

Date: [Insert Date]

To: [Insurance Provider Name]

Attention: Medical Review/Appeals Department

Address: [Insert Address]

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]

To Whom It May Concern,

I am writing to provide a formal letter of medical necessity for [Patient Name] to receive Biofeedback Therapy (CPT Code 90901/90911/90912) as an essential component of their treatment plan for muscular reeducation and rehabilitation.

Diagnosis and Clinical History:

The patient has been diagnosed with [Insert Diagnosis, e.g., Neuromuscular Dysfunction, Incomplete Spinal Cord Injury, Post-Stroke Hemiparesis]. The primary clinical symptoms include [Insert Symptoms, e.g., severe muscle atrophy, lack of voluntary motor control, or chronic spasms].

Medical Necessity:

Biofeedback is medically necessary for this patient to provide real-time physiological data regarding muscle activity that is otherwise imperceptible to the patient. This modality is required to:

- Enhance the patient's ability to recruit specific motor units during voluntary contraction.
- Promote neuroplasticity and neuromuscular re-education following [Insert Event/Condition].
- Reduce pathological muscle tension/spasticity that interferes with activities of daily living.
- Decrease reliance on pharmacological interventions for muscle management.

Treatment Plan:

The recommended treatment plan consists of [Insert Number] sessions at a frequency of [Insert Frequency, e.g., twice per week]. This therapy will be integrated with traditional physical/occupational therapy to maximize functional outcomes. Success will be measured by [Insert Metric, e.g., improved Range of Motion, Manual Muscle Test scores, or reduction in pain scales].

Previous Interventions:

The patient has previously attempted [Insert Previous Treatments, e.g., standard physical

therapy, medication, or home exercise programs] with limited success. Biofeedback is the next necessary step to achieve the stated rehabilitation goals.

I request that you authorize these services to ensure the patient receives the standard of care required for their recovery. Should you require further clinical documentation, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[NPI Number]

[Facility Name]