[Date]

[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Biofeedback Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of Biofeedback Therapy (CPT Code 90901/90912/90913) as a critical component of their neuromotor rehabilitation following a cerebrovascular accident (Stroke) occurred on [Date of Incident].

Clinical Diagnosis:
The patient is currently presenting with [Specific Diagnosis, e.g., Hemiplegia, Muscle Spasticity, or Loss of Motor Control] (ICD-10 Code: [Code]). As a result of the stroke, the patient suffers from significant neuromotor deficits, including [List specific deficits, e.g., foot drop, impaired upper limb function, or lack of muscle recruitment].

Rationale for Treatment:
Biofeedback therapy is required to facilitate neuromuscular re-education. Standard physical and occupational therapy interventions have been utilized; however, the patient requires real-time physiological feedback to regain voluntary control over paretic muscles. Biofeedback will be used to:

- Increase motor unit recruitment in affected muscle groups.
- Reduce compensatory movements and pathological synergies.
- Provide visual/auditory cues to reinforce neural plasticity and motor learning.
- Decrease spasticity through relaxation techniques and reciprocal inhibition.

Treatment Plan:
The proposed treatment plan includes [Number] sessions of biofeedback over [Number] weeks. The goal is to achieve [Specific Functional Goal, e.g., independent ambulation or improved reach and grasp].

Summary:
Based on the patient's clinical presentation and the evidence supporting biofeedback in stroke recovery, this service is medically necessary to prevent further disability and restore functional

independence. Failure to provide this therapy may result in permanent loss of motor function and increased long-term care costs.

Please contact my office at [Phone Number] if you require further clinical documentation or have questions regarding this request.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/Title]
[NPI Number]
[Practice Name/Facility Address]