Transition-Related Surgery
Request for Prior Approval

Important Information

Transition-Related Surgeries (TRS) are insured services under the Medical Care Plan (MCP) when prior approval is obtained from the Assistant Medical Director.

Criteria for MCP coverage of TRS procedures in Newfoundland and Labrador are based on guidelines published by the World Professional Association for Transgender Health (WPATH) in the **Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People** Version 7 (2012).

A list of transition-related surgeries eligible for coverage by MCP is located in Appendix B of this document. If the proposed surgery is not on this list, or if the purpose of the proposed procedure is for a purpose other than changing sex characteristics to affirm gender identity, this request for prior approval is not applicable. Please note that cosmetic procedures are non-insured services.

Requests for surgical revisions should not be made using this form. Requests for surgical revisions are adjudicated based on the opinion of the attending physician along with criteria established in the General Preamble of the Medical Care Plan Medical Payment Schedule Section 3.

This request for prior approval applies to adults seeking TRS. If a child or adolescent is seeking TRS, please refer to the WPATH Standards of Care Chapter 6.

Please review the TRS policy document prior to completing this form. It is located at www.health.gov.nl.ca/health/mcp/pdf/TRS_Policy.pdf

Completed TRS Requests for Prior Approval should be sent by a physician or nurse practitioner to MCP:

Assistant Medical Director – Medical Services Division

Department of Health and Community Services

P.O. 8700 St. John's, NL A1B 4J6

Phone: 709-758-1557

Fax : 709-729-5238

Check List

- ☐ **Patient has completed all sections of the *Patient Information Sheet.***
- ☐ **A physician or nurse practitioner has completed the section on *Clinical Eligibility for TRS*.**
- ☐ **One Surgical Readiness Assessment with a signed *Surgical Readiness Assessor Certification and Recommendation* form is attached**

  OR

- ☐ **Two Surgical Readiness Assessments (required for genital surgeries) with two signed *Surgical Readiness Assessor Certification and Recommendation* forms is attached.**

Transition-Related Surgery
Request for Prior Approval

Instructions

Application to be submitted by a physician/nurse practitioner

Instructions:

- HCS must approve this request prior to the patient receiving surgery in order to ensure MCP funding for TRS patients.

- The patient must complete and sign the *Patient Information Sheet* (page 4).

- Only physicians and nurse practitioners can submit a TRS Request for Prior Approval. The physician or nurse practitioner submitting this request must:
  i. complete *Clinical Eligibility for TRS* (pages 5-7);
  ii. include a copy of the surgical readiness assessment(s) and the Surgical Readiness Assessor Certification and Recommendation form(s); and
  iii. submit the completed application to the Assistant Medical Director at the Department of Health and Community Services (HCS);

For genital surgery, a second practitioner who also meets the requirements set out in the *Surgical Readiness Assessor Certification and Recommendation* form must provide a second surgical readiness assessment along with the *Surgical Readiness Assessor Certification and Recommendation* form. (Two surgical readiness assessment letters are required for all TRS genital surgeries).

- Physicians, nurse practitioners, psychologists, nurses, and social workers with the indicated WPATH competencies (see *Surgical Readiness Assessor Certification and Recommendation* form) may provide surgical readiness assessments. All health professionals providing a surgical readiness assessment for TRS patients must:
  i. complete the *Surgical Readiness Assessor Certification and Recommendation* form and submit it to the physician or nurse practitioner completing the TRS Request for Prior Approval.
  ii. provide a copy of the surgical readiness assessment to the physician or nurse practitioner completing the TRS Request for Prior Approval.

  Appendix A contains the recommended content for TRS surgical readiness assessments.

- The physician or nurse practitioner submitting the request for prior approval may also act as one of the surgical readiness assessors provided they: 1) have the minimum required credentials (see *Surgical Readiness Assessor Certification and Recommendation* form), 2) produce a surgical readiness assessment letter and 3) provide a signature on the *Surgical Readiness Assessor Certification and Recommendation* form.

- A list of health care professionals in the province with the minimum WPATH credentials for performing surgical readiness assessments is available at www.health.gov.nl.ca/health/mcp/pdf/TRS_SRA_NL.pdf.

- The Assistant Medical Director will notify the physician or nurse practitioner in writing of the outcome of the TRS Request for Prior Approval. The Assistant Medical Director will not notify the patient.

Transition-Related Surgery
Request for Prior Approval

Patient Information Sheet
To be completed by the patient.

Name (as it appears on your MCP Card): _____

Name to be used for correspondence: _____
(If different from that which appears on your MCP card)

MCP Number: _____ MCP Expiry Date: _____

Address: _____

_____ Postal Code: _____

Phone Number: _____ Date of Birth (y/m/d):_____ Age:_____

Complete Patient Declaration

- A health care professional has explained the risks and complications associated with the proposed TRS procedure. **Yes / No**

- I understand that MCP covers the insured TRS procedures listed in Appendix B (List of Insured Transition-Related Surgeries) when they are provided within Canada at publically funded facilities. When insured TRS procedures are not available within Canada at publically funded facilities, prior approval may be granted for procedures performed at an approved private facility in Canada. **Yes / No**

- I understand there is no MCP funding for:
  - TRS services received without prior approval from MCP. **Yes / No**
  - TRS procedures not listed in Appendix B including facial feminization, liposuction, tracheal shave, voice pitch surgery and cosmetic surgical revisions. **Yes / No**
  - Any services which are not insured by MCP. **Yes / No**

****

Patient - Certification and consent

- I understand that I am personally responsible for the payment of any services which are not insured by MCP.
- 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: _____

Transition-Related Surgery
Request for Prior Approval

Clinical Eligibility for TRS
To be completed by a physician or nurse practitioner

1. Patient Name (as it appears on the MCP card): _____

MCP: _____

2. Physician or Nurse Practitioner Contact Information:

Name: _____

Provider ID # (if applicable) _____

Address: _____

Phone Number: (____) _____ Fax Number: (___) _____

4. Referring Physician or Nurse Practitioner Professional Declaration:

PRIMARY CLINICAL CRITERIA

I have verified that the patient has:

- Persistent, well-documented gender dysphoria. **Yes / No**
- Capacity to make a fully informed decision and to consent for treatment: **Yes / No**
  - Understands the procedure(s); **Yes / No**
  - Understands the associated risk(s) and complications. **Yes / No**
- Reasonably well-controlled medical or mental health concerns, if present. **Yes / No**
- Has an aftercare / follow-up plan **Yes / No**

SPECIFIC CLINICAL CRITERIA

Breast or Chest Surgery (mastectomy with chest masculinization, breast augmentation). Requires one surgical readiness assessment completed by a mental health professional who has also completed the attached Surgical Readiness Assessor Certification and Recommendation form.

- For breast augmentation, breast aplasia (no breast development) after 12 continuous months of hormone Therapy. **Yes / No / NA**

Genital Surgery: Hysterectomy, Salpingo-oophorectomy, Orchiectomy. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated). **Yes / No / NA**

Genital Reconstructive Surgery: Metoidioplasty, Phalloplasty, Vaginoplasty. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated) **and** 12 continuous months of living in a gender expression that is congruent with their gender identity. **Yes / No / NA**

Transition-Related Surgery
Request for Prior Approval

Patient MCP: _____

ADDITIONAL CLINICAL CRITERIA

- The patient is physically healthy. **Yes / No**
- There are physical health problems that may 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. **Yes / No**
- The gender identity of the individual has remained stable over time. **Yes / No**
- The patient has regular visits with a health care provider. **Yes / No**

5. Please use the space provided below to include any additional information which you may consider relevant to this Request for Prior Approval. For example, you may wish to offer further details on the patient's experience of gender dysphoria or transition, on expectations for surgery, coping strategies, living situation or housing, etc.

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

_____

(Please see list of insured TRS procedures, Appendix B)

7. Proposed facility and surgeon for which prior approval is requested:

_____

8. Referring Physician / Nurse Practitioner Declaration

- I have verified that the patient is a permanent resident of Newfoundland and Labrador and possesses a valid MCP card. **Yes / No**
- I have enclosed:
  - The Patient Information Sheet (completed and signed by the patient). **Yes / No**
  - One surgical readiness assessment and a signed Surgical Readiness Assessor Certification and Recommendation form (for patients recommended for breast or chest surgery). **Yes/No/NA**
  - Two surgical readiness assessments and two signed Surgical Readiness Assessor Certification and Recommendation forms (for patients recommended for genital surgery). **Yes / No/ NA**

9. Certification and Recommendation signature

- I certify that the information given on this form is complete and accurate.
- I recommend this client for Transition-Related Surgery.

Patient's Name (as it appears on the MCP card):_____

Patient's MCP_____

Name of Physician or Nurse Practitioner: _____

Physician/Nurse Practitioner Signature: _____ Date: _____

All information is collected under the authority of Part IV of the *Personal Health Information Act* for the purposes of approving transition-related surgery. For questions on how your information shall be collected, used and disclosed, please contact the Manager of Privacy and Information Security at 709-729-7010.

Transition-Related Surgery
Request for Prior Approval

Surgical Readiness Assessor Certification and Recommendation

I certify that I meet the following 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 behavioural science field. The degree, or a more advanced one, must be granted by an institution accredited by the appropriate national or regional accrediting board. The Mental Health Professional must have documented credentials from a relevant licensing board or equivalent.
2. Competency in using the *Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases* for diagnostic purposes.
3. The ability to recognize and diagnose/assess coexisting mental health concerns and to distinguish these from gender dysphoria.
4. Documented, supervised training and competence in psychotherapy or counseling.
5. Knowledge about gender-nonconforming identities and expression, 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.

WPATH, Standard of Care, V.7

Patient Name (as it appears on the MCP card): _____

Patient's MCP number: _____

I recommend this client for Transition-Related Surgery.
I certify that the information given on this form is complete and accurate.

Name (please Print)

_____

Professional Designation :_____

Signature: _____ Date: _____

APPENDIX A:

WPATH Recommended Content of the Surgical Readiness Assessment

The WPATH recommended content of the surgical readiness assessment 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 counselling 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.

APPENDIX B:

The insured TRS services below are funded by the province's provincial health insurance plans when a TRS Request for Prior Approval document is completed and approved before the procedure takes place.

Breast or Chest Surgery:

- Breast augmentation when there is breast aplasia (no breast development) after 12 continuous months of hormone therapy.
- Mastectomy with chest masculinization (excluding implants and liposuction, which are not covered).

Genital Surgery:

- Hysterectomy
- Orchiectomy
- Salpingo-oophorectomy

Genital Reconstruction:

- Vaginoplasty (includes orchiectomy, penectomy, labiaplasty, clitoroplasty; with or without construction of the vaginal cavity)
- Metoidioplasty
- Phalloplasty (includes urethroplasty, scrotoplasty, vaginectomy, and insertion of testicular and approved penile implants)

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