

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2511789
Decision Date:	12/1/2025	Hearing Date:	10/21/2025
Hearing Officer:	Patrick Grogan	Record Open to:	N/A

Appearance for Appellant:



Appearance for MassHealth:

Ricardo Nunez Soto, MassHealth
Charlestown,
Yvette Prayor, RN, Appeals Reviewer,
Disability Evaluation Services (DES), ForHealth
Consulting at UMass Chan Medical School

Interpreter:

N/A



*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
Decision Date:	12/1/2025	Hearing Date:	10/21/2025
MassHealth's Reps.:	Ricardo Nunez Soto, Yvette Prayor, RN	Appellant's Rep.:	██████████
Hearing Location:	Remote (Tel)	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 July 7, 2025, MassHealth notified the Appellant that the Appellant does not meet the MassHealth disability requirements. (Exhibit 1). The Appellant filed an appeal in a timely manner on August 12, 2025. (130 CMR 610.015(B); Exhibit 2) Denial of assistance is valid grounds for appeal (130 CMR 610.032).

Action Taken by MassHealth

MassHealth notified the Appellant that the Appellant does not meet the 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 Hearing by an eligibility representative and a registered nurse and appeals reviewer from Disability Evaluation Services (DES); both parties participated by telephone. The MassHealth representative testified that the Appellant is a person over [REDACTED] who sought MassHealth benefits. MassHealth explained that the Appellant resides in a household of one and has an income of \$3,923, derived from Social Security and other income. (Testimony) The Appellant confirmed the accuracy of this amount, except noting that she is currently paying \$185/month for Medicare. MassHealth testified that DES determined that the Appellant does not have a verified disability as determined by DES, and that based upon the income, the Appellant exceeds the income limit for MassHealth benefits. (Testimony) MassHealth stated that MassHealth does not count the Medicare Part B payment, however, MassHealth confirmed that removing that amount still calculated that the Appellant was over the income limit for MassHealth benefits. The Appellant confirmed that she was not contesting the income determination, rather she was seeking appeal of the DES determination. (Testimony)

The DES Nurse explained that DES assists MassHealth in determining whether an applicant meets the Social Security Administration (SSA) standard of disability from a clinical perspective. For initial disability determinations, DES follows a 5-step process outlined in SSA regulations (Title 20 Code of Federal Regulations (CFR) §416.920, Exhibit 6, pgs. 14-16), based on an applicant's medical records and disability supplement.

According to SSA (CFR §416.905, Exhibit 6, pg. 13), disability is defined as the inability to engage in substantial gainful activity due to a medically determinable physical or mental impairment expected to result in death or last at least 12 continuous months. To meet this definition, an applicant must have a severe impairment that prevents one from performing past relevant work or any other substantial work available in the regional economy. (Testimony, Exhibit 7)

Per SSA CFR §416.945 (Exhibit 6, pgs. 21-23) 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 one from doing substantial gainful activity, it is this residual functional capacity that is used to determine whether one can still do one's past work or, in conjunction with one's age, education and work experience, any other work. (Testimony, Exhibit 7)

The Appellant is an adult over the age of [REDACTED] who submitted a MassHealth Adult Disability Supplement to DES on June 11, 2025 (Exhibit 6, pg. 44). The Appellant listed multiple health problems including heart disease, coronary artery disease (CAD) hiatal hernia with pain, gastroesophageal reflux disease (GERD) and high blood pressure. (Exhibit 6, pgs. 46-47, 51) DES requested and obtained medical documentation using the medical releases that the Appellant

had provided. (Exhibit 6, pgs. 30-37).

Clinical information was received from [REDACTED] of [REDACTED] with [REDACTED]. Information was reviewed and found to be sufficient to support the Appellant's medical complaints. The disability reviewer (DR) proceeded with the 5-step evaluation. (Testimony, Exhibit 7)

Step 1 asks "Is the claimant engaging in substantial gainful activity (SGA)?" Step 1 was marked, "Yes" (Exhibit 6, pg. 53). This step is waived by MassHealth regardless of the claimant engaging in SGA, while on the federal level engaging in SGA stops the disability review in its entirety.

Step 2 asks "Does the claimant have a medically determinable impairment (MDI) or combination of MDIs (CFR §416.923, Exhibit 6, pg. 19) that is both severe and meets the duration requirement (once again impairment(s) is expected to result in death or has lasted or is expected to last for a continuous period of not less than 12 months)." The DR determined the available provider documentation was sufficient to evaluate the client's complaints and meet the severity/ duration requirements. The DR marked, "Yes" continuing to Step 3.

Step 3 asks "Does the claimant have an impairment(s) that meets an adult SSA listing, or is medically equal to a listing, and meets the listing level duration requirement?" Step 3 was marked, "No" by the DR, citing the applicable adult SSA listings considered: 4.04 – Ischemic Heart Disease (CAD, High Blood Pressure), 5.02 – Gastrointestinal Hemorrhaging from Any Cause (Hiatal hernia) and 5.06 – Inflammatory Bowel Disease (GERD) (Exhibit 6, pgs. 55-59).

For the remainder of the review—Steps 4 and 5—a Residual Functional Capacity (RFC) assessment and a vocational assessment are conducted. The RFC represents the most an applicant can still do despite their limitations. An applicant's RFC is based on all relevant evidence in the case record. (see 20 CFR § 416.945, Exhibit 6, pgs. 21-23, and § 416.920b, Exhibit 6, pgs. 17-18).

A physical RFC, completed by a DES reviewing doctor on July 2, 2025 (Exhibit 6, pgs. 60-62), indicated that the Appellant is capable of performing the full range of sedentary work activity with consideration to postural limitations (i.e. ladders, scaffolding, etc.), manipulative limitations (i.e. overhead reaching) and environmental limitations (i.e. hazards, machinery, heights, and extreme hot or cold etc.). The DR completed a vocational assessment, using the educational and work history reported on the Appellant's supplement. (Exhibit 6, pg. 52) The 5-step review process continued to Step 4.

Step 4 (Exhibit 6, pg. 54) asks, “Does the claimant retain the capacity to perform any past relevant work (PRW)?” The DR marked ‘Yes,’ citing, that the ‘Client is capable of performing past/current work as a Data Scanner.’ The DR determined the client is ‘Not Disabled/Deny.’ Decision Code 230. Review concludes at this step.

The evaluation process concluded with a final review and endorsement of the disability decision by Physician Advisor (PA) on July 7, 2025 (Exhibit 5, pgs. 51, 63). DES transmitted the decision to MassHealth and mailed a Disability Determination Denial letter (Exhibit 6, pg. 64) to the client on July 8, 2025. (Exhibit 6, pg. 41)

The DES Nurse summarized the testimony determining that the Appellant does not meet or equal the high threshold of adult SSA disability listings. Additionally, the Appellant’s RFC indicates that the Appellant can perform the full range of sedentary work activity with consideration to postural, manipulative, and environmental limitations. Finally, there are, within the regional/national economy, a significant number of jobs (in one or more occupations) having requirements which the Appellant can meet based on her mental capabilities and her vocational qualifications. The DES nurse concluded that the Appellant was correctly determined Not Disabled at Title XIV for benefits.

The Appellant, in the Fair Hearing Request, indicated that she has heart disease which does not allow her to work most jobs. (Exhibit 2) The Appellant submitted a one sentence letter from her doctor which stated that the Appellant has chronic, symptomatic heart disease which prevents the Appellant from working more than 3 hours at a time. (Exhibit 5) The Appellant explained that the Appellant has issues related to blood pressure. (Testimony) The Appellant explained that her blood pressure can spike during the day if she is on her feet. (Testimony) The Appellant explained that she was told by her doctors that she should not spend her entire workday sedentary. (Testimony) The Appellant stated that the test results that were sent by her own providers were not entirely accurate. (Testimony) The Appellant explained that she wanted to work, but her heart condition had required multiple visits to the emergency room. (Testimony) The Appellant indicated that she believes that she should be determined disabled. (Testimony)

The DES nurse explained the DES determination process, clarifying that although the Appellant has the life-long conditions described supra, the conditions do not meet the high threshold of a Social Security disability. The DES nurse explained a Residual Functional Capacity (RFC) assessment and a vocational assessment were conducted. (Testimony)

Findings of Fact

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

1. The Appellant is an adult over the age of ■ who has been diagnosed with heart disease, coronary artery disease (CAD), hiatal hernia with pain, gastroesophageal reflux disease (GERD) and high blood pressure. (Exhibit 6, pgs. 46-47, 51)
2. DES requested and obtained medical documentation using the medical releases that the Appellant had provided. (Exhibit 6, pgs. 30-37).
3. 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. (Testimony, Exhibit 6, Exhibit 7)
4. At Step 1, which explores whether an applicant engaged in SGA, DES explained that this step is waived for MassHealth purposes. (Testimony, Exhibit 6, Exhibit 7)
5. At Step 2, DES determined that the Appellant has a severe impairment. (Testimony, Exhibit 6, Exhibit 7)
6. At Step 3, the DR responded no, citing the applicable adult SSA listings considered: 4.04 – Ischemic Heart Disease (CAD, High Blood Pressure), 5.02 – Gastrointestinal Hemorrhaging from Any Cause (Hiatal hernia) and 5.06 – Inflammatory Bowel Disease (GERD) (Exhibit 6, pgs. 55-59).
7. At Step 4 (Exhibit 6, pg. 44) the disability reviewer evaluated the applicant's Past Relevant Work (PRW) and Residual Functional Capacity (RFC) and concluded that the 'Client is capable of performing past/current work as a Data Scanner. The DR determined the Appellant is no disabled. (Exhibit 6, pg. 54)

Analysis and Conclusions of Law

The Appellant has the burden "to demonstrate the invalidity of the administrative determination." Andrews v. Division of Medical Assistance, 68 Mass. App. Ct. 228 (2007). See also Fisch v. Board of Registration in Med., 437 Mass. 128, 131 (2002); Faith Assembly of God of S. Dennis & Hyannis, Inc. v. State Bldg. Code Commn., 11 Mass. App. Ct. 333, 334 (1981); Haverhill Mun. Hosp. v. Commissioner of the Div. of Med. Assistance, 45 Mass. App. Ct. 386, 390 (1998).

In order for an individual to be determined eligible for MassHealth services, the Appellant must undergo an eligibility determination. During the eligibility process, an applicant has certain rights and responsibilities. For individuals under the age of ■, the duty to cooperate is codifying within 130 CMR 501.010:

501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance. The MassHealth agency may request corroborative information necessary to maintain eligibility, including obtaining or maintaining available health insurance. The applicant or member must supply such information within 30 days of the receipt of the agency's request. If the member does not cooperate, MassHealth benefits may be terminated.

(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within ten days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated.

During this eligibility process, in order to be found disabled for MassHealth benefits, 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. The Social Security Administration requirements include the responsibilities for an applicant, which is codified within Title XX § 416.912:

§ 416.912. Responsibility for evidence.

(a) *Your responsibility* —

(1) *General.* In general, you have to prove to us that you are blind or disabled. You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled (see § [416.913](#)). This duty is ongoing and requires you to disclose any additional related evidence about which you become aware. This duty applies at each level of the administrative review process, including the Appeals Council level if the evidence relates to the period on or before the date of the administrative law judge hearing decision. We will consider only impairment(s) you say you have or about which we receive evidence. When you submit evidence received from another source, you must submit that evidence in its entirety, unless you previously submitted the same evidence to us or we instruct you otherwise. If we ask you, you

must inform us about:

- (i) Your medical source(s);
- (ii) Your age;
- (iii) Your education and training;
- (iv) Your work experience;
- (v) Your daily activities both before and after the date you say that you became disabled;
- (vi) Your efforts to work; and
- (vii) Any other factors showing how your impairment(s) affects your ability to work, or, if you are a child, your functioning. In §§ [416.960](#) through [416.969](#), we discuss in more detail the evidence we need when we consider vocational factors.

(2) *Completeness*. The evidence in your case record must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

- (i) The nature and severity of your impairment(s) for any period in question;
- (ii) Whether the duration requirement described in § [416.909](#) is met; and
- (iii) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in §§ [416.920\(e\)](#) or (f)(1) apply, or, if you are a child, how you typically function compared to children your age who do not have impairments.

(3) *Statutory blindness*. If you are applying for benefits on the basis of statutory blindness, we will require an examination by a physician skilled in diseases of the eye or by an optometrist, whichever you may select.

(b) *Our responsibility* —

(1) *Development*. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical evidence from your own medical sources and entities that maintain your medical sources' evidence when you give us permission to request the reports.

- (i) *Every reasonable effort* means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up

request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(ii) *Complete medical history* means the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier.

(2) *Obtaining a consultative examination.* We may ask you to attend one or more consultative examinations at our expense. See §§ [416.917](#) through [416.919t](#) for the rules governing the consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. We may order a consultative examination while awaiting receipt of medical source evidence in some instances, such as when we know a source is not productive, is uncooperative, or is unable to provide certain tests or procedures. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

(3) *Other work.* In order to determine under § [416.920\(g\)](#) that you are able to adjust to other work, we must provide evidence about the existence of work in the national economy that you can do (see §§ [416.960](#) through [416.969a](#)), given your residual functional capacity (which we have already assessed, as described in § [416.920\(e\)](#)), age, education, and work experience. [82 FR 5874, Jan. 18, 2017]

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.

The Appellant listed multiple health problems including heart disease, coronary artery disease (CAD) hiatal hernia with pain, gastroesophageal reflux disease (GERD) and high blood pressure. (Exhibit 6, pgs. 46-47, 51) DES determined that the Appellant's impairments have lasted or were expected to last 12 months. I find this determination is accurate. Accordingly, the Appellant's impairments meet Step 2, and the review process proceeded 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. DES reviewed the appellant's diagnoses, and determined that the impairments do not meet the high threshold of adult SSA listings and the listing level duration requirement, citing the applicable adult SSA listings considered: 4.04 – Ischemic Heart Disease (CAD, High Blood Pressure), 5.02 – Gastrointestinal Hemorrhaging from Any Cause (Hiatal hernia) and 5.06 – Inflammatory Bowel Disease (GERD) (Exhibit 6, pgs. 55-59). I find this determination is accurate.

Accordingly, 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. The reviewer selected "Yes." At Step 4 (Exhibit 6, pg. 44) the disability reviewer evaluated the applicant's Past Relevant Work (PRW) and Residual Functional Capacity (RFC) and concluded that the 'Client is capable of performing past/current work as a Data Scanner. The DR determined the Appellant is not disabled. (Exhibit 6, pg. 54) I find this determination is accurate.

The Appellant has not met the burden, by a preponderance of evidence to show the invalidity of DES' determination. While I find the Appellant testified credibly, the Appellant's testimony regarding her struggles and concerns does not invalidate DES's determination which adheres to the MassHealth Regulations as well as the Federal Code of Regulations. Therefore, I find that DES was correct in determining that the Appellant is not disabled at this time pursuant to the Regulations supra. Accordingly, 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.

Patrick Grogan
Hearing Officer
Board of Hearings

Cc:

Disability Evaluation Services: DES Appeals Unit, 333 South Street, Shrewsbury, MA 01545

MassHealth Representative: Monica Ramirez, Charlestown MassHealth Enrollment Center, 529 Main Street, Suite 1M, Charlestown, MA 02129