

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2511657
Decision Date:	11/24/2025	Hearing Date:	10/01/2025
Hearing Officer:	Kimberly Scanlon		

Appearance for Appellant:
Pro se

Appearances for MassHealth:
Lorena Garcia – Tewksbury MEC;
Eileen Cynamon, R.N. - DES



*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

Appeal Decision:	Denied	Issue:	Disability; Eligibility
Decision Date:	11/24/2025	Hearing Date:	10/01/2025
MassHealth's Reps.:	Lorena Garcia; Eileen Cynamon, R.N.	Appellant's Rep.:	Pro se
Hearing Location:	Tewksbury MassHealth Enrollment Center Room 1 (Remote)	Aid Pending:	No

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 June 25, 2025, MassHealth notified the appellant that she does not meet MassHealth disability requirements. (Exhibit 1). The appellant filed this appeal in a timely manner on July 30, 2025. (130 CMR 610.015(B); Exhibit 2). A hearing was scheduled to take place on September 9, 2025, and was rescheduled to October 1, 2025. (Exhibits 4-6). 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 disability requirements.

Issue

The appeal issue is whether MassHealth was correct in determining that the appellant is not totally and permanently disabled.

Summary of Evidence

MassHealth was represented at the initial hearing by an eligibility representative from the MassHealth Enrollment Center and a registered nurse and appeals reviewer from Disability Evaluation Services (DES); both parties participated by telephone. The MassHealth eligibility representative testified as follows:

On or about June 26, 2025, MassHealth received a denial notice from DES, stating that the appellant was not deemed disabled. The MassHealth representative stated that the appellant is under the age of [REDACTED] and she resides in a household of 2 with her minor child. The appellant grosses \$4,757 per month from employment, which equates to 264.90% of the Federal Poverty Level (FPL). To qualify for MassHealth Standard benefits, an applicant's gross monthly income cannot exceed 133% of the FPL, or \$1,735. To qualify for MassHealth CommonHealth benefits, DES must first deem an applicant is disabled. Here, the appellant was deemed not disabled by DES, and her income is over the allowable limit to qualify for MassHealth Standard coverage. Currently, the appellant is eligible to enroll in a ConnectorCare Type 3B plan through the Health Connector; her son is eligible to receive Family Assistance benefits.

The DES representative testified as follows: DES's role is to determine for MassHealth if an applicant meets the Social Security Administration (SSA) level of disability from a clinical standpoint. To determine such, a 5-step sequential evaluation process is used, as described within the SSA regulations at Title XX of the Code of Federal Regulations (CFR), Chapter III, § 416.920. (Exhibit 7, pp. 8-10). DES applies this 5-step process using the applicant's medical records and disability supplement submissions. Per SSA CFR § 416.905, disability is defined as 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 process of not less than 12 months. To meet this definition, you must have a severe impairment(s) that renders you unable to do your past relevant work or any other substantial gainful work that exists in the regional economy (Exhibit 7, p. 7). Per SSA CFR § 416.945, what a person can still do despite an impairment is called his or her residual functional capacity (RFC). Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity, it is this RFC that is used to determine whether a person can still perform his or her past work, or, in conjunction with the person's age, education, and work experience, any other work. (Exhibit 7, pp. 20-22).

The appellant is an adult female who was initially administratively approved for MassHealth Adult Disability in 2020, in response to the Public Health Emergency (PHE) and consistent with the federal continuous coverage requirements and MassHealth coverage protections which were in effect at that time. The DES representative explained that essentially during the PHE, no member could be denied or disenrolled. Upon conclusion of the PHE, MassHealth returned to standard annual eligibility renewal processes on April 1, 2023, requiring all current MassHealth members renew their health coverage to ensure they still qualify for their current benefits. (Exhibit 7, p. 32). In 2024, the appellant received a clinical disability denial determination from DES. On March 4,

2025, the appellant submitted a MassHealth Adult Disability Supplement to DES. DES noted that on initial screening of the appellant's March 2025 Disability Supplement, one of the medical release forms was not included for one of the providers the appellant listed. Therefore, on March 20, 2025, DES returned the documents to the appellant, along with a Dear Client Letter (DCL) 501 Return (501RL), relevant blank disability evaluation request, directed forms, and a postage paid DES return envelope via mail. The DCL detailed the corrective action(s) needed for DES to process the appellant's Disability Supplement, to call DES with any questions, and to resubmit the Disability Supplement and correctly completed forms to DES within 10 business days. (Exhibit 7, p. 35).

On March 31, 2025, DES received the appellant's completed Adult Disability Supplement, listing the following health problems: cirrhosis, recent gallbladder removal with bile duct stent placement, and right-sided pain in neck and shoulder due to complaints of bulging disc. (Exhibit 7, p. 54). DES requested and obtained medical documentation using the medical releases that the appellant provided from her treating providers, including [REDACTED] (Exhibit 7, pp. 36-45).¹ Once DES receives the medical documentation, the 5-step review process begins, as follows:

Step 1: Is the applicant engaged in substantial gainful activity (SGA)?

For the appellant's review, Step 1 was marked "Undetermined" (Exhibit 7, p. 61). The DES representative explained that Step 1 is waived by MassHealth regardless of whether the applicant is engaging in SGA. However, on the federal level, if an applicant is engaging in SGA, it stops the disability review in its entirety. Here, Step 1 is waived for MassHealth purposes and the review proceeds to Step 2.

Step 2: Does the claimant have a medically determinable impairment (MDI) or a combination of MDIs that is both severe and meets the duration requirement?

The DES representative testified that the duration requirement means that the impairment is expected to result in death, or which has lasted or is expected to last for a continuous process of not less than 12 months at that severity. (Exhibit 7, p. 16). Here, the provider information was sufficient to establish that the appellant's MDIs met the severity and duration requirements for Step 2. Therefore, DES determined that the appellant meets Step 2, and the review process proceeded to Step 3. (Exhibit 7, p. 61).

Step 3: Does the claimant have an impairment(s) that meet an adult SSA listing or is medically equal to a listing and meets the listing level duration requirement?

At Step 3, the DES reviewer marked "no" citing the applicable adult SSA listings that were

¹ DES and the appellant made multiple additional outreach efforts from May 19, 2025 through June 4, 2025, to obtain records from [REDACTED]. On June 4, 2025, DES received the requested records. (Exhibit 7, pp. 78-116).

considered. *Id.* DES explained that 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. Here, the pertinent listings that most closely matched are:

1:15 – Disorders of the Skeletal Spine resulting in a Compromise of a Nerve Root(s);

1:18 – Abnormality of a Major Joint(s) in any Extremity; and

5:05 – Chronic Liver Disease.

(Exhibit 7, pp. 63-69).

The DES representative explained that with respect to the listings, there are certain criteria that must be met. Specifically, for listing 1:15-Disorders of the Skeletal Spine resulting in a Compromise of a Nerve Root, the following criteria includes:

1. A documented medical need for a walker, bilateral canes, or bilateral crutches or a wheeled and seated mobility device involving the use of both hands; **or**
2. An inability to use **one** upper extremity to independently initiate, sustain, and complete work-related activities, involving fine and gross movements, **and** a documented medical need for a one-handed, hand-held assistive device that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand; **or**
3. An inability to use both upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

Fine movements, for the purposes of these listings, involve use of your wrists, hands, and fingers; such movements include picking, pinching, manipulating, and fingering. Gross movements involve the use of your shoulders, upper arms, forearms, and hands; such movements include handling, gripping, grasping, holding, turning, and reaching. Gross movements also include exertional abilities such as lifting, carrying, pushing, and pulling. (Exhibit 7, p. 64). The DES representative explained that at this listing, DES will look to see if certain nerves and parts of the spinal column are impacting the appellant's body continuously for the past 12 months (i.e. numbness, muscle weakness, decreased sensation, etc.). Here, because the appellant's medical records do not include a documented medical need or an inability to use one or both upper extremities, DES determined that she does not meet the criteria for this listing.

DES then reviewed the criteria set forth in listing 1:18 – Abnormality of a Major Joint(s) in any Extremity. The criteria set forth in this listing includes documentation of **A, B, C, and D**, as follows:

- A. Chronic joint pain or stiffness, and

- B. Abnormal motion, instability, or immobility of the affected joint(s), and
- C. Anatomical abnormality of the affected joint(s) noted on:
 - 1. Physical examination (for example, subluxation, contracture, or bony or fibrous ankylosis; **or**
 - 2. Imaging (for example, joint space narrowing, bony destruction, or ankylosis or arthrodesis of the affected joint, and
- D. Impairment related physical limitation of musculoskeletal functioning that has lasted, or is expected to last, for a continuous period of at least 12 months, and medical documentation of at least **one** of the following:
 - 1. A documented medical need for a walker, bilateral canes, or bilateral crutches or a wheeled and seated mobility device involving the use of **both** hands; **or**
 - 2. An inability to use one upper extremity to independently initiate, sustain, and complete work-related activities involving fine and gross movements, **and** a documented medical need for a one-handed , hand-held assistive device that requires the use of the other upper extremity or a wheeled and seated mobility device involving the use of one hand; **or**
 - 3. An inability to use **both** upper extremities to the extent that neither can be used to independently initiate, sustain, and complete work-related activities involving fine and gross movements.

(Exhibit 7, p. 65).

The DES representative explained that for listing 1:18, although the appellant’s RFC indicates that she has limitations of occasional right upper extremity, her medical records do not indicate that she meets all criteria set forth above.

DES next reviewed the criteria set forth in listing 5:05– Chronic Liver Disease. The DES representative stated that for this listing, the appellant must meet one of the requirements set forth in subsections A, B, C, D, E, F, or G, described below. The criteria set forth in listing 5:05– Chronic Liver Disease includes:

- A. Hemorrhaging from esophageal, gastric, or ectopic varices, or from portal hypertensive gastropathy, documented by imaging, resulting in 1 and 2:
 - 1. Hemodynamic instability indicated by signs such as pallor (pale skin), diaphoresis (profuse perspiration), rapid pulse, low blood pressure, postural hypotension (pronounced fall in blood pressure when arising to an upright position from lying down), or syncope (fainting); **and**
 - 2. Requiring hospitalization for transfusion of at least **2** units of blood. Consider under a disability for 1 year following the documented transfusion; after that, evaluate the residual impairment(s).

OR
- B. Ascites or hydrothorax not attributable to other causes, present on **two** evaluations within a consecutive **12-month** period and at least **60** days apart. Each evaluation must

document the ascites or hydrothorax by 1, 2, or 3:

1. Paracentesis; **or**
2. Thoracentesis; **or**
3. Imaging or physical examination with a or b:
 - a. Serum albumin of 3.0 g/dL or less; **or**
 - b. INR of at least 1.5.

OR

- C. Spontaneous bacterial peritonitis documented by peritoneal fluid containing a neutrophil count of at least 250 cells/mm.

OR

- D. Hepatorenal syndrome documented by 1, 2 or 3:
1. Serum creatinine elevation of at least 2mg/dL; **or**
 2. Oliguria with 24-hour urine output less than 500mL; **or**
 3. Sodium retention with urine sodium less than 10mEq per liter.

OR

- E. Hepatopulmonary syndrome documented by 1 or 2:
1. Arterial PaO₂ measured by an ABG test, while at rest, breathing room air, less than or equal to:
 - a. 60 mm Hg, at test sites less than 3,000 feet above sea level; **or**
 - b. 55 mm Hg, at test sites less from 3,000 through 6,000 feet above sea level; **or**
 - c. 50 mm Hg, at test sites over 6,000 ft above sea level; **or**
 2. Intrapulmonary arteriovenous shunting as shown by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

- F. Hepatic encephalopathy with documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on two evaluations within a consecutive **12-month** period and at least **60 days** apart and either 1 or 2:
1. History of trans jugular intrahepatic portosystemic shunt (TIPS) or other surgical portosystemic shunt; **or**
 2. One of the following on at least **two** evaluations at least **60 days** apart within the same consecutive **12-month** period as in F:
 - a. Asterixis or other fluctuating physical neurological abnormalities; **or**
 - b. EEG demonstrating triphasic slow wave activity; **or**
 - c. Serum albumin of 3.0 g/dL or less; **or**
 - d. INR of 1.5 or greater.

OR

- G. **Two** SSA CLD scores of at least 20 within a consecutive 12-month period and at least **60** days apart. Consider under a disability from at least the date of the first score.

(Exhibit 7, pp. 67-69).

The DES representative stated that the appellant's medical records do not indicate that the appellant meets this listing. Thus, the DES reviewer determined that the appellant does not have an impairment that meets a listing or is medically equal to a listing and meets the level duration requirement and continued to Step 4.

For the rest of the review, Steps 4 and 5, both a residual functional capacity (RFC) assessment, along with the vocational assessment are determined. The RFC is the most an applicant can still do, despite his or her limitations. An applicant's RFC is based on all relevant evidence in the case record and there are federal regulations that address how DES determines RFC. (Exhibit 7, pp. 11-13, 20-22, 27). The appellant's physical RFC was completed by [REDACTED] on June 4, 2025, which indicates that the appellant can perform light work activity with consideration of:

- postural limitation for never climbing (ladders, scaffolding, etc.), and crawling;
- manipulative limitation of occasional right upper extremity overhead reaching, and:
- limiting environmental exposure to hazards (machinery, heights, etc.) related to her neck/cervical, right shoulder, and back pain. (Exhibit 7, pp. 70-73).

In completing the appellant's physical RFC, [REDACTED] noted the following:

[The appellant] has a history of cirrhosis of the liver secondary to hepatitis C in 2016. Treated with negative viral load consistent with eradication of the virus. Hep A and Hep B immune. Followed regularly by hepatologist. Recent labs show normal albumin, normal INR. Fibro scan initially showed F4 fibrosis. Recent scan shows heptoses with little evidence of any fibrosis. No ascites, no spleen enlargement. Recent abdominal pain with elevated ALT. Found to have sludge and gallstones. Gallbladder removed in [REDACTED]. Post op pain led to ERCP and biliary stent placement. No bile leak, sludge and retained stone removed. No symptoms since recovery. Discharged from follow up with surgeon. Cervical pain with radiation to right shoulder and auxiliary area led to two ER visits in [REDACTED]. CT of neck performed on second visit. Treated with prednisone, Robaxin, and oxycodone. Shoulder x-ray reported to show mild degenerative changes. 12/17/2024 MRI of C spine showed annular fissure, right paracentral disc protrusion deforming the cord but without compression or canal stenosis at C5-6. Mild left disc bulge and mild foraminal stenosis at C3-4. Progress notes from neurosurgery on 4/7/2025 felt the MRI showed a C5-6 herniated disc without high grade nerve compression. [The appellant] complained of 5/10 pain. Motor reflexes and sensation of the upper extremities were normal. Conservative treatment was recommended with surgery if she did not improve. MRI of the shoulder showed a small humeral head spur of SLAP tear and possible posterior lateral labral tear, in addition to mild supraspinatus tendinopathy. Orthopedic consultation was arranged. Cirrhosis is not currently causing any limitations. The gallbladder has been removed and her biliary

system is no longer causing limitations. (Exhibit 7, p. 72).

A mental RFC was not needed because the appellant did not report any mental health impairments, nor did her medical records document current symptoms or diagnoses. DES completed a vocational assessment, using the educational and work history reported on the appellant's supplement and her physical RFC. (Exhibit 7, pp. 60, 56-57, 23-24).

Step 4: Does the claimant retain the capacity to perform any Past Relevant Work (PRW)?

The DES representative explained that the DES reviewer listed "No" for this question. (Exhibit 7, p. 62). The appellant's employment as a waitress from 2020 to present is unclear because she did not provide the number of hours she works per week to confirm SGA. (See, Exhibit 7, p. 57). The DES reviewer concluded that the incomplete information regarding her current/past work does not alter the final determination, and the review process proceeded to Step 5.

Step 5: Does the claimant have the ability to make an adjustment to any other work, considering the claimant's RFCs, age, education, and work experience?

The DES representative explained that the DES reviewer listed "Yes" for this question, citing 3 unskilled jobs available within both the regional and national economy. (Exhibit 7, pp. 25-31, 62). The DES reviewer referenced the Occupational Employment Quarterly (OEQ) and quoted 3 jobs:

4420 – Ushers, Lobby Attendants, and Ticket Takers;
4740 – Counter and Rental Clerks; and
5400 – Receptionists and Information Clerks.

DES included sample job descriptions for the 3 quoted jobs listed above. (Exhibit 7, pp. 73-74).² DES determined that the appellant was not disabled at Step 5, using Code 231. (Exhibit 7, p. 62). The 5-step evaluation process concluded with a final review and endorsement of the disability decision by Physician Advisor (PA) [REDACTED] on June 25, 2025. (Exhibit 7, pp. 59, 75). DES mailed a disability determination denial letter to the appellant and transmitted the decision to MassHealth on June 26, 2025. (Exhibit 1, Exhibit 7, pp. 76, 48).

The DES representative testified that, in summary, the appellant does not meet the high threshold of adult SSA disability listings. Additionally, the appellant's RFC shows she can perform (light) work activity in the competitive labor market. Further, there are, within the regional/national economy, a sizable number of jobs (in one or more occupations) including requirements which the appellant can perform based on physical and mental capabilities, and her vocational qualifications. DES concluded that the appellant is not clinically eligible for SSA Title XVI level benefits and determined

² At the hearing, the DES representative explained that the sample job descriptions listed for 4740 – Counter and Rental Clerks, were incorrectly selected from the medium work list and were subsequently revised; a copy was sent to the appellant. (Exhibit 8).

that she is not disabled.

The appellant appeared at the hearing telephonically. She did not dispute her income. She explained that she disputes DES's determination. The appellant stated that she previously received CommonHealth coverage due to her medical diagnosis of cirrhosis of the liver. The appellant testified that she did not have issues with her CommonHealth coverage until this year. She stated that MassHealth testified that she is over income, but her income has not changed. Further, she argued that there are not any income requirements to qualify for CommonHealth coverage. Additionally, the appellant stated that her medical diagnoses have remained unchanged and asked what changed for DES. With respect to the PHE ending in 2023, the appellant noted that she did not have an issue with her CommonHealth coverage throughout 2024, until now.

In response, DES acknowledged that it took a while for MassHealth to review all members once the PHE ended. DES explained that there are millions of MassHealth members and therefore not everyone could be re-reviewed at the same time. The appellant stated that while she understands that she presently works and has the capability of working, she feels that the reason being given to her for denying her disability supplement is inaccurate. Further, the appellant has an upcoming neck fusion scheduled surgery scheduled in the upcoming weeks. The DES representative responded, stating that DES has records indicating that the appellant was clinically determined to be not disabled in February 2024. She explained that there may have been other factors that MassHealth took into consideration at that time, factors which DES were not privy to. Additionally, the DES representative stated that according to DES's records, post-PHE, the appellant submitted an adult disability supplement in January 2024. DES returned the appellant's supplement due to it being incomplete. The appellant re-applied at the end of January 2024, and upon receipt of all requested information, DES processed her disability supplement. In February 2024, DES determined that the appellant was not disabled from a clinical standpoint. In March 2025, the appellant submitted another disability supplement to DES. In April 2025, DES returned the appellant's supplement due to it being incomplete. Also in April 2025, MassHealth informed the appellant that her benefits were being downgraded from CommonHealth to Health Safety Net; the appellant appealed MassHealth's downgrade notice.³ During that appeal, DES explained that it was unable to move forward with its review because the appellant's Supplement received was incomplete.

The appellant asked what she can do moving forward to obtain coverage, given her upcoming medical procedure. The MassHealth representative stated that the appellant is eligible to enroll in a health plan through the Health Connector. The appellant asked if she would be able to enroll in a health plan before her scheduled medical procedure; the MassHealth representative stated that she would not be able to enroll in a plan until November 1, 2025. The appellant stated that her procedure is scheduled prior to November 1st and asked whether the medical expenses associated with her procedure would be covered by MassHealth. The MassHealth representative confirmed

³ See, Appeal 2507946.

that the appellant is currently active with Standard coverage. MassHealth stated that it is unclear how or when this change was made, however, it appears that the appellant will remain active with Standard coverage until April 2026.

Findings of Fact

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

1. The appellant is an adult female with diagnoses including cirrhosis, recent gallbladder removal with bile duct stent replacement, and right-sided pain in neck and shoulder due to complaints of bulging disc.
2. In 2020, the appellant was approved for MassHealth Adult Disability in response to the Public Health Emergency (PHE) and consistent with the federal continuous coverage requirements and MassHealth coverage protections in effect at that time.
3. On April 1, 2023, when the PHE protections were lifted, MassHealth returned to standard annual eligibility processes and all current MassHealth members were required to renew their health coverage to ensure they still qualify for their current benefits.
4. In January 2024, the appellant submitted an Adult Disability Supplement to DES; in February 2024, DES determined that she was not clinically disabled.
5. In March 2025, the appellant submitted an Adult Disability Supplement to DES. In April 2025, DES returned the appellant's Supplement because it was incomplete and in April 2025, MassHealth downgraded the appellant's benefits. The appellant appealed MassHealth's downgrade notice.
6. On March 31, 2025, DES received the appellant's completed Supplement and most medical records from her providers. On June 4, 2025 DES received outstanding medical records from her providers.
7. The appellant engaged in past (and present) relevant work as a waitress; the number of hours she presently works or previously worked per week was not reported in her Supplement.
8. DES evaluated whether the appellant has a disability using a 5-step sequential evaluation process as described within the SSA regulations at Title XX of the Code of Federal Regulations, or CFR, Chapter III, § 416.
9. At Step 1, which explores whether the applicant engaged in SGA, DES explained that this

step is waived for MassHealth purposes.

10. At Step 2, DES determined that the appellant has a severe impairment.
11. At Step 3, DES determined that the appellant does not meet listings 1:15 -disorders of the skeletal spine resulting in a compromise of a nerve root; 1:18 – abnormality of a major joint in any extremity; and 5:05-chronic liver disease because it found that there is no clinical evidence submitted to support a finding that the appellant’s impairment(s) meet any of these listings or is medically equal to any of these listings and meets the listing level duration requirement.
12. The appellant’s physical RFC indicates that recent scans show: no evidence of ascites, no spleen enlargement, no symptoms since recovery of her gallbladder removed in March 2025, normal motor reflexes and sensation of her upper extremities, cirrhosis is not currently causing limitations, and her biliary system is no longer causing limitations.
13. At Step 4, DES determined that the appellant is unable to perform past relevant work because her reported past and present employment is unclear due to missing information about the weekly hours she worked. DES concluded that the missing information does not alter its final determination.
14. At Step 5, DES determined that the appellant has the ability to make an adjustment to any other work, considering her RFCs, age, education, and work experience citing 3 unskilled jobs available in the national and regional economy.
15. At the hearing, the appellant was informed by her advocate that she is currently receiving MassHealth Standard benefits; MassHealth confirmed this information is accurate.

Analysis and Conclusions of Law

In order to be found disabled for MassHealth Standard, an individual must be permanently and totally disabled. (130 CMR 501.001). The guidelines used in establishing disability under this program are the same as those that are used by the Social Security Administration. *Id.*

Individuals who meet the Social Security Administration’s definition of disability may establish eligibility for MassHealth Standard, in accordance with 130 CMR 505.002(E). Pursuant to Title XX, § 416.905, the Social Security Administration defines disability as: 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 process of not less than 12 months.

Title XX of the Social Security Act establishes standards and the five-step sequential evaluation process. If a determination of disability can be made at any step, the evaluation process stops at that point. Step 1 considers whether an applicant is engaged in substantial gainful activity. This step is waived in MassHealth cases. Thus, the review proceeds to Step 2.

Step 2 determines whether a claimant has a medically determinable impairment (MDI) or a combination of MDIs that is both severe and meets the duration requirement. To be determined severe, a medically determinable impairment means that said impairment is expected to result in death, or which has lasted or is expected to last for a continuous process of not less than 12 months at that severity.

In the present case, the appellant was reviewed for disability due to cirrhosis, recent gallbladder removal with bile duct stent placement, and right-sided pain in neck and shoulder due to complaints of bulging disc. DES determined that the appellant's impairments have lasted or are expected to last 12 months. I find this determination is accurate. Accordingly, the appellant's impairments meet Step 2, and the review process proceeds to Step 3.

Step 3 requires the reviewer to determine whether the claimant has an impairment(s) that meets an adult SSA listing or is medically equal to a listing and meets the listing level duration requirement. The pertinent adult listings are set forth in the federal *Listing of Impairments* that can be found at 20 CFR Ch. III, Pt. 404, Subpart P, App. 1. As noted by DES, 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. Here, DES reviewed the appellant's diagnoses and determined that her impairments do not meet the high threshold of adult SSA listings and the listing level duration requirement. I find this determination is accurate.

The record reflects that the criteria set forth in listing 1:15-Disorders of the Skeletal Spine resulting in Compromise of a Nerve Root includes: a documented medical need for a walker, bilateral canes or bilateral crutches or a wheeled and seated mobility device involving the use of both hands, or an inability to use one upper extremity independently for work-related activities, involving fine and gross movements and a documented medical need for a one-handed, hand-held assistive device or an inability to use both upper extremities to the extent that neither can be used independently. In this case, the appellant's medical records do not document a medical need for a walker, nor do they indicate that the appellant is unable to use one or both upper body extremities independently. Additionally, the appellant's physical RFC indicates that as of April 7, 2025, the appellant's motor reflexes and sensation of her upper extremities were normal. (Exhibit 7, p. 72).

With respect to listing 1:18-Abnormality of a Major Joint in Any Extremity, the record reflects that the criteria set forth therein includes: chronic joint pain or stiffness and abnormal motion, instability or immobility of the affected joint, and anatomical abnormality of the affected joint(s)

noted by a physical examination or imaging, and impairment related to musculoskeletal functioning that has lasted or is expected to last for a continuous period of 12 months and medical documentation of: a medical need for a walker, etc. involving the use of both hands, or an inability to use one or both upper extremities. Here, the appellant's medical records do not indicate that she meets all requirements set forth in this listing that have lasted or expected to last for a continuous period of 12 months. As noted above, the appellant's physical RFC indicates that as of April 7, 2025, the appellant's motor reflexes and sensation of her upper extremities were normal. *Id.*

As to listing 5:05 – Chronic Liver Disease, criteria include: a) hemorrhaging from esophageal, gastric, or ectopic varices, or from portal hypertensive gastropathy, documented by imaging, resulting in hemodynamic instability indicated by signs and requiring hospitalization for transfusion of at least 2 units of blood, or b) ascites or hydrothorax not attributable to other causes, present on two evaluations within a consecutive 12-month period and at least 60 days apart, or c) spontaneous bacterial peritonitis documented by peritoneal fluid containing a neutrophil count of at least 250 cells/mm., or d) hepatorenal syndrome documented by serum creatinine elevation of at least 2mg/dL; or oliguria with 24-hour urine output less than 500mL; or sodium retention with urine sodium less than 10mEq per liter, or e) hepatopulmonary syndrome documented by arterial PaO₂ measured by an ABG test, while at rest, breathing room air, less than or equal to 60mm Hg, at test sites less than 3,000 feet above sea level; or 55 mm Hg, at test sites less from 3,000through 6,000 feet above sea level; or 50 mm Hg, at test sites over 6,000 ft above sea level; or intrapulmonary arteriovenous shunting as shown by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan, or f) hepatic encephalopathy with documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on two evaluations within a consecutive 12-month period and at least 60 days apart and either: history of trans jugular intrahepatic portosystemic shunt (TIPS) or other surgical portosystemic shunt; or one of the following on at least two evaluations at least 60 days apart within the same consecutive 12-month period and asterixis or other fluctuating physical neurological abnormalities; or EEG demonstrating triphasic slow wave activity; or serum albumin of 3.0 g/dL or less; or INR of 1.5 or greater, or g) two SSA CLD scores of at least 20 within a consecutive 12-month period and at least 60 days apart.

As noted by DES, the appellant's medical records do not indicate that she meets any of the criteria above. Further, the appellant's physical RFC indicates that there is no ascites, no spleen enlargement, her gallbladder was removed in March 2025 with no symptoms since, and that as of April 7, 2025, cirrhosis is not currently causing any limitations. Additionally, the appellant's physical RFC indicates that her biliary system is no longer causing limitations. *Id.* The review process proceeds to Step 4.

Step 4 requires the reviewer to determine whether the claimant retains the capacity to perform any past relevant work. Here, the appellant described her past and present employment a waitress

(2020-present). The appellant did not provide the number of hours she works or worked per week, however, which made her employment unclear to the reviewer to confirm SGA. Thus, DES determined that that the appellant does not retain the capacity to perform any past relevant work. I find this determination is accurate. Accordingly, the appellant's impairments meet Step 4, and the review process proceeds to Step 5.

Step 5 requires the reviewer to determine whether the claimant has the ability to make an adjustment to any other work, considering the claimant's RFCs, age, education, and work experience. Here, the DES reviewer determined that the appellant does have the ability to do so, citing 3 unskilled jobs with both the regional and national economy. As DES noted, the reviewer referenced the OEQ and quoted 3 jobs, namely:

4420 – Ushers, Lobby Attendants and Ticket Takers;
4740 – Counter and Rental Clerks; and
5400 – Receptionists and Information Clerks.

I find this determination is accurate. While the appellant testified credibly, her testimony is insufficient to meet her burden here. Thus, I find that DES was correct in determining that the appellant is not disabled, and this appeal is denied as to that issue.

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.

Kimberly Scanlon

Hearing Officer
Board of Hearings

cc.

MassHealth Representative: Sylvia Tiar, Tewksbury MassHealth Enrollment Center, 367 East Street, Tewksbury, MA 01876-1957

Disability Evaluation Services Unit