Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Medical Review Department]
FAX: [Fax Number]
RE: Letter of Medical Necessity for Biofeedback Therapy

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to formally request coverage for Biofeedback Therapy (CPT Code 90912/90913) for the above-referenced patient. This treatment is medically necessary to address [Patient's Name]'s diagnosis of [Specific Diagnosis, e.g., Stress Urinary Incontinence, Urge Incontinence, or Mixed Incontinence - ICD-10 Code].

Clinical History:
The patient has been suffering from urinary incontinence for [Duration of Symptoms]. This condition significantly impacts their daily activities and quality of life. Clinical evaluations confirm that the patient suffers from pelvic floor muscle dysfunction contributing to their symptoms.

Previous Treatments Attempted:
The patient has attempted conservative management without sufficient success, including:

- [List previous treatments, e.g., Independent Kegel exercises for X months]
- [List medications tried, if any]
- [List behavioral modifications, e.g., fluid management]

Despite these efforts, the patient remains symptomatic.

Treatment Plan:
I am prescribing a course of Biofeedback Therapy to provide the patient with visual and/or auditory feedback of pelvic floor muscle activity. This therapy is essential for the patient to learn correct muscle isolation and strengthening techniques that cannot be achieved through independent exercise alone. The goal of this therapy is to reduce or eliminate incontinent episodes and avoid more invasive surgical interventions.

Medical Necessity:
Biofeedback is a recognized and effective evidence-based treatment for urinary incontinence. For this specific patient, it is the most appropriate next step in the continuum of care to prevent further complications and the need for long-term medication or surgery.

I request that you approve this request for [Number of Sessions] sessions. If you require further clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]