Date: [Date]

TO: [Insurance Company Name]
ATTN: Medical Review/Appeals Department
Fax: [Fax Number]

RE: Letter of Medical Necessity for Biofeedback Therapy

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]
Case/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request coverage for Biofeedback Therapy (CPT Code: 90912 and 90913) for the above-mentioned patient. I have diagnosed [Patient Name] with Pelvic Floor Dysfunction (ICD-10 Code: [Insert Code, e.g., M99.05 or R15.9]).

Clinical History and Diagnosis:
The patient presents with [List specific symptoms, e.g., urinary incontinence, fecal incontinence, chronic pelvic pain, or constipation]. These symptoms have persisted for [Duration] and significantly impact the patient's activities of daily living.

Previous Treatments Attempted:
[Patient Name] has attempted the following conservative treatments without sufficient improvement:

- [Treatment 1, e.g., Home-based Kegel exercises]
- [Treatment 2, e.g., Dietary modifications]
- [Treatment 3, e.g., Medication name]

Despite these interventions, the patient remains symptomatic.

Rationale for Biofeedback Therapy:
Biofeedback is medically necessary for this patient to gain voluntary control over the pelvic floor musculature. Clinical evaluation indicates the patient suffers from [muscle weakness / high-tone pelvic floor / lack of coordination], and they are unable to isolate or relax the correct muscles through standard verbal instruction alone. Biofeedback provides the visual and auditory physiological data required for neuromuscular re-education.

Treatment Plan:
The recommended course of treatment involves [Number] sessions of biofeedback therapy over [Number] weeks. The goal of this therapy is to [List goals, e.g., reduce incontinence episodes by 50% or restore normal voiding patterns].

Based on the patient's clinical presentation and the failure of prior conservative measures, Biofeedback Therapy is the most appropriate and cost-effective next step in their care. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Practice Name]