

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2514717
Decision Date:	1/9/2026	Hearing Date:	11/07/2025
Hearing Officer:	Patrick Grogan	Record Open to:	N/A

Appearance for Appellant:



Appearance for MassHealth:

Joseph Barbuzzi, 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:	1/9/2026	Hearing Date:	11/07/2025
MassHealth's Rep.:	Joseph BarbuZZi, Yvette Prayor, RN	Appellant's Rep.:	[REDACTED]
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 October 1, 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 October 8, 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. MassHealth explained that the Appellant resides in a household of one and has an income of \$1,321/biweekly. (Testimony) The Appellant confirmed the accuracy of the income figures and indicated 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 the SSA regulations (Title 20 Code of Federal Regulations (CFR) §416.920, Exhibit 5, pgs. 9-11), based upon an applicant's medical records and disability supplement.

According to SSA (CFR §416.905, Exhibit 5, pg. 8), 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 them from performing past relevant work or any other substantial work available in the regional economy.

In accordance with SSA CFR §416.945 (Exhibit 5, pgs. 23-25) 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.

The Appellant is an individual under the age of 65, who submitted a MassHealth Adult Disability Supplement to DES on August 29, 2025. (Exhibit 5, pg. 59) The Appellant listed the following health problems: spina bifida with lower back/leg pain and incontinence of bowel and bladder, asthma with history including lung lobe removal, major depressive disorder, as well as anxiety. (Exhibit 5, pgs. 61-62, 66) The Appellant also submitted a form entitled Health Issues along with a supplement which included additional impairments: [REDACTED], constipation, [REDACTED] of lumbar region, neurogenic bladder and bowel, scoliosis of thoracic spine, lumbosacral back pain, irregular menses, deafness in left ear, mild intermittent asthma without complication, anxiety, depression, spina bifida of thoracic region without hydrocephalus, vulvar mass, premature ovarian insufficiency and LGSIL (low-grade squamous intraepithelial lesion) on pap smear of cervix. (Exhibit 5, pgs. 66-67) DES requested and obtained medical documentation using the medical releases the Appellant had provided. (Exhibit 5, pgs. 36-48) Clinical information was received from [REDACTED] with [REDACTED]; [REDACTED] with [REDACTED] and [REDACTED] with [REDACTED]. Documentation from [REDACTED]

████████████████████ indicated that the patient did not receive services within the last 12 months. The remaining information was reviewed and found to be sufficient to support the Appellant’s medical and mental complaints. During the initial review, the disability reviewer (Exhibit 5, pg. 53) indicated that the listed impairments—vulvar mass, premature ovarian insufficiency, LGSL on PAP, and irregular menses—were not pursued, as these are not considered disabling diagnoses. Therefore, the disability reviewer (DR) proceeded with the five-step evaluation.

Step 1 (Exhibit 5, pg. 70) asks “Is the claimant engaging in substantial gainful activity (SGA)?” Step 1 was marked, “Undetermined”. 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 5, pg.17) 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: Spina Bifida (there is no SSI listing), 1.15 Disorders of the Skeletal Spine Resulting in Compromise of a Nerve Root(s), 2.10 – Hearing Loss Not Treated with Cochlear Implantation, 3.03 – Asthma, 12.04 – Depressive, Bipolar and Related Disorders, and 12.06 – Anxiety and Obsessive-Compulsive Disorders.

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 5, pgs. 23-25, and § 416.920a, Exhibit 5, pgs. 12-14)

A physical RFC was completed by a DES doctor on September 25, 2025. (Exhibit 5, pgs. 81-83). The RFC indicates that the Appellant is capable of performing the full range of light work activity with consideration to postural (i.e. climb – ladders, scaffolding, etc.) and environmental (fumes, odors, dust, gases, hazards, extreme hot or cold, humidity, etc.) limitations. A Mental RFC, completed by a DES doctor on September 26, 2025 (Exhibit 5, pgs. 84-85), indicates that the Appellant is capable of performing basic unskilled work activity with consideration to

moderate limitations in the area of maintaining attention and concentration and maintaining the ability to work at a consistent pace. The DR completed a vocational assessment, using the educational and work history reported on the client's supplement (Exhibit 5 pgs. 69, 71) (CFR 416.960, Exhibit 5, pgs. 26-27). The 5-step review process continued to Step 4.

Step 4 (Exhibit 5, pg. 71) asks, "Does the claimant retain the capacity to perform any past relevant work (PRW)?" The DR marked 'No,' citing that "past work exceeds present capabilities.' The process continued to Step 5.

Step 5 asks, "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 DR selected "Yes" citing three unskilled jobs available within both the regional and national economy (CFR §416.966, 416.967, 416.968, 416.969a, Exhibit 5, pgs. 28-34). The DR referenced the Occupational Employment Quarterly (OEQ) and quoted three categories of jobs: 4420: Ushers, Lobby Attendants & Ticket Takers, 4430: Amusement and Recreation Attendants and 5310: Interviewers, except Eligibility and Loan. The DR determined the client is 'Not Disabled' using decision Code 231. (Exhibit 5, pgs. 86-88)

The 5-step evaluation process concluded with a final review and endorsement of the disability decision by physician advisors (PAs) completed on October 1, 2025. (Exhibit 5, pgs. 68, 89) DES transmitted the decision to MassHealth and mailed a Disability Determination Denial letter (Exhibit 5, pg. 90) to the Appellant on October 3, 2025. (Exhibit 5, pgs. 51, 91)

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 physical RFC indicates that the Appellant is capable of performing the full range of light work activity with consideration to postural and environmental limitations and the Appellant's mental RFC indicates that the Appellant is capable of performing basic unskilled work activity with consideration to moderate limitations in the area of attention, concentration and pace. The DES Nurse concluded that 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 the Appellant's mental capabilities and the Appellant's vocational qualifications. The Appellant was correctly found not disabled at Title XIV for benefits.

In the Fair Hearing Request, the Appellant indicated that she disagrees with the decision because she has an active disability. (Exhibit 2) The Appellant submitted medical records spanning from the Appellant's birth into 2025. (Exhibit 7) The Appellant appeared and confirmed that she was seeking appeal of DES' determination that the Appellant is not disabled. (Testimony) The Appellant raised many issues she had regarding the application process. (Testimony) The Appellant stated that she was often provided conflicting or unclear information. (Testimony) The Appellant stated that she did not understand how she could be

approved earlier and denied during the reevaluation process. (Testimony)

The DES nurse explained that during the Public Health Emergency related to covid, evaluations and reevaluations were not performed. (Testimony) The DES nurse confirmed that the Appellant has had multiple conversations with DES. (Testimony, Exhibit 5, pg. 51) The DES nurse began to explain what records were reviewed. (Testimony) The Appellant interrupted the DES nurse to expound upon her ailments and her difficulties regarding obtaining appointments with various providers. (Testimony) The Appellant raised issues with her past care and her PCP. (Testimony). The Appellant indicated that her PCP should have sent her various referrals. (Testimony) Without those referrals, the Appellant stated that she was unable to demonstrate her current conditions to support a disability determination. (Testimony)

Within the Appellant's submitted medical records spanning from the Appellant's birth into 2025, the records are predominately older, however, there are recent reports included regarding 2025 visits. In a recent May of 2025 office visit, it notes that the Appellant's asthma symptoms are "well controlled off maintenance inhalers" although a worsening of asthma symptoms was noted in recent years. (Exhibit 7, pg. 3) In a recent August of 2025 note, it highlights that the Appellant's left kidney is normal sized, and the right kidney is small for the Appellant's age, with no gross evidence of scarring, nor hydronephrosis, concluding the results are an "otherwise unremarkable scan." (Exhibit 7 pgs. 50-51) In a recent September 2025 procedure note, it reviews the Appellant's spinal scan results and concludes "of note, the findings appear similar to prior MRI from 1999." (Exhibit 7, pg. 50)

Additionally, within DES' submission are various documents related to the Appellant's counseling. Within an intake session note, dated from April of 2025, it notes that the Appellant is "ambitious and motivated for treatment, and will be utilizing different modalities to support her and her needs and develop healthy coping skills to manage her depression and anxiety." (Exhibit 5, pg. 113) The note further indicated the Appellant is employed full time; however the Appellant would be seeking alternate employment due to dissatisfaction with management and dramas. (Exhibit 5, pg. 113) In an August 2025 discharge note, it stated that the Appellant "did not spend too much time with biweekly sessions, she would have benefited with continued therapy." (Exhibit 5, pg. 101) The note stated that the Appellant had not been seen in four months. (Exhibit 5, pg. 101)

The DES nurse indicated that the submitted documentation demonstrated stability with her conditions. (Testimony, Exhibit 5) The Appellant listed various medical issues and various hospitalizations in the prior year. (Testimony) The DES nurse explained that this information was not within the submitted documentation. (Testimony) The DES nurse asked the Appellant about various dates regarding doctor and hospital visits and clarified that they were not hospitalizations but rather visits to the hospital for care and treatment, which information was contained within the Appellant's submitted medical records. (Testimony, Exhibit 5, Exhibit 7) The Appellant then expounded on the expenses she incurs for medical equipment and her

concerns regarding losing health insurance coverage. (Testimony)

Findings of Fact

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

1. The Appellant is an adult under the age of 65 who has been diagnosed with spina bifida with lower back/leg pain and incontinence of bowel and bladder, asthma with history including lung lobe removal, major depressive disorder, anxiety, as well as other diagnoses. (Exhibit 5, pgs. 61-62, 66)
2. The Appellant also submitted a form entitled Health Issues along with a supplement which included additional impairments including dysmenorrhea, constipation, [REDACTED] of lumbar region, neurogenic bladder and bowel, scoliosis of thoracic spine, lumbosacral back pain, irregular menses, deafness in left ear, mild intermittent asthma without complication, anxiety, depression, spina bifida of thoracic region without hydrocephalus, vulvar mass, premature ovarian insufficiency and LGSIL(Low-grade squamous intraepithelial lesion) on pap smear of cervix. (Exhibit 5, pgs. 66-67)
3. DES requested and obtained medical documentation using the medical releases that the Appellant had provided. (Exhibit 5, pgs. 36-34).
4. 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 5, Exhibit 6)
5. At Step 1, which explores whether the applicant engaged in SGA, DES explained that this step is waived for MassHealth purposes. (Testimony, Exhibit 5, Exhibit 6)
6. At Step 2, DES determined that the Appellant has a severe impairment. (Testimony, Exhibit 5, Exhibit 6)
7. At Step 3, the DR responded no, citing the applicable adult SSA listings considered: Spina Bifida (there is no SSI listing), 1.15 Disorders of the Skeletal Spine Resulting in Compromise of a Nerve Root(s), 2.10 – Hearing Loss Not Treated with Cochlear Implantation, 3.03 – Asthma, 12.04 – Depressive, Bipolar and Related Disorders, and 12.06 – Anxiety and Obsessive-Compulsive Disorders.
8. At Step 4, the disability reviewer evaluated the applicant's Past Relevant Work (PRW) and Residual Functional Capacity (RFC) and concluded no, citing that “past work

exceeds present capabilities.' The process continued to Step 5.

9. At Step 5, determining whether the Appellant has the ability to make an adjustment to any other work, the DR indicated affirmatively, citing other job descriptions that the Appellant should be able to perform from the Occupational Employment Quarterly (OEQ). Specifically, the DR listed the following: 4420: Ushers, Lobby Attendants & Ticket Takers, 4430: Amusement and Recreation Attendants and 5310: Interviewers, except Eligibility and Loan. The DR determined the client is 'Not Disabled' using decision Code 231.

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 65, 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 spina bifida with lower back/leg pain and incontinence of bowel and bladder, asthma with history including lung lobe removal, major depressive disorder, as well as anxiety. (Exhibit 5, pgs. 61-62, 66) The Appellant also submitted a form entitled *Health Issues* along with a supplement which included additional impairments including dysmenorrhea, constipation, [REDACTED] of lumbar region, neurogenic bladder and bowel, scoliosis of thoracic spine, lumbosacral back pain, irregular menses, deafness in left ear, mild intermittent asthma without complication, anxiety, depression, spina bifida of thoracic region without hydrocephalus, vulvar mass, premature ovarian insufficiency and LGSIL(Low-grade squamous intraepithelial lesion) on pap smear of cervix. (Exhibit 5, pgs. 66-67) DES determined that the Appellant's impairments have lasted or 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. 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: Spina Bifida (there is no SSI listing), 1.15 Disorders of the Skeletal Spine Resulting in Compromise of a Nerve Root(s), 2.10 – Hearing Loss Not Treated with Cochlear Implantation, 3.03 – Asthma, 12.04 – Depressive, Bipolar and Related Disorders, and 12.06 – Anxiety and Obsessive-Compulsive Disorders. 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 "no" citing that "past work exceeds present capabilities." I find this determination is accurate.

At Step 5, determining whether the Appellant has the ability to make an adjustment to any other work, the DR indicated affirmatively, citing other job descriptions that the Appellant should be able to perform from the Occupational Employment Quarterly (OEQ). Specifically, the DR listed the following: 4420: Ushers, Lobby Attendants & Ticket Takers, 4430: Amusement and Recreation Attendants and 5310: Interviewers, except Eligibility and Loan. The DR determined the client is 'Not Disabled' using decision Code 231. 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. The Appellant's statement that without referrals from her PCP she is unable to show her current conditions is belied by the submissions the Appellant provided. (Exhibit 7) The Appellant provided documentation from May of 2025 indicating that the Appellant's asthma symptoms are "well controlled off maintenance inhalers." (Exhibit 7, pg. 3) In the August of 2025 note, it highlights that the Appellant's left kidney is normal sized, and the right kidney is small for the Appellant's age, with no gross evidence of scarring, nor hydronephrosis, concluding the results are an "otherwise unremarkable scan." (Exhibit 7 pgs. 50-51) In the September 2025 procedure note, it reviews the Appellant's spinal scan results and concludes "of note, the findings appear similar to prior MRI from 1999." (Exhibit 7, pg. 50)

These submissions by the Appellant highlight the stability that she has exhibited with her medical conditions. In addition to these notes within the Appellant's submission, DES also reviewed counseling notes, which show initial intake, but upon discharge in August, indicate that the Appellant had not been seen in four months. (Exhibit 5, pg. 101) The intake note from April of 2025 indicated that the Appellant had been employed, full-time, but was seeking a different job due to dissatisfaction with management and workplace drama. (Exhibit 5, pg. 101)

While the Appellant testified regarding her struggles and concerns regarding her conditions, this testimony does not invalidate DES' determination which adheres to the MassHealth Regulations as well as the Federal Code of Regulations. Also, the DES finding of medical stability is buttressed by the Appellant's own submissions, highlighting the Appellant's medical stability. (Exhibit 7) The Appellant's complaints regarding her provider, referrals, and scheduling appointments are contrary to the information that was provided on behalf of the Appellant, incorporated in DES' determination. The Appellant submitted recent office notes and reports from the spring, summer and fall of 2025. (Exhibit 7) 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

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

Disability Evaluation Services (DES)