August 1, 2019

Hon. Sarah R. Smisek
1925 Breton Road, SE
Suite 200
Grand Rapids, MI 49506

RE: **Jane Doe**
SSN: **999-99-9999**
DOB: **9/9/9999**
AOD: **10/15/2016**
DLI: **6/30/2020**
CLAIM: **T2, T16**

Dear Hon. Smisek:

Case Theory

The claimant has medically determinable medical conditions that are severe, have prevented engaging in substantial gainful activity for more than 12 months, and preclude return to work or engaging in work at any exertional level. Therefore, she is disabled under the meaning of the Social Security Act, as amended, and eligible at Step Five of the sequential adjudication process.

Case Foundation

The claimant filed for Social Security Disability Insurance Benefits (DLI 6/30/20) and Supplemental Security Income on May 8, 2018, with an alleged onset date of November 15, 2016. The claimant's date of birth is September 9, 9999; thus, she was a younger individual at the onset of disability and has remained so throughout the period of adjudication. She achieved a GED. The claimant is not currently engaged in substantial gainful activity, nor has she since the onset of disability.

The evidence, as set forth below, demonstrates that the claimant's severe impairments include: low back pain; bilateral sciatica; bilateral leg weakness and numbness; anterior bilateral tibial weakness; cervicalgia; headache; chronic pain syndrome; spondylosis without myelopathy or radiculopathy, lumbar region; spondylosis without myelopathy or radiculopathy, lumbosacral region; spondylosis without myelopathy or radiculopathy, cervical region; PTSD; major depressive disorder, recurrent; and mood disorder. The state agency found that the claimant has four medically determinable impairments: (1) Spine disorders; (2) Migraine; (3) Depressive, bipolar, and related disorders; and (4) Trauma and stressor related disorders (3A/9).

The claimant's well documented medical history provides substantial credibility to the claim (see attached Chronological Summary of Supportive Medical Evidence). In considering the claimant's symptoms, there are underlying medically determinable

impairments that could reasonably be expected to produce the claimant's low back pain; bilaterally leg weakness; anxiety; depression; and fatigue. The claimant has medically determinable medical conditions that are severe, have prevented engaging in substantial gainful activity for more than 12 months, and preclude return to work or engaging in work at any exertional level. Therefore, she is disabled under the meaning of the Social Security Act, as amended, and eligible at Step five of the sequential adjudication process.

Respectfully submitted,

John Doe, MS, CRC, SDA, CBIS, MSCC, ADR
Accredited Disability Representative

CHRONOLOGICAL SUMMARY OF SUPPORTIVE MEDICAL EVIDENCE

DATE	File Page	SOURCE *(Quotation marks indicate verbatim from MER; italics and/or highlighting by Representative for clarity and emphasis)*
8/13/16	5F/9-10	**Spectrum Health Medical Group, Lumbar Spine MRI**, Findings: L5-S1: There is minimal facet arthropathy resulting in no significant spinal canal or neural foraminal stenosis.
1/4/18-5/24/18	3F/1-89	The claimant was seen at **Spectrum Health Medical Group-Psychiatry** with Sarah Frantz, LMSW, for the treatment of PTSD and severe, single, episode of major depressive disorder without psychotic features.
1/8/18-2/20/18	1F/1-30	The claimant was seen at **Spectrum Health Rehabilitation Services** for physical therapy for the treatment of chronic bilateral low back pain with bilateral sciatica and chronic cervical pain.
1/31/18	1F/20-22	**Spectrum Health Rehabilitation Services, Erik Lueck, PT**, Physical Therapy Notes, Assessment: Mr. Lueck reported that the claimant had significant lumbar pain. He noted that the claimant had to ask her teenage daughters to help with the caring for their four-month-old and four-year-old siblings, but did not want to put too much responsibility on her children. Mr. Lueck stated that he found on palpation: (1) Hypertonic in the erector spinae; (2) tenderness of the erector spinae; (3) unable to activate left transverse abdominals, left multifidus; right transverse abdominals, and right multifidus; (4) positive crossed straight leg raising and passive straight leg raising on the left; and (5) positive crossed straight leg raising and passive straight leg raising on the right. Assessment: Chronic bilateral low back pain with bilateral sciatica and chronic cervical pain.
4/11/18	5F/4-5	**Michigan Primary Care Partners, Naeem Haider, M.D., Office Visit Notes**, History of Present Illness: Dr. Haider reported that the claimant presented with complaints of mid to low back pain, migraine. The claimant stated that she developed pain four years earlier when she gave birth to her third child and received an epidural placement performed by two different physicians. She added that she had a blood patch performed for leaking spinal fluid. The claimant noted worsening pain that occurred in the back, legs, feet, neck, and head. She described the pain as constant, aching, sharp, stabbing, cramping, throbbing, shooting, burning, and severe in intensity. The claimant added that she did experience numbness and tingling in her back, legs, feet, and fingertips. She reported that the pain was improved with rest and medication. The claimant stated that her pain was aggravated by movement and staying still for too long. Dr. Haider assessed the claimant with low back pain; cervicalgia; headache; chronic pain syndrome; spondylosis without myelopathy or radiculopathy, lumbar region; spondylosis without myelopathy or radiculopathy, lumbosacral region; spondylosis without myelopathy or radiculopathy, cervical region.

5/4/18	5F/2-3	**Michigan Primary Care Partners, Naeem Haider, M.D., Operative Report**, Pre-operative diagnosis: Lumbar Spondylosis, lumbosacral spondylosis. Post-Operative diagnosis: Lumbar Spondylosis, lumbosacral spondylosis. Procedure performed: (1) facet joint intra-articular injection bilaterally at L4-L5 and L5-S1; (2) Conscious sedation to help perform the procedure with as little pain as possible; and (3) Fluoroscopic examination for needle placement.
6/12/18-9/25/18	9F/1-79	The claimant was seen at **Spectrum Health Medical Group-Psychiatry** by Sarah Frantz, LMSW for the treatment of PTSD; recurrent, major depressive disorder, in partial remission; and mood disorder with minimal improvement.
7/15/18	8F/4-5	**Spectrum Health Neurology, Cervical Spine MRI,** Findings: C6-C7: There is minimal uncovertebral spurring resulting in no significant spinal or neural foraminal stenosis.
8/3/18	14F/108-114	**West Michigan Pain, Naeem Haider, M.D., Operative Report**, Pre-operative Diagnosis: Cervical spondylosis. Post-operative Diagnosis: Cervical spondylosis. Procedure performed: (1) Bilateral C5-C6 and C6-C7 facet joint injection and (2) Fluoroscopic examination for needle placement.
9/20/18	8F/7-10	**Spectrum Health Neurology, Christopher A. Kobat, M.D., Office Visit Notes**, Review of Systems: Dr. Kobat reported that a review of symptoms was positive for fatigue; visual disturbance; chest pain; abdominal pain; arthralgias; back pain; gait problem; neck pain; neck stiffness; dizziness; tremors; weakness; light-headedness; numbness; headaches; decreased concentration; sleep disturbance; and anxiety. He noted that the claimant's past medical history included: adjustment disorder; arachnoiditis; asthma; bronchitis; cervicitis; chronic pain syndrome; depression; dysfunctional uterine bleeding; generalized anxiety disorder; headache; HPV; and lumbar pain. Upon examination, Dr. Kobat assessed the claimant with bilateral leg weakness and numbness. He added that the claimant has an unclear etiology of episodic leg weakness which had reportedly been causing her to fall frequently. Dr. Kobat noted that the claimant did appear to have some anterior bilateral tibial weakness as well as some decreased sensation to light touch in her lower extremities. He recommended an electromyography.
8F/7-10	10F/1-4	**Michigan Primary Care Partners, Mark Clark, M.D., Office Visit Notes,** History of Present Illness: Dr. Clark reported that the claimant presented for a medication follow-up. He stated that a review of symptoms found that the claimant was experiencing abdominal pain; back and neck pain; severe headaches; depression; sleep disturbances; and fatigue. Dr. Clark reported that a physical examination revealed the claimant had an antalgic gait; tenderness to palpation over the bilateral lower lumbar facet joints; tenderness over the right sacroiliac; tenderness to palpation over the lumbar paraspinal musculature on the right; tenderness to palpation over the lumbar paraspinal musculature on the left; and pain with lumbar extension and ipsilateral rotation. He assessed the claimant with chronic pain syndrome; spondylosis without myelopathy; long term current use of opiate analgesic drugs; and cervical spondylosis without myelopathy.