Breast Reconstruction

Chest and Genital Gender-Affirming Surgical Consultation:

1. The individual must have a diagnosis of persistent gender dysphoria.
2. The individual must be able to provide informed consent. Feminizing/masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.
3. A Medical Evaluation Form is to be completed (see Attachment B). Alternatively, the Provider may submit the same content in the clinical documentation.
4. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.

   a. One form/letter (for chest surgeries) from an individual’s treating Primary Care Provider or mental health professional endorsing the request in writing is required for the following chest surgeries:

      i. (M to F) Augmentation mammoplasty;

Facial Reconstruction

   . Facial Reconstructive Surgical Consultation:

      a. The individual must have a diagnosis of persistent gender dysphoria.
      b. The individual must be 18 years of age or older.
      c. The individual must be able to provide informed consent;

         i. Feminizing/Masculinizing gender-affirming surgery will lead to irreversible physical changes and/or potential adverse effects, and the individual must have the capacity to make a fully informed decision to consent to treatment.

         ii. The treating surgeon must show that the individual has received appropriate education prior to the proposed procedure.
      d. Evidence of 12 continuous months of hormone therapy, unless medical contraindication to hormone therapy documented.
      e. Member has lived as the preferred gender for 12 continuous months.
      f. A Medical Evaluation Form is to be completed (see Attachment B).

Alternatively, the Provider may submit the same content in the clinical documentation.

g. The Provider or Therapist Documentation Form for Evaluation for Transgender Surgery is to be completed (see Attachment C). Alternatively, a letter from the Provider addressing the same content as Attachment C is acceptable.

   i. The form/letter must evaluate facial feature(s) that cause persistent gender dysphoria, clarify goals and expectations, and assess self-acceptance, AND

   ii. Address how the presence of stated feature(s) impair function in relation to activities of daily living, AND
iii. Address how reconstruction of said features will improve quality of life and daily function.

2. Facial Reconstructive Surgery requests:
   a. All components of facial reconstructive consultation requests have been completed;
   b. Clear documentation of proposed facial reconstructive procedures with evidence, to include photos, justifying medical necessity and reconstructive purpose of requested surgical procedure.

Permanent Hair Removal

Please refer to UM Subcommittee Approved Guideline Hair Removal for hair reduction consultation and procedure authorization criteria.