The Honorable John Doe
Office of Hearings Operations
111 Federal Plaza
Anywhere, MI 12345-6789

RE:	**Jane Doe**
SSN:	**XXX-XX-XXXX**
DOB:	**January 1, 1960**
AOD:	**January 1, 2020**
DLI:	**September 1, 2023**
CLAIM:	**DIB**

Dear Judge Doe,

Please accept this brief narrative regarding Ms. Jane Doe (claimant), born January 1, 1900, (an individual closely approaching advanced age) outlining the medical impairments that prevent the claimant from performing any substantial gainful activity. The claimant has medically determinable medical conditions that are severe, have prevented in 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. Additionally, the claimant is closely approaching advanced age; a high school graduate – does not provide direct entry into skilled work; semi-skilled to skilled previous work experience, with no transferrable skills; and limited to less than sedentary work activity; therefore, grid rule 201.14 directs a finding of disability.

Background

The evidence, as summarized below, establishes that the claimant's severe impairments include: 1. Diagnosis of left breast cancer in 2007 with lumpectomy, chemotherapy, and radiation. 2. Lymphedema of the upper left extremity. 3. Diverticulitis and irritable bowel syndrome since 2012, status post a partial colon resection, with abdominal pain. 4. Uterine cancer since 2013 with a radical hysterectomy with hernias. 5. Anemia with past blood transfusion. 6. Bilateral knee pain. 7. Status post bilateral knee surgery. 8. Atelectasis since 2020. 9. Unilateral primary osteoarthritis, left knee. 10. Other tear of lateral meniscus, current injury, left knee. 11. Lumbago with sciatica with lumbar radiculopathy, status post laminectomy and fusion. 12. Cervicalgia. 13. Spinal stenosis. 14. Degenerative disc disease. 15. Major depressive disorder. The State agency finds that the claimant has three severe medically determinable impairments: (1) Abnormality of a Major Joint in Any Extremity; (2) Disorders of the Skeletal Spine; and (3) Chronic Bronchitis. (Exhibit 3A/13) The claimant achieved a high school diploma. (Exhibit 3A/19) Her past relevant work includes: secretary and real estate agent. (Exhibit 3A/18)

Due to her severe impairments, the claimant can no longer sit, stand, or walk for prolonged periods of time. The medical and opinion evidence of the record, as summarized herein, demonstrates why the claimant should be found disabled with a less than sedentary residual functional capacity.

Selected Treatment, Physical Examination and Findings

The Medical Assessment of Ability to do Work-Related Activities (Physical) completed by Maria Smith, M.D. on September 14, 2021 stated that the claimant can: (1) occasionally lift five pounds; (2) frequently lift three pounds; (3) stand/walk 10-15 minutes at one time without interruption; (4) stand/walk for three hours total during an eight hour workday; (5) sit for 20 minutes at one time without interruption; (6) sit for three hours total during an eight hour workday; (7) never climb, kneel, balance, crouch, and crawl; (8) reaching and pushing/pulling are affected by her impairment; and (9) temperature extremes, vibrations, moving machinery, and humidity are affected by her impairments. Dr. Smith reports that the medical findings to support her assessment include: bilateral knee pain from meniscal tear status post arthroscopic surgery; lumbago with sciatica with lumbar radiculopathy; status post laminectomy and fusion; cervicalgia; decreased range of motion of the cervical spine, lumbar spine, and bilateral knee; spinal stenosis; and degenerative disc disease. She opines that the claimant will be absent from her job four to six days a month due to her impairments. Dr. Smith notes that the claimant will require unscheduled breaks during an eight-hour workday. (Exhibit 17F/1-3)

The Medical Source Statement of Ability to do Work-Related Activities completed by Anisha Smith, FNP-C on March 22, 2022 states that the claimant can: (1) occasionally lift up to 20 pounds; (2) never lift over 21 pounds; (3) occasionally carry up to 20 pounds; (4) never carry over 21 pounds; (5) sit for one hour at one time without interruption; (6) stand for 30 minutes at one time without interruption; (7) walk for 30 minutes at one time without interruption; (8) sit for four hours total during an eight hour workday; (9) stand for two hours total during an eight hour workday; (10) walk for one hour total during an eight hour workday; (11) when not engaged in sitting, standing, or walking the claimant requires alternate sitting, standing, and walking and stretching; (12) requires the use of a medically necessary cane to ambulate; (13) occasionally operate foot controls; (14) never climb ladders or scaffolds, kneel, or crouch and occasionally climb stairs and ramps, balance, stoop, and crawl; (15) never tolerate exposure to moving mechanical parts and occasionally tolerate unprotected heights; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces or climb a few steps at a reasonable pace with the use of a single hand rail. Ms. Jacob reports that the medical findings that support this assessment include: cervical paravertebral tenderness to palpation, positive Spurling's test, pain with active range of motion, thoracic and lumbar paravertebral tenderness to palpation, and positive straight leg raising. She adds that the claimant is unable to work. (Exhibit Anisha Smith, FNP RFC/1-7)

The Medical Source Statement of Ability to do Work-Related Activities completed by Maria Smith, M.D. on April 20, 2022 states that the claimant can: (1) occasionally lift up to ten pounds; (2) never lift 11 pounds or more; (3) never carry up to ten pounds; (4) sit for 20 minutes at one time without interruption; (5) stand for 15 minutes at one time without interruption; (6) walk for ten minutes at one time without interruption; (7) sit for three hours total during an eight hour workday; (8) stand for two hours total during an eight hour workday; (9) walk for one hour total during an eight hour workday; (10) must lie down or sit on a recliner with her leg elevated for the rest of the time during an eight hour workday; (11) occasionally reach overhead, reach, and push/pull with the right hand; (12) never reach overhead and occasionally reach, handle, and push/pull with the left hand; (13) occasionally operate foot controls; (14) never climb stairs and ramps, climb ladders or scaffolds, balance, kneel, and crawl; (15) never tolerate exposure to unprotected heights, moving mechanical parts, humidity and wetness, extreme cold, extreme heat, and vibrations and occasionally tolerate exposure to operating a motor vehicle and dust, odors, fumes, and pulmonary irritants; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces, use standard public transportation, and climb a few steps at a reasonable pace with the use of a single hand rail. Dr. Smith identifies the clinical findings which support this assessment as: low back pain radiating to the bilateral lower extremity; status post laminectomy/discectomy fusion; neck pain radiating to the bilateral upper extremities; status post ACDF; bilateral knee pain; status post arthroscopic; cervical, lumbar, and knee range of motion and tenderness, decreased sensation bilateral lower extremity, and left shoulder weakness. She adds that the claimant's concentration can be affected by pain and the use of muscle relaxers. Dr. Smith opines that the claimant will miss five to six days of work per month due to her impairments. She notes that the claimant's limitations have lasted 12 consecutive months. (Exhibit Medical Source Statement of Dr. Herrera/1-6)

Diagnostic Testing

Lumbar Spine MRI - July 12, 2017 - Smith Radiology, Impression: 1. Moderate multilevel change without high-grade spinal canal stenosis. 2. Mild to moderate multilevel neural foraminal stenosis. (Exhibit 2F/50-51)

Cervical Spine MRI - August 13, 2017 - Stand-Up MRI, Impression: 1. C3-C4, C4-C5, C5-C6, and C6-C7 disc herniations deforming the thecal sac abutting the spinal cord, with increased conspicuity on extension view at C3-C4, C4-C5 Grade one spondylolisthesis, C5-C6 and C6-C7 bilateral neural foraminal extension abutting the exiting nerve roots contributing to bilateral neural foraminal narrowing at both levels, in addition to C5-C6 mild central spinal stenosis in conjunction with hypertrophic changes. 2. C2-C3 and C7-T1 disc bulges. 3. Cervical spine straightening. (Exhibit 2F/56-57)

Right Hip MRI - August 14, 2017 - Stand-Up MRI, Impression: 1. Edema and inflammation in the peritrochanteric soft tissues. 2. Trace fluid accumulating posteriorly at the femoroacetabular articulation. 3. Tiny subcortical cyst at the lateral margin of the femoral head approximately one to two millimeters in size. (Exhibit 2F/51-52)

Right Knee MRI - August 15, 2017 - Stand-Up MRI, Impression: 1. Inhomogeneity and strain of the anterior cruciate ligament with pericruciate edema. 2. Pericapsular edema at the anterolateral capsular margin. 3. Strain of the iliotibial band at tibial attachment site. 4. Tear involves the lateral meniscal body extending obliquely to the inferior meniscal surface. 5. Distal quadriceps tendinosis/tendinopathy. 6. Patellofemoral joint space narrowing and a component of lateral patellar subluxation. 7. Thinning and chondromalacia of the lateral patellar facet superiorly. 8. Trace fluid at the semimembranous-medial gastrocnemius bursa. 9. Trace fluid inferior in Hoffa fat pad as well as at the patellofemoral and anterior tibiofemoral articulations. 10. Edema in the prepatellar subcutaneous tissues. 11. Insertional patellar tendinosis/tendinopathy present. (Exhibit 2F/54-55)

Electrodiagnostic Report - August 24, 2017 - John Smith, D.C., Impression: Lumbar radiculopathy can be objectively confirmed with lateral bending radiographic studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate away from the side of lateral bending, which is contrary to normal motion toward the side of lateral bending. He added that findings suggest pathology of: 1. Mild left (L4) saphenous nerve. 2. Marked right (L5) peroneal nerve. 3. Moderate left (L5) peroneal nerve. (Exhibit 2F/18-19)

Lumbar Spine-Outside Read MRI - August 30, 2017 - Stand-Up MRI, Impression: 1. L4-L5 and L5-S1 disc herniations deforming the thecal sac contributing to central spinal stenosis in conjunction with facet and ligamentous hypertrophic changes (moderate at L4-L5, mild at L5-S1) with L5-S1 abutment of the proximal S1 nerve roots bilaterally, and L4-L5 abutment of the proximal L5 nerve roots bilaterally and bilateral neural foraminal extension abutting the exiting L4 nerve roots. 2. L3-L4 and L2-L3 disc bulges. (Exhibit 2F/63-64)

Thoracic Spine MRI - September 5, 2017 - Stand-Up MRI, Impression: 1. T7-T8 and T10-T11 disc herniations deforming the thecal sac with T7-T8 cord abutment and T10-T11 right paracentral orientation. 2. T2-T3 and T3-T4 right paracentral disc bulges. 3. Dextroscoliosis. (Exhibit 2F/58-59)

Lumbar Spine EMG/NCS - September 12, 2017 - Smith Medical, Impression: Evidence of bilateral L5-S1 radiculopathy. (Exhibit 2F/77-79)

Upper Extremity EMG/NCS - October 10, 2017 - Smith Medical, Impression: Evidence of bilateral C6-C7 radiculopathy. (Exhibit 2F/68-72)

Electrodiagnostic Report - October 12, 2017 - John Smith, D.C., Impression: Cervical radiculopathy can be objectively confirmed by lateral bending radiographic studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate toward the side of head tilt, which is contrary to normal motion away from the side head tilt. He added that findings suggest pathology of: 1. Marked right

(C5) axillary nerve. 2. Moderate left (C5) axillary nerve. 3. Moderate right (C6) radial nerve lateral branch. 4. Marked left (C6) radial nerve lateral branch. (Exhibit 2F/25-26)

Electrodiagnostic Report - December 14, 2017 - John Smith, D.C., Impression: Lumbar radiculopathy can be objectively confirmed with lateral bending radiographic studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate away from the side of lateral bending, which is contrary to normal motion toward the side of lateral bending. He added that findings suggest pathology of: 1. Mild right (L5) peroneal nerve. 2. Moderate left (L5) peroneal nerve. 3. Marked bilateral (S1) sural nerve. (Exhibit 2F/32-33)

Cervical Spine CT - January 8, 2018 - Smith Radiology, Impression: 1. At C6-C7 disc osteophytic ridging and uncovertebral hypertrophy results in moderate to severe left and mild-to-moderate right foraminal stenosis. 2. There is mild to moderate central canal stenosis. 3. At C5-C6 there is mild to moderate foraminal stenosis. (Exhibit 2F/48-49)

Lumbar Spine MRI - January 15, 2018 - Smith Hospital Medical Center, Impression: Disc bulges and/or degenerative changes are responsible for varying degrees of spinal canal stenosis and neural foraminal encroachment throughout the lumbar spine. (Exhibit 5F/19-20)

Left Knee MRI - January 18, 2019 - Smith Radiology, Impression: 1. Lateral meniscal tear. 2. Moderate sized popliteal cyst. 3. Small knee joint effusion. 4. Low-grade chondromalacia patella and low-grade chondromalacia medial compartment. (Exhibit 6F/62-63)

Left Knee MRI - January 27, 2020 – Smith Radiology, Impression: 1. Interval increase in size of a horizontal tear through the anterior horn and body of the lateral meniscus with progressive lateral compartment chondromalacia compared with the previous exam which is now moderately advanced. 2. Mild free edge fraying of the medial meniscus with mild to moderate generalized medial compartment chondromalacia. 3. Mild to moderate generalized patellofemoral compartment chondromalacia which appears progressed compared with the previous study. (Exhibit 6F/64-65)

Mastoid CT - June 22, 2020 - Smith Hospital Medical Center, Impression: 1. Right temporal bone: Intact middle and inner ear structures. 2. Left temporal bone: soft tissue within the external canal typically inflammatory or possibly infectious, without significant erosive disease, confluent with the tympanic membrane. Contiguous otitis abuts the ossicular chain without displacement or erosion, Mild mastoid effusion. Intact inner ear structures. 3. Small left parotid nodules likely intraparotid lymph nodes. (Exhibit 5F/85)

Left Knee MRI - August 31, 2020 – Smith Radiology, Impression: 1. Small-to-moderate joint effusion. 2. Small popliteal cyst. 3. Surface extension of signal and the lateral meniscus is unchanged compared to prior studies and may represent chronic tearing or postoperative change related to prior debridement. 4. Minimal osteoarthritis. (Exhibit 6F/66-67)

Chest Radiograph - January 19, 2021 - Smith Radiology, Impression: Mild linear scarring versus subsegmental atelectasis of the left lower lung zone. (Exhibit 11F/22)

Spirometry Report - January 21, 2021 - Smith Radiology, Impression: Mild restriction. Post bronchodilator test not clearly improved. (Exhibit 11F/23)

Chest CT - February 13, 2021 - Smith Radiology, Impression: 1. Small focus of right lower lobe ground glass like density possibly infectious in nature. 2. Micronodules. (Exhibit 11F/19-20)

Cervical Spine Imaging - July 23, 2021 - Smith Radiology, Impression: 1. Straightening and reversal of the lordotic curvature cervical spine possibly due to spasm. 2. Anterior fusion discectomy and discoplasty at the level of C5, C6, and C7 with satisfactory position of hardware. (Exhibit 23F/70-71)

Abdominal Ultrasound - August 16, 2021 – Smith Radiology, Impression: Fatty liver. (Exhibit 15F/11-12)

Surgical Procedures

The January 31, 2018 operative report completed by George Smith, M.D. stated that the claimant underwent: 1. C5-C6, C6-C7 anterior cervical discectomy and fusion. 2. Use of titanium gauge six millimeter filled with DBX allograft and autograft. 3. Use of plate. 4. Use of operative microscope. 5. Use of fluoroscopy. Indications: Bilateral radicular pain and severe neck pain. An MRI showed disc degeneration and bilateral foraminal narrowing at C5-C6 and C6-C7. (Exhibit 5F/29-30)

The April 25, 2018 operative report completed by George Smith, M.D. stated that the claimant underwent: 1. L4-S1 laminectomy, mesial facetectomy, bilateral foraminotomy. 2. L4-S1 instrumented fusion. 3. L4-S1 posterolateral fusion using autologous bone and Actifuse. 4. Use of fluoroscopy. Indications: Significant back pain and bilateral radicular symptoms alternating between right and left side. An MRI showed significant facet hypertrophy. (Exhibit 5F/50-52)

The April 25, 2018 operative report completed by Augusto Smith, M.D. stated that the claimant underwent: 1. Bilateral paraspinal muscle flap advancement for coverage of bone graft with vascularized muscle, obliteration of dead space, and hardware coverage. 2. Complex wound closure, 11.0 centimeters. Preoperative diagnoses: Lumbar stenosis with neurogenic claudication status post L4-S1 decompression fusion with image. Postoperative diagnoses: Lumbar stenosis with neurogenic claudication status post L4-S1 decompression fusion with image. (Exhibit 3F/5-6)

The October 15, 2018 operative report completed by Anthony Smith, M.D. stated that the claimant underwent a: 1. Right hip injection of the greater trochanter bursa region. 2. Right knee arthroscopy. 3. Arthroscopic partial lateral meniscectomy. 4. Arthroscopic

patellofemoral, lateral tibial plateau, and medial femoral condyle chondroplasty. 5. Extensive debridement infrapatellar fat pad and anterior synovial thickening. Preoperative diagnoses: Right knee lateral meniscal tear. 2. Chondromalacia. 3. Right hip bursitis. Postoperative diagnoses: 1. Findings of underlying tearing in the body of the meniscus extending into the posterior horn with associated lateral compartment, patellofemoral compartment, and medial femoral condyle chondromalacia. 2. Markedly thickened infrapatellar fat pad. (Exhibit 6F/68-70)

Summary of Clinical and Medical Treatment

The July 12, 2017 Lumbar Spine MRI performed by Smith Radiology reveals: 1. Moderate multilevel change without high-grade spinal canal stenosis. 2. Mild to moderate multilevel neural foraminal stenosis. (Exhibit 2F/50-51)

The July 28, 2017 initial narrative of John Smith, D.C. stated that the claimant presented after being the restrained driver in a May 17, 2017 automobile accident. Dr. Dimitri reported that the claimant complained of cervical spine pain with muscle spasms; decreased cervical ranges of motion; radiating pain in the upper trapezius muscle of the left arm; upper thoracic spine pain; lumbar spine pain with muscle spasms; decreased lumbar ranges of motions; radiating pain into the right leg; thoracic spine pain at the level of T1-T6, bilaterally, right hip pain; and right knee pain. He found that a physical examination revealed: **(1) decreased cervical spine range of motion; (2) decreased lumbosacral range of motion; (3) positive cervical compression test; (4) positive cervical distraction test; (5) positive Soto Hall test; (6) positive Kemp's test, bilaterally; (7) positive Lasagues test, bilaterally; (8) positive Bragards test, bilaterally; (9) positive straight leg raising, bilaterally; and (10) positive Valsalva test, bilaterally.** Upon examination, Dr. Dimitri assessed the claimant with: 1. Post-traumatic cervical sprain/strain. 2. Post-traumatic branchial radiculitis. 3. Post-traumatic lumbar sprain/stain. 4. Post-traumatic lumbar radiculitis. He found the claimant's prognosis for complete recovery to be guarded. Dr. Dimitri added that the accident resulted in significant injuries resulting in neck and low back pain. He noted that the result was injury to the cervical and lumbar spine with associated inflammation that may result in scar tissue formation that prevented a return to pre-injury status. Dr. Dimitri added that those areas may be permanently affected causing restriction, immobility, pain, and future degenerative and arthritic changes in the spinal discs and joints. (Exhibit 2F/1-3)

The August 13, 2017 Cervical Spine MRI performed by Stand-Up MRI reveals: 1. C3-C4, C4-C5, C5-C6, and C6-C7 disc herniations deforming the thecal sac abutting the spinal cord, with increased conspicuity on extension view at C3-C4, C4-C5 Grade one spondylolisthesis, C5-C6 and C6-C7 bilateral neural foraminal extension abutting the exiting nerve roots contributing to bilateral neural foraminal narrowing at both levels, in addition to C5-C6 mild central spinal stenosis in conjunction with hypertrophic changes. 2. C2-C3 and C7-T1 disc bulges. 3. Cervical spine straightening. (Exhibit 2F/56-57)

The August 14, 2017 Right Hip MRI performed by Stand-Up MRI reveals: 1. Edema and inflammation in the peritrochanteric soft tissues. 2. Trace fluid accumulating posteriorly at the femoroacetabular articulation. 3. Tiny subcortical cyst at the lateral margin of the femoral head approximately one to two millimeters in size. (Exhibit 2F/51-52)

The August 15, 2017 Right Knee MRI performed at Stand-Up MRI reveals: 1. Inhomogeneity and strain of the anterior cruciate ligament with pericruciate edema. 2. Pericapsular edema at the anterolateral capsular margin. 3. Strain of the iliotibial band at tibial attachment site. 4. Tear involves the lateral meniscal body extending obliquely to the inferior meniscal surface. 5. Distal quadriceps tendinosis/tendinopathy. 6. Patellofemoral joint space narrowing and a component of lateral patellar subluxation. 7. Thinning and chondromalacia of the lateral patellar facet superiorly. 8. Trace fluid at the semimembranous-medial gastrocnemius bursa. 9. Trace fluid inferior in Hoffa fat pad as well as at the patellofemoral and anterior tibiofemoral articulations. 10. Edema in the prepatellar subcutaneous tissues. 11. Insertional patellar tendinosis/tendinopathy present. (Exhibit 2F/54-55)

The August 24, 2017 electrodiagnostic report performed by John Smith, D.C. reveals: Lumbar radiculopathy can be objectively confirmed with lateral bending radiographic studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate away from the side of lateral bending, which is contrary to normal motion toward the side of lateral bending. He added that findings suggest pathology of: 1. Mild left (L4) saphenous nerve. 2. Marked right (L5) peroneal nerve. 3. Moderate left (L5) peroneal nerve. (Exhibit 2F/18-19)

The August 30, 2017 Lumbar Spine-Outside Read MRI performed by Stand-Up MRI reveals: 1. L4-L5 and L5-S1 disc herniations deforming the thecal sac contributing to central spinal stenosis in conjunction with facet and ligamentous hypertrophic changes (moderate at L4-L5, mild at L5-S1) with L5-S1 abutment of the proximal S1 nerve roots bilaterally, and L4-L5 abutment of the proximal L5 nerve roots bilaterally and bilateral neural foraminal extension abutting the exiting L4 nerve roots. 2. L3-L4 and L2-L3 disc bulges. (Exhibit 2F/63-64)

The September 5, 2017 Thoracic Spine MRI performed by Stand-Up MRI reveals: 1. T7-T8 and T10-T11 disc herniations deforming the thecal sac with T7-T8 cord abutment and T10-T11 right paracentral orientation. 2. T2-T3 and T3-T4 right paracentral disc bulges. 3. Dextroscoliosis. (Exhibit 2F/58-59)

The September 12, 2017 Lumbar Spine EMG/NCS performed by Smith Medical reveals: Evidence of bilateral L5-S1 radiculopathy. (Exhibit 2F/77-79)

The October 10, 2017 Upper Extremity EMG/NCS performed by Smith Medical reveals: Evidence of bilateral C6-C7 radiculopathy. (Exhibit 2F/68-72)

The October 12, 2017 electrodiagnostic report performed by John Smith, D.C. reveals: Cervical radiculopathy can be objectively confirmed by lateral bending radiographic

studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate toward the side of head tilt, which is contrary to normal motion away from the side head tilt. He added that findings suggest pathology of: 1. Marked right (C5) axillary nerve. 2. Moderate left (C5) axillary nerve. 3. Moderate right (C6) radial nerve lateral branch. 4. Marked left (C6) radial nerve lateral branch. (Exhibit 2F/25-26)

The December 14, 2017 electrodiagnostic report completed by John Smith, D.C. reveals: lumbar radiculopathy can be objectively confirmed with lateral bending radiographic studies. Proprioceptive disruption causes the spinous processes above and below an affected nerve root to rotate away from the side of lateral bending, which is contrary to normal motion toward the side of lateral bending. He added that findings suggest pathology of: 1. Mild right (L5) peroneal nerve. 2. Moderate left (L5) peroneal nerve. 3. Marked bilateral (S1) sural nerve. (Exhibit 2F/32-33)

The January 8, 2018 Cervical Spine CT performed by Smith Radiology reveals: 1. At C6-C7 disc osteophytic ridging and uncovertebral hypertrophy results in moderate to severe left and mild-to-moderate right foraminal stenosis. 2. There is mild to moderate central canal stenosis. 3. At C5-C6 there is mild to moderate foraminal stenosis. (Exhibit 2F/48-49)

The January 15, 2018 Lumbar Spine MRI performed by Smith Hospital Medical Center reveals: Disc bulges and/or degenerative changes are responsible for varying degrees of spinal canal stenosis and neural foraminal encroachment throughout the lumbar spine. (Exhibit 5F/19-20)

The January 31, 2018 operative report completed by George Smith, M.D. stated that the claimant underwent: 1. C5-C6, C6-C7 anterior cervical discectomy and fusion. 2. Use of titanium gauge six millimeter filled with DBX allograft and autograft. 3. Use of plate. 4. Use of operative microscope. 5. Use of fluoroscopy. Indications: Bilateral radicular pain and severe neck pain. An MRI showed disc degeneration and bilateral foraminal narrowing at C5-C6 and C6-C7. (Exhibit 5F/29-30)

The April 25, 2018 operative report completed by George Smith, M.D. stated that the claimant underwent: 1. L4-S1 laminectomy, mesial facetectomy, bilateral foraminotomy. 2. L4-S1 instrumented fusion. 3. L4-S1 posterolateral fusion using autologous bone and Actifuse. 4. Use of fluoroscopy. Indications: Significant back pain and bilateral radicular symptoms alternating between right and left side. An MRI showed significant facet hypertrophy. (Exhibit 5F/50-52)

The April 25, 2018 operative report completed by Augusto Smith, M.D. stated that the claimant underwent: 1. Bilateral paraspinal muscle flap advancement for coverage of bone graft with vascularized muscle, obliteration of dead space, and hardware coverage. 2. Complex wound closure, 11.0 centimeters. Preoperative diagnoses: Lumbar stenosis with neurogenic claudication status post L4-S1 decompression fusion

with image. Postoperative diagnoses: Lumbar stenosis with neurogenic claudication status post L4-S1 decompression fusion with image. (Exhibit 3F/5-6)

The October 15, 2018 operative report completed by Anthony Smith, M.D. stated that the claimant underwent a: 1. Right hip injection of the greater trochanter bursa region. 2. Right knee arthroscopy. 3. Arthroscopic partial lateral meniscectomy. 4. Arthroscopic patellofemoral, lateral tibial plateau, and medial femoral condyle chondroplasty. 5. Extensive debridement infrapatellar fat pad and anterior synovial thickening. Preoperative diagnoses: Right knee lateral meniscal tear. 2. Chondromalacia. 3. Right hip bursitis. Postoperative diagnoses: 1. Findings of underlying tearing in the body of the meniscus extending into the posterior horn with associated lateral compartment, patellofemoral compartment, and medial femoral condyle chondromalacia. 2. Markedly thickened infrapatellar fat pad. (Exhibit 6F/68-70)

The January 18, 2019 Left Knee MRI performed by Smith Radiology reveals: 1. Lateral meniscal tear. 2. Moderate sized popliteal cyst. 3. Small knee joint effusion. 4. Low-grade chondromalacia patella and low-grade chondromalacia medial compartment. (Exhibit 6F/62-63)

The April 18, 2019 operative report completed by Anthony Smith, M.D. stated that the claimant underwent: 1. Left knee arthroscopy. 2. Arthroscopic partial lateral meniscectomy. 3. Arthroscopic medial femoral condyle and patellar chondroplasty. Preoperative diagnoses: 1. Right knee lateral meniscal tear. 2. Chondromalacia. Postoperative diagnoses: 1. Complex tearing of the lateral meniscus. 2. Patellar chondromalacia. 3. Medial compartment chondromalacia grade 3, 4 changes. 4. Mild lateral compartment chondromalacia grade 2 pathology. (Exhibit 6F/71-72)

The January 27, 2020 Left Knee MRI performed by Smith Radiology reveals: 1. Interval increase in size of a horizontal tear through the anterior horn and body of the lateral meniscus with progressive lateral compartment chondromalacia compared with the previous exam which is now moderately advanced. 2. Mild free edge fraying of the medial meniscus with mild to moderate generalized medial compartment chondromalacia. 3. Mild to moderate generalized patellofemoral compartment chondromalacia which appears progressed compared with the previous study. (Exhibit 6F/64-65)

The June 22, 2020 Mastoid CT performed at Smith Hospital Medical Center reveals: 1. Right temporal bone: Intact middle and inner ear structures. 2. Left temporal bone: soft tissue within the external canal typically inflammatory or possibly infectious, without significant erosive disease, confluent with the tympanic membrane. Contiguous otitis abuts the ossicular chain without displacement or erosion, Mild mastoid effusion. Intact inner ear structures. 3. Small left parotid nodules likely intraparotid lymph nodes. (Exhibit 5F/85)

The August 31, 2020 Left Knee MRI performed by Smith Radiology reveals: 1. Small-to-moderate joint effusion. 2. Small popliteal cyst. 3. Surface extension of signal and the

lateral meniscus is unchanged compared to prior studies and may represent chronic tearing or postoperative change related to prior debridement. 4. Minimal osteoarthritis. (Exhibit 6F/66-67)

The October 27, 2020 office visit note of Anthony Smith, M.D. stated that the claimant presented with worsening left knee pain located in the left anterior region and in the medial region. Dr. Smith found that a physical examination revealed: **(1) antalgic gait referable to the left lower extremity trace integument; (2) medial joint line tenderness; (3) medial joint line swelling; (4) medial joint line mild effusion; (5) positive patellofemoral grind; (6) posterior tenderness; (7) pain with forced full flexion; (8) patellofemoral crepitus with range of motion; and (9) positive McMurray test.** Upon examination, Dr. Smith assessed the claimant with: 1. Pain in the left knee. 2. Unilateral primary osteoarthritis, left knee. 3. Other tear of lateral meniscus, current injury, left knee. He added that the claimant underwent an Euflexxa injection. (Exhibit 6F/46-49)

The January 19, 2021 Chest Radiograph performed by Smith Radiology reveals: Mild linear scarring versus subsegmental atelectasis of the left lower lung zone. (Exhibit 11F/22)

The January 21, 2021 Spirometry Report completed by Smith Radiology reveals: Mild restriction. Post bronchodilator test not clearly improved. (Exhibit 11F/23)

The February 9, 2021 office visit note of Anthony Smith, M.D. stated that the claimant presented with worsening left knee pain located in the left anterior region and in the medial region. Dr. Smith found that a physical examination of the left knee revealed: (**1) antalgic gait referable to the left lower extremity trace integument; (2) equivocal straight leg raise on the left; (3) medial joint line tenderness; (4) medial joint line swelling; (5) medial joint line mild effusion; (6) positive patellofemoral grind; (7) posterior tenderness; (8) pain with forced full flexion; (9) patellofemoral crepitus with range of motion; (10) positive McMurray test; (11) right sided paralumbar muscular tenderness; (12) left sided paralumbar muscular tenderness; (13) moderately decreased range of motion of the lumbar spine; (14) right sided paralumbar muscular spasm; and (15) left sided paralumbar muscular spasm.** Upon examination, Dr. Smith assessed the claimant with: 1. Pain in the left knee. 2. Unilateral primary osteoarthritis, left knee. 3. Other tear of lateral meniscus, current injury, left knee. 4. Other intervertebral disc degeneration, lumbar region. (Exhibit 6F/58-61)

The February 13, 2021 Chest CT performed by Smith Radiology reveals: 1. Small focus of right lower lobe ground glass like density possibly infectious in nature. 2. Micronodules. (Exhibit 11F/19-20)

The February 16, 2021 internal medicine consultative examination performed by Andrea Smith, M.D. stated that the claimant presented with: 1. Diagnosis of left breast cancer in 2007 with lumpectomy, chemotherapy, and radiation. 2. Lymphedema of the upper left

extremity. 3. Diverticulitis and irritable bowel syndrome since 2012, status post a partial colon resection, with abdominal pain. 4. Uterine cancer since 2013 with a radical hysterectomy with hernias. 5. Anemia with past blood transfusion. 6. Bilateral knee pain. 7. Status post bilateral knee surgery. 8. Atelectasis since 2020. Upon examination, Dr. Pollack assessed the claimant with: 1. History of breast cancer. 2. Lymphedema. 3. Diverticulitis. 4. Irritable bowel syndrome. 5. History of uterine cancer. 6. Anemia. 7. Neck and back pain with radiation. 8. Bilateral knee pain. 9. Atelectasis. She added that the claimant has moderate restriction in squatting, lifting, carrying, pushing, and pulling. Dr. Smith noted that the claimant had mild restriction in walking, standing, climbing stairs, kneeling, and sitting. She opined that the claimant should avoid heights, operating heavy machinery, activities which require heavy exertion, smoke, dust, known respiratory irritants, and activities which may put her at risk for fall or injury. (Exhibit 9F/1-4)

The March 11, 2021 office visit note of Ronald Smith, M.D. stated that the claimant presented with a complaint of a cough that began in late December, associated with a mild wheeze. Dr. Smith noted that the claimant had been treated with a course of antibiotics with no significant change. He reported that a chest x-ray described evidence of mild linear atelectasis of the left lower lobe and was placed on Pulmicort with some improvement of symptoms. Upon examination, Dr. Smith assessed the claimant with: 1. Abnormal computed tomography of the lung. 2. Obstructive sleep apnea. 3. Chronic cough. 4. History of gastrectomy sleeve. (Exhibit 12F/1-9)

The July 23, 2021 Cervical Spine Imaging completed by Smith Radiology reveals: 1. Straightening and reversal of the lordotic curvature cervical spine possibly due to spasm. 2. Anterior fusion discectomy and discoplasty at the level of C5, C6, and C7 with satisfactory position of hardware. (Exhibit 23F/70-71)

The July 29, 2021 office visit note of Maria Smith, M.D. stated that the claimant presented with a history of low back pain, neck pain, and bilateral knee pain that had been gradually worsening since a motor vehicle accident in 2017. Dr. Smith reported that the claimant's complaints included: (1) low back pain radiating to the bilateral lower extremities into the feet. Pain is worsened by sitting/standing/walking for a prolonged period of time, bending, pulling, pushing, and lifting. Can sit for 15-20 minutes, stand for 10-20 minutes, and walk for up to 10 minutes; (2) bilateral lower extremity radiating shooting pain, tingling, cramps, and weakness; (3) neck pain radiating to bilateral shoulders into the last two digits of the hand with pain that was intermittent, sharp, and dull at times; (4) constant bilateral tingling; and (5) bilateral knee pain. She found that a physical examination revealed: **(1) decreased range of motion of the cervical spine; (2) decreased range of motion of the lumbar spine; (3) bilateral positive Kemp's test; (4) positive bilateral straight leg raise; (5) bilateral positive Lasegae; (6) tenderness over bilateral lumbar paraspinal muscles; (7) positive left sided abduction; (8) positive left sided patellar compression test; (9) tenderness on palpation in the left knee lateral joint line; (10) left deltoid muscle strength 4-/5; and (11) decreased sensation to light touch in L5 and S1 bilaterally and dysthesia noted in left L4 dermatome.** Upon examination, Dr. Smith assessed the claimant with:

1. Cervicalgia, status post ACDF. 2. Lumbago with sciatica. 3. Bilateral knee pain, status post laminectomy and fusion. (Exhibit 16F/8-10)

The August 10, 2021 office visit note of Nora Smith, PT stated that the claimant presented with complaints of pain and stiffness in neck; lower back; difficulty in bending forward, lifting objects, performing overhead activities; and sleeping. Ms. Smith found that a physical examination revealed: **(1) forward head, rounded shoulders, and increase in lumbar lordosis; (2) decreased range of cervical and lumbar lordosis; (3) cervical spine muscle strength flexion 3/5, extension, right side rotation, left side rotation 3-/5, side flexion bilateral 2+/5; (4) bilateral shoulder muscle strength 2+/5; (5) middle and lower trapezius muscle strength 2+/5; (6) upper trapezius muscle strength 3/5; (7) bilateral hip muscle strength extensors 2+/5, abductors and flexors 3/5; (8) positive straight leg raise on left side; (9) moderate tightness of upper trapezius, levator scapulae and pectorals, hamstrings, and piriformis; (10) +2 tenderness over bilateral over bilateral upper trapezius and interscapular region and paraspinals of the lower lumbar region; and (11) paraspinal muscle spasm bilaterally.** (Exhibit 16F/5-7)

The August 13, 2021 office visit note of Joe Smith, M.D. stated that the clamant presented with neck pain. Dr. Smith found that a physical examination revealed: limited cervical active range of motion with extension and lateral flexion with pain and a positive left Spurling's maneuver. Upon examination, he assessed the claimant with: 1. Cervical disc herniation. 2. History of fusion of cervical spine. 3. Cervical disc disease. 4. Chronic pain syndrome. 5. Encounter for therapeutic drug level monitoring. 6. History of lumbar fusion. 7. History of gastric surgery. Dr. Smith reported that the claimant underwent epidural injective for the treatment of cervical disc displacement. (Exhibit 23F/50-55)

The August 16, 2021 Abdominal Ultrasound performed by Smith Radiology reveals: Fatty liver. (Exhibit 15F/11-12)

The September 14, 2021 Medical Assessment of Ability to do Work-Related Activities (Physical) completed by Maria Smith, M.D. stated that the claimant can**: (1) occasionally lift five pounds; (2) frequently lift three pounds; (3) stand/walk 10-15 minutes at one time without interruption; (4) stand/walk for three hours total during an eight hour workday; (5) sit for 20 minutes at one time without interruption; (6) sit for three hours total during an eight hour workday; (7) never climb, kneel, balance, crouch, and crawl; (8) reaching and pushing/pulling are affected by her impairment; and (9) temperature extremes, vibrations, moving machinery, and humidity are affected by her impairments.** Dr. Smith reports that the medical findings to support her assessment include: bilateral knee pain from meniscal tear status post arthroscopic surgery; lumbago with sciatica with lumbar radiculopathy; status post laminectomy and fusion; cervicalgia; decreased range of motion of the cervical spine, lumbar spine, and bilateral knee; spinal stenosis; and degenerative disc disease. **She opines that the claimant will be absent from her job four to six days a month due to her impairments. Dr. Smith notes that the claimant will require unscheduled breaks during an eight-hour workday.** (Exhibit 17F/1-3)

The September 21, 2021 internal medicine consultative examination performed by Steven Smith, M.D. stated that the claimant presented with multilevel orthopedic issues since an automobile accident. Dr. Smith found that the claimant had: **(1) deep tendon reflexes of 1+ bilaterally in upper and lower extremities; (2) 4/5 strength in the lower extremities bilaterally; (3) tender cervical spine; and (4) tenderness of the shoulders.** Upon examination, Dr. Smith assessed the claimant with: 1. Cervical discopathy with history of anterior cervical discectomy and fusion following a motor vehicle accident. 2. Lumbar discectomy with radiation into both lower extremities along sciatic nerve distribution. 3. Sciatica in the right lower extremity. 4. Sciatica in left lower extremity. 5. History of lumbar discectomy and fusion. 6. History of otitis media, left ear. 7. History of appendectomy. 8. History of gastric sleeve. 9. Total abdominal hysterectomy. 10. Bilateral salpingo-oophorectomy. 11. Uterine cancer. 12. Postoperative abdominal hernia with infection of mesh. 13. Breast cancer, left breast, pathology of ductal carcinoma in situ, status post chemotherapy and radiation therapy. 14. History of diverticulitis with colon resection. 15. Obesity. 16. Asthma. He found the claimant's prognosis to be guarded. Dr. Smith added that the claimant should avoid smoke, dust, extreme heat, extreme cold, and other respiratory irritants due to the history of asthma. He noted mild to moderate restrictions with prolonged walking, standing, climbing up and down stairs, twisting, turning, crawling, crouching, bending, heavy lifting, carrying, and engaging in strenuous physical activity. (Exhibit 18F/1-5)

The October 5, 2021 office visit notes of Joe Smith, M.D. stated that the claimant presented with lower back pain, neck pain, and trigger point injections. Dr. Smith noted that a physical examination revealed: (1) cervical active range of motion limited mildly; (2) lumbar active range of motion tenderness bilaterally; (3) positive trigger point tenderness bilaterally; and (4) positive straight leg raising. Upon examination, he assessed the claimant with: 1. Disc displacement, lumbar. 2. Myalgia, other site. 3. Chronic pain syndrome. 4. History of fusion of the cervical spine. 5. Cervical disc disease. 6. Encounter for therapeutic drug level monitoring. 7. History of gastric surgery. Dr. Smith reported that the claimant underwent ultrasound guided bilateral lower back trigger point injection at L5-S1. (Exhibit 23F/41-45)

The October 18, 2021 office visit notes of Joe Smith, M.D. stated that the claimant presented with lower back pain, neck pain, and trigger point injections. Dr. Smith noted that a physical examination revealed: (1) ambulates with an antalgic gait; (2) positive for lumbar and gluteal tenderness; (3) lumbar active range of motion is significantly limited on flexion; (4) positive straight leg raising; and (5) cervical active range of motion limited on rotation and lateral flexion. Upon examination, Dr. Smith assessed the claimant with: 1. Disc displacement, lumbar. 2. Myalgia. 3. Chronic pain syndrome. 4. History of fusion of cervical spine. 5. Cervical disc disease. 6. Encounter for therapeutic drug level monitoring. 7. History of gastric surgery. He reported that the claimant underwent a lumbar interlaminar epidural steroid injection. (Exhibit 23F/35-39)

The claimant was seen by Bruce Smith, M.D. between November 30, 2021 and December 3, 2021 for the treatment of iron deficiency anemia secondary to blood loss

and malignant neoplasm of overlapping sites of left breast in female, estrogen receptor positive. (Exhibit Dr. Smith treatment notes/1-23)

The February 22, 2022 office visit notes of Anna Smith, FNP-C stated that the claimant presented with mid-lower back pain and neck pain. Ms. Smith reported that the claimant complained of pain in the mid-lower back and neck with pain that radiated into the bilateral legs, mostly the left. She found that a physical examination revealed: (1) thoracic and lumbar paravertebral tenderness to palpation with pain on active range of motion; (2) positive straight leg raising; (3) antalgic yet steady gait; (4) cervical paravertebral tenderness to palpation with pain in active range of motion; and (5) positive Spurling's maneuver. Upon examination, she assessed the claimant with: 1. Chronic pain syndrome. 2. Effusion, left knee. 3. Internal derangement of the left knee involving posterior horn of lateral meniscus. 4. Disc displacement, lumbar. 5. Myalgia, other site. 6. History of fusion of cervical spine. 7. Cervical disc disease. 8. Encounter for therapeutic drug level monitoring. 9. History of gastric surgery. (Exhibit 23F/7-11)

The March 22, 2022 Medical Source Statement of Ability to do Work-Related Activities completed by Anna Smith, FNP-C states that the claimant can: (1) occasionally lift up to 20 pounds; (2) never lift over 21 pounds; (3) occasionally carry up to 20 pounds; (4) never carry over 21 pounds; (5) sit for one hour at one time without interruption; (6) stand for 30 minutes at one time without interruption; (7) walk for 30 minutes at one time without interruption; (8) sit for four hours total during an eight hour workday; (9) stand for two hours total during an eight hour workday; (10) walk for one hour total during an eight hour workday; (11) when not engaged in sitting, standing, or walking the claimant requires alternate sitting, standing, and walking and stretching; (12) requires the use of a medically necessary cane to ambulate; (13) occasionally operate foot controls; (14) never climb ladders or scaffolds, kneel, or crouch and occasionally climb stairs and ramps, balance, stoop, and crawl; (15) never tolerate exposure to moving mechanical parts and occasionally tolerate unprotected heights; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces or climb a few steps at a reasonable pace with the use of a single hand rail. Ms. Smith reports that the medical findings that support this assessment include: cervical paravertebral tenderness to palpation, positive Spurling's test, pain with active range of motion, thoracic and lumbar paravertebral tenderness to palpation, and positive straight leg raising. She adds that the claimant is unable to work. (Exhibit Anna Smith, FNP RFC/1-7)

The April 11, 2022 office visit notes of Maria Smith, M.D. states that the claimant presents with: 1. Low back pain radiating to the bilateral lower extremities into the feet, worsened by sitting/standing/walking for a prolonged period of time, bending, pulling, pushing, and lifting. 2. Bilateral lower extremity lower extremity radiating shooting pain, tingling, cramps, and weakness. 3. Neck pain radiating to bilateral shoulders into the last two digits of the hand. 4. Bilateral knee pain, very intense at times, left worse than right. Dr. Smith found that a physical examination reveals: **(1) decreased range of motion of the cervical spine; (2) tenderness over bilateral cervical paraspinal and trapezius muscles; (3) decreased lumbar range of motion; (4) bilateral positive Kemp test; (5) bilateral positive straight leg raising; (6) bilateral positive Lasegue**

test; (7) tenderness over bilateral lumbar paraspinal muscles; (8) trigger point noted in bilateral piriformis muscles with pain radiating to the lower extremities; (9) positive left knee abduction stress test; (10) tenderness on palpation in the left knee lateral joint line; (11) right deltoid muscle strength 4-/5; and (12) decreased sensation to light touch in the bilateral L5 and S1. Upon examination, she assessed the claimant with: 1. Cervicalgia, status post ACDF. 2. Lumbago with sciatica, status post laminectomy and fusion. 3. Bilateral piriformis syndrome. 4. Bilateral knee pain status post bilateral arthroscopic surgery. Dr. Smith adds that the claimant was disabled to work in any gainful job. (Exhibit Medical Records Dr. Smith/1-4)

The April 20, 2022 Medical Source Statement of Ability to do Work-Related Activities completed by Maria Smith, M.D. states that the claimant can: (**1) occasionally lift up to ten pounds; (2) never lift 11 pounds or more; (3) never carry up to ten pounds; (4) sit for 20 minutes at one time without interruption; (5) stand for 15 minutes at one time without interruption; (6) walk for ten minutes at one time without interruption; (7) sit for three hours total during an eight hour workday; (8) stand for two hours total during an eight hour workday; (9) walk for one hour total during an eight hour workday; (10) must lie down or sit on a recliner with her leg elevated for the rest of the time during an eight hour workday; (11) occasionally reach overhead, reach, and push/pull with the right hand; (12) never reach overhead and occasionally reach, handle, and push/pull with the left hand; (13) occasionally operate foot controls; (14) never climb stairs and ramps, climb ladders or scaffolds, balance, kneel, and crawl; (15) never tolerate exposure to unprotected heights, moving mechanical parts, humidity and wetness, extreme cold, extreme heat, and vibrations and occasionally tolerate exposure to operating a motor vehicle and dust, odors, fumes, and pulmonary irritants; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces, use standard public transportation, and climb a few steps at a reasonable pace with the use of a single hand rail.** Dr. Smith identifies the clinical findings which support this assessment as: low back pain radiating to the bilateral lower extremity; status post laminectomy/discectomy fusion; neck pain radiating to the bilateral upper extremities; status post ACDF; bilateral knee pain; status post arthroscopic; cervical, lumbar, and knee range of motion and tenderness, decreased sensation bilateral lower extremity, and left shoulder weakness. She adds that the claimant's concentration can be affected by pain and the use of muscle relaxers. Dr. Smith opines that the claimant will miss five to six days of work per month due to her impairments. She notes that the claimant's limitations have lasted 12 consecutive months. (Exhibit Medical Source Statement of Dr. Smith/1-6)

Medications

Medication	Dosage	Frequency	Doctor	Reason

Conclusions

It is clear that the claimant suffers from ongoing severe impairments including: 1. Diagnosis of left breast cancer in 2007 with lumpectomy, chemotherapy, and radiation. 2. Lymphedema of the upper left extremity. 3. Diverticulitis and irritable bowel syndrome since 2012, status post a partial colon resection, with abdominal pain. 4. Uterine cancer since 2013 with a radical hysterectomy with hernias. 5. Anemia with past blood transfusion. 6. Bilateral knee pain. 7. Status post bilateral knee surgery. 8. Atelectasis since 2020. 9. Unilateral primary osteoarthritis, left knee. 10. Other tear of lateral meniscus, current injury, left knee. 11. Lumbago with sciatica with lumbar radiculopathy, status post laminectomy and fusion. 12. Cervicalgia. 13. Spinal stenosis. 14. Degenerative disc disease. 15. Major depressive disorder.

It is our position that the claimant has medically determinable medical conditions that are severe, have prevented in 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. This is supported by Maria Smith, M.D. who states that the claimant can: (1) occasionally lift up to ten pounds; (2) never lift 11 pounds or more; (3) never carry up to ten pounds; (4) sit for 20 minutes at one time without interruption; (5) stand for 15 minutes at one time without interruption; (6) walk for ten minutes at one time without interruption; (7) sit for three hours total during an eight hour workday; (8) stand for two hours total during an eight hour workday; (9) walk for one hour total during an eight hour workday; (10) must lie down or sit on a recliner with her leg elevated for the rest of the time during an eight hour workday; (11) occasionally reach overhead, reach, and push/pull with the right hand; (12) never reach overhead and occasionally reach, handle, and push/pull with the left hand; (13) occasionally operate foot controls; (14) never climb stairs and ramps, climb ladders or scaffolds, balance, kneel, and crawl; (15) never tolerate exposure to unprotected heights, moving mechanical parts, humidity and wetness, extreme cold, extreme heat, and vibrations and occasionally tolerate exposure to operating a motor vehicle and dust, odors, fumes, and pulmonary irritants; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces, use standard public transportation, and climb a few steps at a reasonable pace with the use of a single hand rail. Dr. Smith identifies the clinical findings which support this assessment as: low back pain radiating to the bilateral lower extremity; status post laminectomy/discectomy fusion; neck pain radiating to the bilateral upper extremities; status post ACDF; bilateral knee pain; status post arthroscopic; cervical, lumbar, and knee range of motion and tenderness, decreased sensation bilateral lower extremity, and left shoulder weakness. She adds that the claimant's concentration can be affected by pain and the use of muscle relaxers. Dr. Smith opines that the claimant will miss five to six days of work per month due to her impairments. She notes that the claimant's limitations have lasted 12 consecutive months. (Exhibit Medical Source Statement of Dr. Smith/1-6)

Furthermore, Anna Smith, FNP-C states that the claimant can: (1) occasionally lift up to 20 pounds; (2) never lift over 21 pounds; (3) occasionally carry up to 20 pounds; (4) never carry over 21 pounds; (5) sit for one hour at one time without interruption; (6) stand for 30 minutes at one time without interruption; (7) walk for 30 minutes at one time

without interruption; (8) sit for four hours total during an eight hour workday; (9) stand for two hours total during an eight hour workday; (10) walk for one hour total during an eight hour workday; (11) when not engaged in sitting, standing, or walking the claimant requires alternate sitting, standing, and walking and stretching; (12) requires the use of a medically necessary cane to ambulate; (13) occasionally operate foot controls; (14) never climb ladders or scaffolds, kneel, or crouch and occasionally climb stairs and ramps, balance, stoop, and crawl; (15) never tolerate exposure to moving mechanical parts and occasionally tolerate unprotected heights; and (16) cannot walk a block at a reasonable pace on rough or uneven surfaces or climb a few steps at a reasonable pace with the use of a single hand rail. Ms. Smith reports that the medical findings that support this assessment include: cervical paravertebral tenderness to palpation, positive Spurling's test, pain with active range of motion, thoracic and lumbar paravertebral tenderness to palpation, and positive straight leg raising. She adds that the claimant is unable to work. (Exhibit Anna Smith, FNP RFC/1-7)

Additionally, the claimant is closely approaching advanced age; a high school graduate – does not provide direct entry into skilled work; semi-skilled to skilled previous work experience, with no transferrable skills; and limited to less than sedentary work activity; therefore, grid rule 201.14 directs a finding of disability.

The opinion of the above treating healthcare providers is consistent with a less than sedentary residual functional capacity. All of the above opinions should be found as persuasive as they are the claimant's treating healthcare providers. Their opinions are also in accord with the medical evidence summarized above.

Therefore, we respectfully request a fully favorable on-the-record decision be made in light of the objective medical evidence. In the alternative, we will be honored to appear at the hearing before Your Honor on May 31, 2022.

Very truly yours,