

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Medical Review/Appeals Department

Address: [Insert Address]

City, State, Zip: [Insert City, State, Zip]

RE: Letter of Medical Necessity for Biofeedback Therapy

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Policy Number: [Insert Policy Number]

Group Number: [Insert Group Number]

Claim/Reference Number: [Insert if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for Biofeedback Therapy (CPT Code: 90901) as a medically necessary treatment for Temporomandibular Joint (TMJ) Disorders (ICD-10 Code: [Insert code, e.g., M26.60]).

Clinical History and Diagnosis:

The patient has been under my care since [Date] for chronic TMJ symptoms including [list symptoms, e.g., severe jaw pain, restricted range of motion, muscle spasms, and tension headaches]. These symptoms are primarily exacerbated by bruxism and involuntary myogenic tension in the masseter and temporal muscles.

Prior Treatments Attempted:

The patient has attempted several conservative treatments without adequate relief, including:

- [Insert treatment, e.g., Oral splints/night guards]
- [Insert treatment, e.g., Pharmacotherapy (NSAIDs, muscle relaxants)]
- [Insert treatment, e.g., Physical therapy]

Despite these interventions, the patient continues to experience significant functional impairment.

Medical Necessity for Biofeedback:

Biofeedback is requested to provide the patient with real-time physiological monitoring of muscle activity (EMG). This therapy is essential for the patient to develop voluntary control over hyperactive masticatory muscles, thereby reducing the mechanical stress on the temporomandibular joint and alleviating chronic pain. Evidence-based guidelines support biofeedback as a highly effective, non-invasive modality for myogenic TMJ disorders when standard treatments fail.

Treatment Plan:

The proposed plan includes [Number] sessions of biofeedback therapy over [Duration] weeks. The goal is to reduce EMG activity in the jaw muscles by [Percentage]% and increase the patient's functional jaw opening without pain.

I strongly recommend the approval of this service to prevent the progression of joint degeneration and to avoid more invasive surgical interventions.

Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Printed Name and Title]

[Medical Facility Name]

[NPI Number]