# Gender Confirming Surgery
# Prior Approval Request

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

**Instructions**

**A** - This GCS 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 GCS application form must be completed by a Physician or Mental Health Professional that meet version 7 or the latest version of the World Professional Association for Transgender Health (WPATH) Standard of Care (Appendix B). NOTE: *In New Brunswick, GCS-trained Physicians, Nurse Practitioners, Psychologists, Specialized Registered Nurses and Registered Social Workers with a master's degree are qualified to complete the GCS Prior Approval Request Form.*

**D** - The Physician 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 or Mental Health Professional who meets the WPATH minimum credentials (as described in Appendix B).

- When only one referral letter is needed, a supporting referral letter can be completed by any GCS trained Physician or Mental Health Professional that meets the minimum credentials described in Appendix B.
- When two referral letters are needed, the first referral letter (Supporting referral letter) can be completed by a Physician or a Mental Health Professional (Appendix B) who has a clinical relationship with the patient but the second referral letter (Assessment referral letter) must be from a different physician or Mental Health Professional who had an evaluative role with the patient. The Assessment referral letter needs to be more comprehensive and is expected to cover the topics in the areas outlined in Appendix A. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic), may be sent.

**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 his 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 who will **not** be referred to Montreal, rather will have their surgery performed in New Brunswick (i.e. mastectomy or hysterectomy with BSO), 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.

# Gender Confirming Surgery
# Prior Approval Request

New Nouveau Brunswick

## 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. ❑ Yes ❑ No
- My physician /mental health professional has explained the risks and complications associated with GCS. ❑ Yes ❑ No
- I understand that mastectomy with chest masculinization (excluding implants), hysterectomy and salpingo-oophorectomy for the purpose of GCS are only publically funded if performed in Canada, preferably NB (if no other surgery involved). ❑ 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:
  - › GCS services outside of Canada; ❑ Yes ❑ No
  - › GCS 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, breast augmentation 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: _____

# Gender Confirming Surgery
# Prior Approval Request

New Nouveau Brunswick

## 4. Referring Physician or Mental Health Professional

Last name: _____

First name: _____ Provider ID # : _____

Office Address: _____

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

## 5. Trained Physician / Mental Health 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 World Professional Association for Transgender Health Standards of Care (V 7 or higher) and I am a "qualified health professional" as described by the WPATH Standard of Care. ❑ 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
- Reasonably well controlled medical or mental health concerns, if they are present. ❑ Yes ❑ No
- Has an aftercare / follow-up plan ❑ Yes ❑ No

## SPECIFIC CLINICAL CRITERIA

**Breast Surgery**

Mastectomy with chest masculinization (excluding implants)

- The patient has one supporting referral letter signed by a GCS trained physician or qualified mental health professional (Appendix B). ❑ Yes ❑ No ❑ N/A
- The patient has reached the age of 18. ❑ Yes ❑ No

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

- The patient has two referral letters signed by a GCS trained and qualified mental health professional (Appendix B). If the first referral letter (Supporting referral letter) is from a Physician or a Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter (Assessment referral letter) must be from a different physician or Mental Health Professional who had an evaluative role with the patient. ❑ Yes ❑ No ❑ N/A
- 12 continuous months of hormone replacement therapy as appropriate to the patient's gender roles (unless there is medical contraindication, or inability / unwillingness to undergo hormone replacement therapy). ❑ Yes ❑ No ❑ N/A
- The patient has reached the age of 18. ❑ Yes ❑ No

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

- All of the genital surgery criteria cited above and 12 continuous months of living in a gender role that is congruent with their gender identity (unless a specific reason has been stated in a referral letter). ❑ Yes ❑ No ❑ N/A

## ADDITIONAL CLINICAL CRITERIA

- The patient is physically fit and has no significant physical health problems that would contraindicate or complicate the proposed surgery. ☐ Yes ☐ No
- The patient is psychologically prepared for surgery. ☐ Yes ☐ No
- The patient has realistic goals and expectations of the surgery. ☐ Yes ☐ No
- The patient is informed of and understands any alternative procedures. ☐ Yes ☐ No
- The patient has engaged in a responsible way with the assessment/treatment process. ☐ Yes ☐ No
- The patient has an adequate support network, a stable lifestyle and the gender identity of the individual has remained stable over time. ☐ 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 or two referral letters (depending on the surgery) signed by a GCS trained and qualified Mental Health Professional (as described in the Appendix B). ☐ Yes ☐ No
  *__NOTE__: *If the first referral letter (Supporting referral letter) is from a Physician or a Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter (Assessment referral letter) must be from a different Physician or Mental Health Professional who had an evaluative role with the patient.*
- Proof of training from referring Physician / Mental Health Professional's or signed declaration that confirms that the referent has training in the area of GCS or gender dysphoria (may be included in the referral letter itself) or completed Appendix D. ☐ Yes ☐ No

Other required attachments if applicable:

- Report from physician who has been prescribing and supervising the hormone replacement therapy (HRT). ☐ Yes ☐ No ☐ N/A
- Operative reports of the patient's prior GCS 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

- I certify that the information given on this form is complete and accurate.
- I recommend this client for gender confirming 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 psychosocial assessment, including any diagnoses;
3. The duration of the 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 Mental Health Professional is available for coordination of care and welcomes a phone call to establish this.

WPATH, Standard of Care, V.7

# APPENDIX B: Minimum credentials of Mental Health Professionals who are qualified to complete the GCS Prior Approval Request Form and/or referral letter(s).

The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The Mental Health Professional should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that the mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

NOTE: In New Brunswick, GCS trained Physicians, Nurse Practitioners, Psychologists, Specialized Registered Nurses and Registered Social Workers with a master degree are qualified to complete the GCS Prior Approval Request Form. Only Physicians, Nurse Practitioners and Psychologists are qualified to complete the supportive referral letter or the assessment referral letter.

WPATH, Standard of Care, V.7

## APPENDIX C: List of Procedures in Gender Confirming Surgery

**Breast Surgery:**

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

The above should be performed in a public hospital in Canada, preferably 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)

Solo procedures :

- **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 in the area of Gender Confirming Surgery or Gender Dysphoria. My training include(s):

- ☐ 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: _____