

Date: [Date]
To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Biofeedback Therapy

Patient Name: [Patient First and Last Name]
Date of Birth: [Patient DOB]
Policy Number: [Member ID/Policy Number]
Group Number: [Group Number]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to formally request authorization for Biofeedback Therapy (CPT Code: 90901) for the above-referenced patient. This treatment is medically necessary for the management of [Patient's Specific Diagnosis/Chronic Pain Condition, e.g., Chronic Migraines, Complex Regional Pain Syndrome, or Myofascial Pain].

Clinical History and Diagnosis:

The patient has been diagnosed with [ICD-10 Code] and has been suffering from chronic pain for [Duration]. The patient's condition significantly impacts their daily functioning, causing [List limitations, e.g., sleep disturbance, decreased mobility, or inability to work].

Previous Failed Treatments:

The patient has attempted the following conservative treatments without adequate relief or with adverse side effects:

- [Medication Name/Class] - Result: [Inadequate relief/Side effects]
- [Physical Therapy] - Duration: [X weeks] - Result: [Outcome]
- [Injections/Interventions] - Result: [Outcome]

Rationale for Biofeedback:

Biofeedback is indicated for this patient to regulate physiological responses to pain, specifically [Target, e.g., muscle tension or autonomic arousal]. By providing real-time data, biofeedback will allow the patient to develop self-regulatory skills to reduce the frequency and intensity of pain episodes, thereby reducing the reliance on pharmacological interventions, including opioids.

Treatment Plan:

I am prescribing [Number] sessions of Biofeedback Therapy to be conducted [Frequency, e.g., once weekly]. The goals of this therapy are to [List goals, e.g., reduce pain scores by 30%, increase range of motion, or decrease medication usage]. Progress will be reassessed after the initial course of treatment.

Based on the patient's clinical presentation and the failure of standard treatments, I request that you approve coverage for Biofeedback Therapy. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

NPI Number: [NPI Number]

Practice Name: [Practice Name]