**Date:** [Insert Date]

**To:** [Recipient Name/Insurance Provider]
**Re:** Medical Necessity for Continued Range of Motion (ROM) Therapy
**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]
**Claim/ID Number:** [Policy Number]

To Whom It May Concern,

I am writing to formally recommend the continuation of Range of Motion (ROM) therapy for [Patient Name] regarding the treatment of [Specific Diagnosis/Injury].

The patient has been under my care since [Start Date] and has undergone [Number] sessions of therapy to date. While the patient has shown progress in [mention specific improvement, e.g., flexion/extension], they currently present with a significant deficit in [Specific Body Part]. Current measurements indicate [Insert Degree] of motion, which remains below the functional goal of [Insert Degree].

Continued therapeutic intervention is medically necessary to:

- Prevent permanent joint contracture and tissue shortening.
- Restore functional independence for Activities of Daily Living (ADLs).
- Reduce chronic pain associated with joint stiffness.
- Avoid the necessity for more invasive surgical procedures.

I am recommending an additional [Number] weeks of therapy, at a frequency of [Number] sessions per week. We will re-evaluate the patient's progress at the end of this period to determine if further treatment is required.

Please contact my office at [Phone Number] if you require further clinical documentation or clarification.

Sincerely,

[Doctor/Therapist Signature]
[Printed Name and Title]
[Medical Facility Name]
[NPI Number]