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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 Masculinizing Body Contouring: Liposuction

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

a. Meets above general clinical criteria for surgical procedures

b. Has not already received masculinizing liposuction or other masculinizing surgical body contouring procedures **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*

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d. Requests conform to accepted procedural standards for liposuction and masculinizing body contouring. **Requests for 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.

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.

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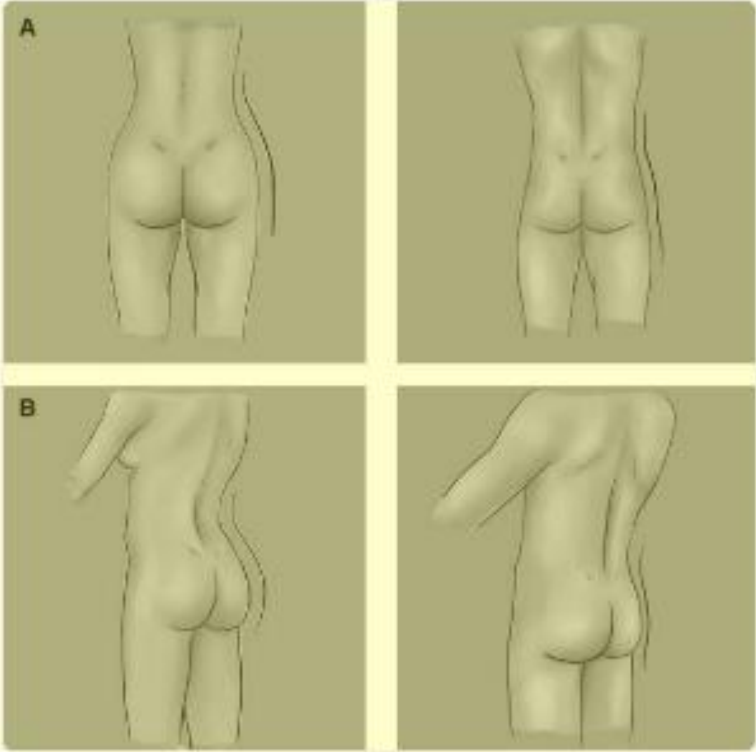
Guidance for Masculinizing Body Contouring

Liposuction can be used to masculinize the body contour by removing lateral hip, buttocks, and abdominal fat bringing the waist-to-hip ratio closer to one and making the underlying musculature more defined (Asokan 2022). 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). In some cases fat grafting into waist region may be necessary for masculinization, or abdominoplasty in cases where prior pregnancies or weight created excess tissue. Different surgical techniques have been described (Asokan 2022, Morrison 2017, Morrison 2018, Nolan 2023, Van Boerum 2023), and while the body of literature is smaller than for feminizing contouring, the core concepts for both procedures are the same. 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)

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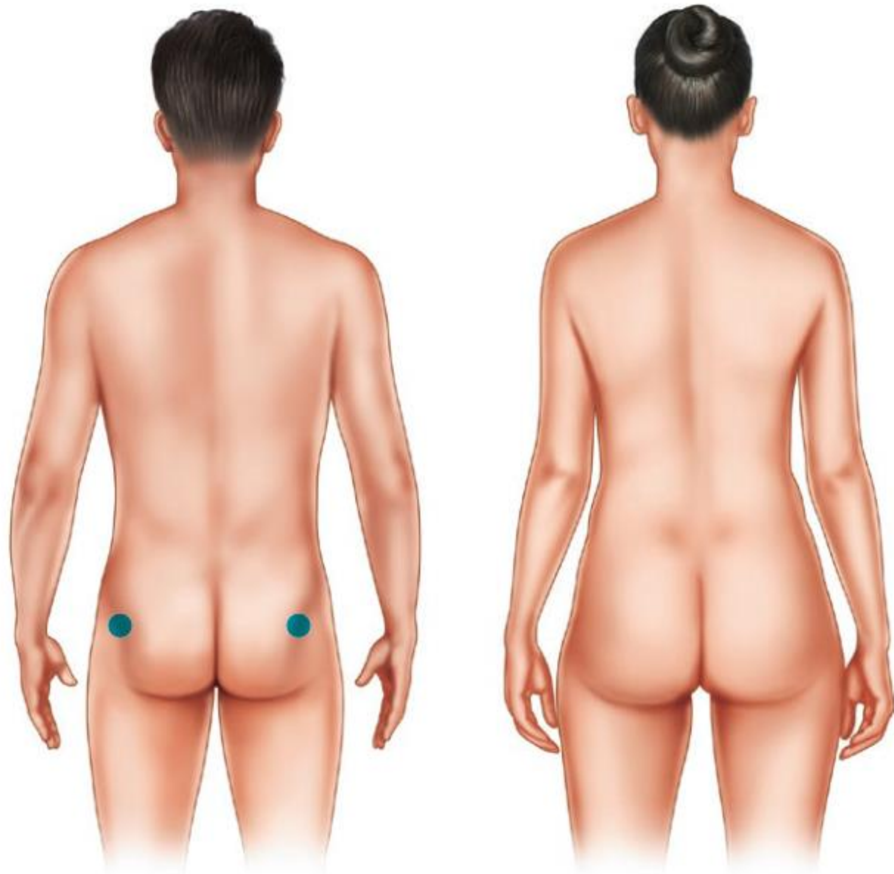
This image further elucidates sex-based differences in body silhouette as well as contour of the glute.

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)

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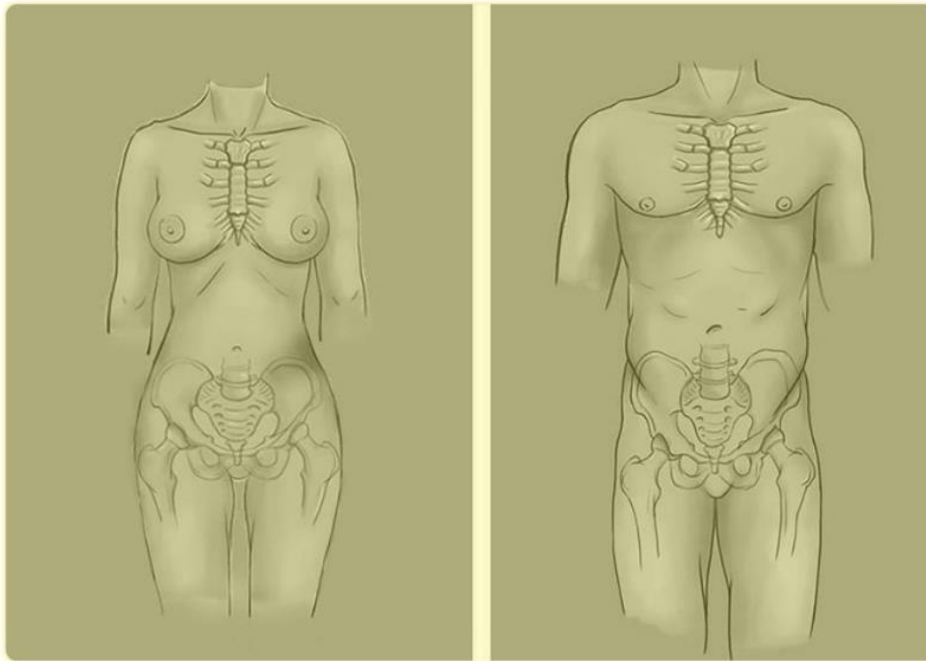
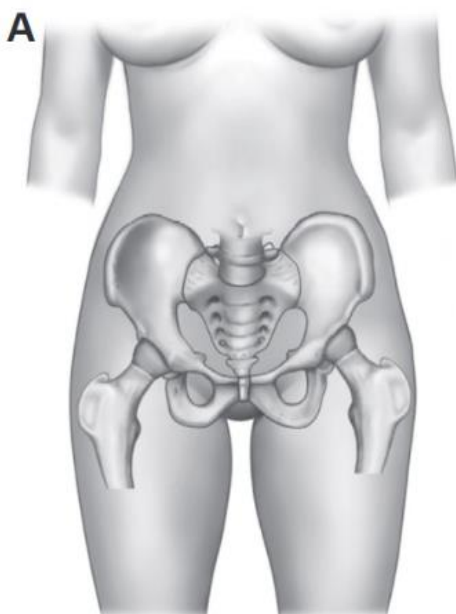
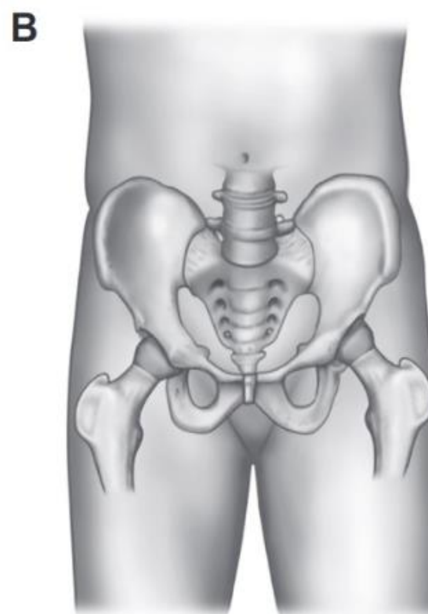
The female-sex pelvis is wider than the male-sex pelvis, with a larger outlet creating the appearance of wide hips. The male-sex pelvis is narrower and taller than the female-sex pelvis, creating a near straight line down the side from the torso to the lower extremity. Note the contributions of sex-based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



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





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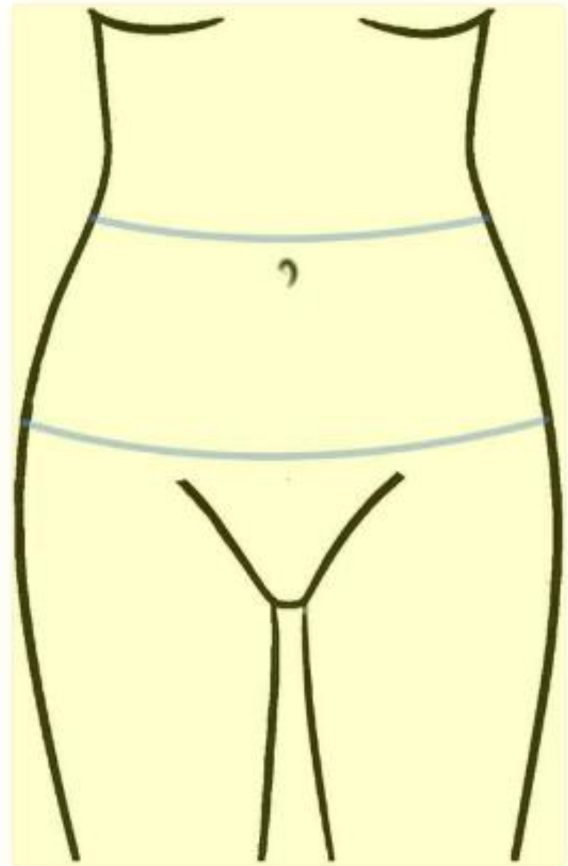
Soft tissue procedures can equalize the waist-to-hip ratio, bringing it closer to one and creating a masculinizing effect. The waist-to-ratio is calculated by measuring the circumference of the waist just above the umbilicus, and dividing it by the circumference of the hip, measured at its widest point. 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:

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

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While masculinizing gender affirming hormone therapy (GAHT) causes fat redistribution – less fat deposition in the hips and glutes and more deposition in the abdomen – in some cases it may not be enough to achieve desired masculinized body contours, especially for people starting with large lateral hip and glute fat deposits.

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.

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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 masculinizing 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 the 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

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CPT Code Guidance

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

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