Gender Affirming Surgery Prior Approval Request

Gender Affirming Surgery (GAS) is insured under the Medicare Insurance Plan when prior authorization has been obtained from the Medicare Medical Consultant.

Instructions

A - This GAS application form must be completed to request prior approval for payment by Medicare.

B - If completed manually, print clearly and ensure that all sections of this form are submitted.

C - This GAS application form must be completed by a Physician, Nurse Practitioner or Mental Health Professional that meet the qualifications listed in version 8 or the latest version of the World Professional Association for Transgender Health (WPATH) Standard of Care (Appendix B).

D - The Physician, Nurse Practitioner or Mental Health Professional (as described in Appendix B) submitting a request for prior authorization may also be one of the providers completing a referral letter.

E - Referral letter(s) recommending surgery must be completed by an appropriately trained Physician, Nurse Practitioner or Mental Health Professional who meets the WPATH minimum credentials (as described in Appendix B).

F - Referring providers will be notified regarding the outcome of this funding application.

G - Forward completed form and attachments by mail or fax to:

Centre Métropolitain de Chirurgie
999 De Salaberry, Montréal, QC,
H3L 1L2

Fax: 514 288-3547

H - The surgeon and their team will assess the documentation and, if satisfied, will send the satisfactory and complete form and formal request indicating the proposed surgery to the New-Brunswick Medicare Medical Consultant for approval of funding.

Medical Consultant – Medicare
Department of Health – 520 King Street
HSBC Place, P.O. Box 5100
Fredericton, NB, E3B 5G8

Fax: 506-457-7671

I - For patients undergoing surgery in New Brunswick instead of being referred to Montreal (e.g., orchidectomy, mastectomy, hysterectomy with BSO, breast augmentation), the completed form and attachments should be sent directly to the local surgeons, who will also assess the patients. If satisfied that the patients meet surgical criteria, said specialists will follow the steps as indicated under item H.

1. Provide your personal information

Last name: _____

First name: _____ Middle name: _____

Address: _____

_____ Postal code: _____

Phone number: _____ Date of birth (yyyy/mm/dd): _____

Medicare #: _____ Expiry Date (yyyy/mm/dd): _____

2. Complete Patient Declaration

- I am a permanent resident of New Brunswick. ❑ Yes ❑ No
- I am registered with Medicare NB and possess a valid Medicare card. ❑ Yes ❑ No
- I am 18 years old (16 years old for chest masculinization surgery). ❑ Yes ❑ No
- My Physician, Nurse Practitioner and/or mental health professional has explained the risks and complications associated with GAS. ❑ Yes ❑ No
- I understand that mastectomy with chest masculinization (excluding implants), hysterectomy and Mastectomy, hysterectomy, orchidectomy, salpingo-oophorectomy, breast augmentation for the purpose of GAS are only publicly funded if performed in Canada, preferably NB (if no other surgery involved) and pre-approved by the Medical Consultant of the NB Department of Health. ❑ Yes ❑ No
- I understand that genital reconstruction (Appendix C) for the purpose of GCS are only publically funded if performed at the Centre Métropolitain de Chirurgie Montréal, Québec, and pre-approved by the Medical Consultant of the NB Department of Health. ❑ Yes ❑ No
- I understand that there is no public funding available for:
  - › GAS services outside of Canada; ❑ Yes ❑ No
  - › GAS services received without prior approval from the Medical Consultant of the NB Department of Health; ❑ Yes ❑ No
  - › Any services which are not insured by Medicare NB, including but not limited to: facial feminization, liposuction, tracheal shave, voice pitch surgery, and hair removal; ❑ Yes ❑ No
  - › Any take-home medications, equipment, meals, travel, accommodation and other personal expenses. ❑ Yes ❑ No

3. Sign the certification and consent—Patient

- I certify that the information given on this form is complete and accurate.
- I understand that my personal health information collected on this form and the attached supporting documents will only be used to process my request and will not be disclosed without my consent unless required by law.

Name (please print): _____

Signature: _____ Date: _____

4. Referring Physician, Nurse Practitioner or Mental Health Professional

Last name: _____

First name: _____ Provider ID # : _____

Office Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

5. Trained Physician, Nurse Practitioner or Mental Health Professional Professional Declaration

- I have verified that the patient is a permanent resident of NB and possesses a valid Medicare card. ❑ Yes ❑ No
- I have reviewed the most recent version of the WPATH Standards of Care (V 8 or higher) and I am a "qualified health professional" as described by the WPATH Standard of Care (Appendix B). ❑ Yes ❑ No

Primary clinical criteria

I have verified that the patient has:

- Persistent, well-documented gender dysphoria diagnosis. ❑ Yes ❑ No
- Capacity to make a fully informed decision and to consent for treatment: ❑ Yes ❑ No
  - › Understands the procedure/s; ❑ Yes ❑ No
  - › Understands associated risk/s and complications. ❑ Yes ❑ No
- Understands the effect of gender-affirming treatment on reproduction. ❑ Yes ❑ No
- Reasonably well controlled medical or mental health concerns, if they are present. ❑ Yes ❑ No
- Considered the role of social transition. ❑ Yes ❑ No
- Has an aftercare / follow-up plan ❑ Yes ❑ No

Specific clinical criteria

Chest Surgery

Mastectomy with chest masculinization (excluding implants). (Liposuction performed inferior to the clavicle, medial to the anterior axillary fold, or superior to the infra-mammary fold is included in the chest masculinization. Sculpting performed external to these boundaries is considered aesthetic.)

- The patient has one supporting referral letter signed by a GAS trained physician or qualified mental health professional (Appendix B). ❑ Yes ❑ No ❑ N/A
- The patient has reached the age of 16 years. ❑ Yes ❑ No ❑ N/A

Breast augmentation

The patient is stable on their gender affirming hormonal treatment regime, which may include at least six (6) months of hormone treatment for adults, and 12 months of hormone treatment for adolescents for breast augmentation (or longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated). Hormone therapy is not a criteria to be eligible for chest surgeries, except for breast augmentation.

Genital Surgery (please refer to the complete list in Appendix C)

- The patient has one referral letter from a qualified health care professional who has competencies in the assessment of transgender and gender diverse people. ❑ Yes ❑ No ❑ N/A
- 6 continuous months of hormone therapy as appropriate to the patient's gender goals before the patient undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual. ❑ Yes ❑ No ❑ N/A
- The patient has reached the age of 18. ❑ Yes ❑ No

6. Proposed procedure(s) for which prior approval is requested:

Please list the recommended procedure(s) for which prior approval is being requested (please refer to the complete list in Appendix C):

7. Attach supporting documents:

Required attachment(s):

- One referral letter (depending on the surgery) signed by a GAS trained and qualified Mental Health Professional (as described in the Appendix B). ❑ Yes ❑ No
- Proof of training and certification in the area of Gender Affirming Surgery or Gender Dysphoria from the referring Physician, Nurse Practitioner or Mental Health Professional's or signed declaration that confirms that the referent has training in the area of GAS or gender dysphoria (may be included in the referral letter itself or included with Appendix D ❑ Yes ❑ No

Other required attachments if applicable:

- Report from Physician, Nurse Practitioner or Mental Health Professional who has been prescribing and supervising the hormone therapy (HT). ❑ Yes ❑ No ❑ N/A
- Operative reports of the patient's prior GAS and/or treatment (For hysterectomies and salpingo/ oophorectomies, a pathology report showing that the entire cervix has been removed is required). ❑ Yes ❑ No ❑ N/A

8. Certification and recommendation – signature of Physician, Nurse Practitioner or Mental Health Professional

- I certify that the information given on this form is complete and accurate.
- I recommend this client for gender affirming surgery.

Name (please print): _____

Signature: _____ Date: _____

For Department of Health Staff Use Only:

The patient has been approved for Medicare funding of the requested gender confirming surgery (see attached approval letter).

Medical Consultant - Medicare

Signature: _____ Date: _____

APPENDIX A

Content of the referral letter(s)

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;
2. Results of the client's biopsychosocial assessment, including any diagnoses;
3. The duration of the physician, nurse practitioner or mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the physician, nurse practitioner or mental health care professional is available for coordination of care and welcomes a phone call to establish this.

WPATH, Standard of Care, V.8

APPENDIX B

Minimum credentials of the physician, nurse practitioner or mental health professionals who are qualified tocomplete the GAS Prior Approval Request Form and/or referral letter(s)

The following are recommended minimum credentials for physician, nurse practitioner or mental health professionals who work with adults presenting with gender dysphoria:

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases for diagnostic purposes.
3. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
4. Are able to assess capacity to consent for treatment.
5. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
6. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

WPATH, Standard of Care, V.8

APPENDIX C

List of Procedures in Gender Affirming Surgery

Chest Surgery

- Mastectomy with chest masculinization (excluding implants, which are not covered)
- Breast Augmentation

The above should be performed in a public hospital in Canada, preferably in New Brunswick.

Genital Surgery

The following procedures must be performed in a public hospital in Canada prior to a referral for genital surgery at the Centre Métropolitain de Chirurgie in Montreal:

- **Salpingo-oophorectomy**
- **Hysterectomy** (the cervix must be completely removed, and a pathology report confirming this must be provided to the Centre Métropolitain de chirurgie in Montreal)
- **Orchidectomy** (can be performed as solo procedure if no vaginoplasty is intended in the future).

Genital Reconstruction at the Centre Métropolitain de Chirurgie in Montreal:

- **Vaginoplasty** (includes orchidectomy, penectomy, construction of the vulva (labia majora, labia minora and clitoris) and, if desired by client, construction of the vaginal cavity.)
- **Metoidioplasty**
- **Phalloplasty**
- **Construction of the urethra**
- **Insertion of testicular implants**
- **Insertion of penile implant**

Depending on the requirements of each individual patient, the above-listed procedures may be performed alone or in combination with each other.

APPENDIX D

Signed declaration

I declare that I obtained training and certification in the area of Gender Affirming Surgery or Gender Dysphoria. My training was obtained at:

- ❑ Attending relevant professional meetings
- ❑ Workshops
- ❑ Seminars
- ❑ Supervision from a mental health professional with relevant experience
- ❑ Participating in research related to gender nonconformity and gender dysphoria
- ❑ Other : _____

Name (please print): _____

Signature: _____ Date: _____