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).

Criteria for Coverage of Feminizing Body Contouring: Hip and Gluteal Augmentation, Liposuction

ALL of the following clinical criteria and documentation requirements must be met in order for body contouring to be considered a medically necessary:

a. Meets above general clinical criteria for surgical procedures

b. Has not already received surgical augmentation of the hip or buttocks, or feminizing liposuction **see section on surgical revision requests for more information*

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

d. Requests conform to accepted procedural standards for liposuction and feminizing body contouring. **Requests for implants, Sculptra, or other body contour modifying procedures beyond liposuction and fat grafting will be considered on a case-by-case basis. Detailed documentation noting the indication, contraindications to other methods, and the treatment plan must be included in requests to be considered for medical necessity. An objective physical exam must be documented and referenced in the indication. Experimental procedures or techniques beyond accepted standards of care are never considered medically necessary*

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, deep hip indentations, or other reasons that make secondary fat transfer 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. Waist-to-hip ratio pre-surgery is documented **See guidance for information on measuring waist-to-hip ratio*

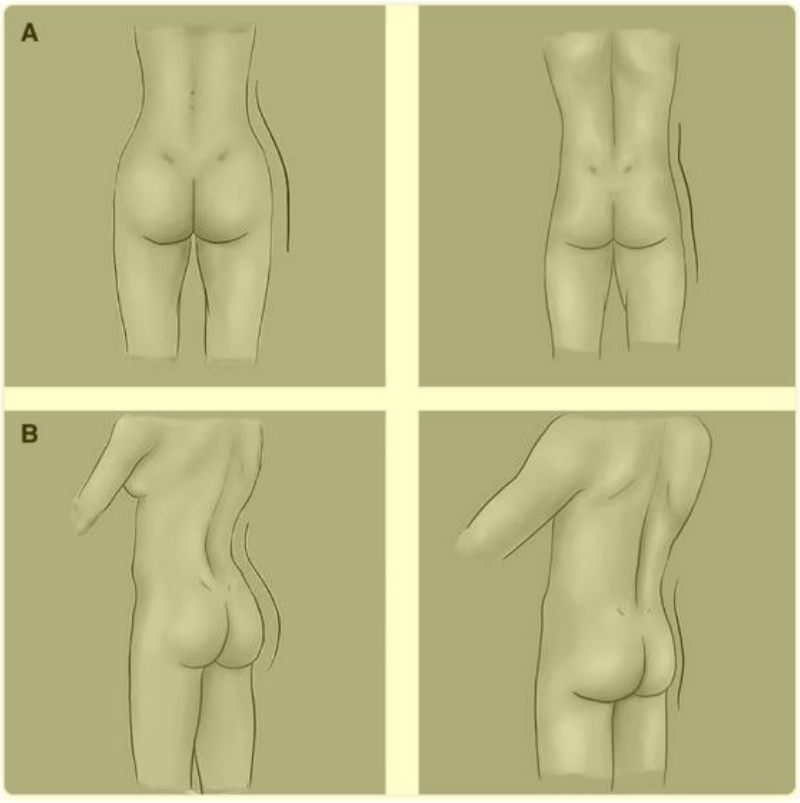
g. Documented discussion with member of prognosis and realistic outcomes of body contouring surgery

Supplemental Procedures – Lymphatic Massage

Amida Care will cover a maximum of 7 sessions of lymphatic massage after body contouring surgery. A referral from the operative surgeon is required for coverage. Any sessions beyond 7 are never considered medically necessary.

Guidance for Feminizing Body Contouring

Feminizing body contouring procedures, specifically liposuction of the waist and augmentation of the hips and glutes via fat grafting or implants, aim to feminize the lower torso and pelvis. Techniques for feminizing body contouring have been described in the literature, but no standard technique has been established (Del Vecchio 2022, Flores Gonzalez 2021, Wilson 2020). There are sex-based differences in both fat distribution and skeletal anatomy in this region. Testosterone, the masculine sex hormone, leads to deposition of fat in the abdomen and prevents fat build up in the hips and glutes, while estrogen, the feminine sex hormone, leads to preferential depositing of fat into these areas (Asokan 2022). The image below demonstrates the difference in the contour of male-sex vs female-sex bodies. It is important to not conflate sex with gender identity.



(Asokan 2022 - Image)

This image further elucidates sex-based differences in body silhouette as well as contour of the glute.

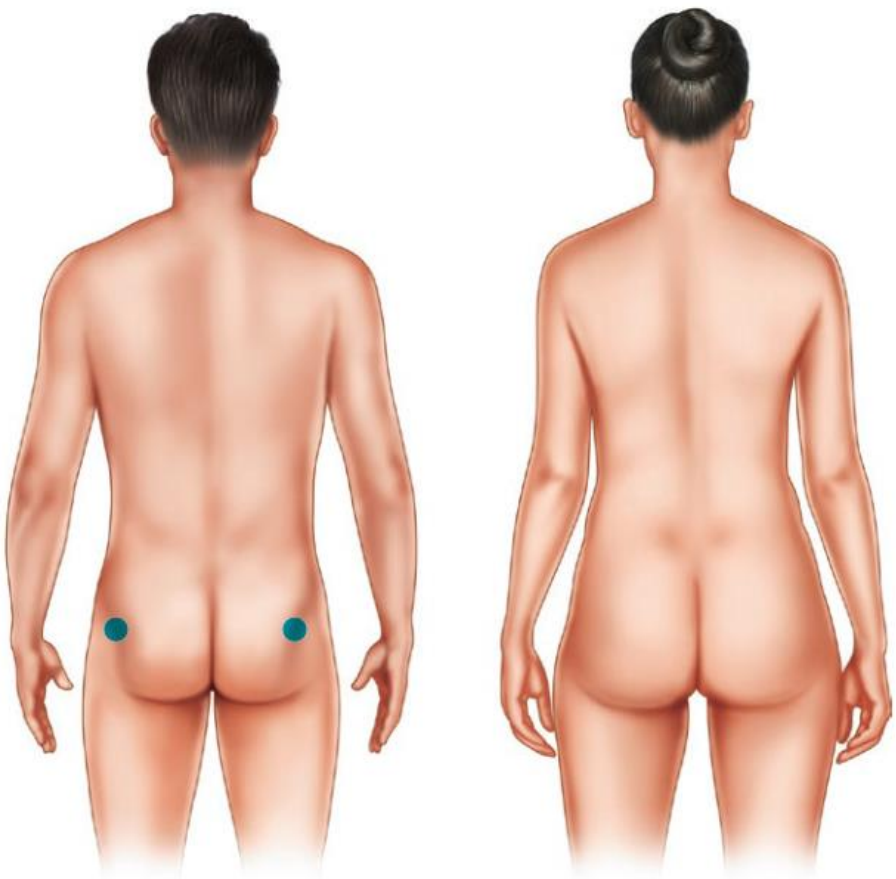
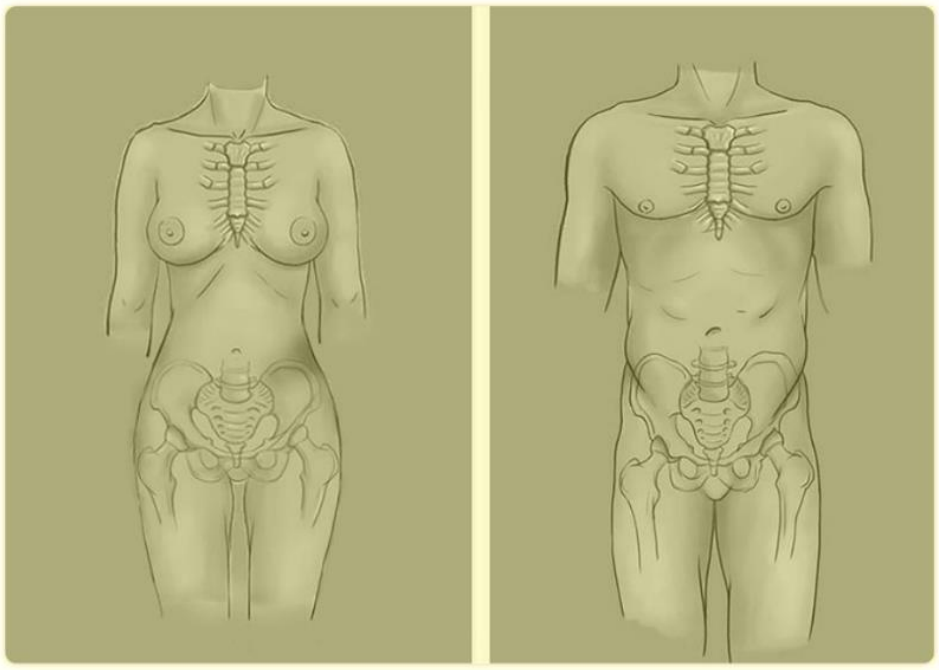


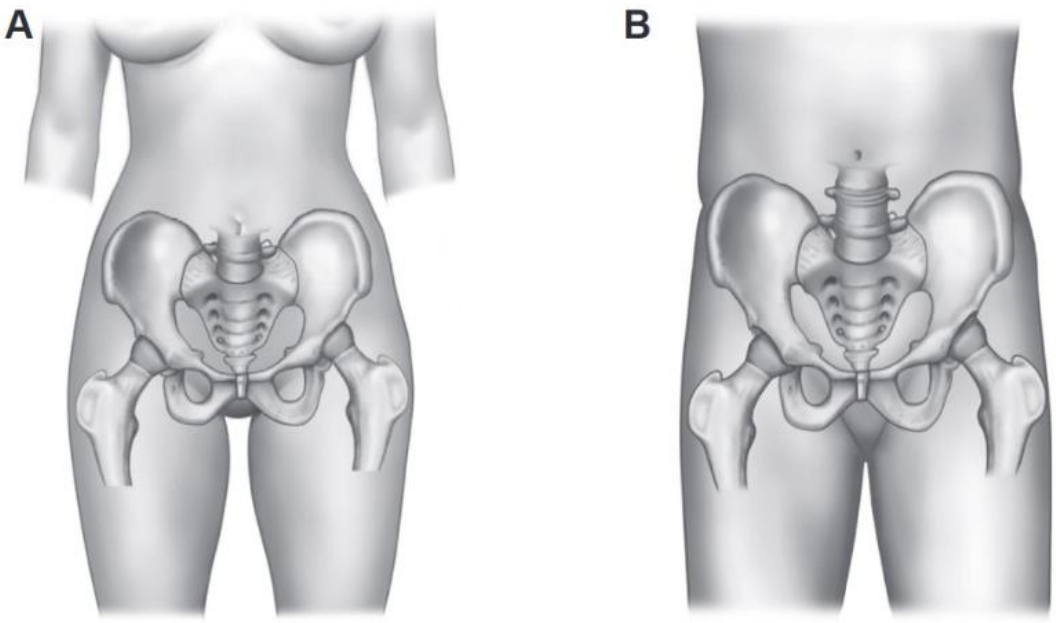
Fig. 10.4 Difference in female and male gluteal forms. In general, gynoid bodies tend to have more adipose deposition in the gluteal region with a distinct transition from the lower back. In addition, the mid-lateral portion of the android buttocks tends to be flat or even has a distinct concavity

(Wilson 2020 - Image)

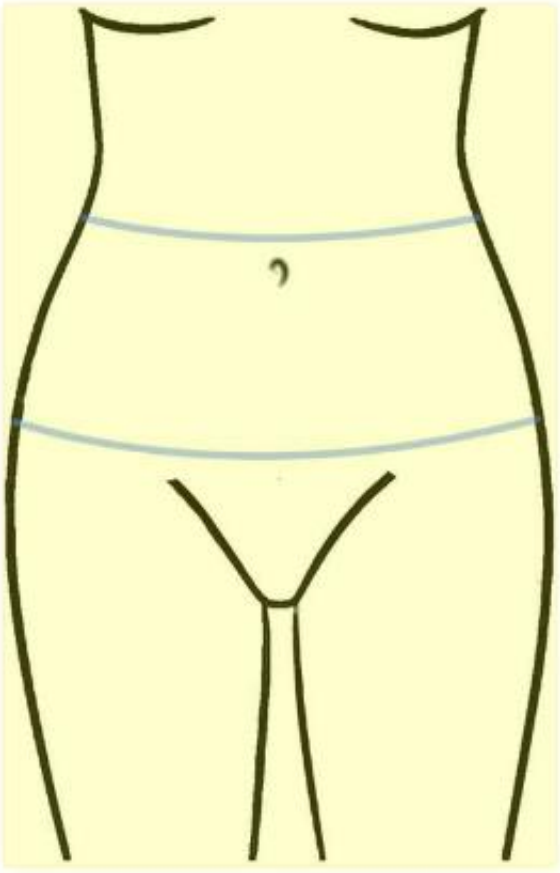
The female-sex pelvis is wider than the male-sex pelvis, with a larger outlet creating the appearance of wide hips. The male-sex pelvis is narrower and taller than the female-sex pelvis, creating a near straight line down the side from the torso to the lower extremity. Note the contributions of sex-based differences in pelvic anatomy to the overall differences in body contour in the images below:



(Asokan 2022 – Image above) (Morrison 2018 - Image below)



Direct surgical alteration of the pelvis, clavicle, and shoulder bones can be dangerous and is not well studied which is why soft tissue body contouring is preferred (Asokan 2022). Soft tissue procedures can reduce the waist-to-hip ratio creating a feminizing effect. The waist-to-ratio is calculated by measuring the circumference of the waist just above the umbilicus, and dividing it by the circumference of the hip, measured at its widest point. In the image to the right (Asokan 2022 – Image right) the two regions used to calculate the waist-to-hip ratio are highlighted. A standardized reference range for waist-to-hip ratio for male-sex and female-sex bodies cannot be established for several reasons, including natural variations in form and body contour. Generally, female-sex bodies are likelier to have a narrower waist circumference and a greater hip circumference equaling a smaller decimal when the fraction is calculated. The male-sex waist circumference, however, is expected to be similar or nearly the same as the circumference of the hip, meaning the male-sex waist-to-hip ratio is expected to be closer to one. In large cohort studies this has translated to female-sex bodies having waist-to-hip ratios between 0.76 – 0.84, and male-sex bodies between 0.87 – 0.99 (Molarius 1999).



See the example equation below:

$$\frac{27\ inch\ waist\ circumference}{36\ inch\ hip\ circumference} = 0.75\ waist - to - hip\ ratio$$

While feminizing gender affirming hormone therapy (GAHT) causes fat redistribution – fat deposition in the hips and glutes and less deposition in the abdomen – in some cases it may not be enough to achieve desired feminized body contours. In the below image (Morrison 2018 – Image) note how retained abdominal fat post GAHT changes the body contour versus the female-sex body. Liposuction and grafting of retained fat alter the outline and feminize the contour.

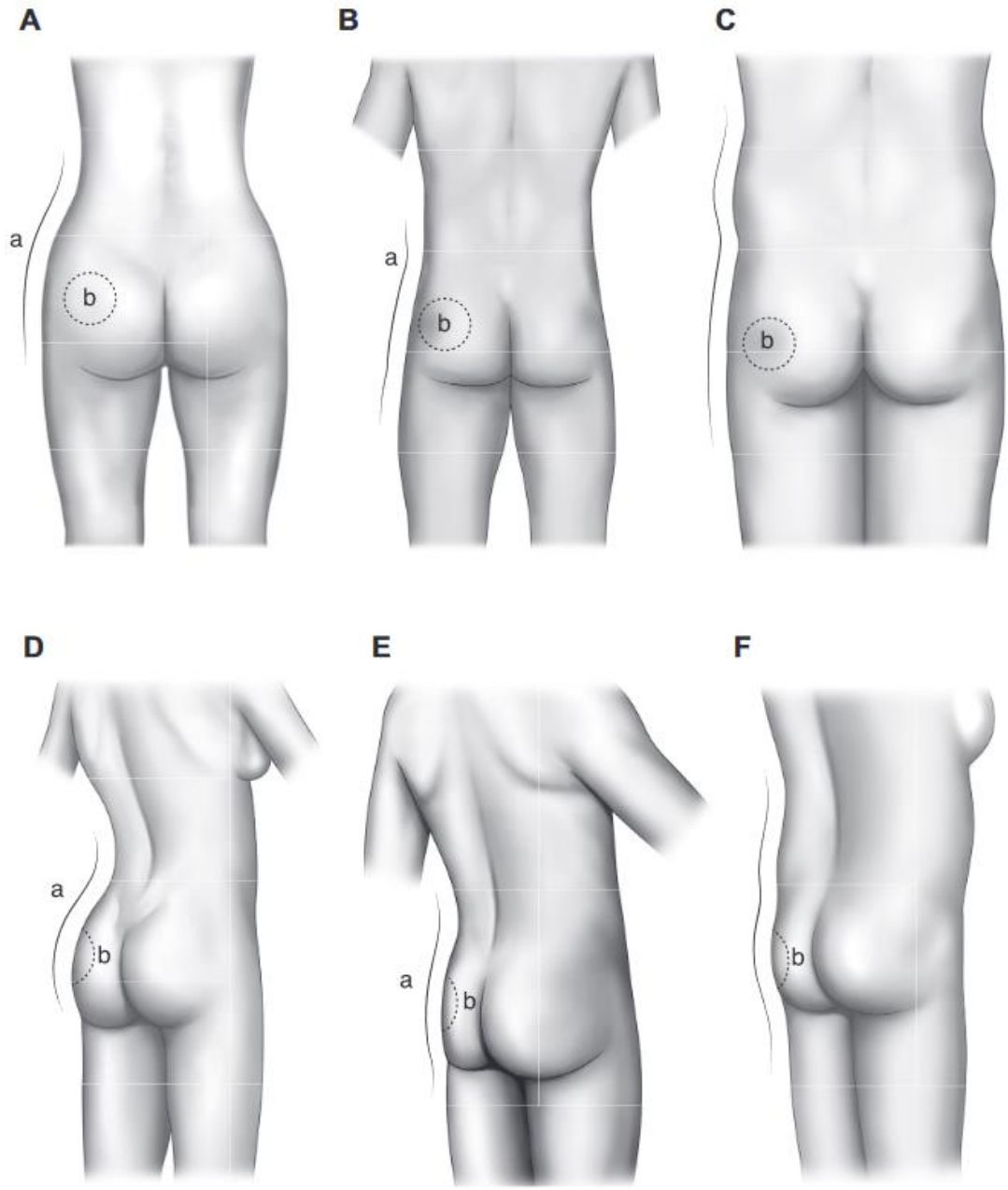


Fig. 2. Differences in male and female trunk, hips, and thighs. Ideal female: (*A*) posterior; (*B*) posterior oblique. Ideal male: (B) posterior; (E) posterior oblique. Posthormone /presurgical transfeminine form: (*C*) posterior; (F) posterior oblique. In the ideal feminine form there is an hourglass shape accentuated as seen in the A and D images. These are illustrated in each panel and labelled (a) to show how they compare. The dotted lines labelled (b) illustrate areas of the mid-lateral gluteal region. In the ideal male form this is a concave area while the ideal female form is more convex. The posthormone /presurgical transfeminine buttock is typically also concave or flattened before a contouring procedure.

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.

Criteria for Coverage of Surgical Revision of Prior Body Contouring Procedures

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.
    - Pre-op and post-op waist-to-hip ratio **must** be documented in requests
    - Body dysmorphia as an alternate cause of distress related to a feature or area must 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, graft loss, etc
    - 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

- 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

CPT Code Guidance

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

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