wrist and ankle fracture, chronic neck and low back pain, opioid addiction, and migraine headaches.

He developed cyclical vomiting syndrome (CVS). Progress notes from GI in [redacted] of 2024 state he was having 1-2 episodes of prolonged nausea and vomiting once or twice

per year in 2019. Over the next few years, he did well on a regimen of Ativan, nortriptyline, and propranolol. He did not have any episodes of CVS for 3-4 years. He began a slow weaning of his medications directed by his gastroenterologist. He did well until contracting COVID in August of 2024 which triggered a severe bout of CVS.

Progress notes from August of 2024 to January of 2025 document nearly monthly flares of his CVS associated with not returning to his previously successful three drug treatment.

ER notes from [redacted] of 2025 state his MSK and neurological examination were unremarkable. ER notes from [redacted] stated "coming off all medication" had caused worsening CVS. He was still using marijuana daily. Gastroenterology had put him back on Inderal and nortriptyline.

Progress notes from March of 2025, state his pain was well controlled, he was exercising regularly, migraines were not intractable, and he had not had a flare of CVS since restarting medications.

The records do not indicate any significant limitations related to his migraines, vitamin D deficiency, left leg pain or shortness of breath. His chronic pain remained controlled with suboxone daily use.

29. **Step 4** asks if there is MI related to ability to work? (Exhibit 5, page 88). The 2002 CPD determination was based on the impairment(s) meeting or equaling a listing; it did not, so therefore the current review proceeded to Step 4a.

30. **Step 4a** asks if the prior listing(s) currently met or equaled (as that listing appeared at CPD)? See SSI listing 1.11 as it appeared in 2002 (Exhibit 5, page 255). The CDR reviewer marked “No,” indicating that the medical improvement relates to the ability to work. Continue to STEP 6.

31. **Step 6** asks is there a current impairment(s) or a combination of impairments that is severe? (Exhibit 5, page 90). The CDR reviewer selected, “Yes” and the review proceeded to Step 7.

32. **Step 7** asks does the claimant retain the capacity to perform PRW? (Exhibit 5, page 91). The appellant is [redacted] English communicating and literate, with an associate degree in liberal arts education. Per his supplement, he indicates he is currently employed (since [redacted]) as a [redacted] working 32 hours/week at a rate of $19.00/ hour (this is approx. $2632.00/ month), which is considered SGA. The appellant indicates he uses a computer, office machines, phone, cash register, drives a car or truck, and performs filing to perform his work. He indicates he typically walks/stands one hour/ workday, sits 3 hours/ workday, and reaches 2 hours/workday, lifts and carries less than 10 lbs. most often, and may need to lift 10 lbs. (Exhibit 5, pages 79-80). While [redacted] is describing his work as light activity, a survey of similar jobs using the Dictionary of Occupational Titles (DOT) more consistently describes this work as

Medium work activity (DOT 299.477-010, 906.683-010, 292.353-010) (Exhibit 5, pages 111-113). Both the light description given by the appellant and the medium description found in the DOT fall within the Physical RFC guidance provided by [redacted] of Medium work activity. The CDR reviewer selected "Yes," indicating the client is capable of performing his current/ past relevant work activity, and the determination of "Not Disabled" using decision code 230; the CDR ceases at this step. The CDR disability process concluded with a final review and endorsement of the disability decision by Medical Physician Advisor (PA) [redacted] on [redacted] 2025, (Exhibit 5, pages 82, 115). A UMass Chan DES Disability Determination denial letter for the client was created on May 15, 2025 (Exhibit 5, page 116), and DES transmitted the decision to MassHealth on May 21, 2025 (Exhibit 5, page 72).

33. In summary, the appellant does not meet or equal the Adult SSI listings either individually or considering the combination of complaints. Additionally, the appellant has had a significant decrease in medical severity in at least one of his impairments present at the time of the 2002 CPD, resulting in Medical Improvement, which is related to his ability to work. The appellant's RFC indicates he is capable of performing medium work activity in the competitive labor market. Finally, his current/past work as a [redacted] is within his current capabilities. The appeals review concludes the appellant was correctly determined "Not Disabled" for Title XVI benefits under the 8-step CDR process.

34. It took the appellant years to learn to walk and talk again.

35. The appellant is cautious about his health due to cyclical vomiting.

36. The appellant is able to work.

## Analysis and Conclusions of Law

In order to be found disabled for MassHealth Standard benefits, an individual adult must be "*permanently and totally disabled*." (130 CMR 501.001). The guidelines used in establishing disability under the MassHealth program are very similar to those used by the SSA. Individuals who meet the SSA's definition of disability may establish eligibility for MassHealth Standard according to 130 CMR 505.002(E), or for CommonHealth according to 130 CMR 505.004. Per 20 CFR 416.905, the SSA defines disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

The federal Social Security Act establishes the eligibility standards and 8-step evaluation tool used to conduct the CDR reevaluations. The CDR reevaluations are periodically required by federal law for those who have already previously been found disabled at some point under the 5-step test. (20 CFR 416.994(b)(5)). If a determination of disability can be made at any step of the process, the specific evaluation process stops at that point.

The purpose of the CDR evaluation is to determine if there has been any medical improvement in the appellant's impairments, and, if so, whether this medical improvement is related to their ability to work. If the appellant's impairment(s) has not medically improved, the reviewer must consider whether one or more of the exceptions to medical improvement apply. If medical improvement related to the appellant's ability to work has not occurred and no exception applies, the appellant's benefits will continue.[1] Even where medical improvement related to the appellant's ability to work has occurred or an exception applies, in most cases, the reviewer must

[1] 20 CFR 416.994(b)(3) *First group of exceptions to medical improvement*. The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies. 20 CFR 416.994(b)(4) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations, the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity. (i) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 416.1488. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time. (ii) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 416.1411 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 416.918 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked. (iii) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will suspend your payments. The month your payments are suspended will be the first month in which the question arose and we could not find you. (iv) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 416.930(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

also show that the appellant is currently able to engage in substantial gainful activity before the reviewer can find that the appellant is no longer disabled.

**The 8-Step Method for Continuous Disability Review**

The 8-step method is the sequential evaluation process established by the Social Security Act and described in 20 CFR 416.994(b)(5) for the purpose of determining initial eligibility for Medicaid benefits such as MassHealth:

At Step 1, it is determined whether the disability applicant is currently engaged in substantial gainful activity. If an applicant is engaged in such work with such income, the applicant may be found to be not disabled. Otherwise, the process continues to Step 2. This step is waived in an applicant's favor during a MassHealth disability review, and MassHealth thus essentially begins its review at Step 2.

At Step 2, a decision is made as to whether the applicant's impairments meet or equal a listing in the current Listing of Impairments. The review then proceeds to Step 3.

At Step 3, it is asked whether there has been medical improvement or decreased severity of the ailment(s), which is determined by the RFC assessment. The review proceeds to Step 4, which asks the question of whether there is Medical Improvement related to the ability to work. In order to determine the Medical Improvement, the CDR reviewer is directed to Step 4b and compares the record at the initial determination of disability with the current record, including the physical and mental RFCs and the MIRS RFC.

At Step 6, the CDR determines whether there are current impairments or a combination of impairments that are severe. If this step is answered "Yes," the review proceeds to Step 7.

At Step 7, a determination is made as to the applicant's RFC and whether the applicant can perform some prior work based on his or her capacity. If the applicant can perform his or her prior work, the review ends, and the applicant is found to be "not disabled." Otherwise, the review proceeds to the final step at Step 8.

At the final step, Step 8, it is asked whether the applicant is able to perform any other work that is available in sufficient quantities in the national economy. If so, the applicant is found to be "not disabled." If the applicant is not found able to do other work, the applicant will be determined to be a "disabled" adult.

DES correctly determined that the appellant no longer qualifies as disabled. The appellant had previously met the criteria for SSI Listing 1.11 – Fracture of the Femur, Tibia, Tarsal Bone or Pelvis in 2002. The appellant does not currently meet the criteria listed in the SSA listing under 1.15 – Disorders of the Skeletal Spine resulting in Compromise of a Nerve Root(s), 1.18 – Abnormality of Major Joint(s) in any Extremity, 5.06 – Inflammatory Bowel Disease (Cyclic Vomiting Syndrome), 11.02 Epilepsy (Migraines/ Headaches), 1.22 - Non-Healing or Complex

Fracture of the Femur, Tibia, Pelvis or one or more of the talocrural bones, 1.23 - Non-Healing or Complex Fracture of an Upper Extremity, 3.03 - Asthma (complaints of shortness of breath with activity), or 5.08 - Weight Loss due to Any Digestive Disorder (CVS) . There is nothing in the medical record to support that the appellant's condition meets or equals a listing utilized by the SSA.

Because no listings were met, DES proceeded to Step 3. At Step 3, the DES correctly found that the appellant's medical situation has improved. At Step 7, the reviewer determined that the appellant could perform past relevant work. DES did not err in determining that the appellant no longer meets or equals the current or prior Adult SSA listings either individually or in combination of complaints, and the appellant was correctly determined to be "Not Disabled."

The appellant currently works and while the appellant testified that he must be cautious about his health, this does not rise to the level of a SSA disability listing. In consideration of the entire record, including the testimony, medical records, and supporting documentation, the appellant has not established that he is permanently and totally disabled.

Therefore, this appeal is **DENIED**.

## Order for MassHealth

None.

## Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Christine Therrien
Hearing Officer
Board of Hearings

cc: MassHealth Representative: Dori Mathieu, Springfield MassHealth Enrollment Center

cc: DES unit, UMass. Medical School