

## Listing §1.04A – Spinal Nerve Root Compression

From: \_\_\_\_\_

Re: \_\_\_\_\_(Name of Patient)

\_\_\_\_\_(Social Security No.)

Please comment on whether your patient has the following impairment:

Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the caudal equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine).

1. Does your patient have a disorder of the spine? ☐ Yes ☐ No

*If yes, please identify the disorder:* \_\_\_\_\_

2. Does your patient have evidence of nerve root compression? ☐ Yes ☐ No

3. Does your patient have neuro-anatomic distribution of pain? ☐ Yes ☐ No

*If yes, please describe:* \_\_\_\_\_

\_\_\_\_\_

4. Does your patient have any limitation of motion of the spine? ☐ Yes ☐ No

*If yes, indicate range of motion with the following movements:*

Flexion \_\_\_\_\_°  
Extension \_\_\_\_\_°

Lateral bending - right \_\_\_\_\_°  
Lateral bending - left \_\_\_\_\_°

Other: \_\_\_\_\_

5. Does your patient have any muscle weakness? ☐ Yes ☐ No

*If yes, please identify the affected muscles and describe using the grading system 0 to 5:*

\_\_\_\_\_

Identify any positive signs of motor loss:

- ☐ Inability to walk on heels ☐ Inability to squat  
☐ Inability to walk on toes ☐ Inability to arise from squatting position  
☐ Atrophy: Indicate circumferential measurements of both thighs and lower legs or upper and lower arms as appropriate:

\_\_\_\_\_

6. Does your patient have sensory *or* reflex loss? ☐ Yes ☐ No

*If yes, please describe:* \_\_\_\_\_  
\_\_\_\_\_

7. Is there involvement of the lower back? ☐ Yes ☐ No

*If yes, does your patient have a positive straight-leg raising test both sitting and supine?*  
☐ Yes ☐ No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

8. If the clinical findings do not match *all* of the findings required above, are your patient's combined impairments medically *equivalent* to the severity of conditions in the above listed impairment? ☐ Yes ☐ No

*If yes, please explain in detail how your patient's impairments are equivalent to the impairment listed above, with reference to **specific supporting clinical findings**.*

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*Signature*

*Printed/Typed Name:* \_\_\_\_\_

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*Address:* \_\_\_\_\_

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