General Criteria for Gender Affirming Surgery (WPATH SOC8)

a. Gender incongruence is marked and sustained

b. Meets diagnostic criteria for gender incongruence prior to surgery

c. Demonstrates capacity to consent for the specific gender-affirming surgery

e. Other possible causes of apparent gender incongruence have been identified and excluded

f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgery have been assessed, with risks and benefits have been discussed

g. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

Primary Breast Augmentation/Mammoplasty Documentation Recommendations

Primary breast augmentation/mammoplasty authorization requests should document fulfillment of the following criteria to demonstrate medical necessity:

a. Meets above general clinical criteria for surgical procedures

b. Has not already received surgical augmentation of breast **see section on surgical revision requests for more information*

c. Body dysmorphia has been excluded as a possible cause for desire for breast augmentation **See guidance for additional information*

d. Member has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones

e. If staged procedures are planned, they must be noted in the **initial request** and justification for why the procedures are staged must be documented. For members with tight skin, or other reasons that make tissue expansion and secondary procedures likely to be necessary, a discussion on the likelihood of need for repeat surgery with the member is documented as well as detailed surgical plan

f. Documented physical exam including members current breast size; breast size relative to body; and grading of any asymmetries or deformities (e.g. mild, moderate, or severe)

g. Documented discussion with member of prognosis and realistic outcomes of breast augmentation surgery

Non-Surgical Breast Augmentation Alternatives

Amida care recognizes breast prostheses as Durable Medical Equipment (DME), and as such will provide coverage for prosthetic bras and similar devices. A single support letter verifying medical necessity from a licensed healthcare provider or mental health professional is required.

Criteria for Coverage of Revision Feminizing Breast Augmentation/Mammoplasty *

**Cases of suspected or confirmed breast implant rupture are not subject to revision criteria*

ALL of the following clinical criteria and documentation requirements must be met in order for revision breast augmentation/mammoplasty to be considered a medically necessary:

Documented recent physical exam performed by the operating surgeon with a detailed assessment of the current state of feature or area proposed to be revised surgically, including:

  - Clear commentary on whether prior procedures produced a feminizing change versus pre-procedure.
    - Body dysmorphia as an alternate cause of distress related to a feature or area should be excluded in letters of support **See guidance for additional information*
  - OR clear description of a functional complication secondary to a prior procedure such as implant infection, capsular contracture, or implant migration
    - If the revision is of an area altered by procedures performed outside of formal medical settings (e.g. silicone injections), past procedures as well as related sequelae are documented along with surgical treatment plan
- Exact date of prior implant placement/implant age if the age of the implant is relevant to medical necessity
- Documentation of the size of the current implant and the implant to be used for the exchange **please note increasing implant size is not an acceptable indication for revision and implants should not be swapped for a larger size unless to correct some deformity or unilateral asymmetry*

- Documentation of discussion of treatment options and prognosis with member, including discussion of the estimated success rate of the requested revision procedure and risks and benefits or repeat surgery
- If staged revision or multiple procedures are planned, **they must be noted in the initial request** and justification for why the procedures are staged must be documented
- For fat grafting procedures, justification of the volume of fat, or number of CCs referencing standards of care or literature. **Oversized volume requests or requests without justification will be voided*

Revision surgeries requested due to weight changes – weight loss or weight gain – are not considered medically necessary

Guidance: Body Dysmorphia and Gender Dysphoria

As part of the evaluation for medical necessity of gender affirming procedures, body dysmorphia must be excluded. The DSM5 defines body dysmorphia by four criteria, listed below:

(1) Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

(2) At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

(3) The preoccupation causes clinically significant distress or impairment in social, occupational or other areas of functioning.

(4) The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Letters of support from behavioral health providers should assess for, and exclude, body dysmorphia. Untreated body dysmorphia can worsen mental

health and pose unique health risks during the surgical gender affirmation process.

CPT Code Guidance

**Please see separate coding guidance document for gender affirming surgeries*

References

New York State Medicaid Guidance